

Summary of Benefits

Jan. 1 – Dec. 31, 2008

Prescription Blue Options A and B

Prescription BlueSM



A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

Prescription Blue is a prescription drug plan with a Medicare contract. Prescription Blue is issued by Blue Cross Blue Shield of Michigan, a nonprofit corporation and an independent licensee of the Blue Cross and Blue Shield Association.



Blue Cross Blue Shield of Michigan

www.bcbsm.com/medicare

Please call Blue Cross Blue Shield of Michigan for more information about this plan.

Visit us at www.bcbsm.com/medicare

or call us: Customer Service Hours: 8 a.m. – 8 p.m. Eastern, 7 days a week.

Current members should call 1-800-565-1770 for questions related to **Prescription Blue**, our Medicare Part D Prescription Drug program. (TTY/TDD users call 1-800-579-0235.)

Prospective members should call 1-800-485-4415 for questions related to **Prescription Blue**, our Medicare Part D Prescription Drug program. (TTY/TDD users call 1-800-481-8704.)

Current members should call 1-877-241-2583 for questions related to **Medicare Plus Blue**, our Medicare Advantage program. (TTY/TDD users call 1-800-579-0235.)

Prospective members should call 1-800-485-4415 for questions related to **Medicare Plus Blue**, our Medicare Advantage program. (TTY/TDD users call 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.

SECTION 1

Introduction to the Summary of Benefits for Prescription Blue Options A and B

January 1, 2008 – December 31, 2008

State of Michigan

Thank you for your interest in **Prescription Blue Options A and B**. Our plans are offered by Blue Cross Blue Shield Of Michigan, a Medicare Prescription Drug Plan that contracts with the Federal government. This Summary of Benefits tells you some features of our plan. It doesn't list every drug we cover, every limitation or exclusion. To get a complete list of our benefits, please call Blue Cross Blue Shield of Michigan and ask for the "Evidence of Coverage".

YOU HAVE CHOICES IN YOUR MEDICARE PRESCRIPTION DRUG COVERAGE

As a Medicare beneficiary, you can choose from different Medicare prescription drug coverage options. One option is to get prescription drug coverage through a Medicare Prescription Drug Plan, like **Prescription Blue Options A or B**. Another option is to get your prescription drug coverage through a Medicare Advantage Plan that offers prescription drug coverage. You make the choice.

HOW CAN I COMPARE MY OPTIONS?

The charts in this booklet list some important drug benefits. You can use this Summary of Benefits to compare the benefits offered by **Prescription Blue Options A and B** to the benefits offered by other Medicare Prescription Drug Plans or Medicare Advantage Plans with prescription drug coverage.

WHERE IS PRESCRIPTION BLUE OPTIONS A AND B AVAILABLE?

The service area for **Prescription Blue** is the **State of Michigan**. You must live in Michigan to join this plan.

There is more than one plan in this Summary of Benefits. If you are enrolled in one and wish to switch to another, you may do so only during certain times of the year. Please call Member Services for more information. If you move out of the state of Michigan, you must call Member Services in order to update your information. If you do not, you may be disenrolled from **Prescription Blue**.

WHO IS ELIGIBLE TO JOIN?

You can join **Prescription Blue** if you are entitled to Medicare Part A and/or enrolled in Medicare Part B and live in Michigan. Eligible individuals may only enroll in one Medicare Prescription Drug Plan at a time and may not be enrolled in a Medicare Advantage Plan (HMO, PPO), unless they are a member of Medicare Private-Fee-For-Service plan or are enrolled in an 1876 Cost Plan.

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

Prescription Blue does not cover drugs that are covered under Medicare Part B as prescribed and dispensed. Generally, we only cover drugs, vaccines, biological products and medical supplies that are covered under the Medicare Prescription Drug Benefit (Part D) and that are on our formulary.

WHERE CAN I GET MY PRESCRIPTIONS?

Prescription Blue has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We will not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases.

Blue Cross Blue Shield of Michigan has a list of preferred pharmacies. At these pharmacies, you may get your drugs at a lower copay or co-insurance. A non-preferred pharmacy is still a network pharmacy, but you may have to pay more for your prescriptions.

The pharmacies in our network can change at any time. You can ask for a Pharmacy Directory or call Member Services for an up-to-date list or access it online at www.bcbsm.com/medicare.

