Anthem CalPERS

Medicare Advantage Enrollment Guide

Your Medicare and more

Anthem Medicare Preferred (PPO)
January 1, 2019 - December 31, 2019
CalPERS

Here's what's inside

Welcome
to your new 2019 health care plan

Your health and well-being are important to you and your family. That's why CalPERS has chosen to offer you this Anthem Medicare Preferred (PPO) plan from Anthem BC Health Insurance Company.

You can feel confident we're here to support your health and provide you with the care you need when you need it. We want you to have the peace of mind that comes with knowing you're our priority. That's why we provide health care services and programs with you in mind.

There are many things we think you'll appreciate about this plan

For instance, you have **National Access Plus**, which allows you to see any doctor that accepts Medicare. You're not tied to a provider network and you pay the same copay or coinsurance percentage whether your provider is in- or out-of-network. You'll find more information about our **National Access Plus** on pages 6 and 7.

Here are a few more benefits designed with you in mind:

- $0 copay for an annual physical exam
- **Freedom** to choose Medicare providers nationwide, without a referral. See page 6 and 7 for more details.
- Access to emergency care both inside and outside of the U.S.
- **Access** to SilverSneakers, LiveHealth Online and SpecialOffers from our partners
- **A dedicated Member Services team** focused on you and your needs

When you enroll in our plan, you're getting more than health care coverage. You're getting support from a team of professionals that provide individual support, tools and resources all for you. **Please read through this enrollment guide and call us with any questions.** We look forward to serving you in 2019!

Warmly,

Your team at Anthem BC Health

Excellent service is our priority

We aim to make a great First Impression (and a lasting one, too)

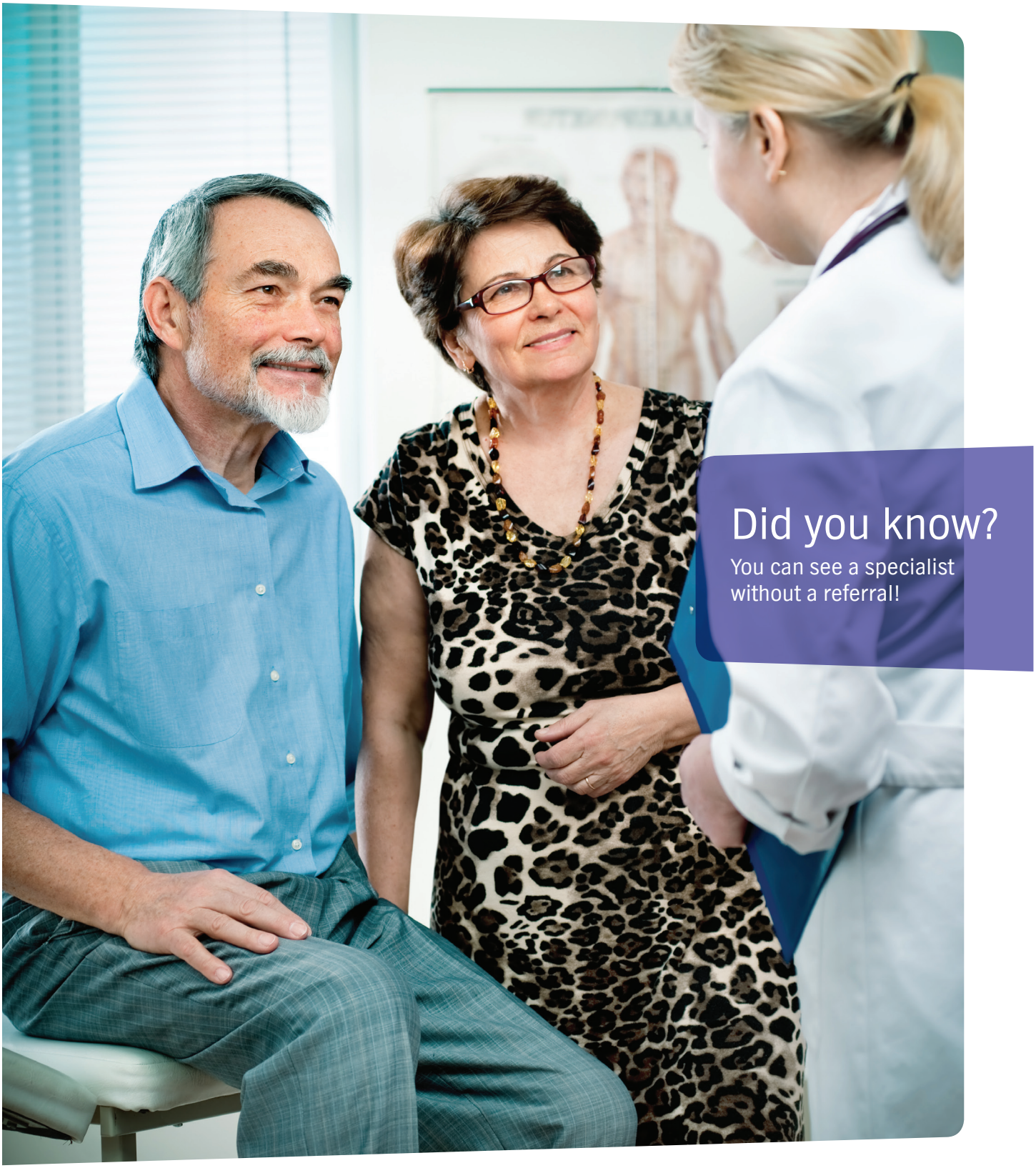
At Anthem BC Health, our goal is to provide you with great health benefits and exceptional service. Our First Impressions Welcome Team is on your side. These experts know the ins and outs of Medicare and are knowledgeable about the details of your plan. They can answer any questions you may have.

We don't read scripts

Call us and you'll talk with a live, friendly person located right here in the United States. We want to have a real conversation with you and we can't do that with a script or a machine. Our team of experts knows Medicare and your plan inside and out. We're always prepared and ready to serve you!

Real people. Real support. Because we care.

Our First Impressions Welcome Team is available Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays. Call us toll free at **1-855-251-8825**, TTY: **711**. We look forward to serving you.



Questions?
Our First Impressions Welcome Team is ready to help. Call **1-855-251-8825**, TTY: **711**, Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays.

Your medical benefit highlights

Our Anthem Medicare Preferred (PPO) plan offers a wealth of benefits designed to help you take advantage of many health resources while keeping expenses down. See some of the key plan highlights and services below.

Our plan includes:

- Your choice of doctors, specialists and hospitals in or out of network without a referral
- $0 copay:
  - An annual routine physical
  - Flu and pneumonia vaccines
  - Most health screenings
- Inpatient hospital care
- Outpatient surgery and rehabilitation
- Ambulance services
- Emergency and urgent care
- Skilled nursing facility benefits
- SilverSneakers® fitness program
- Doctors available anytime, anywhere with LiveHealth Online
- Complex radiology services and radiation therapy
- Diagnostic procedures and testing services received in a doctor's office
- Diabetes services and supplies
- Durable medical equipment and related supplies
- Prosthetic devices
- A 24/7 NurseLine
- Home health agency care
- Lab services
- Outpatient X-rays
- Foreign travel emergency and urgently needed services
- Routine hearing exams

See the full Benefits Chart in the back of this guide for more details.

You have the advantage – the Medicare Advantage

Your Anthem Medicare Preferred (PPO) plan is a Preferred Provider Organization (PPO) plan offered through Medicare Advantage

Your Medicare Advantage plan is explained below and there is an overview of your PPO plan on the next page.

- Medicare Advantage is a Medicare Part C plan. That means it's a Medicare plan offered by a private insurance company. Anthem BC Health is the private insurance company that manages this plan.
- Medicare Advantage offers more than Original Medicare. Original Medicare covers Part A (hospital benefits) and Part B (doctor and outpatient care). Medicare Advantage covers both Part A and B, and more. See examples in the chart below.

OVERVIEW	ORIGINAL MEDICARE	MEDICARE ADVANTAGE
Annual out-of-pocket maximum (or **Max OOP**) is the amount members pay each year	There is no maximum amount members will pay annually.	After the Max OOP is met, Anthem BC Health pays **100%** of covered costs for the rest of the plan year.
Copays and **Coinsurance**	20% coinsurance for common services such as outpatient surgery and health visits.	**Copays are used more often** than coinsurance to help make cost share amounts simple and transparent.
Emergency care when traveling outside the U.S.	No coverage when traveling outside the U.S.	**Emergency care is provided** when traveling outside the U.S.
Additional benefits	Not offered	**Anthem BC Health offers benefits** such as 24/7 NurseLine, SilverSneakers and LiveHealth Online.

Not all of your medical costs add to your annual out-of-pocket maximum. For more details and what services are covered by this plan, please see the Benefits Chart included in this guide.

