Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-230-7338. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-888-230-7338. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-888-230-7338。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-888-230-7338。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-888-230-7338. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-888-230-7338. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-888-230-7338 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-888-230-7338. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-888-230-7338 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-888-230-7338. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على بمساعدتك. هذه مترجم فوري، ليس عليك سوى الاتصال بنا على 1-888-032-8337. سيقوم شخص ما يتحدث العربية خدمة مجانية.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-888-230-7338. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-888-230-7338. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-888-230-7338. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-888-230-7338. Ta usługa jest bezpłatna.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-888-230-7338 पर फोन केंर. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-888-230-7338 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

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Medicare Advantage & Part D

Blue Cross Senior Secure Plan I (HMO)

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Plan Ratings

Summary of Benefits

Enrollment Application

Summary of Privacy Practices

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

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Anthem BlueCross

Thank you...

for your interest in our Medicare Advantage plans.

We know you want a health care plan you can count on. One that can be tailored to fit your lifestyle – that keeps the quality of coverage high and your costs low. This is why our plans feature benefits like these:

- **Premiums as low as $0**[1]
- **Predictable copayments for doctors' office visits, as low as $10**
- **Out-of-pocket limits to protect you from high, unexpected medical costs**
- **Optional Supplemental Benefits – your choice of dental care, dental and vision care, or dental, vision, acupuncture and chiropractic care**[2]
- **SilverSneakers® fitness program, preventive care coverage, and online resources and discounts**
- **Access to large provider networks**
- **One plan and one card for your covered medical, hospital and Part D drug benefits**

Have questions? Let's talk.

To reach a licensed insurance agent, call:

1-888-211-9813 (TTY/TDD **711**),
8 a.m. to 8 p.m., seven days a week.

Customer Service: **1-888-230-7338** TTY/TDD **711**, 8 a.m. to 8 p.m., seven days a week, October 1, 2012 to February 14, 2013; 8 a.m. to 8 p.m., Monday – Friday, except holidays, February 15 to September 30, 2013. **www.anthem.com/ca/medicare**.

1 You must continue to pay your Medicare Part B premium. To find out more about covered benefits, see the *Summary of Benefits* section in this booklet.

2 For an additional fee. See the *Summary of Benefits* section in this booklet for more details and availability. Dental benefit management administered by LIBERTY Dental, an independent company.

Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on January 1 of each year.

Some good terms to know

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

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

Let's talk about...

Medicare.

There's so much to know about Medicare, it's understandable to have lots of questions. Use this section as a guide on how Medicare works, and how the choices can best fit together for you.

What is Original Medicare and who is eligible?

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

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

1. You are 65 or older.
2. You are under 65 with certain disabilities.
3. Original Medicare only: You are any age with end-stage renal disease (ESRD) – permanent kidney failure requiring dialysis or kidney transplant.[1]

Note: If you have ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease), you automatically get Part A and Part B the month your disability benefits begin.

And, if both of these items apply:

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

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

Did you know that Medicare comes in separate parts?

This helps explain what's covered by Medicare's different parts and gives you an idea of costs.
Parts A and B are Original Medicare run by the government.
Parts C and D are offered by private insurers.

Medicare Part A

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

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

Your costs for Medicare Part A:

- **Premium**: You usually won't pay any premium for Part A coverage if you or your spouse paid Medicare taxes while working.
- **Other Costs**: To give you an idea of what to expect, in 2012 the Medicare Part A annual deductible for hospital stays was $1,156. And, after you met this deductible, you would have paid nothing more for up to 60 days in the hospital. Longer stays required daily coinsurance.

Medicare Part B

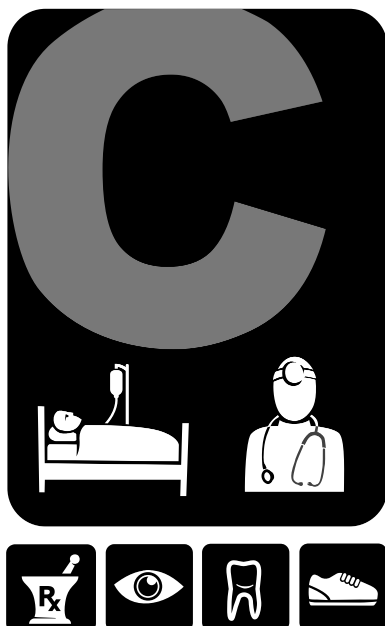
Medicare Part B is medical care coverage that helps cover the cost for:

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

Your costs for Medicare Part B:

- **Premium**: Your monthly premium is on a sliding scale based on your annual income. Most will pay the standard monthly premium, which was $99.90 per month for those who joined Medicare in 2012.
- **Other Costs**: To give you an idea of what to expect, in 2012 the Medicare Part B annual deductible was $140. And, for most services, you would pay 20% of the Medicare-approved amount.

Medicare Part C



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

Unlike Original Medicare Parts A and B, Medicare Part C is offered by private insurers that have been approved by Medicare. Medicare Advantage plans offer similar coverage to Part A (hospital) and Part B (medical), and typically offer additional benefits.[1] These may include prescription drug coverage, vision, dental, and wellness programs, as well as a fitness program.

Your costs for Medicare Part C:

- **Premiums**: A range of options with different monthly premiums based on the type and level of coverage you want. You must continue to pay your Medicare Part B premium.
- **Other Costs**: Deductibles, copays and coinsurance may still apply.[2]

Medicare Part D

Medicare Part D is prescription drug coverage.

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

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

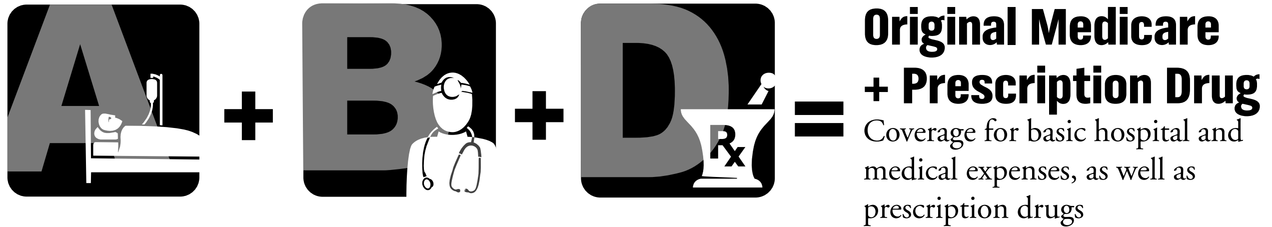
Your costs for Medicare Part D:

