BLUE CROSS AND BLUE SHIELD OF ALABAMA
2006 OUTLINE OF MEDICARE SUPPLEMENT COVERAGE • C PLUS℠ WITH PMD MEDICARE SELECT PLAN B

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A." Some plans may not be available in your state.

Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year $1730 deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses exceed $1730. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

SEE OUTLINES OF COVERAGE SECTIONS FOR DETAILS ABOUT ALL PLANS

Basic Benefits for Plans A - J:

- Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end
- Medical Expenses: Part B coinsurance (20% of Medicare-approved expenses) or copayments for hospital outpatient services
- Blood: First three pints of blood each year

★ **C Plus is a Medicare Supplement Plan B and Medicare Select plan. Compare it with other standardized benefit plans labeled Plan B.**

The following chart gives you a quick and easy look at all the Medigap plans available. The chart on page 2 gives you additional information about Plans K and L. Blue Cross and Blue Shield of Alabama offers only Plans A and B.

PLAN A	PLAN B C Plus with PMD	PLAN C	PLAN D	PLAN E	PLAN F	PLAN G	PLAN H	PLAN I	PLAN J	PLAN K	PLAN L
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	See Chart On Page 2	See Chart On Page 2
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance (50%)	Skilled Nursing Facility Coinsurance (75%)
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible (50%)	Part A Deductible (75%)
*	★	Part B Deductible			Part B Deductible				Part B Deductible		
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)		
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery		
			Preventive Care Not Covered By Medicare						Preventive Care Not Covered By Medicare		

* Plan A offered in addition to our recommended C Plus with PMD, a Medicare Select Plan B.

PLAN J	PLAN K**	PLAN L**
SERVICES		
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	*** $4000 Out Of Pocket Limit	*** $2000 Out Of Pocket Limit

** Plans K and L provide for different cost-sharing for items and services than Plans A – J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called “Excess Charges”. You will be responsible for paying excess charges.

*** The out-of-pocket annual limit will increase each year for inflation.

★ *DISCLOSURES*

Use this outline to compare benefits and premiums among policies.

★ *READ YOUR POLICY VERY CAREFULLY*

This is only an outline describing your policy's most important features. The policy is not your insurance contract. You must read the policy itself to understand all the rights and duties of both you and your insurance company.

★ *RIGHT TO RETURN POLICY*

If you find that you are not satisfied with your policy, you may return it to Blue Cross and Blue Shield of Alabama, 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

★ *POLICY REPLACEMENT*

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

★ *NOTICE*

This contract may not fully cover all of your medical costs.

Blue Cross and Blue Shield of Alabama is not connected with Medicare. Blue Cross and Blue Shield of Alabama acts as the Medicare Carrier and Intermediary in Alabama.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare and You" for more details.

★ *COMPLETE ANSWERS ARE VERY IMPORTANT*

Review the application carefully before you sign it. Be certain that all information has been properly recorded. If your address changes, please call C Plus Customer Service to notify us.

See pages 4 - 6 for C Plus rates and benefits.

See page 7 for payment options.

See pages 7 - 9 for Plan A rates and benefits.

See pages 10 - 11 for services or expenses not covered by C Plus or Plan A.

Highlights — C Plus Select Plan B

- No waiting periods for pre-existing conditions
- With C Plus, you choose your provider:
  - More than 9,000 doctors in Alabama are Preferred Medical Doctors (PMD)–98% of all doctors
  - More than 125 hospitals in Alabama are C Plus Preferred Hospitals
- No referrals required if you need a specialist
- No copays for physician visits, outpatient hospital or emergency room services
- No deductible or daily copay for inpatient hospital care
- No paper work or claim filing — providers file claims to Medicare and C Plus for you
- Predictable out-of-pocket costs — after you pay your monthly premium, all Medicare approved hospital and physician care covered in full after $124 annual deductible for physician service
- Air Medical Services
- For Your Health Internet based health and wellness information service on www.bcbsal.com
- C Plus Health Care hotline available 24 hours a day seven, days a week

Cost of C Plus Select Plan B

C Plus premiums are age-rated based on age category on the date the policy is issued. Current monthly rates for 2006 are listed below.

