



**BCN Advantage HMO-POS<sup>SM</sup>**



**Blue Care  
Network  
of Michigan**

Medicare and more

# **BCN Advantage HMO-POS Summary of Benefits**

**Option 1, Basic, Option 2 and Option 3**

January 1 to December 31, 2011

**[www.MiBCN.com/medicare](http://www.MiBCN.com/medicare)**

Blue Care Network of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association. A health plan with a Medicare contract.

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# Section I

## Introduction to the Summary of Benefits Report

Thank you for your interest in BCN Advantage (HMO-POS). Our plan is offered by BLUE CARE NETWORK OF MICHIGAN/Blue Care Network, a Medicare Advantage Health Maintenance Organization (HMO), with a point-of-service option (POS). This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call BCN Advantage (HMO-POS) and ask for the "Evidence of Coverage".

### **You have choices in your health care**

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like BCN Advantage (HMO-POS). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call BCN Advantage (HMO-POS) at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

### **How can I compare my options?**

You can compare BCN Advantage (HMO-POS) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

### **Where is BCN Advantage (HMO-POS) available?**

There is more than one plan listed in this Summary of Benefits. If you are enrolled in one plan and wish to switch to another plan, you may do so only during certain times of the year. Please call Customer Service for more information. The service area for this plan includes: Allegan, Barry, Bay, Calhoun, Clinton, Eaton, Genesee, Gratiot, Ingham, Ionia, Jackson, Kalamazoo, Kent, Lapeer, Livingston, Macomb, Midland, Monroe, Montcalm, Muskegon, Newaygo, Oakland, Oceana, Ottawa, Saginaw, Shiawassee, St. Clair, Tuscola, Van Buren, Washtenaw and Wayne counties, MI. You must live in one of these areas to join the plan.

### **Who is eligible to join BCN Advantage (HMO-POS)?**

You can join BCN Advantage (HMO-POS) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease are generally not eligible to enroll in BCN Advantage (HMO-POS) unless they are members of our organization and have been since their dialysis began.

### **Can I choose my doctors?**

BCN Advantage (HMO-POS) has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. In some cases, you may also go to doctors outside of our network. The health providers in our network can change at any time.

You can ask for a current Provider Directory or for an up-to-date list visit us at [www.MiBCN.com/medicareproviders](http://www.MiBCN.com/medicareproviders). Our customer service number is listed at the end of this introduction.

## **What happens if I go to a doctor who's not in your network?**

**When you are in Michigan**, if you choose to go to a doctor outside of our network you must pay for these services yourself. Neither BCN Advantage (HMO-POS) nor the Original Medicare Plan will pay for these services.

**If you are traveling outside of Michigan**, you are covered under our point-of-service BlueCard benefit and can access out-of-network doctors, specialists, or hospitals that participate with Blues plans. You may receive most plan-covered services at in-network out-of-pocket cost sharing. You may need to pay higher cost-sharing for routine care from non-network providers. The only services we always cover without an authorization are medical emergencies and urgently needed care. For more information, please call the customer service number at the end of this introduction.

## **Where can I get my prescriptions if I join this plan?**

BCN Advantage (HMO-POS) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at [www.MiBCN.com/medicarepharmacies](http://www.MiBCN.com/medicarepharmacies). Our customer service number is listed at the end of this introduction.

BCN Advantage (HMO-POS) has a list of preferred pharmacies. At these pharmacies, you may get your drugs at a lower copay or coinsurance. You may go to a non-preferred pharmacy, but you may have to pay more for your prescription drugs.

## **Does my plan cover Medicare Part B or Part D drugs?**

BCN Advantage (HMO-POS) Option 1, Basic, Option 2 and Option 3 do cover Medicare Part B prescription drugs. BCN Advantage (HMO-POS) Basic, Option 2 and Option 3 do cover Medicare Part D prescription drugs.

## **What is a prescription drug formulary?**

BCN Advantage (HMO-POS) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our website at [www.MiBCN.com/medicareformulary](http://www.MiBCN.com/medicareformulary).

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

## **How can I get extra help with my prescription drug plan costs or get extra help with other Medicare costs?**

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week; and see [www.medicare.gov](http://www.medicare.gov) 'Programs for People with Limited Income and Resources' in the publication Medicare & You.
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office.

## **What are my protections in this plan?**

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of BCN Advantage (HMO-POS), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of BCN Advantage (HMO-POS), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

## **What is a Medication Therapy Management (MTM) program?**

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate, but it is recommended that you take full advantage of this covered service if you are selected. Contact BCN Advantage (HMO-POS) for more details.

## **What types of drugs may be covered under Medicare Part B?**

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact BCN Advantage (HMO-POS) for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin Alfa or Epogen<sup>®</sup>): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.

- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and Infusion Drugs provided through DME.

### **Where can I find information on plan ratings?**

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the Web, you may use the Web tools on **www.medicare.gov** and select "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap Policies in Your Area" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

Please call Blue Care Network for more information about BCN Advantage (HMO-POS).

Visit us at **www.MiBCN.com/medicare** or, call us:

Customer Service Hours:

8 a.m. - 8 p.m. Eastern, seven days a week.

Current members should call toll-free 1-800-450-3680 for questions related to the Medicare Advantage Program or the Medicare Part D Prescription Drug program. (TTY 1-800-430-3211)

Prospective members should call toll-free 1-877-469-2583 for questions related to the Medicare Advantage Program or the Medicare Part D Prescription Drug program. (TTY 1-800-481-8704)

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, visit **www.medicare.gov** on the Web.

If you have special needs, this document may be available in other formats.

If you have any questions about this plan's benefits or costs, please contact Blue Care Network for details.



# Section II

## Summary of Benefits

| Benefit   | Original Medicare   | BCN Advantage Option 1   |
|---|---|--|
| <b>Important Information</b>  |   |  |
| <p><b>1</b> <b>Premium and Other Important Information</b></p>  | <p>In 2010 the monthly Part B Premium was \$96.40 and may change for 2011 and the yearly Part B deductible amount was \$155 and may change for 2011.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p><b>General</b></p> <p>Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> | <p><b>General</b></p> <p>\$8 to \$28 monthly plan premium in addition to your monthly Medicare Part B premium. Please refer to the Premium Table located after this section to find out what the premium is in your area.</p> <p>This plan covers all Medicare-covered preventive services with zero cost sharing.</p> <p>Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p><b>In-Network</b></p> <p>\$150 yearly deductible.</p> <p>Contact the plan for services that apply.</p> <p>\$4,400 out-of-pocket limit.</p> <p>There is no limit on cost sharing for the following services:</p> <p>Supplemental Services:</p> <ul style="list-style-type: none"> <li>• Eye Exams</li> <li>• Eye Wear</li> <li>• Hearing Exams</li> <li>• Hearing Aids</li> </ul> |
| <p><b>2</b> <b>Doctor and Hospital Choice</b></p> <p>(For more information, see Emergency Care - #15 and Urgently Needed Care - #16.)</p> | <p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>  | <p><b>In-Network</b></p> <p>Referral required for network specialists (for certain benefits).</p>  |

| BCN Advantage Basic  | BCN Advantage Option 2  | BCN Advantage Option 3   |
|--|---|--|
| <p><b>General</b><br/>           \$0 monthly plan premium in addition to your monthly Medicare Part B premium. Please refer to the Premium Table located after this section to find out what the premium is in your area.</p> <p>This plan covers all Medicare-covered preventive services with zero cost sharing.</p> <p>Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p><b>In-Network</b><br/>           \$200 yearly deductible.</p> <p>Contact the plan for services that apply.</p> <p>\$5,000 out-of-pocket limit.</p> <p>There is no limit on cost sharing for the following services:</p> <p>Supplemental Services:</p> <ul style="list-style-type: none"> <li>• Eye Exams</li> <li>• Eye Wear</li> <li>• Hearing Exams</li> <li>• Hearing Aids</li> </ul> | <p><b>General</b><br/>           \$59 to \$89 monthly plan premium in addition to your monthly Medicare Part B premium. Please refer to the Premium Table located after this section to find out what the premium is in your area.</p> <p>This plan covers all Medicare-covered preventive services with zero cost sharing.</p> <p>Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p><b>In-Network</b><br/>           \$100 yearly deductible.</p> <p>Contact the plan for services that apply.</p> <p>\$4,200 out-of-pocket limit.</p> <p>There is no limit on cost sharing for the following services:</p> <p>Supplemental Services:</p> <ul style="list-style-type: none"> <li>• Eye Exams</li> <li>• Eye Wear</li> <li>• Hearing Exams</li> <li>• Hearing Aids</li> </ul> | <p><b>General</b><br/>           \$181 to \$227 monthly plan premium in addition to your monthly Medicare Part B premium. Please refer to the Premium Table located after this section to find out what the premium is in your area.</p> <p>This plan covers all Medicare-covered preventive services with zero cost sharing.</p> <p>Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p><b>In-Network</b></p> <p>\$4,000 out-of-pocket limit.</p> <p>There is no limit on cost sharing for the following services:</p> <p>Supplemental Services:</p> <ul style="list-style-type: none"> <li>• Eye Exams</li> <li>• Eye Wear</li> <li>• Hearing Exams</li> <li>• Hearing Aids</li> </ul> |
| <p><b>In-Network</b><br/>           Referral required for network specialists (for certain benefits).</p>  | <p><b>In-Network</b><br/>           Referral required for network specialists (for certain benefits).</p>   | <p><b>In-Network</b><br/>           Referral required for network specialists (for certain benefits).</p>  |

| Benefit   | Original Medicare   | BCN Advantage Option 1  |
|---|---|---|
| <b>Inpatient Care</b>   |   |   |
| <p><b>3</b> <b>Inpatient Hospital Care</b><br/>(includes Substance Abuse and Rehabilitation Services)</p> | <p>In 2010 the amounts for each benefit period were:<br/> Days 1 - 60: \$1,100 deductible<br/> Days 61 - 90: \$275 per day<br/> Days 91 - 150: \$550 per lifetime reserve day<br/> These amounts will change for 2011.<br/> Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.<br/> Lifetime reserve days can only be used once.<br/> A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p> | <p><b>In-Network</b><br/> No limit to the number of days covered by the plan each benefit period.<br/> For Medicare-covered hospital stays:<br/> Days 1 - 5: \$175 copay per day<br/> Days 6 - 90: \$0 copay per day<br/> \$0 copay for additional hospital days<br/> Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> |
| <p><b>4</b> <b>Inpatient Mental Health Care</b></p>   | <p>Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above).<br/> 190 day lifetime limit in a Psychiatric Hospital.</p>   | <p><b>In-Network</b><br/> You get up to 190 days in a Psychiatric Hospital in a lifetime.<br/> For Medicare-covered hospital stays:<br/> Days 1 - 5: \$175 copay per day<br/> Days 6 - 90: \$0 copay per day<br/> Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>   |

| BCN Advantage Basic  | BCN Advantage Option 2   | BCN Advantage Option 3  |
|--|--|---|
| <p><b>In-Network</b><br/>No limit to the number of days covered by the plan each benefit period.</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 - 5: \$225 copay per day<br/>Days 6 - 90: \$0 copay per day<br/>\$0 copay for additional hospital days</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> | <p><b>In-Network</b><br/>No limit to the number of days covered by the plan each benefit period.</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 - 5: \$125 copay per day<br/>Days 6 - 90: \$0 copay per day<br/>\$0 copay for additional hospital days</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> | <p><b>In-Network</b><br/>No limit to the number of days covered by the plan each benefit period.</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 - 5: \$80 copay per day<br/>Days 6 - 90: \$0 copay per day<br/>\$0 copay for additional hospital days</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> |
| <p><b>In-Network</b><br/>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 - 5: \$225 copay per day<br/>Days 6 - 90: \$0 copay per day</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>  | <p><b>In-Network</b><br/>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 - 5: \$125 copay per day<br/>Days 6 - 90: \$0 copay per day</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>  | <p><b>In-Network</b><br/>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 - 5: \$80 copay per day<br/>Days 6 - 90: \$0 copay per day</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>  |

| Benefit   | Original Medicare   | BCN Advantage Option 1   |
|---|---|--|
| <p><b>5 Skilled Nursing Facility (SNF)</b><br/>(in a Medicare-certified skilled nursing facility)</p>   | <p>In 2010 the amounts for each benefit period after at least a 3-day covered hospital stay were:</p> <p>Days 1 - 20: \$0 per day<br/>Days 21 - 100: \$137.50 per day</p> <p>These amounts will change for 2011.</p> <p>100 days for each benefit period.</p> <p>A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care.</p> <p>If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p> | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>Plan covers up to 100 days each benefit period</p> <p>No prior hospital stay is required.</p> <p>For SNF stays:</p> <p>Days 1 - 20: \$0 copay per day<br/>Days 21 - 100: \$130 copay per day</p>               |
| <p><b>6 Home Health Care</b><br/>(includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p> | <p>\$0 copay.</p>   | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$0 copay for Medicare-covered home health visits.</p>   |
| <p><b>7 Hospice</b></p>   | <p>You pay part of the cost for outpatient drugs and inpatient respite care.</p> <p>You must get care from a Medicare-certified hospice.</p>  | <p><b>General</b><br/>You must get care from a Medicare-certified hospice.</p>   |
| <b>Outpatient Care</b>  |   |  |
| <p><b>8 Doctor Office Visits</b></p>  | <p>20% coinsurance</p>  | <p><b>General</b><br/>See "Physical Exams," for more information.</p> <p>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$20 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$35 copay for each specialist visit for Medicare-covered benefits.</p> |

