Summary of Benefits for Freedom Blue Plans I and II

Available in California

BC Life & Health Insurance Company (BCL&H) is the legal entity who has contracted with the Centers for Medicare and Medicaid Services (CMS) to offer the Medicare Advantage Regional PPO plan(s) (MAPD-RPPO) noted above or herein. BCL&H is the risk-bearing entity licensed under applicable state law to offer the MAPD-RPPO plan(s) noted. BCL&H has retained the services of its related companies and authorized agents/brokers/producers to provide administrative services and/or to make the MAPD-RPPO plan(s) available in this region.

Si usted necesita asistencia en español para poder entender este documento, podrá requerirla sin costo alguno llamándonos gratis al numero telefónico que se muestra en este material.

BC Life & Health Insurance Company

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Section 1

Introduction to the Summary of Benefits for Freedom Blue Plans I and II

January 1, 2008 - December 31, 2008

Thank you for your interest in Freedom Blue Plans I and II. Our plans are offered by BC Life & Health Insurance Company, a Medicare Advantage Preferred Provider Organization (PPO). This Summary of Benefits tells you some features of our plans. 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 Freedom Blue 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 Freedom Blue Plans I and II. 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 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 I and II 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 plans cover 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 Are Freedom Blue Plans I and II Available?

The service area for these plans includes: California. You must live in this area to join these plans.

Who Is Eligible to Join Freedom Blue Plan I or II?

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

Can I Choose My Doctors?

Freedom Blue Plans I and II have 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 I and II do 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 Plans I and II have 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 copay or coinsurance. 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 Plans I and II use 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 our members' ability to fill their prescriptions, we will notify the affected enrollees 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.**

If you are currently taking a drug that is not on our formulary or subject to additional requirements 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 Plan I or II, 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 Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 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 Plan I or II, you have the right to request a coverage determination, which includes 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 BC Life & Health Insurance Company for more information about these plans.

Visit us at **www.bluecrossca.com** or call us.

Customer Service Hours: Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8 a.m. to 8 p.m.

Current members should call **1-877-811-3107** for questions related to the **Medicare Advantage** program (TTY/TDD: 1-888-877-5378).

Prospective members should call **1-888-211-9813** for questions related to the **Medicare Advantage** program (TTY/TDD: 1-800-297-1538).

Current members should call **1-877-811-3107** for questions related to the **Medicare Part D Prescription Drug** program (TTY/TDD: 1-888-877-5378).

Prospective members should call **1-888-211-9813** for questions related to the **Medicare Part D Prescription Drug** program (TTY/TDD: 1-800-297-1538).

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.

Section 2
Summary of Benefits for Freedom Blue Plans I and II

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

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
Important Information			
1. Premium and Other Important Information	You pay the Medicare Part B premium each month. (This amount is $93.50 in 2007, and it may change in 2008.) Most people will pay the standard monthly Part B premium. However, some people will have to pay a higher premium because of their yearly income. For more information on Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.	***General*** $0 monthly plan premium in addition to your monthly Medicare Part B premium. (This amount is $93.50 in 2007, and it may change in 2008.) ***Out-of-Network*** Unless otherwise noted, out-of-network services not covered. ***In- and Out-of-Network*** $1,125 yearly deductible. Contact the plan for services that apply. $3,000 out-of-pocket limit. Contact the plan for services that apply. *See p. 28 for additional information about Premium and Other Important Information.*	***General*** $50 monthly plan premium in addition to your monthly Medicare Part B premium. (This amount is $93.50 in 2007, and it may change in 2008.) ***Out-of-Network*** Unless otherwise noted, out-of-network services not covered. ***In- and Out-of-Network*** $600 yearly deductible. Contact the plan for services that apply. $3,000 out-of-pocket limit. Contact the plan for services that apply. *See p. 28 for additional information about Premium and Other Important Information.*

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
2. Doctor and Hospital Choice (For more information, see Emergency - #15 and Urgently Needed Care - #16.)	You may go to any doctor, specialist or hospital that accepts Medicare.	***In-Network*** Referral required for network specialists (for certain benefits). You may have to pay a separate copay for certain doctor office visits.	***In-Network*** No referral required for network doctors, specialists and hospitals. You may have to pay a separate copay for certain doctor office visits. ***Out-of-Network*** You will pay less if you get prior authorization or let the plan know before you get an out-of-network benefit.
Inpatient Care			
3. Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	For each benefit period[3]: ▪ Days 1 - 60: an initial deductible of $992 in 2007 ▪ Days 61 - 90: $248 per day in 2007 ▪ Days 91 - 150: $496 per lifetime reserve day in 2007 These amounts may change in 2008. Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days[4] Lifetime reserve days can only be used once.	***In-Network*** 10% of the cost for each Medicare-covered hospital stay $0 copay for additional hospital days No limit to the number of days covered by the plan each benefit period. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	***In-Network*** 10% of the cost for each Medicare-covered hospital stay $0 copay for additional hospital days No limit to the number of days covered by the plan each benefit period. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

[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 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.