- **Premiums**: Most people will pay only the standard monthly Part D premium.
- **Other Costs**: Deductibles, copays and coinsurance may apply.[2]

1 Some of these additional benefits may require an additional fee.

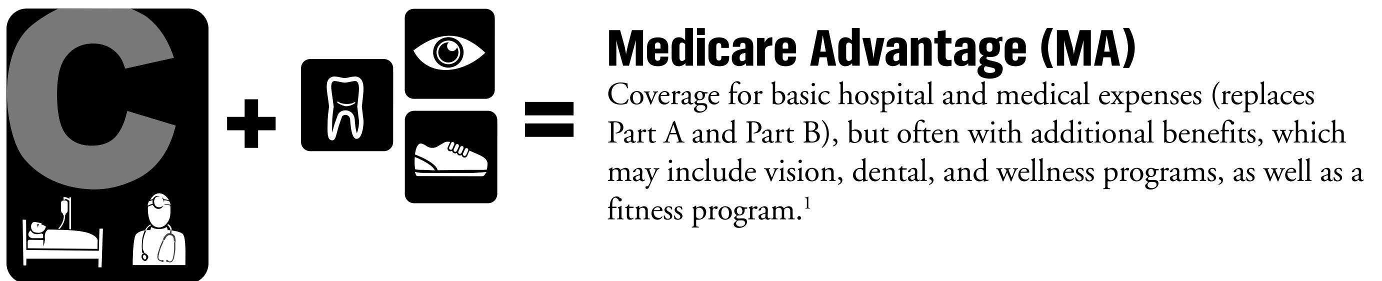
2 See the *Summary of Benefits* section in this booklet for more details.

Here's how our plans work with Medicare



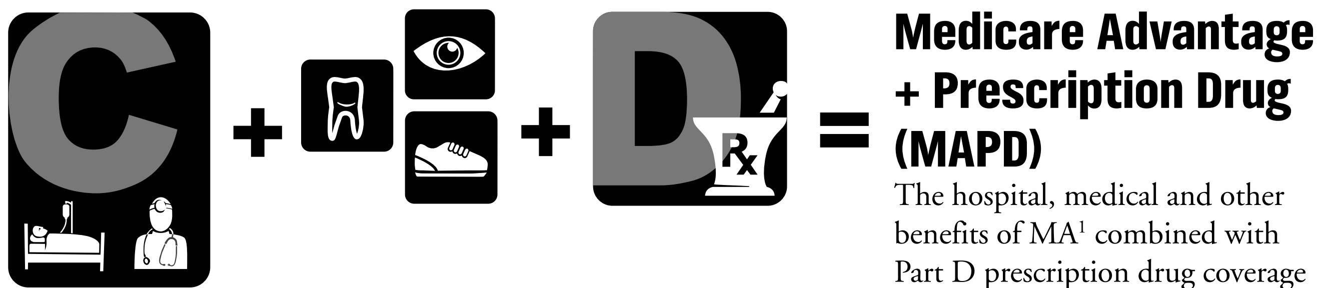
Original Medicare + Prescription Drug

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



Medicare Advantage (MA)

Coverage for basic hospital and medical expenses (replaces Part A and Part B), but often with additional benefits, which may include vision, dental, and wellness programs, as well as a fitness program.[1]



Medicare Advantage + Prescription Drug (MAPD)

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

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

When can you enroll?

When it comes to enrolling ... timing matters!

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

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

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

Initial enrollment period

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

Annual election period

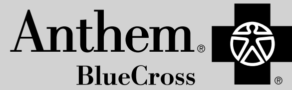
October 15 to December 7, 2012. The period you can enroll in or change your MA or MAPD plan. This is also the period you can enroll in, change or disenroll from a Part D plan. You may also switch to Original Medicare. New coverage will begin January 1, 2013.

Medicare Advantage disenrollment period

January 1 to February 14, 2013. You may disenroll from your MA plan. During this time, you will be enrolled in Original Medicare and will have the option of choosing a stand-alone Part D plan.

Special enrollment period (SEP)

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



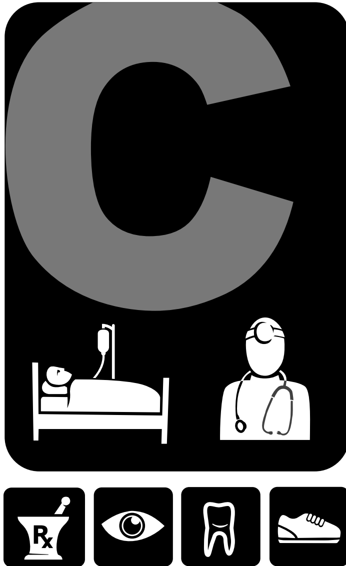
Welcome...

to our 2013 Medicare Advantage plan:

Blue Cross Senior Secure Plan I (HMO)

The benefits you've been looking for at the price you've been hoping for.

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



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

For example, with our Medicare Advantage plans you will enjoy:

- **Premiums as low as $0[1]**
- **Predictable copayments for doctors' office visits, as low as $10**
- **Out-of-pocket limits to protect you from high, unexpected medical costs**
- **SilverSneakers® fitness program, preventive care coverage, and online resources and discounts**
- **Access to large provider networks**
- **One plan and one card for your covered medical and Part D drug benefits**

Take your plan to the next level with dental, vision and other benefits[2]

Optional Supplemental Benefits packages give you coverage for care that is not always covered under Medicare Advantage plans or under Original Medicare. Package choices include dental care, dental and vision care, and dental, vision, acupuncture and chiropractic care. You can choose the package that works for you and add it to most of the Medicare Advantage plans in this booklet for a low, additional premium per month.[2]

1 You must continue to pay your Medicare Part B premium. To find out more about your covered benefits, be sure to check the *Summary of Benefits* section in this booklet.
2 For an additional fee. See the *Summary of Benefits* section in this booklet for more details and availability. Dental benefit management administered by LIBERTY Dental, an independent company.
Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on January 1 of each year.

Choose from a large network

Find a primary care provider in our network

We want you to be happy with your primary care provider (PCP). You probably want to keep the same one you've had for years. First, find out if your PCP is in your HMO plan's network. Chances are, he or she is. After all, we have more than 6,400 PCPs throughout the state. If your PCP is not in the network, you would need to choose a network provider to get covered benefits. To choose a network provider, please use your plan's Provider Directory to find one in your service area.[1]

It's important to note that a provider's participation in the network can change at any time, so please check to ensure that the provider is still part of the network before you receive care. Simply call the provider's office, or call the Customer Service number on your member ID card.

