Medicare Part D Group Plan

Enrollment Guide

Plan overview | Benefit highlights | Brand perks | How to enroll

Anthem

Retired Indiana Public Employees Insurance Trust (RIPEA)

Blue MedicareRx (PDP) with Senior Rx Plus

01/01/24 - 12/31/24

Get to know your group plan

Plan highlights

PDP stands for prescription drug plan

Medicare Part D prescription drug plans (PDPs) cover prescription drugs not covered by Original Medicare (Parts A and B).

RIPEA offers you this Blue MedicareRx (PDP) with Senior Rx Plus plan. As a member, you'll get prescription drug coverage and so much more, including:

- Coverage on commonly prescribed drugs
- $0 copays on select generics
- Plan pharmacies nationwide
- Discounted rates on health products and services
- Savings on prescriptions with home delivery

Questions?

Call our **First Impressions Welcome Team** for answers or plan details, and provide them with this group specific code IN004GRX.
1-866-646-2436 (TTY: **711**) **Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays**

Prescription drug benefit highlights

You'll save money on prescription drugs with:

Covered medications

We cover generic, brand name, and specialty drugs that Medicare Part D allows us to cover.

Choosing covered generic drugs may save you money without sacrificing effectiveness. Generics have the same active ingredients and effects as brand name drugs, generally without the higher cost share. Generic drugs on our select generics list have a $0 copay.

Network pharmacies

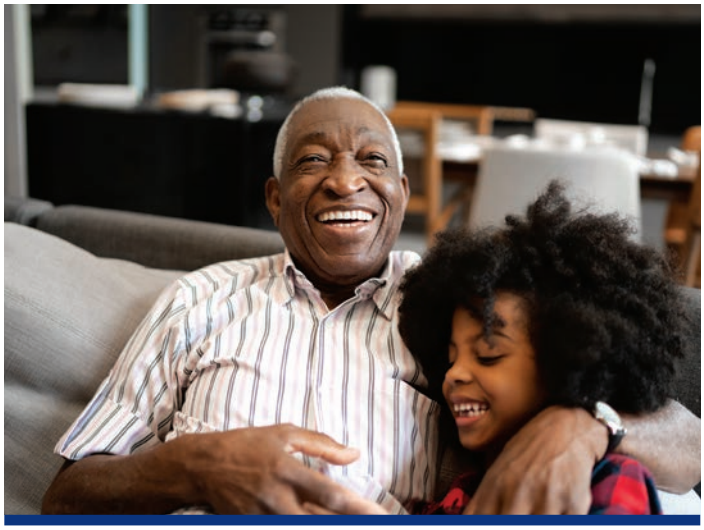
Save by filling your prescriptions at any of our 65,000 network pharmacies. Most national chains and many local pharmacies are in our National Discount Network.

Choose home delivery through CarelonRx pharmacy for convenience and savings. You'll get up to 90 days of supplies — often at a lower cost than if you were to fill the same amount at a regular pharmacy. It saves time as well.

See your *Summary of Benefits* located in the appendix for more details or call our First Impressions Welcome Team if you have questions about RIPEA Blue MedicareRx (PDP) with Senior Rx Plus plan benefits, and provide them with this group specific code IN004GRX. **1-866-646-2436** (TTY: **711**) **Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays**

What is Medicare?

This plan is a Medicare Part D prescription drug plan



Medicare is a federal government health insurance program for people:

- Over age 65.
- Under age 65 with certain disabilities.
- With end-stage renal disease (ESRD).
- With amyotrophic lateral sclerosis (ALS), also called Lou Gehrig's disease.

More information is available at **www.medicare.gov** or you can call **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Medicare is available as follows:

Original Medicare

- Part A provides coverage for hospital benefits.
- Part B provides medical benefits.

Medicare Advantage

- Also called Part C.
- Bundles Parts A and B.
- Offers supplemental benefits and a first class member service experience.
- Can include Part D, the prescription drug plan.

Medicare Part D is a Medicare-approved plan available only through private insurance companies. The added benefits it offers are listed throughout this guide.

Original Medicare = government program		Offered by private insurance companies	
Medicare Part A	Medicare Part B	Medicare Part C	Medicare Part D
Original Medicare + Part C = Medicare Advantage			
Medicare Advantage + Part D = MAPD plan			

Medicare Part D

The prescription drug plan described in this guide is also known as a Medicare Part D plan. All of our covered drugs appear on a drug list called the Part D formulary.

If you take a medicine that is not covered, you have three options:

- Ask your doctor to switch you to a covered drug
- Request an exception
- Request a temporary supply while discussing other drug options

Drug type	Description	Possible tier coverage[2]	Cost
Generic[1]	Same active ingredients and effects as brand-name drug without the brand-name	Tier 1	$
Preferred brand-name	Safe and effective brand-name drugs that may not have a generic alternative	Tier 2	$$
Non-preferred brand-name	Less commonly used brand-name drugs that usually have a generic alternative	Tier 3	$$$
Specialty	Cost $950 or more for a 30-day supply. May require special handling.	Highest tier	$$$$

Covered drugs are divided into levels or tiers. Drugs on the lowest-numbered tier generally cost less, while drugs on the highest-numbered tier generally cost the most. Each tier contains drugs that we cover based on their safety and effectiveness. This chart provides an overview of how the tiers and pricing generally work.

1 High-cost generic medications may also appear on the same tiers as brand-name medications. Please consult the formulary for specific tier details.

2 Some drug lists divide generic drugs into two tiers. For those lists, the tier number increases by one for all tiers after the first. For example, Tier 1 becomes Tier 1 and Tier 2, and the numbering continues up the tiers.

$0 copay for select generics

These select generics have the same active ingredients and effects as brand name drugs for a $0 copay. If you don't see one of your drugs here, you can call us to check the full drug list for you.[1]

Use	Name	
Cardiovascular	Amlodipine/benazepril capsule	Irbesartan tablet
	Atenolol tablet	Irbesartan/hydrochlorothiazide tablet
	Atenolol/chlorthalidone tablet	Lisinopril tablet
	Benazepril tablet	Lisinopril/hydrochlorothiazide tablet
	Benazepril/hydrochlorothiazide tablet	Losartan potassium tablet
	Bisoprolol fumarate tablet	Losartan potassium/ hydrochlorothiazide tablet
	Bisoprolol/hydrochlorothiazide tablet	Metoprolol tartrate tablet
	Carvedilol tablet	Olmesartan tablet
	Chlorthalidone tablet	Quinapril tablet
	Enalapril maleate tablet	Ramipril tablet
	Enalapril/hydrochlorothiazide tablet	Trandolapril tablet
	Fosinopril tablet	Valsartan tablet
	Furosemide tablet	Valsartan/hydrochlorothiazide tablet
	Hydrochlorothiazide capsule/tablet	
Cholesterol	Atorvastatin tablet	Rosuvastatin tablet
	Lovastatin tablet	Simvastatin tablet[2]
	Pravastatin sodium tablet	
Diabetes	Glimepiride tablet	Metformin ER tablet[2]
	Glipizide ER tablet	Metformin tablet
	Glipizide tablet	Pioglitazone tablet
	Glipizide/metformin hcl tablet	
Osteoporosis	Alendronate sodium tablet	