Your National Access Plus explained

You may know how PPO plans can help you save money when your doctor is in your plan. ***However, your PPO plan gives you more.***

Your plan gives you Anthem BC Health's **National Access Plus**

With National Access Plus, your share of the cost is the same no matter if the doctor is in our network or not. You just need to see a doctor approved by Medicare. That's the "plus" – you have access to any Medicare doctor nationwide PLUS your cost share doesn't change for doctors or hospitals not in our network. We want you to have more freedom to see the right Medicare doctor for you. To help explain the benefits of our **National Access Plus**, we've provided answers to our frequently asked questions below.

	IN-NETWORK	OUT-OF-NETWORK
Can I get services from any doctor, provider or hospital that accepts Medicare?	Yes	Yes
Can I continue to see my current doctors and specialists as long as they accept Medicare?	Yes	Yes
Do I need to choose a Primary Care Provider (PCP)?	No	No
If I want to see a specialist, do I need a referral?	No	No

For a list of all Medicare-contracted providers, visit www.medicare.gov
Please note, Anthem BC Health can't pay a doctor or facility that does not accept or has opted out of Medicare. So if you receive care from one of these providers, you'll have to pay the full medical bill without reimbursement.

What if your provider says they don't accept Medicare Advantage or Anthem BC Health plans?
Some providers who are not part of our network don't know they can work with us. Please encourage your provider to call our First Impressions Welcome Team for more information about how they can bill and receive payment for their services. We know finding the right provider is important to you, and we want to help.

Your extra benefits and services highlights

Your Anthem Medicare Preferred (PPO) plan includes a wide variety of programs and tools to help you make choices toward better health in all aspects of your life. All of these resources are available at no additional cost to you.

Information and care when you need it

- Online health and tools
- Find a Doctor tool
- LiveHealth Online
- 24/7 NurseLine
- House Call
- MyHealth Advantage
- Compassionate Support

Preventive health and wellness

- Annual routine physical
- SilverSneakers

Stay well and save money

- SpecialOffers

Read on for more information on all the programs, tools and services listed here!

We provide you with information and care when you need it

As a member, you have direct access to information resources and services that are available outside regular office hours and beyond the doctor's exam room. **Call your First Impressions Welcome Team for more details.**

Online health & tools[1]

With your Anthem Medicare Preferred (PPO) plan, you're always just a click away from information that can help you:

- Take control of your health.
- Stay fit.
- Avoid getting sick.

Our online resources provide 24/7 access to thousands of helpful articles and videos to help you learn all about self-care and medicines, plus various conditions, tests and treatments.

24/7 NurseLine*

When health issues arise after hours, or if it's inconvenient or impractical to see a provider, you can still get the answers and assurance you need — right away. Our 24/7 NurseLine puts you in touch with a registered nurse any time of the day or night. Call our 24/7 NurseLine at **1-800-700-9184** (TTY: **711**).

Find a Doctor tool

Choosing the right doctor can and should be a personal thing. With your Anthem BC Health plan, it's also a very easy thing. Use our online Find a Doctor tool to look for doctors, hospitals, pharmacies, labs and other health care providers in your plan.

LiveHealth Online**

You can visit with a doctor or therapist through live video on your smartphone, tablet or computer. Using LiveHealth Online, you can:

- Access a board-certified doctor 24/7: Doctors can help with common conditions like the flu, colds, sinus infections, pink eye and skin rash. They can also send prescriptions to the pharmacy.
- Get help when you're feeling depressed, anxious or stressed: Set up a 45-minute counseling session with a therapist.

Live video visits are $0 with your plan. Sign up today at **livehealthonline.com**. Or use our free LiveHealth Online mobile app.

* The information contained in this program is for general guidelines only. Your doctor will be specific regarding recommendations for your individual circumstances. Recommended treatments may not be covered under your health plan.

** LiveHealth Online is the trade name of Health Management Corporation, a separate company providing telehealth services on behalf of this plan.

We provide you with information and care when you need it

Our House Call, MyHealth Advantage and Compassionate Support programs are available to members who qualify as a part of their case management. Members who qualify are contacted directly by their case managers.

House Call program*

Our House Call program offers a personalized visit in your home or other appropriate health care setting that can lead to a treatment plan tailored just for you. The House Call program is available at no additional cost for members who qualify.

MyHealth Advantage

Anthem BC Health never stops looking out for your best health interests. MyHealth Advantage is a program that helps to find and suggest ways to both improve your health and help save you money, including:

- Regular reminders about needed care, tests or preventive health steps you can take.
- Prescription drug cost-cutting tips.
- Access to health specialists ready to answer your questions, at no additional cost.

Compassionate Support

Anthem BC Health provides access to thoughtful, compassionate support by highly trained specialists at no additional cost to members who qualify. These specialists help to improve communication among members, family and providers to empower members to fulfill their personal wishes in their end-of-life decision-making.

* House Call program is administered by an independent vendor. It is available to members who qualify.

Preventive health and wellness

Your Anthem BC Health plan is here to help you on your journey to better health with programs and services that let you take an active role in your health – at no additional cost to you

Annual health exams and preventive care

Anthem BC Health cares about your health and well-being. This is why your plan offers the following and more with no additional cost, as long as you see a doctor who accepts Medicare.

- Annual routine physical
- Preventive care services
- Flu and pneumonia shots
- Tobacco cessation counseling

SilverSneakers®*

SilverSneakers® by Tivity Health

Get in shape or stay in shape with this popular program that includes:

- Access to more than 14,000 fitness locations nationwide, with all basic amenities and signature SilverSneakers classes.
- SilverSneakers FLEX classes at neighborhood locations offering activities like tai chi, yoga, dance and walking groups.
- Online tools for meal planning and healthy recipes, plus the SilverSneakers blog.

Find a location near you. Visit **www.SilverSneakers.com.** Or call SilverSneakers at **1-888-423-4632**, TTY: **711**, Monday to Friday, 8 a.m. to 8 p.m. ET.

Stay well and save money with SpecialOffers

Saving money is good. Saving money on things that are good for you is even better. **With SpecialOffers, you can get discounts on products and services that help promote better health and well-being.** These are just a few of the many offers available to Anthem BC Health members.

Vision and hearing

1-800 CONTACTS® or Glasses.com™

- $20 off orders of $100 or more for the latest contact lenses or brand-name frames
- Free shipping

Premier LASIK

- Save $800 on LASIK when you choose any "featured" Premier LASIK Network provider
- Save 15% with all other in-network providers

Hearing Care Solutions

- Digital instruments starting at $500
- Free hearing exam
- 3,100 locations and eight manufacturers
- Three-year warranty
- Two years of batteries
- Unlimited visits for one year

Nations Hearing, powered by the Beltone® network

- Call **1-877-391-8625** to schedule your no-charge hearing test
- Hearing aids start at $599 each

Amplifon®

- 25% off Amplifon hearing aids for qualified members, plus an extra $50 off one hearing aid or $125 off two hearing aids
- A three-year repair/loss/damage warranty
- A free two-year supply of batteries

TruVision

- Save up to 40% on LASIK eye surgery at over 1,000+ locations
- Over 6.5 million procedures performed in the network

* SpecialOffers is a discount program that is not part of your health coverage plan. It is a value-added online service we provide to give our Medicare Advantage members access to discounts offered by different vendors. Vendors and offers are subject to change without prior notice. Anthem BC Health does not endorse and is not responsible for the products, services or information provided by SpecialOffers vendors. Arrangements and discounts were negotiated between vendors and Anthem BC Health for the benefit of our members. The products and services described on this page are not part of our contract with Medicare. They are not subject to the Medicare appeals process. Any disputes about these products or services may be subject to the Anthem BC Health grievance process.

Stay well and save money with SpecialOffers

Fitness and healthy living

ChooseHealthy™

- Discounts on acupuncture, chiropractors, dieticians, fitness clubs and massages
- 40% off select wellness products

SelfHelpWorks

Up to 60% off one online Living Program: weight loss, stress management or treatment of alcohol-related issues

Active & Fit Direct™

- 9,000+ participating fitness centers nationwide
- $25/month membership (plus $25 enrollment fee and applicable taxes)

Jenny Craig®

Two offers:

- Free 3-month program and $70 in food savings
- 50% off All Access enrollment plus 30 days (food costs separate)

GlobalFit™

Discounts on gym memberships, fitness equipment, coaching and more

Lindora

Up to 45% off weight-loss program

Puritan's Pride

10% off vitamins, supplements and minerals

LifeMart®

Deals on beauty/skin care, diet plans, fitness clubs, spas, yoga, sports gear and more

Family and home

HelpCare Plus

For 44 cents a day from HelpCare Plus: 10% to 50% off for the entire family on dental services, chiropractic care, vitamins, natural food and senior care

Allergy Control Products

- 20% off Allergy Control encasings for your bed
- 20% off doctor-recommended home products
- Free shipping for orders of $79 or more in the contiguous U.S.

