



You get the advantage with a Medicare Advantage plan from Anthem Blue Cross

Worthwhile health care coverage is supposed to work for you, not the other way around. That's where the value of SmartValue Classic (PFFS) comes in.

SmartValue Classic (PFFS) is a Medicare Advantage Private Fee-for-Service plan with a Medicare contract. What does that mean for you? The advantage is that you get more from Medicare beyond basic benefits. You get access to preventive care and wellness programs, as well as online tools.

- Most benefits have set copayments, making it easy to know what you'll pay for services
- Virtually no paperwork
- Devoted customer service staff available for our Medicare Advantage members.

SmartValue Classic (PFFS) is a great choice if you:

- Want the freedom to choose your own doctor without having to stay in a provider network. You can go to any doctor who agrees to accept our terms and conditions and thus may choose not to treat you with the exceptions of emergencies.
- Like to have the freedom of choice wherever you are — at home or traveling
- Want predictable copayments for most covered services

One plan. One card. One company taking care of everything.

With a SmartValue Classic (PFFS) plan, you have access to all of the benefits that are available under standard Medicare coverage including:

- primary care and specialist doctor visits
- inpatient hospital stays
- outpatient hospital services
- emergency room or urgent care services
- ambulance services
- durable medical equipment
- diagnostic testing, including X-rays and laboratory services

Check your Summary of Benefits for more information on these and other benefits.

But with a SmartValue Classic (PFFS) plan, you get what you might not expect like:

- the freedom to see the Medicare-participating health care professionals you want without referrals
- one membership identification card to use for medical benefits
- access to advocates, health coaches and trusted professionals dedicated to helping you reach your highest level of wellness
- virtually no paperwork
- one plan that helps you take care of everything

For full information on benefits, call us at the number at the end of this document, or see your Summary of Benefits.

QUICK FACT

Together with our affiliates, Anthem Blue Cross serves more than 34 million members¹.

¹You can learn more about us at [anthem.com/ca/medicare](https://www.anthem.com/ca/medicare).

You have access to the health care professionals of your choice

That's right. The decision of who you see is yours. And you don't need referrals or permission to see the health care professionals you want. However, with the freedom to choose also comes differences in your financial responsibilities for the cost of your care.

You are free to go to virtually any provider who agrees to accept our terms and conditions and thus may choose not to treat you with the exceptions of emergencies. There's no set provider network, so it's not like a typical HMO or PPO.

There are differences between a Medicare Advantage Private-Fee-for-Service plan and a Medicare Supplement plan.

A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare supplement plan. Your doctor or hospital can continue to treat you if it agrees to accept our terms and conditions of payment, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide health care services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at: [anthem.com/ca/medicare](https://www.anthem.com/ca/medicare).

If a provider chooses not to accept the terms and conditions of the plan, you would need to seek care from another provider, except in an emergency. A provider who has accepted our terms and conditions in the past, may choose not to in the future.

Stay connected through the integrated Custom Care Connection Health Program

SmartValue Classic (PFFS) goes beyond Medicare basics to also include access to important resources that can support you when you've got health care decisions to make. It's simple — the focus is on you, not just your medical conditions. Our nurses and other health care professionals work with you and your doctor to complement the plan of care your doctor has developed for you. You'll team with a Custom Care Connection nurse manager who will get to know you and your goals and help you reach those goals in a way that respects your wishes, culture and background.

Have you ever gotten home from the doctor's office only to realize there is something you forgot to ask about, or you are unsure how treating one health condition might affect another? Your Custom Care Connection nurse manager will help you coordinate your care and help you understand elements of your health, including coverage and medications, and provide educational information designed to help you make health care decisions as needed. This enhanced coordination of care access and education could help you prevent potentially unnecessary complications and setbacks and could help you reach your highest level of wellness.

