

SECTION I — INTRODUCTION TO SUMMARY OF BENEFITS

Thank you for your interest in Medicare Blue Private (PFFS). Our plan is offered by BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA/BlueCross BlueShield of South Carolina, a Medicare Advantage Private Fee-for-Service. This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Medicare Blue Private (PFFS) 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 a Medicare Advantage Private Fee-for-Service plan, like Medicare Blue Private (PFFS). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare program.

You may join or leave a plan only at certain times. Please call Medicare Blue Private (PFFS) at the telephone number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?

You can compare Medicare Blue Private (PFFS) 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.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

WHERE IS MEDICARE BLUE PRIVATE (PFFS) AVAILABLE?

The service area for this plan includes the following counties: Abbeville, Aiken, Anderson, Calhoun, Cherokee, Chester, Clarendon, Edgefield, Fairfield, Greenville, Greenwood, Laurens, Lexington, McCormick, Newberry, Oconee, Orangeburg, Pickens, Richland, Saluda, Spartanburg, Sumter, Union, and York, South Carolina. You must live in one of these areas to join the plan.

WHO IS ELIGIBLE TO JOIN MEDICARE BLUE PRIVATE (PFFS)?

You can join Medicare Blue Private (PFFS) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease are generally not eligible to enroll in Medicare Blue Private (PFFS) unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?

A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare supplement 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, they may choose not to provide healthcare services to you, except in emergencies.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 60 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Medicare Blue Private (PFFS), 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 with us if you have any type of problem with us or one of our network 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, "The Carolinas Center for Medical Excellence" (803-251-2215 or 1-800-922-3089).

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

Medicare Blue Private (PFFS) does cover Medicare Part B prescription drugs. Medicare Blue Private (PFFS) does NOT cover Medicare Part D prescription drugs.

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. Contact Medicare Blue Private (PFFS) for more details.

- 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 a 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 provided through DME.

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 site, you may use the Web site tools on www.medicare.gov and select “Compare Medicare Prescription Drug Plans” or “Compare Health Plans and Medigap Policies in Your Area” to compare the plan ratings for Medicare plans in your area. You can also call us directly at 1-888-645-6025, to obtain a copy of the plan ratings for this plan. TTY users call 1-888-645-6023.

Please call BlueCross BlueShield of South Carolina for more information about Medicare Blue Private (PFFS). Visit us at www.SouthCarolinaBlues.com/mbp10 or, call us:

Customer Service Hours:

Monday, Tuesday, Wednesday, Thursday, Friday, 8:00 a.m. – 8:00 p.m. Eastern

Current members should call toll-free 1-888-645-6025. (TTY/TDD 1-888-645-6023)

Prospective members should call toll-free 1-800-760-1790. (TTY/TDD 1-888-899-4219)

Current members should call locally 1-888-645-6025. (TTY/TDD 1-888-645-6023)

Prospective members should call locally 1-800-760-1790. (TTY/TDD 1-888-899-4219)

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, visit www.medicare.gov on the Web site.

If you have special needs, this document may be available in other formats.

If you have any questions about these plans' benefits or costs, please contact BlueCross BlueShield of South Carolina for details. Call Medicare Blue Private (PFFS) Customer Service at 1-888-645-6025 (TTY: 1-888-645-6023).

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	Medicare Blue Private (PFFS)
<p>1 - Premium and Other Important Information</p>	<p>In 2009 the monthly Part B Premium was \$96.40 and will change for 2010 and the yearly Part B deductible amount was \$135 and will change for 2010.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p>Most people will pay the standard monthly Part B premium. However, starting January 1, 2010, some people will pay a higher premium because of their yearly income. (For 2009, this amount was \$85,000 for singles, \$170,000 for married couples. This amount may change for 2010.) For more information about Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>	<p>General</p> <p>\$0.00 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>This plan does not allow providers to balance bill (charging more than your cost share amount).</p> <p>\$3,400 out-of-pocket limit.</p> <p>All plan services included.</p>
<p>2 - Doctor and Hospital Choice (For more information, see Emergency #15 and Urgently Needed Care #16.)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p>You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment.</p>
<p>INPATIENT CARE</p>		
<p>3 - Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)</p>	<p>In 2009 the amounts for each benefit period were: Days 1 - 60: \$1068 deductible Days 61 - 90: \$267 per day Days 91 - 150: \$534 per lifetime reserve day These amounts will change for 2010.</p> <p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once. 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.</p>	<p>General</p> <p>You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment except in emergencies.</p> <p>For Medicare-covered hospital stays: Days 1 - 5: \$225 copay per day Days 6 - 90: \$0 copay per day \$0 copay for additional hospital days No limit to the number of days covered by the plan each benefit period.</p>
<p>4 - Inpatient Mental Health Care</p>	<p>Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above).</p> <p>190 day lifetime limit in a Psychiatric Hospital.</p>	<p>For Medicare-covered hospital stays: Days 1 - 5: \$225 copay per day Days 6 - 90: \$0 copay per day You get up to 190 days in a Psychiatric Hospital in a lifetime.</p>