| BCN Advantage Basic  | BCN Advantage Option 2   | BCN Advantage Option 3   |
|--|--|--|
| <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>Plan covers up to 100 days each benefit period.<br/>No prior hospital stay is required.<br/>For SNF stays:<br/>Days 1 - 20: \$0 copay per day<br/>Days 21 - 100: \$130 copay per day</p>                 | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>Plan covers up to 100 days each benefit period.<br/>No prior hospital stay is required.<br/>For SNF stays:<br/>Days 1 - 20: \$0 copay per day<br/>Days 21 - 100: \$130 copay per day</p>                 | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>Plan covers up to 100 days each benefit period.<br/>No prior hospital stay is required.<br/>For SNF stays:<br/>Days 1 - 20: \$0 copay per day<br/>Days 21 - 100: \$130 copay per day</p>                 |
| <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$0 copay for Medicare-covered home health visits.</p>   | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$0 copay for Medicare-covered home health visits.</p>   | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$0 copay for Medicare-covered home health visits.</p>   |
| <p><b>General</b><br/>You must get care from a Medicare-certified hospice.</p>   | <p><b>General</b><br/>You must get care from a Medicare-certified hospice.</p>   | <p><b>General</b><br/>You must get care from a Medicare-certified hospice.</p>   |
| <p><b>General</b><br/>See "Physical Exams," for more information.<br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$25 copay for each primary care doctor visit for Medicare-covered benefits.<br/>\$40 copay for each specialist visit for Medicare-covered benefits.</p> | <p><b>General</b><br/>See "Physical Exams," for more information.<br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$15 copay for each primary care doctor visit for Medicare-covered benefits.<br/>\$30 copay for each specialist visit for Medicare-covered benefits.</p> | <p><b>General</b><br/>See "Physical Exams," for more information.<br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$10 copay for each primary care doctor visit for Medicare-covered benefits.<br/>\$20 copay for each specialist visit for Medicare-covered benefits.</p> |

| Benefit                |   | Original Medicare  | BCN Advantage Option 1  |
|------------------------|---|--|---|
| <b>Outpatient Care</b> |   |  |   |
| <b>9</b>               | <b>Chiropractic Services</b>  | Routine care not covered<br>20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers. | <b>General</b><br>Authorization rules may apply.<br><b>In-Network</b><br>\$35 copay for each Medicare-covered visit.<br>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers. |
| <b>10</b>              | <b>Podiatry Services</b>  | Routine care not covered.<br>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.   | <b>General</b><br>Authorization rules may apply.<br><b>In-Network</b><br>\$35 copay for each Medicare-covered visit.<br>Medicare-covered podiatry benefits are for medically-necessary foot care.   |
| <b>11</b>              | <b>Outpatient Mental Health Care</b>                                  | 45% coinsurance for most outpatient mental health services.  | <b>General</b><br>Authorization rules may apply.<br><b>In-Network</b><br>\$35 copay for each Medicare-covered individual or group therapy visit.  |
| <b>12</b>              | <b>Outpatient Substance Abuse Care</b>                                | 20% coinsurance  | <b>General</b><br>Authorization rules may apply.<br><b>In-Network</b><br>\$35 copay for Medicare-covered individual or group visits.  |
| <b>13</b>              | <b>Outpatient Services/Surgery</b>                                    | 20% coinsurance for the doctor.<br>Specified copayment for outpatient hospital facility charges. Copay cannot exceed Part A inpatient hospital deductible.<br>20% copayment for ambulatory surgical center facility charges.     | <b>General</b><br>Authorization rules may apply.<br><b>In-Network</b><br>\$75 copay for each Medicare-covered ambulatory surgical center visit.<br>\$50 to \$125 copay for each Medicare-covered outpatient hospital facility visit.  |
| <b>14</b>              | <b>Ambulance Services</b><br>(medically necessary ambulance services) | 20% coinsurance  | <b>General</b><br>Authorization rules may apply.<br><b>In-Network</b><br>\$50 copay for Medicare-covered ambulance benefits.  |

| BCN Advantage Basic  | BCN Advantage Option 2   | BCN Advantage Option 3   |
|--|--|--|
| <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$40 copay for each Medicare-covered visit.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p> | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$30 copay for each Medicare-covered visit.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p> | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$20 copay for each Medicare-covered visit.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p> |
| <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$40 copay for each Medicare-covered visit.</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>   | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$30 copay for each Medicare-covered visit.</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>   | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$20 copay for each Medicare-covered visit.</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>   |
| <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$40 copay for each Medicare-covered individual or group therapy visit.</p>  | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$30 copay for each Medicare-covered individual or group therapy visit.</p>  | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$20 copay for each Medicare-covered individual or group therapy visit.</p>  |
| <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$40 copay for Medicare-covered individual or group visits.</p>  | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$30 copay for Medicare-covered individual or group visits.</p>  | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$20 copay for Medicare-covered individual or group visits.</p>  |
| <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$75 copay for each Medicare-covered ambulatory surgical center visit.</p> <p>\$50 to \$125 copay for each Medicare-covered outpatient hospital facility visit.</p>  | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$60 copay for each Medicare-covered ambulatory surgical center visit.</p> <p>\$40 to \$100 copay for each Medicare-covered outpatient hospital facility visit.</p>  | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$45 copay for each Medicare-covered ambulatory surgical center visit.</p> <p>\$30 to \$75 copay for each Medicare-covered outpatient hospital facility visit.</p>   |
| <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$50 copay for Medicare-covered ambulance benefits.</p>  | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$50 copay for Medicare-covered ambulance benefits.</p>  | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$50 copay for Medicare-covered ambulance benefits.</p>  |

| Benefit   | Original Medicare  | BCN Advantage Option 1  |
|---|--|---|
| <p><b>15</b> <b>Emergency Care</b></p> <p>(You may go to any emergency room if you reasonably believe you need emergency care.)</p>   | <p>20% coinsurance for the doctor<br/>Specified copayment for outpatient hospital emergency room (ER) facility charge.<br/>ER copay cannot exceed Part A inpatient hospital deductible.<br/>You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit<br/>NOT covered outside the U.S. except under limited circumstances.</p> | <p><b>General</b><br/>\$50 copay for Medicare-covered emergency room visits.<br/>Worldwide coverage.<br/>If you are admitted to the hospital within 1-day for the same condition, you pay \$0 for the emergency room visit</p>  |
| <p><b>16</b> <b>Urgently Needed Care</b></p> <p>(This is NOT emergency care, and in most cases, is out of the service area.)</p>  | <p>20% coinsurance, or a set copay<br/>NOT covered outside the U.S. except under limited circumstances.</p>  | <p><b>General</b><br/>\$35 copay for Medicare-covered urgently needed care visits.</p>  |
| <p><b>17</b> <b>Outpatient Rehabilitation Services</b></p> <p>(Occupational Therapy, Physical Therapy, Speech and Language Therapy, Respiratory Therapy Services, Social/ Psychological Services, and more)</p> | <p>20% coinsurance</p>   | <p><b>General</b><br/>Authorization rules may apply.<br/><b>In-Network</b><br/>\$35 copay for Medicare-covered Occupational Therapy visits.<br/>\$35 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.<br/>\$35 copay for Medicare-covered Cardiac Rehab services.</p> |
| <b>Outpatient Medical Services and Supplies</b>   |  |   |
| <p><b>18</b> <b>Durable Medical Equipment</b></p> <p>(includes wheelchairs, oxygen, etc.)</p>   | <p>20% coinsurance</p>   | <p><b>General</b><br/>Authorization rules may apply.<br/><b>In-Network</b><br/>20% of the cost for Medicare-covered items.</p>  |
| <p><b>19</b> <b>Prosthetic Devices</b></p> <p>(includes braces, artificial limbs and eyes, etc.)</p>  | <p>20% coinsurance</p>   | <p><b>General</b><br/>Authorization rules may apply.<br/><b>In-Network</b><br/>20% of the cost for Medicare-covered items.</p>  |

| BCN Advantage Basic   | BCN Advantage Option 2  | BCN Advantage Option 3  |
|---|---|---|
| <p><b>General</b><br/>\$50 copay for Medicare-covered emergency room visits.<br/>Worldwide coverage.<br/>If you are admitted to the hospital within 1-day for the same condition, you pay \$0 for the emergency room visit</p>  | <p><b>General</b><br/>\$50 copay for Medicare-covered emergency room visits.<br/>Worldwide coverage.<br/>If you are admitted to the hospital within 1-day for the same condition, you pay \$0 for the emergency room visit</p>  | <p><b>General</b><br/>\$50 copay for Medicare-covered emergency room visits.<br/>Worldwide coverage.<br/>If you are admitted to the hospital within 1-day for the same condition, you pay \$0 for the emergency room visit</p>  |
| <p><b>General</b><br/>\$35 copay for Medicare-covered urgently needed care visits.</p>  | <p><b>General</b><br/>\$35 copay for Medicare-covered urgently needed care visits.</p>  | <p><b>General</b><br/>\$35 copay for Medicare-covered urgently needed care visits.</p>  |
| <p><b>General</b><br/>Authorization rules may apply.<br/><b>In-Network</b><br/>\$40 copay for Medicare-covered Occupational Therapy visits.<br/>\$40 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.<br/>\$40 copay for Medicare-covered Cardiac Rehab services.</p> | <p><b>General</b><br/>Authorization rules may apply.<br/><b>In-Network</b><br/>\$30 copay for Medicare-covered Occupational Therapy visits.<br/>\$30 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.<br/>\$30 copay for Medicare-covered Cardiac Rehab services.</p> | <p><b>General</b><br/>Authorization rules may apply.<br/><b>In-Network</b><br/>\$20 copay for Medicare-covered Occupational Therapy visits.<br/>\$20 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.<br/>\$20 copay for Medicare-covered Cardiac Rehab services.</p> |
|   |   |   |
| <p><b>General</b><br/>Authorization rules may apply.<br/><b>In-Network</b><br/>20% of the cost for Medicare-covered items.</p>  | <p><b>General</b><br/>Authorization rules may apply.<br/><b>In-Network</b><br/>20% of the cost for Medicare-covered items.</p>  | <p><b>General</b><br/>Authorization rules may apply.<br/><b>In-Network</b><br/>20% of the cost for Medicare-covered items.</p>  |
| <p><b>General</b><br/>Authorization rules may apply.<br/><b>In-Network</b><br/>20% of the cost for Medicare-covered items.</p>  | <p><b>General</b><br/>Authorization rules may apply.<br/><b>In-Network</b><br/>20% of the cost for Medicare-covered items.</p>  | <p><b>General</b><br/>Authorization rules may apply.<br/><b>In-Network</b><br/>20% of the cost for Medicare-covered items.</p>  |

| Benefit   | Original Medicare   | BCN Advantage Option 1   |
|---|---|--|
| <p><b>20</b> <b>Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies</b></p> <p>(includes coverage for glucose monitors, test strips, lancets, screening tests, self-management training, retinal exam/glaucoma test, and foot exam/therapeutic soft shoes)</p> | <p>20% coinsurance</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>   | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$0 copay for diabetes self-monitoring training.<br/>\$0 copay for nutrition therapy for diabetes.<br/>\$0 copay for diabetes supplies.<br/>Separate office visit cost sharing of \$20 to \$35 may apply.</p>  |
| <p><b>21</b> <b>Diagnostic Tests, X-rays, Lab Services, and Radiology Services</b></p> <p>(for people with Medicare age 50 and older)</p>   | <p>20% coinsurance for diagnostic tests and X-rays</p> <p>\$0 copay for Medicare-covered lab services</p> <p>Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.</p> | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$0 copay for Medicare-covered lab services.<br/>\$0 to \$40 copay for Medicare-covered diagnostic procedures and tests.<br/>\$20 to \$40 copay for Medicare-covered X-rays.<br/>\$20 to \$40 copay for Medicare-covered diagnostic radiology services (not including X-rays).<br/>\$0 copay for Medicare-covered therapeutic radiology services.<br/>Separate office visit cost sharing of \$20 to \$35 may apply for outpatient diagnostic procedures, tests and lab services.<br/>Separate office visit cost sharing of \$20 to \$35 may apply for outpatient diagnostic and therapeutic radiological services.</p> |