SECTION 1 — SUMMARY OF BENEFITS

WHAT IS A PRESCRIPTION DRUG FORMULARY?

Prescription Blue 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 Web site at www.bcbsm.com/medicare/formulary.shtml.

If you are currently taking a drug that is not on our formulary or subject to additional requirement 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.

WHAT SHOULD I DO IF I HAVE OTHER INSURANCE IN ADDITION TO MEDICARE?

If you have a Medigap (Medicare Supplement) policy that includes prescription drug coverage, you must contact your Medigap Issuer to let them know that you have joined a Medicare Prescription Drug Plan. If you decide to keep your current Medigap supplement policy, your Medigap Issuer will remove the prescription drug coverage portion of your policy. This will occur as of the effective date of your coverage in the Medicare Prescription Drug Plan and they will adjust your premium. Call your Medigap Issuer for details.

If you or your spouse has, or is able to get, employer group coverage, you should talk to your employer to find out how your benefits will be affected if you join **Prescription Blue Options A or B**. Get this information before you decide to enroll in this plan.

HOW CAN I GET HELP WITH MY DRUG PLAN COSTS?

If you qualify for extra help with your Medicare prescription drug plan costs, your premium and costs at the pharmacy will be lower. When you join Prescription Blue Options A or B, Medicare will tell us how much extra help you are getting. Then we will let you know the amount you will pay. If you are not getting this extra help you can see if you qualify by calling 1-800-Medicare (1-800-633-4227), TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Prescription Drug 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 Prescription Drug Plan leaves the program, you will not lose Medicare prescription drug 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 Prescription Blue, 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.

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.

SECTION 2 — Summary of Benefits

If you have any questions about this plan's benefits or costs, please contact Blue Cross Blue Shield of Michigan for details.

Benefit	Original Medicare	Prescription Blue Option A	Prescription Blue Option B
Prescription Drugs		You pay \$36.50 each month for your Medicare Part D prescription benefits. This plan does not cover Medicare Part B prescription drugs.	You pay \$42.50 each month for your Medicare Part D prescription benefits. This plan does not cover Medicare Part B prescription drugs.
Drugs covered under Medicare Part D <i>(Prescription Drug Benefit)</i>		This plan uses a formulary. The plan will send you a formulary. You can also see the formulary at www.bcbsm.com/medicare/formulary.shtml on the Web.	This plan uses a formulary. The plan will send you a formulary. You can also see the formulary at www.bcbsm.com/medicare/formulary.shtml on the Web.
Deductible		You pay a \$20 yearly deductible.	You pay a \$0 yearly deductible.
Initial Coverage		After you pay your yearly deductible, you pay the following until total yearly drug costs reach \$2,510:	Before the total yearly drug costs (paid by both you and your plan) reach \$2510, you pay the following for prescription drugs:
In-Network Retail Pharmacy <i>One month (34-day) supply</i>		<ul style="list-style-type: none"> – \$7 copay for a one month (34 day) supply of Generic drugs – \$30 copay for a one month (34 day) supply of Preferred Brand drugs – \$55 copay for a one month (34 day) supply of Non-Preferred drugs – 25% coinsurance for a one month (34 day) supply of Specialty drugs – 25% coinsurance for a one month (34 day) supply of Non Self-Administered Injectable drugs 	<ul style="list-style-type: none"> – \$7 copay for a one month (34 day) supply of Generic drugs – \$30 copay for a one month (34 day) supply of Preferred Brand drugs – \$55 copay for a one month (34 day) supply of Non-Preferred drugs – 25% coinsurance for a one month (34 day) supply of Specialty drugs – 25% coinsurance for a one month (34 day) supply of Non Self-Administered Injectable drugs

