Summary of Benefits

PLAN NAME: Anthem Medicare Preferred (PPO) medical plan

PLAN YEAR: January 1, 2019 – December 31, 2019

Please note, you must be enrolled in both Medicare Parts A and B to enroll in the Anthem Medicare Preferred (PPO) medical plan.

Covered Services	What you must pay for these Covered Services
Monthly Premium	**$0**
Deductibles	**$0**
Maximum Out of Pocket	**$0** combined in or out-of-network. All copays, coinsurance, and deductibles listed in this benefits chart are accrued toward the medical plan out-of-pocket maximum with the exception of the routine hearing services, foreign travel emergency and urgently needed care copay or coinsurance amounts.
Inpatient Hospital Coverage* *For Medicare covered hospital stays.*	**$0 copay** per admission or for physician services received while an inpatient, in or out-of-network. No limit to the number of days covered.
Outpatient Hospital Coverage*	**Non-surgical: $0 copay** for a visit to an in or out-of-network primary care physician or specialist in an outpatient hospital setting/clinic or outpatient observation room visit for Medicare-covered non-surgical service. **Surgical: $0 copay** for each Medicare-covered outpatient hospital facility or ambulatory surgical center, or outpatient observation room visit for surgery in or out-of-network.

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Covered Services	What you must pay for these Covered Services
Doctor Visits (Primary Care and Specialists)	**$0 copay** for a visit to an in or out-of-network primary care physician or specialist. No referral is needed.
Preventive Care *For abdominal aortic aneurysm screening, bone mass measurement, colorectal cancer screening/services, HIV screening, sexually transmitted disease (STI) screening, breast cancer screening, cervical/vaginal cancer screening, prostate cancer screening, cardiovascular disease risk reduction visit, cardiovascular disease testing, "Welcome to Medicare" preventive visit, annual wellness visit, depression screening, diabetes screening, Medicare Diabetes Prevention Program (MDPP), obesity screening/therapy to promote sustained weight loss, screening/counseling to reduce alcohol misuse, lung cancer screening with low dose computed tomography (LDCT), medical nutrition therapy, smoking/tobacco cessation.*	There is no coinsurance, copayment or deductible for Medicare-covered visits, tests, therapy or benefits, in or out-of-network.
Emergency Care *Services that are:* *— Furnished by a provider qualified to furnish emergency services, and* *— Needed to evaluate or stabilize an emergency medical condition.*	**$0 copay** for each Medicare-covered emergency room visit worldwide in or out-of-network. Limited to what is allowed under the Medicare fee schedule for the services performed/ received in the United States.
Urgently Needed Services	**$0 copay** for each Medicare-covered urgently needed care visit worldwide in or out-of-network.
Diagnostic Services/Labs/Imaging *X-rays, complex diagnostic tests and radiology services, radiation therapy, testing to confirm chronic obstructive pulmonary disease (COPD), surgical supplies, splints, casts and other devices used to reduce fractures and dislocations, laboratory tests, blood including storage and administration, diagnostic tests, complex diagnostic tests and radiology services including heart catheterizations, sleep studies, CT, MRI/MRA scans, and PET scans.*	**$0 copay** for each Medicare-covered test, visit, therapy treatment, supplies or pint of blood, in or out-of-network.

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Covered Services	What you must pay for these Covered Services
Mental Health Services *Include mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.*	**Outpatient: $0 copay** for each Medicare-covered individual, group, partial hospitalization and outpatient hospital facility visit. **Inpatient: $0 copay** per admission for Medicare-covered hospital stays or physician services received while an inpatient. No limit to the number of days covered by the plan.
Skilled Nursing Facility (SNF)* *Covered services include semi-private room (or a private room if medically necessary); meals, including special diets; skilled nursing services; physical therapy, occupational therapy, and speech language therapy; drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors); blood - including storage and administration; medical/surgical supplies, laboratory tests, X-rays and other radiology services and use of appliances such as wheelchairs ordinarily provided by SNFs; and physician/practitioner services.*	**$0 copay** for Medicare-covered SNF stays, for days 1-100 per benefit period in or out-of-network. No prior hospital stay required.
Physical Therapy *Part of outpatient rehabilitation services which includes physical, occupational and speech language therapy.*	**$0 copay** for Medicare-covered physical therapy, occupational therapy, and speech language therapy visits in or out-of-network.
Ambulance *Your provider must get an approval from the plan before you get ground, air, or water transportation that is not an emergency. This is called getting prior authorization.*	**$0 copay** for Medicare-covered ambulance services in or out-of-network.
Transportation *Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.*	**$0 copay** for Medicare-covered ambulance services in or out-of-network.

