FREEDOM BLUE PPO

Freedom Blue PPO℠

Summary of Benefits and Other Value Added Services

BC Life & Health
Insurance Company

R9943 2007 CO 307 9/06

Introduction to Summary of Benefits for Freedom Blue

January 1, 2007 - December 31, 2007
California

Thank you for your interest in Freedom Blue. 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 or list every limitation or exclusion. To get a complete list of our benefits, please call BC Life & 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 Advantage health plan, like Freedom Blue. 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 Freedom Blue 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 this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?

You can compare Freedom Blue Plans 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 AVAILABLE?

The service area for this plan includes: California. You must live in this state to join the plan.

WHO IS ELIGIBLE TO JOIN FREEDOM BLUE?

You can join Freedom Blue 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 not eligible to enroll in Freedom Blue.

CAN I CHOOSE MY DOCTORS?

Freedom Blue has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory for an up-to-date list or visit us at www.bluecrossca.com. Our customer service 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, please call the customer service number at the end of this introduction.

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

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

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

Freedom Blue has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a current Pharmacy Network List or visit us at www.bluecrossca.com. Our customer service number is listed at the end of this introduction.

BC Life & Health Insurance Company has a list of preferred pharmacies. At these pharmacies, you may get your drugs at a lower co-pay or co-insurance. You may go to a non-preferred pharmacy, but you may have to pay more for your prescription drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

Freedom Blue uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits your ability to fill your prescriptions, we will notify you before the change is made. You and you can see our complete formulary on our Web site at www.bluecrossca.com.

If you are currently taking a drug that is not on our formulary or subject to additional requirement or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

HOW CAN I GET EXTRA HELP WITH PRESCRIPTION DRUG PLAN COSTS?

If you qualify for extra help with your Medicare prescription drug plan costs, your premium and costs at the pharmacy will be lower. When you join Freedom Blue, Medicare will tell us how much extra help you are getting. Then we will let you know the amount you will pay. If you are not getting this extra help you can see if you qualify by calling 1-800-Medicare (1-800-633-4227), TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plan members 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 member leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Freedom Blue, you have the right to request a coverage determination. This is the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug.

If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Freedom Blue for more details.

Please call your agent or BC Life & Health Insurance Company for more information about this plan.

CUSTOMER SERVICE HOURS:

Monday through Friday 8:00am to 6:00pm

Current members should call (877)-811-3107 for questions related to the Medicare Advantage program. (TTY/TDD (877)-247-1657). Prospective members should call (888)-211-9813 for questions related to the Medicare Advantage program, (TTY/TDD (800)-297-1538). Current members should call (877)-811-3107 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (877)-247-1657) Prospective members should call (888)-211-9813 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (877)-247-1657).

You can also visit us at www.bluecrossca.com.

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.

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 $93.50 each month.	You pay $0 each month for your plan benefits. You also continue to pay the Medicare Part B Premium of $93.50 each month. You pay a $ 1000 yearly deductible for the following plan services when received in-network or out-of-network: - 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 - Outpatient Rehabilitation Services - Durable Medical Equipment - Prosthetic Devices - Diabetes Self-Monitoring Training, Supplies - Diagnostic Tests, X-Rays, and Lab Services - Hearing Services - Transportation - Comprehensive Outpatient Rehabilitation Facility (CORF) - Partial Hospitalization - Other Health Care Professional - Cardiac Rehabilitation Services - Renal Dialysis - Blood - Medicare Part B Rx Drugs	You pay $25.10 each month for your plan benefits and $24.90 each month for your Medicare Part D prescription benefits. You also continue to pay the Medicare Part B Premium of $93.50 each month. You pay a $500 yearly deductible for the following plan services when received in-network or out-of-network: - 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 - Outpatient Rehabilitation Services - Durable Medical Equipment - Prosthetic Devices - Diabetes Self-Monitoring Training, Supplies - Diagnostic Tests, X-Rays, and Lab Services - Hearing Services - Transportation - Comprehensive Outpatient Rehabilitation Facility (CORF) - Partial Hospitalization - Other Health Care Professional - Cardiac Rehabilitation Services - Renal Dialysis - Blood - Medicare Part B Rx Drugs

