

State of Michigan Medicare Advantage Plan Summary of Benefits

A summary of your 2009 State Health Plan
Medicare Advantage Plan

Medicare **PLUS Blue** GroupSM



**Blue Cross
Blue Shield**
of Michigan

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

Medicare Plus Blue Group is a private fee-for-service plan with a Medicare contract. Medicare Plus Blue Group is issued by Blue Cross Blue Shield of Michigan, a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.



State of Michigan

GLOSSARY OF TERMS

Approved amount

The lower of the provider's billed charge or the Medicare maximum payment amount, whichever is lower.

Coinsurance

The amount you may be required to pay for services after you pay any plan deductibles. This is a percentage (%). You have to pay this amount after you pay the deductible.

Coordination of benefits

Applies when a member is covered by more than one health plan, to maximize coverage without duplicating payments. One plan is designated as primary for liability. Additional plans may cover remaining balances on the claim.

Copayment

The amount you pay for each medical service, like a doctor's visit. A copayment is usually a set amount you pay. Example: \$15

Deductible

The amount you must pay out-of-pocket for health care services, before your insurance begins to pay. A type of cost sharing in which the individual pays a specified amount for covered services before the health plan pays benefits.

Dependent

A person who is eligible for health care coverage on another individual's contract (a spouse and/or child eligible for coverage).

Medically necessary

Services or supplies that are medically needed for the diagnosis or treatment of your medical condition. Must meet the standards of good medical practice and consistent with Medicare guidelines.

SECTION 1

Introduction to the Summary of Benefits for State of Michigan Medicare-eligible retirees

Medicare Plus Blue Group

January 1, 2009 – December 31, 2009

Hospital and medical coverage for Medicare members

Your State Health Plan PPO coverage continues under the State of Michigan Retiree Medicare Advantage plan called Medicare Plus Blue Group. This plan combines the State Health Plan PPO with Medicare Parts A and B. You will continue to pay your Medicare Part B premium. Blue Cross Blue Shield of Michigan (BCBSM) administers the plan. The Medicare Plus Blue Group plan does not include prescription drug, dental or vision benefits. You will continue to access these benefits using your Express Scripts, Delta Dental or your BCBSM Vision ID card depending on the benefit. If you are enrolled in the Medicare Plus Blue Group plan, your mental health and substance abuse benefits through this plan will be administered by BCBSM.

Eligibility

You will be covered by Medicare Plus Blue Group if you are enrolled in Medicare Part A and Part B. If you become eligible for Medicare on or after January 1, 2009, it is important that you are enrolled in Medicare Part A and Part B coverage in order to continue State Health Plan coverage under the Medicare Plus Blue Group plan. Once you have Medicare Part B coverage, you will be moved to the Medicare Plus Blue Group plan and will receive detailed plan information and a new ID card. Retirees, spouses or dependents who are not Medicare eligible will remain in the State Health Plan PPO. Retirees who are not enrolled in Medicare Part B will continue to be covered under the State Health Plan PPO and will be responsible for the Medicare portion of Part B services. If you are not eligible for Medicare Parts A and B, (e.g., State Police not eligible to participate in Medicare) you will also continue to be covered under the State Health Plan PPO.

SECTION 1

Opting out

You have the option not to take this Medicare Plus Blue Group plan. As a Medicare Beneficiary, you can choose from different Medicare options. For more information, call 1-800-MEDICARE (1-800-633-4227). You can call this number 24 hours a day, 7 days a week. Please be aware that if you decline coverage, everyone on your health care contract (all of your Medicare and non-Medicare-eligible dependents) will also be removed, and WILL NOT have coverage through the State of Michigan's State Health Plan PPO. This means that you will lose your Blue Cross Blue Shield of Michigan coverage. You and your Medicare-eligible dependents will only be covered by Original Medicare.

