BCN Advantage℠ HMO-POS

Elements, Basic, Classic, Prestige

2019

Summary of Benefits

January 1, 2019 — December 31, 2019

This is a summary document, to get a complete list of services we cover, call Customer Service and ask for the *Evidence of Coverage* (phone numbers are printed on the back cover of this booklet).

BCN Advantage is a Health Maintenance Organization with a Point-of-Service (POS) option. To join **BCN Advantage HMO-POS Elements, Basic, Classic or Prestige**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes these counties in Michigan: Alcona, Allegan, Alpena, Antrim, Arenac, Barry, Bay, Benzie, Berrien, Branch, Calhoun, Charlevoix, Cheboygan, Clare, Clinton, Crawford, Eaton, Emmet, Genesee, Gladwin, Grand Traverse, Gratiot, Hillsdale, Huron, Ingham, Ionia, Iosco, Isabella, Jackson, Kalamazoo, Kalkaska, Kent, Lake, Lapeer, Leelanau, Lenawee, Livingston, Luce, Mackinac, Macomb, Manistee, Mason, Mecosta, Midland, Missaukee, Monroe, Montcalm, Montmorency, Muskegon, Newaygo, Oakland, Oceana, Ogemaw, Osceola, Oscoda, Otsego, Ottawa, Presque Isle, Roscommon, Saginaw, Sanilac, Schoolcraft, Shiawassee, St. Clair, St. Joseph, Tuscola, Van Buren, Washtenaw, Wayne and Wexford.

This information is not a complete description of benefits. Call 1-800-450-3680 for more information. TTY users call 711.

BCN Advantage HMO-POS has a network of doctors, hospitals, and other providers. If you use the providers that are not in our network, the plan may not pay for these services. For some services you can use providers that are not in our network. You can see our plan's provider directory at our website at **www.bcbsm.com/providersmedicare**, or call us and we will send you a copy of the provider directory.

BCN Advantage is an HMO-POS plan with a Medicare contract. Enrollment in BCN Advantage depends on contract renewal.

www.bcbsm.com/medicare

Premium/Cost-sharing Table for BCN Advantage HMO-POS

Premiums vary by county in which you permanently reside (rates are based on the use and cost of health care services in each regional segment). You must continue to pay your Medicare Part B premium.

1) Find the county and region that you live in.

2) Look across the plan option columns to find your monthly premium rate.

Regions with counties	BCN Advantage premium rates per month			
	Elements	Basic	Classic	Prestige
Region 1 Allegan, Barry, Ionia, Kalamazoo, Kent, Mason, Muskegon, Newaygo, Oceana, and Ottawa counties	$10	$0	$78.40	$180
Region 2 Berrien, Branch, Calhoun, Eaton, Gratiot, Hillsdale, Ingham, Jackson, Monroe, Montcalm, St. Joseph, and Van Buren counties	$48	$0	$110.40	$287
Region 3 Alcona, Alpena, Arenac, Bay, Charlevoix, Cheboygan, Clare, Crawford, Gladwin, Huron, Iosco, Kalkaska, Luce, Mackinac, Montmorency, Ogemaw, Oscoda, Presque Isle, Roscommon, Saginaw, Sanilac, Schoolcraft, Shiawassee, and Tuscola	$53	$0	$122.40	$282
Region 4 Antrim, Benzie, Clinton, Emmet, Genesee, Grand Traverse, Isabella, Lake, Lapeer, Leelanau, Lenawee, Livingston, Manistee, Mecosta, Midland, Missaukee, Osceola, Otsego, St. Clair, and Wexford counties	$25	$0	$102.40	$259
Region 5 - Macomb, Oakland, Washtenaw, and Wayne counties	$49	$0	$127.40	$282
Optional Supplemental Dental, Hearing and Vision package 1	$21.50			
Optional Supplemental Dental, Hearing and Vision package 2	$32.50			

Benefits	Elements	Basic	Classic	Prestige	What you should know
Deductible	**In-network:** $160 annually **Point-of-service:** $200 annually	**In-network:** $290 annually **Point-of-service:** $200 annually **Prescription drugs:** $405 annually for Part D (applies to Tiers 2, 3, 4 and 5).	**In-network:** $125 annually **Point-of-service:** $200 annually This plan does not have a deductible for Part D prescription drugs.	**In-network:** $0 annually **Point-of-service:** $200 annually This plan does not have a deductible for Part D prescription drugs.	
Deductible – Optional supplemental Dental, Hearing and Vision Package 1	There is no deductible.				
Deductible – Optional supplemental Dental, Hearing and Vision Package 2	There is no deductible.				

