BC Life & Health
Insurance Company

Freedom Blue PPO℠

Summary of Benefits

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Introduction to the Summary of Benefits for Freedom Blue PPO Plan

January 1, 2006 - December 31, 2006
California

Thank you for your interest in the Freedom Blue PPO Plan. Our plan is offered by BC Life & Health Insurance Company, a Medicare Advantage Preferred Provider Organization (PPO). This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover, every limitation, or every exclusion. To get a complete list of our benefits, please call BC Life and Health 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 health plan, like the Freedom Blue PPO Plan. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program. You may be able to join or leave a plan only at certain times. Please call the Freedom Blue Plan at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?

You can compare the Freedom Blue Plan PPO 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 FREEDOM BLUE PPO PLAN AVAILABLE?

The service area for this plan is California. You must live in California to join the plan.

CAN I CHOOSE MY DOCTORS?

The Freedom Blue PPO Plan has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory to receive an up-to-date list. Our number is listed at the end of this introduction.

WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?

You can go to doctors, specialists, or hospitals in or out of network. You may have to pay more for the services you receive outside the network, and you may have to follow special rules prior to getting services in and/or out of network. For more information, call the telephone number at the end of this introduction.

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?

The Freedom Blue PPO Plan has formed a network of pharmacies. You can use any pharmacy in our network. The pharmacies in our network can change at any time. You can ask for a current Pharmacy Network List. Our number is listed at the end of this introduction.

WHAT HAPPENS IF I GO TO A PHARMACY THAT'S NOT IN YOUR NETWORK?

If you go to a pharmacy that's not in our network, you might have to pay more for your prescriptions. You also might have to follow special rules before getting your prescription in order for the prescription to be covered under our plan. For more information, call the telephone number at the end of this introduction.

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

Freedom Blue PPO does cover both Medicare Part B prescription drugs and Part D prescription drugs.

DOES MY PLAN HAVE A PRESCRIPTION DRUG FORMULARY?

Freedom Blue PPO uses a formulary. A formulary is a preferred list of drugs selected to meet patient needs. The plan may periodically make changes to the formulary. If the formulary changes, affected enrollees will be notified in writing, before the change is made.

Contact Freedom Blue PPO for details.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a benefit that your plan may offer. You may be identified to participate in a program designed for your specific health and pharmacy needs. It is recommended that you take full advantage of this covered benefit if you are selected.

Contact Freedom Blue PPO for details.

WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

The following outpatient prescription drugs may be covered under Medicare Part B. This may include, but is not limited to, the following types of drugs. Contact Freedom Blue PPO for 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 alpha 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.
- Injectible Drugs: Most injectible drugs administered as part of 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 injectible form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and infusion drugs provided through DME.

Please call BC Life & Health Insurance Company for more information about this plan. Visit us at www.bluecrossca.com or, call us:

Customer Service Hours:
Monday - Thursday 8:00 a.m. - 5:00 p.m. Pacific
Friday 8:00 a.m. - 3:00 p.m. Pacific

Current and Prospective members should call 1-800-765-2585 for questions related to the Medicare Advantage program. (TTY/TDD 1-877-247-1657)

For more information about Medicare, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-800-486-2048. 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.

Summary of Benefits

If you have any questions about this plan's benefits or costs, please contact BC Life & Health Insurance Company.

Important Information

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
1 – Premium and Other Important Information	You pay the Medicare Part B Premium of $88.50 each month. (This is the 2006 amount and may change in 2007.)	You pay no additional premium for your plan benefits and $7.00 each month for your Medicare Part D prescription benefits. This is in additional premium beyond the Medicare Part B monthly premium of $88.50. You pay a $1000 yearly deductible for the following Medicare Covered plan services when received in network only: - Inpatient Hospital Care - Inpatient Mental Health Care - Skilled Nursing Facility - Home Health Care - Chiropractic Services - Podiatry Services - Outpatient Mental Health Care - Outpatient Substance Abuse Care - Outpatient Services/Surgery - Ambulance Services - Emergency Care - Urgently Needed Care - Outpatient Rehabilitation Services - Durable Medical Equipment - Prosthetic Devices - Diabetes Self-Monitoring Training and Supplies - Diagnostic Tests, X-Rays, and Lab Services - Dental Services - Hearing Services - Vision Services - Comprehensive Outpatient Rehabilitation Facility (CORF) - Partial Hospitalization - Other Health Care Professional - Cardiac Rehabilitation Services - Renal Dialysis - Blood	You pay $ 10.00 each month for your plan benefits and $ 22.00 each month for your Medicare Part D prescription benefits. This is in additional premium beyond the Medicare Part B monthly premium of $88.50. You pay a $500 yearly deductible for the following Medicare Covered plan services when received in network only: - Inpatient Hospital Care - Inpatient Mental Health Care - Skilled Nursing Facility - Home Health Care - Chiropractic Services - Podiatry Services - Outpatient Mental Health Care - Outpatient Substance Abuse Care - Outpatient Services/Surgery - Ambulance Services - Emergency Care - Urgently Needed Care - Outpatient Rehabilitation Services - Durable Medical Equipment - Prosthetic Devices - Diabetes Self-Monitoring Training and Supplies - Diagnostic Tests, X-Rays, and Lab Services - Dental Services - Hearing Services - Vision Services - Comprehensive Outpatient Rehabilitation Facility (CORF) - Partial Hospitalization - Other Health Care Professional - Cardiac Rehabilitation Services - Renal Dialysis - Blood

