

Summary of Benefits for Freedom BlueSM Plan I

Available in California

Si usted necesita asistencia en español para poder entender este documento, podrá requerirla sin costo alguno llamándonos gratis al número telefónico que se muestra en este material. M0013_08_014 07/2007

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Section 1: Introduction to the Summary of Benefits for Freedom Blue Plan I

January 1, 2009 – December 31, 2009

Thank you for your interest in Freedom Blue Plan I. Our plan is offered by Anthem Blue Cross Life and Health Insurance Company, a Medicare Advantage Regional Preferred Provider Organization (RPPO).

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 Freedom Blue Plan I and ask for the "Evidence of Coverage."

You Have Choices in Your Health Care

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like Freedom Blue Plan I. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may be able to join or leave a plan only at certain times. Please call Freedom Blue Plan I at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

How Can I Compare My Options?

You can compare Freedom Blue Plan I and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

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

Where Is Freedom Blue Plan I Available?

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

Who Is Eligible to Join Freedom Blue Plan I?

You can join Freedom Blue Plan I if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with end-stage renal disease are generally not eligible to enroll in Freedom

Blue Plan I unless they are members of our organization and have been since their dialysis began.

Can I Choose My Doctors?

Freedom Blue Plan I 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 or for an up-to-date list, visit us at www.anthem.com/ca. Our customer service number is listed at the end of this introduction.

What Happens If I Go to a Doctor Who's Not in Your Network?

You can go to doctors, specialists, or hospitals in or out of network. You may have to pay more for the services you receive outside the network, and you may have to follow special rules prior to getting services in and/or out of network. For more information, please call the customer service number at the end of this introduction.

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

Freedom Blue Plan I does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

Where Can I Get My Prescriptions If I Join This Plan?

Freedom Blue Plan I 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/medicare. Our customer service number is listed at the end of this introduction.

Freedom Blue Plan I has a list of preferred pharmacies. At these pharmacies, you may get your drugs at a lower copay or coinsurance. You may go to a non-preferred pharmacy, but you may have to pay more for your prescription drugs.

What Is a Prescription Drug Formulary?

Freedom Blue Plan I 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 website at www.anthem.com/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 Prescription Drug Plan Costs?

If you qualify for extra help with your Medicare prescription drug plan costs, your premium and costs at the pharmacy will be lower. When you join Freedom Blue Plan I, Medicare will tell us how much extra help you are getting. Then we will let you know the amount you will pay.

If you are not getting this extra help, you can see if you qualify by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

What Are My Protections in This Plan?

All Medicare Advantage plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Freedom Blue Plan I, you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance.

You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost.

You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request.

If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug.

What Is a Medication Therapy Management (MTM) Program?

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

Please call Anthem Blue Cross for more information about Freedom Blue Plan I.

Visit us at www.anthem.com/medicare or call us:

Customer Service Hours: 8 a.m. to 8 p.m., 7 days a week

Current members should call, toll free, 1-877-811-3107 for questions related to the Medicare Advantage program or Medicare Part D Prescription Drug program (TTY/TDD: 1-877-247-1657).

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

For more information about Medicare, please call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Or, visit www.medicare.gov on the Web.

If you have special needs, this document may be available in other formats.

Section 2: Summary of Benefits for Freedom Blue Plan I

If you have any questions about this plan's benefits or costs, please contact Anthem Blue Cross for details.

Benefit	Original Medicare	Freedom Blue Plan I
<p>1. <i>Premium and Other Important Information</i></p>	<p>In 2008, the monthly Part B Premium was \$96.40 and will change for 2009, and the yearly Part B deductible amount was \$135 and will change for 2009.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p>	<p>General</p> <p>\$0 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>In- and Out-of-Network</p> <p>\$1,050 yearly deductible. Contact the plan for services that apply.</p> <p>\$4,000 combined (in- and out-of-network) out-of-pocket limit.</p> <p>All Medicare services covered under the out-of-pocket limit</p> <p>Expenses for the following services and supplies do not apply to the out-of-pocket limit, even when they are covered under your plan:</p> <ul style="list-style-type: none"> ▪ Health Education/Wellness ▪ Eye Exams ▪ Eye Wear ▪ Part D Prescription Drugs
<p>2. <i>Doctor and Hospital Choice</i></p> <p><i>(For more information see Emergency - #15 and Urgently Needed Care - #16.)</i></p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p>In-Network</p> <p>No referral required for network doctors, specialists, and hospitals.</p> <p>You may have to pay a separate copay for certain doctor office visits.</p>

