

# BCN Advantage HMO-POS

## 2021 Benefits at a Glance

### City of Detroit General Retiree Health



| Deductible, copayments and dollar maximums  |  |
|---|--|
| <b>Deductible</b>   | \$500 per member   |
| <b>Copays</b>   | \$25 for office visits, \$25 for urgent care visits \$65 for emergency room visits |
| • Fixed dollar copay  |  |
| • Percent copay   | 20% for select services  |
| Copoly dollar maximums  |  |
| • Fixed dollar copay  | None   |
| • Fixed dollar and percent copay (Maximum out of pocket)                              | \$1,500 per member<br>\$2,500 per calendar year                                    |
| <b>Dollar maximums</b>  | 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 \$25   |
| Online visits   | Covered – copay \$25   |
| Consulting specialist care — when referred  | Covered – copay \$25   |
| Emergency medical care  |  |
| Hospital emergency room — copay waived if admitted, inpatient hospital benefits apply | Covered – copay \$65 after deductible  |
| Urgent care center  | Covered – copay \$25   |
| Ambulance services — medically necessary  | Covered- 80% after deductible, 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 – 80% after deductible office visit copay may apply per member, per visit  |
| High technology imaging (includes MRI, MRA, CT scan, 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   |
| <b>Alternatives to hospital care</b>   |   |
| Skilled nursing care   | Covered – 100%, after deductible up to 100 days per benefit period  |
| Home health care   | Covered – 100%, physician visit copay may apply   |
| <b>Surgical services</b>   |   |
| Surgery — includes all related surgical services and anesthesia                | Covered- 80% after deductible   |
| Human organ transplants  | Covered- 80% after deductible, subject to medical criteria  |
| <b>Mental health care and substance use treatment</b>                          |   |
| Inpatient mental health care and substance use care                            | <b>Mental Health Care:</b><br>Covered – 100%, unlimited days. Prior authorization required.<br><b>Substance Abuse Care:</b><br>Covered – 100%, unlimited days |
| Outpatient mental health care  | Covered – 100%, unlimited visits  |
| Outpatient substance use care  | Covered – 100%, unlimited visits  |
| <b>Other services</b>  |   |
| 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 – copay \$20 after deductible   |
| Outpatient physical, speech and occupational therapy                           | Covered – copay \$25 after deductible   |
| Durable medical equipment  | Covered – 100%  |
| Prosthetic and orthotic appliances   | Covered – 100%  |
| <b>Prescription drugs</b>  |   |
| Formulary drug — Tier 1 — preferred generic                                    | Covered –<br>Standard Pharmacy: \$ 20 copay up to a 31-day supply<br>Preferred Pharmacy: \$ 10 copay up to a 31-day supply                                    |
| Formulary drug — Tier 2 — generic  | Covered –<br>Standard Pharmacy: \$ 20 copay up to a 31-day supply<br>Preferred Pharmacy: \$ 10 copay up to a 31-day supply                                    |
| Formulary drug — Tier 3 — preferred brand name                                 | Covered –<br>Standard Pharmacy: \$ 60 copay up to a 31-day supply<br>Preferred Pharmacy: \$ 45 copay up to a 31-day supply                                    |
| Formulary drug — Tier 4 — nonpreferred drugs                                   | Covered   |

|   |  |
|---|--|
|   | Standard Pharmacy: 50% coinsurance (\$80 min. copay and \$100 max)<br>Preferred Pharmacy: 50% coinsurance (\$80 min. copay and \$100 max)                  |
| Formulary drug — Tier 5 — specialty drugs     | Covered –<br>Standard Pharmacy: 50% coinsurance (\$160 min. copay and \$200 max)<br>Standard Pharmacy: 50% coinsurance (\$160 min. copay and \$200 max)    |
| <Formulary drug — Tier 6 — generic drugs>     | Covered –<br>Standard Pharmacy: \$copay up to a 31-day supply<br>Preferred Pharmacy: \$copay up to a 31-day supply   |
| 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 \$6,550 the copay is <b>the greater of</b> 5% or \$3.70 generics and \$9.20 brands, not to exceed base copay. |

**To be eligible to enroll in BCN Advantage HMO-POS, you must have Medicare Part A and Part B, and live in our service area.**

You can always view your most current *Evidence of Coverage* and riders 24/7 by signing into the secure Blue Cross online member account site, [www.bcbsm.com/medicare](http://www.bcbsm.com/medicare) or by contacting Customer Service. You must generally use network pharmacies for benefit coverage of Part D drug prescriptions. 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 [www.bcbsm.com/pharmaciesmedicare](http://www.bcbsm.com/pharmaciesmedicare). You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions online at [www.bcbsm.com/formularymedicare](http://www.bcbsm.com/formularymedicare).