Important Information

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
1 – Premium and Other Important Information (cont.)		You pay a $1250 yearly deductible for the following Medicare-covered plan services when received out of network only: - Inpatient Hospital Care - Inpatient Mental Health Care - Skilled Nursing Facility - Home Health Care - Chiropractic Services - Podiatry Services - Outpatient Mental Health Care - Outpatient Substance Abuse Care - Outpatient Services/Surgery - Ambulance Service - Emergency Care - Urgently Needed Care - Outpatient Rehabilitation Services - Durable Medical Equipment - Prosthetic Devices - Diabetes Self-Monitoring Training and Supplies - Diagnostic Tests, X-Rays, and Lab Services - Dental Services - Hearing Services - Vision Services - Comprehensive Outpatient Rehabilitation Facility (CORF) - Partial Hospitalization - Other Health Care Professional - Cardiac Rehabilitation Services - Renal Dialysis - Blood There is a $3000 maximum out-of-pocket limit every year for all Medicare-covered plan services when received in network only. There is a $5000 maximum out-of-pocket limit for all Medicare-covered plan services when received out of network only.	You pay a $750 yearly deductible for the following Medicare-covered plan services when received out of network only: - Inpatient Hospital Care - Inpatient Mental Health Care - Skilled Nursing Facility - Home Health Care - Chiropractic Services - Podiatry Services - Outpatient Mental Health Care - Outpatient Substance Abuse Care - Outpatient Services/Surgery - Ambulance Service - Emergency Care - Urgently Needed Care - Outpatient Rehabilitation Services - Durable Medical Equipment - Prosthetic Devices - Diabetes Self-Monitoring Training and Supplies - Diagnostic Tests, X-Rays, and Lab Services - Dental Services - Hearing Services - Vision Services - Comprehensive Outpatient Rehabilitation Facility (CORF) - Partial Hospitalization - Other Health Care Professional - Cardiac Rehabilitation Services - Renal Dialysis - Blood There is a $3000 maximum out-of-pocket limit every year for all Medicare-covered plan services when received in network only. There is a $5000 maximum out-of-pocket limit for all Medicare-covered plan services when received out of network only.

Important Information

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
1 – Premium and Other Important Information (cont.)		If there is no note on an out of network service, then the note describes the in-network service. Contact plan for details on the covered out of network service.	If there is no note on an out of network service, then the note describes the in-network service. Contact plan for details on the covered out of network service.
2 - Doctor and Hospital Choice (For more information, see Emergency – #15, Urgently Needed Care – #16.)	You may go to any doctor, specialist or hospital that accepts Medicare.	You can go to doctors, specialists, and hospitals in or out of network. You do NOT need a referral to go to network doctors, specialists, and hospitals.	You can go to doctors, specialists, and hospitals in or out of network. You do NOT need a referral to go to network doctors, specialists, and hospitals.

Inpatient Care

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
3 - Inpatient Hospital Care (Includes Substance Abuse and Rehabilitation Services)	You pay for each benefit period (3): Days 1 – 60: an initial deductible of $952 Days 61 – 90: $238 each day Day 91 – 150: $476 each lifetime reserve day (4) (These are the 2006 amounts and may change January 1, 2007.) Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. (4)	You pay 10% of the cost for each Medicare-covered stay at a network hospital. Cost sharing may vary for each Medicare covered stay according to the hospital at which services are received. You pay 20% of the cost for each stay at an out of network hospital. There is no copayment for additional days received at a network hospital. You are covered for unlimited days each benefit period.	You pay 10% of the cost for each Medicare-covered stay at a network hospital. Cost sharing may vary for each Medicare covered stay according to the hospital at which services are received. You pay 20% of the cost for each stay at an out of network hospital. There is no copayment for additional days received at a network hospital. You are covered for unlimited days each benefit period.
4 – Inpatient Mental Health Care	You pay the same deductible and copayments as inpatient hospital care (above) except Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.	You pay 10% of the cost for each Medicare-covered stay at a network hospital. You pay 20% of the cost for each stay at a Medicare-covered out of network hospital. Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.	You pay 10% of the cost for each Medicare-covered stay at a network hospital. You pay 20% of the cost for each stay at a Medicare-covered out of network hospital. Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.

[3] A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. 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.

[4] Lifetime reserve days can only be used once.

Inpatient Care

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
5 – Skilled Nursing Facility (In a Medicare-certified skilled nursing facility)	You pay for each benefit period (3), following at least a 3-day covered hospital stay: Days 1 – 20: $0 for each day Days 21 – 100: $114 for each day (These are the 2006 amounts and may change January 1, 2007.) There is a limit of 100 days for each benefit period. (3)	You pay 10% of the cost for each stay at a Skilled Nursing Facility. You pay 20% of the cost for services at an out of network Skilled Nursing Facility. No prior hospital stay is required. You are covered for 100 days each benefit period.	You pay 10% of the cost for each stay at a Skilled Nursing Facility. You pay 20% of the cost for services at an out of network Skilled Nursing Facility. No prior hospital stay is required. You are covered for 100 days each benefit period.
6 – Home Health Care (Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	There is no copayment for all covered home health visits.	You pay 10% of the cost for Medicare-covered home health visits. You pay 20% for out of network home health visits.	You pay 10% of the cost for Medicare-covered home health visits. You pay 20% for out of network home health visits.
7 – Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must receive care from a Medicare-certified hospice.	You must receive care from a Medicare-certified hospice.	You must receive care from a Medicare-certified hospice.