SECTION 2 — SUMMARY OF BENEFITS

Benefit	Original Medicare	Prescription Blue Option A	Prescription Blue Option B
<p>In-Network Retail Pharmacy</p> <p><i>Three month (90-day) supply at a preferred pharmacy</i></p>		<ul style="list-style-type: none"> – \$17.50 copay for a three month (90 day) supply of Generic drugs you get at a preferred pharmacy – \$75 copay for a three month (90 day) supply of Preferred Brand drugs you get at a preferred pharmacy – \$137.50 copay for a three month (90 day) supply of Non-Preferred drugs you get at a preferred pharmacy 	<ul style="list-style-type: none"> – \$17.50 copay for a three month (90 day) supply of Generic drugs you get at a preferred pharmacy – \$75 copay for a three month (90 day) supply of Preferred Brand drugs you get at a preferred pharmacy – \$137.50 copay for a three month (90 day) supply of Non-Preferred drugs you get at a preferred pharmacy
<p>In-Network Retail Pharmacy</p> <p><i>Three month (90-day) supply at a non-preferred pharmacy</i></p>		<ul style="list-style-type: none"> – \$21 copay for a three month (90 day) supply of Generic drugs you get at a Non-Preferred pharmacy – \$90 copay for a three month (90 day) supply of Preferred Brand drugs you get at a Non-Preferred pharmacy – \$165 copay for a three month (90 day) supply of Non-Preferred drugs you get at a Non-Preferred pharmacy 	<ul style="list-style-type: none"> – \$21 copay for a three month (90 day) supply of Generic drugs you get at a Non-Preferred pharmacy – \$90 copay for a three month (90 day) supply of Preferred Brand drugs you get at a Non-Preferred pharmacy – \$165 copay for a three month (90 day) supply of Non-Preferred drugs you get at a Non-Preferred pharmacy
<p>Long Term Care Pharmacy</p> <p><i>One month (34-day) supply</i></p>		<ul style="list-style-type: none"> – \$7 copay for a one month (34 day) supply of Generic drugs – \$30 copay for a one month (34 day) supply of Preferred Brand drugs – \$55 copay for a one month (34 day) supply of Non-Preferred drugs – 25% coinsurance for a one month (34 day) supply of Specialty drugs – 25% coinsurance for a one month (34 day) supply of non Self-Administered Injectable drugs 	<ul style="list-style-type: none"> – \$7 copay for a one month (34 day) supply of Generic drugs – \$30 copay for a one month (34 day) supply of Preferred Brand drugs – \$55 copay for a one month (34 day) supply of Non-Preferred drugs – 25% coinsurance for a one month (34 day) supply of Specialty drugs – 25% coinsurance for a one month (34 day) supply of non Self-Administered Injectable drugs

Benefit	Original Medicare	Prescription Blue Option A	Prescription Blue Option B
<p>Mail Order</p> <p><i>One month (34-day) supply</i></p>		<ul style="list-style-type: none"> – \$7 copay for a one month (34 day) supply of Generic drugs – \$30 copay for a one month (34 day) supply of Preferred Brand drugs – \$55 copay for a one month (34 day) supply of Non-Preferred drugs – 25% coinsurance for a one month (34 day) supply of Specialty drugs 	<ul style="list-style-type: none"> – \$7 copay for a one month (34 day) supply of Generic drugs – \$30 copay for a one month (34 day) supply of Preferred Brand drugs – \$55 copay for a one month (34 day) supply of Non-Preferred drugs – 25% coinsurance for a one month (34 day) supply of Specialty drugs
<p>Mail Order</p> <p><i>Three month (90-day) supply at a preferred mail order</i></p>		<ul style="list-style-type: none"> – \$17.50 copay for a three month (90 day) supply of Generic drugs you get through a preferred mail order – \$75 copay for a three month (90 day) supply of Preferred Brand drugs you get through a preferred mail order – \$137.50 copay for a three month (90 day) supply of Non-Preferred drugs you get through a preferred mail order 	<ul style="list-style-type: none"> – \$17.50 copay for a three month (90 day) supply of Generic drugs you get through a preferred mail order – \$75 copay for a three month (90 day) supply of Preferred Brand drugs you get through a preferred mail order – \$137.50 copay for a three month (90 day) supply of Non-Preferred drugs you get through a preferred mail order
<p>Mail Order</p> <p><i>Three month (90-day) supply at a non-preferred mail order</i></p>		<ul style="list-style-type: none"> – \$21 copay for a three month (90 day) supply of Generic drugs you get through a Non-Preferred mail order – \$90 copay for a three month (90 day) supply of Preferred Brand drugs you get through a Non-Preferred mail order – \$165 copay for a three month (90 day) supply of Non-Preferred drugs you get through a Non-Preferred mail order 	<ul style="list-style-type: none"> – \$21 copay for a three month (90 day) supply of Generic drugs you get through a Non-Preferred mail order – \$90 copay for a three month (90 day) supply of Preferred Brand drugs you get through a Non-Preferred mail order – \$165 copay for a three month (90 day) supply of Non-Preferred drugs you get through a Non-Preferred mail order

