Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-811-3107. Someone who speaks English/ Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-811-3107. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-811-3107。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電1-877-811-3107。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-811-3107. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-811-3107. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-811-3107 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-811-3107. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-811-3107 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-811-3107. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:
إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا.
للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-778-118-7013. سيقوم شخص
ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे सवासथय या दवा की योजना के बारे में आपके किसी भी पशन के जवाब देने के लिए हमारे पास मुफत दुभाषिया सेवाएँ उपलबध हैं. एक दुभायिषा परापत करने के लिए, बस हमें 1-877-811-3107 पर फोन करें. कोई वयकित जो हिनदी बोलता है आपकी मदद कर सकता है. यह एक मुफत सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-811-3107. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-811-3107. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-811-3107. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-811-3107. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-877-811-3107 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

Anthem Blue Cross Life and Health Insurance Co. - H8552

2014 Medicare Star Ratings*

The Medicare Program rates all health and prescription drug plans each year, based on a plan's quality and performance. Medicare Star Ratings help you know how good a job our plan is doing. You can use these Star Ratings to compare our plan's performance to other plans. The two main types of Star Ratings are:

1. An Overall Star Rating that combines all of our plan's scores.
2. Summary Star Rating that focuses on our medical or our prescription drug services.

Some of the areas Medicare reviews for these ratings include:

- How our members rate our plan's services and care;
- How well our doctors detect illnesses and keep members healthy;
- How well our plan helps our members use recommended and safe prescription medications.

For 2014, Anthem Blue Cross Life and Health Insurance Co. received the following Overall Star Rating from Medicare.

★★★½
3.5 Stars

We received the following Summary Star Rating for Anthem Blue Cross Life and Health Insurance Co.'s health/drug plan services:

Health Plan Services:	Not enough data available
Drug Plan Services:	★★★ 3 Stars

The number of stars shows how well our plan performs.

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

Learn more about our plan and how we are different from other plans at www.medicare.gov.

You may also contact us Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. - 8:00 p.m. Pacific at 800-797-6438 (toll-free) or 711 (TTY).

Current members please call 877-811-3107 (toll-free) or 711 (TTY).

*Star Ratings are based on 5 Stars. Star Ratings are assessed each year and may change from one year to the next

Anthem BlueCross

Summary of Benefits

for Anthem Medicare Preferred Standard (PPO)

Available in Sonoma County, CA

Anthem Blue Cross Life and Health Insurance Company is an LPPO plan with a Medicare contract. Enrollment in Anthem Blue Cross Life and Health Insurance Company depends on contract renewal. 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.

Y0071_14_17593_U_046 CMS Accepted 10/01/2013

38887WPSENMUB_046
H8552_009_CA_LPPO

Section I:

Introduction to 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 INS COMPANY which is also called Anthem Blue Cross Life and Health Insurance Co., a Medicare Advantage Preferred Provider Organization (PPO) that contracts with the Federal government. 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:

Sonoma County, CA.

You must live in this area 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 generally are 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 **http://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 **http://www.anthem.com/ca/medicare**. Our customer service number is listed at the end of this introduction.

Anthem Medicare Preferred Standard (PPO) has a list of preferred pharmacies. At these pharmacies, you may get your drugs at a lower co-pay or co-insurance. You may go to a non-preferred pharmacy, but you may have to pay more for your prescription drugs.

What if my doctor prescribes less than a month's supply?

In consultation with your doctor or pharmacist, you may receive less than a month's supply of certain drugs. Also, if you live in a long-term care facility, you will receive less than a month's supply of certain brand and generic drugs. Dispensing fewer drugs at a time can help reduce cost and waste in the Medicare Part D program, when this is medically appropriate.

The amount you pay in these circumstances will depend on whether you are responsible for paying coinsurance (a percentage of the cost of the drug) or a copay (a flat dollar amount for the drug). If you are responsible for coinsurance for the drug, you will continue to pay the applicable percentage of the drug cost. If you are responsible for a copay for the drug, a "daily cost-sharing rate" will be applied. If your doctor decides to continue the drug after a trial period, you should not pay more for a month's supply than you otherwise would have paid. Contact your plan if you have questions about cost-sharing when less than a one-month supply is dispensed.

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 members before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at **http://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 **http://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 osteoporosis drugs for some women.

