Anthem. Blue Cross
Health. Join In.

Anthem Blue Cross

Medicare Advantage & Part D

California 2012

Anthem Medicare Preferred Standard (PPO)

To see if this plan is available where you live, please refer to the list of available counties in the *Summary of Benefits* section.

This information is available for free in other languages. Please contact our Customer Service number at **1-877-811-3107** (TTY/TDD line at **711**) 8 a.m. to 8 p.m., seven days a week through February 14, 2012, for additional information.*

Esta información está disponible en otros idiomas de manera gratuita. Comuníquese con el número de nuestro Servicio de Atención al Cliente al **1-877-811-3107** (o a la línea TTY/TDD al **711**) de 8 a.m. a 8 p.m., los 7 días de la semana, hasta el 14 de febrero de 2012, para obtener información adicional. A partir del 15 de febrero de 2012, puede llamar al Servicio de Atención al Cliente al **1-877-811-3107** (o a la línea TTY/TDD al **711**), de 8 a.m. a 8 p.m., de lunes a viernes, excepto feriados.

You can also contact Medicare directly at **1-800-MEDICARE** (TTY/TDD **1-877-486-2048**), 24 hours a day, seven days a week. Or visit **www.medicare.gov**.

Medicare beneficiaries may enroll through the Centers for Medicare & Medicaid Services Online Enrollment Center located at **www.medicare.gov**. Call the Customer Service number above for more information.

The benefit information provided herein is a brief summary, not a comprehensive description, of benefits. For more information, contact the plan.

*Beginning February 15, 2012, you may call Customer Service at **1-877-811-3107** (TTY/TDD line at **711**), 8 a.m. to 8 p.m., Monday through Friday, except holidays.

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Anthem Blue Cross
Health. Join In.℠

Thank you...

for your interest in our Medicare Advantage plans.

We know you want a health care plan you can count on. One that can be tailored to fit your lifestyle – that keeps the quality of coverage high and your costs low. Just check out a few of the benefits:

- **Premiums as low as $106[1]**
- **Out-of-pocket limits to protect you from high, unexpected medical costs**
- **One plan and one card for your covered medical and Part D drug benefits**
- **Optional benefits for vision care, dental care, acupuncture services and chiropractic services[2]**
- **SilverSneakers® gym membership, preventive care coverage, online resources and discounts, and more**
- **Service from a company that generations have relied on with confidence**

We invite you to learn more by reading this booklet. For more information about our plans, call your local licensed insurance agent or one of our licensed insurance agents at **1-888-211-9813** (TTY/TDD line at **711**), 8 a.m. to 8 p.m., seven days a week. You may also call Customer Service at **1-877-811-3107** (TTY/TDD line at **711**), 8 a.m. to 8 p.m., seven days a week through February 14, 2012.* Or, visit us online at **www.anthem.com/ca/medicare**.

*Beginning February 15, 2012, you may call Customer Service at **1-877-811-3107** (TTY/TDD line at **711**), 8 a.m. to 8 p.m., Monday through Friday, except holidays.

1 You must continue to pay your Medicare Part B premium. To find out more about covered benefits, see the *Summary of Benefits* section in this booklet. Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on January 1, 2013.

2 For an additional fee. See the *Summary of Benefits* section in this booklet for more details.

You may be able to get help with your prescription drug coverage. See the section, *Extra Help*, and find out how you may be eligible for Medicare's Extra Help program.

Limitations, copayments and restrictions may apply.

Some good terms to know

Before you move on, here are some of the common words you'll find in this booklet:

- **Premium** – The payment you make on a regular basis, usually monthly, to Medicare, an insurance company, or a health care plan for health care or prescription drug coverage.
- **Deductible** – The amount you must pay for health care or prescriptions, before Original Medicare or other insurance begins to pay.
- **Copayment/copay** – The specific dollar amount you may have to pay for certain covered services.
- **Coinsurance** – The percentage of cost you may have to pay for services or prescription drugs after you pay any plan deductibles.
- **Out-of-pocket limit** – Your protection from excessive cost sharing. Your out-of-pocket limit is the most you would pay during a certain time period (usually per year) for deductibles, copayments and coinsurance for in-network covered services.
- **Inpatient hospital care** – Health care that you get when you are admitted to a hospital or skilled nursing facility.
- **Outpatient hospital care** – Health care received in a hospital if you have not been admitted as an inpatient and are registered on hospital records as an outpatient. If a doctor orders that you must be placed under observation, it may be considered outpatient care, even if you stay under observation overnight.
- **Preventive care** – Health care to help keep you healthy or to help prevent illness.
- **Primary care doctor** – The doctor you see first for most health problems. He or she also may speak to other doctors and health care providers about your care and may refer you to them.
- **Specialist** – A doctor with training and expertise in a specific branch of medicine or surgery. For example, a specialist in cardiology treats heart conditions.

Let's talk about...

Medicare.

It really doesn't matter which generation you are from. There's so much to know about Medicare, it's understandable to have lots of questions. We have put together this brief guide to help you get a clearer picture of how Medicare works, and how the choices can best fit together for you.

What is Original Medicare and who is eligible?

Medicare is a health insurance program that is run by the U.S. government. This insurance program offers you a broad range of coverage for medical care.

You are eligible to join this program if one of these items applies:

1. You are 65 or older.
2. You are under 65 with certain disabilities.
3. Original Medicare only: You are any age with end-stage renal disease (ESRD) – permanent kidney failure requiring dialysis or kidney transplant.[1]
4. If you have ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease), you automatically get Part A and Part B the month your disability benefits begin.

And, both of these items describe you:

1. You or your spouse worked and paid Social Security taxes for at least 10 years.
2. You are a permanent resident of the U.S. or a legal citizen who lived in the U.S. for five years in a row.

If you aren't eligible for premium-free Part A, you may be able to buy Part A. To give you an idea of what to expect, in 2011 the Medicare Part A premium for people who bought Part A was $450. In most cases, you must also have Part B and pay monthly premiums for both. If you have limited income and resources, your state may help you pay for Part A and/or Part B. Please call the Social Security Office at **1-800-772-1213** for more information about the Part A premium. TTY users should call **1-800-325-0778**.

1 If you have end-stage renal disease and have not had a kidney transplant, you usually can't join a Medicare Advantage plan. For more information about ESRD, view the booklet *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services* at **http://go.usa.gov/lov.**
To ask for a copy, call **1-800-MEDICARE (1-800-633-4227)** or the TTY/TDD line **1-877-486-2048**, 24 hours a day, seven days a week.

Did you know that Medicare comes in separate parts?

The simplest way to get a handle on Medicare is to understand each of the different parts. Parts A and B are Original Medicare run by the government. Parts C and D are offered by private insurers.

Medicare Part A

Medicare Part A is hospital coverage that helps cover the costs for:

- Inpatient care in hospitals and skilled nursing facilities (not custodial or long-term care).
- Hospice and some home health care services.

What are your costs for Medicare Part A?

- **Premium**: You usually won't pay any premium for Part A coverage if you or your spouse paid Medicare taxes while working.
- **Other Costs**: To give you an idea of what to expect, in 2011 the Medicare Part A annual deductible for hospital stays was $1,132. And, after meeting this deductible, you would pay nothing more for up to 60 days in the hospital. Longer stays required daily coinsurance.

Medicare Part B

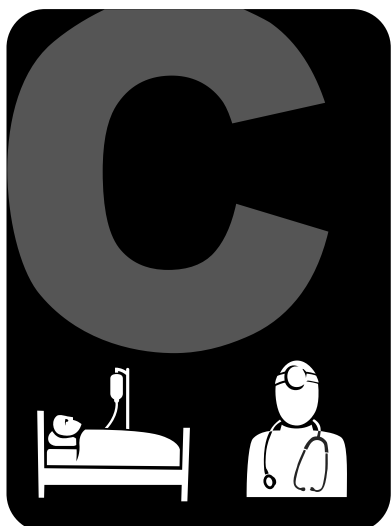
Medicare Part B is medical care coverage that helps cover the cost for:

- Doctors' services, hospital outpatient care and some home health care services as well as lab tests and durable medical equipment.
- Most preventive services, including a yearly wellness exam.

