St. Clair County
Community Blue PPO4 Med-E-Fill Coverage and Medicare Plus Blue

This is not a Medicare document. It is intended as an easy-to-read high level summary only. It is not a contract. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable certificates, riders or Summary of Benefits for each plan. For more detailed information on Medicare benefits, please consult the Medicare handbook.

Member's responsibility (deductibles, copays and dollar maximums) – * Medicare deductible and coinsurance amounts are effective January 1, 2012 and are subject to change yearly.

	Medicare	BCBS PPO 4 Med E Fill Coverage	Medicare Plus Blue PPO
Deductible amounts	• **Medicare Part A** $1,156* (for days 1-60) each benefit period • **Medicare Part B** $140* per calendar year	$500 for one member, $1000 for the family (when two or more members are covered under your contract) each calendar year	There is no in-network deductible. Services are subject to a combined in-network and out-of-network annual deductible of $500.
Fixed dollar copays	• **Hospitalization** $289* per day (for days 61-90) and $578* per day (for days 91-150) • **Skilled nursing facility care** (a limit of 100 days for each benefit period) $144.50* per day (for days 21-100)	• $20 copay for office visits • $50 copay for hospital emergency room visits	For office visits, you pay a copayment of $20. Not subject to a deductible. These services apply to the in-network annual out-of-pocket maximum.
Coinsurance / percent copay amounts	• 20% of Medicare approved amount for most general services • 40%* of Medicare approved amount for outpatient mental health • 50% of Medicare approved amount for outpatient substance abuse	• 50% of BCBSM approved amount for mental health, substance abuse and private duty nursing • 20% of BCBSM approved amount for most other covered services	Your coinsurance is 5% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of pocket maximum.
Annual copay maximum	None	$1,500 for one member, $3,000 for two or more members each calendar year – **excludes** fixed dollar copays and mental health care, substance abuse treatment and private duty nursing percent copays	There is an in-network annual out-of-pocket maximum of $2000. Once your in network coinsurance, copayments and deductible equal $2000, all covered services will be paid at 100% of the approved amount for the remainder of the year. There is a combined in-network and out-of-network annual out-of-pocket maximum of $5000. Once your combined in-network and out-of-network coinsurance, copayments and deductible equal $5000, all covered services will be paid at 100% of the approved amount for the remainder of the year.
Preventive care services dollar maximum	None	$250 per member per calendar year	None
Lifetime dollar maximum	None	$1 million lifetime per covered specified human organ transplant type and a separate $5 million lifetime per member for all other covered services and as noted for individual services	None
Preventive care services	Services are covered up to 100% of the approved amount.	Services are covered up to 100% of the approved amount	Services are covered up to 100% of the approved amount.
Physician office services			
Office visits	Covered at 80% of Medicare approved amount after Part B deductible	Covers Medicare deductible and coinsurance less BCBSM Supplemental $20 copay	For office visits, you pay a copayment of $20. Not subject to a deductible. These services apply to the in-network annual out-of-pocket maximum.
Outpatient and home medical care visits	Covered at 80% of Medicare approved amount after Part B deductible	Covers Medicare deductible and coinsurance less BCBSM Supplemental deductible and percent copay	You pay a copayment of $20. Not subject to a deductible. These services apply to the in-network annual out-of-pocket maximum.
Office consultations	Covered at 80% of Medicare approved amount after Part B deductible	Covers Medicare deductible and coinsurance less BCBSM Supplemental $20 copay	You pay a copayment of $20. Not subject to a deductible. These services apply to the in-network annual out-of-pocket maximum.
Urgent care visits	Covered at 80% of Medicare approved amount after Part B deductible	Covers Medicare deductible and coinsurance less BCBSM Supplemental $20 copay	You pay a copayment of $20. Not subject to a deductible. These services apply to the in-network annual out-of-pocket maximum.
Emergency medical care			
Hospital emergency room (facility charges) – must be medically necessary	Covered at 80% of Medicare approved amount after Part B deductible	Covers Medicare deductible and coinsurance less BCBSM Supplemental $50 copay ($50 copay waived if the patient is admitted or if services were required to treat an accidental injury)	You pay a $50 copayment for Medicare-covered emergency room visits (waived if admitted within three days). Not subject to a deductible. These services apply to the in network annual out-of-pocket maximum.
