Summary of Benefits

for Freedom Blue Plan I℠ (Regional PPO)

Available in California

A health plan with a Medicare contract.

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Section I:

Introduction to Summary of Benefits

Thank you for your interest in Freedom Blue Plan I (Regional PPO). Our plan is offered by Anthem Blue Cross Life and Health Insurance Company, a Medicare Advantage Preferred Provider Organization (PPO). This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Freedom Blue Plan I (Regional PPO) and ask for the "Evidence of Coverage".

You Have Choices in Your Health Care

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

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

How Can I Compare My Options?

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

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

Where Is Freedom Blue Plan I (Regional PPO) Available?

The service area for this plan includes: **California**.

You must live in this area to join the plan.

Who Is Eligible to Join Freedom Blue Plan I (Regional PPO)?

You can join Freedom Blue Plan I (Regional PPO) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease are generally not eligible to enroll in Freedom Blue Plan I (Regional PPO) unless they are members of our organization and have been since their dialysis began.

Can I Choose My Doctors?

Freedom Blue Plan I (Regional PPO) has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of our network. The health providers in our network can change at any time.

You can ask for a current Provider Directory or for an up-to-date list visit us at **www.anthem.com/ca/medicare**.

Our customer service number is listed at the end of this introduction.

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

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

Where Can I Get My Prescriptions If I Join this plan?

Freedom Blue Plan I (Regional PPO) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at **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?

Freedom Blue Plan I (Regional PPO) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

What Is a Prescription Drug Formulary?

Freedom Blue Plan I (Regional PPO) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees 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 year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Freedom Blue Plan I (Regional PPO), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an

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

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

What Is a Medication Therapy Management (MTM) Program?

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

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

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

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- 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 was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and Infusion Drugs provided through DME.

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 "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap Policies in Your Area" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

Please call Anthem Blue Cross Life & Health Insurance Company for more information about Freedom Blue Plan I (Regional PPO).

- Visit us at **www.anthem.com/ca/medicare** or, call us:
- **Customer Service Hours:** 8 a.m. to 8 p.m., Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday Pacific
- **Current members should call toll-free 1-(877)-811-3107 for questions related to the Medicare Advantage Program.** (TTY/TDD 1-(877)-247-1657)
- **Prospective members should call toll-free 1-(888)-211-9813 for questions related to the Medicare Advantage Program.** (TTY/TDD 1-(800)-241-6894)
- **Current members should call locally 1-(877)-811-3107 for questions related to the Medicare Advantage Program.** (TTY/TDD 1-(877)-247-1657)
- **Prospective members should call locally 1-(888)-211-9813 for questions related to the Medicare Advantage Program.** (TTY/TDD 1-(800)-241-6894)
- **Current members should call toll-free 1-(877)-811-3107 for questions related to the Medicare Part D Prescription Drug program.** (TTY/TDD 1-(877)-247-1657)
- **Prospective members should call toll-free 1-(888)-211-9813 for questions related to the Medicare Part D Prescription Drug program.** (TTY/TDD 1-(800)-241-6894)
- **Current members should call locally 1-(877)-811-3107 for questions related to the Medicare Part D Prescription Drug program.** (TTY/TDD 1-(877)-247-1657)
- **Prospective members should call locally 1-(888)-211-9813 for questions related to the Medicare Part D Prescription Drug program.** (TTY/TDD 1-(800)-241-6894)
- **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 a different format or language. For additional information, call customer service at the phone number listed above.
  If you have special needs, this document may be available in other formats.

Section II:

Summary of Benefits

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)

Important Information

1 Premium and Other Important Information	In 2010 the monthly Part B Premium was $96.40 and may change for 2011 and the yearly Part B deductible amount was $155 and may change for 2011. 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. This plan covers all Medicare-covered preventive services with zero cost sharing. **In-Network** $3,300 out-of-pocket limit. This limit includes only Medicare-covered services. **In and Out-of-Network** $300 yearly deductible. Contact the plan for services that apply. $3,300 out-of-pocket limit. In-Network: This limit includes only Medicare-covered services. Out-Of-Network:

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)
		This limit includes only Medicare-covered services.
2 **Doctor and Hospital Choice** (For more information, see Emergency Care - #15 and Urgently Needed Care - #16.)	You may go to any doctor, specialist or hospital that accepts Medicare.	**In-Network** No referral required for network doctors, specialists, and hospitals. **In and Out-of-Network** You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits. **Out of Service Area** Plan covers you when you travel in the U.S.