IMPORTANT INFORMATION

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
1 – Premium and Other Important Information (cont.)		There is a $3000 maximum out-of-pocket limit every year for all plan services when received in or out-of-network. 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. (See "Annual Deductible and Out-of-Pocket Maximum" on page 20 for more information).	There is a $3000 maximum out-of-pocket limit every year for all plan services when received in or out-of-network. 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. (See "Out-of-Pocket Maximum" on page 20 for more information).
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 the network. Higher costs apply for out-of-network services. You do NOT need a referral to go to an in-network doctor, specialist, and hospital. A separate doctor office visit copayment may apply for certain services. You are covered for U.S. and foreign visitor/travel benefits. Contact plan for details.	You can go to doctors, specialists, and hospitals in or out of the network. Higher costs apply for out-of-network services. You do NOT need a referral to go to an in-network doctor, specialist, and hospital. A separate doctor office visit copayment may apply for certain services. You are covered for U.S. and foreign visitor/travel benefits. Contact plan for details.

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 Days 91-150: $476 each lifetime reserve day4 (This is the 2006 amount and may change for January 1, 2007.) Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.	You pay 10% of the cost for each Medicare-covered stay at a network hospital. You pay 10% 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. You pay 10% 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 10% of the cost for each stay at an 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 10% of the cost for each stay at an 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: $119 for each day (This is the 2006 amount and may change for 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 network Skilled Nursing Facility. You pay 20% of the cost for each stay at a 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 network Skilled Nursing Facility. You pay 20% of the cost for each stay at a 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 from a network provider. You pay 20% of the cost for Medicare-covered home health visits from an out-of-network provider.	You pay 10% of the cost for Medicare-covered home health visits from a network provider. You pay 20% of the cost for Medicare-covered home health visits from an out-of-network provider.
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 in-network primary care doctor office visit for Medicare-covered services. You pay $10 for each in-network specialist visit for Medicare-covered services. You pay 20% of cost for services received from an out-of-network provider. See 32 - Physical Exams for more information.	You pay $10 for each in-network primary care doctor office visit for Medicare-covered services. You pay $10 for each in-network specialist visit for Medicare-covered services. You pay 20% of cost for services received from an out-of-network provider. See 32 - Physical Exams for more information.
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 of each Medicare-covered in-network visit (manual manipulation of the spine to correct subluxation). You pay 20% of cost for services received from an out-of-network provider.	You pay 10% of the cost of each Medicare-covered in-network visit (manual manipulation of the spine to correct subluxation). You pay 20% of cost for services received from an out-of-network provider.
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 in-network visit (medically necessary foot care). You pay 20% of cost for services received from an out-of-network provider.	You pay 10% of the cost for each Medicare-covered in-network visit (medically necessary foot care). You pay 20% of cost for services received from an out-of-network provider.

(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 in-network individual/group therapy visit. You pay 20% of cost for services received from an out-of-network provider.	For Medicare-covered Mental Health services, you pay 10% of the cost for each in-network individual/group therapy visit. You pay 20% of cost for services received from an out-of-network provider.
12 – Outpatient Substance Abuse Care	You pay 20% of Medicare-approved amounts. (1)(2)	For Medicare-covered services you pay 10% for each in-network individual/ group visit. You pay 20% of cost for services received from an out-of-network provider.	For Medicare-covered services you pay 10% for each in-network individual/ group visit. You pay 20% of cost for services received from an out-of-network provider.
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 in-network outpatient hospital facility. You pay 20% of cost for services received from an out-of-network ambulatory surgical center. (See "Outpatient Services / Surgery" on page 21 for more information.)	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 in-network outpatient hospital facility. You pay 20% of cost for services received from an out-of-network ambulatory surgical center. (See "Outpatient Services / Surgery" on page 21 for more information.)
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. (See "Ambulance Services" on page 21 for more information.)	You pay 10% of the cost for Medicare-covered ambulance services. (See "Ambulance Services" on page 21 for more information.)