What are your costs for Medicare Part B?

- **Premium**: Your monthly premium is on a sliding scale based on your annual income. Most will pay the standard monthly premium, which was $115.40 per month for those who joined Medicare in 2011.
- **Other Costs**: To give you an idea of what to expect, in 2011 the Medicare Part B annual deductible was $162. And, for most services, you would pay 20% of the Medicare-approved amount.

Medicare Part C



You can replace Medicare Parts A and B with Medicare Part C, also called Medicare Advantage.

Unlike Original Medicare Parts A and B, which are part of the government-run insurance program, Medicare Part C consists of Medicare Advantage plans offered by private insurers that have been approved by Medicare. Medicare Advantage (MA) plans offer similar coverage to Part A (hospital services) and Part B (medical services), but typically offer additional benefits.[1] These may include prescription drug coverage, expanded preventive services, gym membership and wellness programs. Depending on where you live, you may be able to choose MA PPO plans, MA HMO plans and MA plans with prescription drug plans (as well as other options).

What are your costs for Medicare Part C?

- **Premiums**: A range of options with different monthly premiums based on the type and level of coverage you want. **You must continue to pay your Medicare Part B premium.**
- **Other Costs**: Deductibles, copays and coinsurance may still apply.

Medicare Part D

Medicare Part D is for prescription drug coverage.

Medicare Part D is only offered by private insurers approved by Medicare. These plans:

- Help pay for most brand-name and generic prescribed drugs.
- Provide access to retail drugstores across the country and mail-order options.

What are your costs for Medicare Part D?

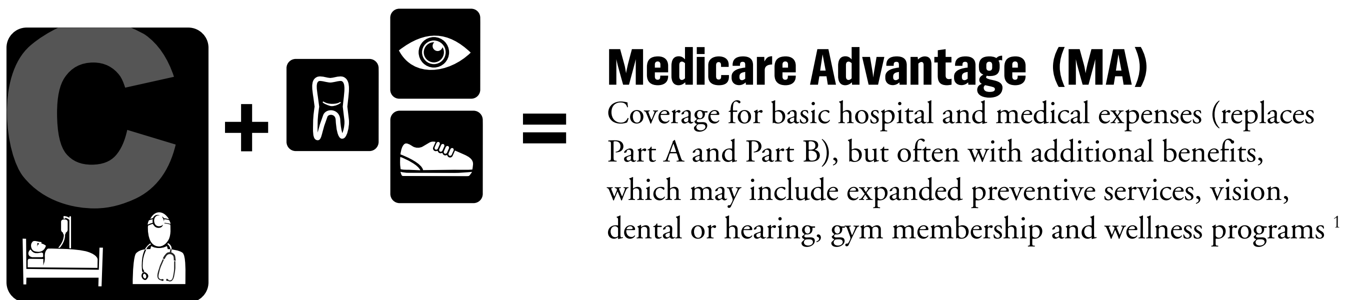
- **Premiums**: Monthly premiums will vary by plan, based on the coverage you choose.
- Most people will pay only the standard monthly Part D premium listed in the *Summary of Benefits*. However, if your annual income is above a certain limit, you will pay an income-related monthly adjustment amount in addition to your premium. If it applies, this amount will be billed by Medicare and deducted from your monthly Social Security check.
- **Other Costs**: Deductibles, copays and coinsurance may apply.

1 Some of these additional benefits may require an additional fee. See the *Summary of Benefits* section in this booklet for more details.

Here's how our plans work with Medicare

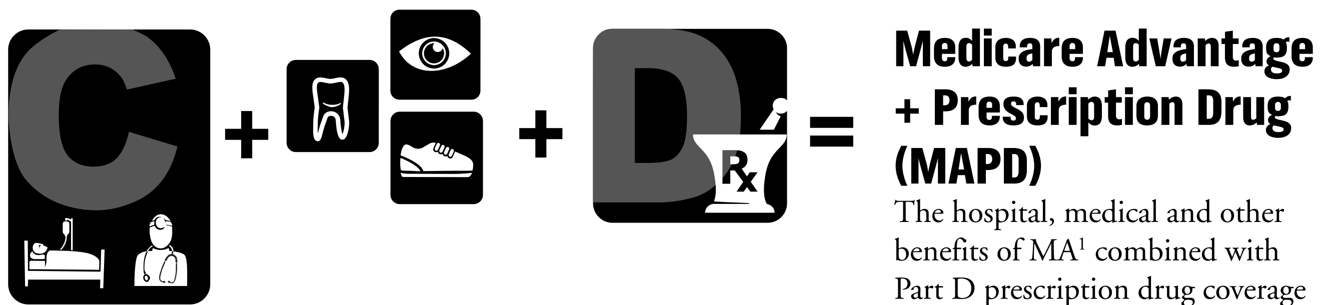
Original Medicare + Prescription Drug

Coverage for basic hospital and medical expenses, as well as prescription drugs



Medicare Advantage (MA)

Coverage for basic hospital and medical expenses (replaces Part A and Part B), but often with additional benefits, which may include expanded preventive services, vision, dental or hearing, gym membership and wellness programs [1]



Medicare Advantage + Prescription Drug (MAPD)

The hospital, medical and other benefits of MA[1] combined with Part D prescription drug coverage

More questions about Medicare?

You can get more details on how Medicare works at **1-800-MEDICARE (1-800-633-4227)** or the TTY/TDD line **1-877-486-2048**, 24 hours a day, seven days a week. The ***Medicare & You*** 2011 handbook at **www.medicare.gov** is also an excellent resource.

1 Some of these additional benefits may require an additional fee. See the *Summary of Benefits* section in this booklet for more details.

When can you enroll?

When it comes to enrolling ... timing matters!

Getting Medicare benefits is not always as simple as just turning 65. There are actions to take during preset "enrollment periods." For example, if you are like most, you must sign up when you are first eligible to receive Part A, Part B and Part D to avoid coverage delays and premium penalties that last for as long as you have Medicare.

A late enrollment penalty may cause your Part A premium to increase 10%, and you will have to pay the higher premium for twice the number of years you could have had Part A, but didn't sign up. Also, a late enrollment penalty may cause your Part B monthly premium to increase 10% for each full 12-month period that you could have had Part B, but didn't sign up.

If you are already enrolled, you should review your plan each year during the annual election period. There may be changes to your costs or coverage. You may even wish to change to another plan, and can typically only do so at this time.

Initial enrollment period

7 months surrounding your Medicare eligibility: This is the 3 months before you turn 65, the month when you turn 65, and the 3 months after.

Annual election period

October 15 to December 7, 2011. The period you can enroll in or change your MA or MAPD plan. This is also the period you can enroll in, change or disenroll from a Part D plan. You may also switch to Original Medicare. New coverage will begin January 1, 2012. **Note that the annual election period dates are new for 2011.**

Medicare Advantage disenrollment period

January 1 to February 14, 2012. You may disenroll from your MA plan. During this time, you will be enrolled in Original Medicare and will have the option of choosing a stand-alone Part D plan.

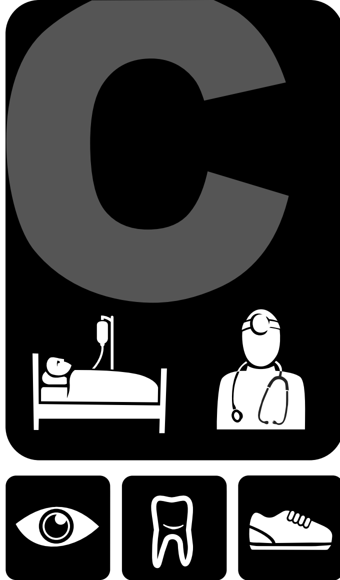
Special enrollment period (SEP)

A common SEP is for those covered under their employer's health plans who retire after 65. In this case, you can enroll with no penalty during the three months before your Part B takes effect. Other examples include: if you qualify for Medicare's Extra Help for Part D (see the *Extra Help* section to follow), if you qualify for both Medicaid and Medicare, or if you have moved outside of the plan's service area.

