2020

BCN Advantage℠ HMO-POS — Elements, Basic, Classic, Prestige

Summary of Benefits

January 1, 2020 — December 31, 2020

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:

Antrim, Benzie, Clinton, Emmet, Genesee, Grand Traverse, Isabella, Lake, Lapeer, Leelanau, Lenawee, Livingston, Manistee, Mecosta, Midland, Missaukee, Osceola, Otsego, St. Clair, and Wexford.

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 witth a Medicare contract. Enrollment in BCN Advantage depends on contract renewal.

www.bcbsm.com/medicare

Medicare Advantage Plans

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 monthly premium			
	Elements	Basic	Classic	Prestige
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	$25	$0	$103.30	$226
Optional Supplemental Dental, Hearing and Vision Package 1	$21.40			
Optional Supplemental Dental, Hearing and Vision Package 2	$32.40			

Benefits	Elements	Basic	Classic	Prestige	What you should know
Deductible	**In-network:** $160 annually **Point-of-service:** $500 annually This plan does not include Part D prescription drug coverage.	**In-network:** $280 annually **Point-of-service:** $500 annually **Prescription drugs:** $200 annually for Part D prescription drugs in Tiers 2, 3, 4 and 5.	**In-network:** $0 annually **Point-of-service:** $500 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	$3,400 annually	The most you pay for copays, coinsurance and other costs for medical services for the year. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of 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 * 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 30 for more about your point-of-service travel benefit. **All plans:** Point-of-service deductible applies **Basic & Elements:** Deductible applies 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 copay per day for days 7 through 90 $0 copay per day for days 91 and beyond **Point-of-service:** $205 copay per day for days 1 through 6 $0 copay per day for days 7 through 90	**In-network:** $285 copay per day for days 1 through 6 $0 copay per day for days 7 through 90 $0 copay per day for days 91 and beyond **Point-of-service:** $285 copay per day for days 1 through 6 $0 copay per day for days 7 through 90	**In-network:** $225 copay per day for days 1 through 6 $0 copay per day for days 7 through 90 $0 copay per day for days 91 and beyond **Point-of-service:** $225 copay per day for days 1 through 6 $0 copay per day for days 7 through 90	**In-network:** $125 copay per day for days 1 through 6 $0 copay per day for days 7 through 90 $0 copay per day for days 91 and beyond **Point-of-service:** $125 copay per day for days 1 through 6 $0 copay per day for days 7 through 90	
Outpatient Hospital Coverage*					See Page 30 for more about your point-of-service travel benefit. **All plans:** Point-of-service deductible applies **Basic & Elements:** Deductible applies If you go to out-of-network providers you pay the full cost.
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	
o Outpatient hospital	**In-network:** $200 copay **Point-of-service:** $200 copay	**In-network:** $225 copay **Point-of-service:** $225 copay	**In-network:** $200 copay **Point-of-service:** $200 copay	**In-network:** $200 copay **Point-of-service:** $200 copay	

Benefits	Elements	Basic	Classic	Prestige	What you should know
Doctor Visits					See Page 30 for more about your point-of-service travel benefit.
o Primary	**In-network:** $10 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:** $0 copay **Point-of-service:** $20 copay	**All plans:** Point-of-service deductible applies **Basic & Elements:** Deductible applies
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:** $20 copay **Point-of-service:** $20 copay	If you go to out-of-network providers you pay the full cost. Specialist services may require a referral.
Preventive Care	In-network: You pay nothing. Our plan covers many preventive services, including:				
	• Abdominal aortic aneurysm screening • Alcohol misuse screening and counseling • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit • Cardiovascular disease testing • 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		• Immunizations, including Flu shots, Hepatitis B shots, Pneumococcal shots • 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 • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • “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 one 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 combined $50,000 lifetime plan coverage limit for emergency and urgent care services outside the U.S. and its territories.*
Urgently Needed Services	$45 copay	$45 copay	$40 copay	$35 copay	*There is a combined $50,000 lifetime plan coverage limit for emergency and urgent care services outside the U.S. and its territories.*
Diagnostic Services/Labs/ Imaging*					Only high-tech X-rays require prior authorization. See Page 30 for more about your point-of-service travel benefit. **All plans:** Point-of-service deductible applies **Basic & Elements:** Deductible applies If you go to out-of-network providers you pay the full cost.
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	
o Lab services	**In-network:** $0 copay **Point-of-service:** $0 copay	**In-network:** $0 copay **Point-of-service:** $0 copay	**In-network:** $0 copay **Point-of-service:** $0 copay	**In-network:** $0 copay **Point-of-service:** $0 copay	

