Summary of Benefits

Medicare Plus Blue Group PFFS℠

January 1, 2010 - December 31, 2010

Medicare PLUS Blue Group PFFS℠

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association. Medicare Plus Blue Group PFFS is a health plan with a Medicare contract.

Chemical Financial

For more information about this plan:

Visit us at **www.bcbsm.com** or call Medicare Plus Blue Group PFFS Member Services.
Hours: 8:30 a.m. to 5 p.m. Eastern Standard Time, Monday through Friday, 1-866-684-8216
(TTY/TDD users call 1-800-579-0235)

For more information about Medicare, please call 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.

SECTION 1

Introduction to the Summary of Benefits for Medicare Plus Blue Group PFFS

January 1, 2010 - December 31, 2010

Thank you for your interest in **Medicare Plus Blue Group PFFS**. Our plan is offered by BLUE CROSS BLUE SHIELD OF MICHIGAN, a Medicare Advantage Private Fee-for-Service organization. This Summary of Benefits tells you some features of the plan. It doesn't list every service we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Medicare Plus Blue Group PFFS Member Services 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 Medicare (fee-for-service) plan. Another option is a Medicare Advantage Private Fee-for-Service plan, like **Medicare Plus Blue Group PFFS**. For more information call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users may call 1-877-486-2048.

You may leave this plan at any time but the timeframe in which you can enroll in another Medicare Advantage plan may be limited. Please call Medicare Plus Blue Group PFFS Member Services at the telephone number listed on the inside front cover of this booklet for more information.

HOW CAN I COMPARE MY OPTIONS?

You can compare **Medicare Plus Blue Group PFFS** 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. You will receive all of the benefits that the Original Medicare Plan offers. Your group health plan also offers more benefits, which may change from year to year.

WHO IS ELIGIBLE TO JOIN MEDICARE PLUS BLUE GROUP PFFS?

You can join **Medicare Plus Blue Group PFFS** if you are entitled to Medicare Part A, enrolled in Medicare Part B and live within the U.S.

CAN I CHOOSE MY DOCTORS?

A Medicare Advantage Private Fee-for-Service plan works differently than your existing plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, or otherwise agree to treat you, you will not be able to receive covered services from them under this plan. Providers can find the plan's terms and conditions on our Web site at: **www.bcbsm.com/ma.**

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

Medicare Plus Blue Group PFFS does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

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 **Medicare Plus Blue Group PFFS** 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®): 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 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 GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?

Medicare Plus Blue Group PFFS 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 by calling Member Services 1-866-684-8216 (TTY 1-800-579-0235) or visiting us at **www.bcbsm.com/ma/**.

Medicare Plus Blue Group PFFS 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.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

Medicare Plus Blue Group PFFS uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, 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. A copy of the formulary will be sent to you. You can see the complete formulary on our Web site at www.bcbsm.com/medicare.

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 PRESCRIPTION DRUG PLAN COSTS?

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

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day, 7 days a week.
- The Social Security Administration at 1-800-772-1213 between 7a.m. and 7p.m., Monday through Friday. TTY/TDD 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 60 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

GRIEVANCE AND APPEALS

As a member of **Medicare Plus Blue Group PFFS**, 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 if you have any type of problem with us or one of our 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.

As a member of **Medicare Plus Blue Group PFFS**, 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.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we may 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 **Medicare Plus Blue Group PFFS,** 1-866-684-8216 (TTY users call 1-800-579-0235) for more details.

SECTION 2 – Summary of Benefits

Your services must be medically necessary with the exception of those listed as preventive care.
If you have any questions about this Plan's benefits or costs, please contact Medicare Plus Blue Group PFFS Member Services, 1-866-684-8216 (TTY 1-800-579-0235).