Welcome...

to the Medicare Advantage plan that offers the benefits you’ve been looking for at the price you’ve been hoping for.

Anthem Blue Cross Medicare Advantage health care plans give you more coverage and more freedom



Our Medicare Advantage (MA) plans were designed to meet the health care needs of people on the go and those who expect more coverage, more freedom … yet still want to keep costs down.

For example, with our MA plans you will enjoy:

- Premiums as low as $106.[1]
- Out-of-pocket limits to keep you protected from high, unexpected medical costs.
- One card for all your covered medical and drug benefits.
- In-network benefits in 29 states and one territory for up to six months through our travel/visitor program.
- SilverSneakers® gym membership, preventive care coverage, online resources and discounts.
- Optional benefits that can be added for vision, dental care, acupuncture and chiropractic.[2]
- Service from a company you may know, and generations have relied on with confidence.

1 You must continue to pay your Medicare Part B premium.
To find out more about your covered benefits, be sure to check the Summary of Benefits section in this booklet. Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on January 1, 2013.

2 For an additional fee. See the *Summary of Benefits* section in this booklet for more details and availability.

Go ahead! Choose your own providers

We know freedom of choice means a lot to you. And, you also want to protect your nest egg. You have the best of both worlds when the provider you choose is in your health plan's Medicare Advantage PPO network. You have the doctor you want. And, you'll pay less for your medical costs. Why? Network providers contract with us to accept agreed-upon rates as payment in full. Except for emergencies, out-of-network providers may charge you more. So, check to see if your provider is in your plan's network. If not, feel free to shop, compare and choose a doctor inside or outside your network.

You don't need referrals

As a PPO member, you don't need a doctor's OK to see any specialist of your choice inside or outside your plan's network.

One card is all you need

Your Medicare Advantage plan ID card from us is all you need to see your doctor, visit your pharmacy or get all your other covered benefits. This card gives you access to your benefits whether you're home or away. You don't need your red, white and blue Medicare card for accessing your benefits. However, keep it in a secure location in case you need it in the future.

Feel free to travel

Now you have more time to travel and play. Go for it! Through our PPO visitor/travel program, you can use your in-network benefits when you visit certain areas within 29 states and Puerto Rico. You may be able to access your benefits while out of our service area for six months if the place you visit is on the coverage list. If you get care from a network provider where the travel program is in place, your out-of-service area cost share will be the same as your in-network cost share while in the service area. Call us at **1-877-811-3107** (TTY/TDD line at **711**), 8 a.m. to 8 p.m., seven days a week through February 14, 2012,* for a list of the states where the travel program applies.

Count on the experience of a name you can trust

Consider the peace of mind you'll enjoy when you are covered by a company that's been a market leader for generations.

74 – number of years we have been offering health coverage

34,000,000 – number of members we serve together with our affiliates

54,000 – number of retail pharmacies across the U.S. you'll have access to

*Beginning February 15, 2012, you may call Customer Service at **1-877-811-3107** (TTY/TDD line at **711**), 8 a.m. to 8 p.m., Monday through Friday, except holidays.

You have drug coverage, too

Your plan includes drug coverage

Original Medicare does not cover most prescribed drugs. However, most of our Medicare Advantage plans do. After all, we think hospital, medical care and prescription drug coverage go hand in hand.

You only have one Customer Service phone number to call for answers to your medical or prescribed drug coverage questions.

Whether or not you take prescribed drugs today, you should sign up for prescription drug coverage when you first become eligible for Medicare. Doing this will help you avoid cost penalties. As our plan member, please keep in mind that you would need to use network pharmacies to get your prescribed drugs, except in emergency instances. Quantity limits and restrictions may apply.

About that gap, or "donut hole"

The "donut hole" is the coverage gap in Medicare Part D. It's the time period when you have to pay most out-of-pocket costs (up to a yearly limit) for your covered prescribed drugs. This happens when you and your plan have reached the Initial Coverage Limit set by Medicare.

Help when you reach the "donut hole"

Part D Gap Generic Drug Coverage:
In 2012, our Part D plan will cover formulary generic drugs through the donut hole. This year, 14% of your costs will be paid. Want to know exactly what you'll pay? We have plans that have set copays for some generic drugs during the gap, so you know exactly what you will pay. See the *Summary of Benefits* for more details.

Part D Brand-Name Drug Discount: In 2012, if you have Medicare Part D and you reach the Medicare coverage gap, you will also get a 50% discount on covered brand-name prescribed drugs. There will be additional savings in the coverage gap each year through 2020, when the donut hole is closed completely.

You have drug coverage, too (continued)

Convenient ordering options

If you need medicine right away, for a limited time, or need it on an ongoing basis, you'll enjoy several time-saving options:

- You can order your first prescription and refills at a retail pharmacy or drugstore, through the mail or by phone.
- When you need medicine right away for a limited time, you can also use retail plan pharmacies or drugstores to fill your order for up to a 90-day supply. (Not all pharmacies are contracted to provide a 90-day supply.)
- In cases where you do not have access to one of our network pharmacies, please call Customer Service at **1-877-811-3107** (TTY/ TDD line at **711**), 8 a.m. to 8 p.m., seven days a week through February 14, 2012.*

When you need Extra Help[1]

If you qualify for Medicare's Extra Help and are enrolled in a Part D plan, Medicare can help by paying up to 100% of your prescribed drug costs. This may include:

- Paying your drug plan's monthly premium, yearly deductible, coinsurance and copays for prescription drugs that are on your plan's list of covered drugs
- No coverage gap
- No late enrollment penalty, if you miss the seven-month eligibility period (three months before you turn 65, the month when you turn 65, and three months after you turn 65)

You will qualify for Extra Help if you have one of these:

- Both Medicare and Medicaid
- Help from Medicaid paying your Medicare Part B
- Both Medicare and Supplemental Security Income (SSI)

Extra Help

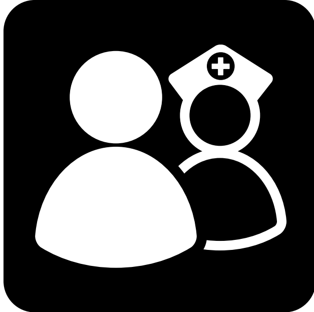
To see if you qualify for Extra Help, call:

- The Social Security Office at **1-800-772-1213** between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call **1-800-325-0778;**
- **1-800-MEDICARE (1-800-633-4227)** TTY users should call **1-877-486-2048,** 24 hours a day/seven days a week; or
- Your State Medicaid Office.

*Beginning February 15, 2012, you may call Customer Service at **1-877-811-3107** (TTY/TDD line at **711**), 8 a.m. to 8 p.m., Monday through Friday, except holidays.

1 You can't get the Part D discount if you get Medicare Extra Help.

Programs for a healthier you



When you use the resources we offer, you can help take charge of your health and control your quality of life.

Keeping your chronic conditions under control

Our **case management** program is designed to help with your needs if you have chronic obstructive pulmonary disease, diabetes, cancer, chronic renal disease (stage 4), end-stage renal disease and major surgery such as some abdominal surgeries or cardiac surgery. You can work with a care team of nurses, social workers and dietitians to help you follow your plan of care and reach your wellness goals. Trained nurses can help you learn to keep symptoms of your chronic condition under control. Nurse care managers offer integrated care management services, including lifestyle coaching, to help you deal with the challenges of having one or more health conditions.

Through **utilization management**, trained nurses help to ensure that you get the right care at the right time in the right setting. You and your doctor can work with these nurses to help you follow your plan of care and reach your wellness goals in a cost-effective way.