| BCN Advantage Basic  | BCN Advantage Option 2   | BCN Advantage Option 3   |
|--|--|--|
| <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$0 copay for diabetes self-monitoring training.<br/>\$0 copay for nutrition therapy for diabetes.<br/>\$0 copay for diabetes supplies.<br/>Separate office visit cost sharing of \$25 to \$40 may apply.</p>  | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$0 copay for diabetes self-monitoring training.<br/>\$0 copay for nutrition therapy for diabetes.<br/>\$0 copay for diabetes supplies.<br/>Separate office visit cost sharing of \$15 to \$30 may apply.</p>  | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$0 copay for diabetes self-monitoring training.<br/>\$0 copay for nutrition therapy for diabetes.<br/>\$0 copay for diabetes supplies.<br/>Separate office visit cost sharing of \$10 to \$20 may apply.</p>  |
| <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$0 copay for Medicare-covered lab services.<br/>\$0 to \$40 copay for Medicare-covered diagnostic procedures and tests.<br/>\$20 to \$40 copay for Medicare-covered X-rays.<br/>\$20 to \$40 copay for Medicare-covered diagnostic radiology services (not including X-rays).<br/>\$0 copay for Medicare-covered therapeutic radiology services.<br/>Separate office visit cost sharing of \$25 to \$40 may apply for outpatient diagnostic procedures, tests and lab services.<br/>Separate office visit cost sharing of \$25 to \$40 may apply for outpatient diagnostic and therapeutic radiological services.</p> | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$0 copay for Medicare-covered lab services.<br/>\$0 to \$40 copay for Medicare-covered diagnostic procedures and tests.<br/>\$20 to \$40 copay for Medicare-covered X-rays.<br/>\$20 to \$40 copay for Medicare-covered diagnostic radiology services (not including X-rays).<br/>\$0 copay for Medicare-covered therapeutic radiology services.<br/>Separate office visit cost sharing of \$15 to \$30 may apply for outpatient diagnostic procedures, tests and lab services.<br/>Separate office visit cost sharing of \$15 to \$30 may apply for outpatient diagnostic and therapeutic radiological services.</p> | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$0 copay for Medicare-covered lab services.<br/>\$0 to \$20 copay for Medicare-covered diagnostic procedures and tests.<br/>\$10 to \$20 copay for Medicare-covered X-rays.<br/>\$10 to \$20 copay for Medicare-covered diagnostic radiology services (not including X-rays).<br/>\$0 copay for Medicare-covered therapeutic radiology services.<br/>Separate office visit cost sharing of \$10 to \$20 may apply for outpatient diagnostic procedures, tests and lab services.<br/>Separate office visit cost sharing of \$10 to \$20 may apply for outpatient diagnostic and therapeutic radiological services.</p> |

| Benefit                    |  | Original Medicare   | BCN Advantage Option 1   |
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| <b>Preventive Services</b> |  |   |  |
| <b>22</b>                  | <b>Bone Mass Measurement</b><br><br>(for people with Medicare who are at risk)   | No coinsurance, copayment or deductible.<br><br>Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.  | <b>In-Network</b><br>\$0 copay for Medicare-covered bone mass measurement<br><br>Separate office visit cost sharing of \$20 to \$35 may apply.   |
| <b>23</b>                  | <b>Colorectal Screening Exams</b><br><br>(for people with Medicare age 50 and older)   | Covered when you are high risk or when you are age 50 and older.  | <b>In-Network</b><br>\$0 copay for <ul style="list-style-type: none"> <li>• Medicare-covered colorectal screenings</li> <li>• Up to 1 additional screening(s) every year</li> </ul> Separate office visit cost sharing of \$20 to \$35 may apply.  |
| <b>24</b>                  | <b>Immunizations</b><br><br>(Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine) | \$0 copay for Flu, Pneumonia Hepatitis B vaccines<br><br>You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.  | <b>In-Network</b><br>\$0 copay for Flu and Pneumonia vaccines.<br><br>\$0 copay for Hepatitis B vaccine.<br><br>No referral needed for Flu and pneumonia vaccines.<br><br>Separate office visit cost sharing of \$20 to \$35 may apply.<br><br>No referral needed for other immunizations. |
| <b>25</b>                  | <b>Mammograms (Annual Screening)</b><br><br>(for women with Medicare age 40 and older)                                       | No coinsurance, copayment or deductible.<br><br>No referral needed.<br><br>Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.                      | <b>In-Network</b><br>\$0 copay for <ul style="list-style-type: none"> <li>• Medicare-covered screening mammograms</li> <li>• Up to 1 additional screening mammogram(s) every year</li> </ul> Separate office visit cost sharing of \$20 to \$35 may apply.                                 |
| <b>26</b>                  | <b>Pap Smears and Pelvic Exams</b><br><br>(for women with Medicare)  | No coinsurance, copayment or deductible for Pap smears.<br><br>No coinsurance, copayment or deductible for Pelvic and clinical breast exams<br><br>Covered once every 2 years.<br><br>Covered once a year for women with Medicare at high risk. | <b>In-Network</b><br>\$0 copay for <ul style="list-style-type: none"> <li>• Medicare-covered pap smears and pelvic exams</li> <li>• Up to 1 additional pap smear(s) and pelvic exam(s) every year</li> </ul> Separate office visit cost sharing of \$20 to \$35 may apply.                 |

| BCN Advantage Basic  | BCN Advantage Option 2   | BCN Advantage Option 3   |
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| <p><b>In-Network</b><br/>\$0 copay for Medicare-covered bone mass measurement</p> <p>Separate office visit cost sharing of \$25 to \$40 may apply.</p>   | <p><b>In-Network</b><br/>\$0 copay for Medicare-covered bone mass measurement</p> <p>Separate office visit cost sharing of \$15 to \$30 may apply.</p>   | <p><b>In-Network</b><br/>\$0 copay for Medicare-covered bone mass measurement</p> <p>Separate office visit cost sharing of \$10 to \$20 may apply.</p>   |
| <p><b>In-Network</b><br/>\$0 copay for</p> <ul style="list-style-type: none"> <li>• Medicare-covered colorectal screenings</li> <li>• Up to 1 additional screening(s) every year</li> </ul> <p>Separate office visit cost sharing of \$25 to \$40 may apply.</p>                                   | <p><b>In-Network</b><br/>\$0 copay for</p> <ul style="list-style-type: none"> <li>• Medicare-covered colorectal screenings</li> <li>• Up to 1 additional screening(s) every year</li> </ul> <p>Separate office visit cost sharing of \$15 to \$30 may apply.</p>                                   | <p><b>In-Network</b><br/>\$0 copay for</p> <ul style="list-style-type: none"> <li>• Medicare-covered colorectal screenings</li> <li>• Up to 1 additional screening(s) every year</li> </ul> <p>Separate office visit cost sharing of \$10 to \$20 may apply.</p>                                   |
| <p><b>In-Network</b><br/>\$0 copay for Flu and Pneumonia vaccines.</p> <p>\$0 copay for Hepatitis B vaccine.</p> <p>No referral needed for Flu and pneumonia vaccines.</p> <p>Separate office visit cost sharing of \$25 to \$40 may apply.</p> <p>No referral needed for other immunizations.</p> | <p><b>In-Network</b><br/>\$0 copay for Flu and Pneumonia vaccines.</p> <p>\$0 copay for Hepatitis B vaccine.</p> <p>No referral needed for Flu and pneumonia vaccines.</p> <p>Separate office visit cost sharing of \$15 to \$30 may apply.</p> <p>No referral needed for other immunizations.</p> | <p><b>In-Network</b><br/>\$0 copay for Flu and Pneumonia vaccines.</p> <p>\$0 copay for Hepatitis B vaccine.</p> <p>No referral needed for Flu and pneumonia vaccines.</p> <p>Separate office visit cost sharing of \$10 to \$20 may apply.</p> <p>No referral needed for other immunizations.</p> |
| <p><b>In-Network</b><br/>\$0 copay for</p> <ul style="list-style-type: none"> <li>• Medicare-covered screening mammograms</li> <li>• Up to 1 additional screening mammogram(s) every year</li> </ul> <p>Separate office visit cost sharing of \$25 to \$40 may apply.</p>                          | <p><b>In-Network</b><br/>\$0 copay for</p> <ul style="list-style-type: none"> <li>• Medicare-covered screening mammograms</li> <li>• Up to 1 additional screening mammogram(s) every year</li> </ul> <p>Separate office visit cost sharing of \$15 to \$30 may apply.</p>                          | <p><b>In-Network</b><br/>\$0 copay for</p> <ul style="list-style-type: none"> <li>• Medicare-covered screening mammograms</li> <li>• Up to 1 additional screening mammogram(s) every year</li> </ul> <p>Separate office visit cost sharing of \$10 to \$20 may apply.</p>                          |
| <p><b>In-Network</b><br/>\$0 copay for</p> <ul style="list-style-type: none"> <li>• Medicare-covered pap smears and pelvic exams</li> <li>• Up to 1 additional pap smear(s) and pelvic exam(s) every year</li> </ul> <p>Separate office visit cost sharing of \$25 to \$40 may apply.</p>          | <p><b>In-Network</b><br/>\$0 copay for</p> <ul style="list-style-type: none"> <li>• Medicare-covered pap smears and pelvic exams</li> <li>• Up to 1 additional pap smear(s) and pelvic exam(s) every year</li> </ul> <p>Separate office visit cost sharing of \$15 to \$30 may apply.</p>          | <p><b>In-Network</b><br/>\$0 copay for</p> <ul style="list-style-type: none"> <li>• Medicare-covered pap smears and pelvic exams</li> <li>• Up to 1 additional pap smear(s) and pelvic exam(s) every year</li> </ul> <p>Separate office visit cost sharing of \$10 to \$20 may apply.</p>          |

| Benefit   | Original Medicare   | BCN Advantage Option 1  |
|---|---|---|
| <p><b>27</b> <b>Prostate Cancer Screening Exams</b></p> <p>(for men with Medicare age 50 and older)</p> | <p>20% coinsurance for the digital rectal exam.</p> <p>\$0 for the PSA test; 20% coinsurance for other related services.</p> <p>Covered once a year for all men with Medicare over age 50.</p>  | <p><b>In-Network</b></p> <p>\$0 copay for</p> <ul style="list-style-type: none"> <li>• Medicare-covered prostate cancer screening</li> <li>• Up to 1 additional screening(s) every year</li> </ul> <p>Separate office visit cost sharing of \$20 to \$35 may apply.</p> |
| <p><b>28</b> <b>End-Stage Renal Disease</b></p>   | <p>20% coinsurance for renal dialysis</p> <p>20% coinsurance for nutrition therapy for End-Stage Renal Disease</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p> | <p><b>General</b></p> <p>Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>\$0 copay for renal dialysis</p> <p>\$0 copay for nutrition therapy for End-Stage Renal Disease</p>   |

| BCN Advantage Basic  | BCN Advantage Option 2   | BCN Advantage Option 3   |
|--|--|--|
| <p><b>In-Network</b><br/>\$0 copay for</p> <ul style="list-style-type: none"> <li>• Medicare-covered prostate cancer screening</li> <li>• Up to 1 additional screening(s) every year</li> </ul> <p>Separate office visit cost sharing of \$25 to \$40 may apply.</p> | <p><b>In-Network</b><br/>\$0 copay for</p> <ul style="list-style-type: none"> <li>• Medicare-covered prostate cancer screening</li> <li>• Up to 1 additional screening(s) every year</li> </ul> <p>Separate office visit cost sharing of \$15 to \$30 may apply.</p> | <p><b>In-Network</b><br/>\$0 copay for</p> <ul style="list-style-type: none"> <li>• Medicare-covered prostate cancer screening</li> <li>• Up to 1 additional screening(s) every year</li> </ul> <p>Separate office visit cost sharing of \$10 to \$20 may apply.</p> |
| <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$0 copay for renal dialysis</p> <p>\$0 copay for nutrition therapy for End-Stage Renal Disease</p>  | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$0 copay for renal dialysis</p> <p>\$0 copay for nutrition therapy for End-Stage Renal Disease</p>  | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$0 copay for renal dialysis</p> <p>\$0 copay for nutrition therapy for End-Stage Renal Disease</p>  |

| Benefit   | Original Medicare         | BCN Advantage Option 1   |
|-----------|---------------------------|--|
| <b>29</b> | <b>Prescription Drugs</b> | <p><b><i>Drugs covered under Medicare Part B</i></b></p> <p><b>General</b><br/>Most drugs not covered.<br/>\$0 copay for Part B-covered drugs.</p> |
|           |                           | <p><b><i>Drugs Covered under Medicare Part D</i></b></p> <p><b>General</b><br/>This plan does not offer prescription drug coverage.</p>            |