1 This list is current as of May 2023 and is subject to change. It is not a complete list of covered drugs.

2 Not all dosages are covered at the select generics cost share.

Top 50 most prescribed drugs we cover

If you don't see one of your drugs here, you can call us to check the full drug list for you.[1]

amlodipine besylate
atorvastatin calcium
amlodipine besylate
levothyroxine sodium
losartan potassium
lisinopril
metoprolol succinate
rosuvastatin calcium
gabapentin
ELIQUIS[2]
omeprazole
pantoprazole sodium
tamsulosin
furosemide
hydrochlorothiazide
metformin
hydrocodone-acetaminophen

simvastatin[2]
metoprolol tartrate
prednisone
carvedilol[2]
tramadol
albuterol sulfate HFA
SYNTHROID
sertraline
potassium chloride
clopidogrel
escitalopram oxalate
trazodone
montelukast sodium
pravastatin sodium
amoxicillin
famotidine
alprazolam

meloxicam
allopurinol
fluticasone propionate
latanoprost
azithromycin
duloxetine
zolpidem tartrate
ezetimibe
metformin ER
cephalexin
finasteride
atenolol
diclofenac sodium
XARELTO
lorazepam
donepezil
oxycodone-acetaminophen

Generic drugs appear in lowercase (lisinopril, for example), while brand-name drugs are in uppercase (ELIQUIS, for example).

1 This list is current as of May 2023 and is subject to change. It is not a complete list of covered drugs.

2 Not all dosages are covered at the select generics cost share.

Health and savings with SpecialOffers

Our members receive discounts on these products and services:

Fitness and healthy living

The ChooseHealthy® program*

- Discounts on services such as acupuncture, chiropractic care, and therapeutic massage, from a nationwide network of healthcare providers.
- Discounts on fitness and wellness products such as activity trackers and equipment, with access to online health and wellness classes at no additional cost.

Fitbit®
Save up to 22% on select Fitbit trackers and smartwatches.

Garmin®
20% off select Garmin wellness devices.

GlobalFit™
Discounts on gym memberships, fitness equipment, and coaching.

Puritan's Pride®
10% off vitamins, supplements, and minerals.

SelfHelpWorks
Choose one of the online living programs and save 15% on coaching to help you lose weight, stop smoking, manage stress or diabetes, restore sound sleep, or address an alcohol problem.

The Active&Fit Direct™ program*

- Choose from 16,000+ participating fitness centers nationwide
- Digital workouts at no extra cost
- No long-term contracts
- Lifestyle coaching is available

* The ChooseHealthy program is provided by ChooseHealthy, Inc. and the Active&Fit Direct program is provided by American Specialty Health Fitness, Inc. (ASH Fitness). ChooseHealthy, Inc. and ASH Fitness are subsidiaries of American Specialty Health Incorporated (ASH). ChooseHealthyand Active&Fit Direct are trademarks of ASH and used with permission herein. The ChooseHealthy program is a discount program; it is not insurance. You can access services from any ChooseHealthy participating provider; referral from a primary care physician is not required. You are responsible for paying the discounted fee directly to the contacted provider.

Health and savings with SpecialOffers

Family and home offerings

Allergy Control and National Allergy

- Save up to 25% on select products.
- Free ground shipping on all orders over $59 when shipping ground within the United States.

23andMe

- $40 off each Health + Ancestry Service kit
- 20% off one 23andMe kit — learn about your wellness, and ancestry.

Vision

1-800 CONTACTS® or Glasses.com™

- $20 off orders of $100 or more for the latest contact lenses or brand-name frames
- Free shipping

Premier LASIK

- Save $800 on LASIK when you choose any featured Premier LASIK Network provider.
- Save 15% with all other in-network provider

TruVision

- Save up to 40% on LASIK eye surgery at more than 1,000+ locations
- 6.5 million procedures performed in the network

Hearing

Amplifon®

- 25% off Amplifon hearing aids for qualified members, plus an extra $50 off one hearing aid or $125 off two hearing aids
- A three-year repair/loss/damage warranty
- A free two-year supply of batteries

Hearing Care Solutions (HCS)

- Digital instruments starting at $500
- Hearing exam at no additional cost
- 3,100 locations and eight manufacturers
- Three-year warranty
- Two years of batteries
- Unlimited visits for one year

NationsHearing

- Save on top-quality hearing aids from major manufacturers with a 60-day, 100% money-back guarantee. It also includes a three-year repair warranty, batteries for three years, and replacement coverage.

SpecialOffers is a discount program that is not part of your health plan coverage. It is a value-added online service we provide to give our Medicare Advantage members access to discounts offered by different vendors. 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 SpecialOffers vendors. Arrangements and discounts were negotiated between vendors and Anthem for the benefit of our members. The products and services described are not part of our contract with Medicare. They are not subject to the Medicare appeals process. Any disputes about these products or services may be subject to the Anthem grievance process.

IMPORTANT: SpecialOffers vendors and discounts are subject to change without notice.

Sydney℠ Health app

The Sydney℠ Health app offers online tools to help you stay healthy and manage your health plan.*