Benefit	Original Medicare	Freedom Blue Plan I
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Inpatient Care

<p>3. <i>Inpatient Hospital Care</i></p> <p>(Includes substance abuse and rehabilitation services)</p>	<p>In 2008, the amounts for each benefit period were:</p> <ul style="list-style-type: none"> ▪ Days 1 - 60: \$1,024 deductible ▪ Days 61 - 90: \$256 per day ▪ Days 91 - 150: \$512 per lifetime reserve day <p>These amounts will change for 2009.</p> <p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</p> <p>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.</p>	<p>In-Network</p> <p>10% of the cost for each Medicare-covered hospital stay</p> <p>\$0 copay for additional hospital days</p> <p>No limit to the number of days covered by the plan each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-Network</p> <p>10% of the cost for each hospital stay.</p>
<p>4. <i>Inpatient Mental Health Care</i></p>	<p>Same deductible and copay as inpatient hospital care (see “Inpatient Hospital Care” above).</p> <p>190-day lifetime limit in a psychiatric hospital.</p>	<p>In-Network</p> <p>10% of the cost for each Medicare-covered hospital stay.</p> <p>You get up to 190 days in a psychiatric hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-Network</p> <p>10% of the cost for each hospital stay.</p>

Benefit	Original Medicare	Freedom Blue Plan I
<p>5. Skilled Nursing Facility</p> <p>(In a Medicare-certified skilled nursing facility)</p>	<p>In 2008, the amounts for each benefit period after at least a 3-day covered hospital stay were:</p> <ul style="list-style-type: none"> ▪ Days 1 - 20: \$0 per day ▪ Days 21 - 100: \$128 per day <p>These amounts will change for 2009.</p> <p>100 days for each benefit period.</p> <p>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.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>For SNF stays:</p> <ul style="list-style-type: none"> ▪ Days 1 - 10: 0% of the cost per day ▪ Days 11 - 100: 10% of the cost per day <p>Plan covers up to 100 days each benefit period</p> <p>No prior hospital stay is required.</p> <p>Out-of-Network</p> <p>20% of the cost for each SNF stay.</p>
<p>6. Home Health Care</p> <p>(Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation service, etc.)</p>	<p>\$0 copay.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>10% of the cost for each Medicare-covered home health visit.</p> <p>Out-of-Network</p> <p>20% for home health visits.</p>
<p>7. Hospice</p>	<p>You pay part of the cost for outpatient drugs and inpatient respite care.</p> <p>You must get care from a Medicare-certified hospice.</p>	<p>General</p> <p>You must get care from a Medicare-certified hospice.</p>

Benefit	Original Medicare	Freedom Blue Plan I
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Outpatient Care

<p>8. <i>Doctor Office Visits</i></p>	<p>20% coinsurance</p>	<p>General See “Physical Exams” for more information.</p> <p>In-Network \$10 copay for each primary care doctor visit for Medicare-covered benefits. \$10 to \$20 copay for each in-area, network urgent care Medicare-covered visit. \$20 copay for each specialist visit for Medicare-covered benefits.</p> <p>Out-of-Network \$25 copay for each primary care doctor visit. \$35 copay for each specialist visit.</p>
<p>9. <i>Chiropractic Services</i></p>	<p>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.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 10% of the cost for Medicare-covered visits. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.</p> <p>Out-of-Network 20% of the cost for chiropractic benefits.</p>
<p>10. <i>Podiatry Services</i></p>	<p>Routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>	<p>In-Network 10% of the cost for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically necessary foot care.</p> <p>Out-of-Network 20% of the cost for podiatry benefits.</p>