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
	A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	***Out-of-Network*** 10% of the cost for each hospital stay	***Out-of-Network*** 10% of the cost for each hospital stay
4. Inpatient Mental Health Care	Same deductible and copay as inpatient hospital care (See "Inpatient Hospital Care" above.) 190-day limit in a Psychiatric Hospital	***In-Network*** 10% of the cost for each Medicare-covered hospital stay You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. ***Out-of-Network*** 10% of the cost for each hospital stay	***In-Network*** 10% of the cost for each Medicare-covered hospital stay You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. ***Out-of-Network*** 10% of the cost for each hospital stay
5. Skilled Nursing Facility (in a Medicare-certified Skilled Nursing Facility)	For each benefit period[3] after at least a 3-day covered hospital stay: ▪ Days 1 - 20: $0 per day in 2007 ▪ Days 21 - 100: $124 per day in 2007 These amounts may change in 2008. 100 days for each benefit period	***General*** Prior authorization is required. ***In-Network*** For SNF stays: Days 1 - 10: 0% of the cost per day	***General*** Prior authorization is required. ***In-Network*** For SNF stays: Days 1 - 10: 0% of the cost per day

[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 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.

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
	A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	Days 11 - 100: 10% of the cost per day 100 days covered for each benefit period. No prior hospital stay is required. ***Out-of-Network*** 15% of the cost for SNF benefits.	Days 11 - 100: 10% of the cost per day 100 days covered for each benefit period. No prior hospital stay is required. ***Out-of-Network*** 15% of the cost for SNF benefits.
6. Home Health Care (includes medically necessary, intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	$0 copay	***General*** Authorization rules may apply. ***In-Network*** 10% of the cost for each Medicare-covered home health visit. ***Out-of-Network*** 15% for home health visits.	***General*** Authorization rules may apply. ***In-Network*** 10% of the cost for each Medicare-covered home health visit. ***Out-of-Network*** 15% for home health visits.
7. Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	***In-Network*** You must get care from a Medicare-certified hospice.	***In-Network*** You must get care from a Medicare-certified hospice.

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
Outpatient Care			
8. Doctor Office Visits	20% coinsurance[1, 2]	***General*** See "Routine Physical Exams" for more information. ***In-Network*** $10 copay for each primary care doctor visit for Medicare-covered benefits. $10 copay for each specialist visit for Medicare-covered benefits. ***Out-of-Network*** 15% for each primary care doctor visit. 15% for each specialist visit. *See p. 28 for additional information about Doctor Office Visits.*	***General*** See "Routine Physical Exams" for more information. ***In-Network*** $10 copay for each primary care doctor visit for Medicare-covered benefits. $10 copay for each specialist visit for Medicare-covered benefits. ***Out-of-Network*** 15% for each primary care doctor visit. 15% for each specialist visit. *See p. 28 for additional information about Doctor Office Visits.*
9. Chiropractic Services	20% coinsurance Routine care not covered 20% coinsurance for manual manipulation of the spine to correct subluxation if you get it from a chiropractor or other qualified provider	***General*** Authorization rules may apply. ***In-Network*** 10% of the cost for Medicare-covered visits.	***General*** Authorization rules may apply. ***In-Network*** 10% of the cost for Medicare-covered visits.

[1] Each year, you pay a total of one deductible. In 2007, this deductible is $131, and it may change in 2008.

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

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
		Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part. ***Out-of-Network*** 15% of the cost for chiropractic benefits.	Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part. ***Out-of-Network*** 15% of the cost for chiropractic benefits.
10. Podiatry Services	20% coinsurance[1, 2] Routine care not covered 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs	***In-Network*** 10% of the cost for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care. ***Out-of-Network*** 15% of the cost for podiatry benefits.	***In-Network*** 10% of the cost for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care. ***Out-of-Network*** 15% of the cost for podiatry benefits.
11. Outpatient Mental Health Care	50% coinsurance for most outpatient mental health services	***General*** Authorization rules may apply. ***In-Network*** 10% of the cost for each Medicare-covered individual or group therapy visit. ***Out-of-Network*** 15% of the cost for Mental Health benefits.	***General*** Authorization rules may apply. ***In-Network*** 10% of the cost for each Medicare-covered individual or group therapy visit. ***Out-of-Network*** 15% of the cost for Mental Health benefits.

[1] Each year, you pay a total of one deductible. In 2007, this deductible is $131, and it may change in 2008.

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

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
		15% of the cost for Mental Health benefits with a psychiatrist.	15% of the cost for Mental Health benefits with a psychiatrist.
12. Outpatient Substance Abuse Care	20% coinsurance[1, 2]	***General*** Authorization rules may apply. ***In-Network*** 10% of the cost for Medicare-covered individual or group visits. ***Out-of-Network*** 15% of the cost for outpatient substance abuse benefits.	***General*** Authorization rules may apply. ***In-Network*** 10% of the cost for Medicare-covered individual or group visits. ***Out-of-Network*** 15% of the cost for outpatient substance abuse benefits.
13. Outpatient Services/Surgery	20% coinsurance for the doctor[1, 2] 20% of outpatient facility[1, 2]	***General*** Authorization rules may apply. ***In-Network*** $100 copay for each Medicare-covered ambulatory surgical center visit. 10% of the cost for each Medicare-covered outpatient hospital facility visit. ***Out-of-Network*** 20% of the cost for ambulatory surgical center benefits.	***General*** Authorization rules may apply. ***In-Network*** $100 copay for each Medicare-covered ambulatory surgical center visit. 10% of the cost for each Medicare-covered outpatient hospital facility visit. ***Out-of-Network*** 20% of the cost for ambulatory surgical center benefits.