Benefits	Elements	Basic	Classic	Prestige	What you should know
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	$4,500 annually	$4,500 annually	$3,800 annually	$3,800 annually	The most you pay for copays, coinsurance and other costs for medical services for the year. **Elements:** Please note that you will still need to pay your monthly premiums. **Basic, Classic, and Prestige:** Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Note: Your primary care provider (PCP) is the best resource for coordinating your care and can help you find an in-network specialist. However, BCN Advantage doesn't require a referral for you to make an appointment with an in-network specialist. Some in-network specialists may still need to confirm with your PCP that you need specialty care.					

Benefits	Elements	Basic	Classic	Prestige	What you should know
Note: Services with a * may require prior authorization, or a referral. For more information on referrals, see page 3.					
Inpatient Hospital Coverage*	The copays are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care for 60 days in a row. Our plan covers an unlimited number of days for an inpatient hospital stay.				See Page 24 for more about your point-of-service travel benefit. If you go to out-of-network providers you pay the full cost.
	In-network: $205 copay per day for days 1 through 6 $0 per day for days 7 through 90 $0 per day for days 91 and beyond **Point-of-service:** $205 copay per day for days 1 through 6 $0 per day for days 7 through 90	**In-network:** $285 copay per day for days 1 through 6 $0 per day for days 7 through 90 $0 per day for days 91 and beyond **Point-of-service:** $285 copay per day for days 1 through 6 $0 per day for days 7 through 90	**In-network:** $225 copay per day for days 1 through 6 $0 per day for days 7 through 90 $0 per day for days 91 and beyond **Point-of-service:** $225 copay per day for days 1 through 6 $0 per day for days 7 through 90	**In-network:** $125 copay per day for days 1 through 6 $0 per day for days 7 through 90 $0 per day for days 91 and beyond **Point-of-service:** $125 copay per day for days 1 through 6 $0 per day for days 7 through 90	
Outpatient Hospital Coverage o Ambulatory surgical center	**In-network:** $100 copay **Point-of-service:** $100 copay	**In-network:** $100 copay **Point-of-service:** $100 copay	**In-network:** $95 copay **Point-of-service:** $95 copay	**In-network:** $70 copay **Point-of-service:** $70 copay	See Page 24 for more about your point-of-service travel benefit.
o Outpatient hospital	**In-network:** $175 copay **Point-of-service:** $175 copay	**In-network:** $175 copay **Point-of-service:** $175 copay	**In-network:** $175 copay **Point-of-service:** $175 copay	**In-network:** $175 copay **Point-of-service:** $175 copay	

Benefits	Elements	Basic	Classic	Prestige	What you should know
Doctor Visits					See Page 24 for more about your point-of-service travel benefit. If you go to out-of-network providers you pay the full cost. Specialist services may require referral.
o Primary	**In-network:** $20 copay **Point-of-service:** $40 copay	**In-network:** $15 copay **Point-of-service:** $45 copay	**In-network:** $15 copay **Point-of-service:** $35 copay	**In-network:** $10 copay **Point-of-service:** $30 copay	
o Specialists	**In-network:** $40 copay **Point-of-service:** $40 copay	**In-network:** $45 copay **Point-of-service:** $45 copay	**In-network:** $35 copay **Point-of-service:** $35 copay	**In-network:** $30 copay **Point-of-service:** $30 copay	
Preventive Care	• In-network: You pay nothing. Our plan covers many preventive services, including:				
	• Abdominal aortic aneurysm screening • Alcohol misuse screening and counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Flexible sigmoidoscopy, Guaiac-based fecal occult blood test, Fecal immunochemical test, DNA based colorectal screening every 3 years) • Depression screening • Diabetes screenings • Glaucoma screening • HIV screening			• Intensive behavioral therapy for obesity • Medical nutrition therapy services • Medicare Diabetes Prevention Program • Prostate cancer screenings (PSA) • Screening for lung cancer with low dose computed tomography • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • “Welcome to Medicare” preventive visit (one-time) • Yearly “Wellness” visit	
	Any additional preventive services approved by Medicare during the contract year will be covered.				