Your primary care provider is your main health care provider

Having the same primary care provider works best for your care. Your PCP:

- Knows you and your health needs when you go for your routine visits and checkups.
- Keeps a record of your medical history.
- Can refer you to the right specialists.

One card is all you need

Your Medicare Advantage plan ID card from us is all you need to see your doctor(s), go to your pharmacy or get all your other covered benefits. You don't need your red, white and blue Medicare card for accessing your benefits. Keep it, though, in case you need it in the future.

1 If you need emergency care or urgent care, go to the nearest health care provider that can help you. In most situations, you must use network providers to get covered medical care, with the exceptions of emergencies, urgently-needed care when network providers are not available (generally, when you are out of the service area) or out-of-area dialysis services. If you get routine care from out-of-network providers, neither Medicare nor Anthem Blue Cross will be responsible for the cost.

You have drug coverage as well

Enjoy added peace of mind with drug coverage

Original Medicare covers some drugs in specific circumstances. However, our Medicare Advantage Prescription Drug coverage helps pay for many brand-name and generic prescribed drugs. This coverage will help you better predict and control your costs at the pharmacy. After all, hospital, medical care and prescription drug coverage go hand in hand when it comes to supporting your well-being.

Whether or not you take prescribed drugs today, it's a good idea to sign up for prescription drug coverage when you first become eligible for Medicare. This will help you avoid the late enrollment fee, which would be added to your premiums for as long as you are enrolled in Part D. This amount may increase every year.

If you receive *Extra Help* or have proof of other creditable coverage, you may not have to pay the late enrollment fees.

Need to see a full list of covered drugs or find a pharmacy?

- Go to **www.anthem.com/ca/medicare**. Click on "Start here!"
- Then, under "Useful Tools," choose "Find your covered drugs" or "Find a Pharmacy."

Some things to know about Prescription Drug Plans

What is a formulary?

The formulary is a list of all the drugs your plan covers. The most current formulary is on our plan's website.

What you pay for your prescription depends, in part, on which tier your drug is in.

For example, Tier 1 usually includes preferred generic drugs with the lowest copay. As the tier number increases, the drugs in that tier generally cost you more than drugs in the lower-numbered tiers. For more information about the tiers in this plan, see the *Summary of Benefits* section in this booklet.

You have drug coverage as well
(continued)

Some things to know about Prescription Drug Plans (continued)

What is the coverage gap?
Your prescription drug coverage has different stages. The coverage gap is the coverage stage with the highest out-of-pocket costs for you.
How the coverage stages work:

1. The initial coverage stage begins after you pay your deductible (if you have one). During this stage, you will pay your copays or coinsurance.

2. If you and your plan, together, spend a certain amount on covered drugs, you will enter the coverage gap stage. What you pay will depend on the coverage your plan offers in the gap, as well as any *Extra Help* you receive, or assistance programs and discounts available for your drugs (see the *When you need Extra Help* section).

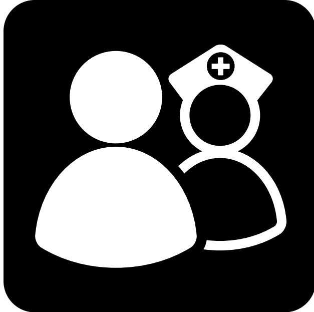
3. When a certain amount has been spent on your covered drugs, you will leave the coverage gap. Then you will enter the catastrophic coverage stage. You will pay a small copay or coinsurance for your covered drugs for the remainder of the year.

Help when you reach the coverage gap

Part D Brand-Name Drug Discount:
In 2013, if you reach the coverage gap, you will also get a 52% discount on covered brand-name prescribed drugs.

There will be additional savings in the coverage gap each year through 2020, when the coverage gap is closed completely.

Programs for a healthier you



Your health goals and needs are unique. What's right for one person is not always right for another. Maybe you're managing a health condition. Or maybe you want to stay healthy, eat better, or get in shape. Whatever your needs, Anthem gives you a choice of programs to help you meet your personal goals in a way that fits you and helps you live your life to the fullest.

Keeping your chronic conditions under control

Our care management program is designed to help with your needs if you have one or more chronic conditions. Program features include:

Preauthorization – You, your doctor or specialist must first contact Care Management (by phone or email) to get an OK before you get some types of care.

Care management – A case manager plans, coordinates and reviews which types of care will help you get the most out of your benefits. A team of trained nurses and social workers can help you:

- Coordinate your preventive care.
- Learn how to keep your symptoms under control.
- Cope with one or more health conditions.
- Get integrated care management services including lifestyle coaching.
- Access community resources you may qualify for.

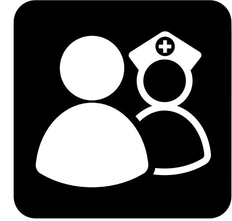
Discharge planning – Your case manager coordinates a discharge plan with your doctor during a hospital stay. This ensures you have access to medically necessary services at the time of your discharge.

Preventive care at no extra cost

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

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

Programs for a healthier you
(continued)



MyHealth Advantage helps you reach better outcomes

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

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

Anthem's 24/7 NurseLine gives you access to trained registered nurses any time of the day or night. Simply call to get help with:

- Answering your general health questions.
- Understanding your symptoms.
- Determining the right care at the right time.

Good health by the numbers

- Hospital, medical care and prescription drug coverage – all **3** are covered by our plans for your peace of mind
- Just **1** ID card and Customer Service phone number for your convenience
- You will have access to **54,000** retail pharmacies across the U.S.

More programs to help with your wellness goals

Achieve health, wellness, peace of mind and savings with SpecialOffers@Anthem℠

When you become a plan member, you have access to products that can help you feel good and keep money in your pocket. You can order online products that range from health and beauty items to pet supplies at a discount. Save on eyeglasses and accessories at popular retail stores. Get help reaching your health goals through these:

- Vitamins and supplements
- Gym and health club memberships
- Local nutritionists and massage therapy

Check out **www.anthem.com/ca/medicare** for a complete list of discounted products and services.[1]

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

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

Get fit, have fun and make friends with SilverSneakers®

Being active and staying fit can lead to a healthier you. That's why you get the SilverSneakers Fitness Program as a benefit at no extra cost.

- Your fitness membership gives you all the basic SilverSneakers amenities.
- You can sign up for group exercise classes at any SilverSneakers site in the country.
- You can also be part of an online member-only community.

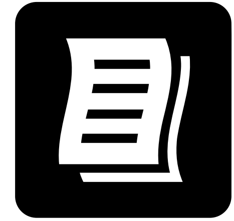
If you can't go to a SilverSneakers fitness site, you may choose to sign up for the SilverSneakers® Steps online.