Benefit	Original Medicare	Freedom Blue Plan I
11. <i>Outpatient Mental Health Care</i>	50% coinsurance for most outpatient mental health services.	<p>General Authorization rules may apply.</p> <p>In-Network 10% of the cost for each Medicare-covered individual or group therapy visit.</p> <p>Out-of-Network 20% of the cost for Mental Health benefits. 20% of the cost for Mental Health benefits with a psychiatrist.</p>
12. <i>Outpatient Substance Abuse Care</i>	20% coinsurance	<p>General Authorization rules may apply.</p> <p>In-Network 10% of the cost for Medicare-covered individual or group visits.</p> <p>Out-of-Network 20% of the cost for outpatient substance abuse benefits.</p>
13. <i>Outpatient Services/ Surgery</i>	20% coinsurance for the doctor 20% of outpatient facility charges	<p>General Authorization rules may apply.</p> <p>In-Network \$100 copay for each Medicare-covered ambulatory surgical center visit. \$20 copay (or 10% of the cost) for each Medicare-covered outpatient hospital facility visit.</p> <p>Out-of-Network 20% of the cost for ambulatory surgical center benefits. 10% of the cost for outpatient hospital facility benefits.</p>

Benefit	Original Medicare	Freedom Blue Plan I
<p>14. <i>Ambulance Services</i></p> <p>(Medically necessary ambulance services)</p>	<p>20% coinsurance</p>	<p>In-Network \$100 copay for Medicare-covered ambulance benefits.</p> <p>Out-of-Network \$100 copay for ambulance benefits.</p>
<p>15. <i>Emergency Care</i></p> <p>(You may go to any emergency room if you reasonably believe you need emergency care.)</p>	<p>20% coinsurance for the doctor 20% of facility charge, or a set copay per emergency room visit</p> <p>You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within three days of the emergency room visit.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>In-Network \$50 copay for Medicare-covered emergency room visits.</p> <p>Out-of-Network Worldwide coverage.</p> <p>In- and Out-of-Network If you are admitted to the hospital within 72-hour(s) for the same condition, you pay \$0 for the emergency room visit</p>
<p>16. <i>Urgently Needed Care</i></p> <p>(This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>20% coinsurance, or a set copay NOT covered outside the U.S. except under limited circumstances.</p>	<p>General \$35 copay for Medicare-covered urgently needed care visits.</p> <p>If you are admitted to the hospital within 72-hour(s) for the same condition, \$0 for the urgent-care visit.</p>
<p>17. <i>Outpatient Rehabilitation Services</i></p> <p>(Occupational therapy, physical therapy, speech and language therapy)</p>	<p>20% coinsurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network 10% of the cost for Medicare-covered occupational therapy visits. 10% of the cost for Medicare-covered physical and/or speech/language therapy visits.</p>

Benefit	Original Medicare	Freedom Blue Plan I
		<p>Out-of-Network 20% of the cost for occupational therapy benefits. 20% of the cost for physical and/or speech/language therapy visits.</p>

Outpatient Medical Services and Supplies

<p>18. <i>Durable Medical Equipment</i> (Includes wheel chairs, oxygen, etc.)</p>	<p>20% coinsurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items.</p> <p>Out-of-Network 30% of the cost for durable medical equipment.</p>
<p>19. <i>Prosthetic Devices</i> (Includes braces, artificial limbs and eyes, etc.)</p>	<p>20% coinsurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items.</p> <p>Out-of-Network 30% of the cost for prosthetic devices.</p>
<p>20. <i>Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies</i> (Includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)</p>	<p>20% coinsurance 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 or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Diabetes self-monitoring training. \$0 copay for Nutrition Therapy for Diabetes. 10% of the cost for Diabetes supplies.</p> <p>Out-of-Network 20% of the cost for Diabetes self-monitoring training. 20% of the cost for Nutrition Therapy for Diabetes. 15% of the cost for Diabetes supplies.</p>

