

Benefits-at-a-Glance for BCN Advantage Michigan Catholic Conference  
July 2010



**Blue Care  
Network**  
of Michigan

**MiBCN.com**

**BCN Advantage HMO is available only to individuals enrolled in both Part A and B.**

This is intended as an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificates and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible and/or copay amounts required by the plan. This coverage is provided pursuant to a contract entered into with the Federal Government. Services must be provided or arranged by member's primary care physician or health plan.

**Deductible, Copays and Dollar Maximums**

<b>Deductible</b>	None
<b>Copays</b>	
• Fixed Dollar Copay	\$20 for office visits, \$35 for urgent care, and \$50 for emergency room visits
• Percent Copay	None
<b>Copay Dollar Maximums</b>	
• Fixed Dollar Copay	None
• Percent Dollar Copay – Medical Services; excludes services with a 50% copay	None
<b>Dollar Maximums</b>	None

**Preventive Services**

Health Maintenance Exam	Covered – \$20 copay
Annual Gynecological Exam	Covered – \$20 copay
Pap Smear Screening – laboratory services only	Covered – 100%, office visit copay may apply per member, per visit
Well-Baby and Child Care	Covered – \$20 copay
Immunizations – pediatric and adult	Covered – 100%, office visit copay may apply per member, per visit
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 100%, office visit copay may apply per member, per visit

**Mammography**

Mammography Screening	Covered – 100%
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**Physician Office Services**

Office Visits	Covered – \$20 copay
Consulting Specialist Care – when referred	Covered – \$20 copay

**Emergency Medical Care**

Hospital Emergency Room – copay waived if admitted, inpatient hospital benefits apply	Covered – \$50 copay
Urgent Care Center	Covered – \$35 copay
Ambulance Services – medically necessary	Covered – 100%, ground and air service

**Diagnostic Services**

Laboratory and Pathology Tests	Covered – 100%, office visit copay may apply per member, per visit
Diagnostic Tests and X-rays	Covered – 100%, office visit copay may apply per member, per visit
Radiation Therapy	Covered – 100%, office visit copay may apply per member, per visit

**Maternity Services Provided by a Physician**

Pre-Natal and Post-Natal Care	Covered – \$20 copay
Delivery and Nursery Care	Covered – 100%

**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
Hospice Care	Covered – 100%
Home Health Care	Covered – 100% Doctor visit \$20 copay

**Surgical Services**

Surgery – includes all related surgical services and anesthesia	Covered – 100%
Human Organ Transplants	Covered – 100%, subject to medical criteria

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**Mental Health Care and Substance Abuse Treatment**

Inpatient Mental Health Care and Substance Abuse Care	<b>Mental Health Care:</b> Covered – 100%, unlimited days <b>Substance Abuse Care:</b> 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
Allergy Injections	Covered – 100%, office visit copay may apply per member, per visit
Chiropractic Spinal Manipulation – when referred	Covered – \$20 copay
Outpatient Physical, Speech and Occupational Therapy	Covered – \$20 copay
Durable Medical Equipment	Covered – 100%
Prosthetic and Orthotic Appliances	Covered – 100%

**Prescription Drugs**

Formulary Drug-Generic (Tier 1)	Covered - \$15 copay
Formulary Drug-Brand Name (Tier 2- 5)	Covered- \$50 copay
Part D-Catastrophic Coverage	Part D out-of-pocket costs over \$4,550, copay is the greater of 5% or \$2.50 generic and \$6.30 brand
Mail Order Prescription Drugs	Covered- Two times the applicable copay for up to a 90 day supply

BCNA, CO20, ER50, UR35, HA2, 1550PD, MOPD2C, PD3600, BCNAP

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