[3] A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. 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.

Outpatient Care

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
8 – Doctor Office Visits	You pay 20% of Medicare-approved amounts. (1)(2)	You pay $10 for each primary care doctor office visit for Medicare-covered services. You pay 20% for each out of network primary care doctor office visit. You pay $10 for each specialist visit for Medicare-covered services. You pay 20% for each in network specialist visit.	You pay $10 for each primary care doctor office visit for Medicare-covered services. You pay 20% for each out of network primary care doctor office visit. You pay $10 for each specialist visit for Medicare-covered services. You pay 20% for each in network specialist visit.
9 – Chiropractic Services	You are covered for manual manipulation of the spine to correct subluxation, provided by chiropractors or other qualified providers. You pay 100% for routine care. You pay 20% of Medicare-approved amounts. (1)(2)	You pay 10% of the cost for each Medicare-covered visit (manual manipulation of the spine to correct subluxation). You pay 20% of the cost for out of network chiropractic services.	You pay 10% of the cost for each Medicare-covered visit (manual manipulation of the spine to correct subluxation). You pay 20% of the cost for out of network chiropractic services.
10 – Podiatry Services	You pay 20% of Medicare- approved amounts. (1)(2) You are covered for medically necessary foot care, including care for medical conditions affecting the lower limbs. You pay 100% for routine care.	You pay 10% of the cost for each Medicare-covered visit (medically necessary foot care). You pay 20% of the cost for out of network podiatry services.	You pay 10% of the cost for each Medicare-covered visit (medically necessary foot care). You pay 20% of the cost for out of network podiatry services.

[1] *Each year, you pay a total of one $124 deductible.*

[2] *If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.*

Outpatient Care

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
11 – Outpatient Mental Health Care	You pay 50% of Medicare-approved amounts with the exception of certain situations and services for which you pay 20% of approved charges. (1)(2)	For Medicare-covered mental health services, you pay 10% of the cost for each individual / group therapy visit. You pay 20% of the cost for out of network Mental Health services. You pay 20% of the cost for out of network Mental Health services with a psychiatrist.	For Medicare-covered mental health services, you pay 10% of the cost for each individual / group therapy visit. You pay 20% of the cost for out of network Mental Health services. You pay 20% of the cost for out of network Mental Health services with a psychiatrist.
12 – Outpatient Substance Abuse Care	You pay 20% of Medicare-approved amounts. (1)(2)	For Medicare-covered services, you pay 10% of the cost for each individual / group visit. You pay 20% of the cost for out of network outpatient substance abuse services.	For Medicare-covered services, you pay 10% of the cost for each individual / group visit. You pay 20% of the cost for out of network outpatient substance abuse services.
13 – Outpatient Services/Surgery	You pay 20% of Medicare-approved amounts for the doctor. (1)(2) You pay 20% of outpatient facility charges. (1)(2)	You pay 10% of the cost for each Medicare-covered visit to an ambulatory surgical center. You pay 10% of the cost for each Medicare-covered visit to an outpatient hospital facility. You pay 20% of the cost for services at an out of network ambulatory surgical center. You pay 20% of the cost for services at an outpatient hospital facility.	You pay 10% of the cost for each Medicare-covered visit to an ambulatory surgical center. You pay 10% of the cost for each Medicare-covered visit to an outpatient hospital facility. You pay 20% of the cost for services at an out of network ambulatory surgical center. You pay 20% of the cost for services at an outpatient hospital facility.
14 – Ambulance Services (Medically necessary ambulance services)	You pay 20% of Medicare-approved amounts or applicable fee schedule charge. (1)(2)	You pay 10% of the cost for Medicare-covered ambulance services.	You pay 10% of the cost for Medicare-covered ambulance services.

[1] Each year, you pay a total of one $124 deductible.

[2] If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

Outpatient Care

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
15 – Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	You pay 20% of the facility charge or applicable Copayment for each emergency room visit; you do NOT pay this amount if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. (1)(2) You pay 20% of doctor charges. (1)(2) NOT covered outside the U.S. except under limited circumstances.	You pay $50 for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 72 hour(s) for the same condition. Worldwide coverage.	You pay $50 for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 72 hour(s) for the same condition. Worldwide coverage.
16 – Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	You pay 20% of Medicare-approved amounts or applicable Copayment. (1)(2) NOT covered outside the U.S. except under limited circumstances.	You pay 10% of the cost for each Medicare-covered urgently needed care visit; you do not pay this amount if you are admitted to the hospital within 72 hour(s) for the same condition. You pay 20% of the cost for each out of network urgent care services. Worldwide coverage.	You pay 10% of the cost for each Medicare-covered urgently needed care visit; you do not pay this amount if you are admitted to the hospital within 72 hour(s) for the same condition. You pay 20% of the cost for each out of network urgent care services. Worldwide coverage.
17 – Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	You pay 20% of Medicare-approved amounts. (1)(2)	You pay 10% of the cost for each Medicare-covered Occupational Therapy visit. You pay 10% of the cost for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit. You pay 20% of the cost for out of network Occupational Therapy services. You pay 20% of the cost for out of network Physical Therapy and/or Speech language therapy services.	You pay 10% of the cost for each Medicare-covered Occupational Therapy visit. You pay 10% of the cost for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit. You pay 20% of the cost for out of network Occupational Therapy services. You pay 20% of the cost for out of network Physical Therapy and/or Speech language therapy services.

