Light plans

PLANS FOR FEWER HEALTH NEEDS		BCN ADVANTAGE HMO-POS Prime Value	MEDICARE PLUS BLUE PPO Essential	BCN ADVANTAGE HMO-POS Elements	BCN ADVANTAGE HMO-POS Community Value
2021 Monthly Premium	Region 1	$0	$0	$8	$20 Premium For residents of: Genesee, St. Clair, Livingston, Macomb, Oakland, Wayne, Washtenaw counties
	Region 2	$0	$0	$23.20	
	Region 3	$0	$10	$33.80	
	Region 4	$0	$0	$25	
	Regions 5/6	$0	$0	$30	
In-network Medical Deductible		$0 Regions 1 / 2 / 4 / 5 / 6 $280 Region 3	$0	$160	$0
Primary Care Office Visit Copay		$0	$0	$0	$0
Specialist Copay		$45	$45	$40	$35
Inpatient Hospital Copay (Days 1-6)		$325	$325	$205	$300
Maximum Out-of-Pocket (MOOP) In-network		$4,500	$6,000	$4,500	$4,500
Over-the-Counter Allowance (No carry-over)		$75 per quarter Regions 1 / 2 / 5 / 6 Region 4: $25 per quarter Region 3: No OTC	$50 per quarter	$25 per quarter	$100 per quarter
Emergency Care Copay		$90	$90	$90	$90
Urgent Care Copay		$0-$45	$0-$50	$0-$45	$45
Dental Services					
Two Oral Exams		$0 copay	$0 copay	$0 copay	Comprehensive dental benefits include a $2,000 annual maximum. $0 copay
Two Cleanings		$0 copay	$0 copay	$0 copay	$0 copay
X-Rays		$0 copay	$0 copay	$0 copay	$0 copay
Vision Services					
Routine Eye Exam		$0	$10	$0	$0
Lenses		Covered in full once/year	Covered in full once/year	Not covered	Covered in full once/year
Frames or Contacts		$100 combined maximum allowance every 12 months for either elective contact lenses or frames.	$100 combined maximum allowance every 12 months for either elective contact lenses or frames.	Not covered	$150 combined maximum allowance every 12 months for either elective contact lenses or frames.
Hearing Services					
Routine Hearing Exam		$0-$45	$0-$45	$0-$40	$0-$35
Hearing Aids		Up to $600 allowance per ear every 3 years	Up to $750 allowance per ear every 3 years	Up to $600 allowance per ear every 3 years	Up to $750 allowance per ear every 3 years
Prescription Drug Deductible		$0 on tiers 1, 2, 6 $50 on tiers 3, 4, 5	$0 on tiers 1, 2, 6 $100 on tiers 3, 4, 5	No Prescription Drug Coverage	$0 on all tiers
Preferred pharmacy network copays / coinsurance					
Prescription drug tiers					
Tier 1 preferred generic		Tier 1: $3	Tier 1: $2	Not Covered	Tier 1: $0
Tier 2 generic		Tier 2: $11	Tier 2: $11		Tier 2: $10
Tier 3 preferred brand		Tier 3: $42	Tier 3: $42		Tier 3: $45
Tier 4 non-preferred drug		Tier 4: 50%	Tier 4: 50%		Tier 4: 50%
Tier 5 specialty tier		Tier 5: 32%	Tier 5: 31%		Tier 5: 33%
Tier 6 select care drugs		Tier 6: $0	Tier 6: $0		Tier 6: N/A

A complete listing of preferred pharmacies can be found at **www.bcbsm.com/pharmaciesmedicare**