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 o Hearing exam to diagnose and treat hearing and balance issues	**In-network:** $10 – $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:** $0 – $20 copay, depending on the service **Point-of-service:** $20 copay, depending on the service	See Page 30 for more about your point-of-service travel benefit. **All plans:** Point-of-service deductible applies **Basic & Elements:** Deductible applies If you go to out-of-network providers you pay the full cost.

Benefits	Elements	Basic	Classic	Prestige	What you should know
Hearing – Optional Supplemental Benefit – Package 1	*$0 cost share for one hearing exam every year* *$0 cost share for one hearing aid fitting evaluation every three years* *Hearing Aids: 50% coinsurance up to a $1,200 ($600 per ear) allowance every three years.*				
Hearing – Optional Supplemental Benefit – Package 2	*$0 cost share for one hearing exam every year* *$0 cost share for one hearing aid fitting evaluation every three years* *Hearing Aids: 50% coinsurance up to a $2,500 ($1,250 per ear) allowance every three years.*				
Dental Services **Limited dental services** (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth)	**In-network:** $10 – $200 copay for Medicare-covered services **Point-of-service:** $40 – $200 copay for Medicare-covered services	**In-network:** $15 – $225 copay for Medicare-covered services **Point-of-service:** $45 – $225 copay for Medicare-covered services	**In-network:** $15 – $200 copay for Medicare-covered services **Point-of-service:** $35 – $200 copay for Medicare-covered services	**In-network:** $0 – $200 copay for Medicare-covered services **Point-of-service:** $20 – $200 copay for Medicare-covered services	See Page 30 for more about your point-of-service travel benefit. **All plans:** Point-of-service deductible applies **Basic & Elements:** Deductible applies for Medicare-covered services. 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) 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) o Oral exam (up to 2 every year)	**In-network:** $0 copay **In-network:** $0 copay **In-network:** $0 copay				

Benefits	Elements	Basic	Classic	Prestige	What you should know
Dental – Optional Supplemental Benefit – Package 1 In addition to preventive dental, we cover:	Comprehensive Dental: $1,500 combined maximum dental benefit for in-network and out-of-network services per calendar year. **In Network** $0 cost-share for fluoride treatments and brush biopsies **50% coinsurance for:** • Resin and amalgam fillings • Crowns • Crown repairs • Root canals • Simple extractions For in-network benefits, you must receive optional supplemental dental services from a participating provider. **Out-of-network** The following items will apply toward your out-of-network maximum benefit. 50% coinsurance of the allowed amount: • Up to two periodic oral exams per calendar year (includes emergency exams). *Emergency exams are also a benefit subject to the two oral exams per year limit.* • Up to two routine cleanings per calendar year (includes periodontal maintenance). • One set of bitewing X-rays (up to four) every two calendar years, or one set (up to six) periapical films every two calendar years, in lieu of one set of bitewing X-rays every two calendar years. • Fluoride treatments. • Brush biopsies • Resin and amalgam fillings • Crowns • Crown repairs • Root canals • Simple extractions				For out-of-network services, if your provider doesn't submit your claim, you may be required to pay costs up front and submit for reimbursement. Out-of-network expenses will be reimbursed at 50% of allowed amounts up to the combined benefit maximum. You may pay higher out-of-pocket amounts if you receive services from out-of-network providers.

Benefits	Elements	Basic	Classic	Prestige	What you should know
Dental – Optional Supplemental Benefit – Package 2 In addition to preventive dental, we cover:	Comprehensive Dental: $2,500 combined maximum dental benefit for in-network and out-of-network services per calendar year. **In Network** $0 cost-share for fluoride treatments and brush biopsies **25% coinsurance for:** • Resin and amalgam fillings • Dentures • Bridges • Onlays • Crowns • Crown repairs • Root canals • Simple extractions • Endodontics and periodontics • Oral surgery • Consultation exams • Anesthesia For in-network benefits, you must receive optional supplemental dental services from a participating provider.				For out-of-network services, if your provider doesn't submit your claim, you may be required to pay costs up front and submit for reimbursement. Out-of-network expenses will be reimbursed at 50% of allowed amounts up to the combined benefit maximum. You may pay higher out-of-pocket amounts if you receive services from out-of-network providers.

