

Plan Name:	Freedom Blue Classic (Regional PPO)	Freedom Blue Plan 1 (Regional PPO)	Freedom Blue Plus (Regional PPO)	SmartValue Classic (PFFS)	SmartValue Plus (PFFS)
Monthly Premium:	\$0.00	\$0.00	\$31.00	\$35.00	\$78.00
Plan Type:	RPPO	RPPO	RPPO	PFFS	PFFS
Office Visits (primary / specialist):	\$15 / \$30	\$15 / \$25	\$10 / \$25	\$25 / \$35	\$25 / \$35
Drug Coverage:	No	Yes	Yes	No	Yes
Physician Choice:	Yes	Yes	Yes	Yes	Yes
Chiropractic Services:	\$30	\$25	\$25	\$35	\$35
Lab Services:	\$10	\$15	\$10	\$35	\$35
Inpatient Hospital Maximum Out-of-Pocket:	Unlimited	Unlimited	Unlimited	\$1,680	\$1,680
Plan Features	Freedom Blue Classic (Regional PPO)	Freedom Blue Plan 1 (Regional PPO)	Freedom Blue Plus (Regional PPO)	SmartValue Classic (PFFS)	SmartValue Plus (PFFS)
Plan Type:	RPPO	RPPO	RPPO	PFFS	PFFS
Physician Choice:	In & Out-of-Network	In & Out-of-Network	In & Out-of-Network	Yes*	Yes*
Prescription Drugs:	No	Yes	Yes	No	Yes
Monthly Premium:	\$0.00	\$0.00	\$31.00	\$35.00	\$78.00
Out-of-Pocket Maximum:	\$500 Annual Deductible; \$3350 Out-of-Pocket Max (combined In and Out of Network)	\$500 Annual Deductible; \$3350 Out-of-Pocket Max (combined In and Out of Network)	\$500 Annual Deductible; \$3350 Out-of-Pocket Max (combined In and Out of Network)	\$5,000	\$5,000
Doctor Office Visits:	In-Network: \$15 copay, Specialists \$30 copay; Out-of-Network: \$30 copay, Specialists \$45 copay	In-Network: \$15 copay, Specialists \$25 copay; Out-of-Network: \$30 copay, Specialists \$40 copay	In-Network: \$10 copay, Specialists \$25 copay; Out-of-Network: \$25 copay, Specialists \$40 copay	\$25 copay, Specialists \$35 copay	\$25 copay, Specialists \$35 copay
Chiropractic Services:	In-Network: \$30 Copay Medicare-covered & \$20 Routine; Out-of-Network: You pay 30% Medicare-covered & 50% Routine	In-Network: \$25 Copay; Out-of-Network: You pay 30%	In-Network: \$25 Copay Medicare-covered & \$20 Routine; Out-of-Network: You pay 30% Medicare-covered & 50% Routine	\$35 copay	\$35 copay
Lab Services:	In-Network: \$10 Copay; Out-of-Network: You pay 30%	In-Network: \$15 Copay; Out-of-Network: You pay 30%	In-Network: \$10 Copay; Out-of-Network: You pay 30%	\$35 copay (Additional office copay may apply)	\$35 copay (Additional office copay may apply)
X-Rays:	In-Network: \$30 Copay; Out-of-Network: You pay 30%	In-Network: \$25 Copay; Out-of-Network: You pay 30%	In-Network: \$25 Copay; Out-of-Network: You pay 30%	\$75 copay	\$75 copay
Complex Diagnostic Tests:	In-Network: \$100 copay; Out-of-Network: \$150 copay	In-Network: \$150 copay; Out-of-Network: \$200 copay	In-Network: \$100 copay; Out-of-Network: \$150 copay	\$125 copay	\$125 copay
Emergency Care:	\$50 copay	\$50 copay	\$50 copay	\$50 copay	\$50 copay
Urgently Needed Care:	\$35 copay	\$35 copay	\$35 copay	\$25 to \$35 copay	\$25 to \$35 copay
Ambulance Services:	\$100 copay	\$175 copay	\$100 copay	\$125 copay	\$125 copay
Durable Medical Equipment:	In-Network: You pay 20% for each item; Out-of-Network: You pay 30% for each item.	In-Network: You pay 20% for each item; Out-of-Network: You pay 30% for each item.	In-Network: You pay 20% for each item; Out-of-Network: You pay 30% for each item.	You pay 20% for each item.	You pay 20% for each item.
Inpatient Hospital Care:	In-Network: You pay \$850 per stay. No out-of-pocket max; Out-of-Network: You pay 15%. No out-of-pocket max.	In-Network: You pay \$850 per stay. No out-of-pocket max; Out-of-Network: You pay 15%. No out-of-pocket max.	In-Network: You pay \$850 per stay. No out-of-pocket max; Out-of-Network: You pay 15%. No out-of-pocket max.	You pay \$280 each day for day(s) 1-6 at a hospital. There is no copayment for additional days at a hospital. Maximum out-of-pocket: \$1,680 each year.	You pay \$280 each day for day(s) 1-6 at a hospital. There is no copayment for additional days at a hospital. Maximum out-of-pocket: \$1,680 each year.
Skilled Nursing Facility:	In-Network: No copay for day(s) 1-20, You pay \$130 for days 21-100. You are covered for 100 days each benefit period; Out-of-Network: You pay 30%. You are covered for 100 days each benefit period.	In-Network: No copay for day(s) 1-20, You pay \$130 for days 21-100. You are covered for 100 days each benefit period; Out-of-Network: You pay 15%. You are covered for 100 days each benefit period.	In-Network: No copay for day(s) 1-20, You pay \$130 for days 21-100. You are covered for 100 days each benefit period; Out-of-Network: You pay 15%. You are covered for 100 days each benefit period.	No copay for day(s) 1-20, \$130 each day for days 21-100. You are covered for 100 days each benefit period.	No copay for day(s) 1-20, \$130 each day for days 21-100. You are covered for 100 days each benefit period.