Benefit	Original Medicare	Prescription Blue Option A	Prescription Blue Option B
<p>Coverage After You Reach Your Initial Coverage Limit</p> <p>In-Network Retail Pharmacy</p>		<p>After the total yearly drug costs (paid by both you and your plan) reach \$2,510, you pay 100% of your prescription drug costs until your yearly out-of-pocket drug costs reach \$4,050.</p>	<p>After the total yearly drug costs (paid by both you and your plan) reach \$2,510, you pay the following until your yearly out-of-pocket drug costs reach \$4,050:</p> <ul style="list-style-type: none"> – \$7 copay for a one month (34 day) supply of Generic drugs – \$17.50 copay for a three month (90 day) supply of Generic drugs you get at a preferred pharmacy – \$21 copay for a three month (90 day) supply of Generic drugs you get at a Non-Preferred pharmacy
<p>Mail Order</p>			<ul style="list-style-type: none"> – \$7 copay for a one month (34 day) supply of Generic drugs – \$17.50 copay for a three month (90 day) supply of Generic drugs you get through a preferred mail order – \$21 copay for a three month (90 day) supply of Generic drugs you get through a Non-Preferred mail order <p>For all other covered drugs and after the total yearly drug costs (paid by both you and your plan) reach \$2,510, you pay 100% of your prescription drug costs up until your yearly out-of-pocket drug costs reach \$4,050.</p>
<p>Catastrophic Coverage</p>		<p>After your yearly out-of-pocket drug costs reach \$4,050 you pay the greater of:</p> <p>\$2.25 copay for generic (including brand drugs treated as generic) and \$5.60 copay for all other drugs, or 5% coinsurance.</p>	<p>After your yearly out-of-pocket drug costs reach \$4,050 you pay the greater of:</p> <p>\$2.25 copay for generic (including brand drugs treated as generic) and \$5.60 copay for all other drugs, or 5% coinsurance.</p>

Benefit	Original Medicare	Prescription Blue Option A	Prescription Blue Option B
Out-of-Network		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 pay more than the copay if you get your drugs at an out-of-network pharmacy.	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 pay more than the copay if you get your drugs at an out-of-network pharmacy.
Out-of-Network Initial Coverage		After you pay your yearly deductible, you pay the following until total yearly drug costs reach \$2510.	After you pay your yearly deductible, you pay the following until total yearly drug costs reach \$2510.
Out-of-Network Pharmacy <i>One month (34-day) supply</i>		<ul style="list-style-type: none"> – \$7 copay for a one month (34 day) supply of Generic drugs – \$30 copay for a one month (34 day) supply of Preferred Brand drugs – \$55 copay for a one month (34 day) supply of Non-Preferred drugs – 25% coinsurance for a one month (34 day) supply of Specialty drugs – 25% coinsurance for a one month (34 day) supply of Non Self-Administered Injectable drugs 	<ul style="list-style-type: none"> – \$7 copay for a one month (34 day) supply of Generic drugs – \$30 copay for a one month (34 day) supply of Preferred Brand drugs – \$55 copay for a one month (34 day) supply of Non-Preferred drugs – 25% coinsurance for a one month (34 day) supply of Specialty drugs – 25% coinsurance for a one month (34 day) supply of Non Self-Administered Injectable drugs
Out-of-Network Catastrophic Coverage		After your yearly out-of-pocket drug costs reach \$4,050 you pay the greater of: \$2.25 copay for generic (including brand drugs treated as generic) and \$5.60 copay for all other drugs, or 5% coinsurance.	After your yearly out-of-pocket drug costs reach \$4,050 you pay the greater of: \$2.25 copay for generic (including brand drugs treated as generic) and \$5.60 copay for all other drugs, or 5% coinsurance.

