Anthem Medicare Preferred (PPO) Group Plan

Your Medicare coverage becomes more complete

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Anthem.

Health. **Join In.**

P.O. Box 110
Fond du Lac, Wisconsin 54936

Anthem Blue Cross and Blue Shield: Providing network based health care solutions that meet your needs

This chapter in your life should be focused on all of the things you've always imagined being able to do some day. Reaching and maintaining optimum health to allow those dreams to become a reality should be one of your goals – it's definitely one of ours.

We are pleased to announce your Medicare Advantage coverage is being transitioned from a Private Fee for Service (PFFS) plan to an Anthem Medicare Preferred (PPO) plan. This is a great advantage for you! Anthem Medicare Preferred (PPO) is a Local Preferred Provider Organization plan with a Medicare Contract. This plan gives you an alternative to traditional Medicare coverage.

The right care at the right place

Your Anthem Medicare Preferred (PPO) plan helps ensure you'll see the physicians of your choice. As an Anthem Medicare Preferred (PPO) member, you can seek care from either **in-network** or **out-of-network** providers, as long as the services are covered benefits and are medically necessary.

Important information about in-network and out-of-network providers:

Anthem Medicare Preferred (PPO) members can see any participating network doctor or hospital and receive the highest level of benefits. If you choose to use an **out-of-network** provider when a participating network provider is available, your share of the costs for your covered services may be higher.

This plan's service area includes all 50 states, Puerto Rico and Washington DC. Through the Blue Medicare Advantage PPO Network Sharing Program, you have access to health care services while traveling or living anywhere in another Blue Cross and/or Blue Shield (Blue) plan's service area. We help make it easy to get the care you need.

Blue Medicare Advantage PPO Network Sharing is a national program that enables members of one of the Blue Cross and/or Blue Shield (Blue) plans to obtain healthcare services while traveling or living in another Blue company's service area. The program links participating healthcare providers with the independent Blue companies across the country, through a single electronic network for claims processing and reimbursement.

Although most Anthem Medicare Preferred (PPO) members will have access to participating **network** providers, you may need to obtain services from **out-of-network** providers.

If you are in an area without **network** providers available for you to see, you can go to an **out-of-network** provider and you will only be responsible to pay the **in-network** co-payment and deductible amounts.

You can get your care from an **out-of-network** provider however, that provider must participate in Medicare. If you receive care from a provider that does not participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they have not opted out of Medicare. You, or someone acting on your behalf, can also access the list of Medicare eligible providers at: http://www.medicare.gov/physician/search/chooseprovider.asp

Finding a Blue Medicare Advantage PPO Provider

To help you locate a participating network provider:

1. Check your Anthem Medicare Preferred (PPO) Provider Directory,
2. Call your Plan's member service phone number on the back of your identification card during regular business hours,
3. Call 1-800-810-2583 to find a Blue Medicare Advantage PPO provider, or
4. Visit the "Doctor & Hospital Finder" at www.anthem.com to find a Blue Medicare Advantage PPO provider.

Finding a provider when no PPO participating network provider is available

If you are in an area without access to the Blue Medicare Advantage PPO **network** providers, you can use **out-of-network** providers and still receive **in-network** benefits.

1. If you are currently using providers that participate with Medicare, you should first inform your current providers that
   - You are enrolled under a new plan
   - Although the new plan is a PPO, you can continue to be seen by them if they agree
   - You, the member, will receive **in-network** benefits
2. If the provider elects to not provide services, you can self refer to another provider that participates in Medicare.
3. If you are unable to find a provider, please contact Member Services who will:
   - Respond with at least one provider of the requested provider type(s) within reasonable travel distance.
   - Respond within 72 hours for standard requests for a provider
   - Respond on the same day for urgent care services (medical services to be furnished within 12 hours in order to avoid the likely onset of an emergency medical condition).

The questions and answers that follow may help you to better understand your new health care plan.

How will my claim be paid?
The claims for your doctor visits will be paid according to the benefits that your plan provides. Providers should submit claims to their local Blue Cross and/or Blue Shield Plan.

Will my identification card be different?
Your identification card will look the same as that of the other members covered by your employer or union's health care plan.

What if my provider won't continue to see me?
If your provider elects to not provide services, you can self refer to another provider that participates in Medicare. You should contact another provider that is convenient to you. It is important for you to know that out-of-network costs will be applied to care or services you get from providers outside of the network when a participating network provider is available.

What should I do if I cannot locate a provider?
Locating a provider should not be a problem given the expanse of our network. However, if you are not able to locate a provider, contact Member Services and a Customer Service Representative will assist you. Prior to calling for assistance, you should contact your own provider and other providers in your immediate community.

Important information for retirees who choose not to take this coverage

Your membership will be automatically transferrred to the new Anthem Medicare Preferred (PPO) plan unless you tell us you do not want to enroll in this new coverage. To opt out of the coverage, please fill out the enclosed opt out form and return to the address included on the form. Please keep in mind that if you choose not to enroll in the Anthem Blue Cross and Blue Shield plan, you or your spouse may not be able to re-enroll in your retiree benefits; please check with your employer or union for their eligibility rules. DO NOT complete the opt-out form if you want to continue your coverage in your employer or union retiree plan.

Check out this enrollment brochure for all of the details on the benefits, programs and resources that make Anthem Medicare Preferred (PPO) plan coverage an attractive option. If you've got questions about the benefits before you enroll, you can call the First Impressions Welcome Center at 1-877-411-1647, TTY/TDD 1-877-247-1657. Helpful customer care associates are available Monday - Friday from 8 a.m. to 8 p.m. to answer your questions and talk with you about the Anthem Medicare Preferred (PPO) plan. If you do choose to opt out, you may be eligible to enroll in another Medicare Advantage plan in your service area or elect to return to Original Medicare. You can also contact Medicare directly at 1-800-MEDICARE (1-800-633-4227) TTY/TTD 1-877-486-2048. Medicare representatives are available 24 hours a day, 7 days a week for any general questions you may have about Medicare health or Part D drug benefits.

We appreciate your business and are here to assist you navigate this transition every step of the way. You can count on a helping hand with your health care and the satisfaction of knowing you've got access to the care you need.

A health plan with a Medicare contract.

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

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WHAT'S INSIDE

SECTION 1

INTRODUCING
ANTHEM MEDICARE PREFERRED (PPO)

SECTION 2

USING YOUR BENEFITS

- Selecting a health care professional or hospital
- Specialist visits
- Preventive care services
- Finding providers
- Getting medical care
- Identification cards
- Customer service
- Value added services
- Emergency care
- Prescription coverage

SECTION 3

INS AND OUTS OF COVERAGE

- Eligibility requirements
- Geographic service areas covered by this plan
- Utilization management
- Preadmission certification
- Concurrent review
- Case management
- Your right to privacy
- Filing complaints
- Continuation of plan benefits
- Exclusions and limitations of your plan coverage
- Medicare basics
- HIPAA Notice of Privacy Practices
- Important contact information
  - First Impressions phone number (before enrollment)
  - Customer service phone number and address (after enrollment)
  - Dedicated website address
  - Medicare phone number and website

If you need this material in an alternate format, please contact Customer Service at the number listed in this brochure.

If you need assistance in Spanish to understand this document, you may request it for free by calling customer service at the number on your identification card or in your enrollment booklet.

Si usted necesita ayuda en español para entender éste documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.

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INTRODUCING ANTHEM MEDICARE PREFERRED (PPO)

All play and no work makes for a great retirement.

Worthwhile health care coverage is supposed to work for you, not the other way around. That's where the value of Anthem Medicare Preferred (PPO) comes in.

As a plan member, you get access to all of the benefits that are available to you under standard Medicare coverage.

But here are just a few differences that set Anthem Medicare Preferred (PPO) plan coverage apart:

- **Plan benefits include set fees for most services** like health care professional's office visits, emergency room visits and inpatient hospital stays so you typically know upfront what you can expect to pay for medical care you receive.
- **Receiving your coverage through a Local PPO plan** instead of through traditional Medicare means that we take care of the paperwork for you.
- **Plan provides all the benefits covered by original Medicare.** In addition, supplemental benefits (e.g. dental, vision) may be provided as part of the same product benefits.
- **The drug coverage** that is included in your plan benefits is better than Original Medicare coverage.

But wait, there's more.

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Anthem Medicare Preferred (PPO)

Anthem Medicare Preferred (PPO) plans do not simply mirror Medicare coverage. They also include access to important resources that can support you when you've got health care decisions to make. And even some extras thrown in like discounts. It's all part of an integrated approach we've developed called Custom Care Connection. What does that mean? Simply put, it's our comprehensive approach that not only helps pay for your medical bills, but also gives you the customized tools and support you need to make the most of your coverage.

Custom Care Connection includes:

- preventive care services that can help you feel healthier or help treat problems at their earliest stages
- condition management for members dealing with chronic conditions such as diabetes, COPD, kidney disease or certain heart ailments
- care management for members dealing with multiple conditions or acute health issues
- a dedicated nurse line available to you 24 hours a day, 7 days a week

Enrolling in Anthem Medicare Preferred (PPO) plan coverage is easy because there are no physicals required upfront and there are no limitations to your coverage if you are already dealing with pre-existing medical conditions.

Your plan coverage will include:

- health care professional office visits for wellness as well as for sick visits
- inpatient hospital stays
- outpatient hospital services
- emergency room or urgent care services
- ambulance services
- durable medical equipment
- diagnostic testing including X-rays and laboratory services
- short-term and maintenance prescription medications

See the value for yourself

Anthem Medicare Preferred (PPO) coverage gives you:

- Full coverage that can begin as soon as your effective date
- Benefits with many set fees, taking the guesswork out of what you'll pay
- Freedom to escape the paper trails that typically come with traditional Medicare coverage
- Devoted customer service staff solely available for our retiree members
- Drug coverage that's better than standard Medicare Part D benefits
- Freedom to "move about the country" with a travel benefit that saves you money

USING YOUR BENEFITS

INSIDE

- Selecting a health care professional or hospital
- Specialist visits
- Preventive care services
- Finding providers
- Getting medical care
- Identification cards
- Customer service
- Value added services
- Emergency care
- Prescription coverage

Y0071_11_10255_I 07/19/2010

Selecting a doctor

With your Anthem Medicare Preferred (PPO) plan, you can see any doctor you want. You have the option of using the doctors in our network who have agreed to participate with us. Or you can use a non-network provider. Generally, you will pay less when using network providers.

Working with network providers has many advantages. These doctors and hospitals will:

- file claims for you so there's no paperwork for you to handle
- work with accepted fees for specific services, so that means less money out of your pocket

Seeing a Specialist

Your plan allows you to seek specialist visits without first receiving a referral from your primary care physician. See your Provider Directory and our website for provider information about network specialists. For certain services, your network physician will need to get prior approval from us. Please refer to your Benefit Chart for the services which require prior authorization.