Out-of-state coverage

The Medicare Plus Blue Group coverage for retirees living out-of-state is the same as retirees living in Michigan. Retirees living out-of-state should seek services from providers who are eligible to participate with Medicare and are willing to accept the Medicare Plus Blue Group terms and conditions of payment. When you go to a doctor or hospital be sure to show them your Medicare Plus Blue Group ID card.

SECTION 2 – SUMMARY OF BENEFITS

Comparing Medicare Plus Blue Group 2009 to State Health Plan PPO

		2009 State Health Plan Medicare Advantage* "Medicare Plus Blue Group"	2009 State Health Plan PPO
Preventive Services			
1	Routine Physical/Health Maintenance Exam	Coverage remains the same as the 2009 State Health Plan PPO	Covered 100% – one every 12-months
2	Pelvic/GYN Exam	Coverage remains the same as the 2009 State Health Plan PPO	Covered 100% – one every 12-months
3	PAP Smear Screening (lab services)	Coverage remains the same as the 2009 State Health Plan PPO	Covered 100% – one every 12-months
4	Immunizations – Pneumonia & Flu Vaccines	Coverage remains the same as the 2009 State Health Plan PPO	Covered – 100%
5	Immunizations – Hepatitis B Vaccine	Coverage remains the same as the 2009 State Health Plan PPO	Covered – 100%
6	Other Immunizations	Coverage remains the same as the 2009 State Health Plan PPO	Covered – 100%
7	Fecal Occult Blood Screening	Coverage remains the same as the 2009 State Health Plan PPO	Covered 100% – for age 50+
8	Flexible Sigmoidoscopy	Coverage remains the same as the 2009 State Health Plan PPO	Covered 100% – for age 50+
9	Prostate Specific Antigen (PSA)	Coverage remains the same as the 2009 State Health Plan PPO	Covered 100% – for age 50+
Other Preventive Services			
10	Mammography – annual screening	Covered – 100%	Covered 100% – no age restrictions
11	Colonoscopy Screening	Coverage remains the same as the 2009 State Health Plan PPO	Covered – 100%

SECTION 2

		2009 State Health Plan Medicare Advantage* "Medicare Plus Blue Group"	2009 State Health Plan PPO
Physician Office Services			
12	Office Visits, Consultations and Urgent Care Visits	Coverage remains the same as the 2009 State Health Plan PPO	Covered – \$15 copay
13	Outpatient and Home Visits (outpatient hospital visit or physician to member's home)	Coverage remains the same as the 2009 State Health Plan PPO	Covered – \$15 copay
Emergency Medical Care			
14	Hospital Emergency Room – Medical Emergency or Accidental Injury	Coverage remains the same as the 2009 State Health Plan PPO	Covered – \$50 copay (waived if admitted)
15	Ambulance Services	Coverage remains the same as the 2009 State Health Plan PPO	Covered – 100% after deductible
Diagnostic Services			
16	Laboratory & Pathology Tests (excludes clinical lab services)	Coverage remains the same as the 2009 State Health Plan PPO	Covered – 100% after deductible
17	Clinical Laboratory Services	Covered 100% (no deductible)	Covered – 100% after deductible
18	Diagnostic Tests and X-rays (excludes chiropractic X-rays)	Coverage remains the same as the 2009 State Health Plan PPO	Covered – 100% after deductible
19	Radiation Therapy	Coverage remains the same as the 2009 State Health Plan PPO	Covered – 100% after deductible
Hospital Care			
20	Inpatient Hospital Care (excludes Mental Health/ Substance Abuse)	Coverage remains the same as the 2009 State Health Plan PPO	Covered – 100% after deductible; unlimited days
21	Inpatient Physician Care (excludes Mental Health/ Substance Abuse)	Coverage remains the same as the 2009 State Health Plan PPO	Covered – 100% after deductible
22	Blood – Inpatient and Outpatient (1st 3 pints)	Coverage remains the same as the 2009 State Health Plan PPO	Covered – 100% after deductible
23	Inpatient Consultation	Coverage remains the same as the 2009 State Health Plan PPO	Covered – 100% after deductible