Benefit	Original Medicare	Prescription Blue Option A	Prescription Blue Option B
General Information		<p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> – have limited incomes, – live in long term care facilities, – have access to Indian/ Tribal/Urban (Indian Health Service) facilities. <p>The plan offers national in-network prescription coverage. This means that you will pay the same 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).</p> <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p> <p>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 have quantity limits. Your provider must get prior authorization from Prescription Blue for certain drugs.</p> <p>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. See page 9 or contact the plan for details.</p> <p>If the actual cost of a drug is less than the normal copay amount for that drug, you will pay the actual cost, not the higher copay amount.</p>	<p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> – have limited incomes, – live in long term care facilities, – have access to Indian/ Tribal/Urban (Indian Health Service) facilities. <p>The plan offers national in-network prescription coverage. This means that you will pay the same 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).</p> <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p> <p>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 have quantity limits. Your provider must get prior authorization from Prescription Blue for certain drugs.</p> <p>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. See page 9 or contact the plan for details.</p> <p>If the actual cost of a drug is less than the normal copay amount for that drug, you will pay the actual cost, not the higher copay amount.</p>

SECTION 3

Important Plan Information

This section explains some of the benefits of **Prescription Blue Options A and B**. It doesn't explain every benefit we cover or list every limitation or exclusion. To get a complete record of our benefits, call our Member Services representatives or visit our Web site, www.bcbsm.com/medicare for the "Evidence of Coverage."

How to Use Your Prescription Drug Plan with Prescription Blue

ACCESS TO PHARMACY SERVICES

With few exceptions, you must use network retail or mail order pharmacies to get your prescription drugs covered.

Our network includes preferred and non-preferred pharmacies. When you go to a "preferred" pharmacy, you get your drugs at a lower copayment or coinsurance. If you get a prescription at a "non-preferred" pharmacy you may have to pay a higher copayment or coinsurance.

You also have the convenience of using a mail-order pharmacy for up to a 90-day supply of your drugs delivered right to your home. For more information about mail-order pharmacies call 1-800-565-1770 (TDD users call 1-800-579-0235) 8am – 8pm, 7 days a week.

Generally, we only cover drugs filled at an out-of-network pharmacy if the prescription is related to care for a medical emergency or urgently needed care; if you are traveling within the US, outside the Plan's service area, and become ill, lose or run out of your drugs; if there are no network pharmacies within reasonable driving distance that provide 24-hour service; or if your covered drug is not regularly stocked at a network pharmacy. In these situations, you will have to pay the full cost (rather than paying just your copayment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form. Before you fill a prescription at an out-of-network pharmacy, please call Member Services to see if there is a network pharmacy available.

The pharmacies in our network can change. Each year we'll send you a Prescription Blue Pharmacy Directory to help you find a network pharmacy closest to you. Or, you can call Member Services for a directory or access our Pharmacy Directory online at www.bcbsm.com/medicare.

OVER THE COUNTER, NON-SEDATING ANTIHISTAMINES

As part of our utilization management program, step therapy for prescription-only non-sedating antihistamine (NSA) products requires the trial of over-the-counter (OTC) NSA products such as Claritin® or Claritin-D®. OTC NSA's will be covered when obtained in coordination with our utilization management, step-therapy program. Contact the plan for details.

ENHANCED BENEFIT FOR PRESCRIPTION BLUE OPTION B ONLY

As part of an enhanced benefit for Prescription Blue Option B members, some Medicare Part D excluded drugs are covered at a 'tier 1' copay. Some covered drugs don't count toward your out-of-pocket drug costs. Contact the plan for details.

SECTION 3

HOW YOUR PRESCRIPTION DRUG BENEFIT WORKS

Prescription Blue will pay part of the costs of your covered drugs and you'll pay part. The amount you pay depends on two things: which drug tier your drug is in and whether you fill your prescription at a preferred network pharmacy.

	Prescription Blue Option A	Prescription Blue Option B
Step 1	You have a \$20 deductible.	You have a \$0 deductible.
Step 2	You pay the required copayments and coinsurances at network pharmacies until your prescription drug costs, paid by both you and your Plan, (not including monthly premiums) reach \$2,510.	You pay the required copayments and coinsurances at network pharmacies until your prescription drug costs, paid by both you and your Plan, (not including your monthly premium) total \$2,510.
Step 3	After your total drug costs reach \$2,510, your "Initial Coverage Limit", there is a gap in your coverage. This means you pay the full amount for your drugs until your total out-of-pocket costs, for covered drugs, reach \$4,050.	After your total drug costs reach \$2,510, your "Initial Coverage Limit", there is a gap in your coverage. This means, for generic drugs, you pay only: \$7 up to 34-day supply; \$17.50 up to 90-day supply at Preferred retail or mail order pharmacy; \$21 up to 90-day supply at Non-Preferred retail or mail order pharmacy. You pay the full amount for all other covered drugs until your total out-of-pocket costs, for covered drugs, reach \$4,050.
Step 4	After you have paid \$4,050 out of pocket, called the "Catastrophic Coverage Limit", you will generally pay the greater of \$2.25 or 5% for generic drugs and \$5.60 or 5% for all other drugs until the end of the calendar year.	