Preventive services to keep you at your healthiest

Research shows that being in tune with your health can help you prevent problems before they occur or at least minimize their progression. That's why your Anthem Medicare Preferred (PPO) plan includes layers of support to give you the tools and resources you need for the best possible health outcomes. Preventive services are available at no additional cost or deductible to pay.

A team of support

Questions about your coverage? That's no problem for the team of dedicated customer service reps who are wholly focused on your coverage and benefit needs and are trained and ready to help you with any coverage and benefit concern you may have.

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Getting medical care

As an Anthem Medicare Preferred (PPO) member, you can seek care from either in-network or out-of-network providers, as long as the services are covered benefits and are medically necessary. Here are other important things to know about using out-of-network providers:

- Anthem Medicare Preferred (PPO) members can see any doctor or hospital that participates with this plan and receive the highest level of benefits. So no matter where life takes you, your health coverage goes with you. With our Anthem Medicare Preferred (PPO) plans, through the Blue Medicare Advantage PPO Network Sharing Program, you have access to health care services while traveling or living anywhere in another Blue plan's service area. We help make it easy to get the care you need.

  Blue Medicare Advantage PPO Network Sharing is a national program that enables members of one Blue company to obtain healthcare services while traveling or living in another Blue company's service area. The program links participating healthcare providers with the independent Blue companies across the country, through a single electronic network for claims processing and reimbursement.

  If you choose to use an out-of-network provider when a participating provider is available, your share of the costs for your covered services may be higher.
- This plan's service area includes all 50 states, Puerto Rico and Washington DC. Although most Anthem Medicare Preferred (PPO) members will have access to contracting providers, you may need to obtain services from out-of-network providers.
- If you are in an area without network providers available for you to see, you can go to an out-of-network provider but you will only be responsible to pay the in-network amounts.
- You can get your care from an out-of-network provider, however, that provider must participate in Medicare. Anthem Medicare Preferred (PPO) cannot pay a provider who has decided not to participate in Medicare. If you receive care from a provider that does not participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they have not opted out of Medicare. You, or someone acting on your behalf, can also access the list of Medicare participating providers at: http://www.medicare.gov/physician/search/chooseprovider.asp

Determining if you are in an area with access to PPO participating providers:

To determine if you are in an area with access to a PPO participating provider, please refer to your provider directory for information on participating network areas or call the member services number on the back of your identification card.

Finding a Blue Medicare Advantage PPO provider

To help you locate a participating provider:

1. call your plan's member service phone number on the back of your identification card during regular business hours,
2. call 1-800-810-BLUE to find a Blue Medicare Advantage PPO provider, or
3. Visit the "Doctor & Hospital Finder" at www.anthem.com to find a Blue Medicare Advantage PPO provider.

Finding a provider when no PPO participating provider network is available

If you are in an area without access to Blue Medicare Advantage PPO network providers, you can use out-of-network providers and still receive in-network benefits.

1. If you are currently using providers that participate with Medicare, you should first inform your current providers that
   - You are enrolled under a new plan
   - Although the new plan is a PPO, you can continue to be seen by them if they agree
   - You, the member, will receive in-network benefits
2. If the provider elects to not provide services, you can self refer to another provider that participates in Medicare.
3. If you are unable to find a provider, please contact member services who will:
   - respond with at least one provider of the requested provider type(s) within reasonable travel distance.
   - respond within 72 hours for standard requests for a provider
   - respond on the same day for urgent care services (medical services to be furnished within 12 hours in order to avoid the likely onset of an emergency medical condition).

Identification cards

Whether you live in an area with or without a participating Blue Medicare Advantage PPO network, your ID card will look the same as other members covered by your employer or union's health care plan.

Excellent customer service

Anthem Medicare Preferred (PPO) members receive the same outstanding customer service afforded to Anthem members. Members can receive service either by calling their Customer Service phone number or submitting inquiries through the Anthem Medicare Preferred (PPO) website. Many plans also have walk-in customer service centers located in major cities.

Valuable extras for added support*

*Valuable extras for added support

Please note: the valued added products and services described on this page are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the Anthem Blue Cross and Blue Shield grievance process.

The SilverSneakers® Fitness Program

As an Anthem Medicare Preferred (PPO) member, it's easy and affordable to stay fit, have fun and make friends. Your SilverSneakers® Fitness Program membership is available to you as part of your Medicare Advantage plan. You'll have access to more than 10,000 locations across the country, to inspire workouts close to home and on your next vacation. Participating SilverSneakers locations offer amenities such as:

- fitness equipment, treadmills and free weights
- SilverSneakers fitness classes, including YogaStretch and SilverSplash, designed specifically for older adults and taught by certified instructors
- a designated on-site staff member to help you along the way
- health education seminars and fun social events SilverSneakers Steps is a personalized fitness program that fits the lifestyle of members who live 15 miles or more from a SilverSneakers fitness location. After registering as a Steps member on www.silversneakers.com, you are able to set your goals and track your accomplishments to create a personalized path to wellness.

You'll receive your free Steps kit, which has the tools you need to get fit, including resistance bands, an exercise DVD and how-to materials.

SpecialOffers@Anthem

Everyone loves a good deal and as a member, you have your pick of discount offerings available through SpecialOffers@Anthem, our online discount program. Visit our website and you'll see special deals on items like:

- books on health and nutrition
- fitness clubs
- alternative therapies such as acupuncture
- hearing aids
- safety products for your home... and more!

24-hour Nurse Information Line and HealthLine Audiotape Library

Health concerns don't always occur during times when your health care professional's office is open. The 24-hour Nurse Information Line is a convenient alternative that you can call any time of the day or night, 365 days a year. Helpful and supportive nurses will guide you on over-the-counter remedies or provide educational information to allow you to make the determination if and when you need to seek care from a health care professional.

Just want to get some information on a particular health-related topic, but don't want to speak to a nurse? You can do that too by calling the HealthLine Audiotape Library with access to prerecorded content on hundreds of health-related topics.

Vendors and offers are subject to change without prior notice. Anthem does not endorse and is not responsible for the products, services or information provided by the Special Offers vendors. Arrangements and discounts were negotiated between each vendor and Anthem for the benefit of our members.

Help for members dealing with chronic conditions

Dealing with a chronic condition can really impact your life. Ongoing symptoms. Visits to the doctor or emergency room. Expensive medications and treatments. After awhile it can feel like your condition has taken over your life. The Disease Management program that is included with Anthem Medicare Preferred (PPO) coverage may be just the solution you've been looking for. The program includes access to nurses trained to help people with these conditions. Once you enroll in this program, our nurses can support you with questions you might have, provide information on treatments that are available for you to discuss with your physician and be a resource and coach, along with your provider. Our clinician acts as your coach to help you better understand your condition(s), helps you better manage your symptoms, and teaches you how to recognize the status of your condition and what action you may need to take. Our goal is your goal... to teach you self management skills so you feel empowered to take action in managing your health as well as who to contact when you need help.

Even more help for members dealing with multiple conditions

Individuals who are dealing with more than one condition need extra support. So that's why your coverage also includes Integrated Care Management with access to nurse care managers who are dedicated to helping members with multiple conditions.

These nurse care managers offer:

- lifestyle coaching
- tips for medication management
- coordination of care when you are being seen by more than one health care professional
- access to medical management programs that can augment the care you're already receiving, and more.

Friendly reminders, useful information

We understand that "retirement" often translates into "busier than ever." That's why you'll hear from us from time to time. We want to help ensure that you don't miss important screenings and that you do have an opportunity to complete your annual health assessment. MyHealth Note is a personalized notice that helps keep you informed about the health issues that are specific to you. Is it time to see your doctor for a recommended test or exam? A MyHealth Note can let you know.

MyHealth Notes include information about health recommendations and potential pharmacy savings, and feature a summary of your recent claims information to keep for your records and share with your treatment providers. If you receive a MyHealth Note in the mail from us, be sure to read it and share it with your doctor. The note will contain specific things you can do to improve your health and remind you of routine tests. And if you have questions about the information in a MyHealth Note, a nurse coach is available to help.

We'll also notify you and your doctor if we see that you may be taking drugs that shouldn't be taken together. If there is a less expensive and equally effective medication available to replace a more expensive drug you are taking now, we'll let you know about it so you can discuss it with your doctor.

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Emergency care/urgent care

There are few things more frightening than being faced with a medical emergency. By all means, if you ever experience a life threatening illness or injury, call 911 or go to the nearest hospital. Your care should be covered no matter where you are.

Sometimes it's hard to know if your illness or injury is truly an emergency. Often you may be experiencing symptoms that need prompt attention, but not the use of an emergency room. Members can call the Nurse Information line for guidance. It is open 24 hours a day, 7 days a week. This Nurse Information line phone number is located on the back of your ID card. In addition, use the guidelines below as a general checklist to keep in mind before visiting an emergency room. Your care will be covered at either an emergency room or urgent care center as long as your illness or condition generally meets the definition for what is considered an emergency or urgent situation.

But, your health care professional's office or urgent care center can normally treat any minor illness or injury and is a more appropriate place to get treatment so that emergency room services can remain available to those who truly need that level of care.

Emergency care versus urgent care. What's the difference?

Emergency care is usually defined as when a person reasonably believes that there is an immediate threat to health.

Examples include:

- convulsions/seizures
- respiratory arrest
- unconsciousness
- poisoning
- broken bone
- shock

Urgent care situations are typically those in which the illness or injury is less severe, but you still need prompt attention.

