Summary of Benefits

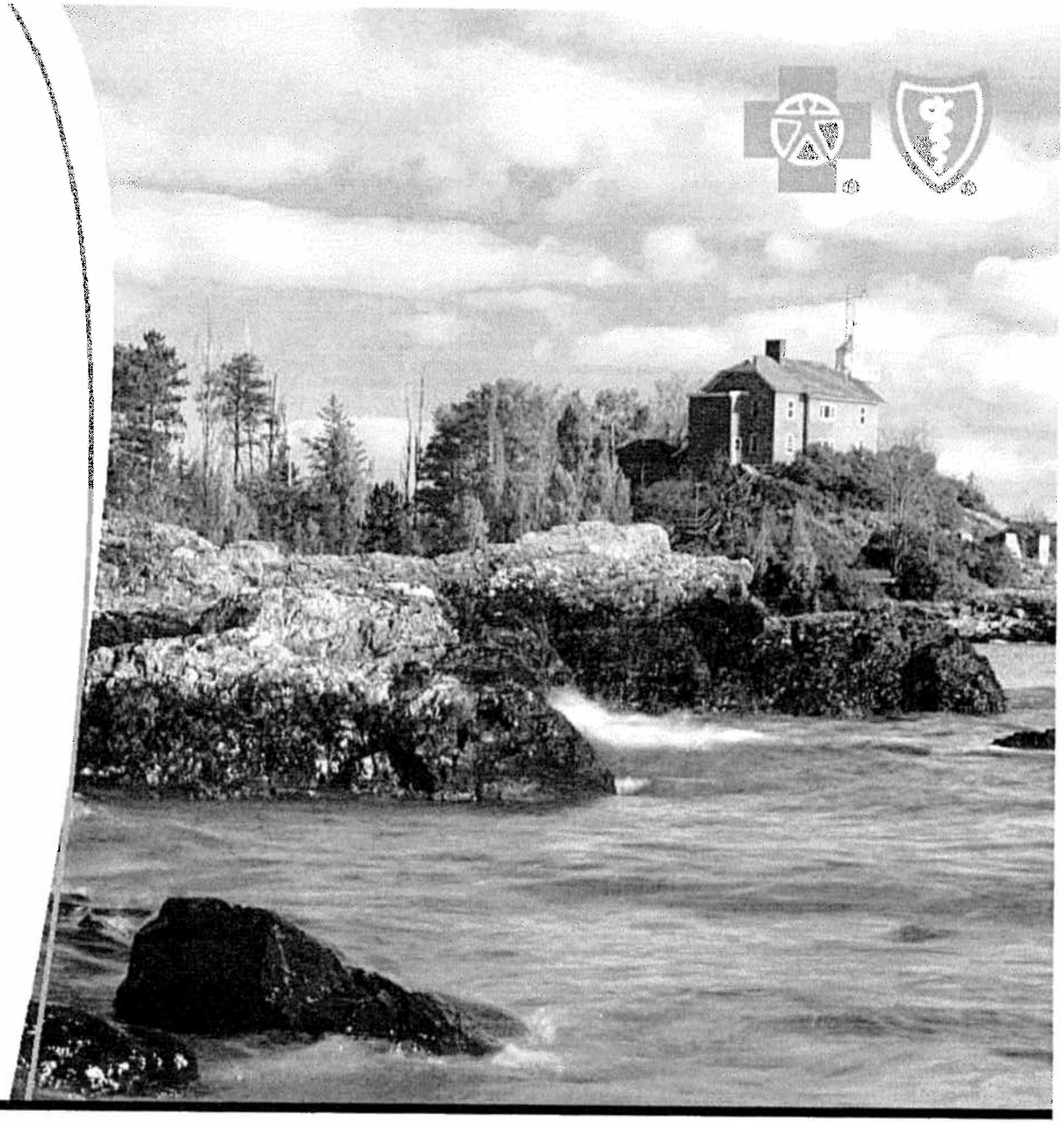
Medicare Plus Blue Group PPO℠

January 1, 2011 - December 31, 2011

Medicare PLUS Blue Group PPO℠

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.



