

**2010 Employer Group Retiree Plan
Medicare Supplement Plan C Benefit Summary
Utica Region**

Part B Premium	Most Medicare beneficiaries will continue to pay the same \$96.40 in 2010.		
Part B Deductible (this applies to covered services noted with an asterisk)	\$155		
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD			
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
- First 60 days	- All but \$1,100	- \$0	- \$0
- 61st through 90th day	- All but \$275/day	- \$275 a day	- \$0
- 91st day and after:			
• While using 60 lifetime reserve days	- All but \$550/day	- \$550 a day	- \$0
• Once lifetime reserve days are used:			
- Additional 365 days (lifetime)	- \$0	- 100% of Medicare-eligible expenses	- \$0
- Beyond the additional 365 days	- \$0	- \$0	- All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	- All approved amounts	- \$0	- \$0
21st thru 100th day	- All but \$137.50 a day	- \$0	- \$0
101st day and after	- \$0	- \$0	- All costs
BLOOD (per calendar year)			
First 3 pints	- \$0	- 3 pints	- \$0
Additional amounts	- 100%	- \$0	- \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	- \$0	- Balance



MEDICARE (PART B)—MEDICAL SERVICES (PER CALENDAR YEAR)			
MEDICAL EXPENSES – in or out of the hospital and outpatient hospital treatment, such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$155 of Medicare-approved amounts*	- \$0	- \$0	- \$0
Remainder of Medicare-approved amounts	- Generally 80%	- Generally 20%	- \$0
Part B excess charges (above Medicare approved amounts)	- \$0	- \$0	- All costs
BLOOD			
First 3 pints	- \$0	- All costs	- \$0
Next \$155 of Medicare-approved amounts*	- \$0	- \$0	- \$0
Remainder of Medicare-approved amounts	- 80%	- 0%	- \$0
CLINICAL LABORATORY SERVICES tests for diagnostic services	- 100%	- \$0	- \$0
PARTS A & B			
HOME HEALTH CARE Medicare-approved services			
• Medically necessary skilled care services and medical supplies	- 100%	- \$0	- \$0
• Durable medical equipment			
First \$155 of Medicare-approved amounts*	- \$0	- \$0	- \$0
Remainder of Medicare-approved amounts	- 80%	- 20%	- \$0
OTHER BENEFITS NOT COVERED BY MEDICARE			
FOREIGN TRAVEL — NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.			
• First \$250 each calendar year	- \$0	- \$0	- \$250
• Remainder of charges	- \$0	- 80% to a lifetime maximum benefit of \$50,000	- 20% and amounts over the \$50,000 lifetime maximum

This is only an outline describing your policy’s most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company. This policy may not fully cover all of your medical costs. Neither Excellus BlueCross BlueShield nor its agents are connected with Medicare. This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare & You* for more details.

MONTHLY SUBSCRIPTION RATE

Benefit	Description	Monthly Premium
Group Option	Medicare Supplement Plan C (Utica)	\$206.96

We, Excellus BlueCross BlueShield, can only raise your premium if we raise the premium for all policies like yours in the State of New York.

Employer Group Name: _____

Signature: _____ **Date:** _____

Name (Please Print): _____

Title: _____

Effective Date: _____

2010 Employer Group Retiree Plan
Simply Prescriptions (PDP) Benefit Summary

MEDICARE PART D PRESCRIPTION DRUG BENEFITS

Annual Deductible: \$0

Initial Coverage:

	<u>30-Day Supply</u>	<u>90-day Supply</u>
Tier 1:	\$10 Copayment	\$30 Copayment
Tier 2:	\$30 Copayment	\$90 Copayment
Tier 3:	\$50 Copayment	\$150 Copayment

Catastrophic Coverage:

After yearly out-of-pocket drug costs paid by both the member and the plan reach \$4,550, the member pays the greater of \$2.50 copayment for generic and a \$6.30 copayment for all other drugs, or 5% coinsurance.

View the formulary, list of covered drugs, at www.simplyprescriptions.com.

The benefit information provided is not comprehensive. Please consult your Evidence of Coverage for a detailed explanation of benefits and any applicable restrictions. To the extent of any discrepancy between this document and the Evidence of Coverage, the Evidence of Coverage terms take priority.

\$126.89 MONTHLY PREMIUM

By signing this rate quote, the employer group agrees to the following:

- Compliance with the Centers for Medicare and Medicaid Services (CMS) requirements for Uniform Premium waivers in relation to premiums charged to our group plan participants. The employer group plan sponsor cannot charge participants covered under this plan an amount greater than the standard Medicare Part D beneficiary premium plus up to 100% of the value of any supplemental prescription drug coverage.
- Administration of any Low Income Subsidy (LIS) premium payments received from Simply Prescriptions (PDP) for plan participants in accordance with CMS regulations (any LIS premium payments Simply Prescriptions (PDP) receives from CMS for plan participants will be passed through to the employer group from Simply Prescriptions (PDP)).
- Compliance with alternative disclosure requirements under ERISA, including Summary Plan Descriptions and other descriptions of benefit offerings to participants covered under this plan.

Employer Group

Name: _____

Signature: _____

Date: _____

Name

(Please Print): _____

Title: _____