Benefit	Original Medicare	Medicare Plus Blue Group PFFS
IMPORTANT INFORMATION		
1 Premium and Other Important Information	In 2010, most people will pay a monthly Medicare Part B premium of $96.40* each month. The Medicare Part B premium may change each year. In 2010, you pay the Medicare Part B deductible of $155 each year. The Medicare Part B deductible may change each year. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. *Some people will pay a higher monthly Part B premium. For more information about the circumstances when a higher premium payment is required, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.should call 1-800-325-0778.	In addition to the Medicare Part B Premium you may also be required to pay a premium contribution as defined by your employer group. For many covered services described below, the following cost share applies: Services are subject to the annual deductible of $150. Services are subject to a coinsurance of 5%. Once the 5% coinsurance payments equal $1000, all covered services otherwise subject to coinsurance [except as noted] will be paid at 100%.
2 Doctor and Hospital Choice (For more information, see Emergency **15** and Urgently Needed Care **16**)	You may go to any doctor, specialist or hospital that accepts Medicare.	You may go to any doctor, specialist, or hospital that accepts BCBSM's terms and conditions of payment. If the doctor or hospital does not agree to accept our payment terms and conditions, they may not provide healthcare services to you, except in emergencies.

Benefit	Original Medicare	Medicare Plus Blue Group PFFS
INPATIENT CARE		
3 Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	In 2010 the amounts for each benefit period (3) are: Days 1-60: $1,1008 deductible Days 61- 90: $275 per day Days 91-150: $550 per lifetime reserve day. (4) Days beyond 150 – all costs for each day Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. (4)	Services are subject to the annual deductible of $150 and a coinsurance of 5%. The coinsurance maximum of $1000 applies to these services. Unlimited days for inpatient care coverage.
4 Inpatient Mental Health Care	Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above). 190 day limit in a Psychiatric Hospital.	Services are subject to the annual deductible of $150 and a coinsurance of 5%. The coinsurance maximum of $1000 applies to these services. Unlimited days for inpatient mental health care coverage.

(3) 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.

(4) Lifetime reserve days can only be used once.

Note: The Medicare Part B deductible may change each year.

Benefit	Original Medicare	Medicare Plus Blue Group PFFS
5 Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	In 2010 the amounts for each benefit period (3) after at least a 3-day covered hospital stay are: Days 1 – 20: $0 per day Days 21-100: $137.50 per day 100 days for each benefit period. (3)	The 3-day hospital stay requirement under Original Medicare is waived. Services are subject to the annual deductible of $150 and a coinsurance of 5%. The coinsurance maximum of $1000 applies to these services. You are covered up to 100 days per benefit period. These days renew when you have been out of a hospital or skilled nursing facility for 60 days in a row. There is no limit to the number of benefit periods you can have. .
6 Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, home infusion, and rehabilitation services, etc.)	You pay $0 for Medicare home health visits.	No member cost-share is applied for home health care, including visiting nurse services.
7 Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must receive care from a Medicare-certified hospice.	You must receive care from a Medicare-certified hospice. Hospice claims must be submitted to Original Medicare. Claims for services that are not covered by Original Medicare in a hospice setting must be submitted to Medicare Plus Blue Group.

(3) 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.

Note: The Medicare Part B deductible may change each year.

Benefit	Original Medicare	Medicare Plus Blue Group PFFS
OUTPATIENT CARE		
8 Doctor Office Visits	20% coinsurance (1)(2)	You pay a $15 copay for office visits. Does not apply to the deductible. Does not apply to the coinsurance maximum. See 'Physical Exams' below for more information.
9 Chiropractic Services	Routine care not covered. 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(1)(2)	For charges for covered manual manipulation of the spine, member cost-share will be applied as follows: You pay a $15 copay. Does not apply to the deductible. Does not apply to the coinsurance maximum.
10 Podiatry Services	Routine care not covered 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs. (1)(2)	You pay a $15 copay for office visits. Does not apply to the deductible. Does not apply to the coinsurance maximum. For some medically necessary services (such as surgery and X-rays), member cost share will be applied as follows: Services are subject to the annual deductible of $150 and a coinsurance of 5%. The coinsurance maximum of $1000 applies to these services.