[1] Each year, you pay a total of one deductible. In 2007, this deductible is $131, and it may change in 2008.

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

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
		10% of the cost for outpatient hospital facility benefits. *See p. 28 for additional information about Outpatient Services/Surgery.*	10% of the cost for outpatient hospital facility benefits. *See p. 28 for additional information about Outpatient Services/Surgery.*
14. Ambulance Services (medically necessary ambulance services)	20% coinsurance[1, 2]	***In-Network*** $125 copay for Medicare-covered ambulance benefits. ***Out-of-Network*** $125 copay for ambulance benefits. *See p. 28 for additional information about Ambulance Services.*	***In-Network*** $125 copay for Medicare-covered ambulance benefits. ***Out-of-Network*** $125 copay for ambulance benefits. *See p. 28 for additional information about Ambulance Services.*
15. Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor[1, 2] 20% of facility charge or a set copay per emergency room visit[1, 2] You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. NOT covered outside the U.S. except under limited circumstances	***In-Network*** $50 copay for Medicare-covered emergency room visits. ***Out-of-Network*** Worldwide coverage ***In- and Out-of-Network*** If you are admitted to the hospital within 72 hour(s) for the same condition, you pay $0 for the emergency room visit. *See p. 28 for additional information about Emergency Care.*	***In-Network*** $50 copay for Medicare-covered emergency room visits. ***Out-of-Network*** Worldwide coverage ***In- and Out-of-Network*** If you are admitted to the hospital within 72 hour(s) for the same condition, you pay $0 for the emergency room visit. *See p. 28 for additional information about Emergency Care.*

[1] Each year, you pay a total of one deductible. In 2007, this deductible is $131, and it may change in 2008.

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

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
16. Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	20% coinsurance or a set copay[1,2] NOT covered outside the U.S. except under limited circumstances	***General*** $50 copay for Medicare-covered urgently needed care visits. If you are admitted to the hospital within 72 hour(s) for the same condition: $0 for the urgent-care visit.	***General*** $50 copay for Medicare-covered urgently needed care visits. If you are admitted to the hospital within 72 hour(s) for the same condition: $0 for the urgent-care visit.
17. Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance[1, 2]	***General*** Authorization rules may apply. ***In-Network*** 10% of the cost for Medicare-covered Occupational Therapy visits. 10% of the cost for Medicare-covered Physical and/or Speech/Language Therapy visits. ***Out-of-Network*** 15% of the cost for Occupational Therapy benefits. 15% of the cost for Physical and/or Speech/Language Therapy visits.	***General*** Authorization rules may apply. ***In-Network*** 10% of the cost for Medicare-covered Occupational Therapy visits. 10% of the cost for Medicare-covered Physical and/or Speech/Language Therapy visits. ***Out-of-Network*** 15% of the cost for Occupational Therapy benefits. 15% of the cost for Physical and/or Speech/Language Therapy visits.
Outpatient Medical Services and Supplies			
18. Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance[1, 2]	***In-Network*** 10% of the cost for Medicare-covered items.	***In-Network*** 10% of the cost for Medicare-covered items.

[1] Each year, you pay a total of one deductible. In 2007, this deductible is $131, and it may change in 2008.

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

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
		Out-of-Network 15% of the cost for durable medical equipment. *See p. 28 for additional information about Durable Medical Equipment.*	***Out-of-Network*** 15% of the cost for durable medical equipment. *See p. 28 for additional information about Durable Medical Equipment.*
19. Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	20% coinsurance[1, 2]	***General*** Authorization rules may apply. ***In-Network*** 10% of the cost for Medicare-covered items. ***Out-of-Network*** 15% of the cost for prosthetic devices. *See p. 28 for additional information about Prosthetic Devices.*	***General*** Authorization rules may apply. ***In-Network*** 10% of the cost for Medicare-covered items. ***Out-of-Network*** 15% of the cost for prosthetic devices. *See p. 28 for additional information about Prosthetic Devices.*
20. Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)	20% coinsurance[1, 2]	***In-Network*** $0 copay for Diabetes self-monitoring training. $0 copay for Nutrition Therapy for Diabetes. 10% of the cost for Diabetes supplies.	***In-Network*** $0 copay for Diabetes self-monitoring training. $0 copay for Nutrition Therapy for Diabetes. 10% of the cost for Diabetes supplies.

[1] Each year, you pay a total of one deductible. In 2007, this deductible is $131, and it may change in 2008.

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

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
		Out-of-Network 15% of the cost for Diabetes self-monitoring training. 15% of the cost for Nutrition Therapy for Diabetes. 15% of the cost for Diabetes supplies. *See p. 29 for additional information about Diabetes Self-Monitoring Training, Nutrition Therapy and Supplies.*	***Out-of-Network*** 15% of the cost for Diabetes self-monitoring training. 15% of the cost for Nutrition Therapy for Diabetes. 15% of the cost for Diabetes supplies. *See p. 29 for additional information about Diabetes Self-Monitoring Training, Nutrition Therapy and Supplies.*
21. Diagnostic Tests, X-Rays, and Lab Services	20% coinsurance for diagnostic tests and x-rays [1, 2] $0 copay for Medicare-covered lab services Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.	***General*** Authorization rules may apply. ***In-Network*** 10% of the cost for Medicare-covered lab services. 10% of the cost for Medicare-covered diagnostic procedures and tests. 10% of the cost for Medicare-covered X-rays. 10% of the cost for Medicare-covered diagnostic radiology services. 10% of the cost for Medicare-covered therapeutic radiology services.	***General*** Authorization rules may apply. ***In-Network*** 10% of the cost for Medicare-covered lab services. 10% of the cost for Medicare-covered diagnostic procedures and tests. 10% of the cost for Medicare-covered X-rays. 10% of the cost for Medicare-covered diagnostic radiology services. 10% of the cost for Medicare-covered therapeutic radiology services.