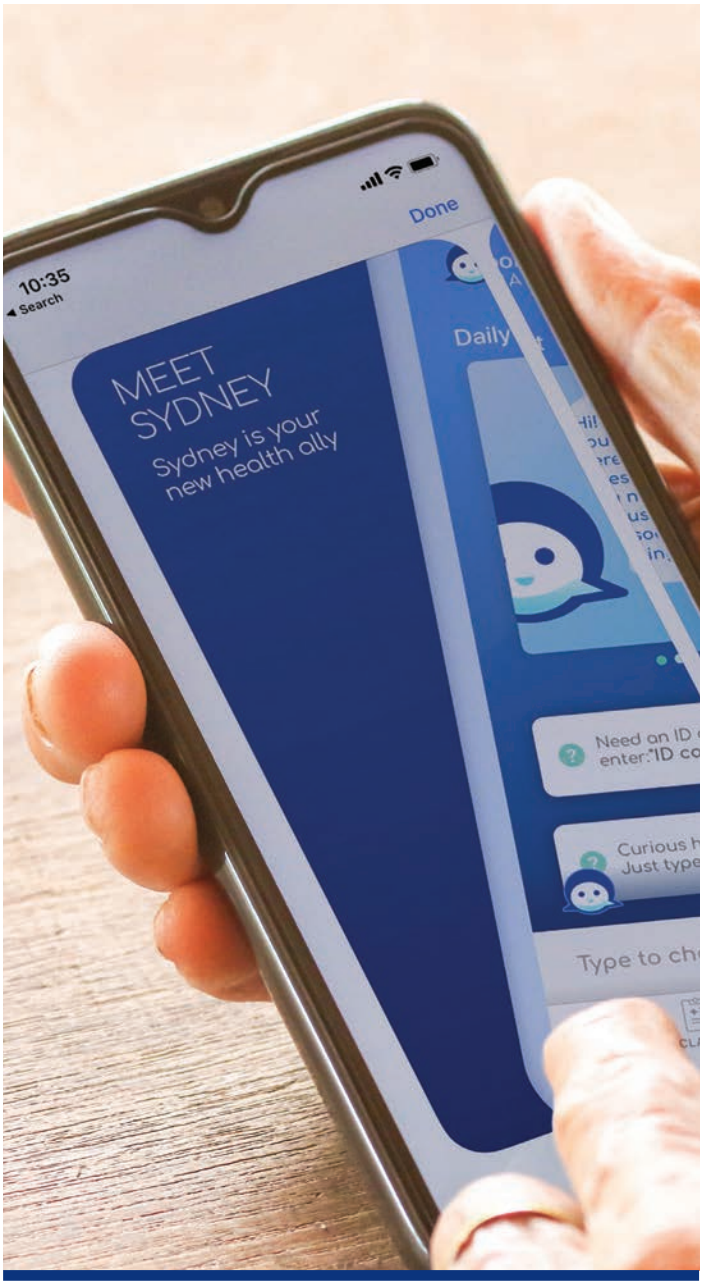
After we send you your plan membership card, use the information on the card to set up your account. It only takes a few minutes to register.

When you're done, you can use the app to:

- See a live doctor with virtual visits.
- Access plan and health resources.
- Check the status of claims.
- Request a replacement membership card or print a temporary one.
- Use home delivery for prescription drugs.

You can also:

- Use your device's GPS to find nearby doctors, hospitals, and urgent care centers in your plan's network.
- Use the chat feature to quickly find answers to your health questions.
- Set health reminders and wellness goals.
- Store and share health records with My Family Health Record (myFHR), which gives you the ability to share your health information with doctors, family members, and caregivers.



Download the Sydney Health app today from the App Store®, Google Play™, or www.anthem.com.

* Online tools are offered to Anthem plan members as extra services. They are not part of the contract and can change or stop.

Common questions and answers

What's a deductible?

A deductible is the amount of money you pay for healthcare services before your plan starts paying. After you reach your deductible, you may still have to pay for your share of the services. Certain plans have no deductible and will cover your costs when the plan starts. Other services will be covered by your plan before you reach the deductible. For more details, please call our First Impressions Welcome Team or see the Summary of Benefits located in the appendix.

What's a copay?

Some services may require a copay. A copay is the fixed dollar amount that you pay for covered services or prescriptions after paying your deductible.

What is coinsurance?

In some cases, you may have to pay coinsurance. Coinsurance is the percentage of the cost you pay for a covered service after you meet your deductible. The plan then pays the rest of the covered cost. If you have not yet met your deductible, you pay the full allowed amount.

What is a true out-of-pocket (TrOOP) limit?

It is an annual out-of-pocket limit that includes payments made by you and the discount you receive on covered brand name drugs in the coverage gap. Once you reach this limit, you may pay a lower copay or coinsurance for your covered drugs until the start of the next plan year. The amount paid by your plan does not count toward your TrOOP costs. Not all of your costs add to the TrOOP. For more details, please see the Benefits Chart included in this guide.

Before enrolling, what do I need to provide my group sponsor?

To ensure a smooth enrollment, make sure your group sponsor has your most up-to-date information and that it matches your Social Security information.

Questions?

Call our **First Impressions Welcome Team** for answers or plan details, and provide them with this group specific code IN004GRX.

1-866-646-2436 (TTY: **711**) **Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays**

How to qualify and enroll

Qualifications for enrolling in Blue MedicareRx (PDP) with Senior Rx Plus:

- You are a United States (U.S.) citizen or are lawfully present in the U.S.
- You live in the plan's service area.
- You are now entitled to Medicare Part A and/or enrolled in Part B.
- You keep paying your Medicare Part B premiums, unless they are paid by Medicaid or through another third party.
- You qualify for coverage under your or your spouse's group-sponsored health plan.

Important

When you're ready to enroll, please complete the enrollment election form on the next page. The scissors icon and dotted line show where to cut it out. Then please mail your form to the address on the form.

Enroll now

How to complete the enrollment election form

You'll need:

- **Your Medicare number** (the number on your red, white, and blue Medicare card). Fill out the requested information as it appears on your Medicare card. If required, also attach a copy of your Medicare card, or your letter from the Social Security Administration, or the Railroad Retirement Board and send it along with your completed enrollment election form.
- **Your permanent address and phone number.**
- **You must complete all items on the enrollment election form.** Complete and sign the enrollment election form that starts on the next page and mail it to the address listed on it.

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Anthem Blue Cross and Blue Shield Group-Sponsored Health Plan Enrollment Election Form

All fields on this form are required unless noted with an asterisk*

Group sponsor name:	Group #:
Retired Indiana Public Employees Insurance Trust (RIPEA)	**IN004GRX**

Plan you will join:

☐ PDP $0 Ded (19/20/47) - $71.00/per month
☐ PDP $505 Ded (3/5/44) - $58.67/per month

_____

Requested effective date of coverage:
(__ __/__ __/__ __ __ __)
(M M / D D / Y Y Y Y)

Generally, the effective date of enrollment will be the first of the month following the enrollment receipt date, unless a future date is requested and is allowed.

FIRST name: LAST name: Middle initial:

Birthdate: (MM/DD/YYYY) (__ __/__ __/__ __ __ __)	Sex: ☐ M ☐ F	Phone number: ( ) ☐ Cell ☐ Other

Permanent residence street address (Do not enter a P.O. Box):

City:	State:	ZIP code:

Mailing address, if different from your permanent address (P.O. Box allowed):

Street address: City: State: ZIP code:

Email address:_____

Your email address will be used for communications only from Anthem Blue Cross and Blue Shield. We will not share your email address. Thank you for providing your email address and phone number. We will only use this information to occasionally contact you by email, phone call, or text with Important Plan Information.

In addition, may we also contact you about additional products and services that might interest you by ☐email and/or ☐text? Messaging and data rates may apply.

Please know you can change your preference at any time by visiting www.anthem.com or contacting customer service.