[1] *Each year, you pay a total of one $124 deductible.*

[2] *If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.*

Outpatient Medical Services and Supplies

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
18 – Durable Medical Equipment (Includes wheel-chairs, oxygen, etc.)	You pay 20% of Medicare-approved amounts. (1)(2)	You pay 10% of the cost for each Medicare-covered item. You pay 20% of the cost for durable medical equipment purchased out of network.	You pay 10% of the cost for each Medicare-covered item. You pay 20% of the cost for durable medical equipment purchased out of network.
19 – Prosthetic Devices (Includes braces, artificial limbs and eyes, etc.)	You pay 20% of Medicare-approved amounts. (1)(2)	You pay 10% of the cost for each Medicare-covered item. You pay 20% of the cost for prosthetic devices purchased out of network.	You pay 10% of the cost for each Medicare-covered item. You pay 20% of the cost for prosthetic devices purchased out of network.
20 – Diabetes Self-Monitoring Training and Supplies (Includes coverage for glucose monitors, test strips, lancets, screening tests, and self-manage-ment training)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no copayment for Diabetes self-monitoring training. You pay 20% of the cost for out of network Diabetes self-monitoring training. You pay 10% of the cost for each Medicare-covered Diabetes Supply item. You pay 20% of the cost for each Diabetes Supply item purchased out of network.	There is no copayment for Diabetes self-monitoring training. You pay 20% of the cost for out of network Diabetes self-monitoring training. You pay 10% of the cost for each Medicare-covered Diabetes Supply item. You pay 20% of the cost for each Diabetes Supply item purchased out of network.
21 – Diagnostic Tests, X-Rays, and Lab Services	You pay 20% of Medicare-approved amounts, except for approved lab services. (1)(2) There is no copayment for Medicare-approved lab services.	You pay: – 10% of the cost for each Medicare-covered clinical/ diagnostic lab service. – 10% of the cost for each Medicare-covered radiation therapy service. – 10% of the cost for each Medicare-covered X-ray visit. – 20% of the cost for each out of network clinical/diagnostic lab service. – 20% of the cost for each out of network radiation therapy service. – 20% of the cost for out of network X-ray services.	You pay: – 10% of the cost for each Medicare-covered clinical/ diagnostic lab service. – 10% of the cost for each Medicare-covered radiation therapy service. – 10% of the cost for each Medicare-covered X-ray visit. – 20% of the cost for each out of network clinical/diagnostic lab service. – 20% of the cost for each out of network radiation therapy service. – 20% of the cost for out of network X-ray services.

[1] *Each year, you pay a total of one $124 deductible.*

[2] *If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.*

Preventive Services

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
22 – Bone Mass Measurement (For people with Medicare who are at risk)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no copayment for each Medicare-covered Bone Mass Measurement. You pay 20% of the cost for each out of network Bone Mass Measurement.	There is no copayment for each Medicare-covered Bone Mass Measurement. You pay 20% of the cost for each out of network Bone Mass Measurement.
23 – Colorectal Screening Exams (For people with Medicare age 50 and older)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no copayment for Medicare-covered Colorectal Screening Exams. You pay 20% of the cost for each out of network Colorectal Screening exam.	There is no copayment for Medicare-covered Colorectal Screening Exams. You pay 20% of the cost for each out of network Colorectal Screening exam.
24 - Immunizations (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)	There is no copayment for the Pneumonia and Flu vaccines. You pay 20% of Medicare-approved amounts for the Hepatitis B vaccine. (1)(2) You may only need the Pneumonia vaccine once in your lifetime. Please contact your doctor for further details.	There is no copayment for pneumonia and flu vaccines. No referral necessary for Medicare-covered influenza and pneumonia vaccines. There is no copayment for the Hepatitis B vaccine. You pay 20% of the cost for each out of network immunization.	There is no copayment for pneumonia and flu vaccines. No referral necessary for Medicare-covered influenza and pneumonia vaccines. There is no copayment for the Hepatitis B vaccine. You pay 20% of the cost for each out of network immunization.
25 - Mammograms (Annual Screening) (For women with Medicare age 40 and older)	You pay 20% of Medicare approved amounts. (2) No referral necessary for Medicare-covered screenings.	There is no copayment for Medicare-covered Screening Mammograms. You pay 20% of the cost for each out of network Screening Mammogram. No referral necessary for Medicare-covered screenings.	There is no copayment for Medicare-covered Screening Mammograms. You pay 20% of the cost for each out of network Screening Mammogram. No referral necessary for Medicare-covered screenings.