| <b>BCN Advantage Basic</b>   | <b>BCN Advantage Option 2</b>   | <b>BCN Advantage Option 3</b>   |
|--|---|---|
| <b>Drugs covered under Medicare Part B</b>   | <b>Drugs covered under Medicare Part B</b>  | <b>Drugs covered under Medicare Part B</b>  |
| <b>General</b><br>\$0 copay for Part B-covered drugs.  | <b>General</b><br>\$0 copay for Part B-covered drugs.   | <b>General</b><br>\$0 copay for Part B-covered drugs.   |
| <b>Home Infusion Drugs, Supplies and Services</b><br><b>General</b><br>\$0 copay for home infusion drugs that would normally be covered under Part D. This cost-sharing amount will also cover the supplies and services associated with home infusion of these drugs.   | <b>Home Infusion Drugs, Supplies and Services</b><br><b>General</b><br>\$0 copay for home infusion drugs that would normally be covered under Part D. This cost-sharing amount will also cover the supplies and services associated with home infusion of these drugs.  | <b>Home Infusion Drugs, Supplies and Services</b><br><b>General</b><br>\$0 copay for home infusion drugs that would normally be covered under Part D. This cost-sharing amount will also cover the supplies and services associated with home infusion of these drugs.  |
| <b>Drugs Covered under Medicare Part D</b>   | <b>Drugs Covered under Medicare Part D</b>  | <b>Drugs Covered under Medicare Part D</b>  |
| <b>General</b><br>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at <a href="http://www.MiBCN.com/medicare-formulary">www.MiBCN.com/medicare formulary</a> on the Web.<br><br>Different out-of-pocket costs may apply for people who <ul style="list-style-type: none"> <li>• have limited incomes,</li> <li>• live in long term care facilities, or</li> <li>• have access to Indian/Tribal/Urban (Indian Health Service).</li> </ul> The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).<br><br>Total yearly drug costs are the total drug costs paid by both you and the plan.<br><br>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.<br><br>Some drugs have quantity limits. Your provider must get prior authorization from BCN Advantage Basic (HMO-POS) for certain drugs. | <b>General</b><br>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at <a href="http://www.MiBCN.com/medicare-formulary">www.MiBCN.com/medicare formulary</a> on the Web.<br><br>Different out-of-pocket costs may apply for people who <ul style="list-style-type: none"> <li>• have limited incomes,</li> <li>• live in long term care facilities, or</li> <li>• have access to Indian/Tribal/Urban (Indian Health Service).</li> </ul> The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).<br><br>Total yearly drug costs are the total drug costs paid by both you and the plan.<br><br>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.<br><br>Some drugs have quantity limits. Your provider must get prior authorization from BCN Advantage Option 2 (HMO-POS) for certain drugs. | <b>General</b><br>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at <a href="http://www.MiBCN.com/medicare-formulary">www.MiBCN.com/medicare formulary</a> on the Web.<br><br>Different out-of-pocket costs may apply for people who <ul style="list-style-type: none"> <li>• have limited incomes,</li> <li>• live in long term care facilities, or</li> <li>• have access to Indian/Tribal/Urban (Indian Health Service).</li> </ul> The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).<br><br>Total yearly drug costs are the total drug costs paid by both you and the plan.<br><br>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.<br><br>Some drugs have quantity limits. Your provider must get prior authorization from BCN Advantage Option 3 (HMO-POS) for certain drugs. |

| Benefit   | Original Medicare | BCN Advantage Option 1 |
|---|-------------------|------------------------|
| <b>Prescription Drugs</b><br><i>(continued)</i> |                   |                        |

| BCN Advantage Basic   | BCN Advantage Option 2   | BCN Advantage Option 3  |
|---|--|---|
| <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on <a href="http://www.medicare.gov">www.medicare.gov</a>.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p><b>In-Network</b><br/>\$310 yearly deductible.</p> <p><b>Initial Coverage</b><br/>After you pay your yearly deductible, you pay 25% until total yearly drug costs reach \$2,840.</p> <p><b>Retail Pharmacy</b><br/>You can get drugs the following way(s):</p> <ul style="list-style-type: none"> <li>• one-month (34-day) supply</li> <li>• three-month (90-day) supply</li> </ul> <p>Not all drugs are available at this extended day supply. Please contact the plan for more information.</p> | <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on <a href="http://www.medicare.gov">www.medicare.gov</a>.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>If you request a formulary exception for a drug and BCN Advantage Option 2 (HMO-POS) approves the exception, you will pay Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs cost sharing for that drug.</p> <p><b>In-Network</b><br/>\$0 deductible.</p> <p><b>Initial Coverage</b><br/>You pay the following until total yearly drug costs reach \$2,840:</p> <p><b>Retail Pharmacy</b></p> <p><b>Tier 1: Preferred Generic Drugs</b></p> <ul style="list-style-type: none"> <li>• \$4 copay for a one-month (34-day) supply of drugs in this tier from a preferred pharmacy</li> <li>• \$10 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy</li> <li>• \$4 copay for a one-month (34-day) supply of drugs in this tier from a non-preferred pharmacy</li> <li>• \$12 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy</li> </ul> <p><b>Tier 2: Preferred Brand Drugs</b></p> <ul style="list-style-type: none"> <li>• \$35 copay for a one-month (34-day) supply of drugs in this tier from a preferred pharmacy</li> </ul> | <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on <a href="http://www.medicare.gov">www.medicare.gov</a>.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>If you request a formulary exception for a drug and BCN Advantage Option 3 (HMO-POS) approves the exception, you will pay Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs cost sharing for that drug.</p> <p><b>In-Network</b><br/>\$0 deductible.</p> <p><b>Initial Coverage</b><br/>You pay the following until total yearly drug costs reach \$2,840:</p> <p><b>Retail Pharmacy</b></p> <p><b>Tier 1: Preferred Generic Drugs</b></p> <ul style="list-style-type: none"> <li>• \$3 copay for a one-month (34-day) supply of drugs in this tier from a preferred pharmacy</li> <li>• \$7.50 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy</li> <li>• \$3 copay for a one-month (34-day) supply of drugs in this tier from a non-preferred pharmacy</li> <li>• \$9 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy</li> </ul> <p><b>Tier 2: Preferred Brand Drugs</b></p> <ul style="list-style-type: none"> <li>• \$30 copay for a one-month (34-day) supply of drugs in this tier from a preferred pharmacy</li> </ul> |

| Benefit   | Original Medicare | BCN Advantage Option 1 |
|---|-------------------|------------------------|
| <b>Prescription Drugs</b><br><i>(continued)</i> |                   |                        |

| BCN Advantage Basic | BCN Advantage Option 2   | BCN Advantage Option 3   |
|---------------------|--|--|
|                     | <ul style="list-style-type: none"> <li>• \$87.50 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy</li> <li>• \$35 copay for a one-month (34-day) supply of drugs in this tier from a non-preferred pharmacy</li> <li>• \$105 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy</li> </ul> <p><b>Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs</b></p> <ul style="list-style-type: none"> <li>• \$75 copay for a one-month (34-day) supply of drugs in this tier from a preferred pharmacy</li> <li>• \$187.50 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy</li> <li>• \$75 copay for a one-month (34-day) supply of drugs in this tier from a non-preferred pharmacy</li> <li>• \$225 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy</li> </ul> <p><b>Tier 4: Specialty Tier Drugs</b></p> <ul style="list-style-type: none"> <li>• 25% coinsurance for a one-month (34-day) supply of drugs in this tier from a preferred pharmacy</li> <li>• 25% coinsurance for a one-month (34-day) supply of drugs in this tier from a non-preferred pharmacy</li> </ul> <p><b>Tier 5: Injectable Drugs</b></p> <ul style="list-style-type: none"> <li>• 25% coinsurance for a one-month (34-day) supply of drugs in this tier from a preferred pharmacy</li> <li>• 25% coinsurance for a one-month (34-day) supply of drugs in this tier from a non-preferred pharmacy</li> </ul> | <ul style="list-style-type: none"> <li>• \$75 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy</li> <li>• \$30 copay for a one-month (34-day) supply of drugs in this tier from a non-preferred pharmacy</li> <li>• \$90 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy</li> </ul> <p><b>Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs</b></p> <ul style="list-style-type: none"> <li>• \$65 copay for a one-month (34-day) supply of drugs in this tier from a preferred pharmacy</li> <li>• \$162.50 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy</li> <li>• \$65 copay for a one-month (34-day) supply of drugs in this tier from a non-preferred pharmacy</li> <li>• \$195 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy</li> </ul> <p><b>Tier 4: Specialty Tier Drugs</b></p> <ul style="list-style-type: none"> <li>• 25% coinsurance for a one-month (34-day) supply of drugs in this tier from a preferred pharmacy</li> <li>• 25% coinsurance for a one-month (34-day) supply of drugs in this tier from a non-preferred pharmacy</li> </ul> <p><b>Tier 5: Injectable Drugs</b></p> <ul style="list-style-type: none"> <li>• 25% coinsurance for a one-month (34-day) supply of drugs in this tier from a preferred pharmacy</li> <li>• 25% coinsurance for a one-month (34-day) supply of drugs in this tier from a non-preferred pharmacy</li> </ul> |

| Benefit   | Original Medicare | BCN Advantage Option 1 |
|---|-------------------|------------------------|
| <b>Prescription Drugs</b><br><i>(continued)</i> |                   |                        |

| BCN Advantage Basic   | BCN Advantage Option 2   | BCN Advantage Option 3  |
|---|--|---|
| <p><b>Long Term Care Pharmacy</b><br/>You can get drugs the following way(s):</p> <ul style="list-style-type: none"> <li>one-month (34-day) supply</li> </ul> <p><b>Mail Order</b><br/>You can get drugs the following way(s):</p> <ul style="list-style-type: none"> <li>one-month (34-day) supply</li> <li>three-month (90-day) supply</li> </ul> <p>Not all drugs are available at this extended day supply. Please contact the plan for more information.</p> | <p><b>Long Term Care Pharmacy</b><br/><b>Tier 1: Preferred Generic Drugs</b></p> <ul style="list-style-type: none"> <li>\$4 copay for a one-month (34-day) supply of drugs in this tier</li> </ul> <p><b>Tier 2: Preferred Brand Drugs</b></p> <ul style="list-style-type: none"> <li>\$35 copay for a one-month (34-day) supply of drugs in this tier</li> </ul> <p><b>Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs</b></p> <ul style="list-style-type: none"> <li>\$75 copay for a one-month (34-day) supply of drugs in this tier</li> </ul> <p><b>Tier 4: Specialty Tier Drugs</b></p> <ul style="list-style-type: none"> <li>25% coinsurance for a one-month (34-day) supply of drugs in this tier</li> </ul> <p><b>Tier 5: Injectable Drugs</b></p> <ul style="list-style-type: none"> <li>25% coinsurance for a one-month (34-day) supply of drugs in this tier</li> </ul> <p><b>Mail Order</b><br/><b>Tier 1: Preferred Generic Drugs</b></p> <ul style="list-style-type: none"> <li>\$4 copay for a one-month (34-day) supply of drugs in this tier</li> <li>\$10 copay for a three-month (90-day) supply of drugs in this tier</li> </ul> <p><b>Tier 2: Preferred Brand Drugs</b></p> <ul style="list-style-type: none"> <li>\$35 copay for a one-month (34-day) supply of drugs in this tier</li> <li>\$87.50 copay for a three-month (90-day) supply of drugs in this tier</li> </ul> <p><b>Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs</b></p> <ul style="list-style-type: none"> <li>\$75 copay for a one-month (34-day) supply of drugs in this tier</li> <li>\$187.50 copay for a three-month (90-day) supply of drugs in this tier</li> </ul> <p><b>Tier 4: Specialty Tier Drugs</b></p> <ul style="list-style-type: none"> <li>25% coinsurance for a one-month (34-day) supply of drugs in this tier</li> </ul> | <p><b>Long Term Care Pharmacy</b><br/><b>Tier 1: Preferred Generic Drugs</b></p> <ul style="list-style-type: none"> <li>\$3 copay for a one-month (34-day) supply of drugs in this tier</li> </ul> <p><b>Tier 2: Preferred Brand Drugs</b></p> <ul style="list-style-type: none"> <li>\$30 copay for a one-month (34-day) supply of drugs in this tier</li> </ul> <p><b>Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs</b></p> <ul style="list-style-type: none"> <li>\$65 copay for a one-month (34-day) supply of drugs in this tier</li> </ul> <p><b>Tier 4: Specialty Tier Drugs</b></p> <ul style="list-style-type: none"> <li>25% coinsurance for a one-month (34-day) supply of drugs in this tier</li> </ul> <p><b>Tier 5: Injectable Drugs</b></p> <ul style="list-style-type: none"> <li>25% coinsurance for a one-month (34-day) supply of drugs in this tier</li> </ul> <p><b>Mail Order</b><br/><b>Tier 1: Preferred Generic Drugs</b></p> <ul style="list-style-type: none"> <li>\$3 copay for a one-month (34-day) supply of drugs in this tier</li> <li>\$7.50 copay for a three-month (90-day) supply of drugs in this tier</li> </ul> <p><b>Tier 2: Preferred Brand Drugs</b></p> <ul style="list-style-type: none"> <li>\$30 copay for a one-month (34-day) supply of drugs in this tier</li> <li>\$75 copay for a three-month (90-day) supply of drugs in this tier</li> </ul> <p><b>Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs</b></p> <ul style="list-style-type: none"> <li>\$65 copay for a one-month (34-day) supply of drugs in this tier</li> <li>\$162.50 copay for a three-month (90-day) supply of drugs in this tier</li> </ul> <p><b>Tier 4: Specialty Tier Drugs</b></p> <ul style="list-style-type: none"> <li>25% coinsurance for a one-month (34-day) supply of drugs in this tier</li> </ul> |