Benefit	Original Medicare	Freedom Blue Plan I
<p>21. <i>Diagnostic Tests, X-Rays, and Lab Services</i></p>	<p>20% coinsurance for diagnostic tests and X-rays</p> <p>\$0 copay for Medicare-covered lab services</p> <p>Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered lab services.</p> <p>\$100 copay (or 10% of the cost) for Medicare-covered diagnostic procedures and tests.</p> <p>\$100 copay (or 10% of the cost) for Medicare-covered X-rays.</p> <p>\$100 copay (or 10% of the cost) for Medicare-covered diagnostic radiology services.</p> <p>20% of the cost for Medicare-covered therapeutic radiology services.</p> <p>Out-of-Network</p> <p>20% of the cost for diagnostic procedures, tests, and lab services.</p> <p>20% of the cost for outpatient X-rays.</p> <p>20% of the cost for diagnostic radiology services</p> <p>30% of the cost for therapeutic radiology services</p> <p>\$150 copay for diagnostic procedures, tests, and lab services.</p> <p>\$150 copay for outpatient X-rays.</p> <p>\$150 copays for diagnostic radiology services</p>

Preventive Services

<p>22. <i>Bone Mass Measurement</i></p> <p><i>(For people with Medicare who are at risk)</i></p>	<p>20% coinsurance</p> <p>Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered bone mass measurement</p> <p>Out-of-Network</p> <p>20% of the cost for Medicare-covered bone mass measurement.</p>
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Benefit	Original Medicare	Freedom Blue Plan I
<p>23. <i>Colorectal Screening Exam</i></p> <p><i>(For people with Medicare age 50 and older)</i></p>	<p>20% coinsurance</p> <p>Covered when you are high risk or when you are age 50 and older.</p>	<p>In-Network</p> <p>\$0 copay for Medicare-covered colorectal screenings.</p> <p>Out-of-Network</p> <p>20% of the cost for colorectal screenings.</p>
<p>24. <i>Immunizations</i></p> <p>(Flu vaccine, Hepatitis B vaccine – for people with Medicare who are at risk; Pneumonia vaccine)</p>	<p>\$0 copay for flu and pneumonia vaccines</p> <p>20% coinsurance for Hepatitis B vaccine</p> <p>You may only need the pneumonia vaccine once in your lifetime. Call your doctor for more information.</p>	<p>In-Network</p> <p>\$0 copay for flu and pneumonia vaccines.</p> <p>\$0 copay for Hepatitis B vaccine.</p> <p>No referral needed for flu and pneumonia vaccines.</p> <p>No referral needed for other immunizations.</p> <p>Out-of-Network</p> <p>20% of the cost for immunizations.</p>
<p>25. <i>Mammograms (Annual Screenings)</i></p> <p>(For women with Medicare age 40 and older)</p>	<p>20% coinsurance</p> <p>No referral needed.</p> <p>Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered screening mammograms.</p> <p>Out-of-Network</p> <p>20% of the cost for screening mammograms.</p>
<p>26. <i>Pap Smears and Pelvic Exams</i></p> <p>(For women with Medicare)</p>	<p>\$0 copay for Pap smears</p> <p>Covered once every 2 years.</p> <p>Covered once a year for women with Medicare at high risk.</p> <p>20% coinsurance for Pelvic Exams</p>	<p>In-Network</p> <p>\$0 copay for Medicare-covered Pap smears and pelvic exams.</p> <p>Out-of-Network</p> <p>20% of the cost for Pap smears and pelvic exams.</p>

Benefit	Original Medicare	Freedom Blue Plan I
<p>27. <i>Prostate Cancer Screening Exams</i></p> <p>(For men with Medicare age 50 and older)</p>	<p>20% coinsurance for the digital rectal exam. \$0 for the PSA test; 20% coinsurance for other related services.</p> <p>Covered once a year for all men with Medicare over age 50.</p>	<p>In-Network</p> <p>\$0 copay for Medicare-covered prostate cancer screening.</p> <p>Out-of-Network</p> <p>20% of the cost for prostate cancer screening.</p>
<p>28. <i>End-Stage Renal Disease</i></p>	<p>20% coinsurance for renal dialysis 20% coinsurance for Nutrition Therapy for end-stage renal disease</p> <p>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 or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>10% of the cost for renal dialysis \$0 copay for Nutrition Therapy for end-stage renal disease</p> <p>Out-of-Network</p> <p>10% of the cost for renal dialysis. 20% of the cost for Nutrition Therapy for end-stage renal disease.</p>
<p>29. <i>Prescription Drugs</i></p>	<p>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.</p>	<p><i>Drugs Covered Under Medicare Part B</i></p> <p>General</p> <p>20% of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs). 20% of the cost for Part B-covered chemotherapy drugs.</p> <p><i>Drugs Covered Under Medicare Part D</i></p> <p>General</p> <p>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.anthem.com/medicare on the Web.</p> <p>Different out-of-pocket costs may apply for people who:</p> <ul style="list-style-type: none"> ▪ have limited incomes, ▪ live in long-term care facilities, or