Benefits	Elements	Basic	Classic	Prestige	What you should know
Emergency Care	$90 copay	$90 copay	$90 copay	$90 copay	If you are admitted to the hospital within 1 day, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs. *There is a $50,000 lifetime plan coverage limit for emergency services outside the U.S. and its territories.*
Urgently Needed Services	$45 copay	$45 copay	$40 copay	$35 copay	
Diagnostic Services/Labs/ Imaging*					Only high-tech X-rays require preauthorization.
o Diagnostic tests and procedures	**In-network:** $20 copay **Point-of-service:** $20 copay	**In-network:** $20 copay **Point-of-service:** $20 copay	**In-network:** $20 copay, **Point-of-service:** $20 copay	**In-network:** $10 copay **Point-of-service:** $10 copay	Diagnostic tests and procedures include screenings, such as EKG, ultrasound and PET imaging.
o Lab services	**In-network:** You pay nothing **Point-of-service:** You pay nothing	**In-network:** You pay nothing **Point-of-service:** You pay nothing	**In-network:** You pay nothing **Point-of-service:** You pay nothing	**In-network:** You pay nothing **Point-of-service:** You pay nothing	See Page 24 for more about your point-of-service travel benefit. If you go to out-of-network providers you pay the full cost.

Benefits	Elements	Basic	Classic	Prestige	What you should know
o Diagnostic radiology service (e.g., MRI)	**In-network:** $20 – $100 copay, depending on the service **Point-of-service:** $20 – $100 copay, depending on the service	**In-network:** $20 – $100 copay, depending on the service **Point-of-service:** $20 – $100 copay, depending on the service	**In-network:** $20 – $75 copay, depending on the service **Point-of-service:** $20 – $75 copay, depending on the service	**On-network:** $10 – $50 copay, depending on the service **Point-of-service:** $10 – $50 copay, depending on the service	
o Outpatient X-rays	**In-network:** $20 – $100 copay, depending on the service **Point-of-service:** $20 – $100 copay, depending on the service	**In-network:** $20 – $100 copay, depending on the service **Point-of-service:** $20 – $100 copay, depending on the service	**In-network:** $20 – $75 copay, depending on the service **Point-of-service:** $20 – $75 copay, depending on the service	**In-network:** $10 – $50 copay, depending on the service **Point-of-service:** $10 – $50 copay, depending on the service	
o Therapeutic radiology services	**In-network:** $25 copay **Point-of-service:** $25 copay	**In-network:** $25 copay **Point-of-service:** $25 copay	**In-network:** $15 copay **Point-of-service:** $15 copay	**In-network:** $0 copay **Point-of-service:** $0 copay	
Hearing Services					See Page 24 for more about your point-of-service travel benefit. If you go to out-of-network providers you pay the full cost.
o Hearing exam to diagnose and treat hearing and balance issues	**In-network:** $20 – $40 copay, depending on the service **Point-of-service:** $40 copay, depending on the service	**In-network:** $15 – $45 copay, depending on the service **Point-of-service:** $45 copay, depending on the service	**In-network:** $15 – $35 copay, depending on the service **Point-of-service:** $35 copay, depending on the service	**In-network:** $10 – $30 copay, depending on the service **Point-of-service:** $30 copay, depending on the service	

Benefits	Elements	Basic	Classic	Prestige	What you should know
Hearing – Optional Supplemental Benefit – Package 1	*Hearing Aid Fitting Exams: 0% coinsurance, every three years* *Hearing Aids: 50% coinsurance up to a $1,200 ($600 per ear) allowance, every 3 years.*				
Hearing – Optional Supplemental Benefit – Package 2	*Hearing Aid Fitting Exams: 0% coinsurance, every three years* *Hearing Aids: 50% coinsurance up to a $2,500 ($1,250 per ear) allowance, every 3 years.*				
Dental Services **Limited dental services** (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth)	**In-network:** $20 – $175 copay, depending on the service **Point-of-service:** $40 – $175 copay, depending on the service	**In-network:** $15 – $175 copay, depending on the service **Point-of-service:** $45 – $175 copay, depending on the service	**In-network:** $15 – $175 copay, depending on the service **Point-of-service:** $35 – $175 copay, depending on the service	**In-network:** $10 – $175 copay, depending on the service **Point-of-service:** $30 – $175 copay, depending on the service	See Page 24 for more about your point-of-service travel benefit. If you go to out-of-network providers you pay the full cost. For preventive dental services, you must obtain services from a participating dentist. Please visit www.mibluedentist.com and search for PPO dentists in the BCN Advantage network or contact Customer Service.
Preventive dental services o Cleaning (for up to 2 every year)	**In-network:** You pay nothing				
o Dental X-rays (one set of up to four bitewing X-rays, or one set of up to six periapical films every two years)	**In-network:** You pay nothing				
o Oral exam (for up to 2 every year)	**In-network:** You pay nothing				
Dental – Optional Supplemental Benefit – Package 1	Comprehensive Dental: $1,500 combined maximum dental allowance for in-network and out-of-network services per calendar year.				
Dental – Optional Supplemental Benefit – Package 2	Comprehensive Dental: $2,500 combined maximum dental allowance for in-network and out-of-network services per calendar year.				

