Blue Advantage®

from Blue Cross and Blue Shield of Alabama

Summary of Benefits

July, 1 2005 - December 31, 2005
Alabama - PPO

Option 2

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

SUMMARY OF BENEFITS
FOR
BLUE ADVANTAGE
H NUMBER H0104, PLAN 002

If you have any questions about this plan's benefits or costs, please contact Blue Advantage at 1 888 578-6775, or TTY 1 800 257-3384.

Benefit Category	Original Medicare	Blue Advantage Option II
IMPORTANT INFORMATION		
1 – Premium and Other Important Information	You pay the Medicare Part B premium of $78.20 each month.	You pay $43 each month. You also continue to pay the Medicare Part B premium of $78.20 each month. You pay one initial deductible of $1,000 for the following plan services when received out of network only: - Inpatient Hospital Care - Inpatient Mental Health Care - Skilled Nursing Facility - Home Health Care - Doctor Office Visits - Chiropractic Services - Podiatry Services - Outpatient Mental Health Care - Outpatient Substance Abuse Care - Outpatient Services/Surgery - Urgently Needed Care - Outpatient Rehabilitation Services - Durable Medical Equipment - Prosthetic Devices - Diabetes Self-Monitoring Training and Supplies - Diagnostic Tests, X-Rays, and Lab Services - Bone Mass Measurement

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Benefit Category	Original Medicare	Blue Advantage Option II
		- Colorectal Screening Exam - Immunizations - Mammograms (Annual Screenings) - Pap Smears and Pelvic Exams - Prostate Cancer Screening Exams - Hearing Services - Vision Services - Routine Physical Exams - Partial Hospitalization - Other Health Care Professional Services - Clinical/Diagnostic Lab Services - Radiation Therapy Services - Cardiac Rehabilitation Services - Renal Dialysis
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.	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 network doctors, specialists, and hospitals.

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		A separate doctor office visit copayment may apply for certain services.
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INPATIENT CARE		
3 – Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	You pay for each benefit period (3): Days 1 – 60: an initial deductible of $912 Days 61 – 90: $228 each day Days 91 – 150: $456 each lifetime reserve day (4) Please call 1-800 MEDICARE (1-800) 633-4227) for information about lifetime reserve days. (4)	You pay: - $125 each day for day(s) 1 - 6; - $0 each day for day(s) 7 – 90 for a Medicare-covered stay at a network hospital. You are covered for unlimited days each benefit period. There is a $750 maximum out of pocket limit every benefit period for in-network services. Cost sharing may vary for each Medicare-covered stay according to the hospital at which services are received. You pay: - 30% of the cost each day for day(s) one and beyond for a stay at an out of network hospital.

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		Please notify Blue Advantage if you are admitted to an Out-of-Network hospital. Notification is not required for emergency and urgent care.
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: - $125 each day for day(s) 1 – 6; - $0 each day for days(s) 7– 90; for a Medicare-covered stay at a network hospital. There is a $750 maximum out of pocket limit every benefit period for in-network services. Cost sharing may vary for each Medicare-covered stay according to the hospital at which services are received. You pay: - 30% of the cost each day for day(s) 1 – 190; for a stay at an out of network hospital. Medicare beneficiaries may only receive 190 days in a

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		Psychiatric Hospital in a lifetime.
5 – Skilled Nursing Facility (in a Medicare certified skilled nursing facility)	You pay for each benefit period (3), following at least a 3-day covered hospital stay: Days 1 – 20: $0 for each day Days 21 – 100: $114.00 for each day There is a limit of 100 days for each benefit period. (3)	You pay: - $50 each day(s) 1 – 50; - $0 each day(s) 51 – 100 for a stay at a Skilled Nursing Facility. There is a $2,500 maximum out of pocket limit for in-network services. You pay 30% of the cost for services at an out of network Skilled Nursing Facility. No prior hospital stay is required. You are covered for 100 days each benefit period.