Benefits	Elements	Basic	Classic	Prestige	What you should know
	Out-of-network The following items will apply toward your out-of-network maximum benefit. **50% coinsurance of the allowed amount:** • Up to two periodic oral exams per calendar year (includes emergency exams). *Emergency exams are also a benefit subject to the two oral exams per year limit.* • Up to two routine cleanings per calendar year (includes periodontal maintenance). • One set of bitewing X-rays (up to four) every two calendar years, or one set (up to six) periapical films every two calendar years, in lieu of one set of bitewing X-rays every two calendar years. • Fluoride treatments • Brush biopsies • Resin and amalgam fillings • Dentures • Bridges • Onlays • Crowns • Crown repairs • Root canals • Simple extractions • Endodontics and periodontics • Oral surgery • Consultation exams • Anesthesia				

Benefits	Elements	Basic	Classic	Prestige	What you should know
Vision Services					See Page 30 for more about your point-of-service travel benefit. **All plans:** Point-of-service deductible applies **Basic & Elements:** Deductible applies for Medicare-covered services. 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**. Services may require prior authorization.
o Exam to diagnose and treat diseases and conditions of the eye	**In-network:** $0 – $40 copay, depending on the service **Point-of-service:** $0 – $40 copay, depending on the service	**In-network:** $0 – $45 copay, depending on the service **Point-of-service:** $0 – $45 copay, depending on the service	**In-network:** $0 – $35 copay, depending on the service **Point-of-service:** $0 – $35 copay, depending on the service	**In-network:** $0 – $20 copay, depending on the service **Point-of-service:** $0 – $20 copay, depending on the service	
o Eyeglasses or contact lenses after Medicare-covered cataract surgery	**In-network:** $0 copay	**In-network:** $0 copay	**In-network:** $0 copay	**In-network:** $0 copay	
o Routine eye exam	**In-network:** $0 copay for up to one routine eye exam every 12 months.	**In-network:** $0 copay for up to one routine eye exam every 12 months.	**In-network:** $0 copay for up to one routine eye exam every 12 months.	**In-network:** $0 copay for up to one routine eye exam every 12 months.	

Benefits	Elements	Basic	Classic	Prestige	What you should know
Every 24 months, we cover one of the following: o Elective contacts o One pair of lenses o One frame o One complete pair of eyeglasses (lenses and frames) If elective contact lenses are chosen, they are unlimited up to the maximum vision benefit	This is not a covered benefit: o Elective contacts o One pair of lenses o One frame o One complete pair of eyeglasses (lenses and frames)	This is not a covered benefit: o Elective contacts o One pair of lenses o One frame o One complete pair of eyeglasses (lenses and frames)	$0 copay The optional eye wear benefit provides a $100 maximum vision benefit every 24 months and may be used for either (a) elective contact lenses or (b) frames. Lenses are covered in full every 24 months. Benefit must be obtained from an in-network provider.	$0 copay The optional eye wear benefit provides a $100 maximum vision benefit every 24 months and may be used for either (a) elective contact lenses or (b) frames. Lenses are covered in full every 24 months. Benefit must be obtained from an in-network provider.	