Entry Category (Your age on the date you apply for C Plus)		MonthlyRate
Age 65	(Category A)	$116
Age 66-69	(Category B)	$129
Age 70 & Above	(Category C)	$143
On Medicare Disability	(Category D)	$190

You can benefit from our issue age-rated system by applying for C Plus Select Plan B when you turn 65 or as soon after as possible. For example, if you are between the ages of 66-69, your C Plus Select Plan B rate will be $129 each month. You will always stay in Category B, even after you reach age 70. However, your neighbor or spouse who is also enrolling in C Plus Select Plan B may already be 70 years or older when they apply. In this case, they would enter in Category C and pay their C Plus Select Plan B at a rate of $143 each month.

Medicare (Part A) — Hospital Services — Per Benefit Period

SERVICES			
INPATIENT HOSPITAL CARE*	***MEDICARE PAYS***	***C PLUS PLAN B PAYS***	***YOU PAY***
Coverage includes semi-private room and board, general nursing and miscellaneous hospital services and supplies in a C Plus Preferred Hospital			
First 60 days	All but $952	$952**(Part A deductible)	$0
61st to 90th day	All but $238 a day	$238 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $476 a day	$476 a day	$0
• Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses**	$0
- Beyond the additional 365 days	$0	$0	All Costs
Note: Medicare coverage for Inpatient Mental Health Care is limited to 190 days per lifetime in a Medicare approved psychiatric hospital.			
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $119 a day	$0	Up to $119 a day
101st day and after	$0	$0	All Costs
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance
BLOOD (INPATIENT)			
First 3 pints	$0	All Costs	$0
Additional Amounts	100%	$0	$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** Or hospital's contractually agreed upon amount. Inpatient hospital services should be received in a C Plus Preferred Hospital unless services are for emergency treatment or it is not reasonable to obtain such services through a C Plus Preferred Hospital.

NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

SERVICES			
OUTPATIENT HOSPITAL CARE*			
Coverage includes outpatient hospital and ambulatory surgery center facility services for surgery, diagnostic x-ray and lab, chemotherapy and radiation therapy.			
First $124 (Part B deductible) of Medicare-approved amounts*	$0	$0	$124*(Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	100%**	$0**
MEDICAL EXPENSES*			
In or out of the hospital, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical, occupational and speech therapy, diagnostic tests, durable medical equipment.			
First $124 (Part B deductible) of Medicare-approved amounts*	$0	$0	$124*(Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	100%**	$0**
BLOOD (OUTPATIENT)			
First 3 pints	$0	All Costs	$0
Next $124 (Part B deductible) of Medicare-approved amounts*	$0	$0	$124*(Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE			
Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable Medical Equipment:			
• First $124 (Part B deductible) of Medicare-approved amounts*	$0	$0	$124*(Part B Deductible)
• Remainder of Medicare-approved amounts	80%	20%	$0

* Once you have been billed $124 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

** If you use a Preferred Medical Doctor (PMD) physician

Payment Options

Please enclose your first payment when you apply for C Plus Select Plan B. Please send a check or money order. Do not send cash.

AUTOMATIC PREMIUM PAYMENT THROUGH BANK DRAFT OR CREDIT CARD

You can be free from worrying that your C Plus Select Plan B premium is paid on time by letting us take that worry from you. You may elect to pay your C Plus Select Plan B premium through Automatic Premium Payment by authorizing a bank draft from your personal checking account. Premiums will then be deducted from your checking account after the fourth day of each month in which money is drawn. With automatic bank draft, you may pay monthly, bi-monthly (two months), or quarterly (three months). Just complete the authorization agreement and include it with your application along with a blank, voided check and one payment.

If you prefer to pay your premiums by credit card or debit card, just complete and return the Blue Cross and Blue Shield of Alabama Individual Credit Card Payments Authorization Agreement form. Your monthly premium can be automatically charged through your credit or debit card and sent directly to Blue Cross and Blue Shield of Alabama for payment of your health care coverage. The form must be fully completed and signed.