[1] Each year, you pay a total of one deductible. In 2007, this deductible is $131, and it may change in 2008.

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

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
		Out-of-Network 15% of the cost for diagnostic procedures, tests and lab services. 15% of the cost for therapeutic radiology services. 15% of the cost for diagnostic radiology services. *See p. 29 for additional information about Diagnostic Tests, X-Rays and Lab Services.*	***Out-of-Network*** 15% of the cost for diagnostic procedures, tests and lab services. 15% of the cost for therapeutic radiology services. 15% of the cost for diagnostic radiology services. *See p. 29 for additional information about Diagnostic Tests, X-Rays and Lab Services.*
Preventive Services			
22. Bone Mass Measurement (for people with Medicare who are at risk)	20% coinsurance[1, 2] Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions	***In-Network*** $0 copay for Medicare-covered bone mass measurement ***Out-of-Network*** 15% of the cost for Medicare-covered bone mass measurement	***In-Network*** $0 copay for Medicare-covered bone mass measurement ***Out-of-Network*** 15% of the cost for Medicare-covered bone mass measurement
23. Colorectal Screening Exams (for people with Medicare age 50 and older)	20% coinsurance [1,2] Covered when you are high risk or when you are age 50 and older	***In-Network*** $0 copay for Medicare-covered colorectal screenings. ***Out-of-Network*** 15% of the cost for colorectal screenings	***In-Network*** $0 copay for Medicare-covered colorectal screenings. ***Out-of-Network*** 15% of the cost for colorectal screenings

[1] Each year, you pay a total of one deductible. In 2007, this deductible is $131, and it may change in 2008.

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

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
24. Immunizations **(Flu vaccine, Hepatitis B Vaccine – for people with Medicare who are at risk, Pneumonia Vaccine)**	$0 copay for Flu and Pneumonia vaccines 20% coinsurance for Hepatitis B vaccine[1, 2] You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.	***In-Network*** $0 copay for Flu and Pneumonia vaccines. $0 copay for Hepatitis B vaccine. No referral needed for Flu and Pneumonia vaccines. No referral needed for other immunizations. ***Out-of-Network*** 15% of the cost for immunizations	***In-Network*** $0 copay for Flu and Pneumonia vaccines. $0 copay for Hepatitis B vaccine. No referral needed for Flu and Pneumonia vaccines. No referral needed for other immunizations. ***Out-of-Network*** 15% of the cost for immunizations
25. Mammograms (Annual Screening) **(for women with Medicare age 40 and older)**	20% coinsurance[2] No referral needed Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39	***General*** Authorization rules may apply. ***In-Network*** $0 copay for Medicare-covered screening mammograms. ***Out-of-Network*** 15% of the cost for screening mammograms	***General*** Authorization rules may apply. ***In-Network*** $0 copay for Medicare-covered screening mammograms. ***Out-of-Network*** 15% of the cost for screening mammograms
26. Pap Smears and Pelvic Exams **(for women with Medicare)**	$0 copay for Pap smears Covered once every 2 years. Covered once a year for women with Medicare at high risk [2] 20% coinsurance for pelvic exams[2]	***In-Network*** $0 copay for Medicare-covered Pap smears and pelvic exams. ***Out-of-Network*** 15% of the cost for Pap smears and pelvic exams.	***In-Network*** $0 copay for Medicare-covered Pap smears and pelvic exams. ***Out-of-Network*** 15% of the cost for Pap smears and pelvic exams.

[1] Each year, you pay a total of one deductible. In 2007, this deductible is $131, and it may change in 2008.

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

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
27. Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	20% coinsurance for the digital rectal exam $0 for the PSA test; 20% coinsurance for other related services[1, 2] Covered once a year for all men with Medicare over age 50	***In-Network*** $0 copay for Medicare-covered prostate cancer screening. ***Out-of-Network*** 15% of the cost for prostate cancer screening	***In-Network*** $0 copay for Medicare-covered prostate cancer screening. ***Out-of-Network*** 15% of the cost for prostate cancer screening
28. ESRD	20% coinsurance for dialysis[1,2]	***In-Network*** 10% of the cost for in-area dialysis. 15% of the cost for out-of-area dialysis. $0 copay for Nutrition Therapy for Renal Disease. ***Out-of-Network*** 15% of the cost for Renal Disease 15% of the cost for Nutrition Therapy.	***In-Network*** 10% of the cost for in-area dialysis. 15% of the cost for out-of-area dialysis. $0 copay for Nutrition Therapy for Renal Disease. ***Out-of-Network*** 15% of the cost for Renal Disease 15% of the cost for Nutrition Therapy.
29. Prescription Drugs	Most drugs not covered (You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan.)	Drugs Covered Under Medicare Part B ***General*** 10% of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs). 10% of the cost for Part B-covered chemotherapy drugs.	Drugs Covered Under Medicare Part B ***General*** 10% of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs). 10% of the cost for Part B-covered chemotherapy drugs.