Benefits	Elements	Basic	Classic	Prestige	What you should know
Vision Services					See Page 24 for more about your point-of-service travel benefit. If you go to out-of-network providers you pay the full cost. Routine vision care must be from a VSP Choice Network provider. To locate a VSP Choice Network provider, call the Customer Service number on the back of this booklet or visit **www.vsp.com**. Authorization rules may apply.
o Exam to diagnose and treat diseases and conditions of the eye	**In-network:** $40 copay **Point-of-service:** $40 copay	**In-network:** $45 copay **Point-of-service:** $45 copay	**In-network:** $35 copay **Point-of-service:** $35 copay	**In-network:** $30 copay **Point-of-service:** $30 copay	
o Eyeglasses or contact lenses after cataract surgery	**In-network:** You pay nothing	**In-network:** You pay nothing	**In-network:** You pay nothing	**In-network:** You pay nothing	
o Routine eye exam	**In-network:** You pay nothing for up to one routine eye exam every year.	**In-network:** You pay nothing for up to one routine eye exam every year.	**In-network:** You pay nothing for up to one routine eye exam every year.	**In-network:** You pay nothing for up to one routine eye exam every year.	
o Elective contact lenses every 24 months.	This is not a covered benefit.	This is not a covered benefit.	$0 copay. Our plan has an allowance of $100 for frames or elective contact lenses every 24 months from an in-network provider.	$0 copay. Our plan has an allowance of $100 for frames or elective contact lenses every 24 months from an in-network provider.	
o Eyeglasses (frames and lenses), eyeglass frames or eyeglass lenses for up to 1 every 24 months.	This is not a covered benefit.	This is not a covered benefit.	or $0 copay. Our plan pays up to $100 every 24 months for eyeglass frames from an in-network provider.	or $0 copay. Our plan pays up to $100 every 24 months for eyeglass frames from an in-network provider.	

Benefits	Elements	Basic	Classic	Prestige	What you should know
Vision – Optional Supplemental Benefit – Package 1	**In-network Eyewear**				
	$300 maximum combined vision allowance for (a) glasses (lenses & frames) or (b) contact lenses (but not both) every 24 months.		$300 maximum combined allowance for (a) frames or (b) contact lenses (but not both) every 24 months. Lenses for glasses are covered in full every 24 months.		
	Out-of-network Eyewear				
	A combined allowance of $300 that can be used for glasses (lenses & frames) or contact lenses (but not both) every 24 months. Exam reimbursed up to a pre-determined amount.		Lenses for glasses are reimbursed at predetermined amounts. A combined allowance of $300 that can be used for frames or contact lenses (but not both) every 24 months. Exam reimbursed up to a pre-determined amount.		
Vision – Optional Supplemental Benefit – Package 2	**In-network Eyewear**				
	$400 maximum combined vision allowance for (a) glasses (lenses & frames) or (b) contact lenses (but not both) every 24 months.		$400 maximum combined allowance for either a) elective contact lenses or b) frames (but not both) every 24 months. Lenses for glasses are covered in full every 24 months.		
	Out-of-network Eyewear				
	A combined allowance of $400 that can be used for glasses (lenses & frames) or contact lenses (but not both) every 24 months. Exam reimbursed up to a pre-determined amount.		Lenses for glasses are reimbursed at predetermined amounts. A combined allowance of $400 that can be used for frames or contact lenses (but not both) every 24 months. Exam reimbursed up to a pre-determined amount.		