National Allergy Supply®

15% off mattress covers, compressors and air filtration systems

23andMe

- $40 off each Health + Ancestry Service Kit
- 20% off one 23andMe kit; learn about your wellness, ancestry and more

Your complete Benefits Chart

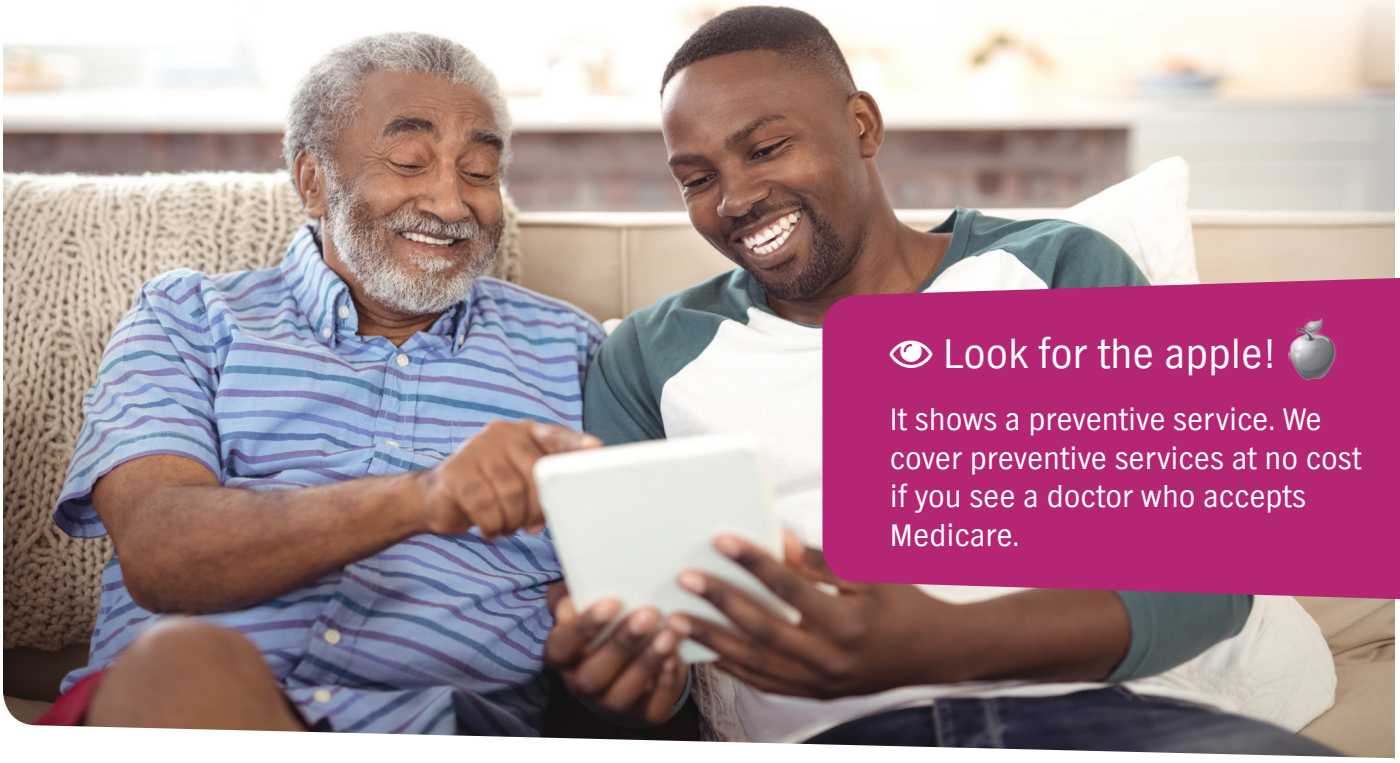
The Benefits Charts give you all of the details about the many medical benefits this Anthem Medicare Preferred (PPO) plan offers, including:

- What we cover.
- The amount of your copay, if any.
- Coinsurance amounts, if any.
- Out-of-pocket costs.

Making your benefits easier to understand

We included two sections after your Benefits Charts to help answer questions you might have about the Anthem Medicare Preferred (PPO) plan. The two sections include:

1. **Frequently asked questions**, such as what's a copay vs. coinsurance, what is an Out-of-Pocket Maximum and more.
2. **How Medicare works,** which covers the ABCDs of Medicare.



Look for the apple!

It shows a preventive service. We cover preventive services at no cost if you see a doctor who accepts Medicare.

Your 2019 Medical Benefits Chart
Local PPO Plan 10P
CalPERS
Effective January 1, 2019

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Doctor and hospital choice You may go to doctors, specialists, and hospitals in or out of the network. You do not need a referral.		
Annual deductible • The deductible applies to covered services as noted within each category below, prior to the copay or coinsurance, if any, being applied.	$0 Combined in-network and out-of-network	
Inpatient services		
Inpatient hospital care* Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals, including special diets • Regular nursing services • Costs of special care units (such as intensive or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs	For Medicare-covered hospital stays: $0 copay per admission No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay	For Medicare-covered hospital stays: $0 copay per admission No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Inpatient hospital care (con't) • Operating and recovery room costs • Physical therapy, occupational therapy, and speech language therapy • Inpatient substance abuse services • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If the plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. The reimbursement for transportation costs are while you and your companion are traveling to and from the medical providers for services related to the transplant care. The plan defines the distant location as a location that is outside of the member's service area AND a minimum of 75 miles from the member's home. Transportation and lodging costs will be reimbursed for travel mileage and lodging consistent with current IRS travel mileage and lodging guidelines. Accommodations for lodging will be reimbursed at the lesser of: 1) billed charges, or 2) $50 per day per covered person up to a maximum of $100 per day per covered person consistent with IRS guidelines. • Blood – including storage and administration. Coverage of whole blood, packed red cells, and all other components of blood begins with the first pint. • Physician services		If you receive authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at an in-network hospital.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Inpatient hospital care (con't) In-network providers should notify us within one business day of any planned, and if possible, unplanned admissions or transfers, including to or from a hospital, skilled nursing facility, long term acute care hospital, or acute rehabilitation center. **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.		

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Inpatient mental health care*	For Medicare-covered hospital stays:	For Medicare-covered hospital stays:
Covered services include mental health care services that require a hospital stay in a psychiatric hospital or the psychiatric unit of a general hospital.	$0 copay per admission	$0 copay per admission
In-network providers should notify us within one business day of any planned, and if possible unplanned admissions or transfers, including to or from a hospital, skilled nursing facility, long term acute care hospital, or acute rehabilitation center.	No limit to the number of days covered by the plan.	No limit to the number of days covered by the plan.
	$0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay	$0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Skilled nursing facility (SNF) care*	For Medicare-covered SNF stays:	For Medicare-covered SNF stays:
Inpatient skilled nursing facility (SNF) coverage is limited to 100 days each benefit period. A "benefit period" begins on the first day you go to a Medicare-covered inpatient hospital or a SNF. The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row.	$0 copay for days 1-100 per benefit period	$0 copay for days 1-100 per benefit period
Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech language therapy • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors) • Blood – including storage and administration. Coverage of whole blood, packed red cells, and all other components of blood begins with the first pint. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services	No prior hospital stay required.	No prior hospital stay required.
Generally, you will receive your SNF care from plan facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a plan provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care)		

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Skilled nursing facility (SNF) care (con't) • A SNF where your spouse is living at the time you leave the hospital In-network providers should notify us within one business day of any planned, and if possible unplanned admissions or transfers, including to or from a hospital, skilled nursing facility, long term acute care hospital, or acute rehabilitation center.		
Inpatient services covered when the hospital or SNF days are not covered or are no longer covered* If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or a skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Prosthetic and orthotic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back and neck braces, trusses and artificial legs, arms, and eyes including adjustments, repairs and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, occupational therapy, and speech language therapy	After your SNF day limits are used up, this plan will still pay for covered physician services and other medical services outlined in this benefits chart at the deductible and/or cost share amounts indicated.	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Home health agency care*	$0 copay for Medicare-covered home health visits	$0 copay for Medicare-covered home health visits
Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech language therapy • Medical and social services • Medical equipment and supplies	Durable Medical Equipment (DME) copay or coinsurance, if any, may apply.	Durable Medical Equipment (DME) copay or coinsurance, if any, may apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Hospice care You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have six months or less to live if your illness runs its normal course. Your hospice doctor can be an in-network provider or an out-of-network provider. For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than this plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Medicare for the services that Original Medicare pays for. Services covered by Original Medicare include: • Drugs for symptom control and pain relief • Short-term respite care • Home care Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need nonemergency, nonurgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network: • If you obtain the covered services from an in-network provider, you only pay the plan cost-sharing amount for in-network services. • If you obtain the covered services from an out-of-network provider, you pay the plan cost-sharing for out-of-network services.	You must receive care from a Medicare-certified hospice. When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan. $10 copay for the one time only hospice consultation	You must receive care from a Medicare-certified hospice. When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan. $10 copay for the one time only hospice consultation

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Hospice care (con't) For services that are covered by this plan but are not covered by Medicare Part A or B: This plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. If you have Part D prescription drug coverage, some drugs may be covered under your Part D benefit. Drugs are never covered by both hospice and your Part D plan at the same time. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.		