(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. (See "Foreign Travel Emergency Care" on page 21 for more information.)	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. (See "Foreign Travel Emergency Care" on page 21 for more information.)
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. Worldwide coverage. (See "Foreign Travel Urgently Needed Care" on page 21 for more information.	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. Worldwide coverage. (See "Foreign Travel Urgently Needed Care" on page 21 for more information.
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 in-network Occupational Therapy visit. You pay 10% of the cost for each Medicare-covered in-network Physical Therapy and/or Speech/Language Therapy visit. You pay 20% of cost for services received from an out-of-network provider.	You pay 10% of the cost for each Medicare-covered in-network Occupational Therapy visit. You pay 10% of the cost for each Medicare-covered in-network Physical Therapy and/or Speech/Language Therapy visit. You pay 20% of cost for services received from an out-of-network provider.

(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 wheelchairs, oxygen, etc.)	You pay 20% of Medicare-approved amounts. (1)(2)	You pay 10% of the cost for each Medicare-covered item from an in-network provider. You pay 20% of cost for services received from an out-of-network provider. (See "Durable Medical Equipment and Prosthetic Devices" on page 21 for more information.)	You pay 10% of the cost for each Medicare-covered item from an in-network provider. You pay 20% of cost for services received from an out-of-network provider. (See "Durable Medical Equipment and Prosthetic Devices" on page 21 for more information.)
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 from an in-network provider. You pay 20% of cost for services received from an out-of-network provider.	You pay 10% of the cost for each Medicare-covered item from an in-network provider. You pay 20% of cost for services received from an out-of-network provider.
20 - Diabetes Self-Monitoring Training and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no copayment for Diabetes self-monitoring training. You pay 10% of the cost for each Medicare-covered Diabetes Supply item from an in-network provider. You pay 20% of cost for services received from an out-of-network provider. (See "Diabetes Supplies" on page 22 for more information.)	There is no copayment for Diabetes self-monitoring training. You pay 10% of the cost for each Medicare-covered Diabetes Supply item from an in-network provider. You pay 20% of cost for services received from an out-of-network provider. (See "Diabetic Supplies" on page 22 for more information.)
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% for each Medicare-covered in-network clinical/diagnostic lab service. 10% for each Medicare-covered in-network radiation therapy service. 10% for each Medicare-covered in-network X-ray visit. You pay 20% of cost for services received from an out-of-network provider. (See "Diagnostic Tests and Therapeutic Services" on page 22 for more information.)	You pay: 10% for each Medicare-covered in-network clinical/diagnostic lab service. 10% for each Medicare-covered radiation in-network therapy service. 10% for each Medicare-covered in-network X-ray visit. You pay 20% of cost for services received from an out-of-network provider. (See "Diagnostic Tests and Therapeutic Services" on page 22 for more information.)