[1] Each year, you pay a total of one deductible. In 2007, this deductible is $131, and it may change in 2008.

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

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
		Drugs Covered Under Medicare Part D ***General*** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at **www.bluecrossca.com** on the web. Different out-of-pocket costs may apply for people who ▪ have limited incomes, ▪ live in long-term care facilities, or ▪ have access to Indian/Tribal/Urban (Indian Health Service). The plan offers national in-network prescription coverage. This means that you will pay the same amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and the plan. Some drugs have quantity limits. Your provider must get prior authorization from Freedom Blue Plan I for certain drugs. If the actual cost of a drug is less than the normal copay amount for that drug, you will pay the actual cost, not the higher copay amount.	**Drugs Covered Under Medicare Part D** ***General*** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at **www.bluecrossca.com** on the web. Different out-of-pocket costs may apply for people who ▪ have limited incomes, ▪ live in long-term care facilities, or ▪ have access to Indian/Tribal/Urban (Indian Health Service). The plan offers national in-network prescription coverage. This means that you will pay the same amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and the plan. Some drugs have quantity limits. Your provider must get prior authorization from Freedom Blue Plan II for certain drugs. If the actual cost of a drug is less than the normal copay amount for that drug, you will pay the actual cost, not the higher copay amount.

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
		In-Network $0 deductible. Some covered drugs don't count toward your out-of-pocket drug costs. **Initial Coverage** You pay the following until total yearly drug costs reach $2,510: ***Retail Pharmacy*** **Generics** ▪ $8 copay for a one-month (30-day) supply of drugs ▪ $24 copay for a three-month (90-day) supply of drugs **Preferred Brand** ▪ $30 copay for a one-month (30-day) supply of drugs ▪ $90 copay for a three-month (90-day) supply of drugs **Non-Preferred Brand** ▪ $64 copay for a one-month (30-day) supply of drugs ▪ $192 copay for a three-month (90-day) supply of drugs **Non-Specialty Injectables** ▪ 33% coinsurance for a one-month (30-day) supply of drugs ▪ 33% coinsurance for a three-month (90-day) supply of drugs	***In-Network*** $0 deductible. Some covered drugs don't count toward your out-of-pocket drug costs. **Initial Coverage** You pay the following until total yearly drug costs reach $2,510: ***Retail Pharmacy*** **Generics** ▪ $8 copay for a one-month (30-day) supply of drugs ▪ $24 copay for a three-month (90-day) supply of drugs **Preferred Brand** ▪ $30 copay for a one-month (30-day) supply of drugs ▪ $90 copay for a three-month (90-day) supply of drugs **Non-Preferred Brand** ▪ $64 copay for a one-month (30-day) supply of drugs ▪ $192 copay for a three-month (90-day) supply of drugs **Non-Specialty Injectables** ▪ 33% coinsurance for a one-month (30-day) supply of drugs ▪ 33% coinsurance for a three-month (90-day) supply of drugs

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
		Specialty ▪ 33% coinsurance for a one-month (30-day) supply of drugs ***Long-Term Care Pharmacy*** **Generics** ▪ $8 copay for a one-month (34-day) supply of drugs **Preferred Brand** ▪ $30 copay for a one-month (34-day) supply of drugs **Non-Preferred Brand** ▪ $64 copay for a one-month (34-day) supply of drugs **Non-Specialty Injectables** ▪ 33% coinsurance for a one-month (34-day) supply of drugs **Specialty** ▪ 33% coinsurance for a one-month (34-day) supply of drugs ***Mail Order*** **Generics** ▪ $12 copay for a three-month (90-day) supply of drugs from a preferred mail-order pharmacy. ▪ $24 copay for a three-month (90-day) supply of drugs from a non-preferred mail-order pharmacy. **Preferred Brand** ▪ $75 copay for a three-month (90-day) supply of drugs from a preferred mail-order pharmacy.	**Specialty** ▪ 33% coinsurance for a one-month (30-day) supply of drugs ***Long-Term Care Pharmacy*** **Generics** ▪ $8 copay for a one-month (34-day) supply of drugs **Preferred Brand** ▪ $30 copay for a one-month (34-day) supply of drugs **Non-Preferred Brand** ▪ $64 copay for a one-month (34-day) supply of drugs **Non-Specialty Injectables** ▪ 33% coinsurance for a one-month (34-day) supply of drugs **Specialty** ▪ 33% coinsurance for a one-month (34-day) supply of drugs ***Mail Order*** **Generics** ▪ $12 copay for a three-month (90-day) supply of drugs from a preferred mail-order pharmacy. ▪ $24 copay for a three-month (90-day) supply of drugs from a non-preferred mail-order pharmacy. **Preferred Brand** ▪ $75 copay for a three-month (90-day) supply of drugs from a preferred mail-order pharmacy.