		2009 State Health Plan Medicare Advantage* "Medicare Plus Blue Group"	2009 State Health Plan PPO
Alternatives to Hospital Care			
24	Chemotherapy	Coverage remains the same as the 2009 State Health Plan PPO	Covered – 100% after deductible
25	Chemotherapy, Oral Cancer & Oral Anti-Nausea Drugs	Coverage remains the same as the 2009 State Health Plan PPO	Covered – 100% after deductible
26	Skilled Nursing Facility (SNF) (in a Medicare-certified SNF)	Coverage – 100% after deductible 120 days per admission	Covered – 100% after deductible 120 visits per admission Renews after 90 days
27	Hospice Care	Covered – 100% (no lifetime dollar maximum)	Covered – 100% (limited to the life-time dollar maximum adjusted annually)
28	Home Health – includes intermittent skilled nursing care, home health aide services and rehabilitation services, etc.	Covered – 100% (no deductible)	Covered – 100% after deductible
Surgical Services			
29	Surgery and Related Surgical Services	Coverage remains the same as the 2009 State Health Plan PPO	Covered – 100% after deductible
Human Organ Transplants			
30	Liver, Heart, Lung, Pancreas & Specified Human Organ Transplants (designated facilities only)	Covered – 100% after deductible (no lifetime maximum)	Covered – 100% after deductible; Up to \$1 million lifetime max per transplant type
31	Transportation, Lodging & Meals	Coverage remains the same as the 2009 State Health Plan PPO	Covered – 100%
Organ and Tissue Transplants			
32	Bone Marrow	Coverage remains the same as the 2009 State Health Plan PPO	Covered – 100% after deductible (designated facilities only)
33	Cornea and Skin	Coverage remains the same as the 2009 State Health Plan PPO	Covered – 100% after deductible
34	Kidney Transplant	Coverage remains the same as the 2009 State Health Plan PPO	Covered – 100% after deductible

SECTION 2

		2009 State Health Plan Medicare Advantage* "Medicare Plus Blue Group"	2009 State Health Plan PPO
Other Services			
35	Allergy Testing and Injections	Coverage remains the same as the 2009 State Health Plan PPO	Covered – 100% after deductible
36	Eye Exam – Diabetic Retinopathy Glaucoma Screening Macular Degeneration	Coverage remains the same as the 2009 State Health Plan PPO	Covered – \$15 copay
37	Glasses After Cataract Surgery	Coverage remains the same as the 2009 State Health Plan PPO	Covered – 100% after deductible
38	Medical Hearing Exam	Coverage remains the same as the 2009 State Health Plan PPO	Covered – \$15 copay
39	Durable Medical Equipment Prosthetic and Orthotic App. Medical Supplies	Covered – 100%	Covered – 100% for Michigan SUPPORT program network
40	Private Duty Nursing	Coverage remains the same as the 2009 State Health Plan PPO	Covered – 90% after deductible
41	Renal Dialysis	Coverage remains the same as the 2009 State Health Plan PPO	Covered – 100% after deductible
Outpatient Physical, Occupational & Speech Therapy			
42	Outpatient Occupational, Physical & Speech Therapy – Facility and Clinic Services	Covered – 100% after deductible Medicare cap applies	Covered – 100% after deductible; Annual 90-visit limitation (combined)
43	Outpatient Physical Therapy – Physician's Office	Covered – 100% after deductible Medicare cap applies	Covered – 100% after deductible; Annual 90-visit limitation (combined)

