2018 Benefits-at-a-Glance for BCN Advantage State of Michigan

To join BCN Advantage℠ HMO-POS, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits and copayments/coinsurance may change on January 1 of each year. You can contact the plan by calling Customer Service at 1-800-450-3680, 8 a.m. to 8 p.m., Monday through Friday, with weekend hours Oct. 1 through Feb. 14. TTY users should call 711. You can always view your most current *Evidence of Coverage* and riders by signing into Member Secured Services at **www.bcbsm.com/medicare** or by requesting them from Customer Service.

Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible and/or copay amounts required by the plan. Services must be provided or arranged by the member's primary care physician or health plan. The formulary, provider network, and/or pharmacy network may change at any time. You will receive notice when necessary.

Deductible, Copays and Dollar Maximums	
Deductible	$125 per calendar year
Copays • Fixed Dollar Copay	$20 office visits, $20 urgent care, $65 emergency room visits
• Percent Copay	None
Copay Dollar Maximums	
• Fixed Dollar Copay	None
• Fixed Dollar and Percent Copay (Maximum-out-of-Pocket)	Medical - $500
Dollar Maximums	None
Preventive Services	
Health Maintenance Exam	Covered – 100%
Annual Gynecological Exam	Covered – 100%
Pap Smear Screening – laboratory services only	Covered – 100%
Immunizations	Covered – 100%
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 100%
Mammography Screening	Covered – 100%
Physician Office Services	
Office Visits	Covered – $20
Consulting Specialist Care – when referred	Covered – $20 after deductible

Emergency Medical Care	
Hospital Emergency Room – copay waived if admitted, inpatient hospital benefits apply	Covered – $65 after deductible
Urgent Care Center	Covered – $20
Ambulance Services – medically necessary	Covered – 100% after deductible, ground and air service
Diagnostic Services	
Laboratory and Pathology Tests	Covered – 100%, office visit copay may apply per member, per visit
Diagnostic Tests and X-rays	Covered – 100% after deductible, office visit copay may apply per member, per visit
High Technology Imaging (includes MRI, MRA, CAT, PET)	Covered-– 100% after deductible
Radiation Therapy	Covered – 100% after deductible, office visit copay may apply per member, per visit
Hospital Care	
Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered –100% after deductible, unlimited days
Outpatient Surgery	Covered – 100% after deductible
Alternatives to Hospital Care	
Skilled Nursing Care	Covered – 100% after deductible, unlimited days
Home Health Care	Covered – 100% after deductible. Doctor visit $20 copay after deductible.
Surgical Services	
Surgery – includes all related surgical services and anesthesia	Covered – 100% after deductible
Human Organ Transplants	Covered – 100% after deductible; subject to medical criteria
Mental Health Care and Substance Abuse Treatment	
Inpatient Mental Health Care and Substance Abuse Care	**Mental Health Care**: Covered – 100%, unlimited days Prior authorization required. **Substance Abuse Care:** Covered – 100%, unlimited days
Outpatient Mental Health Care	Covered – 100%, unlimited visits
Outpatient Substance Abuse Care	Covered – 100%, unlimited visits
Other Services	
Allergy Testing and Therapy	Covered – 100% after deductible, office visit copay may apply per member, per visit
Allergy Injections	Covered – 100%, office visit copay may apply per member, per visit
Chiropractic Spinal Manipulation – when referred	Covered – $20 after deductible
Outpatient Physical, Speech and Occupational Therapy	Covered – $20 after deductible
Durable Medical Equipment	Covered – 100%
Prosthetic and Orthotic Appliances	Covered – 100%
Hearing	Covered – One hearing exam and binaural hearing aids every 36 months

Other Services cont'd	
SilverSneakers® fitness benefit Benefits including: A fitness center membership at any participating location across the country • Conditioning classes, exercise equipment, pool, sauna and other available amenities • Customized SilverSneakers classes and seminars	$0 copay for fitness services. Fitness services must be provided at SilverSneakers participating locations. You can find a location or request SilverSneakers Steps information at www.silversneakers.com or 1-866-584-7352, Monday – Friday, 8 a.m. to 8 p.m. TTY users call 711.
Prescription Drugs	
Formulary Drug – Tier 1 - Preferred Generic	Covered – $10 copay up to a 31-day supply
Formulary Drug – Tier 2 - Generic	Covered – $10 copay up to a 31-day supply
Formulary Drug – Tier 3 - Preferred Brand Name	Covered – $30 copay up to a 31-day supply
Formulary Drug – Tier 4 - Non-Preferred Drugs	Covered – $60 copay up to a 31-day supply
Formulary Drug – Tier 5 - Specialty Drugs	Covered – $60 copay up to a 31-day supply
Mail Order Prescription Drugs	Covered – Two times the applicable generic and brand copay for a 32-day to a 90-day supply
Drugs for the Treatment of Sexual Dysfunction	Covered – 50% coinsurance
Part D- Maximum out of pocket coverage	Once member's out-of pocket costs reach over $5,000, the copay is **the greater of** 5% or $3.35 generics and $8.35 brands, not to exceed base copay.