Note: You should continue to show your **Prescription Blue** ID card during the coverage gap so you only pay the Plan's negotiated amount and we track your out-of-pocket costs to ensure you receive catastrophic coverage benefits as soon as you are eligible.

WHAT ARE OUT-OF-POCKET COSTS?

Out-of-pocket costs include any deductibles, copays and coinsurances you pay for prescription drugs. They do not include your monthly premiums, over-the-counter drugs and vitamins, and prescription drugs purchased outside the U.S. and its territories.

We'll send you an Explanation of Benefits (EOB) each month. It will track the total amount you've spent on your prescription drugs, how much coverage you have left before you reach the Initial Coverage Limit, how much you need to pay to reach the Catastrophic Coverage Limit and your total out-of-pocket costs for the calendar year.

Formulary

Prescription Blue uses a formulary, which is a list of drugs selected to meet member needs. Our formulary covers both generic and brand-name drugs. Generic drugs have a proven record of safety and effectiveness and have the same active ingredient as brand-name drugs. Generic drugs usually cost less than brand-name drugs and are approved by the Food and Drug Administration (FDA). All prescription drugs in our formulary are divided into five categories, known as “tiers.” They are listed at the right.

Tier 1 Generic drugs: Most generic drugs are in Tier 1. Tier 1 drugs have a proven record of safety and effectiveness and may offer the best value for you, as they have the lowest copay.

Tier 2 Preferred Brand drugs: also have a record of safety and effectiveness. Since a more cost-effective therapy or a generic alternative is usually available for preferred brand drugs, Tier 2 drugs require a higher copay.

Tier 3 Non-Preferred drugs: are those where an equally effective, lower cost or safer alternative may exist. You pay an even higher copay for Tier 3 drugs. Check with your doctor or pharmacist for an alternative drug on the formulary that may be right for you.

Tier 4 Specialty drugs: are very high-cost, unique drugs often used to treat chronic or complex conditions.

Tier 5 Non Self-Administered Injectable drugs: are generally administered in a facility setting or at home by a health care professional.

At-A-Glance Prescription Drug Benefits for Prescription Blue Options A and B

Option A has a \$20 deductible. Option B has \$0 deductible.

For both Options A and B, you pay the following copayments and coinsurances at network pharmacies UNTIL your prescription drug costs (paid by both you and your Plan) **total \$2,510 for Option A, \$2,510 for Option B (the Initial Coverage Limit)**

Tier	Description	Up to 34-day supply at All Retail or Mail Order Network Pharmacies	Up to a 90-day supply*	
			Preferred Retail or Mail Order Network Pharmacies	Non-Preferred Retail or Mail Order Network Pharmacies
Tier 1	Generic Drugs	\$7	\$17.50	\$21
Tier 2	Preferred Brand Drugs	\$30	\$75	\$90
Tier 3	Non-Preferred Drugs	\$55	\$137.50	\$165
Tier 4	Specialty Drugs	25% of the Plan's approved amount	Not Available	
Tier 5**	Non-Self Administered Injectables			

* The majority of retail network 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.

