

2014 Benefits-at-a-Glance for BCN Advantage
City of Hamtramck

BCN Advantage™ HMO-POS



Medicare and more

Blue Care Network of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

www.MiBCN.com/medicare

BCN Advantage HMO-POSSM is available only to individuals enrolled in Medicare Part A and Medicare Part B.

The benefit information provided below is a brief summary, not a complete description of benefits. For more information, 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.MiBCN.com/medicare or by requesting them from Customer Service.

Limitations, copayments, and restrictions may apply. Benefits and copayments/coinsurance may change on January 1 of each year. 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.

Deductible, Copays and Dollar Maximums

Deductible	\$100 per member per calendar year
Copays	\$10 for office visits, \$10 for urgent care visits and \$65 for emergency room visits
• Fixed Dollar Copay	
• Percent Copay	5% for select services
Copay Dollar Maximums	
• Fixed Dollar Copay	None
• Percent Dollar Copay/Coinsurance	None
• Fixed Dollar and Percent Dollar Copay (Maximum-out-of-Pocket)	\$1,000 per member per calendar year
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

Mammography Screening	Covered – 100%
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BCN Advantage is an HMO-POS plan with a Medicare contract.
Enrollment in BCN Advantage depends on contract renewal.

20500 Civic Center Drive, Southfield, MI 48076

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Physician Office Services

Office Visits	Covered – \$10 copay
Consulting Specialist Care – when referred	Covered – \$10 copay after deductible

Emergency Medical Care

Hospital Emergency Room – copay waived if admitted, inpatient hospital benefits apply	Covered – \$65 copay after deductible
Urgent Care Center	Covered – \$10 copay
Ambulance Services – medically necessary	Covered – 95% after deductible, with a 5% coinsurance up to \$1,000 per member per calendar year

Diagnostic Services

Laboratory and Pathology Tests	Covered – 100%, office visit copay may apply per member, per visit
Diagnostic Tests and X-rays	Covered – 95% after deductible, with a 5% coinsurance up to \$1,000 per member per calendar year
Radiation Therapy	Covered – 95% after deductible with a 5% coinsurance up to \$1,000 per member per calendar year

Hospital Care

Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 95% after deductible, with a 5% coinsurance up to \$1,000 per member per calendar year
Outpatient Surgery	Covered – 95% after deductible, with a 5% coinsurance up to \$1,000 per member per calendar year

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 100% after deductible. Limited to 100 days per benefit period
Home Health Care	Covered – 100% after deductible

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Surgical Services

Surgery – includes all related surgical services and anesthesia	Covered – 95% after deductible, with a 5% coinsurance up to \$1,000 per member per calendar year
Human Organ Transplants	Covered – 95% after deductible, with a 5% coinsurance up to \$1,000 per member per calendar year

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care and Substance Abuse Care	Mental Health Care: Covered – 100%, unlimited days 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%, office visit copay may apply per member, per visit after deductible
Allergy Injections	Covered – 100%, office visit copay may apply per member, per visit
Chiropractic Spinal Manipulation – when referred	Covered – \$10 copay after deductible
Outpatient Physical, Speech and Occupational Therapy	Covered – \$10 copay after deductible
Durable Medical Equipment	Covered – 100%
Prosthetic and Orthotic Appliances	Covered – 100%

Prescription Drugs

Formulary Drug – Generic (Tier 1)	Covered – \$10 copay
Formulary Drug – Non-Preferred Generic (Tier 2)	Covered – \$10 copay
Formulary Drug – Brand Name (Tier 3)	Covered – \$25 copay
Formulary Drug – Non-Preferred Brand Name (Tier 4)	Covered – \$50 copay
Formulary Drug – Specialty (Tier 5)	Covered – \$50 copay
Mail Order Prescription Drugs	Covered – Two times the applicable generic and

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	brand copay for up to a 90-day supply
Drugs for the Treatment of Sexual Dysfunction	Covered- 50% coinsurance
Part D-Catastrophic Coverage	Once member's out-of pocket costs reach over \$4,550, the copay is the greater of 5% or \$2.55 generics and \$6.35 brands.

BCNA, 10OVCR, UR10, ER65, 100DR, COIN5, MOOP1K, BCNAP, 10255C, MOPD20, PD3600

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