(1) In 2010, you pay a total of one $155 deductible.
(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

Note: The Medicare Part B deductible may change each year.

Benefit	Original Medicare	Medicare Plus Blue Group PFFS
11 Outpatient Mental Health Care	45% coinsurance for most outpatient mental health services. (1)(2)	For doctor, psychiatrist, clinical psychologist, or clinical social worker charges for psychiatric / psychotherapy services, member cost-share will be applied as follows: You pay a $15 copay. Does not apply to the deductible. Does not apply to the coinsurance maximum. For facility charges incurred if these services are hospital-based, member cost-share will be applied as follows: Services are subject to the annual deductible of $150 and a coinsurance of 5%. The coinsurance maximum of $1000 applies to these services.
12 Outpatient Substance Abuse Care	20% coinsurance (1)(2)	For doctor, psychiatrist, clinical psychologist, or clinical social worker charges for psychiatric / psychotherapy services, member cost-share will be applied as follows: You pay a $15 copay. Does not apply to the deductible. Does not apply to the coinsurance maximum. For facility charges incurred if these services are hospital-based, member cost-share will be applied as follows: Services are subject to the annual deductible of $150 and a coinsurance of 5%. The coinsurance maximum of $1000 applies to these services.
13 Outpatient Services / Surgery	20% coinsurance for the doctor (1)(2) 20% of outpatient facility charges (1)(2)	Services are subject to the annual deductible of $150 and a coinsurance of 5%. The coinsurance maximum of $1000 applies to these services.

(1) In 2010, you pay a total of one $155 deductible.
(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

Note: The Medicare Part B deductible may change each year.

Benefit	Original Medicare	Medicare Plus Blue Group PFFS
14 Ambulance Services (Medically necessary ambulance services)	20% coinsurance (1)(2)	Services are subject to the annual deductible of $150 and a coinsurance of 5%. The coinsurance maximum of $1000 applies to these services.
15 Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care)	20% coinsurance for the doctor (1)(2) 20% of facility charge, or a set copay per emergency room visit (1)(2) 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. NOT covered outside the U.S. except under limited circumstances	You pay a $50 copay for ER visits. Does not apply to the deductible. Does not apply to the coinsurance maximum. Cost-share is waived if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. Cost-share is waived if your diagnosis confirms that emergency services were warranted.
16 Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	20% coinsurance or a set copay (1)(2) NOT covered outside of the U.S except under limited circumstances.	You pay a $15 copay. Does not apply to the deductible. Does not apply to the coinsurance maximum.
17 Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech, and Language Therapy)	20% coinsurance (1)(2)	Services are subject to the annual deductible of $150 and a coinsurance of 5%. The coinsurance maximum of $1000 applies to these services. Medicare outpatient rehabilitation caps apply.

Benefit	Original Medicare	Medicare Plus Blue Group PFFS

(1) In 2010, you pay a total of one $155 deductible.
(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

Note: The Medicare Part B deductible may change each year.

OUTPUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18 Durable Medical Equipment (Includes wheelchairs, oxygen, etc.)	20% coinsurance (1)(2)	No member cost-share will be applied for covered Durable Medical Equipment.
19 Prosthetic Devices (Braces, artificial limbs and eyes, etc.)	20% coinsurance (1)(2)	No member cost-share will be applied for covered Prosthetic Devices.
20 Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (Includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)	20% coinsurance (1)(2) 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.	For diabetes screening tests, self-monitoring training, and nutrition therapy, member cost-share will be applied as follows: Services are subject to the annual deductible of $150 and a coinsurance of 5%. The coinsurance maximum of $1000 applies to these services. Some diabetes supplies obtained from DME providers are covered in full. You may pay a pharmacy coinsurance for medical supplies (test strips, lancets, etc.) obtained from a pharmacy.

(1) In 2010, you pay a total of one $155 deductible.
(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

Note: The Medicare Part B deductible may change each year.