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient services		
Physician services, including doctor's office visits*	$10 copay per visit to an in-network Primary Care Physician (PCP) for Medicare-covered services	$10 copay per visit to an out-of-network Primary Care Physician (PCP) for Medicare-covered services
Covered services include: • Office visits, including medical and surgical services in a physician's office • Consultation, diagnosis, and treatment by a specialist • Retail health clinics • Basic diagnostic hearing and balance exams, if your doctor orders it to see if you need medical treatment, when furnished by a physician, audiologist, or other qualified provider • Telehealth office visits, including consultation, diagnosis, and treatment by a specialist • Second opinion by another in-network provider prior to surgery • Physician services rendered in the home • Outpatient hospital services • Non–routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) • Allergy testing and allergy injections	$10 copay per visit to an in-network specialist for Medicare-covered services $10 copay per visit to an in-network retail health clinic for Medicare-covered services $0 copay for Medicare-covered allergy testing $0 copay for Medicare-covered allergy injections See antigen cost share in Part B drug section.	$10 copay per visit to an out-of-network specialist for Medicare-covered services $10 copay per visit to an out-of-network retail health clinic for Medicare-covered services $0 copay for Medicare-covered allergy testing $0 copay for Medicare-covered allergy injections See antigen cost share in Part B drug section.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Chiropractic services • We cover only manual manipulation of the spine to correct subluxation.	$10 copay for each Medicare-covered visit	$10 copay for each Medicare-covered visit
Podiatry services* Covered services include: • Diagnosis and the medical or surgical treatment of injuries and disease of the feet (such as hammer toe or heel spurs) in an office setting • Medicare-covered routine foot care for members with certain medical conditions affecting the lower limbs • A foot exam covered every six months for people with diabetic peripheral neuropathy and loss of protective sensations	$10 copay for each Medicare-covered visit	$10 copay for each Medicare-covered visit
Outpatient mental health care, including partial hospitalization services* Covered services include: • Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	$10 copay for each Medicare-covered professional individual therapy visit $10 copay for each Medicare-covered professional group therapy visit $10 copay for each Medicare-covered professional partial hospitalization visit $0 copay for each Medicare-covered outpatient hospital facility individual therapy visit	$10 copay for each Medicare-covered professional individual therapy visit $10 copay for each Medicare-covered professional group therapy visit $10 copay for each Medicare-covered professional partial hospitalization visit $0 copay for each Medicare-covered outpatient hospital facility individual therapy visit

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient mental health care, including partial hospitalization services (con't)	$0 copay for each Medicare-covered outpatient hospital facility group therapy visit $0 copay for each Medicare-covered partial hospitalization facility visit	$0 copay for each Medicare-covered outpatient hospital facility group therapy visit $0 copay for each Medicare-covered partial hospitalization facility visit
Outpatient substance abuse services, including partial hospitalization services* "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	$10 copay for each Medicare-covered professional individual therapy visit $10 copay for each Medicare-covered professional group therapy visit $10 copay for each Medicare-covered professional partial hospitalization visit $0 copay for each Medicare-covered outpatient hospital facility individual therapy visit	$10 copay for each Medicare-covered professional individual therapy visit $10 copay for each Medicare-covered professional group therapy visit $10 copay for each Medicare-covered professional partial hospitalization visit $0 copay for each Medicare-covered outpatient hospital facility individual therapy visit

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient substance abuse services, including partial hospitalization services (con't)	$0 copay for each Medicare-covered outpatient hospital facility group therapy visit $0 copay for each Medicare-covered partial hospitalization facility visit	$0 copay for each Medicare-covered outpatient hospital facility group therapy visit $0 copay for each Medicare-covered partial hospitalization facility visit
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers* Facilities where surgical procedures are performed and the patient is released the same day. **Note:** If you are having surgery in a hospital, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient." You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	$0 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for surgery $0 copay for each Medicare-covered outpatient observation room visit	$0 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for surgery $0 copay for each Medicare-covered outpatient observation room visit

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient hospital services, non-surgical* Covered services include medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	$10 copay for a visit to an in-network primary care physician in an outpatient hospital setting/clinic for Medicare-covered non-surgical services $10 copay for a visit to an in-network specialist in an outpatient hospital setting/clinic for Medicare-covered non-surgical services $0 copay for each Medicare-covered outpatient observation room visit	$10 copay for a visit to an out-of-network primary care physician in an outpatient hospital setting/clinic for Medicare-covered non-surgical services $10 copay for a visit to an out-of-network specialist in an outpatient hospital setting/clinic for Medicare-covered non-surgical services $0 copay for each Medicare-covered outpatient observation room visit

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Ambulance services • Covered ambulance services include fixed wing, rotary wing, water, and ground ambulance services, to the nearest appropriate facility that can provide care only if the services are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. • Nonemergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. • Ambulance service is not covered for physician office visits.	Your provider must get an approval from the plan before you get ground, air, or water transportation that is not an emergency. $0 copay for Medicare-covered ambulance services Cost share, if any, is applied per one-way trip for Medicare-covered ambulance services.	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. Emergency outpatient copay is waived if the member is admitted to the hospital within 72 hours for the same condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. This coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed/received in the United States. Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. If you receive authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at an in-network hospital.	$50 copay for each Medicare-covered emergency room visit	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Urgently needed services • Urgently needed services are available on a worldwide basis. The urgently needed services copay is waived if the member is admitted to the hospital within 72 hours for the same condition. If you are outside of the service area for your plan, your plan covers urgently needed services, including urgently required renal dialysis. Urgently needed services are services provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by in-network providers or by out-of-network providers when in-network providers are temporarily unavailable or inaccessible. Cost-sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. Generally, however, if you are in the plan's service area and your health is not in serious danger, you should obtain care from an in-network provider.	$25 copay for each Medicare-covered urgently needed care visit	
Outpatient rehabilitation services* Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	$10 copay for Medicare-covered physical therapy, occupational therapy, and speech language therapy visits	$10 copay for Medicare-covered physical therapy, occupational therapy, and speech language therapy visits

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	$10 copay for Medicare-covered cardiac rehabilitation therapy visits	$10 copay for Medicare-covered cardiac rehabilitation therapy visits
Pulmonary rehabilitation services* Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating their chronic respiratory disease.	$10 copay for Medicare-covered pulmonary rehabilitation therapy visits	$10 copay for Medicare-covered pulmonary rehabilitation therapy visits
Durable medical equipment (DME) and related supplies* Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital bed ordered by a provider for use at home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. Copay or coinsurance only applies when you are not currently receiving inpatient care. If you are receiving inpatient care your DME will be included in the copay or coinsurance for those services. We cover all medically necessary durable medical equipment covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you.	10% coinsurance for Medicare-covered DME See the Diabetes self-management training, diabetic services, and supplies benefit section for diabetic supply cost sharing.	10% coinsurance for Medicare-covered DME See the Diabetes self-management training, diabetic services, and supplies benefit section for diabetic supply cost sharing.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Prosthetic devices and related supplies* Devices (other than dental) that replace all or a body part or function. These include, but are not limited to, colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery. See "Vision care" later in this section for more detail.	10% coinsurance for Medicare-covered prosthetics and orthotics	10% coinsurance for Medicare-covered prosthetics and orthotics
Diabetes self-management training, diabetic services, and supplies* For all people who have diabetes (insulin and non-insulin users) Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors • Blood glucose monitors are limited to one every six months • Up to 200 blood glucose test strips for a 30-day supply • One pair per year of therapeutic custom molded shoes (including inserts provided with such shoes) and two additional pairs of inserts or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes) for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts • Diabetes self-management training is covered under certain conditions	10% coinsurance for a 30-day supply on each Medicare-covered purchase of blood glucose test strips, lancets, lancet devices, and glucose control solutions for checking the accuracy of test strips and monitors 10% coinsurance for Medicare-covered blood glucose monitor 10% coinsurance for Medicare-covered therapeutic shoes and inserts $0 copay for Medicare-covered diabetes self-management training	10% coinsurance for a 30-day supply on each Medicare-covered purchase of blood glucose test strips, lancets, lancet devices, and glucose control solutions for checking the accuracy of test strips and monitors 10% coinsurance for Medicare-covered blood glucose monitor 10% coinsurance for Medicare-covered therapeutic shoes and inserts $0 copay for Medicare-covered diabetes self-management training