[1] *Each year, you pay a total of one $124 deductible.*

[2] *If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.*

Preventive Services

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
26 - Pap Smears and Pelvic Exams (For women with Medicare)	There is no copayment for a Pap Smear once every 2 years, annually for beneficiaries at high risk. (2) You pay 20% of Medicare-approved amounts for Pelvic Exams. (2)	There is no copayment for Medicare-covered Pap Smears and Pelvic Exams. You pay 20% of the cost for each out of network Medicare-covered Pap Smear and Pelvic Exam.	There is no copayment for Medicare-covered Pap Smears and Pelvic Exams. You pay 20% of the cost for each out of network Medicare-covered Pap Smear and Pelvic Exam.
27 - Prostate Cancer Screening Exams (For men with Medicare age 50 and older)	There is no copayment for approved lab services and a copayment of 20% of Medicare-approved amounts for other related services. (1)(2)	There is no copayment for Medicare-covered Prostate Cancer Screening exams. You pay 20% of the cost for each out of network Prostate Screening Exam.	There is no copayment for Medicare-covered Prostate Cancer Screening exams. You pay 20% of the cost for each out of network Prostate Screening Exam.
28 - Outpatient Prescription Drugs	You pay 100% for most prescription drugs, unless you enroll in the Medicare Part D Prescription Drug program.	This plan uses a formulary. A formulary is a preferred list of drugs selected to meet patient needs at a lower cost. If the formulary changes, you will be notified in writing. To view the plan's formulary, go to www.bluecrossca.com on the web. People who have low incomes, who live in long term care facilities, or who have access to Indian/Tribal/Urban (Indian Health Services) facilities may have different out-of-pocket drug cost. Contact the plan for details. There is no deductible. Before the total yearly drug costs (paid by both you and your plan) reach $ 2,250, you pay the following for prescription drugs:	This plan uses a formulary. A formulary is a preferred list of drugs selected to meet patient needs at a lower cost. If the formulary changes, you will be notified in writing. To view the plan's formulary, go to www.bluecrossca.com on the web. People who have low incomes, who live in long term care facilities, or who have access to Indian/Tribal/Urban (Indian Health Services) facilities may have different out-of-pocket drug cost. Contact the plan for details. There is no deductible. Before the total yearly drug costs (paid by both you and your plan) reach $ 2,250, you pay the following for prescription drugs:

[1] *Each year, you pay a total of one $124 deductible.*

[2] *If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.*

Preventive Services

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
28 - Outpatient Prescription Drugs (cont.)		– $10 for a one-month (30 day) supply of Formulary Generic - Generic drugs you get at an in-network preferred pharmacy. – $30 for a one-month (30 day) supply of Formulary Brand - Brand drugs you get at an in-network preferred pharmacy. – 25% coinsurance for a one-month (30 day) supply of Non-Specialty Injectables - Generic and Brand drugs you get at an in-network preferred pharmacy. – 25% coinsurance for a one-month (30 day) supply of Specialty Injectables - Generic and Brand drugs you get at an in-network preferred pharmacy. – $30 for a three-month (90 day) supply of Formulary Generic - Generic drugs you get at an in-network preferred pharmacy. – $90 for a three-month (90 day) supply of Formulary Brand - Brand drugs you get at an in-network preferred pharmacy. – 25% coinsurance for a three-month (90 day) supply of Non-Specialty Injectables - Generic and Brand drugs you get at an in-network preferred pharmacy. – 25% coinsurance for a three-month (90 day) supply of Specialty Injectables - Generic and Brand drugs you get at an in-network preferred pharmacy. – 25% coinsurance for a one-month (30 day) supply of Non-Specialty Injectables - Generic and Brand drugs you get at an in-network non-preferred pharmacy.	– $10 for a one-month (30 day) supply of Formulary Generic - Generic drugs you get at an in-network preferred pharmacy. – $30 for a one-month (30 day) supply of Formulary Brand - Brand drugs you get at an in-network preferred pharmacy. – 25% coinsurance for a one-month (30 day) supply of Non-Specialty Injectables - Generic and Brand drugs you get at an in-network preferred pharmacy. – 25% coinsurance for a one-month (30 day) supply of Specialty Injectables - Generic and Brand drugs you get at an in-network preferred pharmacy. – $30 for a three-month (90 day) supply of Formulary Generic - Generic drugs you get at an in-network preferred pharmacy. – $90 for a three-month (90 day) supply of Formulary Brand - Brand drugs you get at an in-network preferred pharmacy. – 25% coinsurance for a three-month (90 day) supply of Non-Specialty Injectables - Generic and Brand drugs you get at an in-network preferred pharmacy. – 25% coinsurance for a three-month (90 day) supply of Specialty Injectables - Generic and Brand drugs you get at an in-network preferred pharmacy. – 25% coinsurance for a one-month (30 day) supply of Non-Specialty Injectables - Generic and Brand drugs you get at an in-network non-preferred pharmacy.