Benefit	Original Medicare	Medicare Plus Blue Group PFFS
PREVENTIVE SERVICES		
21 Diagnostic Tests, X-Rays, and Lab Services	20% coinsurance for diagnostic tests and X-rays (1)(2) $0 copay for Medicare-covered lab services (1)(2) 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.	Services are subject to the annual deductible of $150 and a coinsurance of 5%. The coinsurance maximum of $1000 applies to these services. No member cost-share will be applied for Medicare-approved clinical lab services.
22 Bone Mass Measurement (For people that are at risk)	20% coinsurance (1)(2) Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	Covered once annually. Services are subject to the annual deductible of $150 and a coinsurance of 5%. The coinsurance maximum of $1000 applies to these services.
23 Colorectal Screening Exams (For people with Medicare, age 50 or older)	20% coinsurance (1)(2) Covered when you are high risk or when you are age 50 and older.	Covered once annually. For barium enema, colonoscopy, and flexible sigmoidoscopy, member cost-share will be applied as follows: Services are subject to the annual deductible of $150 and a coinsurance of 5%. The coinsurance maximum of $1000 applies to these services. No member cost-share will be applied for fecal occult blood tests.

(1) In 2010, you pay a total of one $155 deductible.
(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

Note: The Medicare Part B deductible may change each year.

Benefit	Original Medicare	Medicare Plus Blue Group PFFS
24 Immunizations (Flu vaccine, Hepatitis B vaccine –for people with Medicare who are at risk, Pneumonia vaccine)	$0 copay for Flu and Pneumonia vaccines 20% coinsurance for Hepatitis B vaccine(1)(2) You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.	Flu shots are covered once per season with no deductible or coinsurance. Pneumococcal shots are covered once per lifetime, or more frequently if certain criteria are met, with no deductible or coinsurance. For Hepatitis B shots and other Medicare-approved immunizations, member cost-share will be applied as follows: Services are subject to the annual deductible of $150 and a coinsurance of 5%. The coinsurance maximum of $1000 applies to these services.
25 Mammograms (Annual Screening) (for women with Medicare age 40 and older)	20% coinsurance (2) No referral needed. 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.	Services are subject to the annual deductible of $150 and a coinsurance of 5%. The coinsurance maximum of $1000 applies to these services.
26 Pap Screens and Pelvic Exams (For women with Medicare)	$0 copay for Pap smears (2) Covered once every 2 years. Covered once a year for women with Medicare at high risk. 20% coinsurance for Pelvic Exams (2)	Pap smears and pelvic exams are covered annually. Services are subject to the annual deductible of $150 and a coinsurance of 5%. The coinsurance maximum of $1000 applies to these services.

(1) In 2010, you pay a total of one $155 deductible.
(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

Note: The Medicare Part B deductible may change each year.

Benefit	Original Medicare	Medicare Plus Blue Group PFFS
27 Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	20% coinsurance for the digital rectal exam, $0 for the PSA test; 20% coinsurance for other related services (2) Covered once a year for all men with Medicare over age 50	There is no member cost sharing for approved lab services. Prostate Screening Antigen test covered in full once annually. Digital rectal exam covered in full once annually.
28 Cardiovascular Screening	$0 copay (2) Covered every five years	Covered in full once every five years.
29 Tobacco Use Cessation Health/Wellness Education	20% coinsurance (1)(2) Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits	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. Services are subject to the annual deductible of $150 and a coinsurance of 5%. The coinsurance maximum of $1000 applies to these services.

(1) In 2010, you pay a total of one $155 deductible.
(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

Note: The Medicare Part B deductible may change each year.

Benefit	Original Medicare	Medicare Plus Blue Group PFFS
OTHER SERVICES		
30 End Stage Renal Disease	20% coinsurance for renal dialysis (1)(2) 20% coinsurance for Nutrition Therapy for End-Stage Renal Disease (1)(2) 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.	For Medicare-approved dialysis, member cost-share will be applied as follows: Services are subject to the annual deductible of $150 and a coinsurance of 5%. The coinsurance maximum of $1000 applies to these services. For facility charges when ESRD services are performed in an outpatient hospital setting, member cost-sharing will be applied as follows: Services are subject to the annual deductible of $150 and a coinsurance of 5%. The coinsurance maximum of $1000 applies to these services.
31 Dental Services	Preventative dental services (such as cleaning) not covered	Preventive dental services are not covered under this Medicare Plus Blue Group plan. Preventive dental services may be covered as part of a separate dental plan.