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Race*

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Samoan
☐ Guamanian or Chamorro
☐ Other Pacific Islander
☐ I choose not to answer

Ethnicity*

☐ Not of Hispanic, Latino/a, or Spanish Origin
☐ Puerto Rican
☐ Another Hispanic, Latino/a, or Spanish Origin
☐ Mexican, Mexican American, Chicano/a
☐ Cuban
☐ I choose not to answer

Your Medicare information:

Medicare Number: _____

Note: The Medicare Number is required to complete your enrollment. If you do not provide your Medicare Beneficiary ID from your Medicare ID Card, your enrollment into the plan may be delayed.

Please read and answer these important questions

1. Are you the retiree? ☐ Yes ☐ No

If "yes," retirement date (month/date/year): _____

If "no," name of retiree:_____ Retiree Medicare ID #:_____

2. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

If "yes," please provide the following information:

Name of institution:_____

Address (number and street) and phone number of institution:_____

_____

3. Will you have other prescription drug coverage (like VA or TRICARE) in addition to this plan? ☐ Yes ☐ No

Name of other coverage: Member number for this coverage: Group number for this coverage:

_____ _____ _____

Please read this important information:

If you are a member of a Medicare Advantage plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage plan that will meet your needs. By joining Blue MedicareRx (PDP) with Senior Rx Plus, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage, as well as your prescription drug coverage. Read the information that your Medicare Advantage plan sends you, and if you have questions, contact your Medicare Advantage plan.

If you currently have health coverage from a group sponsor, joining Blue MedicareRx (PDP) with Senior Rx Plus could affect your group sponsor health benefits. You could lose your group-sponsored health coverage if you join Blue MedicareRx (PDP) with Senior Rx Plus. Please read the communications your group sponsor sends you. If you have questions, visit their website or contact the office listed in their communications. If there isn't information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

This document may be available in an alternate format, such as large print. Please call the First Impressions Welcome Team at **1-866-830-0296**, TTY: **711**, Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays for additional information or questions you may have.

IMPORTANT: Read and sign below:

- I must keep Medicare Part A and Part B to stay in the plan I have selected.
- **Release of information:** By joining this prescription drug plan, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Anthem Blue Cross and Blue Shield will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations.
- The information on this enrollment election form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.

- I understand that when my Blue MedicareRx (PDP) with Senior Rx Plus coverage begins, I must get all of my prescription drug benefits from Anthem Blue Cross and Blue Shield. Benefits and services authorized by Anthem Blue Cross and Blue Shield and contained in my Blue MedicareRx (PDP) with Senior Rx Plus *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, neither Medicare nor Anthem Blue Cross and Blue Shield will pay for benefits or services.**
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this enrollment election form means that I have read and understand the contents of this enrollment election form. If signed by an authorized representative (as described above), this signature certifies that:
    1) This person is authorized under state law to complete this enrollment election form, and
    2) Documentation of this authority is available upon request by Medicare.

Signature:	**Today's date:**
If you are the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone number:	Relationship to enrollee:

Please return this enrollment election form to:

Retired Indiana Public Employees Insurance Trust (RIPEA)
2415 Directors Row, Suite M
Indianapolis, IN 46241

Please refer to the Anthem Blue Cross and Blue Shield *Evidence of Coverage* for a complete listing of all plan benefits, conditions, limitations, and exclusions of coverage.

Our plan has free language interpreter services available to answer questions from non-English-speaking members. Please call the First Impressions Welcome Team number listed in this document to request interpreter services.

Anthem Blue Cross and Blue Shield is a PDP plan with a Medicare contract. Enrollment in Anthem Blue Cross and Blue Shield depends on contract renewal.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, 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 HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In 17 southeastern counties of New York: Anthem HealthChoice Assurance, Inc., and Anthem HealthChoice HMO, Inc. In these same counties Anthem Blue Cross and Blue Shield HP is the trade name of Anthem HP, LLC. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare Health Services Insurance Corporation (Compcare) or Wisconsin Collaborative Insurance Corporation (WCIC). Compcare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Instructions for completing the *Member Authorization Form*

If you have any questions, please feel free to call us at the customer service number on your member identification card. Please read the following for help completing page one of the form.

Part A: Member information

This section applies to the member who is asking for the release of his or her information to another person or company.

1. Print your last name, first name, and middle initial.
2. Write your date of birth in this format: mmddyyyy. (If you were born on October 5, 1960, you would write 10051960.)
3. Write your full street address, city, state, and ZIP code.
4. Write your daytime phone number (including area code.)
5. Write your cell/mobile number (including area code.)
6. **Identification number**
   You will find this number on your member identification card.
7. **Group number**
   You will find this number on your member identification card. If your identification card does not have a group number leave this blank.

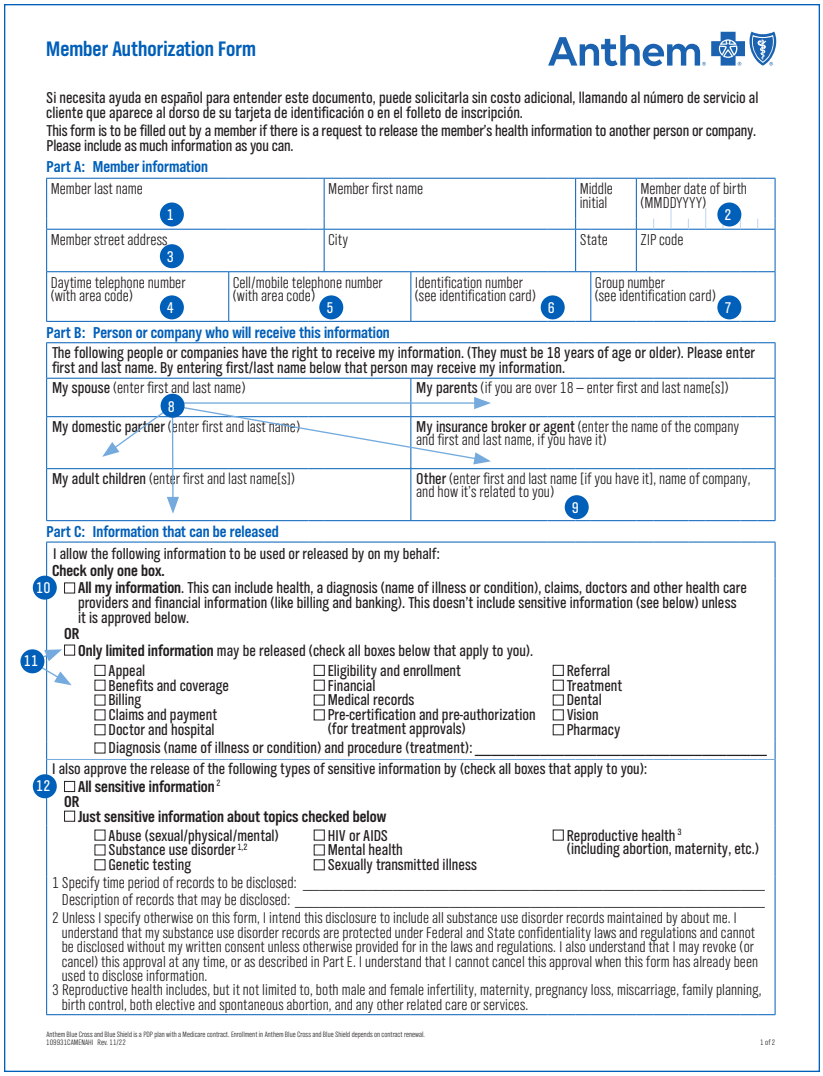
Part B: Person or company who will receive this information

8. Write the full name of the person or company that you want us to give your information to. Please don't use a general term like “my daughter” or “my son” as it will not be accepted. You need to be specific.
9. If you check “Other,” give the first and last name (if available), the name of the company (if applicable), and how they relate to you.