- Erythropoietin: 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 took place in a Medicare-certified facility and was paid for by Medicare or by a private insurance company that was the primary payer for Medicare Part A coverage.
- 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 Durable Medical Equipment.

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 can find the Plan Ratings information by using the "Find health & drug plans" web tool on **http://www.medicare.gov** 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 Life and Health Insurance Co. for more information about **Anthem Medicare Preferred Standard (PPO)**

Visit us at **http://www.anthem.com/ca/medicare** or, call us:

Customer Service Hours for October 1 – February 14: Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. - 8:00 p.m. Pacific

Customer Service Hours for February 15 – September 30: Monday, Tuesday, Wednesday, Thursday, Friday, 8:00 a.m. - 8:00 p.m. Pacific

Current members should call toll-free **1-877-811-3107** for questions related to the Medicare Advantage and Medicare Part D Prescription Drug Program. (TTY/TDD **711**)

Prospective members should call toll-free **1-800-797-6438** for questions related to the Medicare Advantage and Medicare Part D Prescription Drug Program. (TTY/TDD **711**)

Current members should call locally **1-877-811-3107** for questions related to the Medicare Advantage and Medicare Part D Prescription Drug Program. (TTY/TDD **711**)

Prospective members should call locally **1-800-797-6438** for questions related to the Medicare Advantage and Medicare Part D Prescription Drug Program. (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 **http://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.

Este documento podría estar disponible en otros formatos como Braille, textos con letras grandes u otros formatos.

Este documento podría estar disponible en idiomas distintos del inglés. Comuníquese con el número de nuestro Servicio de Atención al Cliente, indicado anteriormente, para obtener más información

Section II:

Summary of Benefits

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
IMPORTANT INFORMATION		
1 **Premium and Other Important Information**	In 2013 the monthly Part B Premium was **$104.90** and may change for 2014 and the annual Part B deductible amount was **$147** and may change for 2014. 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** **$110** 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 **http://www.medicare.gov** for a full listing of benefits under Original Medicare, as well

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
1 **Premium and Other Important Information** (continued)		as for 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 **http://www.medicare.gov/physician** or **http://www.medicare.gov/supplier.** You can also call **1-800-MEDICARE**, or ask your physician, provider, or supplier if they accept assignment. **In-Network** **$4,400** out-of-pocket limit for Medicare-covered services. **In and Out-of-Network** **$300** annual deductible. Contact the plan for services that apply **$4,400** 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. or its territories.

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
SUMMARY OF BENEFITS		
Inpatient Care		
3 **Inpatient Hospital Care** (includes Substance Abuse and Rehabilitation Services)	In 2013 the amounts for each benefit period were: • Days 1 - 60: **$1,184** deductible • Days 61 - 90: **$296** per day • Days 91 - 150: **$592** per lifetime reserve day These amounts may change for 2014. 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. **$705** copay for each Medicare-covered hospital stay **$0** copay for additional non-Medicare-covered 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 Medicare-covered hospital stay.
4 **Inpatient Mental Health Care**	In 2013 the amounts for each benefit period were: • Days 1 - 60: **$1,184** deductible • Days 61 - 90: **$296** per day • Days 91 - 150: **$592** per lifetime reserve day These amounts may change for 2014. 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	**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. **$705** copay for each Medicare-covered hospital stay. Plan covers 60 lifetime reserve days. **$0** copay per lifetime reserve day.

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
4 **Inpatient Mental Health Care** (continued)	conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.	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 Medicare-covered hospital stay.
5 **Skilled Nursing Facility (SNF)** (in a Medicare-certified skilled nursing facility)	In 2013 the amounts for each benefit period after at least a 3-day Medicare-covered hospital stay were: • Days 1 - 20: **$0** per day • Days 21 - 100: **$148** per day These amounts may change for 2014. 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: **$125** copay per day **Out-of-Network** **15%** of the cost for each Medicare-covered 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 Medicare-covered home health visits

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
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. You must consult with your plan before you select hospice.
OUTPATIENT CARE		
8 **Doctor Office Visits**	**20%** coinsurance	**In-Network** **$15** copay for each Medicare-covered primary care doctor visit. **$45** copay for each Medicare-covered specialist visit. **Out-of-Network** **$35** copay for each Medicare-covered primary care doctor visit **$55** copay for each Medicare-covered 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).	**General** Authorization rules may apply. **In-Network** **$20** copay for each Medicare-covered chiropractic 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). **Out-of-Network** **$40** copay for Medicare-covered chiropractic visits.
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 podiatry visit Medicare-covered podiatry visits are for medically necessary foot care. **Out-of-Network** **$55** copay for Medicare-covered podiatry visits