The Custom Care Connection Health Program includes access to:

- preventive care services that can help you feel healthier or help you access care to treat problems at their earliest and most preventable stages
- care management for members dealing with chronic conditions such as asthma, diabetes or certain heart and lung ailments
- care management for members dealing with multiple conditions
- a dedicated nurse line available to you 24 hours a day, 7 days a week
- online tools to help you manage your health

Additional help for members dealing with chronic conditions

Dealing with a chronic condition can really impact your life. Ongoing symptoms. Visits to the doctor or emergency room. Expensive medications and treatments. After awhile it can feel as if your condition has taken over your life. The Custom Care Connection program that is included with SmartValue Classic (PFFS) coverage may be just the solution you've been looking for. The program includes access to nurses trained to help people with these conditions. If you are enrolled in this program, these nurses can help with any questions you have, give you information on treatments that are available for you to discuss with your doctor and be a resource that you can use, along with your doctor, for support and counsel. They also help you determine where you are in terms of controlling your symptoms and help you determine whether you're at a potential risk for developing complications. Ultimately, you can learn how to manage your symptoms so they decrease and you can feel better.

Even more help for members dealing with multiple conditions

Individuals who are dealing with more than one condition need extra support. So that's why your coverage also includes Integrated Care Management with access to nurse care managers who are dedicated to helping members with multiple conditions. These nurse care managers offer access to:

- lifestyle coaching
- tips for medication management
- coordination of care when you are being seen by more than one health care professional
- medical management programs that may augment the care you're already receiving, and more.

What's that mean? Simply put, SmartValue Classic (PFFS) membership not only helps pay for your medical bills, but also gives you the tools you need to live at your highest level of wellness.

Ready to enroll?

We're glad to hear it. Enrolling is easy because there are no physicals required upfront, and you won't be denied enrollment for pre-existing medical conditions (except End-Stage Renal Disease). But there are a few things to go over before you join.

Know for sure you're eligible for a Medicare Advantage plan:

If you have Medicare Part A and Part B and you enroll during one of the enrollment periods, you're eligible to join a Medicare Advantage plan. To be eligible for our plan, you must also reside in our service area. Generally, you can't join if you have End-Stage Renal Disease.

Here's when you can join:

The Medicare program limits when and how often you can change the way you get Medicare, or switch health plans. Switching from one plan to another plan counts as making a change.

Annual Coordinated Election Period (AEP)

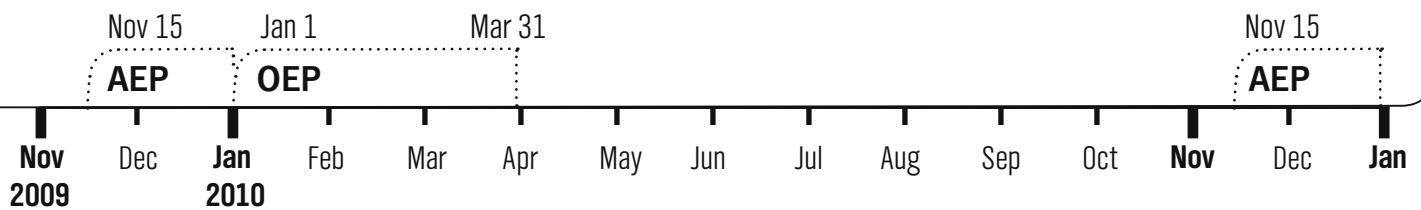
From **November 15 through December 31**, anyone with Medicare will have an opportunity to switch from one way of receiving Medicare to another.

Open Enrollment Period (OEP)

From **January 1 until March 31**, Medicare Advantage eligible individuals may make one enrollment request. However, you are limited in the type of plan you can join. You can't join or leave Medicare prescription drug coverage at this time. For example, if you have a Medicare Advantage plan with prescription drug coverage, you can only choose to join another Medicare Advantage plan that offers Medicare prescription drug coverage, or choose to return to the Original Medicare Plan and join a Medicare Prescription Drug Plan. If you don't have Medicare prescription drug coverage, you can't use this chance to get it.

Generally, you can't make any other changes during the year unless you meet special exceptions, such as if you move or if you have Medicaid coverage. Under

certain circumstances, you will be able to enroll in or change your Medicare Advantage plan outside of the standard enrollment periods. The length of your Special Enrollment Period (SEP) and when your new coverage starts will vary. The plan, and in some cases, the Center for Medicare and Medicaid Services (CMS), will determine whether an SEP applies to you. Later in the year, from **November 15 to December 31**, anyone with Medicare can switch their way of getting Medicare to another way for the following year.