Ambulance services – must be medically necessary	Covered at 80% of Medicare approved amount after Part B deductible	Covers Medicare deductible and coinsurance less BCBSM Supplemental deductible and percent copay	Your coinsurance is 5% of the approved amount, after you meet your annual deductible, for Medicare covered ambulance services. Cost sharing applies for each one-way trip. These services apply to the in network annual out-of-pocket
Clinical laboratory services			
Laboratory and pathology tests – used in the diagnosis and treatment of an illness or injury	Covered at 100% of Medicare approved amount for most diagnostic laboratory and pathology services (covered at 80% of approved amount for certain laboratory services)	Covered in full by Medicare (covers Medicare coinsurance when applicable less BCBSM Supplemental deductible and percent copay)	Your coinsurance is 5% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of pocket maximum.
Radiology services			
X-rays – used in the diagnosis and treatment of an illness or injury	Covered at 80% of Medicare approved amount after Part B deductible	Covers Medicare deductible and coinsurance less BCBSM Supplemental deductible and percent copay	Your coinsurance is 5% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of pocket maximum.
Maternity services			
Delivery	Covered at 80% of Medicare approved amount after Part B deductible	Covers Medicare deductible and coinsurance less BCBSM Supplemental deductible and percent copay	Your coinsurance is 5% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of pocket maximum.
Prenatal and postnatal care visits	Not covered	Covered at 100% of BCBSM approved amount	Not Covered

Hospital care				
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	Days 1-60	Covered at 100% of Medicare approved amount after Part A deductible (also includes inpatient mental health and residential substance abuse)	Covers Medicare deductible less BCBSM Supplemental deductible and percent copay	For facility evaluation and management services, your coinsurance is 5% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. For all other services, your coinsurance is 5% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. Medicare-approved clinical lab services and preventive services are covered at 100% of the approved amount. You have unlimited days for inpatient care coverage.
	Days 61-90	Covered at 100% of Medicare approved amount after Part A daily coinsurance	Covers Medicare daily coinsurance less BCBSM Supplemental deductible and percent copay	
	Lifetime reserve days (60 days)	Covered at 100% of Medicare approved amount after Part A daily coinsurance	Covers Medicare daily coinsurance less BCBSM Supplemental deductible and percent copay	
	Additional days	Not covered	Covered at 80% of BCBSM approved amount after deductible, **unlimited days**	
Chemotherapy		Covered at 80% of Medicare approved amount after Part B deductible for administration and drugs; must meet Medicare criteria	Covers Medicare deductible and coinsurance less BCBSM Supplemental deductible and percent copay	Your coinsurance is 5% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of pocket maximum.
Alternatives to hospital care				
Skilled nursing facility care – specific criteria applies	Days 1-20	Covered at 100% of Medicare approved amount	Covered in full by Medicare	For facility evaluation and management services, your coinsurance is 5% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. For all other services, your coinsurance is 5% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. Plan covers up to 100 days for each benefit period.
	Days 21-100	Covered at 100% of Medicare approved amount after daily coinsurance	Covers Medicare daily coinsurance less BCBSM Supplemental deductible and percent copay	
	Days 101-120	Not covered	Covered at 80% of BCBSM approved amount after deductible	Not Covered
	Days 121 and after	Not covered	Not covered	Not Covered
Hospice care		Covered at Medicare approved amount less small copay for outpatient drugs and less small coinsurance for inpatient respite care	Covers limited cost not covered by Medicare at 100% of BCBSM approved amount	When you enroll in a Medicare certified hospice program, your hospice services are paid for by Original Medicare, not Medicare Plus Blue Group PPO.
Home health care services – must be medically necessary		Covered at 100% of Medicare approved amount	Covered in full by Medicare	Services are covered up to 100% of the approved amount.
Home infusion therapy		Covered at 80% of Medicare approved amount after Part B deductible for limited services	• Covers Medicare deductible and coinsurance less BCBSM Supplemental deductible and percent copay • When **not** covered by Medicare – covered at 80% of BCBSM approved amount after deductible (must be medically necessary and given by home infusion therapy providers approved by BCBSM)	Services are covered up to 100% of the approved amount.