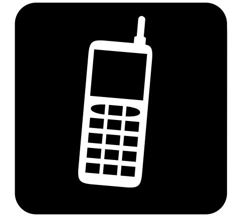
Through **case management**, a team of trained nurses, social workers and dietitians can help you:

- Coordinate your preventive care.
- Learn how to keep your symptoms under control.
- Cope with one or more health conditions.
- Access community resources you may qualify for.

Our **medical management** program has three features designed for you:

- **Preauthorization** – You, your doctor or specialist must first contact Medical Management (via phone or email) to get an OK before you get some types of care.
- **Case management** – A case manager plans, coordinates and reviews which types of care will help you get the most out of your benefits.
- **Discharge planning** – Our case manager coordinates a discharge plan with your doctor during a hospital stay. This ensures you have access to medically necessary services at the time of your discharge.

Your well-being is our concern ... 24/7



MyHealth Advantage helps you reach better outcomes

"I wish I had known sooner" is a regret we don't want you to have. Through MyHealth Advantage, we can review your health claims daily. If we detect risk issues from the drugs you're taking, we will alert you and your doctor right away. We can keep track of your routine tests and checkups as well. You will get mailings to remind you to make your next appointments or to take other preventive care actions. You even get tips that may help cut the costs of your prescribed drugs. If you have questions about the information you get, just call our health coaches toll free.

Registered nurses can help you by phone at anytime, any day

What if you get sick or injured when your doctor's office is closed? Anytime day or night, you can call the 24/7 nurse help line toll free. Registered nurses will help assess your symptoms and talk with you about your options for care. You can program the nurse help line number into all your phones. That way, you're just one touch away from the help you need. You also have access to hundreds of taped health topics in English and Spanish. Just call the nurse line and follow the prompts to get to the health topics audio library.

Preventive care at no extra cost

Help make sure you stay healthy through preventive care. Did you know that your yearly wellness exam, flu and pneumonia shots, even smoking cessation counseling, are available at no cost to you?

It's important that you get your preventive screenings and wellness exams. See the *Summary of Benefits* to find out what types of preventive care won't cost you a penny.

Stay active and informed

Healthways' SilverSneakers® Fitness Program

Being active and staying fit can lead to a healthier you. That's why we provide the **SilverSneakers® Fitness Program** as one of your benefits at no additional cost. SilverSneakers gives you a fitness membership with use of all basic amenities plus signature group exercise classes, access to any participating location in the nation, a secure online members-only community with many resources, fun events, health education and much more. SilverSneakers® Steps, an exercise program that allows you to do your own favorite workouts, is for members who don't have convenient access to a SilverSneakers fitness location.

It's easy to enroll in SilverSneakers. Take your health plan ID card to a participating SilverSneakers location and let the front desk attendant know you'd like to start using your benefit. To find a participating location, visit **www.silversneakers.com**. Get fit, have fun and make friends with SilverSneakers.

Use the tools and resources at www.anthem.com/ca/medicare as often as you want

Your **Anthem Blue Cross** website gives you access to tips and tools 24 hours a day that can help you take control of your health. You'll also find health management programs and the latest news to help you make more informed health care decisions.[1]

SpecialOffers@Anthem:
Savings and discounts just for you
Of course we want to help you save money! As a member, you can cut costs by going to network providers and using generic drugs on our preferred drug list. Depending on the plan you choose, you may get discounts for vision, hearing and dental services. You can access discounts on alternative health products and services. Check our website for a complete list of discounted products and services.[1]

The products and services described above are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the Anthem Medicare Preferred Standard (PPO) grievance process.

1 Vendors and offers are subject to change without prior notice. Anthem Blue Cross does not endorse and is not responsible for the products, services or information provided by the SpecialOffers vendors. Arrangements and discounts were negotiated between each vendor and Anthem Blue Cross for the benefit of our members.

SilverSneakers® is a registered mark of Healthways, Inc. Healthways, Inc. is an independent company.

Things to know before you enroll

Your right to appeal

When you're not happy with your health care service, we're not happy. We hope that never happens. But if ever you have a concern or cannot agree with a claim decision or a denial, feel free to let us know … and trust that we will listen. It's why we have appeals and grievance procedures in place. We will review a grievance, such as a quality-of-care complaint, within 30 days after we receive the complaint. We address appeals issues, such as payment for services, within 60 days after we receive the appeal If the appeal is for a denied service, we must decide no later than 30 days after we receive the appeal. If your health is at risk, we must respond to the appeal within 72 hours. Under some circumstances, you have the right to file an expedited grievance (rush grievance). In such a case, we must respond within 24 hours after we receive the grievance. And we're happy to do so.

What is a medical emergency and what should you do if you have one?

When you have a "medical emergency," you believe that your health is in serious danger. A medical emergency can include severe pain, a bad injury, a sudden illness or a medical condition that is quickly getting much worse. If you have a medical emergency: **Get help as quickly as possible. Call 911** for help or go to the nearest emergency room, hospital or urgent care center. Call for an ambulance if you need it. You do not need to get approval or a referral first from your primary care doctor.

How to enroll and pay for a Medicare Advantage plan

When you have made up your mind, you don't need to get a physical exam to sign up. We will not reject you because of a pre-existing medical condition, except end-stage renal disease.[1]

You will need information from your Medicare card to fill out your enrollment form. Your sales representative or agent can help you and accept a copy for your enrollment. Or, you can tear out a copy and submit the top copy of each page to the address listed on the first page of the application. You can also sign up online at **www.anthem.com/ca/medicare.**

After you submit your enrollment application

1. We will send you a letter that includes your proposed effective date. This letter is your proof of membership until you get your member ID card.
2. We will send your application to the Centers for Medicare & Medicaid Services (CMS) for approval.
3. Once it is approved by CMS, you will get a welcome letter that confirms your effective date with us. You will also get your member ID card and other new member materials.

Paying your monthly premium

If your **plan** has a premium, you can pay your premium in several ways. Simply choose your desired plan payment option on the enrollment application:

Option 1: By check. If you choose to pay your premium directly to us, you will get a bill each month.

Option 2: By automatic withdrawal.

Option 3: Taken out of your monthly Social Security check.

You must continue to pay your Medicare Part B premium.

1 If you have end-stage renal disease and have not had a kidney transplant, you usually can't join a Medicare Advantage plan. For more information about ESRD, view the booklet Medicare Coverage of Kidney Dialysis and Kidney Transplant Services at **http://go.usa.gov/lov.**
Or, to ask for a copy, call **1-800-MEDICARE (1-800-633-4227)** or the TTY/TDD line **1-877-486-2048,** 24 hours a day, seven days a week.

We’re here to help

You can call your local licensed insurance agent or one of our licensed insurance agents at **1-888-211-9813** (TTY/TDD line at **711**), 8 a.m. to 8 p.m., seven days a week. You may also call Customer Service at **1-877-811-3107** (TTY/TDD line at **711**), 8 a.m. to 8 p.m., seven days a week through February 14, 2012.* Or, visit us online at **www.anthem.com/ca/medicare**.

You can call Medicare for basic questions about how Medicare works at **1-800-MEDICARE (1-800-633-4227)** or the TTY/TDD line **1-877-486-2048,** 24 hours a day, seven days a week.

For more information on Anthem Blue Cross’s Medicare plan ratings information, see the following page or go to **www.medicare.gov.**

A health plan with a Medicare contract. The person who is discussing plan options with you is either employed by or contracted with Anthem Blue Cross. The person may be compensated based on your enrollment in a plan.

*Beginning February 15, 2012, you may call Customer Service at **1-877-811-3107** (TTY/TDD line at **711**), 8 a.m. to 8 p.m., Monday through Friday, except holidays.

This plan is a PPO with a Medicare contract.

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Anthem Blue Cross - H8552

CY 2012 Medicare Plan Ratings

The Medicare Program rates how well Medicare health and drug plans perform in different categories (for example, detecting and preventing illness, ratings from patients, patient safety, drug pricing and customer service). The information provided below is an overall plan rating of our plan's performance. This information is available to help you make the best choice. If you would like to get additional information on our plan's performance please contact us at 877-411-1647 (toll-free) or 877-247-1657 (TTY/TDD) for prospective members, 877-411-1640 (toll-free) or 877-247-1657 (TTY/TDD) for current members, or you may visit www.medicare.gov.