| Benefit   | Original Medicare | BCN Advantage Option 1 |
|---|-------------------|------------------------|
| <b>Prescription Drugs</b><br><i>(continued)</i> |                   |                        |

| BCN Advantage Basic   | BCN Advantage Option 2   | BCN Advantage Option 3  |
|---|--|---|
| <p><b>Coverage Gap</b><br/>After your total yearly drug costs reach \$2,840, you pay 93% for all generic drugs and 100% for all brand drugs, until your yearly out-of-pocket drug costs reach \$4,550.</p>  | <p><b>Additional Coverage Gap</b><br/>You pay the following:</p> <p><b>Retail Pharmacy</b><br/><b>Tier 1: Preferred Generic Drugs</b></p> <ul style="list-style-type: none"> <li>• 50% coinsurance for a one-month (34-day) supply of all drugs covered in this tier from a preferred pharmacy</li> <li>• 45% coinsurance for a three-month (90-day) supply of all drugs covered in this tier from a preferred pharmacy</li> <li>• 50% coinsurance for a one-month (34-day) supply of all drugs covered in this tier at a non-preferred pharmacy</li> <li>• 50% coinsurance for a three-month (90-day) supply of all drugs covered in this tier from a non-preferred pharmacy</li> </ul> <p><b>Long Term Care Pharmacy</b><br/><b>Tier 1: Preferred Generic Drugs</b></p> <ul style="list-style-type: none"> <li>• 50% coinsurance for a one-month (34-day) supply of all drugs covered in this tier</li> </ul> <p><b>Mail Order</b><br/><b>Tier 1: Preferred Generic Drugs</b></p> <ul style="list-style-type: none"> <li>• 50% coinsurance for a one-month (34-day) supply of all drugs covered in this tier</li> <li>• 45% coinsurance for a three-month (90-day) supply of all drugs covered in this tier</li> </ul> <p>For all other covered drugs, after your total yearly drug costs reach \$2,840, you pay 93% for all generic drugs and 100% for all brand drugs, until your yearly out-of-pocket drug costs reach \$4,550.</p> | <p><b>Additional Coverage Gap</b><br/>You pay the following:</p> <p><b>Retail Pharmacy</b><br/><b>Tier 1: Preferred Generic Drugs</b></p> <ul style="list-style-type: none"> <li>• \$5 copay for a one-month (34-day) supply of all drugs covered in this tier from a preferred pharmacy</li> <li>• \$12.50 copay for a three-month (90-day) supply of all drugs covered in this tier from a preferred pharmacy</li> <li>• \$5 copay for a one-month (34-day) supply of all drugs covered in this tier at a non-preferred pharmacy</li> <li>• \$15 copay for a three-month (90-day) supply of all drugs covered in this tier from a non-preferred pharmacy</li> </ul> <p><b>Long Term Care Pharmacy</b><br/><b>Tier 1: Preferred Generic Drugs</b></p> <ul style="list-style-type: none"> <li>• \$5 copay for a one-month (34-day) supply of all drugs covered in this tier</li> </ul> <p><b>Mail Order</b><br/><b>Tier 1: Preferred Generic Drugs</b></p> <ul style="list-style-type: none"> <li>• \$5 copay for a one-month (34-day) supply of all drugs covered in this tier</li> <li>• \$12.50 copay for a three-month (90-day) supply of all drugs covered in this tier</li> </ul> <p>For all other covered drugs, after your total yearly drug costs reach \$2,840, you pay 93% for all generic drugs and 100% for all brand drugs, until your yearly out-of-pocket drug costs reach \$4,550.</p> |
| <p><b>Catastrophic Coverage</b><br/>After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:</p> <ul style="list-style-type: none"> <li>• A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or</li> <li>• 5% coinsurance.</li> </ul> | <p><b>Catastrophic Coverage</b><br/>After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:</p> <ul style="list-style-type: none"> <li>• A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or</li> <li>• 5% coinsurance.</li> </ul>  | <p><b>Catastrophic Coverage</b><br/>After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:</p> <ul style="list-style-type: none"> <li>• A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or</li> <li>• 5% coinsurance.</li> </ul>   |

| Benefit   | Original Medicare | BCN Advantage Option 1 |
|---|-------------------|------------------------|
| <b>Prescription Drugs</b><br><i>(continued)</i> |                   |                        |

| BCN Advantage Basic   | BCN Advantage Option 2  | BCN Advantage Option 3  |
|---|---|---|
| <p><b>Out-of-Network</b><br/>Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from BCN Advantage Basic (HMO-POS). You can get drugs the following way:</p> <ul style="list-style-type: none"> <li>• one-month (34-day) supply</li> </ul> <p><b>Out-of-Network Initial Coverage</b><br/>After you pay your yearly deductible, you will be reimbursed up to 75% of the actual cost for drugs purchased out-of-network until your total yearly drug costs reach \$2,840.</p> | <p><b>Out-of-Network</b><br/>Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from BCN Advantage Option 2 (HMO-POS).</p> <p><b>Out-of-Network Initial Coverage</b><br/>You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,840:</p> <p><b>Tier 1: Preferred Generic Drugs</b></p> <ul style="list-style-type: none"> <li>• \$4 copay for a one-month (34-day) supply of drugs in this tier</li> </ul> <p><b>Tier 2: Preferred Brand Drugs</b></p> <ul style="list-style-type: none"> <li>• \$35 copay for a one-month (34-day) supply of drugs in this tier</li> </ul> <p><b>Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs</b></p> <ul style="list-style-type: none"> <li>• \$75 copay for a one-month (34-day) supply of drugs in this tier</li> </ul> <p><b>Tier 4: Specialty Tier Drugs</b></p> <ul style="list-style-type: none"> <li>• 25% coinsurance for a one-month (34-day) supply of drugs in this tier</li> </ul> <p><b>Tier 5: Injectable Drugs</b></p> <ul style="list-style-type: none"> <li>• 25% coinsurance for a one-month (34-day) supply of drugs in this tier</li> </ul> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p> | <p><b>Out-of-Network</b><br/>Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from BCN Advantage Option 3 (HMO-POS).</p> <p><b>Out-of-Network Initial Coverage</b><br/>You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,840:</p> <p><b>Tier 1: Preferred Generic Drugs</b></p> <ul style="list-style-type: none"> <li>• \$3 copay for a one-month (34-day) supply of drugs in this tier</li> </ul> <p><b>Tier 2: Preferred Brand Drugs</b></p> <ul style="list-style-type: none"> <li>• \$30 copay for a one-month (34-day) supply of drugs in this tier</li> </ul> <p><b>Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs</b></p> <ul style="list-style-type: none"> <li>• \$65 copay for a one-month (34-day) supply of drugs in this tier</li> </ul> <p><b>Tier 4: Specialty Tier Drugs</b></p> <ul style="list-style-type: none"> <li>• 25% coinsurance for a one-month (34-day) supply of drugs in this tier</li> </ul> <p><b>Tier 5: Injectable Drugs</b></p> <ul style="list-style-type: none"> <li>• 25% coinsurance for a one-month (34-day) supply of drugs in this tier</li> </ul> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p> |

| Benefit   | Original Medicare | BCN Advantage Option 1 |
|---|-------------------|------------------------|
| <b>Prescription Drugs</b><br><i>(continued)</i> |                   |                        |

| BCN Advantage Basic  | BCN Advantage Option 2   | BCN Advantage Option 3   |
|--|--|--|
| <p><b>Out-of-Network Coverage Gap</b><br/>You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly drug costs reach \$4,550.</p> <p>After your total yearly drug costs reach \$2,840, you pay 100% of the pharmacy's full charge for brand drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550.</p> <p>You will not be reimbursed by BCN Advantage for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to BCN Advantage so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> | <p><b>Additional Out-of-Network Coverage Gap</b><br/>You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following:</p> <p><b>Tier 1: Preferred Generic Drugs</b></p> <ul style="list-style-type: none"> <li>• 50% coinsurance for a one-month (34-day) supply of all drugs covered in this tier</li> </ul> <p><b>Tier 2: Preferred Brand Drugs</b><br/>You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly drug costs reach \$4,550.</p> <p>After your total yearly drug costs reach \$2,840, you pay 100% of the pharmacy's full charge for brand drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550.</p> <p>You will not be reimbursed by BCN Advantage Option 2 (HMO-POS) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to BCN Advantage Option 2 (HMO-POS) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> | <p><b>Additional Out-of-Network Coverage Gap</b><br/>You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following:</p> <p><b>Tier 1: Preferred Generic Drugs</b></p> <ul style="list-style-type: none"> <li>• \$5 copay for a one-month (34-day) supply of all drugs covered in this tier</li> </ul> <p><b>Tier 2: Preferred Brand Drugs</b><br/>You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly drug costs reach \$4,550.</p> <p>After your total yearly drug costs reach \$2,840, you pay 100% of the pharmacy's full charge for brand drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550.</p> <p>You will not be reimbursed by BCN Advantage Option 3 (HMO-POS) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to BCN Advantage Option 3 (HMO-POS) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> |

| Benefit   | Original Medicare | BCN Advantage Option 1 |
|---|-------------------|------------------------|
| <b>Prescription Drugs</b><br><i>(continued)</i> |                   |                        |

| BCN Advantage Basic | BCN Advantage Option 2   | BCN Advantage Option 3   |
|---------------------|--|--|
|                     | <p><b>Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs</b></p> <p>You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly drug costs reach \$4,550.</p> <p>After your total yearly drug costs reach \$2,840, you pay 100% of the pharmacy's full charge for brand drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550.</p> <p>You will not be reimbursed by BCN Advantage Option 2 (HMO-POS) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to BCN Advantage Option 2 (HMO-POS) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p><b>Tier 4: Specialty Tier Drugs</b></p> <p>You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly drug costs reach \$4,550.</p> <p>After your total yearly drug costs reach \$2,840, you pay 100% of the pharmacy's full charge for brand drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550.</p> <p>You will not be reimbursed by BCN Advantage Option 2 (HMO-POS) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to BCN Advantage Option 2 (HMO-POS) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> | <p><b>Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs</b></p> <p>You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly drug costs reach \$4,550.</p> <p>After your total yearly drug costs reach \$2,840, you pay 100% of the pharmacy's full charge for brand drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550.</p> <p>You will not be reimbursed by BCN Advantage Option 3 (HMO-POS) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to BCN Advantage Option 3 (HMO-POS) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p><b>Tier 4: Specialty Tier Drugs</b></p> <p>You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly drug costs reach \$4,550.</p> <p>After your total yearly drug costs reach \$2,840, you pay 100% of the pharmacy's full charge for brand drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550.</p> <p>You will not be reimbursed by BCN Advantage Option 3 (HMO-POS) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to BCN Advantage Option 3 (HMO-POS) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> |

| Benefit   | Original Medicare | BCN Advantage Option 1 |
|---|-------------------|------------------------|
| <b>Prescription Drugs</b><br><i>(continued)</i> |                   |                        |

| BCN Advantage Basic   | BCN Advantage Option 2   | BCN Advantage Option 3   |
|---|--|--|
| <p><b>Out-of-Network Catastrophic Coverage</b><br/>           After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus your cost share, which is the greater of:</p> <ul style="list-style-type: none"> <li>• A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or</li> <li>• 5% coinsurance.</li> </ul> | <p><b>Tier 5: Injectable Drugs</b><br/>           You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly drug costs reach \$4,550.<br/>           After your total yearly drug costs reach \$2,840, you pay 100% of the pharmacy's full charge for brand drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550.<br/>           You will not be reimbursed by BCN Advantage Option 2 (HMO-POS) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to BCN Advantage Option 2 (HMO-POS) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.<br/>           You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p> <p><b>Out-of-Network Catastrophic Coverage</b><br/>           After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus your cost share, which is the greater of:</p> <ul style="list-style-type: none"> <li>• A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or</li> <li>• 5% coinsurance.</li> </ul> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p> | <p><b>Tier 5: Injectable Drugs</b><br/>           You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly drug costs reach \$4,550.<br/>           After your total yearly drug costs reach \$2,840, you pay 100% of the pharmacy's full charge for brand drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550.<br/>           You will not be reimbursed by BCN Advantage Option 3 (HMO-POS) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to BCN Advantage Option 3 (HMO-POS) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.<br/>           You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p> <p><b>Out-of-Network Catastrophic Coverage</b><br/>           After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus your cost share, which is the greater of:</p> <ul style="list-style-type: none"> <li>• A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or</li> <li>• 5% coinsurance.</li> </ul> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p> |