Surgical services provided by a physician				
Surgery – includes related surgical services		Covered at 80% of Medicare approved amount after Part B deductible	Covers Medicare deductible and coinsurance less BCBSM Supplemental deductible and percent copay	Your coinsurance is 5% of the approved amount, after you meet your annual deductible, for outpatient surgery and related services. These services apply to the in-network annual out-of-pocket maximum.
Human organ transplants				
Specified human organ transplants		Covered at 80% of Medicare approved amount after deductible (in a Medicare-certified facility only), under certain conditions (Please call Medicare for more information.)	Covers Medicare deductible and coinsurance (**in designated facilities only**)	Your coinsurance is 5% of the approved amount, after you meet your annual deductible, for outpatient surgery and related services. These services apply to the in-network annual out-of-pocket maximum.
Specified human organ transplants – pancreas transplants only		Not covered	• When covered by Medicare, covers Medicare deductible and coinsurance, up to group's level of benefits	Your coinsurance is 5% of the approved amount, after you meet your annual deductible, for outpatient surgery and related services. These services apply to the in-network annual out-of-pocket maximum.
		Note: Pancreas transplants are covered under certain conditions (Please call Medicare for more information about coverage for this transplant.)	• When **not** covered by Medicare – covered at 100% of BCBSM approved amount (**in designated facilities only**)	Your coinsurance is 5% of the approved amount, after you meet your annual deductible, for outpatient surgery and related services. These services apply to the in-network annual out-of-pocket maximum.
Bone marrow transplants – under certain conditions		Covered at 80% of Medicare approved amount after deductible (Please call Medicare for more information.)	Covers Medicare deductible and coinsurance less BCBSM Supplemental deductible and percent copay	Your coinsurance is 5% of the approved amount, after you meet your annual deductible, for outpatient surgery and related services. These services apply to the in-network annual out-of-pocket maximum.
Kidney, cornea and skin transplants		Covered at 80% of Medicare approved amount after deductible (Please call Medicare for more information.)	Covers Medicare deductible and coinsurance less BCBSM Supplemental deductible and percent copay	Your coinsurance is 5% of the approved amount, after you meet your annual deductible, for outpatient surgery and related services. These services apply to the in-network annual out-of-pocket maximum.
Mental health care				
Inpatient mental health care in psychiatric facility	Days 1-190 **lifetime**	See "Hospital care" benefits (Medicare pays the claim as part of your regular Part A hospital coverage, subject to Part A deductible and coinsurance)	Covers Medicare deductible less BCBSM Supplemental deductible and 50 percent copay	For facility evaluation and management services, your coinsurance is 5% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. For all other services, your coinsurance is 5% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. You have unlimited days for inpatient care coverage.
		Note: In most cases, psychiatric care in general (opposed to psychiatric) hospitals is not subject to the 190-day limit.		
	Additional days after 190 lifetime days are used	Not covered	Covered at 50% of BCBSM approved amount after deductible, **unlimited days**	
Outpatient mental health care		Covered at 60% of Medicare approved amount after Part B deductible (Diagnostic services are covered at 80% of Medicare approved amount after Part B deductible)	Covers Medicare deductible less BCBSM Supplemental deductible and 50 percent copay, in a BCBSM approved facility	For mental health services rendered at a mental health facility, your coinsurance is 5% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. For mental health services in an office setting, you pay a copayment of $20. Not subject to a deductible. These services apply to the in-network annual out-of pocket maximum.
		Note: If you get your services in a hospital outpatient clinic, or hospital outpatient department, you may have to pay an additional copayment or coinsurance amount to the hospital.	**Note:** The BCBSM payment, when added to the Medicare payment, cannot exceed 80% of the BCBSM approved amount.	

Outpatient substance abuse treatment	Covered at 50% of Medicare approved amount after Part B deductible, unlimited visits	Covers Medicare deductible less BCBSM Supplemental deductible and 50 percent copay, **in approved facilities up to the state-dollar amount that is adjusted annually** **Note:** The BCBSM payment, when added to the Medicare payment, cannot exceed 80% of the BCBSM approved amount.	For substance abuse services rendered at a facility, your coinsurance is 5% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out of-pocket maximum. For substance abuse services in an office setting, you pay a copayment of $20. Not subject to a deductible. These services apply to the in network annual out-of-pocket maximum.