Benefits	Elements	Basic	Classic	Prestige	What you should know
Vision – Optional Supplemental Benefit – Package 1 Every 24 months, we cover **<u>one</u>** of the following: o Elective contacts o One pair of lenses o One frame o One complete pair of eyeglasses (lenses and frames) If elective contact lenses are chosen, they are unlimited up to the maximum vision benefit.	**In-network Eyewear**				Supplemental vision benefits are provided in conjunction with standard vision benefit. Frequency limits apply. You may pay higher out-of-pocket amounts if you receive services from out-of-network providers.
		The optional eye wear benefit provides a $300 combined in and out-of-network maximum vision benefit every 24 months and may be used for either (a) elective contact lenses or (b) frames. Lenses are covered in full every 24 months.	The optional eye wear benefit provides a $300 (in addition to the standard benefit) combined in and out-of-network maximum vision benefit every 24 months and may be used for either (a) elective contact lenses or (b) frames. Lenses are covered in the standard benefit.		
	Out-of-network Eyewear				
		The optional eye wear benefit provides a combined in and out-of-network maximum vision benefit with 50% coinsurance up to $300 every 24 months and may be used for either (a) elective contact lenses or (b) frames. Lenses are reimbursed at 50% coinsurance up to allowed amounts. Exams are reimbursed up to allowed amounts.	The optional eye wear benefit provides a combined in and out-of-network maximum vision benefit with 50% coinsurance up to $300 (in addition to the standard benefit) every 24 months and may be used for either (a) elective contact lenses or (b) frames. Lenses are reimbursed at 50% coinsurance up to allowed amounts. Exams are reimbursed up to allowed amounts.		

Benefits	Elements	Basic	Classic	Prestige	What you should know
Vision – Optional Supplemental Benefit – Package 2 Every 24 months, we cover **one** of the following: o Elective contacts o One pair of lenses o One frame o One complete pair of eyeglasses (lenses and frames) If elective contact lenses are chosen, they are unlimited up to the maximum vision benefit.	**In-network Eyewear**				Supplemental vision benefits are provided in conjunction with standard vision benefit. Frequency limits apply. You may pay higher out-of-pocket amounts if you receive services from out-of-network providers.
		The optional eye wear benefit provides a $400 combined in and out-of-network maximum vision benefit every 24 months and may be used for either (a) elective contact lenses or (b) frames. Lenses are covered in full every 24 months.	The optional eye wear benefit provides a $400 (in addition to the standard benefit) combined in and out-of-network maximum vision benefit every 24 months and may be used for either (a) elective contact lenses or (b) frames. Lenses are covered in the standard benefit.		
	Out-of-network Eyewear				
		The optional eye wear benefit provides a combined in and out-of-network maximum vision benefit with 50% coinsurance up to $400 every 24 months and may be used for either (a) elective contact lenses or (b) frames. Lenses are reimbursed at 50% coinsurance up to allowed amounts. Exams are reimbursed up to allowed amounts.	The optional eye wear benefit provides a combined in and out-of-network maximum vision benefit with 50% coinsurance up to $400 (in addition to the standard benefit) every 24 months and may be used for either (a) elective contact lenses or (b) frames. Lenses are reimbursed at 50% coinsurance up to allowed amounts. Exams are reimbursed up to allowed amounts.		

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.				Services may require prior authorization. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **All plans:** Point-of-service deductible applies **Basic & Elements:** Deductible applies for Medicare-covered services.
o Inpatient visit	**In-network:** $205 copay per day for days 1 through 6 $0 copay 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:** $285 copay per day for days 1 through 6 $0 copay per day for days 7 through 90 **Point-of-service:** $285 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 $0 copay 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 $0 copay 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:** $20 copay **Point-of-service:** $20 copay	
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:** $20 copay **Point-of-service:** $20 copay	

Benefits	Elements	Basic	Classic	Prestige	What you should know
Skilled Nursing Facility (SNF)*	**In-network:** Days 1 – 20: $0 copay Days 21 – 100: $178 copay per day **Point-of-service:** Days 1 – 20: $0 copay Days 21 – 100: $178 copay per day	**In-network:** Days 1 – 20: $0 copay Days 21 – 100: $178 copay per day **Point-of-service:** Days 1 – 20: $0 copay Days 21 – 100: $178 copay per day	**In-network:** Days 1 – 20: $0 copay Days 21 – 100: $178 copay per day **Point-of-service:** Days 1 – 20: $0 copay Days 21 – 100: $178 copay per day	**In-network:** Days 1 – 20: $0 copay Days 21 – 100: $178 copay per day **Point-of-service:** Days 1 – 20: $0 copay Days 21 – 100: $178 copay per day	Our plan covers up to 100 days in a SNF. **All plans:** Point-of-service deductible applies **Basic & Elements:** Deductible applies for Medicare-covered services. See Page 30 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	**All plans:** Point-of-service deductible applies **Basic & Elements:** Deductible applies for Medicare-covered services.
Ambulance	**In-network:** $230 copay **Point-of-service:** $230 copay				See Page 30 for more about your point-of-service travel benefit. Copay is for each one-way trip for Medicare-covered services. If you go to out-of-network providers you pay the full cost.