Home Health Care:	In-Network: \$0 Copay; Out-of-Network: You pay 30%.	In-Network: \$0 Copay; Out-of-Network: You pay 30%.	In-Network: \$0 Copay; Out-of-Network: You pay 30%.	You pay 0% for each visit.	You pay 0% for each visit.
Physical Exams:	In-Network: \$0 copay. Up to one exam every year; Out-of-Network: You pay 30%.	In-Network: \$0 copay. Up to one exam every year; Out-of-Network: You pay 30%.	In-Network: \$0 copay. Up to one exam every year; Out-of-Network: You pay 30%.	\$0 copay. Up to one exam every year.	\$0 copay. Up to one exam every year.
Preventive Screenings & Immunizations:	In-Network: \$0 copay (Additional office copay may apply); Out-of-Network: You pay 30%.	In-Network: \$0 copay (Additional office copay may apply); Out-of-Network: You pay 30%.	In-Network: \$0 copay (Additional office copay may apply); Out-of-Network: You pay 30%.	You pay \$0. (Additional office copay may apply)	You pay \$0. (Additional office copay may apply)
Hearing Exams:	In-Network: \$30 copay for each diagnostic hearing exam. \$0 copay for each routine hearing exam; Out-of-Network: You pay 30% for each diagnostic or routine hearing exam.	In-Network: \$25 copay for each diagnostic hearing exam; Out-of-Network: You pay 30% for each diagnostic hearing exam.	In-Network: \$25 copay for each diagnostic hearing exam. \$0 copay for each routine hearing exam; Out-of-Network: You pay 30% for each diagnostic or routine hearing exam.	\$35 copay. Up to one routine test every two years.	\$35 copay. Up to one routine test every two years.
Vision Exams:	In-Network: \$30 copay for each diagnostic vision exam. \$20 copay for each routine exam (one routine exam every 12 months); Out-of-Network: You pay 30% for each diagnostic vision exam. Maximum coverage allowed for each routine exam: \$40 every year.	In-Network: \$25 copay for each diagnostic vision exam. \$20 copay for each routine exam (one routine exam every 12 months); Out-of-Network: You pay 30% for each diagnostic vision exam. Maximum coverage allowed for each routine exam: \$40 every year.	In-Network: \$25 copay for each diagnostic vision exam. \$20 copay for each routine exam (one routine exam every 12 months); Out-of-Network: You pay 30% for each diagnostic vision exam. Maximum coverage allowed for each routine exam: \$40 every year.	\$35 copay for each diagnostic or routine eye exam. Limited to one routine exam per year.	\$35 copay for each diagnostic or routine eye exam. Limited to one routine exam per year.
Outpatient Prescription Drugs:	You pay 100% for most prescription drugs. This plan does not cover Medicare Part D prescription drugs.	Uses formulary. No deductible. In-network preferred pharmacy 30 day supply:\$7 Generic/\$43 Pref. Brand/\$85 Non-Pref. Brand. Mail Order 90 day supply:\$10.50 Generic/\$107.50 Pref. Brand/\$212.50 Non-Pref. Brand. See Summary of Benefits.	Uses formulary. No deductible. In-network preferred pharmacy 30 day supply:\$7 Generic/\$43 Pref. Brand/\$85 Non-Pref. Brand. Mail Order 90 day supply:\$10.50 Generic/\$107.50 Pref. Brand/\$212.50 Non-Pref. Brand. See Summary of Benefits.	You pay 100% for most prescription drugs. This plan does not cover Medicare Part D prescription drugs.	Uses formulary. No deductible. In-network preferred pharmacy 30 day supply:\$8 Generic/\$44 Pref. Brand/\$85 Non-Pref. Brand. Mail Order 90 day supply:\$12 Generic/\$110 Pref. Brand/\$212.50 Non-Pref. Brand. See Summary of Benefits.