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5 - Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	<p>In 2009 the amounts for each benefit period after at least a 3-day covered hospital stay were: Days 1 - 20: \$0 per day Days 21 - 100: \$133.50 per day</p> <p>These amounts will change for 2010.</p> <p>100 days for each benefit period. A "benefit period" starts the day you go into a hospital or SNF. 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.</p>	<p>For Medicare-covered SNF stays: Days 1 - 20: \$0 copay per day Days 21 - 100: \$128 copay per day</p> <p>Plan covers up to 100 days each benefit period.</p> <p>3-day prior hospital stay is required.</p>
6 - Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	\$0 copay.	10% of the cost for each Medicare-covered home health visit.
7 - Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	<p>General You must get care from a Medicare-certified hospice.</p>
OUTPATIENT CARE		
8 - Doctor Office Visits	20% coinsurance	<p>General You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment. See "Physical Exams," for more information. \$20 copay for each primary care doctor visit for Medicare-covered benefits. \$30 copay for each specialist visit for Medicare-covered benefits.</p>
9 - Chiropractic Services	<p>Routine care not covered.</p> <p>20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>	<p>\$30 copay for each Medicare-covered visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>
10 - Podiatry Services	<p>Routine care not covered.</p> <p>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>	<p>\$30 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care.</p>

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11 - Outpatient Mental Health Care	45% coinsurance for most outpatient mental health services.	\$30 copay for each Medicare-covered individual or group therapy visit.
12 - Outpatient Substance Abuse Care	20% coinsurance	\$30 copay for Medicare-covered individual or group visits.
13 - Outpatient Services/ Surgery	20% coinsurance for the doctor 20% of outpatient facility charges	\$100 copay for each Medicare-covered ambulatory surgical center visit. \$200 copay for each Medicare-covered outpatient hospital facility visit.
14 - Ambulance Services (medically necessary ambulance services)	20% coinsurance	\$150 copay for Medicare-covered ambulance benefits.
15 - Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor. 20% of facility charge, or a set copay per emergency room visit. You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. NOT covered outside the U.S. except under limited circumstances.	General \$50 copay for Medicare-covered emergency room visits. \$25,000 limit for emergency services outside the U.S. every year.
16 - Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	20% coinsurance, or a set copay NOT covered outside the U.S. except under limited circumstances.	General \$20 to \$30 copay for Medicare-covered urgently needed care visits.
17 - Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance	\$30 copay for Medicare-covered Occupational Therapy visits. \$30 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance	25% of the cost for Medicare-covered items.
19 - Prosthetic Devices	20% coinsurance	25% of the cost for Medicare-covered items.