Benefits	Elements	Basic	Classic	Prestige	What you should know
Mental Health Services*	Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a general hospital. The copays are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care for 60 days in a row. If you go into a hospital after one benefit period has ended, a new benefit period begins. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.				Authorization rules may apply. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
o Inpatient visit	**In-network:** $205 copay per day for days 1 through 6 You pay nothing per day for days 7 through 90 **Point-of-service:** $205 copay per day for days 1 through 6 You pay nothing per day for days 7 through 90	**In-network:** $260 copay per day for days 1 through 6 You pay nothing per day for days 7 through 90 **Point-of-service:** $260 copay per day for days 1 through 6 You pay nothing per day for days 7 through 90	**In-network:** $225 copay per day for days 1 through 6 You pay nothing per day for days 7 through 90 **Point-of-service:** $225 copay per day for days 1 through 6 You pay nothing per day for days 7 through 90	**In-network:** $125 copay per day for days 1 through 6 You pay nothing per day for days 7 through 90 **Point-of-service:** $125 copay per day for days 1 through 6 You pay nothing per day for days 7 through 90	
o Outpatient group therapy visit	**In-network:** $40 copay **Point-of-service:** $40 copay	**In-network:** $40 copay **Point-of-service:** $40 copay	**In-network:** $35 copay **Point-of-service:** $35 copay	**In-network:** $30 copay **Point-of-service:** $30 copay	

Benefits	Elements	Basic	Classic	Prestige	What you should know
o Outpatient individual therapy visit	**In-network:** $40 copay **Point-of-service:** $40 copay	**In-network:** $40 copay **Point-of-service:** $40 copay	**In-network:** $35 copay **Point-of-service:** $35 copay	**In-network:** $30 copay **Point-of-service:** $30 copay	
Skilled Nursing Facility (SNF)*	**In-network:** Days 1 – 20: You pay nothing Days 21 – 100: $172 copay per day **Point-of-service:** Days 1 – 20: You pay nothing Days 21 – 100: $172 copay per day	**In-network:** Days 1 – 20: You pay nothing Days 21 – 100: $160 copay per day **Point-of-service:** Days 1 – 20: You pay nothing Days 21 – 100: $160 copay per day	**In-network:** Days 1 – 20: You pay nothing Days 21 – 100: $172 copay per day **Point-of-service:** Days 1 – 20: You pay nothing Days 21 – 100: $172 copay per day	**In-network:** Days 1 – 20: You pay nothing Days 21 – 100: $150 copay per day **Point-of-service:** Days 1 – 20: You pay nothing Days 21 – 100: $150 copay per day	Our plan covers up to 100 days in a SNF. See Page 24 for more about your point-of-service travel benefit. If you go to out-of-network providers you pay the full cost.
Physical Therapy o Physical therapy, occupational therapy, and speech and language therapy visit	**In-network:** $30 copay **Point-of-service:** $30 copay	**In-network:** $30 copay **Point-of-service:** $30 copay	**In-network:** $30 copay **Point-of-service:** $30 copay	**In-network:** $15 copay **Point-of-service:** $15 copay	
Ambulance	**In-network:** $200 copay **Point-of-service:** $200 copay				See Page 24 for more about your point-of-service travel benefit. If you go to out-of-network providers you pay the full cost.
Transportation	Not Offered	Not Offered	Not Offered	Not Offered	

Benefits	Elements	Basic	Classic	Prestige	What you should know
Medicare Part B Drugs*					Authorization rules and/or step therapy may apply.
o Part B drugs such as chemotherapy and home infusion drugs	**In-network:** 0% – 20% of the cost depending on the drug **Point-of-service:** 0% – 20% of the cost depending on the drug	**In-network:** 0% – 20% of the cost depending on the drug **Point-of-service:** 0% – 20% of the cost depending on the drug	**In-network:** 0% – 20% of the cost depending on the drug **Point-of-service:** 0% – 20% of the cost depending on the drug	**In-network:** 0% – 20% of the cost depending on the drug. **Point-of-service:** 0% – 20% of the cost depending on the drug	
o Other Part B drugs	**In-network:** 0% – 20% of the cost depending on the drug **Point-of-service:** 0% – 20% of the cost depending on the drug	**In-network:** 0% – 20% of the cost depending on the drug **Point-of-service:** 0% – 20% of the cost depending on the drug	**In-network:** 0% – 20% of the cost depending on the drug **Point-of-service:** 0% – 20% of the cost depending on the drug	**In-network:** 0% – 20% of the cost depending on the drug. **Point-of-service:** 0% – 20% of the cost depending on the drug	
Medical Equipment/ Supplies*					Authorization rules may apply. See Page 24 for more about your point-of-service travel benefit. If you go to out-of-network providers you pay the full cost.
o Durable Medical Equipment (e.g., wheelchairs, oxygen)	**In-network:** 20% of cost **Point-of-service:** 20% of cost	**In-network:** 20% of cost **Point-of-service:** 20% of cost	**In-network:** 20% of cost **Point-of-service:** 20% of cost	**In-network:** 20% of cost **Point-of-service:** 20% of cost	