Summary of Benefits

Inpatient Care

3 **Inpatient Hospital Care** (includes Substance Abuse and Rehabilitation Services)	In 2010 the amounts for each benefit period were: • Days 1 - 60: $1100 deductible • Days 61 - 90: $275 per day • Days 91 - 150: $550 per lifetime reserve day These amounts will change for 2011. 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 benefit period. $850 copay for each Medicare-covered hospital stay $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. **Out-of-Network** 15% of the cost for each hospital stay.

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)
4 **Inpatient Mental Health Care**	Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above). 190-day lifetime limit in a Psychiatric Hospital.	**In-Network** You get up to 190 days in a Psychiatric Hospital in a lifetime. $850 copay for each Medicare-covered hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** 15% of the cost for each hospital stay.
5 **Skilled Nursing Facility (SNF)** (in a Medicare-certified skilled nursing facility)	In 2010 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: $137.50 per day These amounts will change for 2011. 100 days for each benefit period. A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	**General** Authorization rules may apply. **In-Network** Plan covers up to 100 days each benefit period No prior hospital stay is required. For SNF stays: Days 1 - 20: $0 copay per day Days 21 - 100: $120 copay per day **Out-of-Network** 25% of the cost for each SNF stay.
6 **Home Health Care** (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	$0 copay.	**General** Authorization rules may apply. **In-Network** $0 copay for each Medicare-covered home health visit. **Out-of-Network** 30% for home health visits.

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)
7 **Hospice**	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	**General** You must get care from a Medicare-certified hospice.

Outpatient Care

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)
8 **Doctor Office Visits**	20% coinsurance	**General** See "Welcome to Medicare; and Annual Wellness Visit", for more information. **In-Network** $15 copay for each primary care doctor visit for Medicare-covered benefits. $35 copay for each in-area, network urgent care Medicare-covered visit. $25 copay for each specialist visit for Medicare-covered benefits. **Out-of-Network** $30 copay for each primary care doctor visit. $40 copay for each specialist visit.
9 **Chiropractic Services**	Routine care not covered 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	**General** Authorization rules may apply. **In-Network** $10 copay for each Medicare-covered 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 or other qualified providers. **Out-of-Network** $40 copay for chiropractic benefits.

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)
10 Podiatry Services	Routine care not covered 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	**In-Network** $25 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care. **Out-of-Network** $40 copay for podiatry benefits.
11 Outpatient Mental Health Care	45% coinsurance for most outpatient mental health services.	**General** Authorization rules may apply. **In-Network** $40 copay for each Medicare-covered individual or group therapy visit. **Out-of-Network** 30% of the cost for Mental Health benefits. 30% of the cost for Mental Health benefits with a psychiatrist.
12 Outpatient Substance Abuse Care	20% coinsurance	**General** Authorization rules may apply. **In-Network** $40 copay for Medicare-covered individual or group visits. **Out-of-Network** 30% of the cost for outpatient substance abuse benefits.
13 Outpatient Services/Surgery	20% coinsurance for the doctor Specified copayment for outpatient hospital facility charges. Copay cannot exceed Part A inpatient hospital deductible. 20% coinsurance for ambulatory surgical center facility charges	**General** Authorization rules may apply. **In-Network** $100 copay for each Medicare-covered ambulatory surgical center visit. $25 to $250 copay for each Medicare-covered outpatient hospital facility visit. **Out-of-Network** 30% of the cost for ambulatory surgical center benefits.

