

FCCRMC BlueMedicare Group Private-Fee-For-Service (PFFS) Benefits for 2008

Benefits	Network
	Members can see any Medicare provider that accepts Medicare payment and accepts the terms and conditions and payment rates of BCBSF. If a doctor or hospital does not agree to accept our payment terms and conditions, they may not provide healthcare services to you except in emergencies.
Premium (per month)	\$ 198.73
Part B Premium	\$ 93.50 each month 2007
Deductible	None
Out-of-Pocket Max	\$2,000 all plan health services
Physician Office	
Primary Care (per visit)	\$10
Specialist Care (per visit)	\$25
Podiatry Services (Routine foot care up to 6 visits per year)	\$25
Chiropractic Services	\$25 For each Medicare covered visit (manual Manipulation of the spine to correct Subluxation)
Outpatient Mental Health Care (per visit)	\$25 For individual or group therapy
Outpatient Substance Abuse Care (per visit)	\$25
Allergy Injections	\$5
Other Services	
Outpatient Surgery	\$200 for each outpatient hospital facility visit. \$100 for each visit to an ambulatory surgical center. \$0 for Physician Services \$0 for each visit to an ambulatory surgical center
Diagnostic Tests, X-Rays and Lab Services (Office or free standing)	\$0 *Office visit copay may apply
Outpatient hospital Diagnostic Tests, X-Rays and Lab Services Excluding Mammograms	\$75
Urgently Needed Care (This is not emergency care, and in most cases, is out of the service area.)	\$25 for each visit. Worldwide coverage.



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Emergency Services	\$50 Worldwide coverage
Home Health	\$0
Ambulance	\$100 for Medicare covered ambulance services
Outpatient Medical Services and Supplies	
Durable Medical Equipment Electric customized wheelchairs, electric scooters All other Medicare-covered items	\$500 \$0
Prosthetic Devices	\$500 for Medicare covered items
Outpatient Rehabilitation (Free Standing: Services (per visit) Occupational Therapy, Physical Therapy, Speech and Language Therapy and Cardiac Rehab	\$25
Outpatient Rehabilitation (Outpatient Hospital: Services (per visit) Occupational Therapy Physical Therapy Speech and Language Therapy Cardiac Rehab	\$50
Renal Dialysis	\$0
Inpatient Care	
Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	\$150 each day for day(s) 1-5. for a Medicare-covered stay.
Inpatient Mental Health Care (may also include Substance Abuse and Rehabilitation Services)	\$150 each day for day(s) 1-5. for a Medicare-covered. 190-day lifetime limit in a psychiatric hospital.
Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	\$0 (days 1-20). \$75 (days 21-100) There is a limit of 100 days for each benefit period. 3-day prior hospital stay is not required.
Hospice	Member must receive care from a Medicare- certified hospice

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Preventive Services	
Annual Screening - Mammograms (for women with Medicare age 40 and older)	\$0 for Medicare-covered Screening Mammogram \$0 for each additional screening – You are covered for an unlimited number of Screening Mammograms
Pap Smears and Pelvic Exams (for women with Medicare)	\$0 per Pap smear. \$0 per Pelvic exam. \$0 for each additional screening – <i>You are covered for an unlimited number of Pap Smears and Pelvic Exams</i>
Bone Mass Measurement (for people with Medicare who are at risk)	\$0 for each Medicare-covered Bone Mass Measurement
Colorectal Screening Exams (for people with Medicare age 50 and older)	\$0 for Medicare-covered Colorectal screening exam \$0 for each additional screening – <i>You are covered for an unlimited number of Colorectal Screening Exams.</i>
Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	\$0 for Medicare-covered Prostate Cancer Screening exams. <i>You are covered for an unlimited number of Prostate Cancer Screening exams.</i>
Diabetic Supplies	\$0

- * Medicare Part B- the premium provided under this proposal includes the Medicare Part B premium payments required of Medicare eligible members in order for the member to be eligible for the group products.
- * Rates - All rates are calculated based on a Per Member Per Month (PMPM) basis.
- * Plan Eligibility - The rates provided are applicable to Medicare Part A & B -eligible retirees and Medicare eligible dependents that enrolls in BCBSF's BlueMedicare Group PFFS Medicare Advantage plans.
- * Part D Creditable Coverage - The enrolling member may incur late enrollment penalties as defined and set by CMS in accordance with Part D guidelines if prior creditable coverage cannot be proven. This amount would be billed to the group.



2008 FCCRMC BlueMedicare Group Rx

Benefits	Prescription Drug Plan
Deductible	\$0
Tier 1 - Generics This will include the Generic CMS excluded drugs listed below	\$10.00
Tier 2 - Preferred Brand	\$30.00
Tier 3 - Non-Preferred Brand	\$50.00
Tier 4 - Specialty drugs	\$50.00
Mail Order	2x normal copay
Formulary Type	Prime Option 2 formulary Add coverage for selected CMS excluded drugs. Generic & multi source brand prescription drugs will be covered for the following categories: <ul style="list-style-type: none"> • Cough • Cold • Anti-convulsants • Barbiturates • Benzodiazepines
Gap Tier 1 – Generics This will include the Generic & multi source brand CMS excluded drugs listed above.	\$10.00
Gap Tier 2 - Preferred Brand	\$30.00
Gap Tier 3 - Non-Preferred Brand	\$50.00
Gap Tier 4 - Specialty drugs	\$50.00
Catastrophic	Standard \$2.15/\$5.35/5%
Service Coverage Determination Prior Approvals	Prime
Network	Broad Comprehensive Local and National Network Access

- Coverage through the gap for both generic and brand.