Below is a summary of how our plan rated in quality and performance.

The number of stars shows how well our plan performs.

★★★★★	means excellent
★★★★	means above average
★★★	means average
★★	means below average
★	means poor

Anthem Blue Cross - H8552	
Overall Plan Rating	Plan too new to be measured Stars
	The Overall Plan Rating combines scores for the types of services each plan offers: **What is being measured?** • **For plans covering health services**, the overall score for quality of those services covers **36 different topics in 5 categories**: ○ **Staying healthy**: screenings, tests, and vaccines: Includes how often members got various screening tests, vaccines, and other check-ups that help them stay healthy. ○ **Managing chronic (long-term) conditions**: Includes how often members with different conditions got certain tests and treatments that help them manage their condition. ○ **Ratings of health plan responsiveness and care**: Includes ratings of member satisfaction with the plan. ○ **Health plan member complaints and appeals**: Includes how often members filed a complaint against the plan. ○ **Health plan telephone customer service**: Includes how well the plan handles calls from members. • **For plans covering drug services**, the overall score for quality of those services covers **17 different topics in 4 categories**:

  - **Drug plan customer service**: Includes how well the drug plan handles calls and makes decisions about member appeals.
  - **Drug plan member complaints and Medicare audit findings**: Includes how often members filed a complaint about the drug plan.
  - **Member experience with drug plan**: Includes member satisfaction information.
  - **Drug pricing and patient safety**: Includes how well the drug plan prices prescriptions and provides updated information on the Medicare website. Includes information on how often members with certain medical conditions get prescription drugs that are considered safer and clinically recommended for their condition.

- **For plans covering both health & drug services**, the overall score for quality of those services covers **all of the 53 topics listed above**.

Where does the information for the Overall Plan Rating come from?

- For quality of **health services**, the information comes from sources that include:
  - Member surveys done by Medicare
  - Information from clinicians
  - Information submitted by the plans
  - Results from Medicare's regular monitoring activities

- For quality of **drug services**, the information comes from sources that include:
  - Results from Medicare's regular monitoring activities
  - Reviews of billing and other information that plans submit to Medicare
  - Member surveys done by Medicare

Why is the Overall Plan Rating important?

The Overall Plan Rating gives you a single summary score that makes it easy for you to compare plans based on quality and performance. Learn more about differences among plans by looking at the detailed ratings.

Take your plan to the next level with dental, vision and other benefits!

What are Optional Supplement Benefits (OSB) packages?

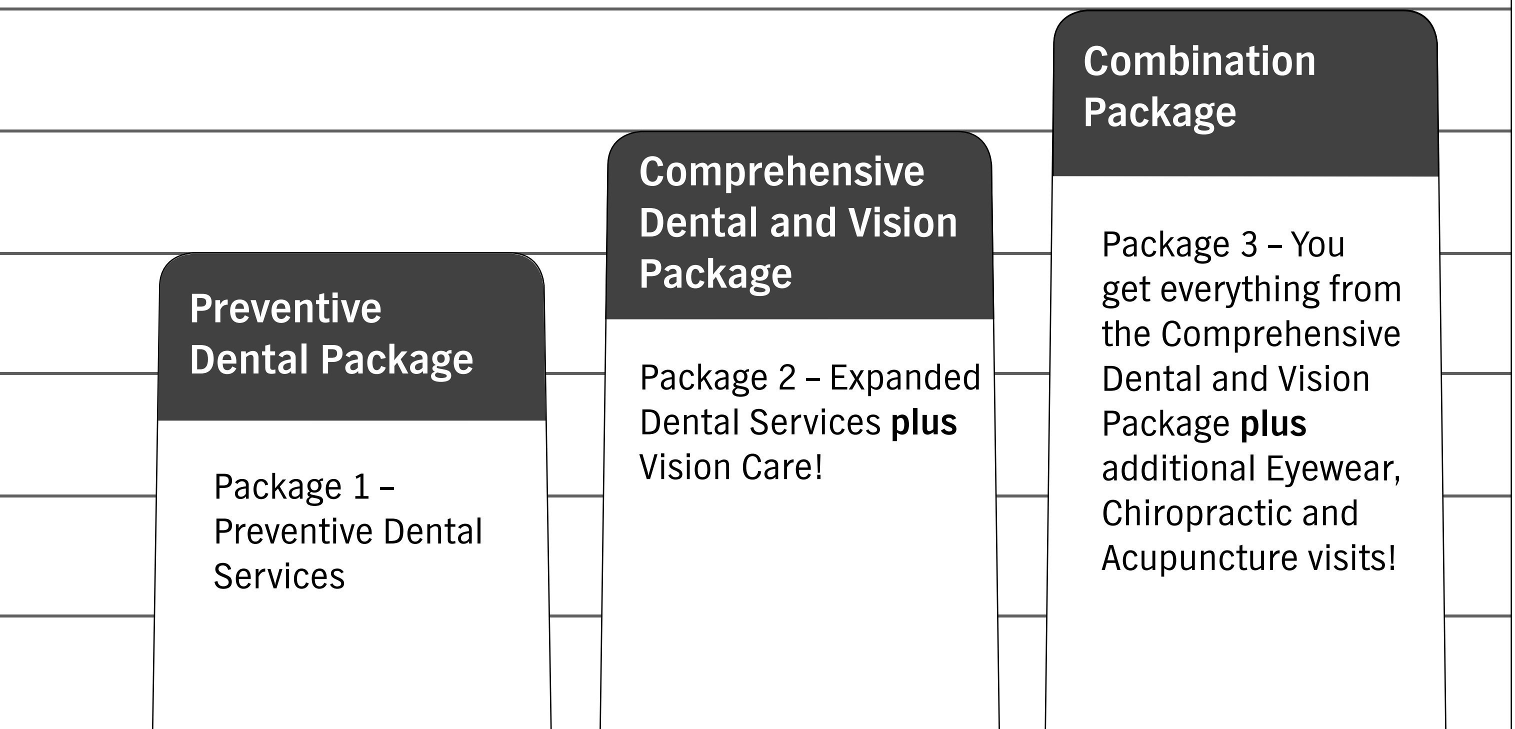
OSB packages provide benefits such as vision and dental, which are not covered under Medicare Advantage (MA) plans or Original Medicare. These packages can be added to most MA plans for a low, additional premium[1] per month.

OSBs are good for your health, in more ways than one.

By adding this extra coverage to your MA plan, you can get the care you need to help maintain good health[2]. OSBs can also help keep your out-of-pocket costs under control, which provides the added benefit of peace of mind. And, because there is no waiting period, you can start enjoying your benefits right away!

There is limited time to add an OSB package.

Don't miss the opportunity to add the benefits you want. For details on OSBs available with your plan, look in the Summary of Benefits section. Then check the box on your enrollment form for your desired OSB package.



1 You must continue to pay your Medicare Part B premium. Refer to your Summary of Benefits for more information or contact the plan.

2 National Institute of Dental and Craniofacial Research: Oral Health in America, 2008, Surgeon General's Report on Oral Health in America, 2000.

Want to talk more about your options?

Call your local licensed insurance agent or one of our licensed insurance agents at **1-888-211-9813** (TTY/TDD line at **711**), 8 a.m. to 8 p.m., seven days a week. You may also call Customer Service at **1-877-811-3107** (TTY/TDD line at **711**), 8 a.m. to 8 p.m., seven days a week through February 14, 2012.*

*Beginning February 15, 2012, you may call Customer Service at **1-877-811-3107**; (TTY/TDD line at **711**) from 8 a.m. to 8 p.m., Monday through Friday, except weekends and holidays.

A health plan with a Medicare contract.

The benefit information provided herein is a brief summary, not a comprehensive description of benefits. For more information contact the plan.