Examples of urgently needed care include:

- abdominal pain
- bad sunburns or other minor burns
- earache
- persistent nausea/vomiting
- significant flu or sore throat
- significant sprain

Y0071_11_10255_I 07/19/2010

Your 2011 Medical Benefit Chart
Local PPO Plan
University of Maine System – Effective January 1, 2010

Covered Services	**What you must pay for these covered services**	
Important Information	In-Network	Out-of-Network
Doctor and hospital choice You may go to doctors, specialists and hospitals in or out of the network. You do not need a referral. However some benefits may require authorization.		Higher costs may apply for out-of-network services.
Annual deductible • The deductible applies to covered services as noted within each category prior to the copay, if any, being applied.	$300 Combined in-network and out-of-network	$300 Combined in-network and out-of-network
Inpatient Services		
Inpatient hospital care Covered services include, but are not limited to, the following: • Semi-private room (or a private room if medically necessary). • Meals including special diets. • Regular nursing services. • Costs of special care units (such as intensive or coronary care units). • Drugs and medications. • Lab tests. • X-rays and other radiology services. • Necessary surgical and medical supplies. • Use of appliances, such as wheelchairs. • Operating and recovery room costs. • Physical, occupational and speech language therapy services.	Prior authorization is required. For Medicare-covered hospital stays: 10% coinsurance per admission. Deductible applies. No limit to the number of days covered by the plan each benefit period $0 copay for physician services received while an inpatient	Prior authorization is requested. For Medicare-covered hospital stays: 20% coinsurance per admission. Deductible applies. No limit to the number of days covered by the plan each benefit period 20% coinsurance for physician services received while an inpatient

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Inpatient hospital care (cont) • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. If you are sent outside of your community for a transplant, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood – including storage and administration. Coverage of whole blood and package red cells begins only with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Physician services. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. If possible, plan should be notified of emergency admissions within one (1) business day of admission.	during a Medicare-covered hospital stay. Deductible applies.	during a Medicare-covered hospital stay. Deductible applies.
Inpatient mental health care Includes mental health care services that require a hospital stay in a psychiatric hospital or the psychiatric unit of a general hospital Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. If possible, plan should be notified of emergency admissions within one (1) business day of admission.	For Medicare-covered hospital stays: Prior authorization is required. Please contact the behavioral health care program associated with your plan. 10% coinsurance per admission. Deductible applies. No limit to the number of days covered by the plan each	For Medicare-covered hospital stays: Prior authorization is requested. Please contact the behavioral health care program associated with your plan. 20% coinsurance per admission. Deductible applies. No limit to the number of days covered by the plan each

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Inpatient mental health care (cont)	benefit period $0 copay for physician services received while an inpatient during a Medicare-covered hospital stay. Deductible applies.	benefit period 20% coinsurance for physician services received while an inpatient during a Medicare-covered hospital stay. Deductible applies.
Skilled nursing facility (SNF) care Inpatient skilled nursing facility (SNF) coverage is limited to 100 days each benefit period. A "benefit period" begins on the first day you go to a Medicare-covered inpatient hospital or a SNF. The benefit period ends when you have not been inpatient at any hospital or SNF for 60 days in a row. Covered services include, but are not limited to, the following: • Semi-private room (or a private room if medically necessary). • Meals, including special diets. • Regular nursing services. • Physical therapy, occupational therapy and speech therapy. • Drugs administered to you as part of your plan of care. (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood – including storage and administration. Coverage of whole blood and package red cells begins only with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs. • Laboratory tests ordinarily provided by SNFs. • X-rays and other radiology services ordinarily provided by SNFs. • Use of appliances such as wheelchairs ordinarily provided by SNFs.	Prior authorization is required. For Medicare-covered SNF stays: 10% coinsurance per admission. Deductible applies.	Prior authorization is requested. For Medicare-covered SNF stays: 20% coinsurance per admission. Deductible applies.

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Skilled nursing facility (SNF) care (cont) • Physician services. Generally, you will get your SNF care from plan facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a plan provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse is living at the time you leave the hospital No prior hospital stay required		
Inpatient services covered when the hospital or SNF days aren't or are no longer covered Covered services include: • Physician services. • Tests (like x-ray or lab tests). • X-ray, radium and isotope therapy including technician materials and services. • Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations. • Prosthetic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices. • Leg, arm, back and neck braces; trusses and artificial legs, arms and eyes including adjustments, repairs and replacements required because of breakage, wear, loss or a change in the patient's physical condition. • Physical therapy, speech therapy and occupational therapy.	After your SNF day limits are used up, this plan will still pay for covered physician services and other medical services outlined in this benefit chart at the deductible and/or cost-share amounts indicated.	

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Home health agency care Covered services include: • Part-time or intermittent skilled nursing and home health aide services. (To be covered under the home health care benefit, your skilled nursing and home health aide services combined cannot exceed up to and including eight (8) hours per day or 35 hours per week.) • Physical therapy, occupational therapy and speech therapy. • Medical social services. • Medical equipment and supplies.	Prior authorization may be required for selected services. $0 copay for Medicare-covered home health visits. Deductible applies. DME copay or coinsurance, if any, may apply. Deductible applies.	Prior authorization is requested. 20% coinsurance for Medicare-covered home health visits. Deductible applies. DME copay or coinsurance, if any, may apply. Deductible applies.
Hospice care You may receive care from any Medicare-certified hospice program. Original Medicare (rather than our plan) will pay the hospice provider for the services you receive. Your hospice doctor can be a network provider or an out-of-network provider. You will still be a plan member and will continue to get the rest of your care that is unrelated to your terminal condition through our plan. However, Original Medicare will pay for all of your Part A and Part B services. Your provider will bill Original Medicare for these services while your hospice election is in force. Covered services include: • Drugs for symptom control and pain relief, short-term respite care and other services not otherwise covered by Original Medicare. • Home care. • Hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit. **Hospice care (cont)**	You must receive care from a Medicare-certified hospice. When you enroll in a Medicare-certified hospice program, your hospice services and your Original Medicare services are paid for by the Original Medicare Plan, not your Medicare Advantage Plan. You pay a $0 copay for the one time only hospice consultation to a network primary care physician. Deductible does not apply. You pay a 10% coinsurance for the	You must receive care from a Medicare-certified hospice. When you enroll in a Medicare-certified hospice program, your hospice services and your Original Medicare services are paid for by the Original Medicare Plan, not your Medicare Advantage Plan. You pay a 20% coinsurance for the one time only hospice consultation to an out-of-network primary care physician. Deductible does

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
	one time only hospice consultation to a network specialist. Deductible does not apply.	not apply. You pay a 20% coinsurance for the one time only hospice consultation to an out-of-network specialist. Deductible does not apply.
Outpatient Services		
Physician services, including doctor's office visits Covered services include: • Office visits, including medical and surgical services in a physician's office or certified ambulatory surgical center. • Consultation, diagnosis and treatment by a specialist. • Hearing and balance exams, if your doctor orders it to see if you need medical treatment. • Telehealth office visits including consultation, diagnosis and treatment by a specialist. • Second opinion by another plan provider prior to surgery. • Physician services rendered in the home. • Outpatient hospital services. • Non-routine dental. 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 doctor. • Allergy testing and allergy injections.	$0 copay per visit to a network primary care physician (PCP) for Medicare-covered services. Deductible applies. 10% coinsurance per visit to a network specialist for Medicare-covered services. Deductible applies. $0 copay for allergy testing or for allergy injections. Deductible applies.	20% coinsurance per visit to an out-of-network primary care physician (PCP) for Medicare-covered services. Deductible applies. 20% coinsurance per visit to an out-of-network specialist for Medicare-covered services. Deductible applies. 20% coinsurance for allergy testing or for allergy injections. Deductible applies.
Chiropractic services Covered services include: • Manual manipulation of the spine to correct subluxation.	Prior authorization may be required. 10% coinsurnace for each Medicare-	Prior authorization is requested. 20% coinsurance for each Medicare-

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Chiropractic services (cont)	covered visit. Deductible applies.	covered visit. Deductible applies.
Podiatry services • Treatment of injuries and disease of the feet (such as hammer toe or heal spurs) • Medicare-covered routine foot care for member with certain medical conditions affecting the lower limbs. A foot exam is covered every six (6) months for people with diabetic peripheral neuropathy and loss of protective sensations.	10% coinsurance for each Medicare-covered visit. Deductible applies.	20% coinsurance for each Medicare-covered visit. Deductible applies.
Outpatient mental health care, including partial hospitalization services Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant or other mental health care professional as allowed under applicable state laws. "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	Prior authorization may be required after the 12th visit. Please contact the behavioral health care program associated with your plan. $0 copay for each Medicare-covered professional individual therapy visit. Deductible applies. $0 copay for each Medicare-covered professional group therapy visit. Deductible applies. $0 copay for each Medicare-covered professional partial hospitalization visit. Deductible applies. $0 copay for	Prior authorization is requested after the 12th visit. Please contact the behavioral health care program associated with your plan. 20% coinsurance for each Medicare-covered professional individual therapy visit. Deductible applies. 20% coinsurance for each Medicare-covered professional group therapy visit. Deductible applies. 20% coinsurance for each Medicare-covered professional partial hospitalization visit.

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Outpatient mental health care, including partial hospitalization services (cont)	each Medicare-covered outpatient hospital individual therapy visit. Deductible applies. $0 copay for each Medicare-covered outpatient hospital group therapy visit. Deductible applies $0 copay for each Medicare-covered partial hospitalization visit. Deductible applies.	Deductible applies. 20% coinsurance for each Medicare-covered outpatient hospital individual therapy visit. Deductible applies. 20% coinsurance for each Medicare-covered outpatient hospital group therapy visit. Deductible applies. 20% coinsurance for each Medicare-covered partial hospitalization visit. Deductible applies.
Outpatient substance abuse services	Prior authorization may be required after the 12th visit. Please contact the behavioral health care program associated with your plan. $0 copay for each Medicare-covered professional individual therapy visit. Deductible applies. $0 copay for each Medicare-	Prior authorization is requested after the 12th visit. Please contact the behavioral health care program associated with your plan. 20% coinsurance for each Medicare-covered professional individual therapy visit. Deductible applies. 20% coinsurance

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Outpatient substance abuse services (cont)	covered professional group therapy visit. Deductible applies. $0 copay for each Medicare-covered outpatient hospital individual therapy visit. Deductible applies. $0 copay for each Medicare-covered outpatient hospital group therapy visit. Deductible applies.	for each Medicare-covered professional group therapy visit. Deductible applies. 20% coinsurance for each Medicare-covered outpatient hospital individual therapy visit. Deductible applies. 20% coinsurance for each Medicare-covered outpatient hospital group therapy visit. Deductible applies.
Outpatient surgery (includes services provided at ambulatory surgical centers) (Facilities where surgical procedures are performed and the patient is released the same day)	Prior authorization is required for UPPP, gastric obesity surgery, Arthroscopy (shoulder/knee) surgery and all medically necessary cosmetic surgery. 10% coinsurance for each outpatient hospital facility or ambulatory surgical center visit for surgery.	Prior authorization is requested for UPPP, gastric obesity surgery, Arthroscopy (shoulder/knee) surgery and all medically necessary cosmetic surgery. $100 copay for each outpatient hospital facility or ambulatory surgical center visit for surgery.

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Outpatient surgery (includes services provided at ambulatory surgical centers) (cont)	Deductible applies. 10% coinsurance for each Medicare-covered observation room stay. Deductible applies.	Deductible applies. $100 copay for each Medicare-covered observation room stay. Deductible applies.
Outpatient hospital services, non-surgical	10% coinsurance for a visit to a physician in an outpatient hospital setting/clinic for non-surgical services. Deductible applies. 10% coinsurance for each Medicare-covered observation room stay. Deductible applies.	20% coinsurance for a visit to a physician in an outpatient hospital setting/clinic for non-surgical services. Deductible applies. $100 copay for each Medicare-covered observation room stay. Deductible applies.
Ambulance services Covered ambulance services include fixed wing, rotary wing and ground ambulance services to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person's health). The member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation are contraindicated (could endanger the person's health) and that transportation by ambulance is medically required. Ambulance service is not covered for physician office visits.	Prior authorization is required for non-emergent air and water transportation from network providers and requested from out-of-network providers. 10% coinsurance for Medicare-covered ambulance services Cost share, if any, is applied per one-way trip for Medicare-covered ambulance services. Deductible does not apply.	