It's easy to sign up for SilverSneakers.
Call **1-888-423-4632** (TTY/TDD: **711**) to ask for your unique SilverSneakers ID number, order your card and find the nearest site. Use your ID number to tour the site, sign up and get started as soon as you join our health plan. You don't need to wait to get your card in the mail. You can also visit **www.silversneakers.com** to find the nearest SilverSneakers site.

1 Vendors and offers are subject to change without prior notice. Anthem Blue Cross does not endorse and is not responsible for the products, services or information offered by the vendors or providers. We negotiated the arrangements and discounts with each independent vendor or provider in order to assist our members.

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

How to enroll and pay for a Medicare Advantage plan



Looking for your enrollment form? You can find it at the back of this booklet

When you have made up your mind, you don't need to get a physical exam to sign up. You will need information from your Medicare card to fill out your enrollment form which you can find in the back of this booklet. Your sales representative or agent can help you and accept a copy for your enrollment. Or, you can tear out a copy and submit the top copy of each page to the address listed on the first page of the application. You can also sign up online at **www.anthem.com/ca/medicare**.

After you submit your enrollment application

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

Paying your monthly premium

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

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

Option 2: By automatic withdrawal.[1]

Option 3: Taken out of your monthly Social Security check.[1]

You must continue to pay your Medicare Part B premium.

When you need Extra Help[2]

If you qualify for Medicare's *Extra Help* and are enrolled in a Part D plan, Medicare can help by paying a percentage of your prescribed drug costs. If you qualify, you will get the following:

- Help paying for your drug plan's monthly premium, yearly deductible, coinsurance and covered copays for covered prescription drugs.
- No coverage gap.
- No late enrollment penalty.

For more information about *Extra Help*, please visit **www.medicare.gov**.

1 This payment option may take up to three months to set up.

2 You can't get Medicare Coverage Gap Discounts on brand-name drugs if you receive *Extra Help*.

Anthem BlueCross

How to reach us

Clip this page out and place it in a handy location.

Anthem's licensed insurance agent............ **1-888-211-9813**
TTY/TDD line **711**
8 a.m. to 8 p.m., seven days a week

Customer Service............ **1-888-230-7338**
TTY/TDD line **711**
8 a.m. to 8 p.m., seven days a week, October 1, 2012 to February 14, 2013;
8 a.m. to 8 p.m., Monday – Friday, except holidays, February 15 to September 30, 2013.

Visit us online............ **www.anthem.com/ca/medicare**
- Find a doctor
- Enroll online
- Find a pharmacy
- Find your covered drugs

Plan ratings............ **www.medicare.gov**

TTY/TDD lines are for those with hearing or speech loss.

Plan performance Star Ratings are assessed each year and may change from one year to the next. For more information on our Medicare plan ratings information, go to **www.medicare.gov**.

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

Limitations, copayments and restrictions may apply.

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

Anthem Blue Cross is a Health plan with a Medicare contract.

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ®ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Anthem Blue Cross - H0564

CY 2012 Medicare Plan Ratings

The Medicare Program rates how well Medicare health and drug plans perform in different categories (for example, detecting and preventing illness, ratings from patients, patient safety, drug pricing and customer service). The information provided below is an overall plan rating of our plan's performance. This information is available to help you make the best choice. If you would like to get additional information on our plan's performance please contact us at 800-797-6438 (toll-free) or 800-241-6894 (TTY/TDD) for prospective members, 888-230-7338 (toll-free) or 877-247-1657 (TTY/TDD) for current members, or you may visit www.medicare.gov.

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

The number of stars shows how well our plan performs.

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

Anthem Blue Cross - H0564	
Overall Plan Rating	★★★ 3 Stars
	The Overall Plan Rating combines scores for the types of services each plan offers: **What is being measured?** • **For plans covering health services**, the overall score for quality of those services covers **36 different topics in 5 categories**: ◦ **Staying healthy**: screenings, tests, and vaccines: Includes how often members got various screening tests, vaccines, and other check-ups that help them stay healthy. ◦ **Managing chronic (long-term) conditions**: Includes how often members with different conditions got certain tests and treatments that help them manage their condition. ◦ **Ratings of health plan responsiveness and care**: Includes ratings of member satisfaction with the plan. ◦ **Health plan member complaints and appeals**: Includes how often members filed a complaint against the plan. ◦ **Health plan telephone customer service**: Includes how well the plan handles calls from members. • **For plans covering drug services**, the overall score for quality of those services covers **17 different topics in 4 categories**:

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

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

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

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

Why is the Overall Plan Rating important?

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

Summary of Benefits

- **Section I**: Introduction to Summary of Benefits
- **Section II**: Summary of Benefits

Summary of Benefits

for Blue Cross Senior Secure Plan I℠ (HMO)

Available in San Bernardino* and San Diego Counties, CA (*Denotes partial county)

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Y0071_13_15448_U_050 CMS Accepted

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H0564_047_CA_HMO

Section I:

Introduction to Summary of Benefits

Thank you for your interest in Blue Cross Senior Secure Plan I (HMO). Our plan is offered by Blue Cross of California/ Anthem Blue Cross, a Medicare Advantage Health Maintenance Organization (HMO) that contracts with the Federal government.

This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Blue Cross Senior Secure Plan I (HMO) and ask for the "Evidence of Coverage".

You Have Choices In Your Health Care

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

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

How Can I Compare My Options?

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

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

Where Is Blue Cross Senior Secure Plan I (HMO) Available?

The service area for this plan includes:

San Bernardino* and San Diego Counties, CA.

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

* denotes partial county

ZIP Codes included:

San Bernardino:

91701; 91708; 91709; 91710; 91729; 91730; 91737; 91739; 91743; 91758; 91759; 91761; 91762; 91763; 91764; 91766; 91784; 91785; 91786; 91792; 91798; 92252; 92256; 92268; 92277; 92278; 92284; 92285; 92286; 92301; 92304; 92305; 92307; 92308; 92310; 92311; 92312; 92313; 92314; 92315; 92316; 92318; 92323; 92324; 92327; 92329; 92332; 92333; 92334; 92335; 92336; 92337; 92338; 92339; 92340; 92341; 92342; 92344; 92345; 92346; 92347; 92350; 92354; 92356; 92357; 92358; 92359; 92365; 92366; 92368; 92369; 92371; 92372; 92373; 92374; 92375; 92376; 92377; 92382; 92386; 92391; 92392; 92393; 92394; 92395; 92397; 92398; 92399; 92401; 92402; 92403; 92404; 92405; 92406; 92407; 92408; 92410; 92411; 92412; 92413; 92414; 92415; 92418; 92420; 92423; 92424; 92427; 92880; 93516; 93555; 93562; 93592

Who Is Eligible to Join Blue Cross Senior Secure Plan I (HMO)?