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)
		30% of the cost for outpatient hospital facility benefits.
14 **Ambulance Services** (medically necessary ambulance services)	20% coinsurance	**General** Authorization rules may apply. **In-Network** $175 copay for Medicare-covered ambulance benefits. **Out-of-Network** $175 copay for 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 Specified copayment for outpatient hospital emergency room (ER) facility charge. ER copay cannot exceed Part A inpatient hospital deductible. You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. NOT covered outside the U.S. except under limited circumstances.	**General** $50 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	Freedom Blue Plan I (Regional PPO)
17 **Outpatient Rehabilitation Services** (Occupational Therapy, Physical Therapy, Speech and Language Therapy, Respiratory Therapy Services, Social/ Psychological Services, and more)	20% coinsurance	**General** Authorization rules may apply. **In-Network** $25 to $50 copay for Medicare-covered Occupational Therapy visits. $25 to $50 copay for Medicare-covered Physical and/or Speech and Language Therapy visits. $25 copay for Medicare-covered Cardiac Rehab services. **Out-of-Network** 30% of the cost for Occupational Therapy benefits. 30% of the cost for Physical and/or Speech and Language Therapy visits. 30% of the cost for Cardiac Rehab services.

Outpatient Medical Services and Supplies

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)
18 **Durable Medical Equipment** (includes wheelchairs, oxygen, etc.)	20% coinsurance	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items. **Out-of-Network** 25% of the cost for 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 items. **Out-of-Network** 30% of the cost for prosthetic devices.

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)
20 Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, self-management training, retinal exam/glaucoma test, and foot exam/therapeutic soft shoes)	20% coinsurance Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.	**In-Network** $0 copay for Diabetes self-monitoring training. $0 copay for Nutrition Therapy for Diabetes. 20% of the cost for Diabetes supplies. **Out-of-Network** 30% of the cost for Diabetes self-monitoring training. 30% of the cost for Nutrition Therapy for Diabetes. 30% of the cost for Diabetes supplies.
21 Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	20% coinsurance for diagnostic tests and X-rays $0 copay for Medicare-covered lab services Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered lab services. $0 to $185 copay for Medicare-covered diagnostic procedures and tests. $25 copay for Medicare-covered X-rays. $40 to $185 copay for Medicare-covered diagnostic radiology services (not including x-rays). 20% of the cost for Medicare-covered therapeutic radiology services. Separate Office Visit cost sharing of $15 to $25 may apply for Outpatient Diagnostic Procedures, Tests and Lab Services. Separate Office Visit cost sharing of $15 to $25 may apply for Outpatient Diagnostic and Therapeutic Radiological Services. **Out-of-Network** 30% of the cost for diagnostic procedures, tests, and lab services.

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)
		30% of the cost for outpatient x-rays. 30% of the cost for diagnostic radiology services. 30% of the cost for therapeutic radiology services.

Preventive Services

22 **Bone Mass Measurement** (for people with Medicare who are at risk)	No coinsurance, copayment or deductible. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	**In-Network** $0 copay for Medicare-covered bone mass measurement. **Out-of-Network** 30% of the cost for Medicare-covered bone mass measurement.
23 **Colorectal Screening Exams** (for people with Medicare age 50 and older)	No coinsurance, copayment or deductible for screening colonoscopy or screening flexible sigmoidoscopy. Covered when you are high risk or when you are age 50 and older.	**In-Network** $0 copay for Medicare-covered colorectal screenings. **Out-of-Network** 30% of the cost for colorectal screenings.
24 **Immunizations** (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)	$0 copay for Flu, Pneumonia, and Hepatitis B vaccines. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.	**In-Network** $0 copay for Flu and Pneumonia vaccines. No referral needed for Flu and pneumonia vaccines. $0 copay for Hepatitis B vaccine. **Out-of-Network** $0 copay for immunizations.
25 **Mammograms (Annual Screening)** (for women with Medicare age 40 and older)	No coinsurance, copayment or deductible. No referral needed. Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.	**In-Network** $0 copay for Medicare-covered screening mammograms. **Out-of-Network** 30% of the cost for screening mammograms.