The person who is discussing plan options with you is either employed by, or contracted with, Anthem Blue Cross. The person may be compensated based on your enrollment in a plan. Benefits and premium may change on January 1, 2013.

This plan is a PPO with a Medicare contract.

Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Summary of Benefits

for Anthem Medicare Preferred Standard (PPO)

Available in Riverside, San Bernardino, and San Mateo Counties in California

This plan is a PPO with a Medicare contract. Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

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Section I:

Introduction to the Summary of Benefits

Thank you for your interest in Anthem Medicare Preferred Standard (PPO). Our plan is offered by Anthem Blue Cross Life and Health Insurance Company, a Medicare Advantage Preferred Provider Organization (PPO). This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Anthem Medicare Preferred Standard (PPO) 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 Anthem Medicare Preferred Standard (PPO). 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 Anthem Medicare Preferred Standard (PPO) at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD 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 Anthem Medicare Preferred Standard (PPO) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

Where Is Anthem Medicare Preferred Standard (PPO) Available?

The service area for this plan includes the following counties:

Riverside, San Bernardino, San Mateo counties, CA.

You must live in one of these areas to join the plan.

Who Is Eligible to Join Anthem Medicare Preferred Standard (PPO)?

You can join Anthem Medicare Preferred Standard (PPO) 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 Anthem Medicare Preferred Standard (PPO) unless they are members of our organization and have been since their dialysis began.

Can I Choose My Doctors?

Anthem Medicare Preferred Standard (PPO) has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of our network. The health providers in our network can change at any time.

You can ask for a current provider directory. For an updated list, visit us at www.anthem.com/ca/medicare. 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.

Where Can I Get My Prescriptions If I Join this plan?

Anthem Medicare Preferred Standard (PPO) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at www.anthem.com/ca/medicare. Our customer service number is listed at the end of this introduction.

Does My Plan Cover Medicare Part B or Part D Drugs?

Anthem Medicare Preferred Standard (PPO) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

What Is a Prescription Drug Formulary?

Anthem Medicare Preferred Standard (PPO) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or 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.anthem.com/ca/medicare.

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 My Prescription Drug Plan Costs or Get Extra Help With Other Medicare Costs?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

* 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week and see www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication Medicare & You.

* The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778 or

* Your State Medicaid Office.

What Are My Protections in this plan?

All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, 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 Anthem Medicare Preferred Standard (PPO), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of Anthem Medicare Preferred Standard (PPO), 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. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

What Is a Medication Therapy Management (MTM) Program?

A Medication Therapy Management (MTM) Program is a free service we 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 Anthem Medicare Preferred Standard (PPO) for more details.

What Types of Drugs May Be Covered Under Medicare Part B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Anthem Medicare Preferred Standard (PPO) for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin Alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.

- Inhalation and Infusion Drugs administered through DME.

Where Can I Find Information On Plan Ratings?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on www.medicare.gov and select "Health and Drug Plans" then "Compare Drug and Health Plans" to compare the Plan Ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the Plan Ratings for this plan. Our customer service number is listed below.

Please call Anthem Blue Cross for more information about Anthem Medicare Preferred Standard (PPO).

- Visit us at **www.anthem.com/ca/medicare** or, call us:
- **Customer Service Hours:** Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. - 8:00 p.m. Pacific
- **Current members should call toll-free for questions related to the Medicare Advantage program or the Medicare Part D Prescription Drug program. 1-877-811-3107** (TTY/TDD 711)
- **Prospective members should call toll-free for questions related to the Medicare Advantage program or the Medicare Part D Prescription Drug program. 1-888-211-9813** (TTY/TDD 711).
- **Current members should call locally for questions related to the Medicare Advantage program or the Medicare Part D Prescription Drug program. 1-877-811-3107** (TTY/TDD 711)
- **Prospective members should call locally for questions related to the Medicare Advantage program or the Medicare Part D Prescription Drug program. 1-888-211-9813** (TTY/TDD 711)
- **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.
- This document may be available in other formats such as Braille, large print or other alternate formats.
- This document may be available in a non-English language. For additional information, call customer service at the phone number listed above.
- Esta información está disponible en otros idiomas de manera gratuita. Comuníquese con el número de nuestro Servicio de Atención al Cliente al **1-877-811-3107** (o a la línea TTY/TDD al 711) de 8 a. m. a 8 p. m., los 7 días de la semana, hasta el 14 de febrero de 2012, para obtener información adicional.*

* A partir del 15 de febrero de 2012, puede llamar al Servicio de Atención al Cliente al **1-877-811-3107** (o a la línea TTY/TDD al 711) de 8 a. m. a 8 p. m., de lunes a viernes, excepto feriados.

Section II:

Summary of Benefits

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
IMPORTANT INFORMATION		
1 **Premium and Other Important Information**	In 2011 the monthly Part B Premium was $96.40 and may change for 2012 and the annual Part B deductible amount was $162 and may change for 2012. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	**General** $106 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. Some physicians, providers and suppliers that are out of a plan's network (i.e., out-of-network) accept "assignment" from Medicare and will only charge up to a Medicare-approved amount. If you choose to see an out-of-network physician who does NOT accept Medicare "assignment," your coinsurance can be based on the Medicare-approved amount plus an additional amount up to a higher Medicare "limiting charge." If you are a member of a plan that charges a copay for out-of-network physician services, the higher Medicare "limiting charge" does not apply. See the publications Medicare You or Your Medicare Benefits available on www.medicare.gov for a full listing of benefits under Original Medicare, as well as for

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
		explanations of the rules related to "assignment" and "limiting charges" that apply by benefit type. To find out if physicians and DME suppliers accept assignment or participate in Medicare, visit www.medicare.gov/physician or www.medicare.gov/supplier. You can also call 1-800-MEDICARE, or ask your physician, provider, or supplier if they accept assignment. **In-Network** $3,400 out-of-pocket limit for Medicare-covered services. **In and Out-of-Network** $300 annual deductible. Contact the plan for services that apply. $3,400 out-of-pocket limit for Medicare-covered services.
2 **Doctor and Hospital Choice** (For more information, see Emergency Care - #15 and Urgently Needed Care - #16.)	You may go to any doctor, specialist or hospital that accepts Medicare.	**In-Network** No referral required for network doctors, specialists, and hospitals. **In and Out-of-Network** You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits. **Out of Service Area** Plan covers you when you travel in the U.S.

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
SUMMARY OF BENEFITS		
Inpatient Care		
3 **Inpatient Hospital Care** (includes Substance Abuse and Rehabilitation Services)	In 2011 the amounts for each benefit period were: • Days 1 - 60: $1132 deductible • Days 61 - 90: $283 per day • Days 91 - 150: $566 per lifetime reserve day These amounts may change for 2012. Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once. 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.	**In-Network** No limit to the number of days covered by the plan each hospital stay. $725 copay for each Medicare-covered hospital stay $0 copay for additional hospital days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** 20% of the cost for each hospital stay.
4 **Inpatient Mental Health Care**	In 2011 the amounts for each benefit period were: • Days 1 - 60: $1132 deductible • Days 61 - 90: $283 per day • Days 91 - 150: $566 per lifetime reserve day These amounts may change for 2012. You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.	**In-Network** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. $725 copay for each Medicare-covered hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
		Out-of-Network 20% of the cost for each hospital stay.
5 **Skilled Nursing Facility (SNF)** (in a Medicare-certified skilled nursing facility)	In 2011 the amounts for each benefit period after at least a 3-day covered hospital stay were: • Days 1 - 20: $0 per day • Days 21 - 100: $141.50 per day These amounts may change for 2012. 100 days for each benefit period. 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.	**General** Authorization rules may apply. **In-Network** Plan covers up to 100 days each benefit period No prior hospital stay is required. For SNF stays: • Days 1 - 20: $0 copay per day • Days 21 - 100: $140 copay per day **Out-of-Network** 20% of the cost for each SNF stay.
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** $0 copay for each Medicare-covered home health visit **Out-of-Network** 30% of the cost 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.	**General** You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
OUTPATIENT CARE		
8 Doctor Office Visits	20% coinsurance	**In-Network** $10 copay for each primary care doctor visit for Medicare-covered benefits. $35 copay for each in-area, network urgent care Medicare-covered visit $45 copay for each specialist visit for Medicare-covered benefits. **Out-of-Network** $35 copay for each primary care doctor visit $55 copay for each specialist visit
9 Chiropractic Services	Supplemental routine care not covered 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	**General** Authorization rules may apply. **In-Network** $20 copay for each Medicare-covered visit Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers. **Out-of-Network** $40 copay for chiropractic benefits.
10 Podiatry Services	Supplemental routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	**In-Network** $45 copay for each Medicare-covered visit Medicare-covered podiatry benefits are for medically-necessary foot care. **Out-of-Network** $55 copay for podiatry benefits.
11 Outpatient Mental Health Care	40% coinsurance for most outpatient mental health services	**General** Authorization rules may apply.