Benefit	Original Medicare	Freedom Blue Plan I
		<ul style="list-style-type: none"> ▪ have access to Indian/Tribal/Urban (Indian Health Service). <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). 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).</p> <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from Freedom Blue Plan I for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan’s website, formulary, and printed materials, as well as on the Medicare Prescription Drug plan finder on www.medicare.gov.</p> <p>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.</p> <p>In-Network</p> <p>\$0 deductible.</p> <p>Some covered drugs don’t count toward your out-of-pocket drug costs.</p> <p><i>Initial Coverage</i></p> <p>You pay the following until total yearly drug costs reach \$2,700:</p> <p>Retail Pharmacy</p> <p><i>Tier 1 Preferred Generic</i></p> <ul style="list-style-type: none"> ▪ \$10 copay for a one-month (30-day) supply of drugs in this tier ▪ \$30 copay for a three-month (90-day) supply of drugs in this tier <p><i>Tier 2 Preferred Brand</i></p> <ul style="list-style-type: none"> ▪ \$35 copay for a one-month (30-day) supply of drugs in this tier ▪ \$105 copay for a three-month (90-day) supply of drugs in this tier

Benefit	Original Medicare	Freedom Blue Plan I
		<p><i>Tier 3 Non-Preferred Brand or Generic</i></p> <ul style="list-style-type: none"> ▪ \$75 copay for a one-month (30-day) supply of drugs in this tier ▪ \$225 copay for a three-month (90-day) supply of drugs in this tier <p><i>Tier 4 Non-Specialty Injectable</i></p> <ul style="list-style-type: none"> ▪ 33% coinsurance for a one-month (30-day) supply of drugs in this tier ▪ 33% coinsurance for a three-month (90-day) supply of drugs in this tier <p><i>Tier 5 Specialty</i></p> <ul style="list-style-type: none"> ▪ 33% coinsurance for a one-month (30-day) supply of drugs in this tier <p>Long-Term-Care Pharmacy</p> <p><i>Tier 1 Preferred Generic</i></p> <ul style="list-style-type: none"> ▪ \$10 copay for a one-month (34-day) supply of drugs in this tier <p><i>Tier 2 Preferred Brand</i></p> <ul style="list-style-type: none"> ▪ \$35 copay for a one-month (34-day) supply of drugs in this tier <p><i>Tier 3 Non-Preferred Brand or Generic</i></p> <ul style="list-style-type: none"> ▪ \$75 copay for a one-month (34-day) supply of drugs in this tier <p><i>Tier 4 Non-Specialty Injectable</i></p> <ul style="list-style-type: none"> ▪ 33% coinsurance for a one-month (34-day) supply of drugs in this tier <p><i>Tier 5 Specialty</i></p> <ul style="list-style-type: none"> ▪ 33% coinsurance for a one-month (34-day) supply of drugs in this tier <p>Mail Order</p> <p><i>Tier 1 Preferred Generic</i></p> <ul style="list-style-type: none"> ▪ \$15 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail-order pharmacy. ▪ \$30 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail-order pharmacy. <p><i>Tier 2 Preferred Brand</i></p> <ul style="list-style-type: none"> ▪ \$87.50 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail-order pharmacy.