Michigan Public School Employees Retirement System

For more information about this plan:

Visit us at **www.bcbsm.com** or call Medicare Plus Blue Group PPO Member Services at 1-800-422-9146
We're available Monday through Friday, from 8:30 a.m. to 5 p.m. Eastern time.
(TTY/TDD users call 1-800-807-4670)

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

January 1, 2011 - December 31, 2011
Thank you for your interest in **Medicare Plus Blue Group PPO**[SM]. Our plan is offered by Blue Cross Blue Shield of Michigan, a Medicare Advantage Preferred Provider Organization (PPO). 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 PPO** 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 (fee-for-service) Medicare plan. Another option is this Medicare Advantage plan offered through your employer or union group: **Medicare Plus Blue Group PPO**. For more information about your Medicare options, 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 PPO** 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 PPO** 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 the Original Medicare plan offers. Your group health plan may also offer more benefits, which may change from year to year.

WHAT IS THE SERVICE AREA FOR MEDICARE PLUS BLUE GROUP PPO?

Medicare Plus Blue Group PPO is available to employer and union group members who live in our plan service area, which are the entire 50 states and territories of the United States. To stay a member of our plan, you must keep living in this service area. If you plan to move out of the service area, please contact Member Services.

WHO IS ELIGIBLE TO JOIN MEDICARE PLUS BLUE GROUP PPO?

You can join **Medicare Plus Blue Group PPO** if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the United States or its territories.

CAN I CHOOSE MY DOCTORS?

Medicare Plus Blue Group PPO has a network of doctors, specialists and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of our network but may pay more. The health providers in our network can change at any time.

Visit our website at **www.bcbsm.com/medicare** for the most up-to-date provider network information. You can also call Member Services to ask for a *Provider Directory* book. If you are outside the state of Michigan, you can receive care from any provider who accepts Medicare.

WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?

With the exception of DME services, your cost sharing requirements are the same, whether you receive services in or out of the network. Call Member Services for more information.

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

Medicare Plus Blue Group PPO covers Medicare Part B prescription drug. This plan does not cover Medicare Part D

prescription drugs. You may have this coverage through a separate plan. Contact your employer or union group for more information.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage plans must 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. You always have Original 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 **Medicare Plus Blue Group PPO**, 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. Refer to the *Evidence of Coverage* for the QIO contact information.

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:

- 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 used with durable medical equipment

Contact Medicare Plus Blue Group PPO for more details.

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 Health Plans and Medigap Policies in your Area" to compare the plan ratings for Medicare plans in your area. You can also call Member Services at 1-800-422-9146 (TTY users call 1-800-807-4670) for more details. Call Monday through Friday from 8:30 a.m. to 5 p.m. Eastern time, to obtain a copy of the plan ratings for this plan.

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 call* ***Medicare Plus Blue Group PPO*** *Member Services at 1-800-422-9146, Monday through Friday from 8:30 a.m. to 5 p.m. Eastern time. (TTY users call 1-800-807-4670)*

Benefit	Original Medicare	Medicare Plus Blue Group PPO In-Network	Out-of-Network
IMPORTANT INFORMATION			
1 Premium and other important information	In 2010, most people will pay a monthly Medicare Part B premium of $96.40*. 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.	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 $300. Services are subject to a coinsurance of 10%. There is an annual combined in-network and out-of-network out-of-pocket maximum of $900. There is a separate annual $1,000 out-of-pocket maximum for durable medical equipment, prosthetic and orthotic devices. Once the in-network and out-of-network coinsurance payments, copayments and deductible equal $900, all covered services will be paid at 100%.	

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

Benefit		Original Medicare	Medicare Plus Blue Group PPO	
			In-Network	Out-of-Network
2	Doctor and hospital choice (See "Emergency" (#15) and "Urgently Needed Care" (#16)	You may go to any doctor, specialist or hospital that accepts Medicare.	No referral required for in-network doctors, specialists and hospitals.	No referral required for out-of-network doctors, specialists and hospitals.

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

Benefit	Original Medicare	Medicare Plus Blue Group PPO In-Network	Medicare Plus Blue Group PPO Out-of-Network
INPATIENT CARE			
3 Inpatient hospital care (includes substance abuse and rehabilitation services)	You pay for each benefit period: A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. 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. Days 1-60: an initial deductible of $1100 Days 61-90: $275 each day Days 91-150: $550 each lifetime reserve day Lifetime reserve days can be used only once. Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum. Unlimited days for inpatient care coverage.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum. Unlimited days for inpatient care coverage.