You can join Blue Cross Senior Secure Plan I (HMO) if you are entitled to Medicare Part A and enrolled in

Medicare Part B and live in the service area. However, individuals with End-Stage Renal Disease are generally not eligible to enroll in Blue Cross Senior Secure Plan I (HMO) unless they are members of our organization and have been since their dialysis began.

Can I Choose My Doctors?

Blue Cross Senior Secure Plan I (HMO) has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time.

You can ask for a current provider directory by contacting our customer service number listed at the end of this introduction.

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

If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither the plan nor the Original Medicare Plan will pay for these services except in limited situations (for example, emergency care).

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

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

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

Blue Cross Senior Secure Plan I (HMO) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

What Is a Prescription Drug Formulary?

Blue Cross Senior Secure Plan I (HMO) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected members before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at **www.anthem.com/ca/medicare**.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

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

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

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

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

* Your State Medicaid Office.

What Are My Protections In This Plan?

All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Blue Cross Senior Secure Plan I (HMO), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of Blue Cross Senior Secure Plan I (HMO), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

What Is a Medication Therapy Management (MTM) Program?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Blue Cross Senior Secure Plan I (HMO) for more details.

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

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Blue Cross Senior Secure Plan I (HMO) for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.

- Osteoporosis Drugs: Injectable osteoporosis drugs for some women.
- Erythropoietin (Epoetin Alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant took place in a Medicare-certified facility and was paid for by Medicare or by a private insurance company that was the primary payer for Medicare Part A coverage.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and Infusion Drugs administered through Durable Medical Equipment.

Where Can I Find Information On Plan Ratings?

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

Please call Anthem Blue Cross for more information about
Blue Cross Senior Secure Plan I (HMO)

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

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

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

Current members should call toll-free **1-888-230-7338** for questions related to the Medicare Advantage and/or Medicare Part D Prescription Drug Programs. (TTY/TDD **711**)

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

Current members should call locally **1-888-230-7338** for questions related to the Medicare Advantage and/or Medicare Part D Prescription Drug Programs. (TTY/TDD **711**)

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

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

This document may be available in other formats such as Braille, large print or other alternate formats.

This document may be available in a non-English language. For additional information, call customer service at the phone number listed above.

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

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

Section II:

Summary of Benefits

Benefit	Original Medicare	Blue Cross Senior Secure Plan I (HMO)
Important Information		
1 **Premium and Other Important Information**	In 2012 the monthly Part B Premium was **$99.90** and may change for 2013 and the annual Part B deductible amount was **$140** and may change for 2013. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over **$85,000** for singles, **$170,000** for married couples). For more information about Part B premiums based on income, call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**. You may also call Social Security at **1-800-772-1213**. TTY users should call**1-800-325-0778**.	**General** **$0** monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over **$85,000** for singles, **$170,000** for married couples). For more information about Part B and Part D premiums based on income, call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**. You may also call Social Security at **1-800-772-1213**. TTY users should call **1-800-325-0778**. **In-Network** **$4,000** out-of-pocket limit for Medicare-covered services.
2 **Doctor and Hospital Choice** (For more information, see Emergency Care - #15 and Urgently Needed Care - #16.)	You may go to any doctor, specialist or hospital that accepts Medicare.	**In-Network** You must go to network doctors, specialists, and hospitals. Referral required for network hospitals and specialists (for certain benefits).
Summary of Benefits		
Inpatient Care		

Benefit	Original Medicare	Blue Cross Senior Secure Plan I (HMO)
3 **Inpatient Hospital Care** (includes Substance Abuse and Rehabilitation Services)	In 2012 the amounts for each benefit period were: • Days 1 - 60: **$1156** deductible • Days 61 - 90: **$289** per day • Days 91 - 150: **$578** per lifetime reserve day These amounts may change for 2013. Call **1-800-MEDICARE (1-800-633-4227)** for information about lifetime reserve days. Lifetime reserve days can only be used once. A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	**In-Network** No limit to the number of days covered by the plan each hospital stay. For Medicare-covered hospital stays: • Days 1 - 7: **$200** copay per day • Days 8 - 90: **$0** copay per day **$0** copay for additional hospital days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
4 **Inpatient Mental Health Care**	In 2012 the amounts for each benefit period were: • Days 1 - 60: **$1156** deductible • Days 61 - 90: **$289** per day • Days 91 - 150: **$578** per lifetime reserve day These amounts may change for 2013. You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.	**In-Network** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. For Medicare-covered hospital stays: • Days 1 - 7: **$200** copay per day • Days 8 - 90: **$0** copay per day Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
5 **Skilled Nursing Facility (SNF)** (in a Medicare-certified skilled nursing facility)	In 2012 the amounts for each benefit period after at least a 3-day covered hospital stay were: • Days 1 - 20: **$0** per day • Days 21 - 100: **$144.50** per day These amounts may change for 2013.	**General** Authorization rules may apply. **In-Network** Plan covers up to 100 days each benefit period No prior hospital stay is required.

Benefit	Original Medicare	Blue Cross Senior Secure Plan I (HMO)
	100 days for each benefit period. A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	For SNF stays: • Days 1 - 20: **$0** copay per day • Days 21 - 100: **$150** copay per day
6 **Home Health Care** (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	**$0** copay.	**General** Authorization rules may apply. **In-Network** **$0** copay for each Medicare-covered home health visit
7 **Hospice**	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	**General** You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.

Outpatient Care

Benefit	Original Medicare	Blue Cross Senior Secure Plan I (HMO)
8 **Doctor Office Visits**	**20%** coinsurance	**General** Authorization rules may apply. **In-Network** **$10** copay for each Medicare-covered primary care doctor visit. **$35** copay for each Medicare-covered specialist visit.
9 **Chiropractic Services**	Supplemental routine care not covered **20%** coinsurance for manual manipulation of the spine to correct subluxation (a	**General** Authorization rules may apply.

