

2017 Benefits-at-a-Glance for BCN Advantage City of Lincoln Park



To join BCN AdvantageSM HMO-POS, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

This information is not a complete description of benefits. 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., 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.bcbsm.com/medicare or by requesting them from Customer Service.

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/or pharmacy network may change at any time. You will receive notice when necessary.

Deductible, Copays and Dollar Maximums	
Deductible	\$500 per calendar year
Copays	\$20 office visits, \$35 specialist, \$20 urgent care, \$65 emergency room visits
• Fixed Dollar Copay	
• Percent Copay	20% coinsurance on select services as detailed below
Copay Dollar Maximums	
• Fixed Dollar Copay	None
• Fixed Dollar and Percent Copay (Maximum-out-of-Pocket)	\$1,500 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 Screening	Covered – 100%
Physician Office Services	
Office Visits	Covered – \$20
Consulting Specialist Care – when referred	Covered – \$35 after deductible

Emergency Medical Care	
Hospital Emergency Room – copay waived if admitted, inpatient hospital benefits apply	Covered – \$65 after deductible
Urgent Care Center	Covered – \$20
Ambulance Services – medically necessary	Covered – 80% after deductible, 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 – 80% after deductible, office visit copay may apply per member, per visit
High Technology Imaging (includes MRI, MRA, CAT, PET)	Covered— 80% after deductible
Radiation Therapy	Covered – 80% after deductible, office visit copay may apply per member, per visit
Hospital Care	
Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered –80% after deductible, unlimited days
Outpatient Surgery	Covered – 80% after deductible
Alternatives to Hospital Care	
Skilled Nursing Care	Covered – 100% after deductible, up to 100 days per benefit period
Home Health Care	Covered – 100% after deductible
Surgical Services	
Surgery – includes all related surgical services and anesthesia	Covered – 80% after deductible
Human Organ Transplants	Covered – 80% after deductible; subject to medical criteria
Mental Health Care and Substance Abuse Treatment	
Inpatient Mental Health Care and Substance Abuse 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 Abuse Care	Covered – 100%, unlimited visits
Other Services	
Allergy Testing and Therapy	Covered – 100% after deductible, 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 after deductible
Outpatient Physical, Speech and Occupational Therapy	Covered – \$35 after deductible
Durable Medical Equipment	Covered – 100%
Prosthetic and Orthotic Appliances	Covered – 100%

Prescription Drugs	
Formulary Drug – Tier 1 & 2 - Generic	Covered – \$20 copay up to a 31-day supply
Formulary Drug – Tier 3 – Brand Name Drugs	Covered – \$60 copay up to a 31-day supply
Formulary Drug – Tier 4 – Non-Preferred Drugs	Covered – \$80 copay up to a 31-day supply
Formulary Drug – Tier 5 – Specialty Drugs	Covered - 20% coinsurance – Maximum \$200 copay per prescription, up to a 31-day supply. Maximum of \$4,800 per calendar year
Mail Order Prescription Drugs	Covered – Two 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 \$4,950, the copay is the greater of 5% or \$3.30 generics and \$8.25 brands.

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

H5883_O_Quote Option 1-BAAG-FVNR 0816



Nonprofit corporations and independent licensees
of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

Blue Cross Blue Shield of Michigan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross Blue Shield of Michigan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Office of Civil Rights Coordinator.

If you believe that Blue Cross Blue Shield of Michigan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Office of Civil Rights Coordinator
600 E. Lafayette Blvd.
MC 1302
Detroit, MI 48226
1-888-605-6461, TTY: 711
Fax: 1-866-559-0578
civilrights@bcbsm.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



Medicare and more

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

Blue Care Network - H5883

2017 Medicare Star Ratings*

The Medicare Program rates all health and prescription drug plans each year, based on a plan's quality and performance. Medicare Star Ratings help you know how good a job our plan is doing. You can use these Star Ratings to compare our plan's performance to other plans. The two main types of Star Ratings are:

1. An Overall Star Rating that combines all of our plan's scores.
2. Summary Star Rating that focuses on our medical or our prescription drug services.

Some of the areas Medicare reviews for these ratings include:

- How our members rate our plan's services and care;
- How well our doctors detect illnesses and keep members healthy;
- How well our plan helps our members use recommended and safe prescription medications.

For 2017, Blue Care Network received the following Overall Star Rating from Medicare.

★★★★★
4.5 Stars

We received the following Summary Star Rating for Blue Care Network's health/drug plan services:

Health Plan Services: ★★★★★
4 Stars

Drug Plan Services: ★★★★★
4.5 Stars

The number of stars shows how well our plan performs.

★★★★★	5 stars - excellent
★★★★	4 stars - above average
★★★	3 stars - average
★★	2 stars - below average
★	1 star - poor

Learn more about our plan and how we are different from other plans at www.medicare.gov.

You may also contact us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time at 888-563-3307 (toll-free) or 711 (TTY), from October 1 to February 14. Our hours of operation from February 15 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time.