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 PPO	
		In-Network	Out-of-Network
4 Inpatient mental health care	You pay the same deductible and copayments as inpatient hospital care (see "Inpatient Hospital Care" above) except Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum. Unlimited days for inpatient care coverage.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum. Unlimited days for inpatient care coverage.
5 Skilled nursing facility You must receive care in a Medicare-certified skilled nursing facility.	You pay for each benefit period, following at least a 3-day covered hospital stay: Days 1-20: $0 for each day Days 21-100: $137.50 for each day All costs for each day after day 100 in a benefit period (There is a limit of 100 days for each benefit period) A "benefit period" begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 6o days in a row. 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.)	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum. Covered up to 100 days per benefit period.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum. Covered up to 100 days per benefit period.

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.

Benefit	Original Medicare	Medicare Plus Blue Group PPO	
		In-Network	Out-of-Network
6 Home health care (Includes medically necessary intermittent skilled nursing care, home health aide services, home infusion, rehabilitation services, etc.)	You pay: $0 for home health care services 20% of the Medicare-approved amount for durable medical equipment	No member cost-share will be applied for home health care services.	No member cost-share will be applied for home health care services.
7 Hospice You must receive care from a Medicare-certified hospice.	You pay: $0 for hospice care A copayment of up to $5 per prescription for outpatient prescription drugs for pain and symptom management 5% of the Medicare-approved amount for inpatient respite care (short-term care given by another caregiver, so the usual caregiver can rest) Medicare doesn't cover room and board when you get hospice care in your home or another facility where you live (like a nursing home).	When you enroll in a Medicare-certified hospice program, your hospice services are paid by Original Medicare, not Medicare Plus Blue Group PPO. Your Medicare Advantage plan may pay the coinsurance and copayments related to your outpatient drugs and respite care.	When you enroll in a Medicare-certified hospice program, your hospice services are paid by Original Medicare, not Medicare Plus Blue Group PPO. Your Medicare Advantage plan may pay the coinsurance and copayments related to your outpatient drugs and respite care.

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 PPO	
		In-Network	Out-of-Network
OUTPATIENT CARE			
8 Doctor office visits	You pay the $155 annual deductible plus 20% coinsurance of Medicare-approved amounts. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.	You pay a coinsurance of 10% of the approved amount after your $300 deductible is met for each primary care or specialist office visit. Applies toward the out-of-pocket maximum. See 'Physical Exams' below for more information.	You pay a coinsurance of 10% of the approved amount after your $300 deductible is met for each primary care or specialist office visit. Applies toward the out-of-pocket maximum. See 'Physical Exams' below for more information.
9 Chiropractic services	You pay the $155 annual deductible plus 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) provided by chiropractors or other qualified providers. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more. You pay 100% for routine care.	You pay a coinsurance of 10% of the approved amount after your $300 deductible is met for each specialist office visit for manual manipulation of the spine to correct subluxation provided by chiropractors or other qualified providers. Applies toward the out-of-pocket maximum. Cost sharing for *Doctor Office Visits* is identified above. You pay coinsurance of 10% of the approved amount after your $300 deductible is met for spine X-rays when rendered by a chiropractor or other qualified providers. Applies toward the out-of-pocket maximum.	You pay a coinsurance of 10% of the approved amount after your $300 deductible is met for each specialist office visit for manual manipulation of the spine to correct subluxation provided by chiropractors or other qualified providers. Applies toward the out-of-pocket maximum. Cost sharing for *Doctor Office Visits* is identified above. You pay coinsurance of 10% of the approved amount after your $300 deductible is met for spine X-rays when rendered by a chiropractor or other qualified providers. Applies toward the out-of-pocket maximum.