		2009 State Health Plan Medicare Advantage* "Medicare Plus Blue Group"	2009 State Health Plan PPO
Other Plan Benefits Covered by State of Michigan			
44	Acupuncture	Coverage remains the same as the 2009 State Health Plan PPO	Covered – 90% after deductible; Up to 20 visits per calendar year
45	Chiropractic Spinal Manipulation	Covered – \$15 copay (unlimited visits)	Covered – \$15 copay (24 visits per calendar year)
46	Chiropractic X-rays	Coverage remains the same as the 2009 State Health Plan PPO	Covered – 100% after deductible
47	Chiropractic Office Visits	Coverage remains the same as the 2009 State Health Plan PPO	Covered – \$15 copay
48	Hearing Aids	Coverage remains the same as the 2009 State Health Plan PPO	Covered – 100% payable every 36 months unless significant hearing loss occurs
49	Routine Hearing Exam	Coverage remains the same as the 2009 State Health Plan PPO	Covered – \$15 copay
50	Weight Loss Benefit	Coverage remains the same as the 2009 State Health Plan PPO	Lifetime maximum of \$300
Mental Health and Substance Abuse Treatment			
51	Inpatient Mental Health (including Substance Abuse)	Covered – 100% (unlimited days)	Inpatient Mental Health covered 365 days per year, with no deductible. Inpatient Substance Abuse limited to two 28-day stays per year with at least 60 days between episodes.
52	Outpatient Mental Health	Coverage remains the same as the 2009 State Health Plan PPO	Covered – 90% unlimited visits
53	Outpatient Substance Abuse	Covered – 90% (no annual maximum)	Covered – 90% \$3500 annual maximum

SECTION 2

		2009 State Health Plan Medicare Advantage* "Medicare Plus Blue Group"	2009 State Health Plan PPO
Deductible, Copays and Out-of-Pocket Dollar Maximum			
54	Out-of-Pocket Maximum	Annual coinsurance maximum: \$1000 per individual member (Family maximums not allowed under Medicare Advantage rules)	Annual coinsurance maximums: \$1000 per person \$2000 per family
55	Medical Deductible	\$300 per individual member (Family deductibles not allowed under Medicare Advantage rules)	\$300 per member \$600 per family
56	Coinsurance	Coverage remains the same as the 2009 State Health Plan PPO	10% coinsurance amount for some professional services
57	Copays	Coverage remains the same as the 2009 State Health Plan PPO	\$15 copay for office visits, clinic visits, office consultations, chiropractic office visits, chiropractic manipulations, urgent care visits, osteopathic manipulations, medical eye exams and medical hearing exams. \$50 emergency room (waived if admitted)
* Any benefit changes will continue to be communicated through official Retiree Benefits Bulletins issued by Employee Benefits Division, Civil Service Commission.			

Your Medicare Plus Blue Group ID card

Your Medicare Plus Blue Group identification card identifies your hospital and medical coverage. Each member enrolled in Medicare Plus Blue Group receives a card in his or her own name. Use this card each time you visit your provider instead of your red, white and blue Medicare card. Be sure to retain your Medicare card even though you will not be using it to access services under the Medicare Plus Blue Group plan. Your covered spouse or dependent who is not yet Medicare eligible will continue to use their BCBSM State Health Plan PPO insurance card.

Using Medicare Plus Blue Group providers

The Medicare Plus Blue Group is a private fee-for-service Medicare Advantage plan, which allows you to see any doctor who is eligible to participate with Medicare and is willing to accept the Medicare Plus Blue Group terms and conditions of payment. Referrals are not needed to see a specialist, and there are no network restrictions. If you are seeking medical treatment, simply present your Medicare Plus Blue Group ID card. If the provider agrees to accept the card, then you are only responsible for your deductible or any copay or coinsurance depending upon the service you receive. You should not be billed for the balance between the approved amount and what the provider charged. If you use a provider that does not accept BCBSM's terms and conditions of payment, you will be responsible for payment to the provider. If your provider is not familiar with the terms and conditions of the Medicare Plus Blue Group plan, he or she may call our Provider Services Representatives at 1-866-309-1719 or visit www.bcbsm.com/ma for more information. As always, in a medical emergency, you are covered regardless of where you receive treatment. This includes when traveling within the United States or abroad.