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient diagnostic tests and therapeutic services and supplies*	$0 copay for each Medicare-covered X-ray visit and/or simple diagnostic test	$0 copay for each Medicare-covered X-ray visit and/or simple diagnostic test
Covered services include, but are not limited to: • X-rays • Complex diagnostic tests and radiology services • Radiation (radium and isotope) therapy, including technician materials and supplies • Testing to confirm chronic obstructive pulmonary disease (COPD) • Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Laboratory tests • Blood – including storage and administration. Coverage of whole blood, packed red cells, and all other components of blood begins with the first pint • Other outpatient diagnostic tests Certain diagnostic tests and radiology services are considered complex and include heart catheterizations, sleep studies, computed tomography (CT), magnetic resonance procedures (MRIs and MRAs), and nuclear medicine studies, which includes PET scans.	$0 copay for Medicare-covered complex diagnostic test and/or radiology visit $0 copay for each Medicare-covered radiation therapy treatment $0 copay for Medicare-covered testing to confirm chronic obstructive pulmonary disease 10% coinsurance for Medicare-covered supplies $0 copay for each Medicare-covered clinical/diagnostic lab test $0 copay per Medicare-covered pint of blood	$0 copay for Medicare-covered complex diagnostic test and/or radiology visit $0 copay for each Medicare-covered radiation therapy treatment $0 copay for Medicare-covered testing to confirm chronic obstructive pulmonary disease 10% coinsurance for Medicare-covered supplies $0 copay for each Medicare-covered clinical/diagnostic lab test $0 copay per Medicare-covered pint of blood

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic-Americans who are age 65 or older. • For people with diabetes, screening for diabetic retinopathy is covered once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)	$10 copay for visits to an in-network primary care physician for Medicare-covered exams to diagnose and treat diseases of the eye $10 copay for visits to an in-network specialist for Medicare-covered exams to diagnose and treat diseases of the eye $0 copay for Medicare-covered glaucoma screening $0 copay for Medicare-covered diabetic retinopathy screening 20% coinsurance for glasses/contacts following Medicare-covered cataract surgery	$10 copay for visits to an out-of-network primary care physician for Medicare-covered exams to diagnose and treat diseases of the eye $10 copay for visits to an out-of-network specialist for Medicare-covered exams to diagnose and treat diseases of the eye $0 copay for Medicare-covered glaucoma screening $0 copay for Medicare-covered diabetic retinopathy screening 20% coinsurance for glasses/contacts following Medicare-covered cataract surgery

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Preventive services care and screening tests  You will see this apple next to preventive services throughout this chart. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you in-network. However, if you are treated or monitored for an existing medical condition or an additional non-preventive service, during the visit when you receive the preventive service, a copay or coinsurance may apply for that care received. In addition, if an office visit is billed for the existing medical condition care or an additional non-preventive service received, the applicable in-network primary care physician or in-network specialist copay or coinsurance will apply.		
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this Medicare-covered preventive screening.	There is no coinsurance, copayment, or deductible for members eligible for this Medicare-covered preventive screening.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months, or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for the Medicare-covered bone mass measurement.	There is no coinsurance, copayment, or deductible for the Medicare-covered bone mass measurement.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Colorectal cancer screening and colorectal services For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy Colorectal services: • Include the biopsy and removal of any growth during the procedure, in the event the procedure goes beyond a screening exam	There is no coinsurance, copayment, or deductible for the Medicare-covered colorectal cancer screening exam and services.	There is no coinsurance, copayment, or deductible for the Medicare-covered colorectal cancer screening exam and services.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for the Medicare-covered preventive HIV screening.	There is no coinsurance, copayment, or deductible for members eligible for the Medicare-covered preventive HIV screening.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Medicare Part B immunizations Covered services include: • Pneumonia vaccine • Flu shots, including H1N1, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk and they meet Medicare Part B coverage rules **If you have Part D prescription drug coverage, some vaccines are covered under your Part D benefit (for example, the shingles vaccine). Please refer to your Part D prescription drug benefits.**	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, or other Medicare-covered vaccines when you are at risk and they meet Medicare Part B rules.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, or other Medicare-covered vaccines when you are at risk and they meet Medicare Part B rules.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for Medicare-covered screening mammograms.	There is no coinsurance, copayment, or deductible for Medicare-covered screening mammograms.
Cervical and vaginal cancer screening Covered services include: • For all women, Pap tests and pelvic exams are covered once every 24 months. • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: 1 Pap test every 12 months.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Prostate cancer screening exams For men age 50 and older, the following are covered once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for a Medicare-covered annual PSA test.	There is no coinsurance, copayment, or deductible for a Medicare-covered annual PSA test.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the Medicare-covered intensive behavioral therapy cardiovascular disease preventive benefit.	There is no coinsurance, copayment, or deductible for the Medicare-covered intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for Medicare-covered cardiovascular disease testing that is covered once every five years.	There is no coinsurance, copayment, or deductible for Medicare-covered cardiovascular disease testing that is covered once every five years.
"Welcome to Medicare" preventive visit The plan covers a one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, measurements of height, weight, body mass index, blood pressure, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important**: We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	There is no coinsurance, copayment, or deductible for the Medicare-covered "Welcome to Medicare" preventive visit.	There is no coinsurance, copayment, or deductible for the Medicare-covered "Welcome to Medicare" preventive visit.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Annual wellness visit If you've had Medicare Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" preventive visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the Medicare-covered annual wellness visit.	There is no coinsurance, copayment, or deductible for the Medicare-covered annual wellness visit.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for a Medicare-covered annual depression screening visit.	There is no coinsurance, copayment, or deductible for a Medicare-covered annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to 2 diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for Medicare-covered diabetes screening tests.	There is no coinsurance, copayment, or deductible for Medicare-covered diabetes screening tests.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive obesity screening and therapy.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive obesity screening and therapy.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible enrollees are:** people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years or who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the enrollee must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor. We cover three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and two hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into another plan year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Smoking and tobacco use cessation (counseling to quit smoking) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover 2 counseling quit attempts within a 12 month period. Each counseling attempt includes up to 4 face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover 2 counseling quit attempts within a 12 month period. Each counseling attempt includes up to 4 face-to-face visits. These visits must be ordered by your doctor and provided by a qualified doctor or other Medicare-recognized practitioner.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Other services		
Services to treat outpatient kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area) • Home dialysis or certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home and outpatient dialysis equipment and supplies Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B drugs, please go to the section below, "Medicare Part B prescription drugs."	You do not need to get an approval from the plan before getting dialysis. But please let us know when you need to start this care, so we can help coordinate with your doctors. $0 copay for each Medicare-covered kidney disease education session $10 copay for Medicare-covered outpatient dialysis $0 copay for Medicare-covered home dialysis or home support services $10 copay for Medicare-covered self-dialysis training 10% coinsurance for Medicare-covered home dialysis equipment and supplies 10% coinsurance for Medicare-covered outpatient dialysis equipment and supplies	You do not need to get an approval from the plan before getting dialysis. But please let us know when you need to start this care, so we can help coordinate with your doctors. $0 copay for each Medicare-covered kidney disease education session $10 copay for Medicare-covered outpatient dialysis $0 copay for Medicare-covered home dialysis or home support services $10 copay for Medicare-covered self-dialysis training 10% coinsurance for Medicare-covered home dialysis equipment and supplies 10% coinsurance for Medicare-covered outpatient dialysis equipment and supplies

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Medicare Part B prescription drugs covered under your medical plan (Part B drugs)*	20% coinsurance for Medicare-covered Part B drugs	20% coinsurance for Medicare-covered Part B drugs
These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan.	20% coinsurance for Medicare-covered Part B drug administration	20% coinsurance for Medicare-covered Part B drug administration
Covered drugs include: • "Drugs" include substances that are naturally present in the body, such as blood clotting factors • Drugs that usually are not self-administered by the patient and are injected or infused while receiving physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home and outpatient dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics and erythropoiesis-stimulating agents such as Erythropoietin (Epogen®), Procrit® or Epoetin Alfa and Darboetin Alfa (Aranesp®) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases	20% coinsurance for Medicare-covered Part B chemotherapy drugs	20% coinsurance for Medicare-covered Part B chemotherapy drugs
	20% coinsurance for Medicare-covered Part B chemotherapy drug administration	20% coinsurance for Medicare-covered Part B chemotherapy drug administration
If you have Part D prescription drug coverage, please refer to your *Evidence of Coverage* for information on your Part D prescription drug benefits.		