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)
26 Pap Smears and Pelvic Exams (for women with Medicare)	No coinsurance, copayment, or deductible for Pap smears. No coinsurance, copayment, or deductible for Pelvic and clinical breast exams. Covered once every 2 years. Covered once a year for women with Medicare at high risk.	**In-Network** $0 copay for Medicare-covered pap smears and pelvic exams **Out-of-Network** 30% of the cost for pap smears and pelvic exams.
27 Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	20% coinsurance for the digital rectal exam. $0 for the PSA test; 20% coinsurance for other related services. Covered once a year for all men with Medicare over age 50.	**In-Network** $0 copay for Medicare-covered prostate cancer screening. **Out-of-Network** 30% of the cost for prostate cancer screening.
28 End-Stage Renal Disease	20% coinsurance for renal dialysis 20% coinsurance for Nutrition Therapy for End-Stage Renal Disease Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.	**In-Network** 10% of the cost for renal dialysis $0 copay for Nutrition Therapy for End-Stage Renal Disease. **Out-of-Network** 30% of the cost for Nutrition Therapy for End-Stage Renal Disease. 10% of the cost for renal dialysis.
29 Prescription Drugs	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	**Drugs Covered Under Medicare Part B General** 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. 25% of the cost for Part B drugs out-of-network. **Drugs Covered Under Medicare Part D General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.anthem.com/ca/medicare on the web.

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)
		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). The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and the 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 Freedom Blue Plan I (Regional PPO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Freedom Blue Plan I (Regional PPO) approves the exception, you will pay Tier 3:

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)
		Non-Preferred Brand Drugs cost sharing for that drug. **In-Network** $0 deductible. Supplemental drugs don't count toward your out-of-pocket drug costs. **Initial Coverage** You pay the following until total yearly drug costs reach $2,840: **Retail Pharmacy** Tier 1: Generic Drugs • $7 copay for a one-month (30-day) supply of drugs in this tier • $21 copay for a three-month (90-day) supply of drugs in this tier Tier 2: Preferred Brand Drugs • $43 copay for a one-month (30-day) supply of drugs in this tier • $129 copay for a three-month (90-day) supply of drugs in this tier Tier 3: Non-Preferred Brand Drugs • $85 copay for a one-month (30-day) supply of drugs in this tier • $255 copay for a three-month (90-day) supply of drugs in this tier Tier 4: Injectable Drugs • 33% coinsurance for a one-month (30-day) supply of drugs in this tier • 33% coinsurance for a three-month (90-day) supply of drugs in this tier Tier 5: Specialty Tier Drugs • 33% coinsurance for a one-month (30-day) supply of drugs in this tier Tier 6: Supplemental Drugs • $7 copay for a one-month (30-day) supply of drugs in this tier • $21 copay for a three-month (90-day) supply of drugs in this tier

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)
		Long-Term Care Pharmacy Tier 1: Generic Drugs • $7 copay for a one-month (34-day) supply of drugs in this tier Tier 2: Preferred Brand Drugs • $43 copay for a one-month (34-day) supply of drugs in this tier Tier 3: Non-Preferred Brand Drugs • $85 copay for a one-month (34-day) supply of drugs in this tier Tier 4: Injectable Drugs • 33% coinsurance for a one-month (34-day) supply of drugs in this tier Tier 5: Specialty Tier Drugs • 33% coinsurance for a one-month (34-day) supply of drugs in this tier Tier 6: Supplemental Drugs • $7 copay for a one-month (34-day) supply of drugs in this tier **Mail Order** Tier 1: Generic Drugs • $10.50 copay for a three-month (90-day) supply of drugs in this tier Tier 2: Preferred Brand Drugs • $107.50 copay for a three-month (90-day) supply of drugs in this tier Tier 3: Non-Preferred Brand Drugs • $212.50 copay for a three-month (90-day) supply of drugs in this tier Tier 4: Injectable Drugs • 33% coinsurance for a three-month (90-day) supply of drugs in this tier Tier 5: Specialty Tier Drugs • 33% coinsurance for a one-month (30-day) supply of drugs in this tier Tier 6: Supplemental Drugs • $10.50 copay for a three-month (90-day) supply of drugs in this tier