(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 in-network Bone Mass Measurement. You pay 20% of cost for services	There is no copayment for each Medicare-covered in-network Bone Mass Measurement. You pay 20% of cost for services
23 - Colorectal Screening Exams (for people with Medicare age 50 and older)	You pay 20% of Medicare-approved amounts. (1)(2)	received from an out-of-network provider. There is no copayment for Medicare-covered in-network Colorectal Screening Exams You pay 20% of cost for services received from an out-of-network provider. (See "Colorectal Screening Exams" on page 22 for more information.)	received from an out-of-network provider. There is no copayment for Medicare-covered in-network Colorectal Screening Exams You pay 20% of cost for services received from an out-of-network provider. (See "Colorectal Screening Exams" on page 22 for more information.)
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 the Pneumonia and Flu vaccines obtained from an in-network provider. No referral necessary for Medicare-covered influenza and pneumonia vaccines. No referral necessary for other immunizations. There is no copayment for the Hepatitis B vaccine obtained from a network provider. You pay 20% of cost for services received from an out-of-network provider.	There is no copayment for the Pneumonia and Flu vaccines obtained from an in-network provider. No referral necessary for Medicare-covered influenza and pneumonia vaccines. No referral necessary for other immunizations. There is no copayment for the Hepatitis B vaccine obtained from a network provider. You pay 20% of cost for services received from an out-of-network provider.
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 in-network Screening Mammograms. No referral necessary for Medicare-covered screenings. You pay 20% of cost for services received from an out-of-network provider.	There is no copayment for Medicare-covered in-network Screening Mammograms. No referral necessary for Medicare-covered screenings. You pay 20% of cost for services received from an out-of-network provider.

(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 in-network Pap Smears and Pelvic Exams. You pay 20% of cost for services received from an out-of-network provider.	There is no copayment for Medicare-covered in-network Pap Smears and Pelvic Exams. You pay 20% of cost for services received from an out-of-network provider.
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 in-network Prostate Cancer Screening exams. You pay 20% of cost for services received from an out-of-network provider.	There is no copayment for Medicare-covered in-network Prostate Cancer Screening exams. You pay 20% of cost for services received from an out-of-network provider.

(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
28 - Outpatient Prescription Drugs	You pay 100% for most prescription drugs, unless you enroll in the Medicare Part D Prescription Drug program.		
Drugs covered under Medicare Part B (Original Medicare)		You pay 10 % of the cost for Part B-covered drugs at network pharmacies.	You pay 10 % of the cost for Part B-covered drugs at network pharmacies.
Drugs covered under Medicare Part D (Prescription Drug Benefit)		This plan uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits your ability to fill your prescriptions, we will notify you before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at www.bluecrossca.com. People who have limited incomes, who live in long term care facilities, or who have access to Indian/Tribal/Urban (Indian Health Service) facilities may have different out-of-pocket drug costs. Contact plan for details.	This plan uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits your ability to fill your prescriptions, we will notify you before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at www.bluecrossca.com. People who have limited incomes, who live in long term care facilities, or who have access to Indian/Tribal/Urban (Indian Health Service) facilities may have different out-of-pocket drug costs. Contact plan for details.
Deductible		There is no deductible.	There is no deductible.
Initial Coverage		Before the total yearly drug costs (paid by both you and your plan) reach $2400, you pay the following for prescription drugs:	Before the total yearly drug costs (paid by both you and your plan) reach $2400, you pay the following for prescription drugs:

ADDITIONAL BENEFITS (What Original Medicare Does Not Cover)

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
In-Network Retail Pharmacy		- $10 for a one month (30 day) supply of Generic drugs - $30 for a one month (30 day) supply of Preferred Brand drugs - $60 for a one month (30 day) supply of Non-Preferred Brand drugs - 30% coinsurance for a one month (30 day) supply of Non-Specialty Injectables drugs - 30% coinsurance for a one month (30 day) supply of Specialty Injectables drugs - $30 for a three month (90 day) supply of Generic drugs - $90 for a three month (90 day) supply of Preferred Brand drugs - $180 for a three month (90 day) supply of Non-Preferred Brand drugs - 30% coinsurance for a three month (90 day) supply of Non-Specialty Injectables drugs - 30% coinsurance for a three month (90 day) supply of Specialty Injectables drugs	- $10 for a one month (30 day) supply of Generic drugs - $30 for a one month (30 day) supply of Preferred Brand drugs - $60 for a one month (30 day) supply of Non-Preferred Brand drugs - 30% coinsurance for a one month (30 day) supply of Non-Specialty Injectables drugs - 30% coinsurance for a one month (30 day) supply of Specialty Injectables drugs - $30 for a three month (90 day) supply of Generic drugs - $90 for a three month (90 day) supply of Preferred Brand drugs - $180 for a three month (90 day) supply of Non-Preferred Brand drugs - 30% coinsurance for a three month (90 day) supply of Non-Specialty Injectables drugs - 30% coinsurance for a three month (90 day) supply of Specialty Injectables drugs
Mail Order		- $15 for a three month (90 day) supply of Generic drugs you get through a preferred mail order - $75 for a three month (90 day) supply of Preferred Brand drugs you get through a preferred mail order - $150 for a three month (90 day) supply of Non-Preferred Brand drugs you get through a preferred mail order - 25% coinsurance for a three month (90 day) supply of Non-Specialty Injectables drugs you get through a preferred mail order	- $15 for a three month (90 day) supply of Generic drugs you get through a preferred mail order - $75 for a three month (90 day) supply of Preferred Brand drugs you get through a preferred mail order - $150 for a three month (90 day) supply of Non-Preferred Brand drugs you get through a preferred mail order - 25% coinsurance for a three month (90 day) supply of Non-Specialty Injectables drugs you get through a preferred mail order