(1) In 2010, you pay a total of one $155 deductible.
(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

Note: The Medicare Part B deductible may change each year.

Benefit	Original Medicare	Medicare Plus Blue Group PFFS
32 Hearing Services	Routine hearing exams and hearing aids not covered 20% coinsurance for diagnostic hearing exams (1)(2)	Hearing aids are not covered. Routine hearing exams are not covered. For diagnostic hearing office visits, member cost-share will be applied as follows: You pay a $15 copay. Does not apply to the deductible. Does not apply to the coinsurance maximum. For diagnostic testing, member cost-share is applied as follows: Services are subject to the annual deductible of $150 and a coinsurance of 5%. The coinsurance maximum of $1000 applies to these services.

(1) In 2010, you pay a total of one $155 deductible.
(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

Note: The Medicare Part B deductible may change each year.

Benefit	Original Medicare	Medicare Plus Blue Group PFFS
33 Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye (1)(2) Routine eye exams and glasses not covered Medicare Pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.	People who are at risk are covered for annual glaucoma screenings. Services are subject to the annual deductible of $150 and a coinsurance of 5%. The coinsurance maximum of $1000 applies to these services. Corrective lenses following cataract surgery are covered in full. For office visits for vision services, member cost-share will be applied as follows: You pay a $15 copay. Does not apply to the deductible. Does not apply to the coinsurance maximum. For diagnosis and treatment of diseases and conditions of the eye, member cost share will be applied as follows: Services are subject to the annual deductible of $150 and a coinsurance of 5%. The coinsurance maximum of $1000 applies to these services. Routine eye exams and glasses are not covered under this Medicare Plus Blue Group plan. Routine eye exams and glasses may be covered as part of a separate vision plan.

(1) In 2010, you pay a total of one $155 deductible.
(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

Note: The Medicare Part B deductible may change each year.

Benefit	Original Medicare	Medicare Plus Blue Group PFFS
34 Physical Exams	20% coinsurance for one exam within the first 12 months of your Medicare Part B coverage (1)(2) When you get Medicare Part B, you can get a one time physical exam within the first twelve months of your new Part B coverage. The coverage does not include lab tests.	A 'Welcome (Physical)' Exam is covered once within the first 12 months after you have your Medicare Part B coverage. For this physical, member cost-share will be applied as follows: Services are subject to the annual deductible of $150 and a coinsurance of 5%. The coinsurance maximum of $1000 applies to these services. For office visits for annual routine physicals, member cost-share will be applied as follows: You pay a $15 copay. Does not apply to the deductible. Does not apply to the coinsurance maximum.
35 Private Duty Nursing	Private duty nursing is not covered.	Private Duty Nursing is not a covered benefit.

(1) In 2010, you pay a total of one $155 deductible.
(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

Note: The Medicare Part B deductible may change each year.

Benefit	Original Medicare	Medicare Plus Blue Group PFFS
PRESCRIPTION DRUGS		
Prescription Drugs	Most prescription drugs are not covered by Original Medicare.	**Deductible** There is no deductible for prescription drugs.
		Preferred Generic Drugs ("Tier 1") $10.00 copay for a one-month (Up-to-31-day) supply of drugs in this tier from a preferred or non-preferred retail or mail-order pharmacy. $25.00 copay for a three-month (Up-to-90-day) supply of drugs in this tier from a preferred retail or mail-order pharmacy. $30.00 copay for a three-month (Up-to-90-day) supply of drugs in this tier from a non-preferred retail or mail-order pharmacy.
		Preferred Brand Drugs ("Tier 2") $40.00 copay for a one-month (Up-to-31-day) supply of drugs in this tier from a preferred or non-preferred retail or mail-order pharmacy. $100.00 copay for a three-month (Up-to-90-day) supply of drugs in this tier from a preferred retail or mail-order pharmacy. $120.00 copay for a three-month (Up-to-90-day) supply of drugs in this tier from a non-preferred retail or mail-order pharmacy.