Benefit	Original Medicare	Blue Cross Senior Secure Plan I (HMO)
	displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	**In-Network** **$20** copay for each Medicare-covered chiropractic visit Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor.
10 Podiatry Services	Supplemental routine care not covered. **20%** coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	**General** Authorization rules may apply. **In-Network** **$35** copay for each Medicare-covered podiatry visit **$35** copay for up to 12 supplemental routine podiatry visit(s) every year Medicare-covered podiatry visits are for medically-necessary foot care.
11 Outpatient Mental Health Care	**35%** coinsurance for most outpatient mental health services Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copay cannot exceed the Part A inpatient hospital deductible. "Partial hospitalization program" is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	**General** Authorization rules may apply. **In-Network** **$40** copay for each Medicare-covered individual therapy visit **$40** copay for each Medicare-covered group therapy visit **$40** copay for each Medicare-covered individual therapy visit with a psychiatrist **$40** copay for each Medicare-covered group therapy visit with a psychiatrist **$35** copay for Medicare-covered partial hospitalization program services
12 Outpatient Substance Abuse Care	**20%** coinsurance	**General** Authorization rules may apply. **In-Network** **$40** copay for Medicare-covered individual substance abuse outpatient treatment visits

Benefit	Original Medicare	Blue Cross Senior Secure Plan I (HMO)
		$40 copay for Medicare-covered group substance abuse outpatient treatment visits
13 **Outpatient Services**	**20%** coinsurance for the doctor's services Specified copayment for outpatient hospital facility services Copay cannot exceed the Part A inpatient hospital deductible. **20%** coinsurance for ambulatory surgical center facility services	**General** Authorization rules may apply. **In-Network** **$0** to **$125** copay for each Medicare-covered ambulatory surgical center visit **$0** to **$150** copay for each Medicare-covered outpatient hospital facility visit
14 **Ambulance Services** (medically necessary ambulance services)	**20%** coinsurance	**General** Authorization rules may apply. **In-Network** **$200** copay for Medicare-covered ambulance benefits.
15 **Emergency Care** (You may go to any emergency room if you reasonably believe you need emergency care.)	**20%** coinsurance for the doctor's services Specified copayment for outpatient hospital facility emergency services. Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital. You don't have to pay the emergency room copay if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit. Not covered outside the U.S. except under limited circumstances.	**General** **$65** copay for Medicare-covered emergency room visits Worldwide coverage. If you are admitted to the hospital within 72-hour(s) for the same condition, you pay **$0** for the emergency room visit.
16 **Urgently Needed Care** (This is NOT emergency care, and in most cases, is out of the service area.)	**20%** coinsurance, or a set copay NOT covered outside the U.S. except under limited circumstances.	**General** **$35** copay for Medicare-covered urgently-needed-care visits If you are admitted to the hospital within 72-hour(s) for the same condition, you pay **$0** for the urgently-needed-care visit.

Benefit	Original Medicare	Blue Cross Senior Secure Plan I (HMO)
17 **Outpatient Rehabilitation Services** (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	**20%** coinsurance	**General** Authorization rules may apply. **In-Network** **$50** copay for Medicare-covered Occupational Therapy visits **$50** copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits
Outpatient Medical Services and Supplies		
18 **Durable Medical Equipment** (includes wheelchairs, oxygen, etc.)	**20%** coinsurance	**General** Authorization rules may apply. **In-Network** **20%** of the cost for Medicare-covered durable medical equipment
19 **Prosthetic Devices** (includes braces, artificial limbs and eyes, etc.)	**20%** coinsurance	**General** Authorization rules may apply. **In-Network** **20%** of the cost for Medicare-covered prosthetic devices
20 **Diabetes Programs and Supplies**	**20%** coinsurance for diabetes self-management training **20%** coinsurance for diabetes supplies **20%** coinsurance for diabetic therapeutic shoes or inserts	**In-Network** **$0** copay for Medicare-covered Diabetes self-management training **$0** copay for Medicare-covered Diabetes monitoring supplies **20%** of the cost for Medicare-covered Therapeutic shoes or inserts
21 **Diagnostic Tests, X-Rays, Lab Services, and Radiology Services**	**20%** coinsurance for diagnostic tests and x-rays **$0** copay for Medicare-covered lab services Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified	**General** Authorization rules may apply. **In-Network** **$0** copay for Medicare-covered lab services **$0** to **$195** copay for Medicare-covered diagnostic procedures and tests **$50** copay for Medicare-covered X-rays

Benefit	Original Medicare	Blue Cross Senior Secure Plan I (HMO)
	laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most supplemental routine screening tests, like checking your cholesterol.	**$50** to **$195** copay for Medicare-covered diagnostic radiology services (not including X-rays) **20%** of the cost for Medicare-covered therapeutic radiology services If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of **$10** to **$35** may apply If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of **$10** to **$35** may apply
22 Cardiac and Pulmonary Rehabilitation Services	**20%** coinsurance for Cardiac Rehabilitation services **20%** coinsurance for Pulmonary Rehabilitation services **20%** coinsurance for Intensive Cardiac Rehabilitation services This applies to program services provided in a doctor's office. Specified cost sharing for program services provided by hospital outpatient departments.	**General** Authorization rules may apply. **In-Network** **$35** copay for Medicare-covered Cardiac Rehabilitation Services **$35** copay for Medicare-covered Intensive Cardiac Rehabilitation Services **$35** copay for Medicare-covered Pulmonary Rehabilitation Services
Preventive Services, Wellness/Education and Other Supplemental Benefit Programs		
23 Preventive Services, Wellness/ Education and Other Supplemental Benefit Programs	No coinsurance, copayment or deductible for the following: • Abdominal Aortic Aneurysm Screening • Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. • Cardiovascular Screening	**General** **$0** copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. **In-Network** The plan covers the following supplemental education/wellness programs:

Benefit	Original Medicare	Blue Cross Senior Secure Plan I (HMO)
	• Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk. • Colorectal Cancer Screening • Diabetes Screening • Influenza Vaccine • Hepatitis B Vaccine for people with Medicare who are at risk • HIV Screening. **$0** copay for the HIV screening, but you generally pay **20%** of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. • Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39. • Medical Nutrition Therapy Services. Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease • Personalized Prevention Plan Services (Annual Wellness Visits) • Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information. • Prostate Cancer Screening	• Health Club Membership/Fitness Classes • Nursing Hotline

Benefit	Original Medicare	Blue Cross Senior Secure Plan I (HMO)
	• Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50. • Smoking and Tobacco Use Cessation (counseling to stop smoking and tobacco use). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. • Screening and behavioral counseling interventions in primary care to reduce alcohol misuse • Screening for depression in adults • Screening for sexually transmitted infections (STI) and high-intensity behavioral counseling to prevent STIs • Intensive behavioral counseling for Cardiovascular Disease (bi-annual) • Intensive behavioral therapy for obesity • Welcome to Medicare Preventive Visits (initial preventive physical exam). When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Preventive Visit or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months.	
24 Kidney Disease and Conditions	**20%** coinsurance for renal dialysis **20%** coinsurance for kidney disease education services	**In-Network** **20%** of the cost for Medicare-covered renal dialysis **$0** copay for Medicare-covered kidney disease education services

Prescription Drug Benefits

<table>
<tr><th>Benefit</th><th>Original Medicare</th><th>Blue Cross Senior Secure Plan I (HMO)</th></tr>
<tr><td>25 Outpatient Prescription Drugs</td><td>Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</td><td>Drugs Covered Under Medicare Part B General
20% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs.