Benefit	Original Medicare	Medicare Plus Blue Group PPO In-Network	Medicare Plus Blue Group PPO Out-of-Network
9 Chiropractic Services *(continued)*	These services are not covered	For approved radiological services, you pay coinsurance of 10% the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum.	For approved radiological, you pay coinsurance of 10% the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum.
10 Podiatry services	You pay the $155 annual deductible plus 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more. You pay 100% for routine care.	You pay a coinsurance of 10% of the approved amount after your $300 deductible is met for each specialist office visit. Applies toward the out-of-pocket maximum. Cost sharing for *Doctor Office Visits* is identified above. For medically necessary services (such as surgery and X-rays), you pay coinsurance of 10% of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum.	You pay a coinsurance of 10% of the approved amount after your $300 deductible is met for each specialist office visit. Applies toward the out-of-pocket maximum. Cost sharing for *Doctor Office Visits* is identified above. For medically necessary services (such as surgery and X-rays), you pay coinsurance of 10% of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum.
11 Outpatient mental health care	You pay the $155 annual deductible plus 45% coinsurance for most outpatient mental health services. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum. Cost sharing for *Doctor Office Visits* is identified above.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum. Cost sharing for *Doctor Office Visits* is identified above.

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

Benefit	Original Medicare	Medicare Plus Blue Group PPO	
		In-Network	Out-of-Network
12 Outpatient substance abuse care	You pay the $155 annual deductible plus 20% coinsurance of Medicare-approved services. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum. Cost sharing for Doctor Office Visits is identified above.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum. Cost sharing for Doctor Office Visits is identified above.
13 Outpatient services / surgery	You pay the $155 annual deductible plus 20% coinsurance for the doctor. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more. You pay the $155 annual deductible plus 20% coinsurance of outpatient facility charges. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum.
14 Ambulance services (Medically necessary ambulance services)	You pay the $155 annual deductible plus 20% coinsurance of Medicare-approved amounts or applicable fee schedule charge. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum.

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

Benefit	Original Medicare	Medicare Plus Blue Group PPO	
		In-Network	Out-of-Network
15 Emergency care (You may go to any emergency room if you reasonably believe you need emergency care.)	You pay the $155 annual deductible plus 20% coinsurance for the facility charge or set copay per emergency room visit; you do NOT pay this amount if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. You pay the $155 annual deductible plus 20% coinsurance of doctor charges. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more. Not covered outside of the U.S except under limited circumstances.	Worldwide Coverage You pay $50 copay for ER visits. (waived if admitted or related to injury). Not subject to the deductible. Applies toward the out-of-pocket maximum.	Worldwide Coverage You pay $50 copay for ER visits. (waived if admitted or related to injury). Not subject to the deductible. Applies toward the out-of-pocket maximum.
16 Urgently needed care (This is NOT emergency care, and in most cases, is out of the service area.)	You pay the $155 annual deductible plus 20% coinsurance of Medicare-approved amounts or applicable copayment. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more. Not covered outside of the U.S except under limited circumstances.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum.

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

Benefit	Original Medicare	Medicare Plus Blue Group PPO	
		In-Network	Out-of-Network
17 Outpatient rehabilitation services (Occupational therapy, physical therapy, speech, and language therapy)	You pay the $155 annual deductible plus 20% coinsurance of Medicare-approved amounts. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum. Medicare outpatient rehabilitation caps do not apply.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum. Medicare outpatient rehabilitation caps do not apply.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES			
18 Durable medical equipment (Includes wheelchairs, oxygen, etc.)	You pay the $155 annual deductible plus 20% coinsurance of Medicare-approved amounts. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.	No member cost-share will be applied for Durable Medical Equipment obtained from a DMEnsions provider.	You pay coinsurance of 20% of the cost for Durable Medical Equipment obtained from a non-DMEnsions provider. Applies toward the separate $1000 out-of-pocket maximum for durable medical equipment, prosthetic and orthotic devices.
19 Prosthetic devices and/or Orthotic (Braces, artificial limbs and eyes, etc.)	You pay the $155 annual deductible plus 20% coinsurance of Medicare-approved amounts. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.	No member cost-share will be applied for Prosthetic and/or Orthotic devices obtained from a DMEnsions provider.	You pay coinsurance of 20% of the cost for Prosthetic and/or Orthotic devices obtained from a non-DMEnsions provider. Applies toward the separate $1000 out-of-pocket maximum for durable medical equipment, prosthetic and orthotic devices.

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

Benefit	Original Medicare	Medicare Plus Blue Group PPO In-Network	Medicare Plus Blue Group PPO Out-of-Network
20 Diabetes self-monitoring training, nutrition therapy, and supplies (Includes coverage for glucose monitors, test strips, lancets, screening tests and self-management training.)	You pay the $155 annual deductible plus 20% coinsurance of Medicare-approved amounts. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more. 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.	No member cost-share will be applied for these services. Some diabetes supplies obtained from DME providers are covered in full.	No member cost-share will be applied for these services. Some diabetes supplies obtained from DME providers are covered in full.