ADDITIONAL BENEFITS (What Original Medicare Does Not Cover)

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
Mail Order (cont.)		- 25% coinsurance for a three month (90 day) supply of Specialty Injectables drugs you get through a preferred mail order - $30 for a three month (90 day) supply of Generic drugs you get through a non-preferred mail order - $90 for a three month (90 day) supply of Preferred Brand drugs you get through a non-preferred mail order - $180 for a three month (90 day) supply of Non-Preferred Brand drugs you get through a non-preferred mail order - 25% coinsurance for a three month (90 day) supply of Non-Specialty Injectables drugs you get through a non-preferred mail order - 25% coinsurance for a three month (90 day) supply of Specialty Injectables drugs you get through a non-preferred mail order	- 25% coinsurance for a three month (90 day) supply of Specialty Injectables drugs you get through a preferred mail order - $30 for a three month (90 day) supply of Generic drugs you get through a non-preferred mail order - $90 for a three month (90 day) supply of Preferred Brand drugs you get through a non-preferred mail order - $180 for a three month (90 day) supply of Non-Preferred Brand drugs you get through a non-preferred mail order - 25% coinsurance for a three month (90 day) supply of Non-Specialty Injectables drugs you get through a non-preferred mail order - 25% coinsurance for a three month (90 day) supply of Specialty Injectables drugs you get through a non-preferred mail order
Coverage After You Reach Your Initial Coverage Limit		You pay the following:	You pay the following:
In-Network Retail Pharmacy		- $10 for a one month (30 day) supply of Generic drugs - $30 for a three month (90 day) supply of Generic drugs	- $10 for a one month (30 day) supply of Generic drugs - $30 for a three month (90 day) supply of Generic drugs
Mail Order		- $15 for a three month (90 day) supply of Generic drugs you get through a preferred mail order - $30 for a three month (90 day) supply of Generic drugs you get through a non-preferred mail order	- $15 for a three month (90 day) supply of Generic drugs you get through a preferred mail order - $30 for a three month (90 day) supply of Generic drugs you get through a non-preferred mail order

ADDITIONAL BENEFITS (What Original Medicare Does Not Cover)