SECTION 3

Your out-of-pocket costs

As a member of Medicare Plus Blue Group, you can use any Medicare doctor, specialist, or hospital that is eligible to participate with Medicare and accepts the terms and conditions of payment of the BCBSM Medicare Plus Blue Group plan. BCBSM has the right to determine if the service or treatment ordered by your health care provider is covered under the Medicare Plus Blue Group plan. This decision is based on your plan design.

You are responsible for your annual deductible, coinsurance and copayments. Your coinsurance and copayments vary according to the services you receive as we have outlined in this benefit summary. The annual deductible in 2009 is \$300 per member per year. This is applied from January 1, 2009, through December 31, 2009. Under the Medicare Plus Blue Group plan, there is not a family deductible.

The following are some examples to show you how the deductible under Medicare Plus Blue Group would apply:

Scenario #1: *Both retiree and spouse are enrolled in the Medicare Plus Blue Group.*

The retiree's deductible is \$300 and the spouse's deductible is \$300 each year.

Scenario #2: *The retiree is enrolled in the Medicare Plus Blue Group. The spouse has the State Health Plan PPO.*

The retiree's deductible is \$300 and the spouse's deductible is \$300 each year.

Scenario #3: *Both the retiree and the spouse are enrolled in Medicare Plus Blue Group. A dependent child is covered under the State Health Plan PPO.*

The retiree's deductible is \$300 and the spouse's deductible is \$300. The deductible for the dependent child is \$300. That results in a total of \$900 for all deductibles each year.

Scenario #4: *Both the retiree and the spouse are enrolled in Medicare Plus Blue Group. There are three additional dependents that are covered under the State Health Plan PPO.*

The retiree's deductible is \$300 and the spouse's deductible is \$300 each year for Medicare Plus Blue Group. Their three dependents are covered as "family" under the State Health Plan PPO, which has a \$600 deductible each year. This results in a total of \$1,200 for all deductibles each year.

Grievances

As a member of Medicare Plus Blue Group you have the right to file a grievance. If you have a complaint, we encourage you to call Customer Service at 1-888-322-5557, TTY/TDD 1-800-579-0235, 8:30 a.m. to 5:00 p.m. EST, Monday through Friday. We will try to resolve any complaint you might have over the phone. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. If you wish to file a grievance, contact us in writing at: Medicare Plus Blue Group, Appeal and Grievance Dept. Mail code: X509, 600 E. Lafayette, Detroit, Michigan 48226-2998.

Appeals

As a member of Medicare Plus Blue Group you have the right to file an appeal if you are not satisfied with the outcome of the plan's determination of health care services. An appeal is a request in writing for a reconsideration of health care service or an amount the member pays for service. If the situation requires an urgent response, we can expedite your request. Please call us at 1-888-322-5557, TTY/TTD 1-800-579-0235 from 8:30 a.m. to 5:00 p.m. EST, Monday through Friday, or fax us at 1-877-894-9531, or write to us at Medicare Plus Blue Group, Appeal and Grievance Dept. Mail code: X509, 600 E. Lafayette, Detroit, Michigan 48226-2998.

Terms & agreements

A Medicare Advantage private-fee-for-service plan works differently than a Medicare supplement plan. Your doctor or hospital must agree to accept the plan's terms and conditions of payment prior to providing health care services to you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may not provide health care services to you, except in emergencies. Providers can find the plan's terms and conditions of payment on our Web site at: www.bcbsm.com/ma.

For more information about PFFS plans see Beneficiary Qs&As at CMS's Web site:
<http://www.cms.hhs.gov/PrivateFeeforServicePlans/downloads/benqa.pdf>.