Benefits	Elements	Basic	Classic	Prestige	What you should know
o Prosthetics (e.g., braces, artificial limbs)	**In-network:** 20% of cost **Point-of-service:** 20% of cost	**In-network:** 20% of cost **Point-of-service:** 20% of cost	**In-network:** 20% of cost **Point-of-service:** 20% of cost	**In-network:** 20% of cost **Point-of-service:** 20% of cost	Member must obtain diabetic supplies (except diabetic shoes) from BCN's supplier, J&B Medical Supply Company at 1-888-896-6233 from 8 a.m. to 5 p.m., Monday through Friday. TTY users call 711. Member must obtain diabetic shoes and inserts from BCN's DME supplier, Northwood at 1-800-667-4896, 8:30 a.m. to 5 p.m., Monday through Friday. TTY users call 711. When outside of the plan's service area, members must contact the appropriate vendor listed above. Prosthetics must be obtained from a preferred vendor. Contact us for a list of preferred vendors.
o Diabetes supplies (e.g., monitoring, shoes or inserts)	**In-network:** You pay nothing **Point-of-service:** You pay nothing	**In-network:** You pay nothing **Point-of-service:** You pay nothing	**In-network:** You pay nothing **Point-of-service:** You pay nothing	**In-network:** You pay nothing **Point-of-service:** You pay nothing	

Benefits	Elements	Basic	Classic	Prestige	What you should know
Wellness Programs (e.g., fitness)	All members can join the SilverSneakers® Fitness program at no additional cost. SilverSneakers is a leading fitness program for people with Medicare. • Locations nationwide • Low-impact classes to improve strength and balance • Health education events You must use network facilities to obtain this benefit. Tivity Health is an independent corporation retained by Blue Care Network to provide health and fitness services to its BCN Advantage members. Tivity Health and SilverSneakers are registered trademarks or trademarks of Tivity Health, Inc. and/or its subsidiaries and/or affiliates in the USA and/or other countries. © 2017 Tivity Health, Inc. All rights reserved.				
Chiropractic Care o Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position)	**In-network:** $20 copay **Point-of-service:** $20 copay	**In-network:** $20 copay **Point-of-service:** $20 copay	**In-network:** $20 copay **Point-of-service:** $20 copay	**In-network:** $20 copay. **Point-of-service:** $20 copay	Routine chiropractic visits give members coverage for one set of X-rays (up to 3 views) per year performed by a chiropractor. Cost share is the same as diagnostic X-rays.
o Routine care/other	**In-network:** $20 – $40 copay depending on the service **Point-of-service:** $20 – $40 copay, depending on the service.	**In-network:** $20 – $45 copay depending on the service **Point-of-service:** $20 – $45 copay, depending on the service.	**In-network:** $20 – $35 copay depending on the service **Point-of-service:** $20 – $35 copay, depending on the service.	**In-network:** $10 – $30 copay depending on the service **Point-of-service:** $10 – $30 copay depending on the service.	See Page 24 for more about your point-of-service travel benefit. If you go to out-of-network providers you pay the full cost.
Home Health Care	**In-network:** You pay nothing **Point-of-service:** You pay nothing	**In-network:** You pay nothing **Point-of-service:** You pay nothing	**In-network:** You pay nothing **Point-of-service:** You pay nothing	**In-network:** You pay nothing **Point-of-service:** You pay nothing	