| Benefit   | Original Medicare  | BCN Advantage Option 1  |
|-----------|--|---|
| <b>30</b> | <b>Dental Services</b><br>Preventive dental services (such as cleaning) not covered.   | <b>In-Network</b><br>\$0 copay for Medicare-covered dental benefits.<br>\$0 copay for the following preventive dental benefits: <ul style="list-style-type: none"> <li>• Up to 2 oral exam(s) every year</li> <li>• Up to 2 cleaning(s) every year</li> <li>• Up to 1 dental X-ray(s) every two years</li> </ul>  |
| <b>31</b> | <b>Hearing Services</b><br>Routine hearing exams and hearing aids not covered.<br>20% coinsurance for diagnostic hearing exams.  | <b>General</b><br>Authorization rules may apply.<br><b>In-Network</b> <ul style="list-style-type: none"> <li>• \$0 copay for up to 2 hearing aid(s) every three years.</li> <li>• \$25 copay for Medicare-covered diagnostic hearing exams</li> <li>• \$25 copay for up to 1 routine hearing test(s) every year</li> <li>• \$0 copay for up to 1 hearing aid fitting evaluation(s) every three years</li> </ul> \$1,000 plan coverage limit for hearing aids every three years. |
| <b>32</b> | <b>Vision Services</b><br>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.<br>Routine eye exams and glasses not covered.<br>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.<br>Annual glaucoma screenings covered for people at risk. | <b>In-Network</b><br>Non-Medicare-covered eye exams and glasses not covered. <ul style="list-style-type: none"> <li>• \$0 copay for diagnosis and treatment for diseases and conditions of the eye</li> <li>• \$0 copay for one pair of eyeglasses or contact lenses after cataract surgery</li> </ul>  |

| BCN Advantage Basic  | BCN Advantage Option 2  | BCN Advantage Option 3  |
|--|---|---|
| <p><b>In-Network</b><br/>\$0 copay for Medicare-covered dental benefits.</p> <p>In general, preventive dental benefits (such as cleaning) not covered.</p>   | <p><b>In-Network</b><br/>\$0 copay for Medicare-covered dental benefits.</p> <p>\$0 copay for the following preventive dental benefits:</p> <ul style="list-style-type: none"> <li>• Up to 2 oral exam(s) every year</li> <li>• Up to 2 cleaning(s) every year</li> <li>• Up to 1 dental X-ray(s) every two years</li> </ul>  | <p><b>In-Network</b><br/>\$0 copay for Medicare-covered dental benefits.</p> <p>\$0 copay for the following preventive dental benefits:</p> <ul style="list-style-type: none"> <li>• Up to 2 oral exam(s) every year</li> <li>• Up to 2 cleaning(s) every year</li> <li>• Up to 1 dental X-ray(s) every two years</li> </ul>  |
| <p><b>In-Network</b><br/>This plan does not cover Hearing Services.</p>  | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b></p> <ul style="list-style-type: none"> <li>• \$0 copay for up to 2 hearing aid(s) every three years.</li> <li>• \$25 copay for Medicare-covered diagnostic hearing exams</li> <li>• \$25 copay for up to 1 routine hearing test(s) every year</li> <li>• \$0 copay for up to 1 hearing aid fitting evaluation(s) every three years</li> </ul> <p>\$1,000 plan coverage limit for hearing aids every three years.</p>  | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b></p> <ul style="list-style-type: none"> <li>• \$0 copay for up to 2 hearing aid(s) every three years.</li> <li>• \$25 copay for Medicare-covered diagnostic hearing exams</li> <li>• \$25 copay for up to 1 routine hearing test(s) every year</li> <li>• \$0 copay for up to 1 hearing aid fitting evaluation(s) every three years</li> </ul> <p>\$1,000 plan coverage limit for hearing aids every three years.</p>  |
| <p><b>In-Network</b><br/>Non-Medicare-covered eye exams and glasses not covered.</p> <ul style="list-style-type: none"> <li>• \$0 copay for diagnosis and treatment for diseases and conditions of the eye</li> <li>• \$0 copay for one pair of eyeglasses or contact lenses after cataract surgery</li> </ul> | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b></p> <ul style="list-style-type: none"> <li>• \$0 copay for one pair of eyeglasses or contact lenses after cataract surgery</li> <li>• \$0 copay for exams to diagnose and treat diseases and conditions of the eye</li> <li>• \$10 copay for up to 1 routine eye exam(s) every year</li> <li>• \$10 copay for up to 1 pair(s) of contacts every two years</li> <li>• \$0 copay for up to 1 pair(s) of lenses every two years</li> <li>• \$10 copay for up to 1 frame(s) every two years</li> </ul> <p>\$100 plan coverage limit for eye wear every two years.</p> | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b></p> <ul style="list-style-type: none"> <li>• \$0 copay for one pair of eyeglasses or contact lenses after cataract surgery</li> <li>• \$0 copay for exams to diagnose and treat diseases and conditions of the eye</li> <li>• \$10 copay for up to 1 routine eye exam(s) every year</li> <li>• \$10 copay for up to 1 pair(s) of contacts every two years</li> <li>• \$0 copay for up to 1 pair(s) of lenses every two years</li> <li>• \$10 copay for up to 1 frame(s) every two years</li> </ul> <p>\$100 plan coverage limit for eye wear every two years.</p> |

| Benefit   | Original Medicare   | BCN Advantage Option 1  |
|-----------|---|---|
| <b>33</b> | <p><b>Physical Exams<br/>Welcome to Medicare;<br/>and Annual Wellness<br/>Visit</b></p> <p>When you join Medicare Part B, then you are eligible as follows.</p> <p>During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare exam or an Annual Wellness visit. After your first 12 months, you can get one Annual Wellness visit every 12 months.</p> <p>There is no coinsurance, copayment or deductible for either the Welcome to Medicare exam or the Annual Wellness visit.</p> <p>The Welcome to Medicare exam does not include lab tests.</p>  | <p><b>In-Network</b><br/>\$20 copay for routine exams.</p> <p>Limited to 1 exam(s) every year.</p> <p>\$0 copay for the required Medicare-covered initial preventive physical exam and annual wellness visits.</p>  |
| <b>34</b> | <p><b>Health/Wellness<br/>Education</b></p> <p>Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits.</p> <p>You pay coinsurance, and Part B deductible applies.</p> <p>\$0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy.</p> | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>The plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> <li>• Additional Smoking Cessation</li> </ul> <p>\$0 copay for each Medicare-covered smoking cessation counseling session.</p> <p><b>In-Network</b><br/>\$0 copay for each Medicare-covered HIV screening.</p> <p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy.</p> |

| BCN Advantage Basic  | BCN Advantage Option 2   | BCN Advantage Option 3  |
|--|--|---|
| <p><b>In-Network</b><br/>\$25 copay for routine exams.<br/>Limited to 1 exam(s) every year.<br/>\$0 copay for the required Medicare-covered initial preventive physical exam and annual wellness visits.</p>   | <p><b>In-Network</b><br/>\$15 copay for routine exams.<br/>Limited to 1 exam(s) every year.<br/>\$0 copay for the required Medicare-covered initial preventive physical exam and annual wellness visits.</p>   | <p><b>In-Network</b><br/>\$10 copay for routine exams.<br/>Limited to 1 exam(s) every year.<br/>\$0 copay for the required Medicare-covered initial preventive physical exam and annual wellness visits.</p>  |
| <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>The plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> <li>• Additional Smoking Cessation</li> <li>• Health Club Membership/<br/>Fitness Classes</li> </ul> <p>\$0 copay for each Medicare-covered smoking cessation counseling session.</p> <p><b>In-Network</b><br/>\$0 copay for each Medicare-covered HIV screening.</p> <p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy.</p> | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>The plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> <li>• Additional Smoking Cessation</li> <li>• Health Club Membership/<br/>Fitness Classes</li> </ul> <p>\$0 copay for each Medicare-covered smoking cessation counseling session.</p> <p><b>In-Network</b><br/>\$0 copay for each Medicare-covered HIV screening.</p> <p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy.</p> | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>The plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> <li>• Additional Smoking Cessation</li> </ul> <p>\$0 copay for each Medicare-covered smoking cessation counseling session.</p> <p><b>In-Network</b><br/>\$0 copay for each Medicare-covered HIV screening.</p> <p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy.</p> |

| Benefit                         | Original Medicare   | BCN Advantage Option 1   |
|---------------------------------|---|--|
| <b>Transportation (Routine)</b> | Not covered.  | <b>In-Network</b><br>\$0 copay for up to 12 round trip(s) to plan-approved location.   |
| <b>Acupuncture</b>              | Not covered.  | <b>In-Network</b><br>This plan does not cover Acupuncture.   |
| <b>Point of Service</b>         | You may go to any doctor, specialist or hospital that accepts Medicare. | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>Out-of-Network</b><br/>Point of Service coverage is available for the following benefits:</p> <ul style="list-style-type: none"> <li>• Inpatient Hospital Acute</li> <li>• Inpatient Hospital Psychiatric</li> <li>• Skilled Nursing Facility (SNF)</li> <li>• Comprehensive Outpatient Rehabilitation Facility (CORF)</li> <li>• Partial Hospitalization</li> <li>• Home Health Services</li> <li>• Primary Care Physician Services</li> <li>• Chiropractic Services</li> <li>• Occupational Therapy Services</li> <li>• Physician Specialist Services</li> <li>• Mental Health Specialty Services</li> <li>• Podiatry Services</li> <li>• Other Health Care Professional</li> <li>• Psychiatric Services</li> <li>• Physical Therapy and Speech/Language Pathology Services</li> <li>• Outpatient Diag Procs/Tests/Lab Services</li> <li>• Diagnostic Radiological Services</li> <li>• Therapeutic Radiological Services</li> <li>• Outpatient X-rays</li> <li>• Outpatient Hospital Services</li> <li>• Ambulatory Surgical Center (ASC) Services</li> <li>• Outpatient Substance Abuse</li> <li>• Cardiac Rehabilitation Services</li> <li>• Ambulance Services</li> <li>• DME</li> <li>• Prosthetics/Medical Supplies</li> <li>• Diabetes Monitoring Supplies</li> <li>• Blood</li> <li>• Immunizations</li> </ul> |