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
		▪ $90 copay for a three-month (90-day) supply of drugs from a non-preferred mail-order pharmacy. **Non-Preferred Brand** ▪ $160 copay for a three-month (90-day) supply of drugs from a preferred mail-order pharmacy. ▪ $192 copay for a three-month (90-day) supply of drugs from a non-preferred mail-order pharmacy. **Non-Specialty Injectables** ▪ 33% coinsurance for a three-month (90-day) supply of drugs from a preferred mail-order pharmacy. ▪ 33% coinsurance for a three-month (90-day) supply of drugs from a non-preferred mail-order pharmacy. **Specialty** ▪ 33% coinsurance for a one-month (30-day) supply of drugs from a preferred mail-order pharmacy. ▪ 33% coinsurance for a one-month (30-day) supply of drugs from a non-preferred mail-order pharmacy. **Coverage Gap** You pay the following: The plan covers only select Generics through the gap.	▪ $90 copay for a three-month (90-day) supply of drugs from a non-preferred mail-order pharmacy. **Non-Preferred Brand** ▪ $160 copay for a three-month (90-day) supply of drugs from a preferred mail-order pharmacy. ▪ $192 copay for a three-month (90-day) supply of drugs from a non-preferred mail-order pharmacy. **Non-Specialty Injectables** ▪ 33% coinsurance for a three-month (90-day) supply of drugs from a preferred mail-order pharmacy. ▪ 33% coinsurance for a three-month (90-day) supply of drugs from a non-preferred mail-order pharmacy. **Specialty** ▪ 33% coinsurance for a one-month (30-day) supply of drugs from a preferred mail-order pharmacy. ▪ 33% coinsurance for a one-month (30-day) supply of drugs from a non-preferred mail-order pharmacy. **Coverage Gap** You pay the following: The plan covers only select Generics through the gap.

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
		Retail Pharmacy **Generics** ▪ $8 copay for a one-month (30-day) supply of drugs ▪ $24 copay for a three-month (90-day) supply of drugs ***Long-Term Care Pharmacy*** **Generics** ▪ $8 copay for a one-month (34-day) supply of drugs ***Mail Order*** **Generics** ▪ $12 copay for a three-month (90-day) supply of drugs from a preferred mail order ▪ $24 copay for a three-month (90-day) supply of drugs from a non-preferred mail order For all other covered drugs, after your total yearly drug costs reach $2,510, you pay 100% until your yearly out-of-pocket drug costs reach $4,050. **Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,050, you pay the greater of: ▪ $2.25 copay for generic (including brand drugs treated as generic) and $5.60 copay for all other drugs, or ▪ 5% coinsurance.	***Retail Pharmacy*** **Generics** ▪ $8 copay for a one-month (30-day) supply of drugs ▪ $24 copay for a three-month (90-day) supply of drugs ***Long-Term Care Pharmacy*** **Generics** ▪ $8 copay for a one-month (34-day) supply of drugs ***Mail Order*** **Generics** ▪ $12 copay for a three-month (90-day) supply of drugs from a preferred mail order ▪ $24 copay for a three-month (90-day) supply of drugs from a non-preferred mail order For all other covered drugs, after your total yearly drug costs reach $2,510, you pay 100% until your yearly out-of-pocket drug costs reach $4,050. **Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,050, you pay the greater of: ▪ $2.25 copay for generic (including brand drugs treated as generic) and $5.60 copay for all other drugs, or ▪ 5% coinsurance.

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
		Out-of-Network Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may pay more than the copay if you get your drugs at an out-of-network pharmacy. **Out-of-Network Initial Coverage** You pay the following until total yearly drug costs reach $2,510: ***Out-of-Network Pharmacy*** **Generics** ▪ $8 copay for a one-month (30-day) supply of drugs **Preferred Brand** ▪ $30 copay for a one-month (30-day) supply of drugs **Non-Preferred Brand** ▪ $64 copay for a one-month (30-day) supply of drugs **Non-Specialty Injectables** ▪ 33% coinsurance for a one-month (30-day) supply of drugs **Specialty** ▪ 33% coinsurance for a one-month (30-day) supply of drugs	***Out-of-Network*** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may pay more than the copay if you get your drugs at an out-of-network pharmacy. **Out-of-Network Initial Coverage** You pay the following until total yearly drug costs reach $2,510: ***Out-of-Network Pharmacy*** **Generics** ▪ $8 copay for a one-month (30-day) supply of drugs **Preferred Brand** ▪ $30 copay for a one-month (30-day) supply of drugs **Non-Preferred Brand** ▪ $64 copay for a one-month (30-day) supply of drugs **Non-Specialty Injectables** ▪ 33% coinsurance for a one-month (30-day) supply of drugs **Specialty** ▪ 33% coinsurance for a one-month (30-day) supply of drugs

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
		Out-of-Network Coverage Gap You pay the following: **Generics** ▪ $8 copay for a one-month (30-day) supply of drugs **Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,050, you pay the greater of: ▪ $2.25 copay for generic (including brand drugs treated as generic) and $5.60 copay for all other drugs, or ▪ 5% coinsurance. *See p. 29 for additional information about Prescription Drugs.*	**Out-of-Network Coverage Gap** You pay the following: **Generics** ▪ $8 copay for a one-month (30-day) supply of drugs **Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,050, you pay the greater of: ▪ $2.25 copay for generic (including brand drugs treated as generic) and $5.60 copay for all other drugs, or ▪ 5% coinsurance. *See p. 29 for additional information about Prescription Drugs.*
30. Dental Services	Preventive dental services (such as cleaning) not covered	$0 copay for Medicare-covered dental benefits. In general, preventive dental benefits (such as cleaning) not covered.	$0 copay for Medicare-covered dental benefits. In general, preventive dental benefits (such as cleaning) not covered.
31. Hearing Services	Routine hearing exams and hearing aids not covered 20% coinsurance for diagnostic hearing exams [1, 2]	***In-Network*** $0 copay for hearing aids. ▪ $10 copay for diagnostic hearing exams.	***In-Network*** $0 copay for hearing aids. ▪ $10 copay for diagnostic hearing exams.