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
	Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copay cannot exceed the Part A inpatient hospital deductible. "Partial hospitalization program" is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	**In-Network** $40 copay for each Medicare-covered individual therapy visit $40 copay for each Medicare-covered group therapy visit $40 copay for each Medicare-covered individual therapy visit with a psychiatrist $40 copay for each Medicare-covered group therapy visit with a psychiatrist $45 copay for Medicare-covered partial hospitalization program services **Out-of-Network** 30% of the cost for Mental Health benefits with a psychiatrist 30% of the cost for Mental Health benefits 30% of the cost for partial hospitalization program services
12 Outpatient Substance Abuse Care	20% coinsurance	**General** Authorization rules may apply. **In-Network** $40 copay for Medicare-covered individual visits $40 copay for Medicare-covered group visits **Out-of-Network** 30% of the cost for outpatient substance abuse benefits.
13 Outpatient Services/Surgery	20% coinsurance for the doctor's services Specified copayment for outpatient hospital facility services Copay cannot exceed the Part A inpatient hospital deductible. 20% coinsurance for ambulatory surgical center facility services	**General** Authorization rules may apply. **In-Network** $0 to $225 copay for each Medicare-covered ambulatory surgical center visit $0 to $275 copay for each Medicare-covered outpatient hospital facility visit

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
		Out-of-Network 30% of the cost for outpatient hospital facility benefits. 30% of the cost for ambulatory surgical center benefits.
14 **Ambulance Services** (medically necessary ambulance services)	20% coinsurance	**General** Authorization rules may apply. **In-Network** $200 copay for Medicare-covered ambulance benefits. **Out-of-Network** $200 copay for ambulance benefits.
15 **Emergency Care** (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor's services Specified copayment for outpatient hospital facility emergency services. Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital. You don't have to pay the emergency room copay if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit. Not covered outside the U.S. except under limited circumstances.	**General** $65 copay for Medicare-covered emergency room visits Worldwide coverage. If you are admitted to the hospital within 72-hour(s) for the same condition, you pay $0 for the emergency room visit.
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 NOT covered outside the U.S. except under limited circumstances.	**General** $35 copay for Medicare-covered urgently-needed-care visits If you are admitted to the hospital within 72-hour(s) for the same condition, you pay $0 for the urgently-needed-care visit.

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
17 Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance	**General** Authorization rules may apply. **In-Network** $50 copay for Medicare-covered Occupational Therapy visits $50 copay for Medicare-covered Physical and/or Speech and Language Therapy visits **Out-of-Network** 30% of the cost for Physical and/or Speech and Language Therapy visits 30% of the cost for Occupational Therapy benefits.
Outpatient Medical Services and Supplies		
18 Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items **Out-of-Network** 30% of the cost for durable medical equipment
19 Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	20% coinsurance	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items **Out-of-Network** 30% of the cost for prosthetic devices.
20 Diabetes Programs and Supplies	20% coinsurance for diabetes self-management training 20% coinsurance for diabetes supplies 20% coinsurance for diabetic therapeutic shoes or inserts	**General** Authorization rules may apply. **In-Network** $0 copay for Diabetes self-management training $0 copay for Diabetes monitoring supplies

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
		$0 copay for Therapeutic shoes or inserts **Out-of-Network** 30% of the cost for Diabetes self-management training 30% of the cost for Diabetes monitoring supplies 30% of the cost for Therapeutic shoes or inserts
21 Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	20% coinsurance for diagnostic tests and x-rays $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 supplemental routine screening tests, like checking your cholesterol.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered lab services $0 to $200 copay for Medicare-covered diagnostic procedures and tests $65 copay for Medicare-covered X-rays $65 to $200 copay for Medicare-covered diagnostic radiology services (not including X-rays) 20% of the cost for Medicare-covered therapeutic radiology services If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of $10 to $45 may apply If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of $10 to $45 may apply **Out-of-Network** 30% of the cost for therapeutic radiology services 30% of the cost for outpatient X-rays 30% of the cost for diagnostic radiology services

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
		$15 copay [or 30% of the cost] for diagnostic procedures, tests, and lab services
22 Cardiac and Pulmonary Rehabilitation Services	20% coinsurance Cardiac Rehabilitation services 20% coinsurance for Pulmonary Rehabilitation services 20% coinsurance for Intensive Cardiac Rehabilitation services This applies to program services provided in a doctor's office. Specified cost sharing for program services provided by hospital outpatient departments.	**In-Network** $45 copay for Medicare-covered Cardiac Rehabilitation Services $45 copay for Medicare-covered Intensive Cardiac Rehabilitation Services $45 copay for Medicare-covered Pulmonary Rehabilitation Services **Out-of-Network** 30% of the cost for Cardiac Rehabilitation Services 30% of the cost for Intensive Cardiac Rehabilitation Services 30% of the cost for Pulmonary Rehabilitation Services
PREVENTIVE SERVICES		
23 Preventive Services and Wellness/ Education Programs	No coinsurance, copayment or deductible for the following: • Abdominal Aortic Aneurysm Screening • Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. • Cardiovascular Screening • Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk. • Colorectal Cancer Screening • Diabetes Screening • Influenza Vaccine • Hepatitis B Vaccine for people with Medicare who are at risk	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing: • Abdominal Aortic Aneurysm screening • Bone Mass Measurement • Cardiovascular Screening • Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) • Colorectal Cancer Screening • Diabetes Screening • Influenza Vaccine • Hepatitis B Vaccine • HIV Screening • Breast Cancer Screening (Mammogram) • Medical Nutrition Therapy Services • Personalized Prevention Plan Services (Annual Wellness Visits)

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
	• HIV Screening. $0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. • Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39. • Medical Nutrition Therapy Services Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease • Personalized Prevention Plan Services (Annual Wellness Visits) • Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information. • Prostate Cancer Screening - Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50. • Smoking Cessation (counseling to stop smoking). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.	• Pneumococcal Vaccine • Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) • Smoking Cessation (Counseling to stop smoking) • Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details. **In-Network** The plan covers the following supplemental education/wellness programs: • Health Club Membership/Fitness Classes • Nursing Hotline **Out-of-Network** $0 copay for supplemental education/wellness programs 30% of the cost for Medicare-covered preventive services

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
	• Welcome to Medicare Physical Exam (initial preventive physical exam) When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Physical Exam or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months.	
24 Kidney Disease and Conditions	20% coinsurance for renal dialysis 20% coinsurance for kidney disease education services	**In-Network** 20% of the cost for renal dialysis $0 copay for kidney disease education services **Out-of-Network** 30% of the cost for kidney disease education services 20% of the cost for renal dialysis
25 Outpatient Prescription Drugs	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	**Drugs Covered Under Medicare Part B General** 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. 20% of the cost for Part B drugs out-of-network. **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.anthem.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) providers. The plan offers national in-network prescription coverage (i.e., this would include

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
		50 states and the District of Columbia). This means that you will pay the same cost-sharing 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 a Part D plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from Anthem Medicare Preferred Standard (PPO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Anthem Medicare Preferred Standard (PPO) approves the exception, you will pay Tier 4: Non-Preferred Brand Drugs cost sharing for that drug. **In-Network** $316 annual deductible.