COUPON BOOK

If you do not have a checking account or do not wish to pay by automatic bank draft, you may pay by coupon book. Coupon book options are monthly, bi-monthly (two monthly), or quarterly (three months). Send a check for your first premium along with your application and a coupon book will be mailed to you for future payments.

SEMI-ANNUAL

If you prefer, you may arrange to pay your C Plus Select Plan B premiums once every six months (semi-annually) or once per year (annually). Please make a note on your application to indicate six months' payment or annual payment of dues.

A check for the total amount of either six or twelve months should be sent with your application. Simply multiply your monthly premium amount by six or twelve to determine the correct amount for your check if you are paying semi-annually or annually.

THE CARING COMPANY PROMISE

We will not increase your rates unless we increase rates for all C Plus Select Plan B members.

Plan A (Basic Benefits)

Plan A provides Basic Benefits only

PLAN A IS NOT AGE-RATED. You must be at least 65 years of age to be eligible for Plan A.

PLAN A HAS A 180-DAY WAITING PERIOD FOR PRE-EXISTING CONDITIONS. If you decide to purchase Plan A, you must serve a waiting period of 180 consecutive days before benefits for "pre-existing conditions" are available to you under the Plan A contract. The 180-day waiting period begins with your effective date. To be entitled to benefits, the entire 180-day waiting period must be served before you receive coverage for services and/or supplies, or to be admitted to the hospital for pre-existing conditions. A "pre-existing condition" includes any condition, disease, disorder or ailment (including those present at birth) for which there was any medical or surgical treatment, advice or diagnosis within 180-days prior to your effective date.

This provision applies unless you have completed a waiting period under any other Medicare Supplement Contract besides this one. The time you completed under any other Medicare Supplement Contract shall be credited toward the 180-day waiting period required by this contract. If you were covered by another health plan before becoming covered by this contract, we'll credit the time toward the 180-day waiting period, if there was no greater than a 63-day break in coverage, and the plan was "creditable coverage." Creditable coverage means coverage under a health plan including a group health plan, health insurance coverage, COBRA, Medicare, Medicaid, U. S. Military, Tricare (Champus), Federal Employee Program, Indian Health Service, Peace Corps Service, a state risk pool or public health service. If you had 180 days of continuous creditable coverage and enroll within 63 days of the end of that coverage, you will not have to serve a waiting period under this contract.

THE COST OF PLAN A $97 per month or $1,164 per year
We will not increase your rates unless we increase rates for all Plan A members.

SERVICES			
INPATIENT HOSPITAL CARE*	***MEDICARE PAYS***	***PLAN A PAYS***	***YOU PAY***
Coverage includes semi-private room and board, general nursing and miscellaneous hospital services and supplies			
First 60 days	All but $952	$0	$952
61st to 90th day	All but $238 a day	$238 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $476 a day	$476 a day	$0
• Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0
- Beyond the additional 365 days	$0	$0	All Costs
Note: Medicare coverage for inpatient Mental Health Care is limited to 190 days per lifetime in a Medicare approved psychiatric hospital..			
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $119 a day	$0	Up to $119 a day
101st day and after	$0	$0	All Costs
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance
BLOOD (INPATIENT)			
First 3 pints	$0	ALL COST	$0
Additional Amounts	100%	$0	$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES			
OUTPATIENT HOSPITAL CARE	***MEDICARE PAYS***	***PLAN A PAYS***	***YOU PAY***
Coverage includes outpatient hospital and ambulatory surgery center facility services for surgery, diagnostic x-ray and lab, chemotherapy and radiation therapy.			
First $124 (Part B deductible) of Medicare-approved amounts*	$0	$0	$124* (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	$0	Balance
MEDICAL EXPENSES*			
In or out of the hospital, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical, occupational and speech therapy, diagnostic tests, durable medical equipment.			
First $124 (Part B deductible) of Medicare-approved amounts*	$0	$0	$124* (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	$0	Balance
PART B EXCESS CHARGES			
Above Medicare-approved amounts	$0	$0	All Costs
BLOOD (OUTPATIENT)			
First 3 pints	$0	All Costs	$0
Next $124 (Part B deductible) of Medicare-approved amounts*	$0	$0	$124*(Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE			
Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable Medical Equipment:			
• First $124 (Part B deductible) of Medicare-approved amounts*	$0	$0	$124* (Part B Deductible)
• Remainder of Medicare-approved amounts	80%	20%	$0