[1] Each year, you pay a total of one deductible. In 2007, this deductible is $131, and it may change in 2008.

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

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
		▪ $10 copay for up to 1 routine hearing test(s) every year. $100 limit for routine hearing aids every two years. ***Out-of-Network*** 15% of the cost for hearing exams.	▪ $10 copay for up to 1 routine hearing test(s) every year. $100 limit for routine hearing aids every two years. ***Out-of-Network*** 15% of the cost for hearing exams.
32. Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye[1, 2] Routine eye exams and glasses not covered Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery[1, 2] Annual glaucoma screenings covered for people at risk [1, 2]	***In-Network*** ▪ 10% of the cost for one pair of eyeglasses or contact lenses after each cataract surgery. ▪ $20 copay for exams to diagnose and treat diseases and conditions of the eye. ▪ $20 copay for up to 1 routine eye exam(s) every year. ▪ 0% of the cost for up to 1 pair(s) of contacts every two years ▪ 0% of the cost for up to 1 pair(s) of lenses every two years ▪ 0% of the cost for up to 1 frame(s) every two years $175 limit for eye wear every two years ***Out-of-Network*** 15% of the cost for eye exams. 15% of the cost for eye wear.	***In-Network*** ▪ 10% of the cost for one pair of eyeglasses or contact lenses after each cataract surgery. ▪ $20 copay for exams to diagnose and treat diseases and conditions of the eye. ▪ $20 copay for up to 1 routine eye exam(s) every year. ▪ 0% of the cost for up to 1 pair(s) of contacts every two years ▪ 0% of the cost for up to 1 pair(s) of lenses every two years ▪ 0% of the cost for up to 1 frame(s) every two years $175 limit for eye wear every two years ***Out-of-Network*** 15% of the cost for eye exams. 15% of the cost for eye wear.

[1] Each year, you pay a total of one deductible. In 2007, this deductible is $131, and it may change in 2008.

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

Benefit Category	Original Medicare	Freedom Blue Plan I	Freedom Blue Plan II
33. Physical Exams	20% coinsurance for one exam within the first 6 months of your new Medicare Part B coverage risk [1, 2] When you get Medicare Part B, you can get a one-time physical exam within the first 6 months of your new Part B coverage. The coverage does not include lab tests.	***In-Network*** $10 copay for routine exams. Limited to 1 exam(s) every year. $10 copay for Medicare-covered benefits. ***Out-of-Network*** 15% of the cost for routine exams.	***In-Network*** $10 copay for routine exams. Limited to 1 exam(s) every year. $10 copay for Medicare-covered benefits. ***Out-of-Network*** 15% of the cost for routine exams.
Health/Wellness Education	Not covered	***In-Network*** The plan covers health/wellness education benefits: ▪ Written health education materials, including Newsletters ▪ Health Club Membership/Fitness Classes ▪ Nursing Hotline ▪ Other Wellness Benefits *See p. 29 for additional information about Health/Wellness Education Benefits.*	***In-Network*** The plan covers health/wellness education benefits: ▪ Written health education materials, including Newsletters ▪ Health Club Membership/Fitness Classes ▪ Nursing Hotline ▪ Other Wellness Benefits *See p. 29 for additional information about Health/Wellness Education Benefits.*

[1] Each year, you pay a total of one deductible. In 2007, this deductible is $131, and it may change in 2008.

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

Section 3

2008 Summary of Benefits for Freedom Blue

It's important that you understand your benefits so you can get the most out of your health care services, and we can serve you better. We want your benefit information to be easy to understand and simple for you to use.

Your plan was created to provide Medicare beneficiaries with coverage for medically-necessary hospital and doctor services with low or no monthly plan premiums. Some of our plans also include Medicare Part D Prescription Drug Coverage and coverage for routine vision care, dental care, and hearing examinations. *Please refer to Section 2 to find out which services are covered by each plan described in this Summary of Benefits.*

This section provides important additional information about some of the benefits listed earlier in Section 2.

Out-of-Pocket Maximum/Annual Deductible *(see #1 in Section 2)*

Your plan has an annual deductible for most services. You must pay all costs for these services until you have met your annual plan deductible. Office visit copayments, preventive services, routine hearing and vision exams, emergency room visits, and physical exams are not subject to the annual deductible.

Expenses for any service or supply not listed in this summary of benefits will not apply toward the annual deductible.

The annual out-of-pocket maximum is combined for network and non-network services. Once you reach your annual out-of-pocket maximum, the plan will cover Medicare-covered services at 100%.

The deductible and coinsurance amounts are based on the plan's contracted rate or, for noncontracted providers, the Medicare-allowed amount.

Screening Services *(see #8 in Section 2)*

You do not pay a copayment for the following screening services when you use network providers, but you may pay an appropriate office visit copayment or coinsurance: *colorectal screenings, screening mammograms, bone mass measurement, Pap smears and pelvic exams, and prostate cancer screening exams.*

Outpatient Surgery/Services *(see #13 in Section 2)*

You pay your office visit copayment for any associated physician services (nonsurgical) in an outpatient hospital facility. In addition, after you meet your deductible, you pay your outpatient surgery coinsurance for elective, scheduled (nonurgent, nonemergency) Medicare-covered surgeries in an outpatient hospital or ambulatory surgical center.