Benefit	Original Medicare	Freedom Blue Plan I
		<ul style="list-style-type: none"> ▪ \$105 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail-order pharmacy. <p><i>Tier 3 Non-Preferred Brand or Generic</i></p> <ul style="list-style-type: none"> ▪ \$187.50 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail-order pharmacy. ▪ \$225 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail-order pharmacy. <p><i>Tier 4 Non-Specialty Injectable</i></p> <ul style="list-style-type: none"> ▪ 33% coinsurance for a three-month (90-day) supply of drugs in this tier from a preferred mail-order pharmacy. ▪ 33% coinsurance for a three-month (90-day) supply of drugs in this tier from a non-preferred mail-order pharmacy. <p><i>Tier 5 Specialty</i></p> <ul style="list-style-type: none"> ▪ 33% coinsurance for a one-month (30-day) supply of drugs in this tier from a preferred mail-order pharmacy. ▪ 33% coinsurance for a one-month (30-day) supply of drugs in this tier from a non-preferred mail-order pharmacy. <p><i>Coverage Gap</i></p> <p>The plan covers all Preferred Generics through the coverage gap.</p> <p>You pay the following:</p> <p>Retail Pharmacy</p> <p><i>Tier 1 Preferred Generic</i></p> <ul style="list-style-type: none"> ▪ \$10 copay for a one-month (30-day) supply of all drugs covered in this tier ▪ \$30 copay for a three-month (90-day) supply of all drugs covered in this tier <p>Long-Term-Care Pharmacy</p> <p><i>Tier 1 Preferred Generic</i></p> <ul style="list-style-type: none"> ▪ \$10 copay for a one-month (34-day) supply of all drugs

Benefit	Original Medicare	Freedom Blue Plan I
		<p>Mail Order</p> <p><i>Tier 1 Preferred Generic</i></p> <ul style="list-style-type: none"> ▪ \$15 copay for a three-month (90-day) supply of all drugs covered in this tier from a preferred mail order ▪ \$30 copay for a three-month (90-day) supply of all drugs covered in this tier from a non-preferred mail order <p>For all other covered drugs, after your total yearly drug costs reach \$2,700, you pay 100%, until your yearly out-of-pocket drug costs reach \$4,350.</p> <p><i>Catastrophic Coverage</i></p> <p>After your yearly out-of-pocket drug costs reach \$4,350, you pay the greater of:</p> <ul style="list-style-type: none"> ▪ A \$2.40 copay for generic (including brand drugs treated as generic) and a \$6 copay for all other drugs, or ▪ 5% coinsurance. <p>Out-of-Network</p> <p>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 Freedom Blue Plan I.</p> <p><i>Out-of-Network Initial Coverage</i></p> <p>You will be reimbursed up to the full cost of the drug, minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,700:</p> <p>Out-of-Network Pharmacy</p> <p><i>Tier 1 Preferred Generic</i></p> <ul style="list-style-type: none"> ▪ \$10 copay for a one-month (30-day) supply of drugs in this tier <p><i>Tier 2 Preferred Brand</i></p> <ul style="list-style-type: none"> ▪ \$35 copay for a one-month (30-day) supply of drugs in this tier

Benefit	Original Medicare	Freedom Blue Plan I
		<p><i>Tier 3 Non-Preferred Brand or Generic</i></p> <ul style="list-style-type: none"> ▪ \$75 copay for a one-month (30-day) supply of drugs in this tier <p><i>Tier 4 Non-Specialty Injectable</i></p> <ul style="list-style-type: none"> ▪ 33% coinsurance for a one-month (30-day) supply of drugs in this tier <p><i>Tier 5 Specialty</i></p> <ul style="list-style-type: none"> ▪ 33% coinsurance for a one-month (30-day) supply of drugs in this tier <p><i>Out-of-Network Coverage Gap</i></p> <p>The plan covers all Preferred Generics through the gap. You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following:</p> <p><i>Tier 1 Preferred Generic</i></p> <ul style="list-style-type: none"> ▪ \$10 copay for a one-month (30-day) supply of all drugs covered in this tier <p><i>Tier 2 Preferred Brand</i></p> <ul style="list-style-type: none"> ▪ After your total yearly drug costs reach \$2,700, you pay 100% of the pharmacy’s full charge for drugs purchased out-of-network, until your yearly out-of-pocket drug costs reach \$4,350. ▪ You will not be reimbursed by Freedom Blue Plan I for out-of-network purchases when you are in the coverage gap. ▪ However, you should still submit documentation to Freedom Blue Plan I so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year. <p><i>Tier 3 Non-Preferred Brand or Generic</i></p> <ul style="list-style-type: none"> ▪ After your total yearly drug costs reach \$2,700, you pay 100% of the pharmacy’s full charge for drugs purchased out-of-network, until your yearly out-of-pocket drug costs reach \$4,350. ▪ You will not be reimbursed by Freedom Blue Plan I for out-of-network purchases when you are in the coverage gap. ▪ However, you should still submit documentation to Freedom Blue Plan I so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.