Benefits	Elements	Basic	Classic	Prestige	What you should know
Transportation	Not Offered	Not Offered	Not Offered	Not Offered	
Medicare Part B Drugs* o Part B drugs such as chemotherapy drugs o Other Part B drugs o 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	Services may require prior authorization and/or step therapy may apply. **All plans:** Point-of-service deductible applies **Basic & Elements:** Deductible applies for Medicare-covered services.
Medical Equipment/ Supplies* o Durable Medical Equipment (e.g., wheelchairs, oxygen)	**In-network:** 20% coinsurance of the cost for Medicare-covered items. **Point-of-service:** 20% coinsurance of the cost for Medicare-covered items.	**In-network:** 20% coinsurance of the cost for Medicare-covered items. **Point-of-service:** 20% coinsurance of the cost for Medicare-covered items.	**In-network:** 20% coinsurance of the cost for Medicare-covered items. **Point-of-service:** 20% coinsurance of the cost for Medicare-covered items.	**In-network:** 20% coinsurance of the cost for Medicare-covered items. **Point-of-service:** 20% coinsurance of the cost for Medicare-covered items.	Services may require prior authorization. See Page 30 for more about your point-of-service travel benefit. **All plans:** Point-of-service deductible applies **Basic & Elements:** Deductible applies for Medicare-covered services. If you go to out-of-network providers you pay the full cost.

Benefits	Elements	Basic	Classic	Prestige	What you should know
o Prosthetics (e.g., braces, artificial limbs)	**In-network:** 20% coinsurance of the cost for Medicare-covered items. **Point-of-service:** 20% coinsurance of the cost for Medicare-covered items.	**In-network:** 20% coinsurance of the cost for Medicare-covered items. **Point-of-service:** 20% coinsurance of the cost for Medicare-covered items.	**In-network:** 20% coinsurance of the cost for Medicare-covered items. **Point-of-service:** 20% coinsurance of the cost for Medicare-covered items.	**In-network:** 20% coinsurance of the cost for Medicare-covered items. **Point-of-service:** 20% coinsurance of the cost for Medicare-covered items.	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, Eastern time. TTY users call 711.
o Diabetes supplies (e.g., monitoring, shoes or inserts)	**In-network:** $0 copay **Point-of-service:** $0 copay	**In-network:** $0 copay **Point-of-service:** $0 copay	**In-network:** $0 copay **Point-of-service:** $0 copay	**In-network:** $0 copay **Point-of-service:** $0 copay	Member must obtain diabetic shoes and inserts from BCN's DME supplier, Northwood at 1-800-667-8496, 8:30 a.m. to 5 p.m. Monday through Friday, Eastern time. 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.

Benefits	Elements	Basic	Classic	Prestige	What you should know
Health Fitness Programs	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 one or more bones in your spine moves 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 three views) per year performed by a chiropractor. Cost share is the same as diagnostic X-rays. **All plans:** Point-of-service deductible applies **Basic & Elements:** Deductible may apply for Medicare-covered services. See Page 30 for more about your point-of-service travel benefit. If you go to out-of-network providers you pay the full cost.
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 – $20 copay depending on the service **Point-of-service:** $10 – $20 copay depending on the service.	

Benefits	Elements	Basic	Classic	Prestige	What you should know
Home Health Care	**In-network:** $0 copay **Point-of-service:** $0 copay	**In-network:** $0 copay **Point-of-service:** $0 copay	**In-network:** $0 copay **Point-of-service:** $0 copay	**In-network:** $0 copay **Point-of-service:** $0 copay	Includes medically necessary intermittent skilled nursing care, home health aide services, rehabilitation services, etc. Custodial care is not a benefit. Services may require prior authorization.
Hospice	$0 copay 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 o Remote access technologies give you the opportunity to meet with a health care provider through electronic forms of communication (such as online). o 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.	**Medical:** $0 copay **Mental Health:** $20 copay	**Medical:** $15 copay **Mental Health:** $40 copay	**Medical:** $15 copay **Mental Health:** $35 copay	**Medical:** $0 copay **Mental Health:** $20 copay	**Basic & Elements:** Deductible may apply for Medicare-covered services. You must use an authorized vendor to get services. The copays listed are valid for services you get from an authorized vendor. You may pay more when you go outside of the authorized vendor.