Drugs Covered Under Medicare Part D General
This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.anthem.com/ca/medicare on the web.

Different out-of-pocket costs may apply for people who
• have limited incomes,
• live in long term care facilities, or
• have access to Indian/Tribal/Urban (Indian Health Service) providers.
The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).

Total yearly drug costs are the total drug costs paid by both you and a Part D plan.

The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.

Some drugs have quantity limits.

Your provider must get prior authorization from Blue Cross Senior Secure Plan I (HMO) for certain drugs.

You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the</td></tr>
</table>

Benefit	Original Medicare	Blue Cross Senior Secure Plan I (HMO)
		Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Blue Cross Senior Secure Plan I (HMO) approves the exception, you will pay Tier 4: Non-Preferred Brand cost sharing for that drug. **In-Network** **$0** deductible. **Initial Coverage** You pay the following until total yearly drug costs reach **$2,970**: **Retail Pharmacy** **Tier 1: Preferred Generic** • **$7** copay for a one-month (30-day) supply of drugs in this tier • **$14** copay for a two-month (60-day) supply of drugs in this tier • **$21** copay for a three-month (90-day) supply of drugs in this tier **Tier 2: Non-Preferred Generic** • **$15** copay for a one-month (30-day) supply of drugs in this tier • **$30** copay for a two-month (60-day) supply of drugs in this tier • **$45** copay for a three-month (90-day) supply of drugs in this tier **Tier 3: Preferred Brand** • **$45** copay for a one-month (30-day) supply of drugs in this tier • **$90** copay for a two-month (60-day) supply of drugs in this tier • **$135** copay for a three-month (90-day) supply of drugs in this tier

Benefit	Original Medicare	Blue Cross Senior Secure Plan I (HMO)
		Tier 4: Non-Preferred Brand • **$95** copay for a one-month (30-day) supply of drugs in this tier • **$190** copay for a two-month (60-day) supply of drugs in this tier • **$285** copay for a three-month (90-day) supply of drugs in this tier **Tier 5: Injectable Drugs** • **$95** copay for a one-month (30-day) supply of drugs in this tier • **$190** copay for a two-month (60-day) supply of drugs in this tier • **$285** copay for a three-month (90-day) supply of drugs in this tier **Tier 6: Specialty Tier** • **33%** coinsurance for a one-month (30-day) supply of drugs in this tier **Long-Term Care Pharmacy** **Tier 1: Preferred Generic** • **$7** copay for a one-month (34-day) supply of drugs in this tier **Tier 2: Non-Preferred Generic** • **$15** copay for a one-month (34-day) supply of drugs in this tier **Tier 3: Preferred Brand** • **$45** copay for a one-month (34-day) supply of drugs in this tier **Tier 4: Non-Preferred Brand** • **$95** copay for a one-month (34-day) supply of drugs in this tier **Tier 5: Injectable Drugs** • **$95** copay for a one-month (34-day) supply of drugs in this tier **Tier 6: Specialty Tier** • **33%** coinsurance for a one-month (34-day) supply of drugs in this tier Please note that brand drugs must be dispensed incrementally in long-term care

Benefit	Original Medicare	Blue Cross Senior Secure Plan I (HMO)
		facilities. Generic drugs may be dispensed incrementally. Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed. **Mail Order** **Tier 1: Preferred Generic** • **$7** copay for a one-month (30-day) supply of drugs in this tier • **$14** copay for a two-month (60-day) supply of drugs in this tier • **$10.50** copay for a three-month (90-day) supply of drugs in this tier **Tier 2: Non-Preferred Generic** • **$15** copay for a one-month (30-day) supply of drugs in this tier • **$30** copay for a two-month (60-day) supply of drugs in this tier • **$22.50** copay for a three-month (90-day) supply of drugs in this tier **Tier 3: Preferred Brand** • **$45** copay for a one-month (30-day) supply of drugs in this tier • **$90** copay for a two-month (60-day) supply of drugs in this tier • **$112.50** copay for a three-month (90-day) supply of drugs in this tier **Tier 4: Non-Preferred Brand** • **$95** copay for a one-month (30-day) supply of drugs in this tier • **$190** copay for a two-month (60-day) supply of drugs in this tier • **$237.50** copay for a three-month (90-day) supply of drugs in this tier **Tier 5: Injectable Drugs** • **$95** copay for a one-month (30-day) supply of drugs in this tier • **$190** copay for a two-month (60-day) supply of drugs in this tier

Benefit	Original Medicare	Blue Cross Senior Secure Plan I (HMO)
		• **$237.50** copay for a three-month (90-day) supply of drugs in this tier **Tier 6: Specialty Tier** • **33%** coinsurance for a one-month (30-day) supply of drugs in this tier **Coverage Gap** After your total yearly drug costs reach **$2,970,** you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than **47.5%** for the plan's costs for brand drugs and **79%** of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach **$4,750.** **Additional Coverage Gap** The plan covers many formulary generics (**65%** - **99%** of formulary generic drugs) through the coverage gap. The plan offers additional coverage in the gap for the following tiers. You pay the following: **Retail Pharmacy** **Tier 1: Preferred Generic** • **$7** copay for a one-month (30-day) supply of all drugs covered in this tier • **$14** copay for a two-month (60-day) supply of all drugs covered in this tier • **$21** copay for a three-month (90-day) supply of all drugs covered in this tier **Tier 2: Non-Preferred Generic** • **$15** copay for a one-month (30-day) supply of all drugs covered in this tier • **$30** copay for a two-month (60-day) supply of all drugs covered in this tier • **$45** copay for a three-month (90-day) supply of all drugs covered in this tier