| BCN Advantage Basic  | BCN Advantage Option 2   | BCN Advantage Option 3   |
|--|--|--|
| <p><b>In-Network</b><br/>This plan does not cover routine transportation.</p>  | <p><b>In-Network</b><br/>\$0 copay for up to 12 round trip(s) to plan-approved location.</p>   | <p><b>In-Network</b><br/>\$0 copay for up to 12 round trip(s) to plan-approved location.</p>   |
| <p><b>In-Network</b><br/>This plan does not cover Acupuncture.</p>   | <p><b>In-Network</b><br/>This plan does not cover Acupuncture.</p>   | <p><b>In-Network</b><br/>This plan does not cover Acupuncture.</p>   |
| <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>Out-of-Network</b><br/>Point of Service coverage is available for the following benefits:</p> <ul style="list-style-type: none"> <li>• Inpatient Hospital Acute</li> <li>• Inpatient Hospital Psychiatric</li> <li>• Skilled Nursing Facility (SNF)</li> <li>• Comprehensive Outpatient Rehabilitation Facility (CORF)</li> <li>• Partial Hospitalization</li> <li>• Home Health Services</li> <li>• Primary Care Physician Services</li> <li>• Chiropractic Services</li> <li>• Occupational Therapy Services</li> <li>• Physician Specialist Services</li> <li>• Mental Health Specialty Services</li> <li>• Podiatry Services</li> <li>• Other Health Care Professional</li> <li>• Psychiatric Services</li> <li>• Physical Therapy and Speech/Language Pathology Services</li> <li>• Outpatient Diag Procs/Tests/Lab Services</li> <li>• Diagnostic Radiological Services</li> <li>• Therapeutic Radiological Services</li> <li>• Outpatient X-rays</li> <li>• Outpatient Hospital Services</li> <li>• Ambulatory Surgical Center (ASC) Services</li> <li>• Outpatient Substance Abuse</li> <li>• Cardiac Rehabilitation Services</li> <li>• Ambulance Services</li> <li>• DME</li> <li>• Prosthetics/Medical Supplies</li> <li>• Diabetes Monitoring Supplies</li> <li>• Blood</li> <li>• Immunizations</li> </ul> | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>Out-of-Network</b><br/>Point of Service coverage is available for the following benefits:</p> <ul style="list-style-type: none"> <li>• Inpatient Hospital Acute</li> <li>• Inpatient Hospital Psychiatric</li> <li>• Skilled Nursing Facility (SNF)</li> <li>• Comprehensive Outpatient Rehabilitation Facility (CORF)</li> <li>• Partial Hospitalization</li> <li>• Home Health Services</li> <li>• Primary Care Physician Services</li> <li>• Chiropractic Services</li> <li>• Occupational Therapy Services</li> <li>• Physician Specialist Services</li> <li>• Mental Health Specialty Services</li> <li>• Podiatry Services</li> <li>• Other Health Care Professional</li> <li>• Psychiatric Services</li> <li>• Physical Therapy and Speech/Language Pathology Services</li> <li>• Outpatient Diag Procs/Tests/Lab Services</li> <li>• Diagnostic Radiological Services</li> <li>• Therapeutic Radiological Services</li> <li>• Outpatient X-rays</li> <li>• Outpatient Hospital Services</li> <li>• Ambulatory Surgical Center (ASC) Services</li> <li>• Outpatient Substance Abuse</li> <li>• Cardiac Rehabilitation Services</li> <li>• Ambulance Services</li> <li>• DME</li> <li>• Prosthetics/Medical Supplies</li> <li>• Diabetes Monitoring Supplies</li> <li>• Blood</li> <li>• Immunizations</li> </ul> | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>Out-of-Network</b><br/>Point of Service coverage is available for the following benefits:</p> <ul style="list-style-type: none"> <li>• Inpatient Hospital Acute</li> <li>• Inpatient Hospital Psychiatric</li> <li>• Skilled Nursing Facility (SNF)</li> <li>• Comprehensive Outpatient Rehabilitation Facility (CORF)</li> <li>• Partial Hospitalization</li> <li>• Home Health Services</li> <li>• Primary Care Physician Services</li> <li>• Chiropractic Services</li> <li>• Occupational Therapy Services</li> <li>• Physician Specialist Services</li> <li>• Mental Health Specialty Services</li> <li>• Podiatry Services</li> <li>• Other Health Care Professional</li> <li>• Psychiatric Services</li> <li>• Physical Therapy and Speech/Language Pathology Services</li> <li>• Outpatient Diag Procs/Tests/Lab Services</li> <li>• Diagnostic Radiological Services</li> <li>• Therapeutic Radiological Services</li> <li>• Outpatient X-rays</li> <li>• Outpatient Hospital Services</li> <li>• Ambulatory Surgical Center (ASC) Services</li> <li>• Outpatient Substance Abuse</li> <li>• Cardiac Rehabilitation Services</li> <li>• Ambulance Services</li> <li>• DME</li> <li>• Prosthetics/Medical Supplies</li> <li>• Diabetes Monitoring Supplies</li> <li>• Blood</li> <li>• Immunizations</li> </ul> |

| Benefit  | Original Medicare | BCN Advantage Option 1  |
|--|-------------------|---|
| <p><b>Point of Service</b><br/>(continued)</p> |                   | <ul style="list-style-type: none"> <li>• Routine Physical Exams</li> <li>• Pap Smears and Pelvic Exams</li> <li>• Prostate Screening</li> <li>• Colorectal Screening</li> <li>• Bone Mass Measurement</li> <li>• Mammography Screening</li> <li>• Diabetes Monitoring</li> <li>• Nutrition therapy for Diabetes and Renal Disease</li> </ul> <p>You may need a referral for the following Point-of-service benefits:</p> <ul style="list-style-type: none"> <li>• Inpatient Hospital Acute</li> <li>• Inpatient Hospital Psychiatric</li> <li>• Skilled Nursing Facility (SNF)</li> <li>• Comprehensive Outpatient Rehabilitation Facility (CORF)</li> <li>• Partial Hospitalization</li> <li>• Home Health Services</li> <li>• Primary Care Physician Services</li> <li>• Chiropractic Services</li> <li>• Occupational Therapy Services</li> <li>• Physician Specialist Services</li> <li>• Mental Health Specialty Services</li> <li>• Podiatry Services</li> <li>• Other Health Care Professional</li> <li>• Psychiatric Services</li> <li>• Physical Therapy and Speech/Language Pathology Services</li> <li>• Outpatient Diag Procs/Tests/Lab Services</li> <li>• Diagnostic Radiological Services</li> <li>• Therapeutic Radiological Services</li> <li>• Outpatient X-rays</li> <li>• Outpatient Hospital Services</li> <li>• Ambulatory Surgical Center (ASC) Services</li> <li>• Outpatient Substance Abuse</li> <li>• Cardiac Rehabilitation Services</li> <li>• Ambulance Services</li> <li>• DME</li> <li>• Prosthetics/Medical Supplies</li> <li>• Diabetes Monitoring Supplies</li> <li>• Blood</li> </ul> |

| BCN Advantage Basic   | BCN Advantage Option 2  | BCN Advantage Option 3  |
|---|---|---|
| <ul style="list-style-type: none"> <li>• Routine Physical Exams</li> <li>• Pap Smears and Pelvic Exams</li> <li>• Prostate Screening</li> <li>• Colorectal Screening</li> <li>• Bone Mass Measurement</li> <li>• Mammography Screening</li> <li>• Diabetes Monitoring</li> <li>• Nutrition therapy for Diabetes and Renal Disease</li> </ul> <p>You may need a referral for the following Point-of-service benefits:</p> <ul style="list-style-type: none"> <li>• Inpatient Hospital Acute</li> <li>• Inpatient Hospital Psychiatric</li> <li>• Skilled Nursing Facility (SNF)</li> <li>• Comprehensive Outpatient Rehabilitation Facility (CORF)</li> <li>• Partial Hospitalization</li> <li>• Home Health Services</li> <li>• Primary Care Physician Services</li> <li>• Chiropractic Services</li> <li>• Occupational Therapy Services</li> <li>• Physician Specialist Services</li> <li>• Mental Health Specialty Services</li> <li>• Podiatry Services</li> <li>• Other Health Care Professional</li> <li>• Psychiatric Services</li> <li>• Physical Therapy and Speech/Language Pathology Services</li> <li>• Outpatient Diag Procs/Tests/Lab Services</li> <li>• Diagnostic Radiological Services</li> <li>• Therapeutic Radiological Services</li> <li>• Outpatient X-rays</li> <li>• Outpatient Hospital Services</li> <li>• Ambulatory Surgical Center (ASC) Services</li> <li>• Outpatient Substance Abuse</li> <li>• Cardiac Rehabilitation Services</li> <li>• Ambulance Services</li> <li>• DME</li> <li>• Prosthetics/Medical Supplies</li> <li>• Diabetes Monitoring Supplies</li> <li>• Blood</li> </ul> | <ul style="list-style-type: none"> <li>• Routine Physical Exams</li> <li>• Pap Smears and Pelvic Exams</li> <li>• Prostate Screening</li> <li>• Colorectal Screening</li> <li>• Bone Mass Measurement</li> <li>• Mammography Screening</li> <li>• Diabetes Monitoring</li> <li>• Nutrition therapy for Diabetes and Renal Disease</li> </ul> <p>You may need a referral for the following Point-of-service benefits:</p> <ul style="list-style-type: none"> <li>• Inpatient Hospital Acute</li> <li>• Inpatient Hospital Psychiatric</li> <li>• Skilled Nursing Facility (SNF)</li> <li>• Comprehensive Outpatient Rehabilitation Facility (CORF)</li> <li>• Partial Hospitalization</li> <li>• Home Health Services</li> <li>• Primary Care Physician Services</li> <li>• Chiropractic Services</li> <li>• Occupational Therapy Services</li> <li>• Physician Specialist Services</li> <li>• Mental Health Specialty Services</li> <li>• Podiatry Services</li> <li>• Other Health Care Professional</li> <li>• Psychiatric Services</li> <li>• Physical Therapy and Speech/Language Pathology Services</li> <li>• Outpatient Diag Procs/Tests/Lab Services</li> <li>• Diagnostic Radiological Services</li> <li>• Therapeutic Radiological Services</li> <li>• Outpatient X-rays</li> <li>• Outpatient Hospital Services</li> <li>• Ambulatory Surgical Center (ASC) Services</li> <li>• Outpatient Substance Abuse</li> <li>• Cardiac Rehabilitation Services</li> <li>• Ambulance Services</li> <li>• DME</li> <li>• Prosthetics/Medical Supplies</li> <li>• Diabetes Monitoring Supplies</li> <li>• Blood</li> </ul> | <ul style="list-style-type: none"> <li>• Routine Physical Exams</li> <li>• Pap Smears and Pelvic Exams</li> <li>• Prostate Screening</li> <li>• Colorectal Screening</li> <li>• Bone Mass Measurement</li> <li>• Mammography Screening</li> <li>• Diabetes Monitoring</li> <li>• Nutrition therapy for Diabetes and Renal Disease</li> </ul> <p>You may need a referral for the following Point-of-service benefits:</p> <ul style="list-style-type: none"> <li>• Inpatient Hospital Acute</li> <li>• Inpatient Hospital Psychiatric</li> <li>• Skilled Nursing Facility (SNF)</li> <li>• Comprehensive Outpatient Rehabilitation Facility (CORF)</li> <li>• Partial Hospitalization</li> <li>• Home Health Services</li> <li>• Primary Care Physician Services</li> <li>• Chiropractic Services</li> <li>• Occupational Therapy Services</li> <li>• Physician Specialist Services</li> <li>• Mental Health Specialty Services</li> <li>• Podiatry Services</li> <li>• Other Health Care Professional</li> <li>• Psychiatric Services</li> <li>• Physical Therapy and Speech/Language Pathology Services</li> <li>• Outpatient Diag Procs/Tests/Lab Services</li> <li>• Diagnostic Radiological Services</li> <li>• Therapeutic Radiological Services</li> <li>• Outpatient X-rays</li> <li>• Outpatient Hospital Services</li> <li>• Ambulatory Surgical Center (ASC) Services</li> <li>• Outpatient Substance Abuse</li> <li>• Cardiac Rehabilitation Services</li> <li>• Ambulance Services</li> <li>• DME</li> <li>• Prosthetics/Medical Supplies</li> <li>• Diabetes Monitoring Supplies</li> <li>• Blood</li> </ul> |

| Benefit  | Original Medicare | BCN Advantage Option 1  |
|--|-------------------|---|
| <p><b>Point of Service</b><br/>(continued)</p> |                   | <ul style="list-style-type: none"> <li>• Immunizations</li> <li>• Routine Physical Exams</li> <li>• Pap Smears and Pelvic Exams</li> <li>• Prostate Screening</li> <li>• Colorectal Screening</li> <li>• Bone Mass Measurement</li> <li>• Mammography Screening</li> <li>• Diabetes Monitoring</li> <li>• Nutrition therapy for Diabetes and Renal Disease</li> </ul> <p><b>For hospital stays:</b><br/>Days 1 - 5: \$175 copay per day<br/>Days 6 and beyond: \$0 copay per day</p> <p><b>For Inpatient Psychiatric Hospital stays:</b><br/>Days 1 - 5: \$175 copay per day<br/>Days 6 and beyond: \$0 copay per day</p> <p><b>For each SNF stay:</b><br/>Days 1 - 20: \$0 copay per SNF day<br/>Days 21 - 100: \$130 copay per SNF day</p> <p><b>\$35 copay for:</b></p> <ul style="list-style-type: none"> <li>• Comprehensive Outpatient Rehabilitation Facility (CORF)</li> <li>• Partial Hospitalization</li> <li>• Chiropractic Services</li> <li>• Occupational Therapy Services</li> <li>• Physician Specialist Services</li> <li>• Mental Health Specialty Services</li> <li>• Podiatry Services</li> <li>• Other Health Care Professional</li> <li>• Psychiatric Services</li> <li>• Physical Therapy and Speech/Language Pathology Services</li> <li>• Outpatient Substance Abuse</li> <li>• Cardiac Rehabilitation Services</li> </ul> |