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Emergency care • This coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed/received in the United States. • Emergency care copay is waived if the member is admitted to the hospital within 72 hours for the same condition.	$50 copay for each Medicare-covered emergency room visit. Deductible does not apply.	
Urgently needed care • Urgently needed care is available on a worldwide basis. • If you are outside of the service area for your plan, your plan covers urgently needed care, including urgently required renal dialysis. Your plan also covers urgently needed care if you are within the plan's service area, but it isn't reasonable under the circumstances to obtain medical care from a network provider. Generally, however, if you are in the plan's service area and your health is not in serious danger, you should obtain care from a network provider. • Urgently needed care copay is waived if the member is admitted to the hospital within 72 hours for the same condition.	10% coinsurance for each Medicare-covered urgently needed care visit. Deductible does not apply.	
Outpatient rehabilitation services Physical therapy, occupational therapy, speech and language therapy, cardiac rehabilitation services, intensive cardiac rehabilitation services, pulmonary rehabilitation services and Comprehensive Outpatient Rehabilitation Facility (CORF) services, in outpatient, office or home setting. Cardiac rehabilitation therapy is covered for patients who have had a heart attack in the last 12 months, have had coronary bypass surgery and/or have stable angina pectoris, have had a heart valve repair/replacement, angioplasty or coronary stenting or have had a heart or heart-lung transplant or other cardiac conditions as specified through a national coverage determination (NCD).	Prior authorization may be required for physical therapy, occupational therapy and speech therapy. 10% coinsurance for Medicare-covered physical, speech and occupational therapy visits. Deductible applies. 10% coinsurance for Medicare-	Prior authorization is requested for physical therapy, occupational therapy and speech therapy. 20% coinsurance for Medicare-covered physical, speech and occupational therapy visits. Deductible applies. 20% coinsurance for Medicare-

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Outpatient rehabilitation services (cont)	covered cardiac and pulmonary rehabilitation visits. Deductible applies.	covered cardiac and pulmonary rehabilitation visits. Deductible applies.
Durable medical equipment (DME) and related supplies Covered items include: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer and walker. Coinsurance only applies when you are not currently receiving inpatient care. If you are receiving inpatient care your DME will be included in the copay or coinsurance for those services.	Prior authorization is required for power operated vehicles, power wheelchairs and accessories, non-standard wheelchairs and non-standard beds. 10% coinsurance on all Medicare-covered DME. Deductible applies. $0 copay for supplies Deductible applies	Prior authorization is requested for power operated vehicles, power wheelchairs and accessories, non-standard wheelchairs and non-standard beds. 20% coinsurance on all Medicare-covered DME. Deductible applies. 20% coinsurance for supplies Deductible appies
Prosthetic devices and related supplies Devices (other than dental) that replace a body part or function. These include, but are not limited to, colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices and repair and/or replacement of prosthetic devices.	Prior authorization is required for prosthetics and orthotics. 10% coinsurance on all Medicare-covered prosthetics and orthotics. Deductible applies. $0 copay for supplies Deductible applies	Prior authorization is requested for prosthetics and orthotics. 20% coinsurance on all Medicare-covered prosthetics and orthotics. Deductible applies 20% coinsurance for supplies Deductible applies.

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Diabetes self-monitoring training and supplies For all people who have diabetes (insulin and non-insulin users) • Covered services include: blood glucose monitor, blood glucose test strips, lancet devices and lancets and glucose control solutions for checking the accuracy of test strips and monitors. • One (1) pair per year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two (2) additional pairs of inserts, or one (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes) for people with diabetes who have severe diabetic foot disease. • Self-management training is covered under certain conditions. • For persons at risk of diabetes, fasting plasma glucose tests are covered.	For Medicare-covered: 10% coinsurance for a 30-day supply on each purchase of glucose test strips, urine test strips, lancet devices and lancets and glucose control solutions for checking the accuracy of test strips and monitors. Deductible applies. 10% coinsurance for blood glucose monitor and therapeutic shoes. Deductible applies. 10% coinsurance for self-management training. Deductible applies. 10% coinsurance fasting plasma glucose tests covered up to twice a year. Deductible applies.	For Medicare-covered: 20% coinsurance for a 30-day supply on each purchase of glucose test strips, urine test strips, lancet devices and lancets and glucose control solutions for checking the accuracy of test strips and monitors. Deductible applies. 20% coinsurance for blood glucose monitor and therapeutic shoes. Deductible applies. 20% coinsurance for self-management training. Deductible applies. 20% coinsurance for fasting plasma glucose tests covered up to twice a year. Deductible applies.
Medical nutrition therapy For people with diabetes, renal (kidney) disease (but not on dialysis) and after a transplant when referred by your doctor	10% coinsurance for each Medicare-covered visit. Deductible applies.	20% coinsurance for each Medicare-covered visit. Deductible applies.

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Kidney disease education services Education to teach kidney care and help members make informed decisions about their care. For people with stage IV chronic kidney disease when referred by their doctor. We cover up to six (6) sessions of kidney disease education services per lifetime.	$0 copay for each Medicare-covered session Deductible applies.	20% coinsurance for each Medicare-covered session. Deductible applies.
Outpatient diagnostic tests, therapeutic services and supplies Covered services include: • X-rays. • Complex diagnostic tests and x-rays. • Radiation/chemotherapy. • Surgical supplies, such as dressings. • Supplies, such as splints and casts. • Laboratory tests. • Blood – including storage and administration. Coverage of whole blood and package red cells begins only with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. Certain diagnostic tests and x-rays are considered complex and include heart catheterizations, sleep studies, computed tomography (CT), magnetic resonance procedures (MRIs and MRAs) and nuclear medicine studies, which includes PET scans.	Prior authorization may be required for complex imaging, as well as limited diagnostic and therapeutic radiology services including but not limited to injectable/infusible medications, radiation therapy, PET, echocardiograms, CT, SPECT and MRI scans. $10 copay for each Medicare-covered x-ray visit. Deductible applies. $10 copay for each Medicare-covered complex diagnostic radiology visit. Deductible applies. $10 copay for each Medicare-covered radiation therapy & chemotherapy treatment.	Prior authorization is requested for complex imaging, as well as limited diagnostic and therapeutic radiology services including but not limited to injectable/infusible medications, radiation therapy, PET, echocardiograms, CT, SPECT and MRI scans. 20% coinsurance for each Medicare-covered x-ray visit. Deductible applies. 20% coinsurance for each Medicare-covered complex diagnostic radiology visit. Deductible applies. 20% coinsurance for each Medicare-covered radiation therapy & chemotherapy treatment.

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Outpatient diagnostic tests, therapeutic services and supplies (cont)	Deductible applies. $0 copay for supplies. Deductible applies. $0 copay for each Medicare-covered clinical/diagnostic lab test. Deductible applies. $0 copay per pint of blood. Deductible does not apply.	Deductible applies. 20% coinsurance for supplies. Deductible applies. 20% coinsurance for each Medicare-covered clinical/ diagnostic lab test. Deductible applies. $0 copay per pint of blood. Deductible does not apply.
Vision care Covered services include: • Outpatient physician services for eye care. • For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes and African-Americans who are age 50 and older: glaucoma screening once per year. • Eye exams: An eye exam to check for diabetic retinopathy once every 12 months. • One (1) pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.	For Medicare-covered services: 10% coinsurance for visits to a network primary care physician for exams to diagnose and treat diseases of the eye 10% coinsurance for visits to a network specialist for exams to diagnose and treat diseases of the eye. Deductible applies. 10% coinsurance for glaucoma screening Deductible does not apply.	For Medicare-covered services: 20% coinsurance for visits to an out-of-network primary care physician for exams to diagnose and treat diseases of the eye 20% coinsurance for visits to an out-of-network specialist for exams to diagnose and treat diseases of the eye. Deductible applies. 20% coinsurance for glaucoma screening Deductible does not apply.

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Vision care (cont)	10% coinsurance for glasses/ contacts following cataract surgery. Deductible applies.	20% coinsurance for glasses/ contacts following cataract surgery. Deductible applies.
Preventive Care and Screening Tests		
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it as a result of your "Welcome to Medicare" physical exam.	$0 copay for Medicare-covered screening. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a $0 copay will be applied for office services received from a network primary care physician, or a 10% coinsurance will be applied for office services received from a network specialist.	20% coinsurance Medicare-covered screening. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a 20% coinsurance will be applied for office services received from an out-of-network primary care physician, or a 20% coinsurance will be applied for office services received from an out-of-network specialist.
Bone mass measurements For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every two (2) years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	$0 copay for Medicare-covered bone mass measurement. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in	20% coinsurance for Medicare-covered bone mass measurement. Deductible does not apply. If an office visit, other than a routine physical

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Bone mass measurements (cont)	addition to the preventive service, a $0 copay will be applied for office services received from a network primary care physician, or a 10% coinsurance will be applied for office services received from a network specialist.	exam, is billed in addition to the preventive service, a 20% coinsurance will be applied for office services received from an out-of-network primary care physician, or a 20% coinsurance will be applied for office services received from an out-of-network specialist.
Colorectal screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. • Fecal occult blood test, every 12 months. For people at high risk of colorectal cancer, the following are covered: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months. For people not at high risk of colorectal cancer, the following is covered: • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy. In the event the procedure goes beyond a screening exam and involves biopsy or removal of any growth during the procedure, the procedure will be considered outpatient surgery, and the outpatient surgery member copayment will apply.	$0 copay for Medicare-covered screenings. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a $0 copay will be applied for office services received from a network primary care physician, or a 10% coinsurance will be applied for office services received from a network specialist.	20% coinsurance for Medicare-covered screenings. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a 20% coinsurance will be applied for office services received from an out-of-network primary care physician, or a 20% coinsurance will be applied for office services received from an out-of-network specialist.