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
11 **Outpatient Mental Health Care**	**20%** coinsurance for most outpatient mental health services 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.	**General** Authorization rules may apply. **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 Medicare-covered Mental Health visits with a psychiatrist **30%** of the cost for Medicare-covered Mental Health visits **30%** of the cost for Medicare-covered partial hospitalization program services
12 **Outpatient Substance Abuse Care**	**20%** coinsurance	**General** Authorization rules may apply. **In-Network** **$40** copay for Medicare-covered individual substance abuse outpatient treatment visits **$40** copay for Medicare-covered group substance abuse outpatient treatment visits **Out-of-Network** **30%** of the cost for Medicare-covered substance abuse outpatient treatment visits
13 **Outpatient Services**	**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 **15%** of the cost for each Medicare-covered ambulatory surgical center visit

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
13 **Outpatient Services** (continued)		**$0** to **$45** copay [or **0%** to **15%** of the cost] for each Medicare-covered outpatient hospital facility visit **Out-of-Network** **25%** of the cost for Medicare-covered outpatient hospital facility visits **25%** of the cost for Medicare-covered ambulatory surgical center visits
14 **Ambulance Services** (medically necessary ambulance services)	**20%** coinsurance	**In-Network** **$200** copay for Medicare-covered ambulance benefits. **Out-of-Network** **$200** copay for Medicare-covered 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.
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 If you are admitted to the hospital within 3 days for the same condition, you pay **$0** for the urgently-needed-care visit. NOT covered outside the U.S. except under limited circumstances.	**General** **$45** copay for Medicare-covered urgently-needed-care visits

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
17 **Outpatient Rehabilitation Services** (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	**20%** coinsurance Medically necessary physical therapy, occupational therapy, and speech and language pathology services are covered.	**General** Authorization rules may apply. Medically necessary physical therapy, occupational therapy, and speech and language pathology services are covered. **In-Network** **$50** copay for Medicare-covered Occupational Therapy visits **$50** copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits **Out-of-Network** **30%** of the cost for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits **30%** of the cost for Medicare-covered Occupational Therapy visits.
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 durable medical equipment **Out-of-Network** **20%** of the cost for Medicare-covered durable medical equipment
19 **Prosthetic Devices** (includes braces, artificial limbs and eyes, etc.)	**20%** coinsurance **20%** coinsurance for Medicare-covered medical supplies related to prosthetics, splints, and other devices.	**General** Authorization rules may apply. **In-Network** **20%** of the cost for Medicare-covered prosthetic devices **20%** of the cost for Medicare-covered medical supplies related to prosthetics, splints, and other devices

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
		Out-of-Network **20%** of the cost for Medicare-covered 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 Medicare-covered Diabetes self-management training **$0** copay for Medicare-covered Diabetes monitoring supplies **20%** of the cost for Medicare-covered Therapeutic shoes or inserts Diabetic Supplies and Services are limited to specific manufacturers, products and/or brands. Contact the plan for a list of covered supplies. **Out-of-Network** **30%** of the cost for Medicare-covered Diabetes self-management training **20%** of the cost for Medicare-covered Diabetes monitoring supplies **20%** of the cost for Medicare-covered 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

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
21 **Diagnostic Tests, X-Rays, Lab Services, and Radiology Services** (continued)		If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of **$15** to **$45** may apply If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of **$15** to **$45** may apply **Out-of-Network** **30%** of the cost for Medicare-covered therapeutic radiology services **30%** of the cost for Medicare-covered outpatient X-rays **30%** of the cost for Medicare-covered diagnostic radiology services **30%** of the cost for Medicare-covered diagnostic procedures and tests **$15** copay for Medicare-covered lab services
22 **Cardiac and Pulmonary Rehabilitation Services**	**20%** coinsurance for Cardiac Rehabilitation services **20%** coinsurance for Pulmonary Rehabilitation services **20%** coinsurance for Intensive Cardiac Rehabilitation services	**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 Medicare-covered Cardiac Rehabilitation Services **30%** of the cost for Medicare-covered Intensive Cardiac Rehabilitation Services **30%** of the cost for Medicare-covered Pulmonary Rehabilitation Services