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
Mail Order (cont.)		For all other covered drugs and after the total yearly drug costs (paid by both you and your plan) reach $ 2400, you pay 100% of your prescription drug costs up until your yearly out-of-pocket drug costs reach $ 3850.	For all other covered drugs and after the total yearly drug costs (paid by both you and your plan) reach $ 2400, you pay 100% of your prescription drug costs up until your yearly out-of-pocket drug costs reach $ 3850.
Catastrophic Coverage		After your yearly out-of-pocket drug costs reach $3850 you pay the greater of: $2.15 for generic (including brand drugs treated as generic) and $5.35 for all other drugs, or 5% coinsurance, whichever is greater	After your yearly out-of-pocket drug costs reach $3850 you pay the greater of: $2.15 for generic (including brand drugs treated as generic) and 5.35 for all other drugs, or 5% coinsurance, whichever is greater.
General Information		In some cases, the plan requires you to first try one drug to treat your medical condition before they will cover another drug for that condition. Certain prescription drugs will have maximum quantity limits. Your provider must get prior authorization from Freedom Blue for certain prescription drugs. Some of the drugs covered by this plan do not count toward your out-of-pocket expenses. Covered Part D drugs are available at out-of-network pharmacies in special circumstances including illness while traveling outside of the plan's service area where there is no network pharmacy. You may also incur an additional cost for drugs received at an out-of-network pharmacy. Please contact the plan for details.	In some cases, the plan requires you to first try one drug to treat your medical condition before they will cover another drug for that condition. Certain prescription drugs will have maximum quantity limits. Your provider must get prior authorization from Freedom Blue for certain prescription drugs. Some of the drugs covered by this plan do not count toward your out-of-pocket expenses. Covered Part D drugs are available at out-of-network pharmacies in special circumstances including illness while traveling outside of the plan's service area where there is no network pharmacy. You may also incur an additional cost for drugs received at an out-of-network pharmacy. Please contact the 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 in-network hearing exam (diagnostic hearing exams). - $10 for each routine in-network hearing test up to 1 test(s) every year. You are covered up to $ 100 for hearing aids every two years. You pay 20% of cost for services received from an out-of-network provider. (See "Routine Hearing Services" on page 23 for more information.)	There is no copayment for hearing aids. You pay: - $10 for each Medicare-covered in-network hearing exam (diagnostic hearing exams). - $10 for each routine in-network hearing test up to 1 test(s) every year. You are covered up to $ 100 for hearing aids every two years. You pay 20% of cost for services received from an out-of-network provider. (See "Routine Hearing Services" on page 23 for more information.)
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 pair of eyeglasses or contact lenses after each cataract surgery). Glasses, limited to 1 pair of glasses every two years. Contacts, limited to 1 pair of contacts every two years. You pay: - $20 for each Medicare-covered in-network eye exam (diagnosis and treatment for diseases and conditions of the eye) . - $20 of the cost for each in-network Routine eye exam, limited to 1exam(s) every year.	There is no copayment for the following items: Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery). Glasses, limited to 1 pair of glasses every two years. Contacts, limited to 1 pair of contacts every two years. You pay: - $20 for each Medicare-covered in-network eye exam (diagnosis and treatment for diseases and conditions of the eye) . - $20 of the cost for each in-network Routine eye exam, limited to 1exam(s) 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 are covered up to $175 for eye wear every two years. You pay 20% of cost for services received from an out-of-network provider. (See "Vision Services" on page 23 for more information.)	You are covered up to $175 for eye wear every two years. You pay 20% of cost for services received from an out-of-network provider. (See "Vision Services" on page 23 for more information.)
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 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 obtained from an in-network provider. You pay $10 for each in-network exam. You are covered up to 1 exam every year. You pay 20% of cost for services received from an out-of-network provider. (See "Routine Physical Exams" on page 23 for more information.)	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 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 obtained from an in-network provider. You pay $10 for each in-network exam. You are covered up to 1 exam every year. You pay 20% of cost for services received from an out-of-network provider. (See "Routine Physical Exams" on page 23 for more information.)

(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.

FREEDOM BLUE IMPORTANT PLAN INFORMATION

Freedom Blue plans were created to provide seniors and other Medicare beneficiaries with access to broad coverage for medically-necessary hospital and doctor services with low monthly plan premiums. Plans include valuable brand and generic prescription drug benefits and coverage for routine vision care and hearing examinations.

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

ANNUAL DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM

Freedom Blue plans have an annual deductible. Members must pay all costs for these services until they have met their annual plan deductible. Office visit copayments, preventive services, routine hearing, vision, emergency room visits and physical exams are not subject to the annual deductible.