Preventive Services

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
28 - Outpatient Prescription Drugs (cont.)		– 25% coinsurance for a one-month (30 day) supply of Specialty Injectables - Generic and Brand drugs you get at an in-network non-preferred pharmacy. – 25% coinsurance for a three-month (90 day) supply of Non-Specialty Injectables - Generic and Brand drugs you get at an in-network non-preferred pharmacy. – 25% coinsurance for a three-month (90 day) supply of Specialty Injectables - Generic and Brand drugs you get at an in-network non-preferred pharmacy. – $10 for a one-month (30 day) supply of Formulary Generic - Generic drugs you get at an out-of-network pharmacy. – $30 for a one-month (30 day) supply of Formulary Brand - Brand drugs you get at an out-of-network pharmacy. – 25% coinsurance for a one-month (30 day) supply of Non-Specialty Injectables - Generic and Brand drugs you get at an out-of-network pharmacy. – 25% coinsurance for a one-month (30 day) supply of Specialty Injectables - Generic and Brand drugs you get at an out-of-network pharmacy. – $30 for a three-month (90 day) supply of Formulary Generic - Generic drugs you get at an out-of-network pharmacy. – $90 for a three-month (90 day) supply of Formulary Brand - Brand drugs you get at an out-of-network pharmacy.	– 25% coinsurance for a one-month (30 day) supply of Specialty Injectables - Generic and Brand drugs you get at an in-network non-preferred pharmacy. – 25% coinsurance for a three-month (90 day) supply of Non-Specialty Injectables - Generic and Brand drugs you get at an in-network non-preferred pharmacy. – 25% coinsurance for a three-month (90 day) supply of Specialty Injectables - Generic and Brand drugs you get at an in-network non-preferred pharmacy. – $10 for a one-month (30 day) supply of Formulary Generic - Generic drugs you get at an out-of-network pharmacy. – $30 for a one-month (30 day) supply of Formulary Brand - Brand drugs you get at an out-of-network pharmacy. – 25% coinsurance for a one-month (30 day) supply of Non-Specialty Injectables - Generic and Brand drugs you get at an out-of-network pharmacy. – 25% coinsurance for a one-month (30 day) supply of Specialty Injectables - Generic and Brand drugs you get at an out-of-network pharmacy. – $30 for a three-month (90 day) supply of Formulary Generic - Generic drugs you get at an out-of-network pharmacy. – $90 for a three-month (90 day) supply of Formulary Brand - Brand drugs you get at an out-of-network pharmacy.

Preventive Services

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
		– 25% coinsurance for a three-month (90 day) supply of Non-Specialty Injectables - Generic and Brand drugs you get at an out-of-network pharmacy. – 25% coinsurance for a three-month (90 day) supply of Specialty Injectables - Generic and Brand drugs you get at an out-of-network pharmacy. – $15 for a three-month (90 day) supply of mail order Formulary Generic Generic drugs $ 75 for a three-month (90 day) supply of mail order Formulary Brand Brand drugs 25 % coinsurance for a three-month (90 day) supply of mail order Non-Specialty Injectables - Generic and Brand drugs 25 % coinsurance for a three-month (90 day) supply of mail order Specialty Injectables - Generic and Brand drugs After your yearly out-of-pocket drug costs reach $3,600, you pay the greater of: – $2 for generic or a preferred brand drug and $5 for all other drugs, or – 5% coinsurance. Certain prescription drugs will have maximum quantity limits. Contact plan for details. Your provider must get prior authorization from Freedom Blue Plan I for certain prescription drugs. Contact plan for details.	– 25% coinsurance for a three-month (90 day) supply of Non-Specialty Injectables - Generic and Brand drugs you get at an out-of-network pharmacy. – 25% coinsurance for a three-month (90 day) supply of Specialty Injectables - Generic and Brand drugs you get at an out-of-network pharmacy. – $15 for a three-month (90 day) supply of mail order Formulary Generic Generic drugs $ 75 for a three-month (90 day) supply of mail order Formulary Brand Brand drugs 25 % coinsurance for a three-month (90 day) supply of mail order Non-Specialty Injectables - Generic and Brand drugs 25 % coinsurance for a three-month (90 day) supply of mail order Specialty Injectables - Generic and Brand drugs After your yearly out-of-pocket drug costs reach $3,600, you pay the greater of: – $2 for generic or a preferred brand drug and $5 for all other drugs, or – 5% coinsurance. Certain prescription drugs will have maximum quantity limits. Contact plan for details. Your provider must get prior authorization from Freedom Blue Plan II for certain prescription drugs. Contact plan for details.

Additional Benefits *(What Original Medicare Does Not Cover)*

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
29 - Dental Services	In general, you pay 100% for dental services.	In general, you pay 100% for dental services.	In general, you pay 100% for dental services.
30 - Hearing Services	You pay 100% for routine hearing exams and hearing aids. You pay 20% of Medicare-approved amounts for diagnostic hearing exams. (1)(2)	There is no copayment for hearing aids. You pay: – $10 for each Medicare-covered hearing exam (diagnostic hearing exams). – $10 for each routine hearing test up to 1 test every year. You pay 20% of the cost for out of network hearing exams. You are covered up to $100 for hearing aids every two years.	There is no copayment for hearing aids. You pay: – $10 for each Medicare-covered hearing exam (diagnostic hearing exams). – $10 for each routine hearing test up to 1 test every year. You pay 20% of the cost for out of network hearing exams. You are covered up to $100 for hearing aids every two years.
31 - Vision Services	You are covered for one pair of eyeglasses or contact lenses after each cataract surgery. (1)(2) For people with Medicare who are at risk, you are covered for annual glaucoma screenings. (1)(2) You pay 20% of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye. (1)(2) You pay 100% for routine eye exams and glasses.	There is no copayment for the following items: – Medicare-covered eye wear (one paid of eyeglasses or contact lenses after each cataract surgery) – Contacts, limited to 1 pair of contacts every two years. – Lenses, limited to 1 pair of lenses every two years. – Frames, limited to 1 frame every two years. You pay: – $20 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye) – 20% for each Routine eye exam, limited to 1 exam every year.	There is no copayment for the following items: – Medicare-covered eye wear (one paid of eyeglasses or contact lenses after each cataract surgery) – Contacts, limited to 1 pair of contacts every two years. – Lenses, limited to 1 pair of lenses every two years. – Frames, limited to 1 frame every two years. You pay: – $20 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye) – 20% for each Routine eye exam, limited to 1 exam every year.