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
PREVENTIVE SERVICES		
23 Preventive Services	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 • 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.	**General** **$0** copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. **Out-of-Network** **30%** of the cost for Medicare-covered preventive services

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
23 **Preventive Services** (continued)	• 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 and Tobacco Use Cessation (counseling to stop smoking and tobacco use). 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. • Screening and behavioral counseling interventions in primary care to reduce alcohol misuse • Screening for depression in adults • Screening for sexually transmitted infections (STI) and high-intensity behavioral counseling to prevent STIs • Intensive behavioral counseling for Cardiovascular Disease (bi-annual) • Intensive behavioral therapy for obesity	

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
23 **Preventive Services** (continued)	• Welcome to Medicare Preventive Visits (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 Preventive Visits 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 Medicare-covered renal dialysis **$0** copay for Medicare-covered kidney disease education services **Out-of-Network** **30%** of the cost for Medicare-covered kidney disease education services **20%** of the cost for Medicare-covered renal dialysis
PRESCRIPTION DRUG BENEFITS		
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** **19%** of the cost for Medicare Part B chemotherapy drugs and other Part B drugs. **19%** of the cost for Medicare 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 **http://www.anthem.com/medicare** on the web. Different out-of-pocket costs may apply for people who • have limited incomes,

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
25 **Outpatient Prescription Drugs** (continued)		• 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 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 cost sharing for that drug.

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
25 **Outpatient Prescription Drugs** (continued)		**In-Network** **$149** deductible on all drugs except Tier 1: Preferred Generic, Tier 5: Injectable Drugs, Tier 6: Specialty Tier drugs. **Initial Coverage** After you pay your yearly deductible, you pay the following until total yearly drug costs reach **$2,850**: **Retail Pharmacy** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. You can get drugs from a preferred and non-preferred pharmacy the following way(s): **Tier 1: Preferred Generic** • **$5** copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy • **$10** copay for a two-month (60-day) supply of drugs in this tier from a preferred pharmacy • **$15** copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy • **$10** copay for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy • **$20** copay for a two-month (60-day) supply of drugs in this tier from a non-preferred pharmacy • **$30** copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy **Tier 2: Non-Preferred Generic** • **$16** copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
25 **Outpatient Prescription Drugs** (continued)		• **$32** copay for a two-month (60-day) supply of drugs in this tier from a preferred pharmacy • **$48** copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy • **$21** copay for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy • **$42** copay for a two-month (60-day) supply of drugs in this tier from a non-preferred pharmacy • **$63** copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy **Tier 3: Preferred Brand** • **$39** copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy • **$78** copay for a two-month (60-day) supply of drugs in this tier from a preferred pharmacy • **$117** copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy • **$44** copay for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy • **$88** copay for a two-month (60-day) supply of drugs in this tier from a non-preferred pharmacy • **$132** copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy **Tier 4: Non-Preferred Brand** • **$81** copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy • **$162** copay for a two-month (60-day) supply of drugs in this tier from a preferred pharmacy

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
25 **Outpatient Prescription Drugs** (continued)		• **$243** copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy • **$86** copay for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy • **$172** copay for a two-month (60-day) supply of drugs in this tier from a non-preferred pharmacy • **$258** copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy **Tier 5: Injectable Drugs** • **33%** coinsurance for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy • **33%** coinsurance for a two-month (60-day) supply of drugs in this tier from a preferred pharmacy • **33%** coinsurance for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy • **33%** coinsurance for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy • **33%** coinsurance for a two-month (60-day) supply of drugs in this tier from a non-preferred pharmacy • **33%** coinsurance for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy **Tier 6: Specialty Tier** • **33%** coinsurance for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy • **33%** coinsurance for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
25 **Outpatient Prescription Drugs** (continued)		**Long-Term Care Pharmacy** Long term care pharmacies must dispense brand name drugs in amounts less than a 14 days supply at a time. They may also dispense less than a month's supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. You can get drugs the following way(s): **Tier 1: Preferred Generic** • **$10** copay for a one-month (34-day) supply of drugs in this tier **Tier 2: Non-Preferred Generic** • **$21** copay for a one-month (34-day) supply of drugs in this tier **Tier 3: Preferred Brand** • **$44** copay for a one-month (34-day) supply of drugs in this tier **Tier 4: Non-Preferred Brand** • **$86** copay for a one-month (34-day) supply of drugs in this tier **Tier 5: Injectable Drugs** • **33%** coinsurance for a one-month (34-day) supply of drugs in this tier **Tier 6: Specialty Tier** • **33%** coinsurance for a one-month (34-day) supply of drugs in this tier **Mail Order** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. You can get drugs the following way(s):