After you enroll:

1. Shortly after we receive your application, we will send you a letter confirming receipt. The letter will include your proposed effective date. You may use the letter as proof of membership until your member identification (ID) card arrives.
2. We will send your application to the Centers for Medicare and Medicaid Services (CMS) for approval.
3. When approved, you will receive a welcome letter confirming your effective date with us. You will also receive your membership contract, called the Evidence of Coverage, your member identification (ID) card and other new member materials.

You must continue to pay your Medicare Part B premium.

Paying your monthly premium:

If you decide to switch to premium withhold or move from premium withhold to direct bill, it could take up to three months for it to take effect and you will be responsible for those premiums.

You will receive an Evidence of Coverage which will provide more detail on your benefits.

It will also tell you about some exclusions to the plan, which include:

- services that are not reasonable and necessary under Original Medicare program standards.
- experimental or investigational medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under an approved clinical trial.
- custodial care, which is not covered unless it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services.
- charges imposed by immediate relatives or members of your household.

If you choose to, you can go back to Original Medicare and get a Medicare Supplement (Medigap) policy.

But keep in mind that you can only join or leave a plan at certain times during the year.

Remember, if you ever disagree with a claim decision or have a concern, you have options.

We will do our best to give you all the information you need and listen to your concerns. That's why we have both appeals and grievance procedures. We review complaints about grievances, including quality of care within 30 days from the receipt date of the grievance. Issues about payment for services (appeals) will be addressed within 60 days from the receipt date of the appeal. If the appeal is for a denied service, the reconsideration decision must be made no later than 30 days after receipt date of the appeal. However, if your health is at stake, we are required to respond to the appeal within 72 hours. Under certain circumstances, you also have the right to file an expedited grievance, which we must respond to within 24 hours from the grievance receipt date.

We renew our contract with Medicare annually.

Anthem Blue Cross renews its contract with Medicare (the federal government) each year on January 1. Premiums and benefits may change at that time, but not during the year unless the change is to your advantage. In addition, the plan may reduce its service area and no longer offer services in the area where the beneficiary resides. If we do not renew our contract, we'll tell you at least 60 days in advance. You may then switch to a standard Medigap plan (A, B, C, F, K or L) that won't deny coverage because of a pre-existing condition. It will normally go into effect the day after your Medicare Advantage membership ends.

QUICK FACT

Did you know? More than 1 in 3 Americans carries a Blue Cross and Blue Shield card. The Blue Cross and Blue Shield Association is a national federation of independent, community based and locally operated Blue Cross and Blue Shield companies².

²You can learn more about it at [bcbs.com](https://www.bcbs.com).

Join in!

When you enroll, you're joining a community of thousands of other Medicare beneficiaries who've decided to take an active role in their health. You get access to online tools and resources to help keep you connected, a gym membership you can participate in with your fellow members, and access to an integrated approach to health benefits with the support you need, when you need it.

We're here to help.

- Call your local agent or one of our Medicare specialists at 1-888-211-9813 (TTY/TDD 1-800-241-6894) 8 a.m. – 8 p.m., 7 days a week. Or, visit us online at anthem.com/ca/medicare
- You can also call Medicare for basic questions about how Medicare works at 1-800-MEDICARE (1-800-633-4227) or TTY/TDD: 1-877-486-2048, 24 hours a day, 7 days a week.

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.

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A Medicare Advantage organization 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.

Blue Cross of California, doing business as Anthem Blue Cross, is the legal entity that has contracted with the Centers for Medicare and Medicaid Services (CMS) to offer the Private Fee for Service plan(s) (PFFS) noted above or herein. Anthem is the risk-bearing entity licensed under applicable state law to offer the PFFS plan(s) noted. Anthem has retained the services of its related companies and the authorized agents/brokers/producers to provide administrative services and/or to make the PFFS plan(s) available in this region.

Anthem Blue Cross is the trade name of Blue Cross of California. 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.