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)
		Additional Coverage Gap The plan covers many formulary generics (65%-99% of formulary generic drugs) through the coverage gap. You pay the following: **Retail Pharmacy** Tier 1: Generic Drugs • $7 copay for a one-month (30-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 6: Supplemental Drugs • $7 copay for a one-month (30-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 **Long-Term Care Pharmacy** Tier 1: Generic Drugs • $7 copay for a one-month (34-day) supply of all drugs covered in this tier Tier 6: Supplemental Drugs • $7 copay for a one-month (34-day) supply of all drugs covered in this tier **Mail Order** Tier 1: Generic Drugs • $10.50 copay for a three-month (90-day) supply of all drugs covered in this tier Tier 6: Supplemental Drugs • $10.50 copay for a three-month (90-day) supply of all drugs covered in this tier After your total yearly drug costs reach $2,840, 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 93% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach $4,550.

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)
		Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,550, you pay the following: Tier 1: Generic Drugs • $2.50 copay or 5% coinsurance [whichever costs more] for drugs in this tier Tier 2: Preferred Brand Drugs • $6.30 copay or 5% coinsurance [whichever costs more] for drugs in this tier Tier 3: Non-Preferred Brand Drugs • $6.30 copay or 5% coinsurance [whichever costs more] for drugs in this tier Tier 4: Injectable Drugs • $3.25 copay or 5% coinsurance [whichever costs more] for drugs in this tier Tier 5: Specialty Tier Drugs • $6.30 copay or 5% coinsurance [whichever costs more] for drugs in this tier Tier 6: Supplemental Drugs • $7 copay for drugs in this tier **Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Freedom Blue Plan I (Regional PPO). **Out-of-Network Initial Coverage** You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,840: Tier 1: Generic Drugs

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)
		• $7 copay for a one-month (30-day) supply of drugs in this tier Tier 2: Preferred Brand Drugs • $43 copay for a one-month (30-day) supply of drugs in this tier Tier 3: Non-Preferred Brand Drugs • $85 copay for a one-month (30-day) supply of drugs in this tier Tier 4: Injectable Drugs • 33% coinsurance for a one-month (30-day) supply of drugs in this tier Tier 5: Specialty Tier Drugs • 33% coinsurance for a one-month (30-day) supply of drugs in this tier Tier 6: Supplemental Drugs • $7 copay 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. **Additional Out-of-Network Coverage Gap** You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following: Tier 1: Generic Drugs • $7 copay for a one-month (30-day) supply of all drugs covered in this tier Tier 2: Preferred Brand Drugs You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly drug costs reach $4,550. You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly drug costs reach $4,550. Tier 3: Non-Preferred Brand Drugs

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)
		You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly drug costs reach $4,550. You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly drug costs reach $4,550. Tier 4: Injectable Drugs You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly drug costs reach $4,550. You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly drug costs reach $4,550. Tier 5: Specialty Tier Drugs You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly drug costs reach $4,550. You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly drug costs reach $4,550. Tier 6: Supplemental Drugs • $7 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 $4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following:

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)
		Tier 1: Generic Drugs • $2.50 copay or 5% coinsurance [whichever costs more] for drugs in this tier Tier 2: Preferred Brand Drugs • $6.30 copay or 5% coinsurance [whichever costs more] for drugs in this tier Tier 3: Non-Preferred Brand Drugs • $6.30 copay or 5% coinsurance [whichever costs more] for drugs in this tier Tier 4: Injectable Drugs • $3.25 copay or 5% coinsurance [whichever costs more] for drugs in this tier Tier 5: Specialty Tier Drugs • $6.30 copay or 5% coinsurance [whichever costs more] for drugs in this tier Tier 6: Supplemental Drugs • $7 copay for 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.
30 Dental Services	Preventive dental services (such as cleaning) not covered.	**In-Network** In general, preventive dental benefits (such as cleaning) not covered. However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits.") 0% of the cost for Medicare-covered dental benefits. **Out-of-Network** $0 copay for comprehensive dental benefits.
31 Hearing Services	Routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	**In-Network** In general, routine hearing exams and hearing aids not covered.