Ambulance Services *(see #14 in Section 2)*

After you meet your deductible, you pay your ambulance copayment for each medically-necessary trip to the hospital or dialysis center, from the hospital or dialysis center, or between facilities.

Emergency Care *(see #15 in Section 2)*

You pay your emergency room (ER) copayment for each covered ER visit. If you are admitted to a hospital from an ER within 72 hours, you will not pay your ER copayment, but you will pay your inpatient hospital coinsurance, if you have one.

Durable Medical Equipment and Prosthetic Devices *(see #18 and #19 in Section 2)*

Durable Medical Equipment includes items such as oxygen, wheelchairs, walkers, and hospital beds for home use.

Prosthetic Devices include arm, leg, back, and neck braces; artificial eyes; artificial limbs (and their replacement parts); breast prostheses (after mastectomy); and prosthetic devices needed to replace an internal body part or function, including Medicare-covered therapeutic shoes.

Diabetes Training/Supplies *(see #20 in Section 2)*

There is no copayment for diabetes self-monitoring training from a network provider, however a copayment may apply for an associated office visit.

If your plan includes Medicare Part D Prescription Drug coverage, supplies associated with the injection of insulin (specifically syringes, needles, alcohol swabs, and gauze) are covered under Medicare Part D and not under Medicare Part B.

Diagnostic Tests, X-Rays and Lab Services *(see #21 in Section 2)*

After you meet your deductible, you pay your coinsurance for diagnostic tests, X-rays and lab services. In addition, you may pay an office visit copayment if you are charged for an office visit.

Prescription Drugs *(see #29 in Section 2)*

Since this plan includes Medicare Part D coverage, you will automatically be disenrolled from this plan if you apply for a Part D plan. You cannot have two Part D plans at the same time. Your copayments for Medicare Part D drugs do not count toward your plan out-of-pocket maximum.

Our plans also cover generic barbiturates and benzodiazepines. These classes of generic drugs are not required to be covered by Medicare Part D plans. A list of these drugs is included in our formulary. Your copayments for barbiturates and benzodiazepines do not count toward your Initial Coverage Limit or yearly out-of-pocket maximum (also known as the "true out-of-pocket maximum" or TrOOP). Brand-name barbiturates and benzodiazepines are not covered.

For Medicare Part B-covered drugs, you pay 10% coinsurance when you use network providers.

You will be responsible for the difference between network and non-network retail pharmacy costs, unless it is an emergency or you do not have adequate access to a network pharmacy.

90-Day Supply: You can purchase a 90-day supply of most prescriptions through our mail-order pharmacy or from certain retail pharmacies that contracted with the plan to provide 90-day supplies. These pharmacies are identified in the provider directory with an asterisk (*).

Health/Wellness Education *(see p. 27 in Section 2)*

As part of your plan, you can enroll in the Forever Fit[SM] program — a fitness plan designed especially for Medicare-eligible individuals. The Forever Fit[SM] program includes:

- complimentary basic membership in a participating fitness center in your area. You can use all the services available to fitness center members with a basic membership.
- discounts for exercise and movement programs, such as yoga, Pilates, Tai Chi, Qi Gong and personal training.
- discounts on selected health and fitness magazines and access to online education tools.

There is not a separate charge for this program, as long as you only use services available with basic fitness center memberships.

After you enroll in this Medicare Advantage plan, you will receive a brochure that shows the participating fitness centers in your area and describes how to enroll in Forever Fit.[SM]

Contact Customer Service for more information on this program, or visit **www.WholeHealthMD.com.**

Precertification/Prior Authorization

Prior authorization (also called precertification) is used to improve the safety, efficiency, and cost-effectiveness of medical treatment for our members. We consider the patterns of health care services requested and used and the potential for risk to our members when deciding whether to require prior authorization.

Prior authorization is required in order for certain services to be covered. If you receive services from a network provider, the provider is responsible for obtaining the necessary authorization. Please see below for a listing of some services that require prior authorization. (After you enroll, refer to the benefits chart in the Evidence of Coverage for the services that require prior authorization.)

Chiropractic Services: Prior authorization is required for in-network chiropractic visits after the fifth visit.

Diagnostic Tests, X-Rays, and Lab Services: Prior authorization is required for high-tech imaging and other select diagnostic services, including, but not

limited to, injectable/infusible medications and nonemergency CT, MRI, and PET screening of the breast. Prior authorization is also required for nonstandard therapy, such as proton beam radiation.

Outpatient Services/Surgery: Certain outpatient hospital procedures require prior authorization, including high-tech imaging and other limited diagnostic and therapeutic procedures.

You can request prior authorization by calling our Customer Service Center at 1-877-811-3107. Representatives are available Monday through Friday, 8 a.m. to 6 p.m. If you are hearing or speech impaired and have access to a TDD system, please call 1-888-877-5378.

Foreign Travel

If you are traveling outside the United States for less than six months, your plan covers medically necessary care in an emergency room, urgent care center or physician's office. You first must meet your deductible. Then you are responsible for a copayment per visit.

Your inpatient copayment applies for emergency or urgent inpatient admissions while you are traveling outside the United States. This benefit is limited to 60 inpatient days per lifetime.