The deductible for Plan I $1000 and Plan II $500 will be based on the BC Life and Health contracted rate or, for non-contracted providers, the Medicare allowed amount. Expenses incurred for any service or supply not listed in this summary of benefits will not accrue toward the annual deductible.

The annual out of pocket maximum is $3000 for in network and out of network services. Once your annual out of pocket maximum is reached, the plan will cover Medicare covered services at 100%.

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

IMPORTANT PLAN INFORMATION

OUTPATIENT SERVICES / SURGERY

The office visit copayment of $10 will apply for any associated physician services (non-surgical) rendered in an outpatient hospital facility. In addition, the 10% outpatient surgery coinsurance applies for elective, scheduled (non-urgent, non-emergency) Medicare-covered surgeries when performed in an outpatient hospital or ambulatory surgical center.

There is a 20% coinsurance if outpatient services are received at an out of network ambulatory surgical center only.

AMBULANCE SERVICES

Freedom Blue offers you coverage for Medicare-covered ambulance services with 10% coinsurance. This coinsurance amount is for each medically-necessary trip to the hospital or dialysis center, from the hospital or dialysis center, or between different facilities associated with medically necessary and covered services. Ambulance services apply to the annual plan deductible.

Coinsurance will be applied towards the annual $3000 out of pocket maximum.

FOREIGN TRAVEL EMERGENCY CARE

Freedom Blue offers coverage for medically necessary emergency room services with a $50 copayment while traveling outside the United States during a temporary absence of less than 6 months. The copay is not waived if member is admitted to a foreign hospital while traveling.

Inpatient coinsurance applies for emergent or urgent inpatient admissions while traveling outside the United States. This benefit is limited to 60 days per lifetime.

FOREIGN TRAVEL URGENTLY NEEDED CARE

Freedom Blue provides members with coverage for urgently needed care at a foreign urgent care center or foreign physician's office with a 10% coinsurance while member is traveling outside the United States, during a temporary absence of less than 6 months. This coinsurance is not waived if member is admitted to hospital.

Inpatient coinsurance applies for emergent or urgent inpatient admissions while traveling outside the United States. This benefit is limited to 60 days per lifetime.

DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES

Examples of Durable Medical Equipment include items such as oxygen, wheelchairs, walkers, and hospital beds needed for use in the home.

Examples of Prosthetic Devices include arm, leg, back, and neck braces; artificial eyes; artificial limbs (and their replacement parts); breast prostheses (after mastectomy); and prosthetic devises needed to replace an internal body part or function.

Medically necessary Durable Medical Equipment and Prosthetic Devices are covered with a 10% coinsurance when obtained from in-network providers and 20% coinsurance out-of-network.

IMPORTANT PLAN INFORMATION

DIABETES SUPPLIES

There is no copayment for diabetes self-monitoring training, however an office visit copay may apply for an associated office visit. Blood glucose meters/glucose monitors will be covered with a 10% coinsurance.

Blood glucose test strips, lancet devices and lancets, and glucose control solutions are covered diabetes supplies with a 10% coinsurance.

Supplies associated with the injection of insulin, specifically syringes, needles, alcohol swabs, and gauze are covered under Medicare Part D and no longer covered in Medicare Part B. This plan does include Part D drug benefits, this plan will include coverage for these items.

DIAGNOSTIC TESTS AND THERAPEUTIC SERVICES

A 10% coinsurance for most clinical or diagnostic lab services, however an additional $10 copayment may apply for an associated office visit.

A 10% coinsurance for Complex Diagnostic tests. These tests include: MRIs, PET scans, CT scans, nuclear medicine studies, EKGs, and cardiac stress tests. An $10 office visit copayment may apply for an associated office visit.

A 10% coinsurance applies for radiological therapeutic lab services (Radiation Therapy), renal dialysis, and chemotherapy regardless of place of treatment.

An $10 office visit copayment may apply for an associated office visit.