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
HIV screening For people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test • Covered once every 12 months for persons without a pregnancy diagnosis • Covered up to three (3) times during a pregnancy	$0 copay for Medicare-covered screening. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a $0 copay will be applied for office services received from a network primary care physician, or a 10% coinsurance will be applied for office services received from a network specialist.	20% coinsurance for Medicare-covered screening. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a 20% coinsurance will be applied for office services received from an out-of-network primary care physician, or a 20% coinsurance will be applied for office services received from an out-of-network specialist.
Medicare Part B Immunizations Covered services include: • Pneumonia vaccine. • Flu shots, including H1N1, once a year in the fall or winter. • If you are at high or intermediate risk of getting Hepatitis B: Hepatitis B vaccine. • Other vaccines if you are at risk. If Part D prescription drug coverage is included with your medical plan, we also cover some vaccines under our outpatient prescription drug benefit.	$0 copay for Medicare-covered immunizations. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a $0 copay will be applied for office services received from a network primary care	$0 copay for Medicare-covered immunizations. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a 20% coinsurance will be applied for office services received from an

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Medicare Part B Immunizations (cont)	physician, or a 10% coinsurance will be applied for office services received from a network specialist.	out-of-network primary care physician, or a 20% coinsurance will be applied for office services received from an out-of-network specialist.
Mammography screening You can get this service on your own, without a referral from your provider. • One (1) baseline exam between the ages of 35 and 39 • One (1) screening every 12 months for women age 40 and older	Prior authorization is required for CT scans, MRIs and PET scans of the breast for non-emergent services. $0 copay for Medicare-covered screening exams. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a $0 copay will be applied for office services received from a network primary care physician, or a 10% coinsurance will be applied for office services received from a network specialist.	Prior authorization is requested for CT scans, MRIs and PET scans of the breast for non-emergent services. 20% coinsurance for Medicare-covered screening exams. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a 20% coinsurance will be applied for office services received from an out-of-network primary care physician, or a 20% coinsurance will be applied for office services received from an out-of-network specialist.

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Pap test, pelvic exam and clinical breast exam Covered services include: For all women, Pap tests, pelvic exams and clinical breast exams once every 24 months. If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one (1) Pap test every 12 months.	$0 copay for Medicare-covered screening exams. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a $0 copay will be applied for office services received from a network primary care physician, or a 10% coinsurance will be applied for office services received from a network specialist.	20% coinsurance for Medicare-covered screening exams. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a 20% coinsurance will be applied for office services received from an out-of-network primary care physician, or a 20% coinsurance will be applied for office services received from an out-of-network specialist.
Prostate cancer screening exams For men age 50 and older, the following are covered once every 12 months: • Digital rectal exam. • Prostate Specific Antigen (PSA) test.	$0 copay for Medicare-covered screening exams. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a $0 copay will be applied for office services received from a	20% coinsurance for Medicare-covered screening exams. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a 20% coinsurance will be applied for office

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Prostate cancer screening exams (cont)	network primary care physician, or a $10% coinsurance will be applied for office services received from a network specialist.	services received from an out-of-network primary care physician, or a 20% coinsurance will be applied for office services received from an out-of-network specialist.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) every five (5) years	$0 copay for Medicare-covered tests. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a $0 copay will be applied for office services received from a network primary care physician, or a 10% coinsurance will be applied for office services received from a network specialist.	20% coinsurance for Medicare-covered tests. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a 20% coinsurance will be applied for office services received from an out-of-network primary care physician, or a 20% coinsurance will be applied for office services received from an out-of-network specialist.
Other Services		
Physical exams Routine physical exams (limited to one (1) exam per year) are performed without relationship to treatment or diagnosis for specific illness, symptom, complaint, or injury and are not required by a third party (i.e., insurance companies, business	$0 copay for services rendered by a network primary care	20% coinsurance for services rendered by an out-of-

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Physical exams (cont) establishments, governmental agencies). Includes measurement of height, weight, body mass index, blood pressure, visual acuity screen and other routine measurements; an electrocardiogram; education, counseling and referral with respect to covered screening and preventive services. Routine labs and x-rays ordered in conjunction with the physical exam are covered under "Outpatient diagnostic tests and therapeutic services and supplies" unless otherwise specified in this benefit chart.	physician (PCP) $0 copay for services rendered by a network physician specialist Deductible does not apply.	network primary care physician (PCP) 20% coinsurance for services rendered by an out-of-network physician specialist Deductible does not apply.
Personalized prevention plan services (Annual Wellness Visit) Available to members in the first 12 months that they have Medicare Part B or 12 months after the member has the one-time initial preventative physical exam (Welcome to Medicare Physical Exam)	$0 copay for services rendered by a network primary care physician (PCP) $0 copay for services rendered by a network physician specialist Deductible does not apply.	$0 copay for services rendered by an out-of-network primary care physician (PCP) $0 copay for services rendered by an out-of-network physician specialist Deductible does not apply.
Renal Dialysis (Kidney) Covered services include: • Outpatient or physician office (including dialysis treatments when temporarily out of the service area). • Home dialysis or certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies and check your dialysis equipment and water supply). • Inpatient dialysis treatments (if you are admitted to a hospital for special care).	Prior notice is requested for all members initiating dialysis treatment. For Medicare-covered services: $0 copay for outpatient or, physician office visits.	Prior notice is requested for all members initiating dialysis treatment. For Medicare-covered services: $0 copay for outpatient or, physician office visits.

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Renal Dialysis (Kidney) (cont) • Self-dialysis training (includes training for you and others for the person helping you with your home dialysis treatments) • Home dialysis equipment and supplies.	Deductible does not apply. $0 copay for home dialysis or home support services. Deductible does not apply. Inpatient hospital coinsurance applies to inpatient dialysis. $0 copay for self-dialysis training. Deductible does not apply. $0 copay for home dialysis equipment and supplies. Deductible applies.	Deductible does not apply. $0 copay for home dialysis or home support services. Deductible does not apply. Inpatient hospital coinsurance applies to inpatient dialysis. 20% coinsurance for self-dialysis training. Deductible does not apply. 20% coinsurance for home dialysis equipment and supplies. Deductible applies.
Prescription drugs covered under your medical plan (Part B) "Drugs" includes substances that are naturally present in the body, such as blood clotting factors. Drugs that usually are not self-administered by the patient and are injected while receiving physician services. Your Medicare Advantage plan also covers some drugs that are "usually not self-administered" even if you inject them at home. • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by your Medicare Advantage plan • Clotting factors you give yourself by injection if you have hemophilia	Prior authorization may be required for certain injectables/ infusibles. 10% coinsurance up to a $100 out of pocket for Medicare Part B covered drugs. Deductible does not apply. 10% coinsurance up to a $100 out of	Prior authorization is requested for certain injectables/ infusibles. 10% coinsurance up to a $100 out of pocket for Medicare Part B covered drugs. Deductible does not apply. 10% coinsurance

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Prescription drugs covered under your medical plan (Part B) (cont) • Immunosuppressive drugs, if you have had an organ transplant that was covered by Medicare • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, Erythropoietin (Epogen®) or Epoetin Alfa and Darboetin Alfa (Aranesp®) • Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in your home If Part D prescription drug coverage is included with your medical plan, please refer to your prescription drug Evidence of Coverage for information on your Part D prescription drug benefits.	pocket for Medicare Part B covered chemotherapy drugs. Deductible does not apply.	up to a $100 out of pocket for Medicare Part B covered chemotherapy drugs. Deductible does not apply.
Additional Benefits		
Routine foot care Up to four (4) covered visits per year. Routine foot care includes the cutting or removal of corns and calluses, the trimming, cutting, clipping or debriding of nails and other hygienic and preventive maintenance care.	$0 copay for each routine foot care visit to network primary care physicians (PCP) 10% coinsurance for each routine foot care visit to network physician specialists Deductible applies.	$50 copay for each routine foot care visit to out-of-network primary care physicians (PCP) $50 copay for each routine foot care visit to out-of-network physician specialists Deductible applies.

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Hearing services Benefits include: • Routine hearing exams. Routine hearing exam is limited to one (1) per year.	10% coinsurance for routine hearing exams. Deductible does not apply.	20% coinsurance for routine hearing exams. Deductible does not apply.
Routine vision care • Routine vision exams Routine vision exams are limited to a $50 benefit maximum per year. Routine vision exam is limited to one (1) per year.	10% coinsurance for routine vision exams. Deductible does not apply.	20% coinsurance for routine vision exams. Deductible does not apply.
Acupuncture The services of a physician for acupuncture treatment to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion. We will pay for up to 24 visits during a calendar year. Chinese herbs and supplements are excluded	$0 copay per visit up to 24 visits per calendar year	Not covered
Health and Wellness		
SilverSneakers® You can enroll in this fitness program provided by SilverSneakers®, an independent company. A fitness plan designed especially for Medicare-eligible individuals, SilverSneakers® includes: • A complimentary basic membership in a participating fitness center in your area. You can use all the services available to fitness center members with a basic membership, such as steam and sauna rooms, exercise equipment and SilverSneakers® classes custom-designed for all levels of fitness.	$0 copay for the SilverSneakers® fitness benefit. Deductible does not apply.	

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
SilverSneakers® (cont) • Opportunities to join in fitness promotions and health education seminars. There is not a separate charge for this program, as long as you only use services available with basic fitness center memberships. After you enroll in this Medicare Advantage plan, you will receive a brochure that shows the participating fitness centers in your area and describes how to enroll in SilverSneakers®. Contact Customer Service for more information on this program, or visit www.SilverSneakers.com.		
Smoking cessation (counseling to quit smoking) Up to eight (8) face-to-face visits in a 12 month period if you are diagnosed with an illness caused or complicated by tobacco use; or, you take a medication that is affected by tobacco. These visits must be ordered by your doctor and provided by a qualified doctor or other Medicare-recognized practitioner.	$0 copay for each Medicare-covered visit. Deductible does not apply.	20% coinsurance for each Medicare-covered visit. Deductible does not apply.
Foreign travel emergency and urgently needed care Emergency or urgently needed care services while traveling outside the United States during a temporary absence of less than six (6) months. Outpatient copay is waived if member is admitted to hospital within 72 hours for the same condition. • Emergency outpatient care • Urgently needed care • Inpatient care (60 days per lifetime) This coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed/received in the United States.	$50 copay for emergency care. Deductible does not apply. 10% coinsurance for urgent care. Deductible does not apply. 10% coinsurance per admission for emergency inpatient care. Deductible does not apply.	
Medicare-approved clinical research studies A clinical research study is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study.	After Original Medicare has paid its share of Medicare-approved study, this plan will pay the difference between what Medicare has paid and this plan's	

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Medicare-approved clinical research studies (cont) If you participate in a Medicare-approved study, Original Medicare pays the doctors and other providers for the covered services you receive as part of the study. Although not required, we ask that you notify us if you participate in a Medicare-approved research study.	cost sharing for like services. Any remaining plan cost sharing you are responsible for will accrue toward this plan's out of pocket maximum.	
Annual out of pocket maximum All coinsurance, copayments and deductibles listed in this benefit chart are accrued toward the medical plan out of pocket maximum with the exception of routine vision, routine hearing, routine foot care, and any foreign travel emergency and urgently needed care cost-sharing amounts. Part D prescription drug deductibles and copays do not apply to the medical plan out of pocket maximum.	$1,100	

Access to prescription coverage just makes sense.

Medical care and prescription needs seem to go hand in hand. So that's why your Anthem Medicare Preferred (PPO) plan includes prescription drug benefits, so you don't have to purchase a separate prescription drug plan. Your coverage includes access to all of the same prescription options you would have under a stand alone Medicare Part D drug plan, but with typically less out-of-pocket costs. What's more, you have the convenience of having one ID card you can use for either medical or drug plan coverage and just one customer service phone number to call with any questions you might have.