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
25 **Outpatient Prescription Drugs** (continued)		**Tier 1: Preferred Generic** • **$5** copay for a one-month (30-day) supply of drugs in this tier • **$10** copay for a two-month (60-day) supply of drugs in this tier • **$10** copay for a three-month (90-day) supply of drugs in this tier **Tier 2: Non-Preferred Generic** • **$16** copay for a one-month (30-day) supply of drugs in this tier • **$32** copay for a two-month (60-day) supply of drugs in this tier • **$32** copay for a three-month (90-day) supply of drugs in this tier **Tier 3: Preferred Brand** • **$39** copay for a one-month (30-day) supply of drugs in this tier • **$117** copay for a two-month (60-day) supply of drugs in this tier • **$117** copay for a three-month (90-day) supply of drugs in this tier **Tier 4: Non-Preferred Brand** • **$81** copay for a one-month (30-day) supply of drugs in this tier • **$243** copay for a two-month (60-day) supply of drugs in this tier • **$243** copay for a three-month (90-day) supply of drugs in this tier **Tier 5: Injectable Drugs** • **33%** coinsurance for a one-month (30-day) supply of drugs in this tier • **33%** coinsurance for a two-month (60-day) supply of drugs in this tier • **33%** coinsurance for a three-month (90-day) supply of drugs in this tier

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
25 **Outpatient Prescription Drugs** (continued)		**Tier 6: Specialty Tier** • **33%** coinsurance for a one-month (30-day) supply of drugs in this tier **Coverage Gap** After your total yearly drug costs reach **$2,850,** you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than **47.5%** for the plan's costs for brand drugs and **72%** of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach **$4,550.** **Catastrophic Coverage** After your yearly out-of-pocket drug costs reach **$4,550,** you pay the greater of: • **5%** coinsurance, or • **$2.55** copay for generic (including brand drugs treated as generic) and a **$6.35** 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). You can get out-of-network drugs the following way: **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

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
25 **Outpatient Prescription Drugs** (continued)		out-of-network until your total yearly drug costs reach **$2,850**: **Tier 1: Preferred Generic** • **$10** copay for a one-month (30-day) supply of drugs in this tier **Tier 2: Non-Preferred Generic** • **$21** copay for a one-month (30-day) supply of drugs in this tier **Tier 3: Preferred Brand** • **$44** copay for a one-month (30-day) supply of drugs in this tier **Tier 4: Non-Preferred Brand** • **$86** copay for a one-month (30-day) supply of drugs in this tier **Tier 5: Injectable Drugs** • **33%** coinsurance for a one-month (30-day) supply of drugs in this tier **Tier 6: Specialty Tier** • **33%** 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. **Out-of-Network Coverage Gap** You will be reimbursed up to **28%** of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach **$4,550.** Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). You will be reimbursed up to **52.5%** of the plan allowable cost for brand name drugs purchased out-of-network until your total

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
25 **Outpatient Prescription Drugs** (continued)		yearly out-of-pocket drug costs reach **$4,550.** Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). **Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach **$4,550,** 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 • **$2.55** copay for generic (including brand drugs treated as generic) and a **$6.35** copay for all other drugs. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.
Outpatient Medical Services and Supplies		
26 **Dental Services**	Preventive dental services (such as cleaning) not covered.	**In-Network** This plan covers some preventive dental benefits for an extra cost (see "Optional Supplemental Benefits.") **$0** copay for Medicare-covered dental benefits **Out-of-Network** **$0** copay for Medicare-covered 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 Medicare-covered diagnostic hearing exams.

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
28 Vision Services	**20%** coinsurance for diagnosis and treatment of diseases and conditions of the eye, including an annual glaucoma screening for people at risk Supplemental routine eye exams and eyeglasses (lenses and frames) not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.	**In-Network** This plan covers some vision benefits for an extra cost (see "Optional Supplemental Benefits"). **$0** copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye, including an annual glaucoma screening for people at risk **$0** copay for one pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery. **Out-of-Network** **$0** copay for Medicare-covered eye exams **$0** copay for Medicare-covered eyewear
Wellness/Education and Other Supplemental Benefits & Services	Not covered.	**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
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 and Other Alternative Therapies	Not covered.	**In-Network** This plan does not cover Acupuncture and other alternative therapies.