| BCN Advantage Basic   | BCN Advantage Option 2  | BCN Advantage Option 3  |
|---|---|---|
| <ul style="list-style-type: none"> <li>• Immunizations</li> <li>• Routine Physical Exams</li> <li>• Pap Smears and Pelvic Exams</li> <li>• Prostate Screening</li> <li>• Colorectal Screening</li> <li>• Bone Mass Measurement</li> <li>• Mammography Screening</li> <li>• Diabetes Monitoring</li> <li>• Nutrition therapy for Diabetes and Renal Disease</li> </ul> <p><b>For hospital stays:</b><br/>Days 1 - 5: \$225 copay per day<br/>Days 6 and beyond: \$0 copay per day</p> <p><b>For Inpatient Psychiatric Hospital stays:</b><br/>Days 1 - 5: \$225 copay per day<br/>Days 6 and beyond: \$0 copay per day</p> <p><b>For each SNF stay:</b><br/>Days 1 - 20: \$0 copay per SNF day<br/>Days 21 - 100: \$130 copay per SNF day</p> <p><b>\$40 copay for:</b></p> <ul style="list-style-type: none"> <li>• Comprehensive Outpatient Rehabilitation Facility (CORF)</li> <li>• Partial Hospitalization</li> <li>• Chiropractic Services</li> <li>• Occupational Therapy Services</li> <li>• Physician Specialist Services</li> <li>• Mental Health Specialty Services</li> <li>• Podiatry Services</li> <li>• Other Health Care Professional</li> <li>• Psychiatric Services</li> <li>• Physical Therapy and Speech/Language Pathology Services</li> <li>• Outpatient Substance Abuse</li> <li>• Cardiac Rehabilitation Services</li> </ul> | <ul style="list-style-type: none"> <li>• Immunizations</li> <li>• Routine Physical Exams</li> <li>• Pap Smears and Pelvic Exams</li> <li>• Prostate Screening</li> <li>• Colorectal Screening</li> <li>• Bone Mass Measurement</li> <li>• Mammography Screening</li> <li>• Diabetes Monitoring</li> <li>• Nutrition therapy for Diabetes and Renal Disease</li> </ul> <p><b>For hospital stays:</b><br/>Days 1 - 5: \$125 copay per day<br/>Days 6 and beyond: \$0 copay per day</p> <p><b>For Inpatient Psychiatric Hospital stays:</b><br/>Days 1 - 5: \$125 copay per day<br/>Days 6 and beyond: \$0 copay per day</p> <p><b>For each SNF stay:</b><br/>Days 1 - 20: \$0 copay per SNF day<br/>Days 21 - 100: \$130 copay per SNF day</p> <p><b>\$30 copay for:</b></p> <ul style="list-style-type: none"> <li>• Comprehensive Outpatient Rehabilitation Facility (CORF)</li> <li>• Partial Hospitalization</li> <li>• Chiropractic Services</li> <li>• Occupational Therapy Services</li> <li>• Physician Specialist Services</li> <li>• Mental Health Specialty Services</li> <li>• Podiatry Services</li> <li>• Other Health Care Professional</li> <li>• Psychiatric Services</li> <li>• Physical Therapy and Speech/Language Pathology Services</li> <li>• Outpatient Substance Abuse</li> <li>• Cardiac Rehabilitation Services</li> </ul> | <ul style="list-style-type: none"> <li>• Immunizations</li> <li>• Routine Physical Exams</li> <li>• Pap Smears and Pelvic Exams</li> <li>• Prostate Screening</li> <li>• Colorectal Screening</li> <li>• Bone Mass Measurement</li> <li>• Mammography Screening</li> <li>• Diabetes Monitoring</li> <li>• Nutrition therapy for Diabetes and Renal Disease</li> </ul> <p><b>For hospital stays:</b><br/>Days 1 - 5: \$80 copay per day<br/>Days 6 and beyond: \$0 copay per day</p> <p><b>For Inpatient Psychiatric Hospital stays:</b><br/>Days 1 - 5: \$80 copay per day<br/>Days 6 and beyond: \$0 copay per day</p> <p><b>For each SNF stay:</b><br/>Days 1 - 20: \$0 copay per SNF day<br/>Days 21 - 100: \$130 copay per SNF day</p> <p><b>\$20 copay for:</b></p> <ul style="list-style-type: none"> <li>• Comprehensive Outpatient Rehabilitation Facility (CORF)</li> <li>• Partial Hospitalization</li> <li>• Chiropractic Services</li> <li>• Occupational Therapy Services</li> <li>• Physician Specialist Services</li> <li>• Mental Health Specialty Services</li> <li>• Podiatry Services</li> <li>• Other Health Care Professional</li> <li>• Psychiatric Services</li> <li>• Physical Therapy and Speech/Language Pathology Services</li> <li>• Outpatient Substance Abuse</li> <li>• Cardiac Rehabilitation Services</li> </ul> |

| Benefit                                       | Original Medicare | BCN Advantage Option 1   |
|---|-------------------|--|
| <b>Point of Service</b><br><i>(continued)</i> |                   | <p><b>\$0 copay for:</b></p> <ul style="list-style-type: none"> <li>• Home Health Services</li> <li>• Therapeutic Radiological Services</li> <li>• Diabetes Monitoring Supplies</li> <li>• Blood</li> <li>• Immunizations</li> <li>• Routine Physical Exams</li> <li>• Pap Smears and Pelvic Exams</li> <li>• Prostate Screening</li> <li>• Colorectal Screening</li> <li>• Bone Mass Measurement</li> <li>• Mammography Screening</li> <li>• Diabetes Monitoring</li> <li>• Nutrition therapy for Diabetes and Renal Disease</li> </ul> <p><b>\$20 copay for:</b></p> <ul style="list-style-type: none"> <li>• Primary Care Physician Services</li> <li>• Outpatient X-rays</li> <li>• Routine Physical Exams</li> </ul> <p><b>\$20 to \$40 copay for:</b></p> <ul style="list-style-type: none"> <li>• Diagnostic Radiological Services</li> </ul> <p><b>\$0 to \$40 copay for:</b></p> <ul style="list-style-type: none"> <li>• Outpatient Diag Procs/Tests/Lab Services</li> </ul> <p><b>\$50 to \$125 copay for:</b></p> <ul style="list-style-type: none"> <li>• Outpatient Hospital Services</li> </ul> <p><b>\$75 copay for:</b></p> <ul style="list-style-type: none"> <li>• Ambulatory Surgical Center (ASC) Services</li> </ul> <p><b>\$50 copay for:</b></p> <ul style="list-style-type: none"> <li>• Ambulance Services</li> </ul> <p><b>20% of the cost for:</b></p> <ul style="list-style-type: none"> <li>• DME</li> <li>• Prosthetics/Medical Supplies</li> </ul> |

| BCN Advantage Basic   | BCN Advantage Option 2   | BCN Advantage Option 3   |
|---|--|--|
| <p><b>\$0 copay for:</b></p> <ul style="list-style-type: none"> <li>• Home Health Services</li> <li>• Therapeutic Radiological Services</li> <li>• Diabetes Monitoring Supplies</li> <li>• Blood</li> <li>• Immunizations</li> <li>• Pap Smears and Pelvic Exams</li> <li>• Prostate Screening</li> <li>• Colorectal Screening</li> <li>• Bone Mass Measurement</li> <li>• Mammography Screening</li> <li>• Diabetes Monitoring</li> <li>• Nutrition therapy for diabetes and Renal Disease</li> </ul> <p><b>\$25 copay for:</b></p> <ul style="list-style-type: none"> <li>• Primary Care Physician Services</li> <li>• Outpatient X-rays</li> <li>• Routine Physical Exams</li> </ul> <p><b>\$20 to \$40 copay for:</b></p> <ul style="list-style-type: none"> <li>• Diagnostic Radiological Services</li> </ul> <p><b>\$0 to \$40 copay for:</b></p> <ul style="list-style-type: none"> <li>• Outpatient Diag Procs/Tests/Lab Services</li> </ul> <p><b>\$50 to \$125 copay for:</b></p> <ul style="list-style-type: none"> <li>• Outpatient Hospital Services</li> </ul> <p><b>\$75 copay for:</b></p> <ul style="list-style-type: none"> <li>• Ambulatory Surgical Center (ASC) Services</li> </ul> <p><b>\$50 copay for:</b></p> <p>Ambulance Services</p> <p><b>20% of the cost for:</b></p> <ul style="list-style-type: none"> <li>• DME</li> <li>• Prosthetics/Medical Supplies</li> </ul> | <p><b>\$0 copay for:</b></p> <ul style="list-style-type: none"> <li>• Home Health Services</li> <li>• Therapeutic Radiological Services</li> <li>• Diabetes Monitoring Supplies</li> <li>• Blood</li> <li>• Immunizations</li> <li>• Pap Smears and Pelvic Exams</li> <li>• Prostate Screening</li> <li>• Colorectal Screening</li> <li>• Bone Mass Measurement</li> <li>• Mammography Screening</li> <li>• Diabetes Monitoring</li> <li>• Nutrition therapy for diabetes and Renal Disease</li> </ul> <p><b>\$15 copay for:</b></p> <ul style="list-style-type: none"> <li>• Primary Care Physician Services</li> <li>• Outpatient X-rays</li> <li>• Routine Physical Exams</li> </ul> <p><b>\$20 to \$40 copay for:</b></p> <ul style="list-style-type: none"> <li>• Diagnostic Radiological Services</li> </ul> <p><b>\$0 to \$40 copay for:</b></p> <ul style="list-style-type: none"> <li>• Outpatient Diag Procs/Tests/Lab Services</li> </ul> <p><b>\$40 to \$100 copay for:</b></p> <ul style="list-style-type: none"> <li>• Outpatient Hospital Services</li> </ul> <p><b>\$60 copay for:</b></p> <ul style="list-style-type: none"> <li>• Ambulatory Surgical Center (ASC) Services</li> </ul> <p><b>\$50 copay for:</b></p> <ul style="list-style-type: none"> <li>• Ambulance Services</li> </ul> <p><b>20% of the cost for:</b></p> <ul style="list-style-type: none"> <li>• DME</li> <li>• Prosthetics/Medical Supplies</li> </ul> | <p><b>\$0 copay for:</b></p> <ul style="list-style-type: none"> <li>• Home Health Services</li> <li>• Therapeutic Radiological Services</li> <li>• Diabetes Monitoring Supplies</li> <li>• Blood</li> <li>• Immunizations</li> <li>• Pap Smears and Pelvic Exams</li> <li>• Prostate Screening</li> <li>• Colorectal Screening</li> <li>• Bone Mass Measurement</li> <li>• Mammography Screening</li> <li>• Diabetes Monitoring</li> <li>• Nutrition therapy for diabetes and Renal Disease</li> </ul> <p><b>\$10 copay for:</b></p> <ul style="list-style-type: none"> <li>• Primary Care Physician Services</li> <li>• Outpatient X-rays</li> <li>• Routine Physical Exams</li> </ul> <p><b>\$10 to \$20 copay for:</b></p> <ul style="list-style-type: none"> <li>• Diagnostic Radiological Services</li> </ul> <p><b>\$0 to \$20 copay for:</b></p> <ul style="list-style-type: none"> <li>• Outpatient Diag Procs/Tests/Lab Services</li> </ul> <p><b>\$30 to \$75 copay for:</b></p> <ul style="list-style-type: none"> <li>• Outpatient Hospital Services</li> </ul> <p><b>\$45 copay for:</b></p> <ul style="list-style-type: none"> <li>• Ambulatory Surgical Center (ASC) Services</li> </ul> <p><b>\$50 copay for:</b></p> <p>Ambulance Services</p> <p><b>20% of the cost for:</b></p> <ul style="list-style-type: none"> <li>• DME</li> <li>• Prosthetics/Medical Supplies</li> </ul> |

# Premium Table for H5883 BCN Advantage (HMO-POS) plans

The premiums vary by county in which you permanently reside.  
(Rates are based on the use and cost of health care services in each regional segment.)

| 1. Locate the segment/county in which you permanently reside.<br>2. Look at the options to find your monthly premium rate |                                      |       |          |          |
|---|--------------------------------------|-------|----------|----------|
| Segment with Counties   | BCN Advantage Premium Rate Per Month |       |          |          |
|   | Option 1                             | Basic | Option 2 | Option 3 |
| <b>Segment 1</b><br><b>Southwest Michigan</b><br>Allegan, Kent, Muskegon, Newaygo, Oceana, Ottawa, Van Buren              | \$10                                 | \$0   | \$59     | \$194    |
| <b>Segment 2</b><br><b>Mid-Michigan</b><br>Barry, Clinton, Eaton, Gratiot, Ingham, Ionia, Kalamazoo, Midland              | \$8                                  | \$0   | \$69     | \$207    |
| <b>Segment 3</b><br><b>South Michigan</b><br>Calhoun, Jackson, Livingston, Monroe, Montcalm, Washtenaw                    | \$24                                 | \$0   | \$69     | \$193    |
| <b>Segment 4</b><br><b>Central Michigan</b><br>Bay, Genesee, Lapeer, Saginaw, Shiawassee, Tuscola                         | \$28                                 | \$0   | \$64     | \$227    |
| <b>Segment 5</b><br><b>Southeast Michigan</b><br>Macomb, Oakland, St. Clair, Wayne  | \$24                                 | \$0   | \$89     | \$181    |