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Additional benefits		
Routine hearing services • Routine hearing exams Routine hearing exams are limited to 1 every 12 months. Routine hearing exams are limited to a $70 maximum benefit every 12 months combined in-network and out-of-network. • Hearing aid fitting evaluations are limited to 1 per covered hearing aid • Hearing aids Hearing aids are limited to a $1,000 maximum benefit every 36 months combined in-network and out-of-network. Includes digital hearing aid technology and inner ear, outer ear, and over the ear models. Fitting adjustment after hearing aid is received, if necessary. To receive in-network benefits for routine hearing services in California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia, and Wisconsin members must use a HearUSA participating provider. To receive in-network benefits in all other states, members must use a Blue Medicare Advantage (PPO) in-network provider for routine hearing services. For additional benefit information and to locate a HearUSA or Blue Medicare Advantage (PPO) in-network participating provider, please contact customer service. Hearing benefit management administered by HearUSA, an independent company.	$0 copay for routine hearing exams $0 copay for hearing aid fitting evaluations $0 copay for hearing aids Members receive a free battery supply during the first 3 years with a 48-cell limit per year, per hearing aid. After the plan pays benefits for routine hearing exams, hearing aids, and hearing aid fitting evaluations, you are responsible for the remaining cost.	$0 copay for routine hearing exams $0 copay for hearing aid fitting evaluations $0 copay for hearing aids Members receive a free battery supply during the first 3 years with a 48-cell limit per year, per hearing aid. After the plan pays benefits for routine hearing exams, hearing aids, and hearing aid fitting evaluations, you are responsible for the remaining cost.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Routine vision services • Routine vision exams Routine vision exams are limited to one per year combined in-network and out-of-network.	$10 copay for routine vision exams After the plan pays benefits for routine vision exams, you are responsible for the remaining cost.	$10 copay for routine vision exams After the plan pays benefits for routine vision exams, you are responsible for the remaining cost.
Routine foot care • Up to six covered visits per year combined in-network and out-of-network Routine foot care includes the cutting or removal of corns and calluses, the trimming, cutting, clipping or debriding of nails, and other hygienic and preventive maintenance care.	$10 copay for each visit to an in-network primary care physician for routine foot care $10 copay for each visit to an in-network specialist for routine foot care After the plan pays benefits for routine foot care, you are responsible for the remaining cost.	$10 copay for each visit to an out-of-network primary care physician for routine foot care $10 copay for each visit to an out-of-network specialist for routine foot care After the plan pays benefits for routine foot care, you are responsible for the remaining cost.
Annual routine physical exam The annual routine physical exam benefit covers a standard physical exam in addition to the Medicare-covered "Welcome to Medicare" or “Annual Wellness Visit.”	$0 copay for an annual physical exam	$0 copay for an annual physical exam

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Video Doctor Visits LiveHealth Online lets you see board-certified doctors and licensed therapists/psychologists through live, two-way video on your smartphone, tablet or computer. It's easy to get started! You can sign up at livehealthonline.com or download the free LiveHealth Online mobile app and register. Make sure you have your health insurance card ready – you'll need it to answer some questions. **Sign up for Free:** • You must enter your health insurance information during enrollment, so have your card ready when you sign up. **Benefits of a video doctor visit:** • The visit is just like seeing your regular doctor face-to-face, but just by web camera. • **It's a great** option for medical care when your doctor can't see you. Board-certified doctors can help **24/7 for most types of care** and common conditions like the flu, colds, pink eye and more. • The doctor can send prescriptions to the pharmacy of your choice, if needed.[1] • If you're feeling stressed, worried or having a tough time, you can make an appointment to talk to a licensed **therapist or psychologist from your home or on the road.** In most cases, you can make an appointment and see a therapist or psychologist in four days or less.[2] Video doctor visits are intended to complement face-to-face visits with a board-certified physician and are available for most types of care. A maximum allowance of $49 for each visit with a board-certified doctor. A maximum allowance of $80 for each visit with a therapist and $95 for each visit with a psychologist.	$0 copay for video doctor visits using LiveHealth Online After the plan pays benefits for LiveHealth Online services, you are responsible for the remaining cost.	$0 copay for video doctor visits. After the plan pays benefits for video doctor visits, you are responsible for the remaining cost.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Video Doctor Visits (con't) LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of this Plan. 1 Prescription is prescribed based on physician recommendations and state regulations (rules). 2 Appointments are based on therapist/psychologist availability. Video psychologists or therapists cannot prescribe medications.		

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Health and wellness education programs **SilverSneakers** The SilverSneakers® fitness program is your fitness benefit. It includes: • support from trained instructors • group classes for all fitness levels and abilities • access to 14,000+ participating locations* • use of all basic amenities • group fitness classes outside traditional gyms • on-demand workout videos plus health and nutrition tips To get started: Simply show your SilverSneakers ID number at the front desk of any SilverSneakers participating location. Visit **SilverSneakers.com/StartHere** to: • get your SilverSneakers ID number • find participating locations • see class descriptions If you have questions about SilverSneakers, please call 1-888-423-4632 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET. *At-home kits are offered for members who want to start working out at home or for those who can't get to a fitness location due to injury, illness or being homebound. SilverSneakers is not just a gym membership, but a specialized program designed specifically for older adults. Gym memberships or other fitness programs that do not meet the SilverSneakers criteria are excluded. The SilverSneakers fitness program is provided by Tivity Health, an independent company. Tivity Health and SilverSneakers are registered trademarks or trademarks of Tivity Health, Inc. and/or its subsidiaries and/or affiliates in the USA and/or other countries. © 2018. All rights reserved.	$0 copay for the SilverSneakers fitness benefit	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Nurse HelpLine Also, as a member, you have access to a 24-hour nurse line, 7 days a week, 365 days a year. When you call our nurse line, you can speak directly to a registered nurse who will help answer your health-related questions. The call is toll free and the service is available anytime, including weekends and holidays. Plus, your call is always confidential. Call the Nurse HelpLine at 1-800-700-9184. TTY users should call 711. Only Nurse HelpLine is included in our plan. All other nurse access programs are excluded.	$0 copay for Nurse HelpLine	
Foreign travel emergency and urgently needed services Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months. Outpatient copay is waived if member is admitted to hospital within 72 hours for the same condition. • Emergency outpatient care • Urgently needed services • Inpatient care (60 days per lifetime) This coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed/received in the United States. If you are in need of emergency care outside of the United States or its territories, you should call the Blue Cross Blue Shield Global Core Program at 800-810 BLUE or collect at 804-673-1177. Representatives are available 24 hours a day, 7 days a week, 365 days a year to assist you. When you are outside the United States or its territories, this plan provides coverage for emergency/urgent services only. This is a Supplemental Benefit and not a benefit covered under the Federal Medicare program. For more coverage, you may have the option of purchasing additional travel insurance through an authorized agency.	$50 copay for emergency care $25 copay for urgently needed services $0 copay per admission for emergency inpatient care	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Acupuncture The services of a licensed acupuncturist for acupuncture treatment to treat a disease, illness or injury. Benefits include: • Initial patient exam, as well as acupuncture treatment, re-examinations and other services in various combinations Acupuncture services and Medicare non-covered chiropractic services, combined, are limited to 20 visits per year combined in-network and out-of-network. For additional benefit information please contact customer service.	$15 copay per visit After the plan pays benefits for acupuncture services and Medicare non-covered chiropractic services, you are responsible for the remaining cost.	$15 copay per visit After the plan pays benefits for acupuncture services and Medicare non-covered chiropractic services, you are responsible for the remaining cost.
Additional Chiropractic services For Medicare non-covered chiropractic services rendered by a physician to treat a disease, illness or injury. Benefits include: • Diagnostic services, other than diagnostic scanning, when provided during an initial examination or re-examination; • Adjustments; • Radiological x-rays and laboratory tests; and • Medically necessary therapy when provided in conjunction with the visit specifically for spinal or joint adjustment. Medicare non-covered chiropractic services and acupuncture services, combined, are limited to 20 visits per year combined in-network and out-of-network. For additional benefit information please contact customer service.	$15 copay per visit After the plan pays benefits for Medicare non-covered chiropractic services and acupuncture services, you are responsible for the remaining cost.	$15 copay per visit After the plan pays benefits for Medicare non-covered chiropractic services and acupuncture services, you are responsible for the remaining cost.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Medicare-approved clinical research studies A clinical research study is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. If you participate in a Medicare-approved study, Original Medicare pays the doctors and other providers for the covered services you receive as part of the study. Although not required, we ask that you notify us if you participate in a Medicare-approved research study.	After Original Medicare has paid its share of the Medicare-approved study, this plan will pay the difference between what Medicare has paid and this plan's cost-sharing for like services. Any remaining plan cost-sharing you are responsible for will accrue toward this plan's out-of-pocket maximum.	
Annual out-of-pocket maximum All copays, coinsurance, and deductibles listed in this benefits chart are accrued toward the medical plan out-of-pocket maximum with the exception of the routine hearing services and the foreign travel emergency and urgently needed care copay or coinsurance amounts. Part D Prescription drug deductibles and copays do not apply to the medical plan out-of-pocket maximum.	$1,500 Combined in-network and out-of-network	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
New CMS benefit released 7/24/18		
Supervised Exercise Therapy (SET)* SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise–training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	$10 copay for Medicare-covered supervised exercise therapy visits	$10 copay for Medicare-covered supervised exercise therapy visits

* Some services that fall within this benefit category require prior authorization. Based on the service you are receiving, your provider will know if prior authorization is needed. This means an approval in advance is needed, by your plan, to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other in-network provider gets prior authorization from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, we recommend you ask for a pre-visit coverage decision to confirm that the services you are getting are covered and medically necessary. Benefit categories that include services that require prior authorization are marked with an asterisk in the Benefits Chart.