Benefits	Elements	Basic	Classic	Prestige	What you should know
Hospice	You pay $0 for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details (phone numbers are on the back of this booklet).				
Online visits (remote access technology) Online visits give you the opportunity to meet with a health care provider through electronic forms of communication. This does not replace an in-person visit, but allows you to meet with a health care provider when it is not possible for you to meet with your doctor in the office.	$20 copay for medical or $40 copay for behavioral health.	$15 copay for medical or $40 copay for behavioral health.	$15 copay for medical or $35 copay for behavioral health.	$10 copay for medical or $30 copay for behavioral health.	
Outpatient Substance Abuse*					Authorization rules may apply.
o Group therapy visit	**In-network:** $40 copay **Point-of-service:** $40 copay	**In-network:** $45 copay **Point-of-service:** $45 copay	**In-network:** $35 copay **Point-of-service:** $35 copay	**In-network:** $30 copay **Point-of-service:** $30 copay	
o Individual therapy visit	**In-network:** $40 copay **Point-of-service:** $40 copay	**In-network:** $45 copay **Point-of-service:** $45 copay	**In-network:** $35 copay **Point-of-service:** $35 copay	**In-network:** $30 copay **Point-of-service:** $30 copay	
Renal dialysis	**In-network:** $20 copay **Point-of-service:** $20 copay	**In-network:** $30 copay **Point-of-service:** $30 copay	**In-network:** $30 copay **Point-of-service:** $30 copay	**In-network:** $20 copay **Point-of-service:** $20 copay	

Outpatient Prescription Drugs
This plan does not cover Part D prescription drugs.

Basic

Phase 1: The Deductible Stage

You pay $405 per year for Part D prescription drugs except for drugs listed on Tier 1 and Tier 6 which are excluded from the deductible.

Phase 2: The Initial Coverage Stage

After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $3,820. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

Your share of the cost when you get a *one-month* (31-day) supply of a covered Part D prescription drug:

	Standard retail and standard mail-order cost sharing (in-network)	Preferred retail and preferred mail-order cost sharing (in-network)
Tier 1: Preferred Generic	$9	$3
Tier 2: Generic	$20	$11
Tier 3: Preferred Brand	$47	$42
Tier 4: Non-Preferred Drug	50%	50%
Tier 5: Specialty	25%	25%
Tier 6: Select Care Drugs	$5	$0

Your share of the cost when you get a *long-term* (90-day) supply of a covered Part D prescription drug:

	Standard retail and standard mail-order cost sharing (in-network)	Preferred retail and preferred mail-order cost sharing (in-network)
Tier 1: Preferred Generic	$27	$9
Tier 2: Generic	$60	$33
Tier 3: Preferred Brand	$141	$126
Tier 4: Non-Preferred Drug	50%	50%
Tier 5: Specialty	Not offered	Not offered
Tier 6: Select Care Drugs	$15	$0

Cost sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please call us or access our *Evidence of Coverage* online at **www.bcbsm.com/medicare-evidence-of-coverage.**

Phase 3 & 4: The Coverage Gap & The Catastrophic Stages

Most members do not reach the Coverage Gap stage or the Catastrophic Coverage stage. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage* online at **www.bcbsm.com/medicare-evidence-of-coverage.**

*Your plan requires prior authorization and has step therapy and quantity limit restrictions for certain drugs. Please refer to your formulary to determine if your drugs are subject to any limitations. You can see the most complete and current information about which drugs are covered on our website (**www.bcbsm.com/formularymedicare**).*

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies. You can see our plan's pharmacy directory at our website (**www.bcbsm.com/pharmaciesmedicare**).

Classic

Phase 1: The Deductible Stage

You pay nothing.

Phase 2: The Initial Coverage Stage

You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. You stay in this stage until your year-to-date "total drug costs" (your payments plus any Part D plan's payments) total $3,820.

Your share of the cost when you get a *one-month* (31-day) supply of a covered Part D prescription drug:

	Standard retail and standard mail-order cost sharing (in-network)	Preferred retail and preferred mail-order cost sharing (in-network)
Tier 1: Preferred Generic	$6	$1
Tier 2: Generic	$12	$7
Tier 3: Preferred Brand	$43	$38
Tier 4: Non-Preferred Drug	45%	45%
Tier 5: Specialty	33%	33%
Tier 6: Select Care Drugs	$5	$0

Your share of the cost when you get a *long-term* (90-day) supply of a covered Part D prescription drug:

	Standard retail and standard mail-order cost sharing (in-network)	Preferred retail and preferred mail-order cost sharing (in-network)
Tier 1: Preferred Generic	$18	$3
Tier 2: Generic	$36	$21
Tier 3: Preferred Brand	$129	$114
Tier 4: Non-Preferred Drug	45%	45%
Tier 5: Specialty	Not offered	Not offered
Tier 6: Select Care Drugs	$15	$0

Cost sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please call us or access our *Evidence of Coverage* online at **www.bcbsm.com/medicare-evidence-of-coverage**.