Part C: Information that can be released

This section tells us what information you would like us to release: all or just some.

10. For “all of your information,” check the first box.
11. For “limited information,” check the second box and the boxes that apply to you.
12. Some topics may be very personal or sensitive to you. If you wish to approve the release of this type of information, check the box(es) that apply to you.



Member Authorization Form

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Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This form is to be filled out by a member if there is a request to release the member's health information to another person or company. Please include as much information as you can.

Part A: Member information

Member last name (1)	Member first name	Middle initial	Member date of birth (MMDDYYYY) (2)
Member street address (3)	City	State	ZIP code
Daytime telephone number (with area code) (4)	Cell/mobile telephone number (with area code) (5)	Identification number (see identification card) (6)	Group number (see identification card) (7)

Part B: Person or company who will receive this information

The following people or companies have the right to receive my information. (They must be 18 years of age or older). Please enter first and last name. By entering first/last name below that person may receive my information.

My spouse (enter first and last name) (8)	My parents (if you are over 18 – enter first and last name(s))
My domestic partner (enter first and last name)	My insurance broker or agent (enter the name of the company and first and last name, if you have it)
My adult children (enter first and last name(s))	Other (enter first and last name (if you have it), name of company, and how it's related to you) (9)

Part C: Information that can be released

I allow the following information to be used or released by on my behalf:

Check only one box.

(10) ☐ **All my information**. This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

OR

(11) ☐ **Only limited information** may be released (check all boxes below that apply to you).

- ☐ Appeal
- ☐ Benefits and coverage
- ☐ Billing
- ☐ Claims and payment
- ☐ Doctor and hospital
- ☐ Eligibility and enrollment
- ☐ Financial
- ☐ Medical records
- ☐ Pre-certification and pre-authorization (for treatment approvals)
- ☐ Referral
- ☐ Treatment
- ☐ Dental
- ☐ Vision
- ☐ Pharmacy
- ☐ Diagnosis (name of illness or condition) and procedure (treatment): _____

I also approve the release of the following types of sensitive information by (check all boxes that apply to you):

(12) ☐ **All sensitive information**[2]

OR

☐ **Just sensitive information about topics checked below**

- ☐ Abuse (sexual/physical/mental)
- ☐ Substance use disorder[1,2]
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Mental health
- ☐ Sexually transmitted illness
- ☐ Reproductive health[3] (including abortion, maternity, etc.)

1 Specify time period of records to be disclosed: _____

Description of records that may be disclosed: _____

2 Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by about me. I understand that my substance use disorder records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

3 Reproductive health includes, but it not limited to, both male and female infertility, maternity, pregnancy loss, miscarriage, family planning, birth control, both elective and spontaneous abortion, and any other related care or services.

Anthem Blue Cross and Blue Shield is a PDP plan with a Medicare contract. Enrollment in Anthem Blue Cross and Blue Shield depends on contract renewal.
109931CAMENAHI Rev. 11/22

1 of 2

Please read the following for help completing page two of the form.

Part D: Purpose of this approval

This section tells us the reason you've asked for the release of your information.

1. Check the first box to let us know to give out this information as shown on this form.
2. Check the second box for a specific reason. An example might be to settle a life insurance claim.

Part E: Date your approval expires

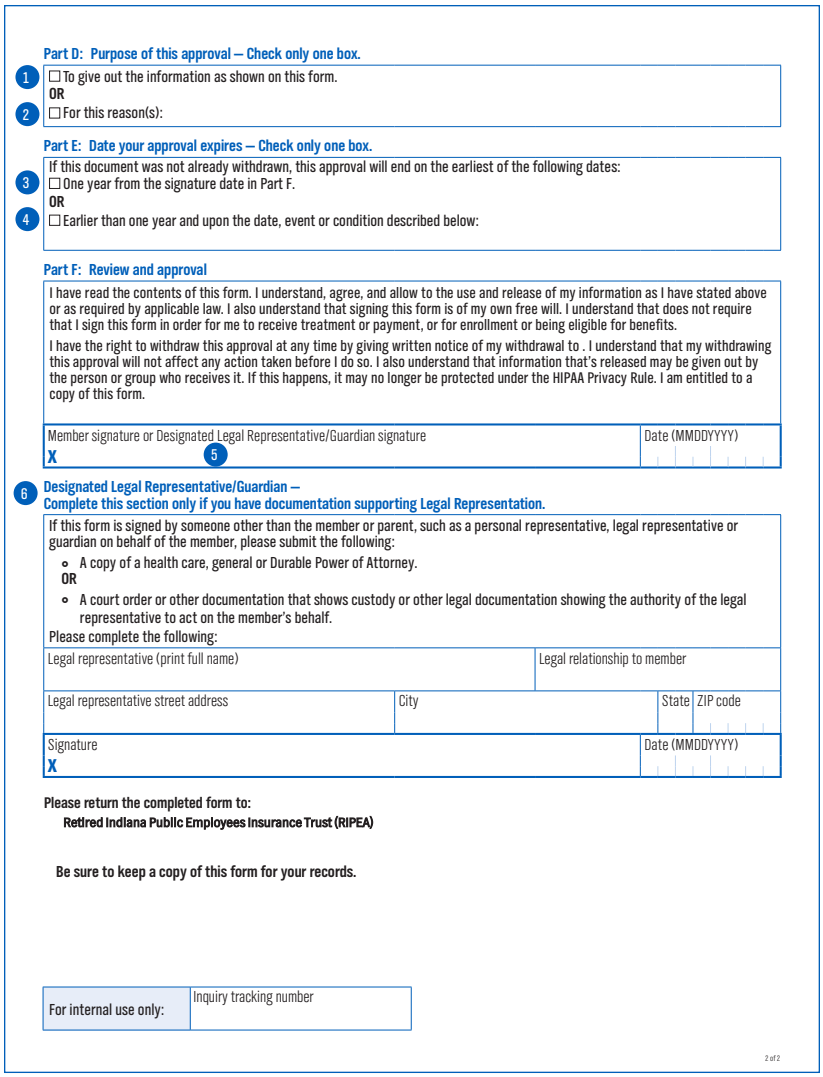
You have two choices of when you would like this approval to end.