Frequently asked questions

What is a deductible?

A deductible is the amount of money you pay for health care services before your plan starts paying. After you reach your deductible, you'll still have to pay toward your cost share for services. Some plans have no deductible and will cover your health care services from the start. Some services will be covered by your plan before you reach the deductible. For more details, please see the Benefits Chart included in this guide.

What is a copay?

Your copay is a fixed dollar amount that you pay for covered services. Your copay is often charged to you after your appointment.

What is an annual out-of-pocket maximum (or Max OOP)?

Another feature of Medicare Advantage is the Max OOP. It is the maximum total amount you will pay every plan year for your covered health care costs, including copays, coinsurance and deductibles. Once you reach your Max OOP, you pay nothing for your covered health care costs until the start of the next plan year.

Not all of your medical costs add to your annual out-of-pocket maximum. For more details and what services are covered by this plan, please see the Benefits Chart included in this guide.

How is inpatient care different from outpatient care?

Outpatient care is any health care services provided to a patient who is not admitted to a facility. Outpatient care may be provided in a doctor's office, clinic or hospital outpatient department.

Inpatient care is medical treatment that is provided when you have been formally admitted to the hospital or other facility with a doctor's order. If you are not admitted with a doctor's order, you may be considered an outpatient even if you stay in the hospital overnight.

What is a Primary Care Physician?

A Primary Care Physician is a general practice doctor who treats basic medical conditions. Primary care doctors do physicals or checkups and give vaccinations. They can help diagnose health problems and either provide care or refer patients to specialists if the condition requires. They are often the first doctor most patients see when they have a health concern.

What are preventive services?

Preventive care and services help you avoid an illness or injury. Common examples of preventive care are immunizations and annual physicals. Any screening test done in order to catch a disease early is considered a preventive service. Advice or counseling, such as nutrition and exercise guidance, are also examples of preventive care and services.

Before enrolling, what do I need to provide my former employer, union or group sponsor?

To ensure a smooth enrollment, make sure your former employer, union or group sponsor has your most up-to-date information and that it matches your Social Security information.

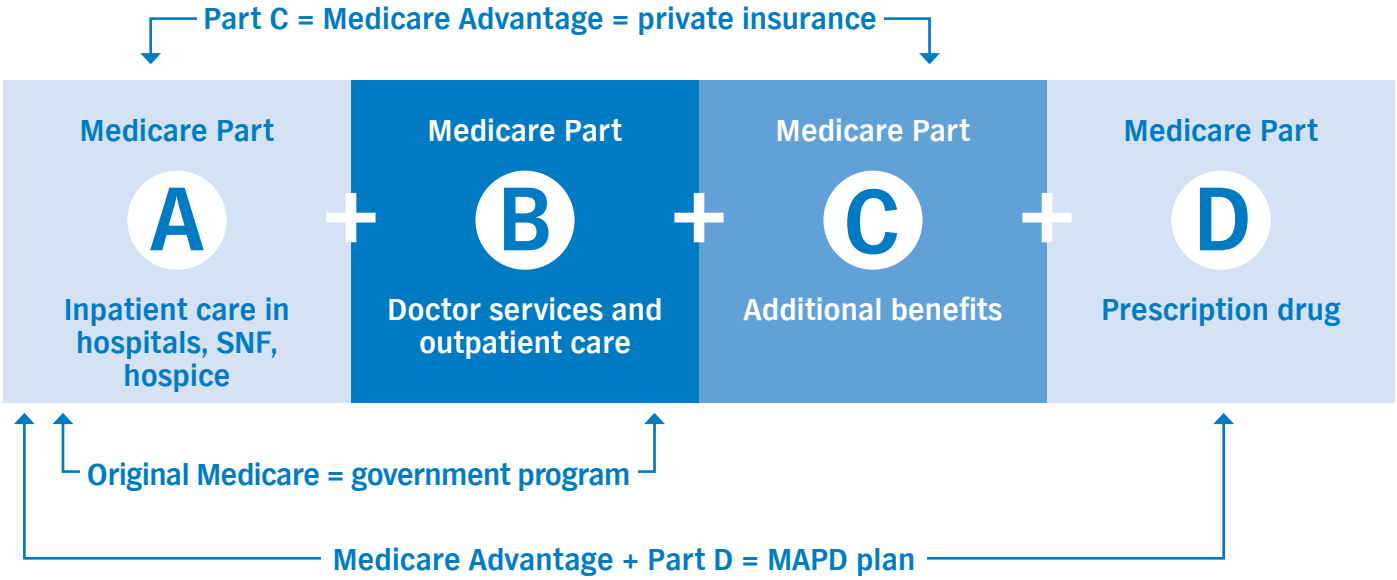
How Medicare works

Medicare is a federal government health insurance program offered to people 65 years of age or older, people under age 65 with certain disabilities and anyone with end-stage renal disease (ESRD)

The ABCDs of Medicare

You may have heard about the different parts of Medicare. Here's a quick look at what they mean to your medical coverage:

- **Medicare Parts A + B** = Original Medicare, the government program.
- **Medicare Part C** = Original Medicare + Additional Benefits. Part C is also called Medicare Advantage (MA).
- **Medicare Part D** is the prescription drug benefit.



Learn more about Medicare

Download the booklet *Medicare & You* at **www.medicare.gov**. Or you can order a printed copy by calling **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users, call **1-877-486-2048**.

Appendix: Required information for 2019 Qualifying and enrolling

How you qualify for this plan

To qualify for Anthem Medicare Preferred (PPO), you must meet all of these conditions:

- You are now entitled to Medicare Part A and enrolled in Part B.
- You are a permanent resident in Anthem BC Health's service area.
- You are a U.S. citizen or are lawfully present here.
- You keep paying your Medicare Part B premiums, unless they are paid by Medicaid or through another third party.
- You qualify for coverage under your or your spouse's current or former employer's group health plan.

How to enroll

When you are ready to enroll, contact your CalPERS Customer Contact Center at **888 CalPERS** (or **888-225-7377**) or visit the website at **https://www.calpers.ca.gov**.

Once you're enrolled

Once your enrollment in the Anthem Medicare Preferred (PPO) plan is processed, we'll send you:

- Acknowledgement of your enrollment request and your effective start date.
- A letter showing proof of membership — until your Anthem BC Health membership card arrives.
- Your Anthem BC Health membership card.
- A *Welcome Kit* containing important information, plus instructions for ordering a *Provider and Pharmacy Directory*.

We care enough to ask about your health

Be sure to look for the simple health survey that should arrive about 90 days after your health plan starts. Answering these questions helps us care for your health needs in the best way possible.

For more information on enrollment, call the First Impressions Welcome Team at **1-855-251-8825,** TTY: **711**.

Appendix: Required information for 2019 Your rights, protections and Medicare options

As a Medicare beneficiary, you have many rights and options put in place to protect you as a consumer

You have choices. As a Medicare beneficiary, you can choose between:

- The Original (Fee-for-Service) Medicare plan
- A Medicare health plan like this one — Anthem Medicare Preferred (PPO)

➔ You may have other options, too

The important thing to remember is that the choice is yours, keeping in mind that you may be able to join or leave a plan only at certain times. Please note that if you do not take your retiree benefits, it may impact other retiree benefits your employer offers. No matter what you decide, you are still in the Medicare program.

➔ Your Medicare protections

Your Anthem Medicare Preferred (PPO) plan must offer Medicare benefits to you for a full calendar year at a time, although benefits and cost sharing may change from year to year. Anthem BC Health can decide each year whether to keep participating with Medicare Advantage, or whether or not to continue offering plans in specific geographic areas like yours.

Also, Medicare may decide to end our contract. But rest assured, even if this happens or if your plan is discontinued, you will not lose coverage.

If for some reason this plan is discontinued, we will send you a letter at least 90 days before your coverage ends explaining your options for Medicare coverage in your area.

For more information on the options and rights you have as a Medicare Advantage member with Anthem Medicare Preferred (PPO), please contact our First Impressions Welcome Team and ask for a copy of the *Evidence of Coverage*.

➔ Geographic service areas covered by this plan

Your Anthem Medicare Preferred (PPO) plan offers coverage in our CMS-defined geographic service area of all 50 states, Washington, D.C., American Samoa, Guam, Northern Mariana Islands, U.S. Virgin Islands and Puerto Rico.

Appendix: Required information for 2019 Information about Medicare

To help you make more informed health care decisions, we are providing this important information about Medicare to use as a resource. If you have any questions, please contact our First Impressions Welcome Team.

Pay your Medicare Part B premiums

Once you enroll in this plan, you must still pay your Medicare Part B premiums. If you don't, Medicare will terminate your coverage and then you may have to pay a late-enrollment penalty (LEP) if you decide to re-enroll.

Enrolling in other plans

If you decide to enroll in other plans, you will be disenrolled from your current plan.