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

Benefit	Original Medicare	Medicare Plus Blue Group PPO	
		In-Network	Out-of-Network
PREVENTIVE SERVICES			
21 Diagnostic tests, X-rays and lab services	You pay the $155 annual deductible plus 20% coinsurance for diagnostic tests and X-rays. 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. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more. There is no copayment for Medicare-approved clinical lab services.	For diagnostic radiology services, you pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum. For diagnostic pathology lab services, you pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum. For diagnostic clinical lab services, no member cost share will be applied.	For diagnostic radiology services, you pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum. For diagnostic pathology lab services, you pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum. For diagnostic clinical lab services, no member cost share will be applied.

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

Benefit	Original Medicare	Medicare Plus Blue Group PPO	
		In-Network	Out-of-Network
22 Bone mass measurement (For people who are at risk.)	You pay the $155 annual deductible plus 20% coinsurance of Medicare-approved amounts. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	No member cost-share will be applied for these services. Covered once annually.	No member cost-share will be applied for these services. Covered once annually.
23 Colorectal screening exams (For people with Medicare, age 50 or older.)	You pay the $155 annual deductible plus 20% coinsurance of Medicare-approved amounts. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more. You are covered when you are high risk or when you are age 50 and older.	No member cost-share will be applied for these services. Covered once annually.	No member cost-share will be applied for these services. Covered once annually.

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

Benefit	Original Medicare	Medicare Plus Blue Group PPO	
		In-Network	Out-of-Network
24 Immunizations (Flu vaccine, hepatitis B vaccine (for people with Medicare who are at risk), pneumonia vaccine.)	Flu shots covered in full once each flu season. Pneumococcal shot covered in full. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information. You pay the $155 annual deductible plus 20% coinsurance of Medicare-approved amounts for the Hepatitis B shots. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.	No member cost-share will be applied for these services. 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.	No member cost-share will be applied for these services. 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.
25 Mammograms (annual screening) (For women with Medicare age 40 and older.)	You pay 20% coinsurance of Medicare-approved amounts. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more. 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 the age of 35 and 39.	No member cost-share will be applied for these services. Covered once annually.	No member cost-share will be applied for these services. Covered once annually.

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

Benefit	Original Medicare	Medicare Plus Blue Group PPO	
		In-Network	Out-of-Network
26 Pap screens and pelvic exams (For women with Medicare.)	There is no copayment for a Pap Smear once every 2 years. Pap Smears are covered once a year for women with Medicare at high risk. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more. You pay 20% coinsurance of Medicare-approved amounts for Pelvic Exams. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.	No member cost-share will be applied for these services. Covered once annually.	No member cost-share will be applied for these services. Covered once annually.
27 Prostate cancer screening exams (For men with Medicare age 50 and older.)	You pay the $155 annual deductible plus 20% coinsurance for the digital rectal exam. $0 for the PSA test; and 20% coinsurance of Medicare-approved amounts for other related services. Covered once a year for all men with Medicare over age 50. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.	No member cost-share will be applied for these services. Prostate Screening Antigen test covered in full once annually. Digital rectal exam covered in full once annually.	No member cost-share will be applied for these services. Prostate Screening Antigen test covered in full once annually. Digital rectal exam covered in full once annually.

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

Benefit	Original Medicare	Medicare Plus Blue Group PPO	
		In-Network	Out-of-Network
28 Cardiovascular screening	Covered in full once every five years. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.	No member cost-share will be applied for these services. Covered once every five years.	No member cost-share will be applied for these services. Covered once every five years.
29 Tobacco use cessation Health and wellness education	You pay the $155 annual deductible plus 20% coinsurance of Medicare-approved amounts for smoking cessation 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. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.	No member cost-share will be applied for these services. 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.	No member cost-share will be applied for these services. 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.
30 HIV screening	No coinsurance, copayment or deductible for screening test. 20% coinsurance for doctor visits. Covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Covered once every 12 months or up to three times during a pregnancy.	No member cost-share will be applied for these services.	No member cost-share will be applied for these services.

