BCN Advantage HMO-POS with Prescription Drugs
2021 Benefits-at-a-Glance
City of Traverse City Quote Op 1.1

To join BCN Advantage℠ HMO-POS, you must have both Medicare Part A and Medicare Part B and live in our group service area.

The benefit information provided is a summary of what we cover and what you pay. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits and copayments/coinsurance may change on January 1 of each year. You can contact the plan by calling Customer Service at 1-800-450-3680, 8 a.m. to 8 p.m. Eastern, Monday through Friday, with weekend hours Oct. 1 through March 31. TTY users should call 711. To get a complete list of services we cover, call Customer Service and ask for the *Evidence of Coverage*.

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

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. Visit our online search tool at www.bcbsm.com/pharmaciesmedicare to find a network pharmacy near you. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at **www.bcbsm.com/formularymedicare**.

Deductible, copayments and dollar maximums	
Deductible	None
Copays • Fixed dollar copay	$20 office visits, $50 urgent care visits, $50 emergency room visits, $50 ambulance, $35 specialist visits
• Percent copay	20% for DME services
Copay dollar maximums	
• Fixed dollar copay	None
• Fixed dollar and percent copay (Maximum out of pocket)	$6,700
Dollar maximums	None
Preventive care 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, or PSA, screening — laboratory services only	Covered – 100%
Mammography screening	Covered – 100%

Physician office services	
Office visits	Covered – copay $20
Online visits	Covered – copay $20
Consulting specialist care*	Covered – copay $35
Emergency medical care	
Hospital emergency room — copay waived if admitted, inpatient hospital benefits apply	Covered – copay $50
Urgent care center	Covered – copay $50
Ambulance services — medically necessary	Covered – copay $50, ground and air service
Diagnostic care	
Laboratory and pathology tests	Covered – 100%, office visit copay may apply per member, per visit
Diagnostic tests and X-rays	Covered – 100%, office visit copay may apply per member, per visit
High-technology imaging (includes MRI, MRA, CT scan, PET)	Covered – copay $150
Hospital care	
Inpatient physician care, general nursing care, hospital services and supplies	Covered- 100% unlimited days
Outpatient surgery	Covered- 100%
Alternatives to hospital care	
Skilled nursing care	Covered – 100%, up to 100 days per benefit period
Home health care	Covered – 100%, physician visit copay may apply
Surgical services	
Surgery — includes all related surgical services and anesthesia	Covered – 100%
Human organ transplants	Covered- 100%, subject to medical criteria
Mental health care and substance use treatment	
Inpatient mental health and substance use care	**Mental Health Care**: Covered – 100%, unlimited days. Prior authorization required. **Substance Abuse Care:** Covered – 100%, unlimited days
Outpatient mental health care	Covered – 100%, unlimited visits
Outpatient substance use care	Covered – 100%, unlimited visits
Other services	
Allergy testing and therapy	Covered – 100%, office visit copay may apply per member, per visit
Allergy injections	Covered – 100%, office visit copay may apply per member, per visit
Chiropractic spinal manipulation*	Covered – copay $20
Outpatient physical, speech and occupational therapy	Covered – copay $35
Durable medical equipment	Covered – 80%
Prosthetic and orthotic appliances	Covered – 100%

Radiation therapy	Covered – 100%, office visit copay may apply per member, per visit
Vision	Eye Exam-$5 copay, one exam every 12 months; Lenses and frames- one pair every 12 months
Hearing Aid	Binaural hearing aids and exam every 36 months covered 100%
SilverSneakers® fitness benefit, includes: • A fitness center membership at any participating location across the country • Conditioning classes, exercise equipment, pool, sauna and other available amenities • Customized SilverSneakers classes and seminars	$0 copay for fitness services. Fitness services must be provided at SilverSneakers participating locations. You can find a location or request SilverSneakers Steps information at www.silversneakers.com or 1-866-584-7352, Monday – Friday, 8 a.m. to 8 p.m. TTY users call 711.
Other services cont'd	
SilverSneakers® fitness benefit, cont'd • Online classes • SilverSneakers apps SilverSneakers is a registered trademark of Tivity Health, Inc. © 2020 Tivity Health, Inc. All rights reserved.	
Prescription drugs	
Formulary drug — Tier 1 — preferred generic	Covered – Standard Pharmacy: $ 10 copay up to a 31-day supply Preferred Pharmacy: $ 3 copay up to a 31-day supply
Formulary drug — Tier 2 — generic	Covered – Standard Pharmacy: $ 10 copay up to a 31-day supply Preferred Pharmacy: $ 3 copay up to a 31-day supply
Formulary drug — Tier 3 — preferred brand name	Covered – Standard Pharmacy: $ 40 copay up to a 31-day supply Preferred Pharmacy: $ 30 copay up to a 31-day supply
Formulary drug — Tier 4 — nonpreferred drugs	Covered – Standard Pharmacy: $ 40 copay up to a 31-day supply Preferred Pharmacy: $ 30 copay up to a 31-day supply
Formulary drug — Tier 5 — specialty drugs	Covered – Standard Pharmacy: $ 40 copay up to a 31-day supply Preferred Pharmacy: $ 30 copay up to a 31-day supply
Mail-order prescription drugs	Covered – Three times the applicable generic and brand copay for a 32-day to a 90-day supply

Drugs for the treatment of sexual dysfunction	Covered – 50% coinsurance
Part D catastrophic coverage	Once member's out of pocket costs reach over $6,550 the copay is **the greater of** 5% or $3.70 generics and $9.20 brands, not to exceed base copay.

*Some in-network specialists may need to confirm with your primary care physician that you need specialty care. Your PCP is the best resource for coordinating your care and can help you find an in-network specialist.

If you want to know more about the coverage and cost of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at www.medicare.gov or get a copy by calling **1-800-633-4227**, 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.