There is a 20% coinsurance for all diagnostic services if received out of network. Diagnostic Tests and Therapeutic Services apply to annual plan deductible.

COLORECTAL SCREENING EXAMS

Colorectal screening exams are covered with no copayment. In the event the procedure goes beyond a screening exam and involves biopsy or removal of any growth, the procedure will be considered outpatient surgery and the outpatient surgery coinsurance will apply.

OUTPATIENT PRESCRIPTION DRUGS

Freedom Blue provides benefits for Medicare Part B-covered drugs with 10% coinsurance when received in-network.

There is a 20% coinsurance if Medicare Part B covered drugs are received out of network.

OUT-OF-NETWORK RETAIL COVERAGE

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 Pharmacy.

90 DAY SUPPLY

A 90 Day supply for most prescriptions can be obtained through mail order or select retail pharmacies that have contracted to dispense an extended supply.

IMPORTANT PLAN INFORMATION

GENERIC BENZODIAZEPINES AND BARBITURATES

Freedom Blue provides coverage for Generic Benzodiazepines and Barbiturates. Copayments for these drugs do not count toward your total drug costs or your true out-of-pocket expenses. Generic Benzodiazepines and Barbiturates are covered even after your total drug costs reach $2400 and your total out-of-pocket expenses reach $3850. The copayments for these generic drugs always apply, regardless of whether you have met either of these coverage limits.

The Medicare Prescription Drug Benefit is available to members of the Medicare Advantage Prescription Drug Plan, Freedom Blue Plan I and Plan II. If a beneficiary is already enrolled in a Medicare Advantage Part D Plan or a stand alone Prescription Drug plan, then the beneficiary will be automatically disenrolled from their old plan and will be enrolled in the Freedom Blue plan and will receive their prescription drug benefit through Freedom Blue.

ROUTINE HEARING SERVICES

Freedom Blue members are covered for one routine screening hearing exam every 24 months with a $10 copayment. Routine screening hearing exams are performed without relationship to treatment or diagnosis for specific illness, symptom, complaint, or injury.

VISION CARE

Freedom Blue members pay no copayment for Medicare covered eyewear following cataract surgery.

Freedom Blue members pay $20 copay for a routine eye examination each calendar year. Services must be obtained from an in network provider or Vision Service Plan (VSP). Routine eye exams are for the purpose of prescribing, fitting, changing eye glasses (and contact lenses), or determining the refractive state of the eyes.

We offer 100% coverage for one pair of standard eyeglass lenses (including single vision, bifocal and trifocal lenses) and frames up to $150 per 24-month period or one pair of contact lenses up to $175 per 24-month period.

ROUTINE PHYSICAL EXAMS

Freedom Blue provides coverage for one routine physical exam each year with a $10 copayment (not including lab services). Routine physical exams are performed without relationship to treatment or diagnosis for specific illness, symptom, complaint or injury.

OTHER VALUE ADDED SERVICES

PASSPORT SAVINGS PROGRAM*

As a Freedom Blue Member, you automatically receive membership in the Passport Savings Program at no additional charge. With the Passport Savings Program, you receive year-round access to a wide range of discount programs and information services. Here's an example of what the program consists of:

HealthyExtensions - Tells you about discounts offered by independent vendors to help members meet their personal fitness and wellness goals.

Included are discounts on a variety of nutritional supplements and educational products.

PLUS, save on:

– Eyewear

– Gym Memberships

– Hearing Aids

– Weight Management Programs

– Smoking Cessation Programs

*Discounts are offered by independent vendors and may be withdrawn or changed at any time without notice.

These products and services are not subject to the Medicare appeals process. Freedom Blue has arranged for the availability of these discount offers as a service to our members, however we do not endorse or in any way assume responsibility or liability for the goods and services offered. The companies making these offers are solely responsible for them and any products or services they furnish. Any disputes regarding these products and services must be settled between the Freedom Blue member and the independent vendor offering the product or service.

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