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Covered Services	What you must pay for these Covered Services
Medicare Part B Drugs* *Covered services include: Pneumonia vaccine; flu shots, including H1N1, once each flu season in the fall and winter, with additional flu shots if medically necessary; Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B; other vaccines if you are at risk and they meet Medicare Part B coverage rules. If you have Part D prescription drug coverage, some vaccines are covered under your Part D benefit (for example, the shingles vaccine). Please refer to your Part D prescription drug benefits.*	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, or other Medicare-covered vaccines when you are at risk and meet Medicare Part B rules, in or out-of-network.
Hearing Services *Routine exams, hearing aids and fittings.*	**$0 copay** for routine hearing exams, hearing aid fittings and devices in or out-of-network. Routine hearing exams are limited to 1 every 12 months, and a **$70** maximum benefit every 12 months. Hearing aids are **$1750** per ear maximum benefit every 36 months, in or out-of-network. Free battery supply first 3 years, with a 48 cell limit per year, per hearing aid.
Chiropractic Services *For manual manipulation of the spine to correct subluxation only.* *For Medicare non-covered chiropractic services rendered by a physician to treat a disease, illness or injury. Benefits include: diagnostic services, other than diagnostic scanning, when provided during an initial examination or reexamination; adjustments; radiological x-rays and laboratory tests; and medically necessary therapy when provided in conjunction with the visit specifically for spinal or joint adjustment.*	**$0 copay** for each Medicare-covered visit in or out-of-network. **$0 copay** per visit, limited to 25 visits per year combined in or out-of-network After the plan pays benefits for Medicare non-covered chiropractic services you are responsible for the remaining cost.
Acupuncture Services *Services of a licensed acupuncturist for acupuncture treatment to treat a disease, illness, or injury. Benefits include: initial patient exam, as well as acupuncture treatment, reexaminations and other services in various combinations.*	**$0 copay** per visit, limited to 12 visits per year combined with in or out-of-network. After the plan pays benefits for acupuncture services, you are responsible for the remaining cost.

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The Anthem Medicare Preferred (PPO) medical plan also has benefits that cover Dental and Vision for specific medical services and situations. Please see descriptions and coverage below.	
Covered Services	**What you must pay for these Covered Services**
Dental Services *Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician).*	**$0 copay** for Medicare-covered services of non-routine dental care in or out-of-network when provided by a primary care physician/specialist.
Vision Services *Includes outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration; one glaucoma screening each year for people who are at high risk; screening for diabetic retinopathy once per year for people with diabetes; and one pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens.*	**$0 copay** for visits to a primary care physician/specialist in or out-of-network for Medicare-covered exams, glaucoma and retinopathy screening and glasses/contacts following Medicare-covered cataract surgery.

Service area: All 50 states, Washington, D.C., American Samoa, Guam, Northern Mariana Islands, U.S. Virgin Islands, and Puerto Rico.

Eligibility: You are eligible for the Anthem Medicare Preferred (PPO) medical plan if you are enrolled in both Medicare Parts A and B. Most people qualify for Medicare at age 65. If you, your spouse/domestic partner, or dependent have certain disabilities and/or have end-stage renal disease (ESRD), you may qualify for Medicare before age 65.

While the Summary of Benefits does not list every service, limitation or exclusion, the *Evidence of Coverage (EOC)* does. If you have questions or would like to request a copy of the *EOC* please call **First Impressions Team** at **1-833-277-5221**, TTY: **711**, **Monday - Friday, 5 a.m. to 6 p.m. PT, except holidays**.

Learn more about Medicare

If you're unclear on what Medicare is and how it works, refer to your current ***Medicare & You*** handbook. If you do not have a copy you can also view it online or download the booklet at **www.medicare.gov**. Or you can order a printed copy by calling **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users, call **1-877-486-2048**.

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

Anthem BC Health Insurance Company – H4909

2018 Medicare Star Ratings*

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

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

Some of the areas Medicare review for these ratings include:

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

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

4.5 Stars

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

Health Plan Services:

4 Stars

Drug Plan Services:

4.5 Stars

The number of stars shows how well our plan performs.

5 stars – excellent

4 stars – above average

3 stars – average

2 stars – below average

1 star – poor

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

You may also contact us Monday through Friday from 5:00 a.m. to 6:00 p.m. Pacific time at 1-833-277-5221 (toll-free) or 711 (TTY).

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

Anthem BC Health Insurance Company is an LPPO plan with a Medicare contract. Enrollment in Anthem BC Health Insurance Company depends on contract renewal.

Important Information Regarding Your Medicare Advantage Plan

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

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

I understand that by enrolling in this Medicare Advantage plan, I will automatically be disenrolled by the Centers for Medicare & Medicaid Services (CMS) from any other Medicare Advantage plan of which I am currently a member. **I can only be in one Medicare Advantage plan at a time.** Your prescription drug coverage is a separate benefit plan provided through the Los Angeles Unified School District pharmacy benefit manager. No other prescription coverage in permitted.

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

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

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

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

Counseling services may be available in my state to provide advice concerning Medicare supplemental insurance or other Medicare Advantage plan options as well as and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

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The Anthem Medicare Preferred (PPO) medical plan serves a specific service area of all 50 states, Washington, DC, American Samoa, Guam, Northern Mariana Islands, US Virgin Islands, and Puerto Rico. If I move out of the area that plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of this Medicare Advantage plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* from the plan when I receive it to know which rules I must follow to receive coverage with this Medicare Advantage plan.

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

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

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

Out-of-network/non-contracted providers are under no obligation to treat Anthem BC Health Insurance Company members, except in emergency situations. Out-of-network coverage is part of your Anthem Medicare Preferred (PPO) medical plan and you do not need prior authorization to obtain out-of-network services. However, we recommend you ask for a pre-visit coverage decision to confirm that the service you are receiving is covered and medically necessary. If an out-of-network/non-contracted provider, who accepts Medicare, provides treatment that is medically necessary then it will be covered. Please call our First Impressions Welcome Team at **1-833-277-5221**, TTY: **711**, for more information.

This information is not a complete description of benefits. Contact the plan for more information. Limitations and restrictions may apply. Benefits and/or premiums may change on January 1 of each year.

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