Matching Group Medicare Advantage and Part D Prescription (PDP) plans

If you are enrolled in a Group Medicare Advantage plan, your PDP must also be a Group PDP. This is important because enrolling in a non-Group plan could result in termination of your enrollment.

Notifying your former employer, union or group sponsor

To ensure a smooth enrollment, make sure your former employer, union or group sponsor has your most up-to-date information and that it matches your Social Security information.

If you have end-stage renal disease

If you have end-stage renal disease (ESRD), you could be covered under this plan. But you may not be eligible to enroll. Please contact our First Impressions Welcome Team to learn about possible exceptions. Call **1-855-251-8825**, TTY: **711**.

High-income surcharges

If you must pay a high-income surcharge on your Medicare Part B premium to the Social Security Administration, please be sure to do so to avoid a mandatory disenrollment.

Appendix: Required information for 2019

1 Website tools are offered to Anthem BC Health plan members as extra services. They are not part of the contract and can change or stop.

Our plan has free language interpreter services available to answer questions from non-English speaking members. Please call the First Impressions Welcome Team at the number listed in this guide to request interpreter services.

Out-of-network/non-contracted providers are under no obligation to treat Anthem BC Health members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our First Impressions Welcome Team at 1-855-251-8825, TTY: 711, for more information.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year. The formulary, pharmacy network and/or provider network may change at any time. You will receive notice when necessary. For those with Medicare Part B: You must continue to pay your Medicare Part B premium. Medicare evaluates plans based on a five-star rating system. Star Ratings are calculated each year and may change from one year to the next.

This guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits and exclusions are contained in the Benefits Chart and Evidence of Coverage (EOC), which are received upon enrollment. In the event of a conflict between the Benefits Chart/EOC and this guide, the terms of the Benefits Chart and EOC will prevail.

It's important we treat you fairly

That's why we follow Federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters. Interested in these services? Call Member Services for help (TTY: **711**).

If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, 4361 Irwin Simpson Rd, Mailstop: OH0205-A537; Mason, Ohio 45040-9498. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling **1-800-368-1019** (TTY: **1-800-537-7697**) or online at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**. Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Get help in your language

Separate from our language assistance program, we make documents available in alternate formats. If you need a copy of this document in an alternate format, please call Member Services.

English: You have the right to get this information and help in your language for free. Call Member Services for help. (TTY: **711**)

Spanish: Tiene el derecho de obtener esta información y ayuda en su idioma de forma gratuita. Llame al número de Servicios para Miembros para obtener ayuda. (TTY: **711**)

Arabic:
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجاناً. اتصل بخدمة العملاء للمساعدة.
(TTY: **711**)

Armenian: Դուք իրավունք ունեք Ձեր լեզվով ստանալու այս տեղեկատվությունը և ցանկացած օգնություն՝ անվճար: Օգնություն ստանալու համար զանգահարեք հաճախորդների սպասարկման կենտրոն: (TTY: **711**)

Chinese: 您有權使用您的語言免費獲得該資訊和協助。請致電客戶服務部尋求協助。
(TTY: **711**)

Farsi:
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید.
برای دریافت کمک با مرکز خدمات مشتریان تماس بگیرید.
(TTY: **711**)

French: Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour obtenir de l'aide, veuillez appeler le service client. (TTY: **711**)

Haitian: Ou gen dwa resevwa enfòmasyon sa a ak asistans nan lang ou pale a pou gratis. Rele nimewo Sèvis Kliyan an pou jwenn èd. (TTY: **711**)

Italian: Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il Servizio clienti. (TTY: **711**)

Japanese: この情報と支援を希望する言語で無料で受けることができます。サポートが必要な場合はカスタマー サービスにお電話ください。(TTY: **711**)

Korean: 귀하께는 본 정보와 도움을 비용없이 귀하의 언어로 받으실 권리가 있습니다. 도움을 받으시려면 고객 서비스부로 연락해 주십시오. (TTY: **711**)

Polish: Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. Zadzwoń pod numer Działu Obsługi Klienta w celu uzyskania pomocy. (TTY: **711**)

Portuguese: Você tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o Atendimento ao Cliente para obter ajuda. (TTY: **711**)

Russian: Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания клиентов. (TTY: **711**)

Tagalog: May karapatan kang makuha ang impormasyon at tulong na ito sa sarili mong wika ng walang kabayaran. Tumawag sa Serbisyo para sa mga Kustomer para matulungan ka. (TTY: **711**)

Vietnamese: Bạn có quyền được biết về thông tin này và được hỗ trợ bằng ngôn ngữ của bạn miễn phí. Hãy liên hệ với Dịch vụ khách hàng để được hỗ trợ. (TTY: **711**)

Anthem BC Health Insurance Company - H4909

2018 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 2018, Anthem BC Health Insurance Company received the following Overall Star Rating from Medicare.

4.5 Stars

We received the following Summary Star Rating for Anthem BC Health Insurance Company's health/drug plan services:

Health Plan Services:	 4 Stars
Drug Plan Services:	 4.5 Stars

The number of stars shows how well our plan performs.

	5 stars - excellent
	4 stars - above average
	3 stars - average
	2 stars - below average
	1 star - poor

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

You may also contact us Monday through Friday from 8:00 a.m. to 9:00 p.m. Eastern time at 855-251-8825 (toll-free) or 711 (TTY).

Current members please call 855-251-8825 (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 BC Health Insurance Company is an LPPO plan with a Medicare contract. Enrollment in Anthem BC Health Insurance Company depends on contract renewal.

Important information regarding your Medicare Advantage plan

I understand that the effective date of coverage is when I can begin using the plan services and the Medicare Advantage plan will send me written notification of the effective date of my enrollment in the plan. I understand this is a Medicare Advantage plan that has a contract with the federal government.

I understand that I need to keep my Medicare Parts A and B. I must maintain my Medicare Part B insurance by continuing to pay the Part B premium, if applicable.

I understand that by enrolling in this Medicare Advantage plan, I will automatically be disenrolled by the Centers for Medicare & Medicaid Services (CMS) from any other Medicare Advantage plan of which I am currently a member. **I can only be in one Medicare Advantage plan at a time.** It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future.

I understand that enrollment in this plan is generally for the entire year. **I may leave this plan only at certain times of the year if an enrollment period is available or under certain special circumstances.** I may disenroll from this Medicare Advantage plan only by sending a written request to my prior employer **or by calling 1-800-MEDICARE (TTY users should call 1-877-486-2048), 24 hours a day, 7 days a week.** However, this should be discussed with your prior employer so that your retiree benefits are not jeopardized.

I will read the *Evidence of Coverage* document from this Medicare Advantage plan when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. *I understand that beneficiaries of Medicare generally are not covered under Medicare while out of the country except for limited coverage near the U.S. border.*

Release of information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations.

I also acknowledge that this Medicare Advantage plan will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. I understand that if false enrollment information is provided, I will be disenrolled from this Medicare Advantage plan.

I understand that if I am receiving assistance from a sales agent, broker or other individual employed by or contracted with this Medicare Advantage plan, he/she may be compensated based on my enrollment in this plan.

Counseling services may be available in my state to provide advice concerning Medicare supplemental insurance or other Medicare Advantage plan options as well as concerning

medical assistance through the state Medicaid program and the Medicare Savings Program.

This Medicare Advantage plan serves a specific service area. If I move out of the area that plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of this Medicare Advantage plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* from the plan when I receive it to know which rules I must follow to receive coverage with this Medicare Advantage plan.

I understand that beginning on the date plan coverage begins, using services in network can cost less than using services out of network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, the plan provides refunds for all covered benefits, even if I get services out of network. Services authorized by the plan and other services contained in my plan *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THE PLAN WILL PAY FOR THE SERVICES.**

I understand that as a member of this plan, I have the right to ask about the plan's decision about payments or coverage for services I receive, if I disagree.

I understand that my coverage will come into effect only if this enrollment is approved by the plan and the Centers for Medicare & Medicaid Services (CMS). I, the applicant, acknowledge that I have read and understand the enrollment process and the accompanying sales and marketing materials in their entirety.

I understand that this Medicare Advantage plan is offered under a contract with CMS and CMS' review and approval of its benefits.

Anthem BC Health Insurance Company is an LPPO plan with a Medicare contract. Enrollment in Anthem BC Health Insurance Company depends on contract renewal. Anthem Insurance Companies, Inc., operating in California as Anthem BC Health Insurance Company (Anthem BC Health), is the legal entity that has contracted with the Centers for Medicare & Medicaid Services (CMS) to offer the LPPO plan(s) noted above or herein. Anthem BC Health is the risk-bearing entity licensed under applicable state law to offer the LPPO plan(s) noted. Anthem BC Health has retained the services of its related companies and the authorized agents/brokers/producers to provide administrative services and/or to make the LPPO plan(s) available in this region. Anthem BC Health Insurance Company is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross Association.

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