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
OPTIONAL SUPPLEMENTAL PACKAGE #1		
Premium and Other Important Information		**General** Package: 1 - Preventive Dental Package: **$18** monthly premium, in addition to your **$110** monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: • Preventive Dental
Dental Services		**In-Network** **$0** copay for up to 2 supplemental oral exam(s) every year **$0** copay for up to 2 supplemental cleaning(s) every year **$0** copay for up to 1 supplemental dental x-ray(s) every year **Out-of-Network** **20%** of the cost for supplemental preventive dental services **In and Out-of-Network** **$500** plan coverage limit for supplemental preventive dental benefits every year. This limit applies to both in-network and out-of-network benefits.
OPTIONAL SUPPLEMENTAL PACKAGE #2		
Premium and Other Important Information		**General** Package: 2 - Dental and Vision Package: **$32** monthly premium, in addition to your **$110** monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: • Preventive Dental • Comprehensive Dental • Eye Exams • Eyewear

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
Dental Services		**In-Network** **$0** copay for up to 2 supplemental oral exam(s) every year **$0** copay for up to 2 supplemental cleaning(s) every year **$0** copay for up to 1 supplemental dental x-ray(s) every year **Out-of-Network** **30%** of the cost for supplemental preventive dental services **30%** to **75%** of the cost for supplemental comprehensive dental services **In and Out-of-Network** Contact the plan for availability of additional supplemental in-network and out-of-network comprehensive dental benefits. **$1,000** plan coverage limit for supplemental dental benefits every year. This limit applies to both in-network and out-of-network benefits.
Vision Services		**In-Network** **$0** copay for up to 1 pair(s) of contact lenses every year **$0** copay for up to 1 pair(s) of eyeglasses (lenses and frames) every year **$0** copay for up to 1 supplemental routine eye exam(s) every year **Out-of-Network** **$0** copay for supplemental routine eye exams **$0** copay for supplemental eyewear **In and Out-of-Network** **$69** plan coverage limit for supplemental routine eye exams every year. This limit applies to both in-network and out-of-network benefits.

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
Vision Services (continued)		**$130** plan coverage limit for eyeglasses (lenses and frames) every year. This limit applies to both in-network and out-of-network benefits. **$80** plan coverage limit for contact lenses every year. This limit applies to both in-network and out-of-network benefits.
OPTIONAL SUPPLEMENTAL PACKAGE #3		
Premium and Other Important Information		**General** Package: 3 - Enhanced Dental and Vision Package: **$40** monthly premium, in addition to your **$110** monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: • Preventive Dental • Comprehensive Dental • Eye Exams • Eyewear
Dental Services		**In-Network** **$0** copay for up to 2 supplemental oral exam(s) every year **$0** copay for up to 2 supplemental cleaning(s) every year **$0** copay for up to 1 supplemental dental x-ray(s) every year **Out-of-Network** **30%** of the cost for supplemental preventive dental services **30%** to **75%** of the cost for supplemental comprehensive dental services **In and Out-of-Network** Contact the plan for availability of additional supplemental in-network and out-of-network comprehensive dental benefits. **$1,500** plan coverage limit for supplemental dental benefits every year. This limit applies

Benefit	Original Medicare	Anthem Medicare Preferred Standard (PPO)
Dental Services (continued)		to both in-network and out-of-network benefits.
Vision Services		**In-Network** **$0** copay for up to 1 pair(s) of contact lenses every year **$0** copay for up to 1 pair(s) of eyeglasses (lenses and frames) every year **$0** copay for up to 1 supplemental routine eye exam(s) every year **Out-of-Network** **$0** copay for supplemental routine eye exams **$0** copay for supplemental eyewear **In and Out-of-Network** **$69** plan coverage limit for supplemental routine eye exams every year. This limit applies to both in-network and out-of-network benefits. **$200** plan coverage limit for eyeglasses (lenses and frames) every year. This limit applies to both in-network and out-of-network benefits. **$80** plan coverage limit for contact lenses every year. This limit applies to both in-network and out-of-network benefits.