Coverage Gap

AFTER your drug costs reach \$2,510 for Option A, \$2,510 for Option B, you pay the following UNTIL your total out-of-pocket costs for covered drugs reach \$4,050 (the Catastrophic Coverage Limit)***

Prescription Blue Option A	You pay 100% of the plan's approved amount at network pharmacies
Prescription Blue Option B	You pay the following for Generic Drugs: \$7 (up to 34-day supply) \$17.50 (up to 90-day supply at Preferred Retail or Mail Order Pharmacy) \$21 (up to 90-day supply at Non-Preferred Retail or Mail Order Pharmacy)

Catastrophic Coverage

AFTER your yearly out-of-pocket drug costs (including copays, coinsurance and 100% drug payments) reach \$4,050 (the Catastrophic Coverage Limit), you pay the following at network pharmacies

Tier	Description	Up to 34-day supply at All Retail or Mail Order Network Pharmacies	Up to a 90-day supply*	
			Preferred Retail or Mail Order Network Pharmacies	Non-Preferred Retail or Mail Order Network Pharmacies
Tier 1	Generic Drugs	The greater of \$2.25 or 5% of the Plan's approved amount		
Tier 2	Preferred Brand Drugs	The greater of \$5.60 or 5% of the Plan's approved amount		
Tier 3	Non-Preferred Drugs			
Tier 4	Specialty Drugs	The greater of \$5.60 or 5% of the Plan's approved amount	Not Available	
Tier 5**	Non-Self Administered Injectables			

* The majority of retail network 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: Continue to show your **Prescription Blue** ID card during the coverage gap so you only pay the Plan's negotiated amount and we track your out-of-pocket costs to ensure you receive catastrophic coverage benefits as soon as you are eligible.

Glossary

Brand-Name drugs: Prescription drugs that are sold under a trademarked brand name.

Catastrophic Coverage Limit: After your yearly out-of-pocket costs reach \$4,050 you will generally pay the greater of \$2.25 copay or 5% coinsurance for generic drugs and \$5.60 copay or 5% coinsurance for all other drugs until the end of the calendar year.

Coinsurance: Cost sharing where you pay a percentage of the full cost.

Copayment: Cost Sharing where you pay a pre-set flat dollar amount for each service.

Coverage Gap: The period after the total yearly prescription drug costs (paid by both you and your plan) reach \$2,510 for **Option A** or **Option B**, until your yearly out-of-pocket drug costs reach \$4,050. With **Option A** you pay 100% of your prescription drug costs. With **Option B** you pay only small copays for generic drugs and 100% for all other covered drugs. Be sure to continue showing your **Prescription Blue** card during this gap so you only pay the Plan's negotiated amount and we continue to track your out-of-pocket costs to ensure you receive Catastrophic Coverage as soon as you are eligible.

Deductible: The amount one pays first before a health care plan starts to pay. **Prescription Blue Option A** has a \$20 deductible. **Option B** has \$0 deductible.

Initial Coverage Limit: When your total yearly drug costs (paid by both you and your plan) reach \$2,510 for **Option A**, or **Option B**, you go into the Coverage Gap (see definition above).

Network Pharmacy: With few exceptions, you must use network pharmacies to get your prescription drugs covered because they contract with **Prescription Blue**.

Non-Network Pharmacy: Most services you get are not covered unless certain conditions apply.

Preferred Pharmacy: You pay a lower copayment or coinsurance for covered drugs at these network pharmacies.

Non-Preferred Pharmacy: Is still a network pharmacy but you may have to pay a higher copayment or coinsurance than at a Preferred pharmacy.

Out-of Network Pharmacy: Generally, we only cover drugs filled at an out-of-network pharmacy if the prescription is related to care for a medical emergency or urgently needed care; if you are traveling within the U.S., outside the Plan's service area, and become ill, lose or run out of your drugs; if there are no network pharmacies within reasonable driving distance that provide 24-hour service; or if your covered drug is not regularly stocked at a network pharmacy. In these situations, you will have to pay the full cost (rather than paying just your copayment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form. Before you fill a prescription at an out-of-network pharmacy, please call Member Services to see if there is a network pharmacy available.

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

Customer Service Hours: 8:00 a.m. to 8:00 p.m. Eastern, 7 days a week

Current members should call 1-800-565-1770 for questions related to Prescription Blue, our Medicare Part D Prescription Drug program. (TTY/TDD users call 1-800-579-0235.)

Prospective members should call 1-800-485-4415 for questions related to Prescription Blue, our Medicare Part D Prescription Drug program. (TTY/TDD users call 1-800-481-8704.)

Current members should call 1-877-241-2583 for questions related to Medicare Plus Blue, our Medicare Advantage program. (TTY/TDD users call 1-800-579-0235.)

Prospective members should call 1-800-485-4415 for questions related to Medicare Plus Blue, our Medicare Advantage program. (TTY/TDD users call 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.