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Most members do not reach the Coverage Gap stage or the Catastrophic Coverage stage. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage* online at **www.bcbsm.com/medicare-evidence-of-coverage**.

*Your plan requires prior authorization and has step therapy and quantity limit restrictions for certain drugs. Please refer to your formulary to determine if your drugs are subject to any limitations. You can see the most complete and current information about which drugs are covered on our website (**www.bcbsm.com/formularymedicare**).*

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies. You can see our plan's pharmacy directory at our website (**www.bcbsm.com/pharmaciesmedicare**).

Prestige

Phase 1: The Deductible Stage

You pay nothing.

Phase 2: The Initial Coverage Stage

You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. You stay in this stage until your year-to-date "total drug costs" (your payments plus any Part D plan's payments) total $3,820.

Your share of the cost when you get a *one-month* (31-day) supply of a covered Part D prescription drug:

	Standard retail and standard mail-order cost sharing (in-network)	Preferred retail and preferred mail-order cost sharing (in-network)
Tier 1: Preferred Generic	$6	$1
Tier 2: Generic	$12	$7
Tier 3: Preferred Brand	$43	$38
Tier 4: Non-Preferred Drug	45%	45%
Tier 5: Specialty	33%	33%
Tier 6: Select Care Drugs	$5	$0

Your share of the cost when you get a *long-term* (90-day) supply of a covered Part D prescription drug:

	Standard retail and standard mail-order cost sharing (in-network)	Preferred retail and preferred mail-order cost sharing (in-network)
Tier 1: Preferred Generic	$18	$3
Tier 2: Generic	$36	$21
Tier 3: Preferred Brand	$129	$114
Tier 4: Non-Preferred Drug	45%	45%
Tier 5: Specialty	Not offered	Not offered
Tier 6: Select Care Drugs	$15	$0

Cost sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please call us or access our *Evidence of Coverage* online at **www.bcbsm.com/medicare-evidence-of-coverage**.

Phase 3 & 4: The Coverage Gap & The Catastrophic Stages

Most members do not reach the Coverage Gap stage or the Catastrophic Coverage stage. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage* online at **www.bcbsm.com/medicare-evidence-of-coverage**.

Your plan requires prior authorization and has step therapy and quantity limit restrictions for certain drugs. Please refer to your formulary to determine if your drugs are subject to any limitations. You can see the most complete and current information about which drugs are covered on our website ***(www.bcbsm.com/formularymedicare)****.*

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies. You can see our plan's pharmacy directory at our website (**www.bcbsm.com/pharmaciesmedicare**).

What does “point-of-service” mean?

This is an HMO-POS plan. HMO means Health Maintenance Organization; POS means Point-of-Service. You can use certain providers outside the BCN Advantage network when traveling, often for your in-network cost-sharing amount.

When you’re **out of Michigan**, our POS benefit (offered through BlueCard® via the Blue Cross and Blue Shield Association) lets you get care from providers who participate with Blues plans. **In Michigan**, except for emergency or urgent care, if you go to an out-of-network doctor, you must pay for this care yourself.

Note: POS is not the same as out-of-network; you pay all costs for POS services from out-of-network providers.

For more information

A complete list of services is found in the Evidence of Coverage. For a copy of the Evidence of Coverage, go to **www.bcbsm.com/medicare-evidence-of-coverage**, or contact customer service at 1-800-450-3680 for more information. TTY users call 711.

You can order a copy of the “Medicare & You” handbook at **www.medicare.gov**, or you can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

For more information, please call us at the phone number below or visit us at **www.bcbsm.com/medicare**.

If you are not a member of this plan, call toll-free 1-888-563-3307. TTY users should call 711.
From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 9 p.m. Eastern time. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 9 p.m. Eastern time.

If you are a member of this plan, call toll-free 1-800-450-3680. TTY users should call 711.
From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. Eastern time. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. Eastern time.

If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at **www.medicare.gov** or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

This document is available in other formats such as audio CD and large print. This document may be available in a non-English language. For additional information, call us at 1-800-450-3680.

BCN Advantage℠ HMO-POS

Blue Care Network of Michigan

Medicare and more

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