Other covered services			
Outpatient diabetes management program (includes syringes)	Covered at 80% of Medicare approved amount after Part B deductible	Covers Medicare deductible and coinsurance less BCBSM Supplemental deductible and percent copay	Services are covered up to 100% of the approved amount for diabetes screenings, diabetes-related durable medical equipment or supplies, and self-management training.
Allergy testing and therapy – with approved diagnosis	Covered at 80% of Medicare approved amount after Part B deductible	Covers Medicare deductible and coinsurance	You pay a copayment of $20. Not subject to a deductible. These services apply to the in-network annual out-of-pocket maximum.
Chiropractic spinal manipulation – must be medically necessary	Covered at 80% of Medicare approved amount after Part B deductible	Covers Medicare deductible and coinsurance (up to group's level of benefits- $20 copay per office visit), **up to 24 visits per calendar year**	For manual manipulation of the spine to correct subluxation, provided by chiropractors or other qualified providers, and for evaluation and management services, you pay a copayment of $20. Not subject to a deductible. These services apply to the in network annual out-of-pocket maximum. For spine X-rays, other chiropractic radiological and chiropractic physical therapy services, you pay a copayment of $20. Not subject to a deductible. These services apply to the in-network annual out-of pocket maximum.
Chiropractic x-rays	Not covered	Covered at 100% of BCBSM approved amount	
Outpatient physical, speech and occupational therapy	Covered at 80% of Medicare approved amount after Part B deductible or set copay **Note:** There may be a limit on the amount Medicare will pay for these services in a single year and there may be certain exceptions to these limits.	Covers Medicare deductible and coinsurance or set copay less BCBSM Supplemental deductible and percent copay, **up to a combined maximum of 60 visits per calendar year**	Your coinsurance is 5% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of pocket maximum. Medicare therapy limits apply to rehabilitation services provided.
Durable medical equipment	Covered at 80% of Medicare approved amount after Part B deductible	Covers Medicare deductible and coinsurance less BCBSM Supplemental deductible and percent copay	Your coinsurance is 5% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of pocket maximum.
Prosthetic appliances	Covered at 80% of Medicare approved amount after Part B deductible	Covers Medicare deductible and coinsurance less BCBSM Supplemental deductible and percent copay	Your coinsurance is 5% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of pocket maximum.
Private duty nursing	Not covered	Covered at 50% of BCBSM approved amount after deductible	Not Covered
Foreign travel			
Hospital services	Not covered, except as specified in the Medicare handbook	Covered at 80% of BCBSM approved amount after deductible, up to group's level of Community Blue coverage benefits (mental health and substance abuse benefits covered at 50% of BCBSM approved amount after deductible)	Your coinsurance is 5% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of pocket maximum.
Physician services	Not covered, except as specified in the Medicare handbook	Covered at 80% of BCBSM approved amount after deductible, up to group's level of Community Blue coverage benefits (mental health, substance abuse and private duty nursing benefits covered at 50% of BCBSM approved amount after deductible)	Your coinsurance is 5% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of pocket maximum.
Prescription Drugs			
**Tier 1 Generic up to a 31 day supply	Covered Through BCBSM	$10	$10
Tier 2 Preferred Brand up to a 31 day supply	Covered Through BCBSM	$20 (Hardship) $40 (NonHardship)	$20 (Hardship) $40 (NonHardship)
Tier 3 Non Preferred Brand up to a 31 day supply	Covered Through BCBSM	$40 (Hardship) $80 (NonHardship)	$40 (Hardship) $80 (NonHardship)
**Tier 1 Generic up to a 90 day supply	Covered Through BCBSM	$20	$20
Tier 2 Preferred Brand up to a 90 day supply	Covered Through BCBSM	$40 (Hardship) $80 (NonHardship)	$40 (Hardship) $80 (NonHardship)
Tier 3 Non Preferred Brand up to a 90 day supply	Covered Through BCBSM	$80 (Hardship) $160 (NonHardship)	$80 (Hardship) $160 (NonHardship)

** Copay for generic prescriptions is $0 if purchased through Medtipster