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
		Initial Coverage After you pay your yearly deductible, you pay the following until total yearly drug costs reach $2,930: **Retail Pharmacy** Tier 1: Preferred Generic Drugs • $2 copay for a one-month (30-day) supply of drugs in this tier • $6 copay for a three-month (90-day) supply of drugs in this tier Tier 2: Non-Preferred Generic Drugs • $5 copay for a one-month (30-day) supply of drugs in this tier • $15 copay for a three-month (90-day) supply of drugs in this tier Tier 3: Preferred Brand Drugs • $43 copay for a one-month (30-day) supply of drugs in this tier • $129 copay for a three-month (90-day) supply of drugs in this tier Tier 4: Non-Preferred Brand Drugs • $90 copay for a one-month (30-day) supply of drugs in this tier • $270 copay for a three-month (90-day) supply of drugs in this tier Tier 5: Injectable Drugs • 25% coinsurance for a one-month (30-day) supply of drugs in this tier • 25% coinsurance for a three-month (90-day) supply of drugs in this tier Tier 6: Specialty Tier Drugs • 25% coinsurance for a one-month (30-day) supply of drugs in this tier **Long-Term Care Pharmacy** Tier 1: Preferred Generic Drugs • $2 copay for a one-month (34-day) supply of drugs in this tier

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
		Tier 2: Non-Preferred Generic Drugs • $5 copay for a one-month (34-day) supply of drugs in this tier Tier 3: Preferred Brand Drugs • $43 copay for a one-month (34-day) supply of drugs in this tier Tier 4: Non-Preferred Brand Drugs • $90 copay for a one-month (34-day) supply of drugs in this tier Tier 5: Injectable Drugs • 25% coinsurance for a one-month (34-day) supply of drugs in this tier Tier 6: Specialty Tier Drugs • 25% coinsurance for a one-month (34-day) supply of drugs in this tier **Mail Order** Tier 1: Preferred Generic Drugs • $3 copay for a three-month (90-day) supply of drugs in this tier Tier 2: Non-Preferred Generic Drugs • $7.50 copay for a three-month (90-day) supply of drugs in this tier Tier 3: Preferred Brand Drugs • $107.50 copay for a three-month (90-day) supply of drugs in this tier Tier 4: Non-Preferred Brand Drugs • $225 copay for a three-month (90-day) supply of drugs in this tier Tier 5: Injectable Drugs • 25% coinsurance for a three-month (90-day) supply of drugs in this tier Tier 6: Specialty Tier Drugs • 25% coinsurance for a one-month (30-day) supply of drugs in this tier

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
		Coverage Gap After your total yearly drug costs reach $2,930, you receive a discount on brand name drugs and pay 86% of the plan's costs for all generic drugs until your yearly out-of-pocket drug costs reach $4,700. **Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,700, you pay the greater of: • 5% coinsurance, or • $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other 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 have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Anthem Medicare Preferred Standard (PPO). **Out-of-Network Initial Coverage** After you pay your yearly deductible, you will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until your total yearly drug costs reach $2,930: Tier 1: Preferred Generic Drugs • $2 copay for a one-month (30-day) supply of drugs in this tier Tier 2: Non-Preferred Generic Drugs • $5 copay for a one-month (30-day) supply of drugs in this tier

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
		Tier 3: Preferred Brand Drugs • $43 copay for a one-month (30-day) supply of drugs in this tier Tier 4: Non-Preferred Brand Drugs • $90 copay for a one-month (30-day) supply of drugs in this tier Tier 5: Injectable Drugs • 25% coinsurance for a one-month (30-day) supply of drugs in this tier Tier 6: Specialty Tier Drugs • 25% coinsurance for a one-month (30-day) supply of drugs in this tier You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Additional Out-of-Network Coverage Gap** You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach $4,700. You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: • 5% coinsurance, or • $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs.

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
		You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.
26 Dental Services	Preventive dental services (such as cleaning) not covered.	**In-Network** In general, preventive dental benefits (such as cleaning) not covered. However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits.") 0% of the cost for Medicare-covered dental benefits **Out-of-Network** $0 copay for comprehensive dental benefits
27 Hearing Services	Supplemental routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	**In-Network** In general, supplemental routine hearing exams and hearing aids not covered. • $45 copay for Medicare-covered diagnostic hearing exams **Out-of-Network** 30% of the cost for hearing exams.
28 Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Supplemental routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.	**In-Network** In general, supplemental routine eye exams and eye wear not covered. However, this plan covers some vision benefits for an extra cost (see "Optional Benefits"). • $0 copay for one pair of eyeglasses or contact lenses after cataract surgery. • $0 copay for exams to diagnose and treat diseases and conditions of the eye. **Out-of-Network** $0 copay for eye exams. $0 copay for eye wear.

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
Over-the-Counter Items	Not covered.	**General** The plan does not cover Over-the-Counter items.
Transportation (Routine)	Not covered.	**In-Network** This plan does not cover supplemental routine transportation.
Acupuncture	Not covered.	**In-Network** This plan does not cover Acupuncture.
OPTIONAL SUPPLEMENTAL PACKAGE #1		
Premium and Other Important Information		**General** Package: 1 - Preventive Dental Package: $12 monthly premium, in addition to your $106 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: • Preventive Dental
Dental Services		**In-Network** $0 copay for the following preventive dental benefits: • up to 2 oral exam(s) every year • up to 2 cleaning(s) every year • up to 1 dental x-ray(s) every year **Out-of-Network** 20% of the cost for preventive dental services **In and Out-of-Network** $500 plan coverage limit for preventive dental benefits every year. This limit applies to both in-network and out-of-network benefits.

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
OPTIONAL SUPPLEMENTAL PACKAGE #2		
Premium and Other Important Information		**General** Package: 2 - Comprehensive Dental and Vision Package: $32 monthly premium, in addition to your $106 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: • Preventive Dental • Comprehensive Dental • Eye Exams • Eye Wear
Dental Services		**In-Network** • $0 copay for up to 2 cleaning(s) every year • $0 copay for up to 2 oral exam(s) every year • $0 copay for up to 1 dental x-ray(s) every year **Out-of-Network** 30% of the cost for preventive dental services 30% to 75% of the cost for comprehensive dental services **In and Out-of-Network** $1,000 plan coverage limit for dental benefits every year. This limit applies to both in-network and out-of-network benefits. Contact the plan for availability of additional in-network and out-of-network comprehensive dental benefits.
Vision Services		**In-Network** $0 copay for: • and up to 1 supplemental routine eye exam(s) every year $0 copay for • up to 1 pair(s) of glasses every year

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
		• up to 1 pair(s) of contacts every year
OPTIONAL SUPPLEMENTAL PACKAGE #3		
Premium and Other Important Information		**General** Package: 3 - Combination Package: $45 monthly premium, in addition to your $106 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: • Chiropractic Services • Acupuncture • Preventive Dental • Comprehensive Dental • Eye Exams • Eye Wear
Chiropractic Services		**In-Network** $20 copay for up to 10 supplemental routine visit(s) every year **Out-of-Network** $30 copay for chiropractic services
Dental Services		**In-Network** • $0 copay for up to 2 cleaning(s) every year • $0 copay for up to 2 oral exam(s) every year • $0 copay for up to 1 dental x-ray(s) every year **Out-of-Network** 30% of the cost for preventive dental services 30% to 75% of the cost for comprehensive dental services **In and Out-of-Network** $1,000 plan coverage limit for dental benefits every year. This limit applies to both in-network and out-of-network benefits.

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Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
		Contact the plan for availability of additional in-network and out-of-network comprehensive dental benefits.
Vision Services		**In-Network** • $0 copay for up to 1 pair(s) of contacts every year • $0 copay for up to 1 pair(s) of glasses every year • $0 copay for up to 1 supplemental routine eye exam(s) every year **Out-of-Network** $0 copay for eye exams. $0 copay for eye wear.