3. Check the first box for the standard one year that it will end.
4. Check the second box for an earlier date (other than one year), and give the date you wish this approval to end.

Your authorization/approval can't be granted for more than one year.

Part F: Review and approval

5. **Sign your name and put the date on the form.** Your name and signature must match the information in Part A.
6. **If you are signing this form on behalf of another person, or if you have Power of Attorney for health care, or are a legal guardian/conservator you must do the following:**
   - You must complete the Designated Legal Representative/Guardian section.
   - You must also provide us with a copy of the legal document showing that you are approved and include it with this form.



Part D: Purpose of this approval – Check only one box.

1 ☐ To give out the information as shown on this form.

OR

2 ☐ For this reason(s):

Part E: Date your approval expires – Check only one box.

If this document was not already withdrawn, this approval will end on the earliest of the following dates:

3 ☐ One year from the signature date in Part F.

OR

4 ☐ Earlier than one year and upon the date, event or condition described below:

Part F: Review and approval

I have read the contents of this form. I understand, agree, and allow to the use and release of my information as I have stated above or as required by applicable law. I also understand that signing this form is of my own free will. I understand that does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to . I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Member signature or Designated Legal Representative/Guardian signature 5	Date (MMDDYYYY)
X	

6 **Designated Legal Representative/Guardian – Complete this section only if you have documentation supporting Legal Representation.**

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following:

- A copy of a health care, general or Durable Power of Attorney.

OR

- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Please complete the following:

Legal representative (print full name)	Legal relationship to member		
Legal representative street address	City	State	ZIP code
Signature X		Date (MMDDYYYY)	

Please return the completed form to:

Retired Indiana Public Employees Insurance Trust (RIPEA)

Be sure to keep a copy of this form for your records.

For internal use only:	Inquiry tracking number

2 of 2

Examples of legal documents:

- **Health Care, General or Durable Power of Attorney**. This document gives someone you trust the legal power to act on your behalf and make health care decisions for you.
- **Legal Guardianship**. This is when the court appoints someone to care for another person.
- **Conservatorship**. This happens when a judge appoints a responsible person to make decisions for someone who can't make responsible decisions for him/herself.
- **Executor of estate**. This type of document would be used when the person who is being represented has died.

Member Authorization Form

Anthem

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This form is to be filled out by a member if there is a request to release the member's health information to another person or company. Please include as much information as you can.

Part A: Member information

Member last name	Member first name	Middle initial	Member date of birth (MMDDYYYY)
Member street address	City	State	ZIP code

Daytime telephone number (with area code)	Cell/mobile telephone number (with area code)	Identification number (see identification card)	Group number (see identification card)

Part B: Person or company who will receive this information

The following people or companies have the right to receive my information. (They must be 18 years of age or older). Please enter first and last name. By entering first/last name below that person may receive my information.

My spouse (enter first and last name)	**My parents** (if you are over 18 – enter first and last name[s])
My domestic partner (enter first and last name)	**My insurance broker or agent** (enter the name of the company and first and last name, if you have it)
My adult children (enter first and last name[s])	**Other** (enter first and last name [if you have it], name of company, and how it's related to you)

Part C: Information that can be released

I allow the following information to be used or released by on my behalf:

Check only one box.

☐ **All my information**. This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

OR

☐ **Only limited information** may be released (check all boxes below that apply to you).

- ☐ Appeal
- ☐ Benefits and coverage
- ☐ Billing
- ☐ Claims and payment
- ☐ Doctor and hospital
- ☐ Eligibility and enrollment
- ☐ Financial
- ☐ Medical records
- ☐ Pre-certification and pre-authorization (for treatment approvals)
- ☐ Referral
- ☐ Treatment
- ☐ Dental
- ☐ Vision
- ☐ Pharmacy
- ☐ Diagnosis (name of illness or condition) and procedure (treatment): _____

I also approve the release of the following types of sensitive information by (check all boxes that apply to you):

☐ **All sensitive information** [2]

OR

☐ **Just sensitive information about topics checked below**

- ☐ Abuse (sexual/physical/mental)
- ☐ Substance use disorder [1,2]
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Mental health
- ☐ Sexually transmitted illness
- ☐ Reproductive health [3] (including abortion, maternity, etc.)

1 Specify time period of records to be disclosed: _____

Description of records that may be disclosed: _____

2 Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by about me. I understand that my substance use disorder records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

3 Reproductive health includes, but it not limited to, both male and female infertility, maternity, pregnancy loss, miscarriage, family planning, birth control, both elective and spontaneous abortion, and any other related care or services.

Part D: Purpose of this approval – Check only one box.

☐ To give out the information as shown on this form.
OR
☐ For this reason(s):

Part E: Date your approval expires – Check only one box.

If this document was not already withdrawn, this approval will end on the earliest of the following dates:
☐ One year from the signature date in Part F.
OR
☐ Earlier than one year and upon the date, event or condition described below:

Part F: Review and approval

I have read the contents of this form. I understand, agree, and allow to the use and release of my information as I have stated above or as required by applicable law. I also understand that signing this form is of my own free will. I understand that does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to . I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Member signature or Designated Legal Representative/Guardian signature	Date (MMDDYYYY)
X	

Designated Legal Representative/Guardian – Complete this section only if you have documentation supporting Legal Representation.

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following:

- A copy of a health care, general or Durable Power of Attorney.

OR

- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Please complete the following:

Legal representative (print full name)	Legal relationship to member		
Legal representative street address	City	State	ZIP code

Signature	Date (MMDDYYYY)
X	

Please return the completed form to:
Retired Indiana Public Employees Insurance Trust (RIPEA)
2415 Directors Row, Suite M
Indianapolis, IN 46241

Be sure to keep a copy of this form for your records.

For internal use only:	Inquiry tracking number

What to expect after you enroll

After your enrollment is processed, you will receive:

- Proof of your enrollment request with your membership start date listed.
- A plan membership card. Begin using this card on your membership start date.
- A health survey to help us understand and address your needs. We'll call you within 90 days to talk about your experience to understand how we can better take care of you.

We will also send you a plan Welcome Guide with ways to:

- Make the most of your benefits.
- Find plan doctors and facilities.
- Access information online.

IMPORTANT INFORMATION:

Official U.S. Government Medicare Information

2023 Medicare Star Ratings

Anthem Blue Cross and Blue Shield - S5596

For 2023, Anthem Blue Cross and Blue Shield - S5596 received the following Star Ratings from Medicare:

Overall Star Rating:	N/A
Health Services Rating:	N/A
Drug Services Rating:	★★★½☆

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings are important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care.
- The number of members who left or stayed with the plan.
- The number of complaints Medicare got about the plan.
- Data from doctors and hospitals that work with the plan.