Notes:				*You may see and obtain services from any licensed physician, hospital, or other provider who can provide services to Medicare beneficiaries and who is willing to accept the terms and conditions of the plan.	*You may see and obtain services from any licensed physician, hospital, or other provider who can provide services to Medicare beneficiaries and who is willing to accept the terms and conditions of the plan.
Misc:	Please note that this is an overview of benefits. Please refer to the plan's Summary of Benefits for a complete description of coverage. Premium rates are based upon responses to the previous demographic questions.	Please note that this is an overview of benefits. Please refer to the plan's Summary of Benefits for a complete description of coverage. Premium rates are based upon responses to the previous demographic questions.	Please note that this is an overview of benefits. Please refer to the plan's Summary of Benefits for a complete description of coverage. Premium rates are based upon responses to the previous demographic questions.	Please note that this is an overview of benefits. Please refer to the plan's Summary of Benefits for a complete description of coverage. Premium rates are based upon responses to the previous demographic questions.	Please note that this is an overview of benefits. Please refer to the plan's Summary of Benefits for a complete description of coverage. Premium rates are based upon responses to the previous demographic questions.

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Medicare Advantage and Medicare Advantage with Prescription Drug Plans:

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The Medicare Contract is renewed annually, and the availability of coverage beyond the end of the current year is not guaranteed. You are eligible to enroll if you are entitled to Medicare Part A and enrolled in Medicare Part B and you live in the service area. You must continue to pay your Medicare Part B premium if not otherwise paid for under Medicaid or by another third party. With some exceptions you can only enroll during certain times of the year.

If you decide to switch to premium withhold or move from premium withhold to direct bill, it could take up to three months for it take effect and you will ultimately be held responsible for those premiums. Medicare beneficiaries may enroll in our Medicare Advantage and Part D plans through the Centers for Medicare & Medicaid Services Online Enrollment Center, located at www.medicare.gov. For more information please contact our [Customer Service Department](#).

Please reference the Evidence of Coverage for information rights and responsibilities upon disenrollment, and any

applicable conditions associated with using the plan benefits.

For information on the availability of other formats, or full information on Plan benefits please call our [Customer Service Department](#).

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for getting Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/days a week;
- The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778; or
- Your State Medicaid Office.

Medicare Prescription Drug Plans:

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