Accessing your pharmacy benefits is as simple as using your medical benefits.

- ✓ Visit one of our participating plan pharmacies.
- ✓ Show your ID card.
- ✓ Pay the required amount, based on whether the drug is generic or brand name.
- ✓ You're done!

As a reminder, you should always use a participating network pharmacy unless you're facing an unusual circumstance in which no participating pharmacy is near your location.

Anthem takes care of the rest, including any paperwork that would normally be filed.

Your coverage includes access to broad pharmacy networks with more than 63,000 retail pharmacies available across the country. You can feel confident that your Anthem Member ID card will be accepted and honored without question when you use any Anthem Medicare Preferred (PPO) plan pharmacy.

Y0071_11_10255_I 07/19/2010

Assistance for those who need help paying for prescriptions

If you have concerns about being able to afford the cost of your coverage, you may qualify for assistance. This assistance includes help with paying for your monthly premium as well as any required out-of-pocket costs you would typically pay as required by your benefits coverage, such as a copayment. Our customer service staff can help you determine if this additional layer of support is available to you. You can also call 1-800 MEDICARE (1-800-663-4227). TTY/TDD users should call 1-877-486-2048. Representatives from Medicare are available to help you 24 hours a day, 7 days a week. Or you can contact the Social Security Administration at 1-800-772-1213 between the hours of 7 a.m. to 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778 or your local State Medicaid office.

Retail plan pharmacies for short-term prescriptions

Retail plan pharmacies will fill your prescription for up to a 30-day supply of medication. For added convenience, some retail plan pharmacies will fill prescriptions for the mail order quantity listed in your benefit chart.

Mail order pharmacy services for maintenance medications

For prescriptions that you take on an ongoing basis, we offer the convenience of ordering through our preferred mail order pharmacy. You will get the most from your prescription drug benefits when you use our mail order pharmacy. You may order through the mail or by phone.

Using your pharmacy benefits is as easy as 1–2–3

1. Use participating **retail plan pharmacies** for short-term prescriptions
2. Sign up for **mail order pharmacy services** for prescriptions you'll need longer term
3. Members can order their long-term prescription refills by **phone or through the mail.**

Generic versus brand name drugs — don't be fooled by brand name promises

Television and radio ads. Magazine ads. Even free samples at your health care professional's office. It's no coincidence that certain brand name prescriptions have become so well known. But don't get caught by the hype. Generic drugs contain all of the same active ingredients as their brand name counterparts and must undergo all of the same scrutiny by the Food and Drug Administration before they can be made available to the public. Generic medications simply cost less, making them a great alternative if you're looking to save on your medication expenses.

In fact, your plan benefits may include coverage for "select generics" at no cost! Select generics are a specific list of drugs that have been on the market long enough to have a proven track record for effectiveness and value. Check the enclosed drug benefit chart to see if your plan covers select generics.

Sometimes your health care professional will prescribe a particular brand name drug to treat a specific condition. Because brand name drugs are more expensive, your share of the costs will be higher for brand name prescription medications.

But even if you need to take a particular brand name drug because your health care professional thinks it will work better for you, you can still save on costs because your Anthem Medicare Preferred (PPO) plan provides two levels of brand name drug coverage – preferred brand name drugs and non-preferred brand name drugs. Your share of the costs will be lower for preferred brand name drugs because we pass our preferred brand savings on to you.

The complete package of information you will receive following your enrollment will include more details about your prescription drug coverage.

Y0071_11_10255_I 07/19/2010

Your 2011 LPPO Prescription Drug Benefit Chart
Premier 10/25/40
University of Maine System – Effective January 1, 2011

Formulary	Premier 3 Tier – Open
Deductible	**$0**
Covered Services	**What you pay**
Initial Coverage	
Below is your payment responsibility until the cost paid by you for your prescriptions reaches your True Out of Pocket costs of $4,550.	
Retail Pharmacy	per 30-day supply (Specialty limited to a 30 day supply)
• Generics, including Specialty Drugs • Select Generics	$10 copay $0 copay for Select Generics
• Preferred Brands, including Specialty Drugs and Vaccines	$25 copay
• Non-Preferred Brands and Non-Formulary Drugs	$40 copay
Typically retail pharmacies dispense a 30-day supply of medication. Some of our retail pharmacies can dispense up to a 90-day supply of medication. If you purchase more than a 30-day supply at these retail pharmacies, you will need to pay one copay for each full or partial 30-day supply filled. For example, if you order a 90-day supply, you will need to pay three 30-day supply copays. If you get a 45-day or 50-day supply, you will need to pay two 30-day copays.	
Mail Order Pharmacy	per 90-day supply (Specialty limited to a 30 day supply; 30 day Retail copay applies)
• Generics, including Specialty Drugs • Select Generics	$20 copay $0 copay for Select Generics
• Preferred Brands, including Specialty Drugs and Vaccines	$50 copay
• Non-Preferred Brands and Non Formulary Drugs	$80 copay
If you purchase drugs at Retail or Mail Order Pharmacies that are not listed in our participating pharmacy directory, you will be responsible for all amounts over our negotiated cost. If you need an emergency supply of drugs and you are not near a Retail Pharmacy in our participating pharmacy directory, you will not be responsible for amounts over our negotiated costs.	
Vaccine Coverage	
The up front costs for vaccines will vary based upon where the vaccine is purchased and administered. Some vaccines, such as Flu Vaccines, are paid under your Medicare Part B coverage. Vaccines that are covered by Medicare Part B are not covered by your Part D plan. Please see your Evidence of Coverage booklet for a complete explanation of your vaccine coverage.	

A health plan with a Medicare contract.

Covered Services	What you pay
Catastrophic Coverage	
Your payment responsibility changes after the cost you have paid for prescription drugs reaches your True Out of Pocket cost of $4,550.	
• Generics, including Specialty Drugs • Select Generics	$2.50 copay or 5% coinsurance, whichever is greater (Specialty limited to 30 day supply) $0 copay for Select Generics
Preferred and Non-Preferred Brands including Specialty Drugs, Vaccines, and Non-Formulary Drugs	$6.30 copay or 5% coinsurance, whichever is greater (Specialty limited to 30 day supply)
Extra Covered Drug Group	
These are drugs that are covered by your plan that are often excluded from Part D Prescription Drug Plans. These drugs do not count towards your True Out of Pocket expenses. They do not qualify for lower Catastrophic copays.	
Benzodiazepines and Barbiturates **Cosmetics** **Cough and Cold** **DESI** **Over the Counter Vitamins and Minerals** **Erectile Dysfunction**	See Formulary for complete list of drugs covered
• Generics	You pay your retail or mail order generic copay
• Brands	You pay your retail or mail order brand copay

● Beginning in 2011, when the cost of Part D qualified drugs paid by you and this plan is more than $2840, you will receive help paying your share of the cost of most covered brand drugs from Drug Manufacturers. This help will continue until the cost of Part D qualified drugs paid by you and the Drug Manufacturer Discount reaches the True Out of Pocket amount shown on this Benefit Chart. Drug Manufacturers have agreed to provide a discount on brand drugs which Medicare considers Part D qualified drugs. Your plan covers some brand drugs beyond those covered by Medicare. The discount will not apply to benefits described in the “Extra Covered Drugs” section of this Benefit Chart.

For the best member experience, get to know the entire website.

Having access to prescription drug coverage is just one part of helping ensure you have a healthy retirement. That's why your Anthem Medicare Preferred (PPO) membership gives you full access to a website designed just for our retiree members for up-to-the minute health content and tools that can help you take your health to the next level.

Health Topics

Through Health Topics, a feature of MyHealth@Anthem on our member website, you can learn how to eat better, exercise more, and get information about avoiding illness. Health Topics also includes information about alternative health options, daily health tips and condition centers for women and men, with topics ranging from important preventive care screenings all adults should take advantage of to dealing with stress and tips for better fitness routines. You can also access a library with thousands of articles related to health topics on self-care, medications, conditions, tests and treatments.

Online preventive care guidelines

When it comes to knowing what screenings you need and when, let our website be your guide. By using the Google search feature that is embedded within our site, you can type in preventive care guidelines and you'll be able to download and print them off. These guidelines are consistent with those endorsed by the American Academy of Family Physicians.

Electronic Newsletters

Take advantage of the weekly e-newsletters available through Health Topics that are tailored to the topics most important to you.

Web tools you can use 24/7*

- ✓ Online pharmacy with drug interaction checker
- ✓ MyHealth@Anthem Health Topics
- ✓ Online preventive care guidelines
- ✓ E-mailed newsletter featuring information on topics you've selected

*These website tools are available to you as perks to your membership. Because they are not contract benefits, they can change or be discontinued.

INS AND OUTS OF COVERAGE

INSIDE

- Eligibility requirements
- Geographic service areas covered by this plan
- Utilization management
- Preadmission certification
- Concurrent review
- Case management
- Your right to privacy
- Filing complaints
- Continuation of plan benefits
- Exclusions and limitations of your plan coverage
- Medicare basics
- HIPAA Notice of Privacy Practices
- Important contact information
  - First Impressions phone number (before enrollment)
  - Customer service phone number and address (after enrollment)
  - Dedicated website address
  - Medicare phone number and website

Y0071_11_10255_I 07/19/2010

Ins and Outs of Coverage

By now you should have a good overview of how your Anthem Medicare Preferred (PPO) plan benefits are designed. Be sure to read through this section as well to get more information about other details associated with plan coverage. This section includes information on your rights as a member, our commitment to ensuring your privacy, limitations and exclusions regarding your plan benefits, and your right to challenge coverage denials if you disagree with them.

Geographic service areas covered by this plan

This plan's service area includes all 50 states, Puerto Rico and Washington DC.

Eligibility requirements

As a general guideline, the following requirements must be met in order to be eligible for this prescription drug plan:

- you are currently entitled to Medicare Part A and/or enrolled in Part B
- your permanent residence is within the service area covered by this plan
- you continue to pay your Medicare Part B premiums, if not already being paid for under Medicaid or through another third party
- you are eligible for coverage under your (or your spouse's) current or former employer's group health plan retiree benefits

Note: Persons with End Stage Renal Disease may not be eligible to enroll. Please contact our Customer Service department for information on exceptions.

Utilization Management Disclosure Statement

Anthem staff will review some of the medical care proposed by your doctors to determine whether or not it meets benefit criteria for health care benefits as defined in your Evidence of Coverage and by applicable Medicare and Anthem guidelines. Additionally, Anthem staff may assist you in coordinating your care in order to maximize your benefits coverage and assist you in accessing the care you need. These activities are called "utilization management." For Anthem Medicare Preferred (PPO) products, the Utilization Management (UM) program components include:

- Preadmission Certification
- Concurrent Review
- Case Management

Preadmission Certification

Preadmission certification is the process of obtaining approval in advance of care. Advance approval may be necessary to receive coverage for medical care such as non-emergency hospital admissions, outpatient tests, outpatient surgery, visits to specialists, home health visits or nursing home admissions.