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)
		• $25 copay for Medicare-covered diagnostic hearing exams **Out-of-Network** 30% of the cost for hearing exams.
32 Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. 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** In general, routine eye exams and eye wear not covered. However, this plan covers some vision benefits for an extra cost (see "Optional Benefits"). • $0 copay for one pair of eyeglasses or contact lenses after cataract surgery. • $0 copay for exams to diagnose and treat diseases and conditions of the eye. **Out-of-Network** $0 copay for eye exams. $0 copay for eye wear.
33 Welcome to Medicare; and Annual Wellness Visit	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 exam or an Annual Wellness visit. After your first 12 months, you can get one Annual Wellness visit every 12 months. There is no coinsurance, copayment or deductible for either the Welcome to Medicare exam or the Annual Wellness visit. The Welcome to Medicare exam does not include lab tests.	**In-Network** $0 copay for routine exams. Limited to 1 exam(s) every year. $0 copay for the required Medicare-covered initial preventive physical exam and annual wellness visits. **Out-of-Network** $30 copay for routine exams.
34 Health/Wellness Education	Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four	**In-Network** The plan covers the following health/wellness education benefits: • Health Club Membership/Fitness Classes • Nursing Hotline $0 copay for each Medicare-covered smoking cessation counseling session.

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)
	face-to-face visits. You pay coinsurance, and Part B deductible applies. $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 of up to three times during a pregnancy.	$0 copay for each Medicare-covered HIV screening. 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. **Out-of-Network** $0 copay for Health and Wellness services.
Transportation (Routine)	Not covered.	**In-Network** This plan does not cover routine transportation.
Acupuncture	Not covered.	**In-Network** This plan does not cover Acupuncture.

OPTIONAL SUPPLEMENTAL PACKAGE #1

Premium and Other Important Information		**General** Package: 1 - Preventive Dental Package: $9 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 the following preventive dental benefits: • up to 1 oral exam(s) every six months • up to 1 cleaning(s) every six months • up to 1 dental x-ray(s) every year **Out-of-Network** 20% of the cost for preventive dental services.

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)
		In and Out-of-Network $500 plan coverage limit for preventive dental benefits every year. This limit applies to both in-network and out-of-network benefits.

OPTIONAL SUPPLEMENTAL PACKAGE #2

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)
Premium and Other Important Information		**General** Package: 2 - Comprehensive Dental and Vision Package: $25 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		**In-Network** $0 copay for the following preventive dental benefits: • up to 1 oral exam(s) every six months • up to 1 cleaning(s) every six months • up to 1 dental x-ray(s) every year **Out-of-Network** 30% of the cost for preventive dental services. 60% to 75% of the cost for comprehensive dental services. **In and Out-of-Network** $1,000 plan coverage limit for dental benefits every year. This limit applies to both in-network and out-of-network benefits. Contact the plan for availability of additional in-network and out-of-network comprehensive dental benefits.

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)
Vision Services		**In-Network** $0 copay for: • and up to 1 routine eye exam(s) every year $0 copay for • up to 1 pair(s) of glasses every year • up to 1 pair(s) of contacts every year **Out-of-Network** $0 copay for eye exams. $0 copay for eye wear.

OPTIONAL SUPPLEMENTAL PACKAGE #3

Premium and Other Important Information		**General** Package: 3 - Combination Package: $39 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 up to 10 routine visit(s) every year **Out-of-Network** $30 copay for chiropractic services.
Dental Services		**In-Network** $0 copay for the following preventive dental benefits: • up to 1 oral exam(s) every six months • up to 1 cleaning(s) every six months • up to 1 dental x-ray(s) every year

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)
		Out-of-Network 30% of the cost for preventive dental services. 60% to 75% of the cost for comprehensive dental services. **In and Out-of-Network** $1,000 plan coverage limit for dental benefits every year. This limit applies to both in-network and out-of-network benefits. Contact the plan for availability of additional in-network and out-of-network comprehensive dental benefits.
Vision Services		**In-Network** • $0 copay for up to 1 pair(s) of contacts every year • $0 copay for up to 1 routine eye exam(s) every year • $0 copay for up to 1 pair(s) of glasses every year **Out-of-Network** $0 copay for eye exams. $0 copay for eye wear.