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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.	There is no copayment for Medicare-covered home health visits. You pay 30% for out of network home health visits.
7 – Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must receive care from a Medicare-certified hospice.	You must receive care from a Medicare-certified hospice.
8 – Doctor Office Visits	You pay 20% of Medicare-approved amounts. (1)(2) If your coverage to Medicare Part B begins on or after January 1, 2005, you may receive a one time physical exam within the first six months of your new Part B coverage. This will not include laboratory tests. Please contact your physician for further details.	You pay $10 for each primary care doctor office visit for Medicare-covered services. You pay 30% for each out of network primary care doctor office visit. You pay $15 for each specialist visit for Medicare-covered services. You pay 30% for each out of network specialist visit.

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		See #31 – Routine Physical Exams for more information.
9 – Chiropractic Services	You pay 20% of Medicare-approved amounts. (1)(2) 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 $15 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation). You pay $15 for each routine visit. You pay 30% of the cost for out of network chiropractic services. Maximum of 12 routine visit(s) per year, applies to in-network and out-of-network.
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 $15 for each Medicare-covered visit (medically necessary foot care). You pay $15 for each routine visit. You pay 30% of the cost for out of network podiatry services.

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		Maximum of 6 routine visit(s) per year, applies to in-network and out-of-network.
11 – Outpatient Mental Health	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 $40 for each individual/group therapy visit. You pay 30% of the cost for out of network Mental Health services. You pay 30% of the cost for out of network Mental Health services with a psychiatrist.
12 – Outpatient Substance Abuse Care	You pay 20% of Medicare-approved amounts. (1)(2)	For Medicare-covered services, you pay $40 for each individual/group visit. You pay 30% of the cost for out of network outpatient substance abuse services.

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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 $75 for each Medicare-covered visit to an ambulatory surgical center. You pay $75 for each Medicare-covered visit to an outpatient hospital facility. You pay 30% of the cost for services at an out of network ambulatory surgical center. You pay 30% of the cost for services at an out of network outpatient hospital facility.
14 – Ambulance Services (medically necessary ambulance services)	You pay 20% of Medicare-approved amounts or applicable fee schedule charge. (1)(2)	You pay $100 for Medicare-covered ambulance services.

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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. NOT covered outside the U.S. except under limited circumstances.
16 – Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	You pay 20% of the Medicare-approved amounts or applicable copayment. (1)(2) NOT covered outside the U.S. except under limited circumstances.	You pay $50 for each Medicare-covered urgently needed care visit. You pay 30% of the cost for out of network urgent care services. NOT covered outside the U.S. except under limited circumstances.

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17 – Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	You pay 20% of Medicare-approved amounts. (1)(2)	You pay $15 for each Medicare-covered Occupational Therapy, Physical Therapy and/or Speech/Language Therapy visit. An additional facility charge may be included in the cost for services. You pay 30% of the cost for out of network Occupational Therapy, Physical Therapy and/or Speech/Language Therapy services.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18 – Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	You pay 20% of Medicare-approved amounts. (1)(2)	You pay 20% of the cost for each Medicare-covered item. You pay 30% of the cost for durable medical equipment purchased out of network.
19 – Prosthetic Devices (includes braces, artificial limbs and dyes, etc.)	You pay 20% of Medicare-approved amounts. (1)(2)	You pay 20% of the cost for each Medicare-covered item. You pay 30% of the cost for prosthetic devices purchased out of network.

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20 – Diabetes Self-Monitoring Training and Supplies (includes coverage for glucose monitors, test strips, lancets, and self-management training)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no copayment for Diabetes self-monitoring training. You pay 30% of the cost for out of network Diabetes self-monitoring training. You pay 20% of the cost for each Medicare-covered Diabetes Supply item. You pay 30% of the cost for each Diabetes Supply item purchased out of network.
21 – Diagnostic Tests, X-Rays, and Lab Services	You pay 20% of Medicare-approved amounts, except for approved lab services. (1)(2) There is no copayment for Medicare-approved lab services.	There is no copayment for the following Medicare-covered service(s): - clinical/diagnostic lab services - radiation therapy - X-ray visits You pay 30% of the cost for each out of network clinical/diagnostic lab service, radiation therapy and, X-ray services.