More stars mean a better plan – for example, members may get better care and better, faster customer service.

The number of stars show how well a plan performs.

★★★★★	EXCELLENT
★★★★☆	ABOVE AVERAGE
★★★☆☆	AVERAGE
★★☆☆☆	BELOW AVERAGE
★☆☆☆☆	POOR

Get more information on Star Ratings online

Compare Star Ratings for this and other plans online at **www.medicare.gov/plan-compare**.

Questions about this plan?

Contact Anthem Blue Cross and Blue Shield seven days a week from Monday to Friday from 8 a.m. to 9 p.m. ET at **1-866-646-2436** (toll free) or **711** (TTY). Current members please call **1-866-470-6265** or **711** (TTY).

Anthem Blue Cross and Blue Shield is a PDP plan with a Medicare contract. Enrollment in Anthem Blue Cross and Blue Shield depends on contract renewal.

Summary of Benefits

We've provided a *Summary of Benefits* so you can have a better understanding of what's covered and what's not, including:

- Costs you are responsible for
- What we cover under the plan
- Any copays or percentage of the cost
- Any out-of-pocket costs

Questions?

Call our First Impressions Welcome Team for answers or plan details, and provide them with this group specific code IN004GRX. **1-866-646-2436** (TTY: **711**) Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays

Your 2024 Prescription Drug Benefits Chart
Formulary B5, 3/5/44/40%/25%/250 (Generic Gap) (with Senior Rx Plus)
Retired Indiana Public Employees Insurance Trust (RIPEA)

Your retiree drug coverage includes Medicare Part D drug benefits and non-Medicare supplemental drug benefits. The cost shown below is what you pay after all benefits under your retiree drug coverage have been provided.

Formulary	B5
Deductible	$505
Supplemental Gap Coverage	Select Generics and Tier 1 and Tier 2 Generics
Covered Services	What you pay
Part D Initial Coverage	

Below is your payment responsibility from the time you meet your deductible, until the amount paid by you and your retiree drug plan for covered Part D prescriptions reaches your Initial Coverage Limit of $5,030.

Retail Pharmacy	per 30-day supply (Specialty limited to a 30-day supply)
• Select Generics	$0 copay Deductible waived on Select Generics
• Preferred Generics	$3 copay
• Generics	$5 copay
• Preferred Brands	$44 copay
• Non-Preferred Drugs	40% coinsurance with a maximum of $250
• Specialty Drugs	25% coinsurance with maximum of $250 Deductible waived

Covered Services	What you pay
Retail Pharmacy	per 90-day supply
• Select Generics	$0 copay Deductible waived on Select Generics
• Preferred Generics	$9 copay
• Generics	$15 copay
• Preferred Brands	$132 copay
• Non-Preferred Drugs	40% coinsurance with a maximum of $750

Many of our retail pharmacies can dispense more than a 30-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.

Covered Services	What you pay
Mail-Order Pharmacy	per 90-day supply (Specialty limited to a 30-day supply; 30-day Retail copay or coinsurance applies)
• Select Generics	$0 copay Deductible waived on Select Generics
• Preferred Generics	$3 copay
• Generics	$9 copay
• Preferred Brands	$129 copay
• Non-Preferred Drugs	40% coinsurance with a maximum of $500
• Specialty Drugs	25% coinsurance with maximum of $250 Deductible waived

Covered Services	What you pay
Part D Gap Coverage	
Your payment responsibility changes once you reach your Initial Coverage Limit of $5,030. Below is your payment responsibility during the period after you meet your Initial Coverage Limit and until you meet your True Out of Pocket limit.	
Retail Pharmacy	per 30-day supply (Specialty limited to a 30-day supply)
• Select Generics	$0 copay
• Preferred Generics	$3 copay
• Generics	$5 copay
• Preferred Brands	25% coinsurance
• Non-Preferred Drugs	25% coinsurance
• Specialty Drugs	25% coinsurance
Retail Pharmacy	per 90-day supply
• Select Generics	$0 copay
• Preferred Generics	$9 copay
• Generics	$15 copay
• Preferred Brands	25% coinsurance
• Non-Preferred Drugs	25% coinsurance
Mail-Order Pharmacy	per 90-day supply (Specialty limited to a 30-day supply; 30-day Retail copay or coinsurance applies)
• Select Generics	$0 copay
• Preferred Generics	$3 copay
• Generics	$9 copay
• Preferred Brands	25% coinsurance
• Non-Preferred Drugs	25% coinsurance
• Specialty Drugs	25% coinsurance

Covered Services	What you pay
Part D Catastrophic Coverage	
Your payment responsibility changes after the cost you and the Coverage Gap Discount Program have paid for covered drugs reaches your True Out of Pocket limit of $8,000.	
Retail and Mail-Order Pharmacies	Up to a 90-day supply (Specialty limited to a 30-day supply)
• Select Generics	$0 copay
• Generics	$0 copay
• Brand-Name Drugs	$0 copay

- **Important Message About What You Pay for Vaccines:** All Advisory Committee on Immunization Practices (ACIP) recommended Part D vaccines are covered at no cost to you.

- **Important Message About What You Pay for Insulin:** You won't pay more than $35 for a one month supply of each insulin product covered by your plan, no matter what cost-sharing tier it is on.

- **Coverage Gap Discount Program**: If you are not receiving help to pay your share of drug cost through the Low Income Subsidy or PACE programs, you qualify for a discount on the cost you pay for most covered brand drugs through the Medicare Coverage Gap Discount Program. For prescriptions filled in 2024, once the cost paid by you and your retiree drug plan reaches $5,030 the cost share you pay will reflect all benefits provided by your retiree drug coverage and the Coverage Gap Discount. The Coverage Gap Discount applies until the cost paid by you and the Discount reaches $8,000. Drug manufacturers have agreed to provide a discount on brand drugs which Medicare considers Part D qualified drugs. **Please note:** Your retiree drug plan may cover some brand drugs beyond those covered by Medicare. The discount will not apply to drugs listed as "Extra Covered Drugs" in your benefits.

- **Vaccines:** Medicare covers some vaccines under Medicare Part B medical coverage and other vaccines under Medicare Part D drug coverage. Vaccines for Flu, including H1N1, and Pneumonia are covered under Medicare medical coverage. Vaccines for Chicken Pox, Shingles, Tetanus, Diphtheria, Meningitis, Rabies, Polio, Yellow Fever and Hepatitis A are covered under Medicare drug coverage. Hepatitis B is covered under drug coverage unless you fall into a high risk category, then it is covered under medical coverage. All other Advisory Committee on Immunization Practices (ACIP) recommended Part D vaccines are also covered under Medicare drug coverage for Medicare-eligible individuals under 65. You can fill and receive your vaccines at a network pharmacy or they can be administered at a physician's office. However, the physician will only submit a claim for a Part B vaccine. If you want to get a Part D vaccine at your physician's office you will pay for the entire cost of the vaccine and its administration and then ask your drug plan to

reimburse you the cost of the vaccine and it's administration. Please see your Evidence of Coverage for complete details on what you pay for vaccines.