* Once you have been billed $124 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

- Services or expenses which are excluded by Medicare.
- Services, care or treatment for which Medicare does not make a determination and which we determine not to have been medically necessary.
- Services, care or treatment received by you during the 30-day grace period if we do not actually receive the required amount of your fees during the grace period.
- Services, care or treatment you receive before the effective date or after the end of the contract. If you are in the hospital when the contract ends, we will not provide benefits during the remainder of your hospitalization.
- Services or expenses for cosmetic surgery not covered by Medicare.
- Services or expenses for the care, treatment, filling, extraction, removal, replacement or augmentation of teeth or structures directly supporting teeth. “Structures directly supporting the teeth” means the periodontium, which includes the gingivae, dentogingivial junction, periodontal membrane, cementum and aveolar process. Also excluded are periodontal care, prosthodontal care, endodontic care or any other dental care. Services or expenses for hydro-xylapatite or any material with a similar purpose are also excluded.
- Services or expenses in any governmental hospital or facility which is not a Selective Contracting Facility, except Department of Defense Hospitals as provided by Medicare.
- Services or expenses in cases covered in whole or in part by workers’ compensation or employers’ liability laws, state or federal. This applies regardless of whether or not: you fail to file a claim under that law; liability is enforced against or assumed by the employer; the law provides for hospital or medical services; or the employer has insurance coverage for benefits under the law.
- Services or expenses furnished by a Federal provider of services or other Federal agency, or furnished at public expense under Federal law or a Federal contract, except as otherwise required by Medicare regulations.
- Services or expenses for routine physical examinations, convalescent care, rest cures or sanatorium care.
- Services or expenses for custodial care, meaning care primarily for providing room and board (with or without nursing care, training in personal hygiene or self care, or supervisory care by a physician) for a person physically or mentally disabled even if covered by Medicare.
- Any medical or surgical treatment or procedures, any facilities, drugs, drug usage, equipment or supplies which are experimental or investigative.
- Services or expenses for a claim not properly filed. You must file on proper forms all the information we need on or before December 31st of the year following the year services were received. Or, if you received services in the last three months of any calendar year, you must file by the end of the second year following the one in which services were rendered.

- Hearing aids, eyeglasses/contact lenses or for their examination or fittings. We will pay for eyeglasses or contact lenses that replace the human lens function and are required by surgery in the eye or due to an eye injury defect. Our payment in these cases is limited to one pair of eyeglasses or contact lenses or one pair of each if both are medically necessary.

- Travel, whether or not recommended by a physician.

- Private duty nurses and their board.

- Prescription drugs and medicines, except those drugs and medicines covered under Part A and/or B of Medicare.

- Services or expenses for home health or hospice services (other than the 20% copayment for durable medical equipment).

- Services or expenses of any kind covered under Part A of Medicare for a skilled nursing facility, nursing home, assisted living facility or intermediate care facility.

- Services or expenses in a non-participating or non-C Plus Preferred hospital for inpatient or outpatient treatment, except as otherwise allowed under the benefit portions of the C Plus contract.

- Charges in excess of the reasonable and allowable charge under Medicare.

- Any difference (due to federal law, regulations, or both) in the amount of Medicare benefits paid and the Medicare approved amount, except for deductible and copayment amounts covered by the C Plus Contract.

- The $124 annual Medicare Part B deductible.

Plan A **also does not** cover any portion of the following:

- The $952 inpatient Medicare Part A deductible.

- Part B excess charges (above Medicare-approved amounts)

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association.

450 Riverchase Parkway East, Birmingham, Alabama 35244-2858
205 733-7044 or 1 888 417-4775
www.bcbsal.com

MKT-19 (Rev. 11-2005)