Benefit	Original Medicare	Blue Cross Senior Secure Plan I (HMO)
		Long-Term Care Pharmacy **Tier 1: Preferred Generic** • **$7** copay for a one-month (34-day) supply of all drugs covered in this tier **Tier 2: Non-Preferred Generic** • **$15** copay for a one-month (34-day) supply of all drugs covered in this tier Please note that brand drugs must be dispensed incrementally in long-term care facilities. Generic drugs may be dispensed incrementally. Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed. **Mail Order** **Tier 1: Preferred Generic** • **$7** copay for a one-month (30-day) supply of all drugs covered in this tier • **$14** copay for a two-month (60-day) supply of all drugs covered in this tier • **$10.50** copay for a three-month (90-day) supply of all drugs covered in this tier **Tier 2: Non-Preferred Generic** • **$15** copay for a one-month (30-day) supply of all drugs covered in this tier • **$30** copay for a two-month (60-day) supply of all drugs covered in this tier • **$22.50** copay for a three-month (90-day) supply of all drugs covered in this tier **Catastrophic Coverage** After your yearly out-of-pocket drug costs reach **$4,750,** you pay the greater of: • **5%** coinsurance, or • **$2.65** copay for generic (including brand drugs treated as generic) and a **$6.60** copay for all other drugs. **Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while

Benefit	Original Medicare	Blue Cross Senior Secure Plan I (HMO)
		traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Blue Cross Senior Secure Plan I (HMO). **Out-of-Network Initial Coverage** You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach **$2,970**: **Tier 1: Preferred Generic** • **$7** copay for a one-month (30-day) supply of drugs in this tier **Tier 2: Non-Preferred Generic** • **$15** copay for a one-month (30-day) supply of drugs in this tier **Tier 3: Preferred Brand** • **$45** copay for a one-month (30-day) supply of drugs in this tier **Tier 4: Non-Preferred Brand** • **$95** copay for a one-month (30-day) supply of drugs in this tier **Tier 5: Injectable Drugs** • **$95** copay for a one-month (30-day) supply of drugs in this tier **Tier 6: Specialty Tier** • **33%** coinsurance for a one-month (30-day) supply of drugs in this tier You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.

Benefit	Original Medicare	Blue Cross Senior Secure Plan I (HMO)
		Out-of-Network Coverage Gap You will be reimbursed up to **21%** of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach **$4,750.** Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). You will be reimbursed up to **52.5%** of the plan allowable cost for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach **$4,750.** Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). **Additional Out-of-Network Coverage Gap** The plan covers many formulary generics (**65%** - **99%** of formulary generic drugs) through the coverage gap. You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following: **Tier 1: Preferred Generic** • **$7** copay for a one-month (30-day) supply of all drugs covered in this tier **Tier 2: Non-Preferred Generic** • **$15** copay for a one-month (30-day) supply of all drugs covered in this tier You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach **$4,750,** you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: • **5%** coinsurance, or

Benefit	Original Medicare	Blue Cross Senior Secure Plan I (HMO)
		• **$2.65** copay for generic (including brand drugs treated as generic) and a **$6.60** copay for all other drugs. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.

Outpatient Medical Services and Supplies

Benefit	Original Medicare	Blue Cross Senior Secure Plan I (HMO)
26 Dental Services	Preventive dental services (such as cleaning) not covered.	**In-Network** This plan covers some preventive dental benefits for an extra cost (see "Optional Supplemental Benefits.") **$0** copay for Medicare-covered dental benefits
27 Hearing Services	Supplemental routine hearing exams and hearing aids not covered. **20%** coinsurance for diagnostic hearing exams.	**In-Network** In general, supplemental routine hearing exams and hearing aids not covered. **$35** copay for Medicare-covered diagnostic hearing exams
28 Vision Services	**20%** coinsurance for diagnosis and treatment of diseases and conditions of the eye. Supplemental routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.	**In-Network** This plan covers some vision benefits for an extra cost (see "Optional Supplemental Benefits"). • **$0** copay for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery. • **$0** copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye.
Over-the-Counter Items	Not covered.	**General** The plan does not cover Over-the-Counter items.
Transportation (Routine)	Not covered.	**In-Network** This plan does not cover supplemental routine transportation.
Acupuncture	Not covered.	**In-Network** This plan does not cover Acupuncture.

Benefit	Original Medicare	Blue Cross Senior Secure Plan I (HMO)
OPTIONAL SUPPLEMENTAL PACKAGE #1		
Premium and Other Important Information		**General** Package: 1 - Preventive Dental Package: **$11** monthly premium, in addition to your **$0** monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: • Preventive Dental
Dental Services		**In-Network** • **$0** copay for up to 2 cleaning(s) every year • **$0** copay for up to 2 oral exam(s) every year • **$0** copay for up to 1 dental x-ray(s) every year **$500** plan coverage limit for preventive dental benefits every year
OPTIONAL SUPPLEMENTAL PACKAGE #2		
Premium and Other Important Information		**General** Package: 2 - Comprehensive Dental and Vision Package: **$28** monthly premium, in addition to your **$0** monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: • Preventive Dental • Comprehensive Dental • Eye Exams • Eye Wear
Dental Services		**General** Plan offers additional comprehensive dental benefits. **In-Network** • **$0** copay for up to 2 cleaning(s) every year • **$0** copay for up to 2 oral exam(s) every year

Benefit	Original Medicare	Blue Cross Senior Secure Plan I (HMO)
		• **$0** copay for up to 1 dental x-ray(s) every year **$1,000** plan coverage limit for dental benefits every year
Vision Services		**In-Network** • **$0** copay for up to 1 pair(s) of contacts every year • **$0** copay for up to 1 pair(s) of glasses every year • **$0** copay for up to 1 supplemental routine eye exam(s) every year **$69** plan coverage limit for eye exams every year.
OPTIONAL SUPPLEMENTAL PACKAGE #3		
Premium and Other Important Information		**General** Package: 3 - Combination Package: **$33** monthly premium, in addition to your **$0** monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: • Chiropractic Services • Acupuncture • Preventive Dental • Comprehensive Dental • Eye Exams • Eye Wear
Chiropractic Services		**In-Network** **$20** copay for each supplemental routine chiropractic visit
Dental Services		**General** Plan offers additional comprehensive dental benefits. **In-Network** • **$0** copay for up to 2 cleaning(s) every year • **$0** copay for up to 2 oral exam(s) every year

Benefit	Original Medicare	Blue Cross Senior Secure Plan I (HMO)
		• **$0** copay for up to 1 dental x-ray(s) every year **$1,000** plan coverage limit for dental benefits every year
Vision Services		**In-Network** • **$0** copay for up to 1 pair(s) of contacts every year • **$0** copay for up to 1 pair(s) of glasses every year • **$0** copay for up to 1 supplemental routine eye exam(s) every year **$69** plan coverage limit for eye exams every year.