Benefit	Original Medicare	Medicare Plus Blue Group PFFS
Prescription Drugs	Most prescription drugs are not covered by Original Medicare.	**Non-Preferred Drugs (“Tier 3”)** $60.00 copay for a one-month (Up-to-31-day) supply of drugs in this tier from a preferred or non-preferred retail or mail-order pharmacy. $150.00 copay for a three-month (Up-to-90-day) supply of drugs in this tier from a preferred retail or mail-order pharmacy. $180.00 copay for a three-month (Up-to-90-day) supply of drugs in this tier from a non-preferred retail or mail-order pharmacy.
		Specialty Drugs (“Tier 4”) $60.00 copay for a one-month (Up-to-31-day) supply of drugs in this tier from a preferred or non-preferred retail or mail-order pharmacy. Supplies longer than 31days are not covered for this tier.
		Non-Self-Administered Injectable Drugs (“Tier 5”) $60.00 copay for a one-month (Up-to-31-day) supply of drugs in this tier from a preferred or non-preferred retail or mail-order pharmacy. Supplies longer than 31 days are not covered for this tier.

Note: The Medicare Part B deductible may change each year.

PRESCRIPTION DRUGS

Drugs Covered under Medicare Part D - General

This plan uses a formulary. The Plan will send you the formulary. You can also see the formulary at www.bcbsm.com/medicare. Different out-of-pocket costs may apply for people who have limited incomes, live in long term care facilities, or have access to Indian/Tribal/Urban (Indian Health Service).

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).

Total yearly drug costs are the total drug costs paid by both you and the plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs may have quantity limits. Your provider may be required to get prior authorization from Medicare Plus Blue Group PFFS for certain drugs.

The plan will pay for certain over-the-counter drugs as part of its utilization management program. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. Contact the plan for details. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's Web site, formulary, and printed materials.

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. You may have to pay more than your normal cost-sharing amount if you choose to use a higher cost drug when a lower cost drug is available. This may also occur if a new, lower cost generic version of a brand name drug is added to the plan's formulary after you enroll. You pay $0 the first time you fill a prescription for certain drugs. These drugs will be listed as "free first fill" on the plan's Web site, formulary, and printed materials.

After you have paid $4,550 out of pocket, called the "Catastrophic Coverage Limit", you will generally pay the greater of $2.50 or 5% for generic drugs and $6.30 or 5% for all other drugs until the end of the calendar year.

SECTION 3

Prescription Benefits At-A-Glance

Tier	Description	Up-to-31-day Supply	Up-to-90-day Supply*	
		Preferred or Non-Preferred Retail or Mail-Order Network Pharmacies	Preferred Retail or Mail-Order Network Pharmacies	Non-Preferred Retail or Mail-Order Network Pharmacies
Tier 1	Preferred Generic Drugs	$10.00	$25.00	$30.00
Tier 2	Preferred Brand Drugs	$40.00	$100.00	$120.00
Tier 3	Non-Preferred Drugs	$60.00	$150.00	$180.00
Tier 4	Specialty Drugs	$60.00**	These drugs are not covered for supplies greater than 31 days	
Tier 5	Non-Self-Administered Injectables**	$60.00**		

***Many retail pharmacies, but not all, will fill a 90-day supply of medication. Check with your pharmacist.**

****Tier 5 Drugs are not available through mail-order.**

Note: The Medicare Part B deductible may change each year.

Notes

Medicare PLUS **Blue** Group PFFS℠

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association. Medicare Plus Blue Group PFFS is a health plan with a Medicare contract.