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PREVENTIVE SERVICES		
22 – Bone Mass Measurement (for people with Medicare who are at risk)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no copayment for each Medicare-covered Bone Mass Measurement. You pay 30% of the cost for each out of network Bone Mass Measurement.
23 – Colorectal Screening Exams (for people with Medicare age 50 and older)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no copayment for Medicare-covered Colorectal Screening Exams. You pay 30% of the cost for each out of network Colorectal Screening exam.
24 – Immunizations (Flu vaccine, Hepatitis B vaccine – for people with Medicare who are at risk, Pneumonia vaccine)	There is no copayment for the Pneumonia and Flu vaccines. You pay 20% of Medicare-approved amounts for the Hepatitis B vaccine. (1)(2) You may only need the Pneumonia vaccine once in your lifetime. Please contact your doctor for further details.	There is no copayment for the Pneumonia and Flu vaccines. No referral necessary for Medicare-covered influenza and pneumococcal vaccines. There is no copayment for the Hepatitis B vaccine.

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		You pay 30% of the cost for each out of network immunization.
25 – Mammograms (annual Screening) (for women with Medicare age 40 and older)	You pay 20% of Medicare-approved amounts. (2) No referral necessary for Medicare-covered screenings.	There is no copayment for Medicare-covered Screening Mammograms. You pay 30% of the cost for each out of network Screening Mammogram. No referral necessary for Medicare-covered screenings.
26 – Pap Smears and Pelvic Exams (for women with Medicare)	There is no copayment for a Pap Smear once every 2 years, annually for beneficiaries at high risk. (2) You pay 20% of Medicare-approved amounts for Pelvic Exams. (2)	There is no copayment for: - Medicare-covered Pap Smears and Pelvic Exams - additional Pap Smears up to one Pap Smear(s) every year You pay 30% of the cost for each out of network Pap Smear and Pelvic Exam.

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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. (2)	There is no copayment for Medicare-covered Prostate Cancer screening exams. You pay 30% of the cost for each out of network Prostate Screening Exam.
ADDITIONAL BENEFITS (WHAT ORIGINAL MEDICARE DOES NOT COVER)		
28 – Outpatient Prescription Drugs	You pay 100% for most prescription drugs.	For prescription drugs, you pay for each prescription or refill: - $10 for Generic drugs up to a 30-day supply There is no individual limit on Generic drugs. You must use designated retail pharmacies to get your prescription drugs.
29 – Hearing Services	You pay 100% for routine hearing exams and hearing aids. You pay 20% of Medicare-approved amounts for	There is no copayment for hearing aids. You pay: - $10 for each Medicare-covered hearing exam (diagnostic hearing exams).

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	diagnostic hearing exams.(1)(2)	- $10 for each routine hearing test up to one test(s) every year - $10 for each fitting-evaluation for a hearing aid up to one fitting(s)-evaluation(s) every two years You pay 30% of the cost for out of network hearing exams and, hearing aids. You are covered up to $400 for hearing aids every two years. This maximum applies to in-network and out-of-network.
30 – 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)	There is no copayment for the following items: - Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery) - Glasses - Contacts You pay: - $10 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye).

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	You pay 100% for routine eye exams and glasses.	- $10 for each Routine eye exam, limited to one exam(s) every year. You pay 30% of the cost for out of network eye exams and, eyewear. You are covered up to $150 for eyewear every year. This maximum applies to in-network and out-of-network.
31 – Routine Physical Exam	You pay 100% for routine physical exams.	You pay $0 for each exam. You pay 30% of the cost for each out of network routine physical exam.

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(1) Each year, you pay a total of one $110 deductible.
(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.
(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.

NOTES

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