Your treating physician plays a central role in this process. Your physician may request preadmission certification from Anthem's precertification department by telephoning, faxing or mailing his/her request to Anthem. The precertification nurse at Anthem will then review the diagnosis and procedures for medical appropriateness under the terms of your benefit coverage. If the nurse can certify the service, the request will be authorized. If the service cannot be initially certified, the nurse will refer your physician's request to an Anthem physician reviewer for a decision. The Anthem physician reviewer may consult with your physician during the review process.

Anthem's precertification decisions are made using Medicare coverage criteria and guidelines. In addition, Anthem uses nationally recognized clinical guidelines such as Milliman and Roberts for medical necessity review, as well as internally developed clinical criteria. The Medicare guidelines, national clinical guidelines and internally developed criteria are available to physicians upon request for particular precertification decisions.

Concurrent Review

Anthem Utilization Management staff monitor hospital care during the inpatient stay. Utilization Managers from Anthem monitor hospital stays to help make sure that Anthem Medicare Preferred (PPO) members receive care that is medically necessary as defined in their Evidence of Coverage. During the concurrent review process the nurse may review patient charts and conduct face-to-face interviews with the patient (if appropriate), family members (if available) and hospital staff. Concurrent review also facilitates discharged planning for the member. In addition, the nurse may also help arrange post hospital care, including nursing home placement, home health care and durable medical equipment.

Case Management

Case management is a collaborative process between the member, the member's physician(s) and all other relevant individuals involved in the member's care that assesses, develops, implements, coordinates, monitors and evaluates case management plans designed to optimize the member's health care benefits. Using written or telephonic communication, the case manager empowers the member in exercising their benefit option(s) appropriate to individual health needs. The Case Managers assist the treating physician in coordinating benefits and care for members with complex and serious medical conditions.

A Case Manager:

- Collects and analyzes data about actual and potential member benefit needs for the purpose of developing a case management plan and this is accomplished through interaction with the member, significant other(s) and provider(s).
- Assessment includes gathering relevant data in the domains of not only benefit issues but cognitive status, medication management, social support, nutritional status, emotional status, environmental and care access issues.
- Develops a case management plan in collaboration with the member and provider and specifies individualized goals and interventions to meet the needs of the member within their available benefits.
- Monitors the interventions to ensure that the case management plan is effective and to determine if revisions or modifications are needed. Evaluation is ongoing during the coordination and monitoring phases to determine whether the plan is being implemented and if desired outcomes are being achieved.

The value of case management will be in the quality outcomes that contribute to the optimal health, function, benefit coverage and satisfaction of our members.

Your rights as a member of Anthem Medicare Preferred (PPO) plan coverage

Your privacy is important

Your medical records and other such information from physicians, facilities and /or other service providers shall be kept confidential. This information will not be disclosed in any manner that would be in violation of applicable federal or states laws.

Disenrolling from coverage

You may disenroll from your Anthem Medicare Preferred (PPO) plan, dependent on the terms established by either your former employer or the administrator of your plan coverage. Once we are notified in writing of your desire to disenroll, we will transfer the administration of your Medicare benefits back to Medicare by the first of the next month following receipt of your written notice.

You will have continued access to medical benefits until your effective date with Medicare resumes. Medicare will not penalize you in any way. You will also be provided with written notification of the effective date of your disenrollment.

If you choose to disenroll, you must continue to receive all medical services from your Anthem Medicare Preferred (PPO) plan until the effective date of your disenrollment.

Remember, if you ever disagree with a claim decision, a denial, a prior authorization request for prescription drug coverage or have a concern, you have options.

We will do our best to give you all the information you need and listen to your concerns. That's why we have both appeals and grievance procedures. We review complaints about grievances, including quality of care within 30 days from the receipt date of the grievance. Issues about payment for services (appeals) will be addressed within 60 days from the receipt date of the appeal. If the appeal is for a denied service, the reconsideration decision must be made no later than 30 days after receipt date of the appeal. However, if your health is at stake, we are required to respond to the appeal within 72 hours. Under certain circumstances, you also have the right to file an expedited grievance, which we must respond to within 24 hours from the grievance receipt date.

Important information about continuation of your plan benefits

By law, Anthem Blue Cross and Blue Shield can decide to terminate its agreement with the Centers for Medicaid and Medicare Services (CMS). In addition, CMS has the right to terminate its contract with Anthem. Termination by either party may result in the termination of your enrollment in Anthem Medicare Preferred (PPO) plan coverage. Anthem can also choose to reduce its service areas, for example no longer offering plan coverage in the state in which you live. For any of these scenarios, we would be required to notify you 60 days in advance in order to give you plenty of time to select other coverage to continue meeting your health care benefits needs.

Anthem Medicare Preferred (PPO) Medical Exclusions and Limitations

In addition to any exclusions or limitations described in the benefit chart, or anywhere else in this booklet, the following items and services are not covered by the plan:

1. Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as a covered services.
2. Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare. However, certain services may be covered under a Medicare-approved clinical research study.
3. Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.
4. Private room in a hospital, except when it is considered medically necessary.
5. Private duty nurses.
6. Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
7. Full-time nursing care in your home.
8. Custodial care, unless it is provided with covered skilled nursing care and/or skilled rehabilitation services. Custodial care, or non-skilled care, is care that helps you with activities of daily living, such as bathing, walking, getting in and out of bed, dressing, eating, using the restroom, preparation of special diets and supervision of medication that is usually self-administered.
9. Homemaker services which provide basic household assistance, including light housekeeping or light meal preparation.
10. Fees charged by your immediate relatives or members of your household.
11. Meals delivered to your home.
12. Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.

Y0071_11_10255_I 07/19/2010

13. Cosmetic surgery or procedures unless needed because of an accidental injury or to improve a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.

14. Routine dental care, such as cleanings, fillings or dentures unless specified otherwise in the benefit chart. However, non-routine dental care received at a hospital may be covered.

15. Unless specified otherwise in the benefit chart, chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.

16. Unless specified otherwise in the benefit chart, routine foot care, except for the limited coverage provided according to Medicare guidelines.

17. Unless specified otherwise in the benefit chart, Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease.

18. Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.

19. Unless specified otherwise in the benefit chart, hearing aids and routine hearing examinations.

20. Unless specified otherwise in the benefit chart, eyeglasses, routine eye examinations, radial keratotomy, LASIK surgery, vision therapy and other low vision aids. However, eyeglasses are covered for people after cataract surgery.

21. Unless specified otherwise in the benefit chart, prescription drugs for treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.

22. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.

23. Unless specified otherwise in the benefit chart, acupuncture.

24. Naturopath services (uses natural or alternative treatments).

25. Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan. We will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.

26. Benefits to the extent that they are available as benefits through any governmental unit (except Medicaid), unless otherwise required by law or regulation. The payment of benefits will be coordinated with such governmental units to the extent required under existing state or federal laws.

27. Services for illness or injury that occur as a result of any act of war, declared or undeclared if care is received in a governmental facility.

28. Services for court-ordered testing or care unless medically necessary and authorized by the plan.

29. Services for which you have no legal obligation to pay in the absence of this or like coverage.

30. Services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.

31. Charges in excess of the maximum allowable amount, unless otherwise specified in your Evidence of Coverage.

32. Charges for completion of claim forms or charges for medical records or reports unless otherwise required by law.

33. Charges for missed or canceled appointments.

34. Charges for services incurred prior to your effective date.

35. Charges for services incurred after the termination date of this coverage, except as specified elsewhere in your Evidence of Coverage.

36. Services or supplies primarily for educational, vocational or training purposes, except as otherwise specified in your Evidence of Coverage.

37. For self-help training and other forms of non-medical self-care, except as otherwise provided in your Evidence of Coverage.

38. Services that are not covered by Medicare unless specified in the benefit chart.

39. Any services listed above that aren't covered will remain not covered even if received at an emergency facility. For example, non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.

Anthem Medicare Preferred (PPO) Prescription Drug Exclusions and Limitations

In addition to any exclusions or limitations described in the benefit chart, or anywhere else in this booklet, the following items and services are not covered by the plan, unless the plan covers them as “Extra Covered Drug Groups”. Please see the “Extra Covered Drug Groups” section of the benefit chart in this booklet to find out which of the drugs listed below are covered under your plan.

1. Non-prescription drugs (or over-the-counter drugs)
2. Drugs when used to promote fertility
3. Drugs when used for the symptomatic relief of cough or colds
4. Drugs when used for treatment of anorexia, weight loss, or weight gain
5. Drugs when used for cosmetic purposes or to promote hair growth
6. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
7. Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
8. Drugs, such as Viagra, Cialis, Levitra, and Caverject, when used for the treatment of sexual or erectile dysfunction
9. Barbiturates and Benzodiazepines

Medicare Program Basics

What is Medicare?*

Medicare is a nationwide federal health insurance program available to most people age 65 or older, people under age 65 with certain disabilities, and people with End-Stage Renal Disease. Medicare benefits are divided into four parts: Medicare Parts A,B,C and D.

What is Medicare Part A?

Medicare Part A pays for services that hospitals provide, such as the room, nursing services and supplies for an inpatient stay. In some cases, Part A may pay for a skilled nursing facility, as well as home health and hospice care.

Part A will not cover all of your hospital costs. There is a deductible amount that you must pay each year before Medicare Part A will cover any hospital expenses. After your deductible has been paid, Medicare Part A pays 100% of your covered hospital charges for up to a 60-day hospital stay. If your hospital stay is over 60 days, you will have to pay coinsurance charges for each additional day.

Most people do not have to pay a monthly premium because Part A is funded by a portion of the Social Security tax you and your employers have already paid.

What is Medicare Part B?

Medicare Part B pays for services that doctors provide, in the hospital or in their offices. It also pays for outpatient hospital services, medically necessary long-lasting equipment such as wheelchairs and walkers, and other medical services and supplies.

Medicare Part B coverage has a monthly premium that you may arrange to pay by having it taken out of your Social Security check.

There is a deductible amount you must pay each year before Part B covers any of your expenses. After your deductible amount is met, Medicare pays a percentage of your covered health care services, and you are responsible for paying the remaining balance, or a set copay amount. If your doctor does not accept Medicare assignment, and charges you more than the Medicare approved amount for the health services you received, you may also be responsible for paying your doctor up to 15% over Medicare's approved charge.

* This document is intended to provide you with some basic facts about the Original Medicare Program. Detailed information about the Medicare Program is available through the Social Security Administration (1-800-772-1213, TTY/TDD 1-800-325-0778 or www.ssa.gov), Centers for Medicare & Medicaid Services (CMS) (1-800-MEDICARE (800-633-4227), TTY/TDD 1-877-486-2048 or www.cms.hhs.gov) and the National Association of Insurance Commissioners (NAIC) (1-800-686-1578, TTY/TDD 1-573-526-4536 or www.naic.org).