[1] *Each year, you pay a total of one $124 deductible.*

[2] *If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.*

Additional Benefits *(What Original Medicare Does Not Cover)*

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
31 - Vision Services (cont.)		You pay 20% of the cost for out of network eye exams. You pay 20% of the cost for out of network eye wear. You are covered up to $ 75 for eye wear every two years.	You pay 20% of the cost for out of network eye exams. You pay 20% of the cost for out of network eye wear. You are covered up to $ 75 for eye wear every two years.
32 - Physical Exams	If your coverage to Medicare Part B begins on or after January 1, 2005, you may receive a one time physical exam within the first six months of your new Part B coverage. This will not include laboratory tests. Please contact your plan for further details. You pay 20% of the Medicare-approved amount. (1)(2)	If your coverage to Medicare Part B begins on or after January 1, 2005, you may receive a one time physical exam within the first six months of your new Part B coverage. This will not include laboratory tests. Please contact your plan for further details. You pay $10 for Medicare covered services. You pay 20% for each out of network routine physical exam. You pay $ 10 for each exam. You are covered up to 1 exam every year.	If your coverage to Medicare Part B begins on or after January 1, 2005, you may receive a one time physical exam within the first six months of your new Part B coverage. This will not include laboratory tests. Please contact your plan for further details. You pay $10 for Medicare covered services. You pay 20% for each out of network routine physical exam. You pay $ 10 for each exam. You are covered up to 1 exam every year.

[1] *Each year, you pay a total of one $124 deductible.*

[2] *If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.*

Important Information

ANNUAL DEDUCTIBLE

This plan has an annual deductible, which applies only to the following covered services. Members must pay all costs for these services until they have met their annual plan deductible.

Inpatient Services:
Medicare covered Inpatient Hospital care and associated charges

- Medicare covered Inpatient Mental Health care
- Medicare covered Skilled Nursing Facility care
- Outpatient Services
- Home Health Care including home IV therapy
- Durable Medical Equipment
- Prosthetic devices
- Diabetes self-monitoring supplies
- Medicare-covered ambulance services
- Outpatient surgery in an ambulatory surgical center or outpatient hospital facility
- Medicare covered eye wear
- Inpatient Hospital Care
- Inpatient Mental Health Care
- Skilled Nursing Facility
- Home Health Care
- Chiropractic Services
- Podiatry Services
- Outpatient Mental Health Care
- Outpatient Substance Abuse Care
- Ambulance Services
- Emergency Care
- Urgently Needed Care

Member's cost share for covered services and supplies that will accrue toward the annual deductible (In Network deductible for Plan I is [$1000], Plan II [$500]) will be based on the BC Life and Health contracted rate or, for non-contracted providers, the Medicare allowed amount. Once the member has met the annual deductible for any combination of these services and supplies, BC pays all costs for these services and supplies. Expenses incurred for any service or supply not listed above under annual deductible will not accrue toward the annual deductible.

Following is additional information about some of the benefits listed in this brochure. Please note that Member coinsurance amounts, whenever indicated below, are based on the Freedom Blue PPO contracted rate, or for non-contracted providers, the Medicare allowed amount.

ADDITIONAL INFORMATION:

Outpatient Services
There is a 10% coinsurance for elective, scheduled (non-emergency) Medicare covered services when received at an in network provider. There is a 20% coinsurance if services are received at an out of network provider. Coinsurance will be applied toward the annual $3,000 out of pocket maximum ($5000 if out of network). There is an annual plan deductible of $500 or $1000 ($750 or $1250 if out of network).

Ambulance Services
Freedom Blue PPO offers you coverage for in network Medicare-covered ambulance services for a 10% coinsurance. This coinsurance is for each medically-necessary trip to the hospital or dialysis center, from the hospital or dialysis center, or between facilities. Coinsurance will be applied towards the annual $3000 out of pocket maximum ($5000 if out of network). There is an annual plan deductible of $500 ($750 if out of network).

Important Information

Diabetes Self-Monitoring Supplies

There is no copayment for Diabetes self-monitoring training. You pay 20% of the cost for Diabetes self-monitoring training and Medicare-covered Diabetes Supplies purchased out of network.

A free Glucose meter is available to members of BC Life and Health Freedom Blue Plan by calling Accuchek at (800) 835-8108 from 8AM - 8PM Eastern Time or Lifescan at (888) 611-9891, open 24 hrs. Free Glucose meter is limited to 1 meter per year, per member.

Diagnostic Tests, X-Rays and Lab Services

There is a 10% coinsurance for Diagnostic Tests, X-Rays and Lab Services that are received in-network. There is a 20% coinsurance if services are received out of network.