Benefits	Elements	Basic	Classic	Prestige	What you should know
Outpatient Substance Abuse*					Services may require prior authorization
o Individual or 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:** $20 copay **Point-of-service:** $20 copay	**All plans:** Point-of-service deductible applies **Basic & Elements:** Deductible applies for Medicare-covered services.
Renal dialysis	**In-network:** 20% coinsurance **Point-of-service:** 20% coinsurance	**In-network:** 20% coinsurance **Point-of-service:** 20% coinsurance	**In-network:** 20% coinsurance **Point-of-service:** 20% coinsurance	**In-network:** 20% coinsurance **Point-of-service:** 20% coinsurance	**All plans:** Point-of-service deductible applies **Basic & Elements:** Deductible applies for Medicare-covered services.

Benefits	Elements	Basic	Classic	Prestige	What you should know
Over-the-counter items (from authorized vendor only)* Items are drugs and health related products that do not need a prescription. There are three ways to use the benefit: 1) **Online.** Beginning January 1, 2020, you can go to **www.bcbsm.com/medicareotc** and follow the prompts to place your order using the online catalog. 2) **Mail.** Complete and mail the order form included with the catalog you'll receive in the mail. 3) **Phone.** Choose items using the catalog and call 1-855-856-7878, Monday to Friday, 8 a.m. to 11 p.m., Eastern time, to place an order. TTY users call 711. Items will be mailed to you.	You get up to $15 every quarter to spend on certain approved non-prescription over-the-counter drugs and health related items. One order can be placed per quarter. Benefits are available each quarter (January, April, July, October) Covered items include but aren't limited to antacids, cough drops, denture adhesive, eye drops, ibuprofen, toothpaste and first aid items.	Not Offered	You get up to $25 every quarter to spend on certain approved non-prescription over-the-counter drugs and health related items. One order can be placed per quarter. Benefits are available each quarter (January, April, July, October). Covered items include but aren't limited to antacids, cough drops, denture adhesive, eye drops, ibuprofen, toothpaste and first aid items.		There is a limit on the total dollar amount you can order each quarter. All orders must be placed through the plan's approved vendor. Unused OTC amounts do not carry over from quarter to quarter. Note: Items cannot be obtained from any other vendor or retailer. Direct member reimbursement is not available.

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

Basic

Phase 1: The Deductible Stage

You pay $0 for Tiers 1 and 6. You pay $200 per year for Tiers 2, 3, 4 and 5.

Phase 2: The Initial Coverage Stage

After you pay your deductible, 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 $4,020.

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	29%	29%
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

You have additional coverage in the Coverage Gap stage for Tier 6 drugs. For generic drugs, you pay a $0 copayment for Tier 6 drugs at a preferred pharmacy or 25% of the costs, whichever is lower, for up to a 31-day supply. You pay 25% of the cost for all other generic drugs. For brand-name drugs, you pay 25% of the price (plus a portion of the dispensing fee). 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

Because there is no deductible for the plan, this stage does not apply to you.

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 $4,020.

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

You have additional coverage in the Coverage Gap stage for Tier 6 drugs. For generic drugs, you pay a $0 copayment for Tier 6 drugs at a preferred pharmacy or 25% of the costs, whichever is lower, for up to a 31-day supply. You pay 25% of the cost for all other generic drugs. For brand-name drugs, you pay 25% of the price (plus a portion of the dispensing fee). 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

Because there is no deductible for the plan, this stage does not apply to you.

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 $4,020.

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

You have additional coverage in the Coverage Gap stage for Tier 6 drugs. For generic drugs, you pay a $0 copayment for Tier 6 drugs at a preferred pharmacy or 25% of the costs, whichever is lower, for up to a 31-day supply. You pay 25% of the cost for all other generic drugs. For brand-name drugs, you pay 25% of the price (plus a portion of the dispensing fee). 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 from 8 a.m. to 8 p.m., Eastern time, seven days a week from October 1 through March 31; 8 a.m. to 8 p.m., Eastern time, Monday through Friday from April 1 through September 30, 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. TTY users should call 711.

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