Y0071_11_10255_I 07/19/2010

Medicare Part C – A Medicare Advantage Plan

Certain private insurance companies offer Medicare Advantage plans, also referred to as Medicare Part C. Medicare Advantage Plans have a contract with Medicare that allows them to administer your Medicare benefits (Part A and Part B and sometimes Part D). The government, in turn, assigns your Medicare benefits to your Medicare Advantage Plan.

Medicare Advantage Plans also may provide enhanced benefits that go beyond those covered by Original Medicare; however, you may have to pay more or different cost sharing for the additional coverage.

With Medicare Part C, most and sometimes all of your Medicare covered benefits are handled by the Medicare Advantage Plan. Two exceptions are prescription drug benefits and Hospice. These may or may not be included in your Medicare Advantage Plan.

Medicare Part D – Prescription Drug Coverage

Anyone who is entitled to Medicare Part A or Medicare Part B is eligible to enroll in a Medicare Prescription Drug Plan (Medicare Part D). Once you are enrolled in Medicare Parts A and/or B, you have six months to enroll in an individual Part D plan. If you enroll after this time period, you may pay a late enrollment penalty unless you have other prescription coverage that is as good as or better than Standard Part D benefits. Retirees with employer coverage should contact their prior employers for Part D coverage options.

Medicare contracts with private companies to offer Medicare Part D prescription drug coverage. These companies are called Medicare Prescription Drug Plan Sponsors (PDPs). The drug benefits offered by PDPs vary across companies, but all plans must meet Medicare's standard benefit requirements or their equivalent to be Medicare approved PDPs.

Y0071_11_10255_I 07/19/2010

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Every year, we're required to send you specific information about your rights, your benefits and more. This can use up a lot of trees, so we've combined a couple of these required annual notices. Please take a few minutes to read about:

- State notice of privacy practices
- HIPAA notice of privacy practices
- Breast reconstruction surgery benefits

Want to save more trees? Go to www.anthem.com and sign up to receive these types of notices by e-mail.

State notice of privacy practices

As mentioned in our Health Insurance Portability and Accountability Act (HIPAA) notice, we must follow state laws that are stricter than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law. This applies to life insurance benefits, in addition to health, dental and vision benefits that you may have.

Your personal information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter.

We may collect PI about you from other persons or entities, such as doctors, hospitals or other carriers. We may share PI with persons or entities outside of our company — without your OK in some cases. If we take part in an activity that would require us to give you a chance to opt out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI. Because PI is defined as any information that can be used to make judgements about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you. A more detailed state notice is available upon request.

Please call the phone number printed on your ID card.

HIPAA notice of privacy practices

This notice describes how health, vision and dental information about you may be used and disclosed, and how you can get access to this information with regard to your health benefits. Please review it carefully.

We keep the health and financial information of our current and former members private, as required by law, accreditation standards and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For health care operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.

For treatment activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To you: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As allowed or required by law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and with coroners, funeral directors or medical examiners (about decedents). PHI can also be shared with organ donation groups for certain reasons, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for Workers' Compensation, to respond to requests from the U.S. Department of Health and Human Services, and to alert proper authorities if we reasonably believe

that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law. If you are enrolled with us through an employer-sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic Information: If we use or disclose PHI for underwriting purposes, we are prohibited from using or disclosing PHI that is genetic information of an individual for such purposes.

Your rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI, or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask him or her to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also, let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI. Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. Customer Service representatives can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information

We are dedicated to protecting your PHI, and have set up a number of policies and practices to help make sure your PHI is kept secure.

We keep your oral, written and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong out of areas where sensitive data is kept. Also, where required by law, our affiliates and nonaffiliates must protect the privacy of

data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential impact of other applicable laws

HIPAA (the federal privacy law) generally does not preempt, or override, other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact information

Please call Customer Service at the phone number printed on your ID card. Representatives can help you apply your rights, file a complaint or talk with you about privacy issues.

Copies and changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Breast reconstruction surgery benefits

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Anthem benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.

All applicable benefit provisions will apply, including existing deductibles, copayments and/or co-insurance. Contact your Plan administrator for more information.

Y0071_11_10255_I 07/19/2010

CONTACT INFORMATION

Questions or concerns? Keep these phone numbers as a handy future reference.

Anthem First Impressions Welcome Line

1-877-411-1647
TTY: 1-877-247-1657

Monday - Friday
8 a.m. to 8 p.m.

Please note:
The First Impressions phone number listed above is available to you for any initial questions you may have prior to your effective date. Please note that once your coverage is activated, future questions or concerns should be raised to the customer service phone number listed to the right.

Anthem Blue Cross and Blue Shield Customer Service

1-877-411-1640
TTY: 1-877-247-1657

Seven days a week
8 a.m. to 8 p.m.

P.O. Box 110
Fond du Lac, Wisconsin 54936

www.anthem.com/medicare
(Once on the site, select the Employer Groups link.)

Medicare

1-800-MEDICARE (1-800-633-4227)
TTY/TDD 1-877-486-2048

Seven days a week, 24 hours a day

www.medicare.gov

Finding a Blue Medicare Advantage PPO provider

To help you locate a participating provider:

1. call your plan's member service phone number on the back of your identification card during regular business hours,
2. call 1-800-810-BLUE to find a Blue Medicare Advantage PPO provider, or
3. Visit the "Doctor & Hospital Finder" at www.anthem.com to find a Blue Medicare Advantage PPO provider.

Y0071_11_10255_I 07/19/2010

TEAR OUT AND SHARE

HELPFUL INFORMATION TO SHARE WITH YOUR DOCTOR

INSIDE

The next few pages contain important information that can help those Anthem Medicare Preferred (PPO) living in or visiting areas without a provider network.

Please be sure to tear out this section and share it with your out-of-network doctor at your next visit.

Y0071_11_10255_I 07/19/2010

This Blue member is enrolled in an Anthem Medicare Preferred (PPO) plan. Under this plan, you do not need to be a contracting provider to see and treat this member. Members seeking services from providers located in an area without a Blue Medicare Advantage PPO provider network **receive the same benefits as members seeking services from network providers. Claims will be paid at the in-network benefit level.** If the member is an existing patient, please continue to care for them.

You can recognize an Anthem Medicare Preferred (PPO) member when their Blue Cross Blue Shield Member ID card has the following logo. All ID cards must display the Medicare Advantage PPO suitcase logo.

Recent government rule changes effective in 2009 enable health plans to enroll and cover some retiree group members in an Anthem Medicare Preferred (PPO) plan, even in areas where a formal provider network is not available.

Members seeking services from providers located in areas without a provider network, receive the same benefits as members seeking services in areas where network providers are available. The benefits will be paid at the in-network benefit level, resulting in lower copays and deductibles. They may receive care from any Medicare eligible provider, including all Medicare participating providers.

Out-of-network providers are not required to render services to members, although they are encouraged to do so. Please submit claims to your local Blue Cross and/or Blue Shield Plan. You will continue to receive payment based on Medicare Allowed Amount. You will be paid the full amount in a single payment – there is no need to file a claim for supplemental coverage. Members' claims will be adjudicated according to the benefits that their health care plan provides. The claims will be paid according to CMS guidelines. At a minimum, eligible claims will be reimbursed at the Medicare Allowed Amount. The Medicare Allowed Amount is the fee schedule reimbursement that Medicare would pay to a provider who accepts assignment of benefits for services rendered to a member.

For further information about this member's benefits, you may call 1-800-676-BLUE or send an electronic eligibility request transaction. Please contact your local Blue Cross and/or Blue Shield Plan for questions regarding claims submission or payment.

Y0071_11_10255_I 07/19/2010

UNIVERSITY OF MAINE SYSTEMS Anthem Medicare Preferred (PPO) Plan
OPT OUT FORM

Important information for retirees who choose not to take this coverage

Your membership will be automatically transferred to the new Anthem Medicare Preferred (PPO) plan unless you tell us you do not want to enroll in this new coverage. To opt out of this coverage, please fill out this Opt out form and return to the address at the bottom of the form. Please keep in mind that if you choose not to enroll in the Anthem Medicare Preferred (PPO) plan, you, or your spouse, may not be able to re-enroll in your retiree benefits, please check with your employer or union for their eligibility rules. DO NOT Complete this Opt-out form if you want to continue coverage in your employer or union retiree plan.

By my signature below, I acknowledge that I **do not** wish to participate in the **Anthem Medicare Preferred (PPO)** plan offering and hereby elect to cease participation in the **University Of Maine Systems** Retiree Plan **December 31, 2010** (last day of coverage).

I also acknowledge that:

- Once I drop my coverage I cannot re-enroll in **University of Maine Systems** Retiree Plan at a later date.
- As of **January 1, 2011**, I can see any doctor through the Original Medicare PART A & B Plan, unless I have enrolled in another Medicare Advantage Plan.

If you choose to opt-out, you may be eligible to enroll in another Medicare Advantage plan in your service area or elect to return to Original Medicare. You can also get information about the Medicare Program and Medicare health plans by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227) TTY/TTD 1-877-486-2048. Medicare representatives are available 24 hours a day, 7 days a week for any general questions you may have about Medicare health <or Part D drug> benefits.

Retiree Name: ______________________________ Medicare ID: ________________
Please print

Covered Spouse: ______________________________ Medicare ID: ________________
Please print

____ ____________________
Retiree Signature Date

____ ____________________
Covered Spouse Signature Date

Kindly provide a daytime telephone number: ______________________.

RETURN THIS FORM NO LATER THAN November 30, 2010 TO:

EBPA
Attn: Helen
37 Industrial Dr Ste E
Exeter, NH 03833

A Health plan with a Medicare contract.

Y0071_11_10528_I 8_27_2010

A PPO plan with a Medicare contract. Rocky Mountain Hospital and Medical Service, Inc. (dba Anthem Blue Cross and Blue Shield) is the legal entity that has contracted with the Centers for Medicare and Medicaid Services (CMS), and is the risk-bearing entity licensed under applicable state law, to offer the Preferred Provider Organization plan(s) (PPO) noted above or herein. Rocky Mountain has retained the services of the following related Anthem Blue Cross and Blue Shield companies and their authorized agents/brokers/producers to provide administrative services and/or to make the PPO plan(s) available in these regions: In Connecticut: Anthem Health Plans, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC) and RIT and certain affiliates administer non-HMO benefits underwritten by HALIC. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. In Wisconsin: Blue Cross Blue Shield of Wisconsin ("BCBSWi"), which underwrites or administers the PPO and indemnity policies. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

The SilverSneakers Fitness Program is provided by Healthways, Inc., an independent company. SilverSneakers® is a registered mark of Healthways, Inc.

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