Current members please call 800-450-3680 (toll-free) or 711 (TTY).

*Star Ratings are based on 5 Stars. Star Ratings are assessed each year and may change from one year to the next.

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ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-450-3680 (TTY: 711).

ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-450-3680 (رقم هاتف الصم والبكم: 711).

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

BCN Advantage HMO-POS Application

BCN AdvantageSM HMO-POS



Blue Care
Network
of Michigan

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2017 Employer Group/Union Enrollment Form (Coverage effective 2017)

1 Complete the following information to enroll in BCN Advantage HMO-POS.

Name of employer group/union sponsoring this coverage:

Employer group/union number (employer group/union sponsoring this coverage can provide this):

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	First name	Middle initial	Last name
Birth date / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Daytime phone number ()	Alternate phone number ()
Permanent residence street address (No P.O. box)		City	State
ZIP code	County	Email address (optional)	

Mailing address (only if different from your permanent residence street address)

Street address

City	State	ZIP code
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OPTIONAL INFORMATION

Emergency contact name

Relationship to you	Phone number ()
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Continued

2

Please provide your Medicare insurance information.

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card.
- OR -
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

MEDICARE			HEALTH INSURANCE	
SAMPLE ONLY				
NAME OF BENEFICIARY _____				
MEDICARE CLAIM NUMBER _____				
IS ENTITLED TO		EFFECTIVE DATE		
HOSPITAL (PART A)		_____ - _____ - _____		
MEDICAL (PART B)		_____ - _____ - _____		

3

Please read and answer these important questions.

1. Do you have other drug coverage, including other private insurance, workers' compensation, VA benefits or state pharmaceutical assistance programs? **Yes** **No**

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____	ID # for this coverage: _____	Employer group/union # for this coverage: _____
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2. Are you a resident in a long-term care facility, such as a nursing home? **Yes** **No**

If "yes," please provide the following information:

Name of facility _____			
Address _____			
City _____	State _____	ZIP code _____	Phone number _____

3. Do you have End-Stage Renal Disease (ESRD)? Yes No

If you have had a successful kidney transplant and/or you don't need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis. Otherwise, we may need to contact you for additional information.

4. Are you enrolled in Medicaid? Yes No

If "yes," please provide your Medicaid number: _____

5. Please enter the name and telephone number of your primary doctor:

Name: _____

Phone number: _____

- Are you a current patient of this doctor? Yes No

6. Are you the retiree of the employer group/union sponsoring this coverage? Yes No

If "no," name of retiree you are getting coverage through: _____

7. Are you a surviving spouse? Yes No

8. Is this a Consolidated Omnibus Budget Reconciliation Act (COBRA) enrollment? Yes No

If "yes," Start date ___ / ___ / ___ End date ___ / ___ / ___

Medicare Eligible Spouse must also complete an employer group/union application form. If the spouse or dependents are under age 65, are covered by the employer group/union and will receive Blue Care Network coverage, please complete the *Enrollment Change of Status* form.

Please contact BCN Advantage HMO-POS at **1-866-966-BLUE (1-866-966-2583)** if you need information in another format or to be referred to our foreign language line. **TTY users should call 711**. Call center hours are 8 a.m. to 5 p.m., Monday through Friday.



4

Please read and sign below

By completing this enrollment application, I agree to the following:

- BCN Advantage HMO-POS is a Medicare Advantage plan and has a contract with the federal government. I need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It's my responsibility to tell you about any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.
- BCN Advantage serves a specific area. If I move out of the area that BCN Advantage serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of BCN Advantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document (also known as a member contract or subscriber agreement) from BCN Advantage when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out-of-the-country except for limited coverage near the U.S. border.
- I understand that beginning on the date BCN Advantage coverage begins, I must get all of my health care from BCN Advantage, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by BCN Advantage and other services contained in my BCN Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR BCN ADVANTAGE WILL PAY FOR THE SERVICES.
- I understand that if I get help from a sales agent, broker or other individual employed by or contracted with BCN Advantage, he/she may be paid based on my enrollment in BCN Advantage.

Release of Information:

By joining this Medicare health plan, I acknowledge that BCN Advantage will release my information to Medicare and other plans as needed for treatment, payment and health care operations. I also acknowledge that BCN Advantage will release my information including my prescription drug data to Medicare, who may release it for research or other purposes that follow all applicable federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means that I have read and understand the content of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Continued 

Signature	Date	/	/
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If you are the authorized representative of the enrollee, you must sign above and provide the following information:

Name		Phone ()	
Street address	City	State	ZIP code
Relationship to applicant			

Please note: Not all BCN providers are contracted with BCN Advantage. Please verify that the primary care physician listed in this form is contracted with BCN Advantage by calling **1-866-966-BLUE. TTY users should call 711.**

Please send your completed enrollment application to:

BCN Advantage HMO-POS
 Mail Code H300
 P.O. Box 5013
 Southfield, MI 48086

BCN AdvantageSM HMO-POS



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www.bcbsm.com/medicare