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	Medicare Blue Private (PFFS)
(includes braces artificial limbs and eyes, etc.)		
20 - Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, self-management training)	<p>20% coinsurance</p> <p>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.</p>	<p>\$0 copay for Diabetes self-monitoring training.</p> <p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>\$0 copay for Diabetes supplies.</p> <p>Separate Office Visit cost sharing of \$20 to \$30 copay may apply.</p>
21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	<p>20% coinsurance for diagnostic tests and x-rays.</p> <p>\$0 copay for Medicare-covered lab services.</p> <p>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.</p>	<p>\$15 copay for Medicare-covered lab services.</p> <p>\$30 copay for Medicare-covered diagnostic procedures and tests.</p> <p>\$15 copay for Medicare-covered X-rays.</p> <p>\$100 copay for Medicare-covered diagnostic radiology services.</p> <p>\$100 copay for Medicare-covered therapeutic radiology services.</p> <p>Separate Office Visit cost sharing of \$20 to \$30 copay may apply.</p>
PREVENTIVE SERVICES		
22 - Bone Mass Measurement (for people with Medicare who are at risk)	<p>20% coinsurance</p> <p>Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.</p>	<p>\$0 copay for Medicare-covered bone mass measurement</p> <p>Separate Office Visit cost sharing of \$20 to \$30 copay may apply.</p>
23 - Colorectal Screening Exams (for people with Medicare age 50 and older)	<p>20% coinsurance</p> <p>Covered when you are high risk or when you are age 50 and older.</p>	<p>\$0 copay for Medicare-covered colorectal screenings.</p> <p>Separate Office Visit cost sharing of \$20 to \$30 copay may apply.</p>
24 – Immunizations (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)	<p>\$0 copay for Flu and Pneumonia vaccines</p> <p>20% coinsurance for Hepatitis B vaccine</p> <p>You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.</p>	<p>\$0 copay for Flu and Pneumonia vaccines.</p> <p>\$0 copay for Hepatitis B vaccine.</p>
25 - Mammograms	<p>20% coinsurance</p>	<p>\$0 copay for Medicare-covered screening mammograms.</p>

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Benefit	Original Medicare	Medicare Blue Private (PFFS)
(Annual Screening) (for women with Medicare age 40 and older)	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 age 35 and 39.	Separate Office Visit cost sharing of \$20 to \$30 copay may apply.
26 – Pap Smears and Pelvic Exams (for women with Medicare)	\$0 copay for Pap smears Covered once every 2 years. Covered once a year for women with Medicare at high risk. 20% coinsurance for Pelvic Exams	\$0 copay for Medicare-covered pap smears and pelvic exams. Separate Office Visit cost sharing of \$20 to \$30 copay may apply.
27 - Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	20% coinsurance for the digital rectal exam. \$0 for the PSA test; 20% coinsurance for other related services. Covered once a year for all men with Medicare over age 50.	\$0 copay for - Medicare-covered prostate cancer screening Separate Office Visit cost sharing of \$20 to \$30 copay may apply.
28 - End-Stage Renal Disease	20% coinsurance for renal dialysis. 20% coinsurance for 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.	20% of the cost for renal dialysis \$0 copay for Nutrition Therapy for End-Stage Renal Disease
29 - Prescription Drugs	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	Drugs covered under Medicare Part B General Most drugs not covered. 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. Drugs covered under Medicare Part D General This plan does not offer prescription drug coverage.
30 – Dental Services	Preventive dental services (such as cleaning) not covered.	In general, preventive dental benefits (such as cleaning) not covered. 20% of the cost for Medicare-covered dental benefits.
31 – Hearing Services	Routine hearing exams and hearing aids not covered.	In general, routine hearing exams and hearing aids not covered.

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	Medicare Blue Private (PFFS)
	20% coinsurance for diagnostic hearing exams.	- \$30 copay for Medicare-covered diagnostic hearing exams
32 – Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.	- \$10 copay for one pair of eyeglasses or contact lenses after cataract surgery - \$25 copay for exams to diagnose and treat diseases and conditions of the eye - \$25 copay for up to 1 routine eye exam every year - \$10 copay for glasses - \$0 copay for contacts - \$10 copay for lenses - \$0 copay for frames \$125 limit for eyewear every year.
33 – Physical Exams	20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage When you get Medicare Part B, you can get a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.	\$20 copay for routine exams. Limited to 1 exam every year. \$20 copay for Medicare-covered benefits. Separate Office Visit cost sharing of \$20 to \$30 copay may apply.
Health/Wellness Education	Smoking Cessation: Covered if 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. You pay coinsurance, and Part B deductible applies.	The plan covers the following health/wellness education benefits: - Written health education materials, including Newsletters - Nursing Hotline - Other Wellness Benefits \$0 copay for each Medicare-covered smoking cessation counseling session.
Transportation (Routine)	Not covered.	This plan does not cover routine transportation.
Acupuncture	Not covered.	This plan does not cover Acupuncture.