SECTION 3

Please read this important information regarding Medicare Plus Blue Group

As a State of Michigan retiree I understand that:

- BCBSM Medicare Plus Blue Group plan is a Medicare Advantage plan which requires that I keep my Parts A and B.
- I can only be in one Medicare Advantage plan at a time.
- I understand that if I do not have Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.
- Once I am a member of Medicare Plus Blue Group, I have the right to appeal plan decisions about payment or services if I disagree.
- I will read an Evidence of Coverage document from BCBSM Medicare Plus Blue Group that will provide detailed guidelines I must follow to receive coverage.
- By joining the BCBSM Medicare Plus Blue Group plan, I acknowledge that this Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations.

If you are opting out of coverage, please read this information about Medigap rights:

If you will be changing to the Original Medicare Plan you might have a special temporary right to buy a Medigap policy, also known as Medicare supplemental insurance, even if you have health problems. For example, if you are age 65 or older and you enrolled in Medicare Part B within the past six months or if you move out of the service area, you may have this special right.

Federal law requires the protections described above. Your state may have laws that provide more Medigap protections. If you have questions about Medigap or any special temporary rights you may have, you should contact your State Health Insurance Program Medicare/Medicaid Assistance Program of Michigan (MMAP) at 1-800-803-7174 to get more information about Medigap policies in your state.

Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week for more information about trial periods.

SECTION 3

What people on Medicare need to know about private-fee-for-service plans

Medicare Plus Blue Group is a Medicare Advantage private-fee-for-service (PFFS) plan authorized by the Centers for Medicare & Medicaid Services (CMS). A PFFS plan is different than Original Medicare or an HMO, PPO, or Medicare supplement plan. With Medicare Plus Blue Group, you are able to choose your health care provider. However, just like with the State Health Plan PPO and Original Medicare, most but not all providers may accept this plan. As with your current health care plan, if you choose this plan, it is important that your providers know that you have Medicare Plus Blue Group coverage before providing services to you. You must show your Medicare Plus Blue Group ID card every time you visit a health care provider because providers have the right to decide if they will accept Medicare Plus Blue Group each time they see you. By agreeing to accept your Medicare Plus Blue Group ID card, your provider is agreeing to accept Medicare Plus Blue Group's terms and conditions of payment for treating you. They will bill Medicare Plus Blue Group for services rendered to you. If a provider does not agree to BCBSM's Medicare Plus Blue Group's terms and conditions of payment, you will need to find another provider that will. You may contact us at Customer Service at 1-888-322-5557 for assistance in locating another provider in your area. If a provider will not accept Medicare Plus Blue Group's terms and conditions of payment, they should not treat you unless it is an emergency. If they choose to provide non-emergency services to you, they may not bill you. They must bill Medicare Plus Blue Group for your covered health care services. All you will have to pay is your copay or coinsurance at the time of service. For more information about PFFS plans, see Beneficiary Q&As at CMS's Web site at: <http://www.cms.hhs.gov/Privatefeeforserviceplans/downloads/benqa.pdf>. If you have questions about BCBSM's Medicare Plus Blue Group, please call our Customer Service at 1-888-322-5557, TTY/TDD 1-800-579-0235.

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

This publication is not a contract, but a brief outline of Blue Cross Blue Shield of Michigan's Medicare Advantage health plan for State of Michigan retirees for 2009. The information provided here does not include all covered and non-covered services or conditions of coverage. Coverage, including deductibles and copays, are subject to change. You always have the right to ask BCBSM to review claims.

BCBSM's contract with the Center for Medicare and Medicaid Services (CMS) is renewed annually and the availability of coverage beyond the end of the current contract year is not guaranteed. We may, at a future date, decide to discontinue integrating health coverage with Medicare Part A or Part B. If this occurs, we will notify you in writing at least 90 days before participation ends. You will not lose Medicare coverage and State Health Plan retiree coverage will continue.

For more information about this plan:

Visit us at www.bcbsm.com or, call Customer Service,
Hours: 8:30 a.m. to 5:00 p.m., EST,
Monday through Friday 1-888-322-5557,
TTY/TDD 1-800-579-0235

For more information about Medicare,
please call Medicare at 1-800-MEDICARE (1-800-633-4227).

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.

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