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

Benefit	Original Medicare	Medicare Plus Blue Group PPO In-Network	Medicare Plus Blue Group PPO Out-of-Network
OTHER SERVICES			
31 End stage renal disease	You pay the $155 annual deductible plus 20% coinsurance of Medicare-approved renal dialysis and Nutrition Therapy for End-Stage Renal Disease. 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. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum.
32 Dental services	Preventive dental services are not covered.	Preventive dental services are not covered under this Medicare Plus Blue Group plan.	Preventive dental services are not covered under this Medicare Plus Blue Group plan.

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

Benefit	Original Medicare	Medicare Plus Blue Group PPO	
		In-Network	Out-of-Network
33 Hearing services	You pay 100% for routine hearing exams and hearing aids. You pay the $155 annual deductible plus 20% coinsurance of Medicare approved amounts for diagnostic hearing exams. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.	For routine/diagnostic exams and for binaural/monaural hearing aids you pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum. .	For routine/diagnostic exams and for binaural/monaural hearing aids you pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum.
34 Vision services	You pay the $155 annual deductible plus 20% coinsurance of Medicare pays for one pair of eyeglasses or contact lenses after each cataract surgery. People who are at risk are covered for annual glaucoma screenings. You pay the $155 annual deductible plus 20% coinsurance of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.	Routine eye exams and glasses are not covered under this Medicare Plus Blue Group plan. People who are at risk are covered for annual glaucoma screenings. No member cost-share will be applied for these services. Corrective lenses following cataract surgery are covered in full. For diagnosis and treatment of diseases and conditions of the eye, you pay coinsurance of 10% of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum.	Routine eye exams and glasses are not covered under this Medicare Plus Blue Group plan. People who are at risk are covered for annual glaucoma screenings. No member cost-share will be applied for these services. Corrective lenses following cataract surgery are covered in full. For diagnosis and treatment of diseases and conditions of the eye, you pay coinsurance of 10% of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum.

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

Benefit		Original Medicare	Medicare Plus Blue Group PPO In-Network	Medicare Plus Blue Group PPO Out-of-Network
35	Physical exams, including Welcome to Medicare and Annual Wellness exams	You pay the $155 annual deductible plus 20% coinsurance for one exam within the first 12 months of your Medicare Part B coverage. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more. 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. No member cost-share will be applied for this service.	A 'Welcome (Physical)' Exam is covered once within the first 12 months after you have your Medicare Part B coverage. No member cost-share will be applied for this service.
ADDITIONAL SERVICES				
36	Human Organ Transplants	Medicare covers only certain organs for transplants.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum. $1 million maximum for non-Medicare covered organs, per organ. No member cost-share for Travel, Meals and Lodging associated with human organ transplants. Works as per diem.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum. $1 million maximum for non-Medicare covered organs, per organ. No member cost-share for Travel, Meals and Lodging associated with human organ transplants. Works as per diem.

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

Benefit		Original Medicare	Medicare Plus Blue Group PPO In-Network	Medicare Plus Blue Group PPO Out-of-Network
37	Foreign Travel - Not Restricted to Emergency / Urgent Care	Non-emergency/urgent care services rendered outside of the United States are generally not covered by Medicare	Cost same as if services was provided in the U.S.	Cost same as if services was provided in the U.S.
38	Abortion	These services are not covered.	For Medicare approved abortions you pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum. Voluntary abortions are not a benefit.	For Medicare approved abortions you pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum. Voluntary abortions are not a benefit.
39	Determination of a Refractive State	Determination of refractive state not covered.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum.
40	Home Infusion Therapy	Medicare covers certain home infusion therapy services.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum.
41	Private Duty Nursing	Private duty nursing is not covered.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum.
42	Sterilization	These services are not covered.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum.
43	Hospice Respite Care	These services are not covered.	No member cost-share will be applied for this service.	No member cost-share will be applied for this service.

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

Benefit		Original Medicare	Medicare Plus Blue Group PPO In-Network	Medicare Plus Blue Group PPO Out-of-Network
44	Chiropractic Approved Radiological	These services are not covered.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum.
45	Annual GYN Exam	These services are not covered.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum.
46	TMJ Device	These services are not covered.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum.	You pay a 10% coinsurance of the approved amount after your $300 deductible is met. Applies toward the out-of-pocket maximum.

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

Notes

Medicare PLUS Blue Group PPO℠

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