Benefit	Original Medicare	Freedom Blue Plan I
		<p><i>Tier 4 Non-Specialty Injectable</i></p> <ul style="list-style-type: none"> ▪ After your total yearly drug costs reach \$2,700, you pay 100% of the pharmacy’s full charge for drugs purchased out-of-network, until your yearly out-of-pocket drug costs reach \$4,350. ▪ You will not be reimbursed by Freedom Blue Plan I for out-of-network purchases when you are in the coverage gap. ▪ However, you should still submit documentation to Freedom Blue Plan I so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year. <p><i>Tier 5 Specialty</i></p> <ul style="list-style-type: none"> ▪ After your total yearly drug costs reach \$2,700, you pay 100% of the pharmacy’s full charge for drugs purchased out-of-network, until your yearly out-of-pocket drug costs reach \$4,350. ▪ You will not be reimbursed by Freedom Blue Plan I for out-of-network purchases when you are in the coverage gap. ▪ However, you should still submit documentation to Freedom Blue Plan I so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year. <p><i>Out-of-Network Catastrophic Coverage</i></p> <p>After your yearly out-of-pocket drug costs reach \$4,350, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug, minus the following:</p> <ul style="list-style-type: none"> ▪ A \$2.40 copay for generic (including brand drugs treated as generic) and a \$6 copay for all other drugs, or ▪ 5% coinsurance.
30. Dental Services	Preventive dental services (such as cleaning) not covered.	<p>In-Network</p> <p>\$0 copay for Medicare-covered dental benefits</p> <p>In general, preventive dental benefits (such as cleaning) not covered.</p> <p>Out-of-Network</p> <p>20% of the cost for comprehensive dental benefits.</p>

Benefit	Original Medicare	Freedom Blue Plan I
31. <i>Hearing Services</i>	<p>Routine hearing exams and hearing aids not covered.</p> <p>20% coinsurance for diagnostic hearing exams.</p>	<p>In-Network</p> <p>\$0 copay for hearing aids.</p> <p>\$20 copay for Medicare-covered diagnostic hearing exams</p> <p>\$0 copay for up to one routine hearing test(s) every year</p> <p>\$100 limit for hearing aids every two years.</p> <p>Out-of-Network</p> <p>20% of the cost for hearing exams.</p> <p>20% of the cost for hearing aids.</p>
32. <i>Vision Services</i>	<p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.</p> <p>Routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for:</p> <ul style="list-style-type: none"> ▪ one pair of eyeglasses or contact lenses after cataract surgery ▪ up to one pair(s) of glasses every two years ▪ up to one pair(s) of contacts every two years <p>\$20 copay for exams to diagnose and treat diseases and conditions of the eye.</p> <p>\$20 copay for up to one routine eye exam(s) every year</p> <p>\$100 limit for eye wear every two years.</p> <p>Plan offers additional vision benefits.</p> <p>Out-of-Network</p> <p>20% of the cost for eye exams.</p> <p>20% of the cost for eye wear.</p>
33. <i>Physical Exams</i>	<p>20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage</p> <p>When you get Medicare Part B, you can get a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.</p>	<p>In-Network</p> <p>\$0 copay for routine exams.</p> <p>Limited to one exam(s) every year.</p> <p>Out-of-Network</p> <p>20% of the cost for routine exams.</p>

Benefit	Original Medicare	Freedom Blue Plan I
<i>Health/Wellness Education</i>	<p>Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.</p>	<p>In-Network This plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> ▪ Health club membership/fitness classes ▪ Nursing hotline <p>Out-of-Network \$0 copay for health and wellness services.</p>
<i>Transportation</i> (Routine)	Not covered.	<p>In-Network This plan does not cover routine transportation.</p>
<i>Acupuncture</i>	Not covered.	<p>In-Network This plan does not cover Acupuncture.</p>