Coinsurance will be applied towards the annual $3000 out of pocket maximum ($5000 if out of network). There is an annual plan deductible of $500 ($750 if out of network).

Colorectal Screening Exams

There is no copayment for Medicare-covered Colorectal Screening Exams. There is a 20% coinsurance when services are received out of network. Coinsurance will be applied towards the annual $3000 out of pocket maximum ($5000 if out of network). In the event the procedure goes beyond a screening exam and involves biopsy or removal of any growth during the procedure, the procedure will be considered outpatient surgery.

Outpatient Prescription Drugs

Out-of-Network Retail Pharmacy: Member will be responsible for the difference between network and out-of-network retail pharmacy costs, unless it is an emergency or member does not have adequate access to an In-Network Retail Pharmacy.

Non-Preferred Mail Order Pharmacy: Member cost sharing is increased if non-preferred mail order pharmacy is used. Copay for formulary drugs is three (3) times the retail copay for a 90-day supply for Tiers 1 & 2 drugs and 30% coinsurance for Tiers 3 & 4.

90 day supply: A 90 day supply can be obtained through mail order or select retail pharmacies that have contracted to dispense an extended supply.

Freedom Blue PPO provides benefits for Medicare-covered drugs under Medicare Part B with 10% member coinsurance if received at an in network provider (20% coinsurance if received out of network).

As a member of the BC Life and Health Freedom Blue Plan, you are entitled to plan network discounts on prescription drugs that are not included on the formulary. Discounts also apply after you have reached your initial coverage limit ($2250 in claims costs). Please note: once you reach the out of pocket threshold of $3,600, you will qualify for catastrophic coverage.

With the exception of emergency situations, or when the beneficiary cannot reasonably be expected to have access to a network pharmacy, you must use a network pharmacy in order to access your benefits.

Low-income subsidy is extra help with prescription drug costs for Medicare-eligible individuals whose income and resources are limited. This help takes the form of payments to the Prescription Drug Plan. Persons eligible for Medicaid, Supplemental Security Income (SSI), or a Medicare Saving Program qualify for the extra help automatically and do not need to apply. All others may apply beginning July 1, 2005, with Social Security (SSA) by mail, by telephone, on the Internet at http://www.socialsecurity.gov or in person at a community event or an SSA office. Applications may also be filed at the local Medicaid office.

If you have qualified for additional assistance for your Medicare Prescription Drug Plan costs, the amount of your premium and cost at the pharmacy will be less. Once you have enrolled in Freedom Blue, Medicare will tell us how much assistance you are receiving, and we will send you information on the amount you will pay. If you are not receiving this additional assistance, you should contact 1-800-MEDICARE (TTY/TDD users call 877-486- 2048), your State Medicaid Office, or local Social Security Administration Office to see if you might qualify.

Important Information

Routine Hearing Services

You may receive one routine hearing examination per year for Medicare-covered hearing exam for $10 copay. If routine hearing examination is performed out of network, you will have a 20% coinsurance. Payment will be applied towards the annual $3000 out of pocket maximum ($5000 if out of network). Routine hearing exams are performed without relationship to treatment or diagnosis for specific illness, symptom, complaint, or injury and are not required by third parties (i.e., insurance companies, business establishments, governmental agencies). We offer up to $100 coverage per 24-month period for hearing aids.

Vision Care

We offer coverage for one pair of standard eyeglass lenses (including single vision, bifocal and trifocal lenses) and frames up to $75 per 24-month period or one pair of contact lenses up to $95 per 24-month period.

Physical Exams

Freedom Blue PPO provides coverage for 1 physical exam(s) per calendar year with $10 copay (not including lab services). Physical exams are performed without relationship to treatment or diagnosis for specific illness, symptom, complaint or injury and are not required by third parties (i.e., insurance companies, business establishments, governmental agencies).

Satisfaction Guarantee Conversion Option

Gives you the freedom, if you are not completely satisfied with the services you receive, if you are over the age of 65, to have a one-time opportunity to convert from the PPO to our Medicare Supplement Standard Plan A or Select Plan. You can choose the Medicare supplement plan which best suits your needs and BC Life & Health will allow you to conveniently convert your plan without underwriting.

"Seasons" Newsletter

As a member, every three months you will receive a copy of our member newsletter titled "Seasons", which is filled with helpful information about health, travel, cooking, lifestyle topics and the latest information about new products and programs available from BC Life & Health.

Freedom Blue PPO is backed by the stability and financial strength of BC Life & Health Insurance Company. For over 65 years, BC Life & Health has been an industry leader and innovator serving the healthcare needs of generations of Californians.

Freedom Blue is a PPO with a Medicare Advantage contract. To be accepted into Freedom Blue PPO, you must maintain Part A of Medicare and must continue to pay your Part B premiums. If you are not entitled to Medicare Part A benefits, you can purchase Part A from the Social Security Administration. You must continue to pay the Part A premiums and receive care from plan providers. Freedom Blue PPO contracts with the Federal government. Medicare Beneficiaries may be enrolled in only one Part D Plan at a time.

BC Life & Health
Insurance Company

BC Life & Health Insurance Company is an Independent Licensee of the Blue Cross Association (BCA). The Blue Cross name and symbol are registered marks of the BCA.

Medical coverage provided by BC Life & Health Insurance Company

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