- **Senior Rx Plus:** Your supplemental drug benefit is non-Medicare coverage that reduces the amount you pay, after your Group Part D benefits and the Coverage Gap Discount. The copay or coinsurance shown in this benefits chart is the amount you pay for covered drugs filled at network pharmacies.

Your 2024 Prescription Drug Benefits Chart
Formulary B5, 19/20/47/50%/33%-250 (Generic Gap) (with Senior Rx Plus)
Retired Indiana Public Employees Insurance Trust (RIPEA)

Your retiree drug coverage includes Medicare Part D drug benefits and non-Medicare supplemental drug benefits. The cost shown below is what you pay after all benefits under your retiree drug coverage have been provided.

Formulary	B5
Deductible	$0
Supplemental Gap Coverage	Select Generics and Tier 1 and Tier 2 Generics
Covered Services	What you pay
Part D Initial Coverage	
Below is your payment responsibility until the amount paid by you and your retiree drug plan for covered Part D prescriptions reaches your Initial Coverage Limit of $5,030.	
Retail Pharmacy	per 30-day supply (Specialty limited to a 30-day supply)
• Select Generics	$0 copay
• Preferred Generics	$19 copay
• Generics	$20 copay
• Preferred Brands	$47 copay
• Non-Preferred Drugs	50% coinsurance with a maximum of $250
• Specialty Drugs	33% coinsurance with a maximum of $250

Covered Services	What you pay
Retail Pharmacy	per 90-day supply
• Select Generics	$0 copay
• Preferred Generics	$57 copay
• Generics	$60 copay
• Preferred Brands	$141 copay
• Non-Preferred Drugs	50% coinsurance with a maximum of $750

Many of our retail pharmacies can dispense more than a 30-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.

Covered Services	What you pay
Mail-Order Pharmacy	per 90-day supply (Specialty limited to a 30-day supply; 30-day Retail copay or coinsurance applies)
• Select Generics	$0 copay
• Preferred Generics	$3 copay
• Generics	$12 copay
• Preferred Brands	$141 copay
• Non-Preferred Drugs	50% coinsurance with a maximum of $500
• Specialty Drugs	33% coinsurance with a maximum of $250

Covered Services	What you pay
Part D Gap Coverage	
Your payment responsibility changes once you reach your Initial Coverage Limit of $5,030. Below is your payment responsibility during the period after you meet your Initial Coverage Limit and until you meet your True Out of Pocket limit.	
Retail Pharmacy	per 30-day supply (Specialty limited to a 30-day supply)
• Select Generics	$0 copay
• Preferred Generics	$19 copay
• Generics	$20 copay
• Preferred Brands	25% coinsurance
• Non-Preferred Drugs	25% coinsurance
• Specialty Drugs	25% coinsurance
Retail Pharmacy	per 90-day supply
• Select Generics	$0 copay
• Preferred Generics	$57 copay
• Generics	$60 copay
• Preferred Brands	25% coinsurance
• Non-Preferred Drugs	25% coinsurance
Mail-Order Pharmacy	per 90-day supply (Specialty limited to a 30-day supply; 30-day Retail copay or coinsurance applies)
• Select Generics	$0 copay
• Preferred Generics	$3 copay
• Generics	$12 copay
• Preferred Brands	25% coinsurance
• Non-Preferred Drugs	25% coinsurance
• Specialty Drugs	25% coinsurance

Covered Services	What you pay
Part D Catastrophic Coverage	
Your payment responsibility changes after the cost you and the Coverage Gap Discount Program have paid for covered drugs reaches your True Out of Pocket limit of $8,000.	
Retail and Mail-Order Pharmacies	Up to a 90-day supply (Specialty limited to a 30-day supply)
• Select Generics	$0 copay
• Generics	$0 copay
• Brand-Name Drugs	$0 copay

- **Important Message About What You Pay for Vaccines:** All Advisory Committee on Immunization Practices (ACIP) recommended Part D vaccines are covered at no cost to you.

- **Important Message About What You Pay for Insulin:** You won't pay more than $35 for a one month supply of each insulin product covered by your plan, no matter what cost-sharing tier it is on.

- **Coverage Gap Discount Program**: If you are not receiving help to pay your share of drug cost through the Low Income Subsidy or PACE programs, you qualify for a discount on the cost you pay for most covered brand drugs through the Medicare Coverage Gap Discount Program. For prescriptions filled in 2024, once the cost paid by you and your retiree drug plan reaches $5,030 the cost share you pay will reflect all benefits provided by your retiree drug coverage and the Coverage Gap Discount. The Coverage Gap Discount applies until the cost paid by you and the Discount reaches $8,000. Drug manufacturers have agreed to provide a discount on brand drugs which Medicare considers Part D qualified drugs. **Please note:** Your retiree drug plan may cover some brand drugs beyond those covered by Medicare. The discount will not apply to drugs listed as "Extra Covered Drugs" in your benefits.

- **Vaccines:** Medicare covers some vaccines under Medicare Part B medical coverage and other vaccines under Medicare Part D drug coverage. Vaccines for Flu, including H1N1, and Pneumonia are covered under Medicare medical coverage. Vaccines for Chicken Pox, Shingles, Tetanus, Diphtheria, Meningitis, Rabies, Polio, Yellow Fever and Hepatitis A are covered under Medicare drug coverage. Hepatitis B is covered under drug coverage unless you fall into a high risk category, then it is covered under medical coverage. All other Advisory Committee on Immunization Practices (ACIP) recommended Part D vaccines are also covered under Medicare drug coverage for Medicare-eligible individuals under 65. You can fill and receive your vaccines at a network pharmacy or they can be administered at a physician's office. However, the physician will only submit a claim for a Part B vaccine. If you want to get a Part D vaccine at your physician's office you will pay for the entire cost of the vaccine and its administration and then ask your drug plan to

reimburse you the cost of the vaccine and it's administration. Please see your Evidence of Coverage for complete details on what you pay for vaccines.

- **Senior Rx Plus:** Your supplemental drug benefit is non-Medicare coverage that reduces the amount you pay, after your Group Part D benefits and the Coverage Gap Discount. The copay or coinsurance shown in this benefits chart is the amount you pay for covered drugs filled at network pharmacies.

Required information for this plan year

Your rights, protections, and Medicare options

As a Medicare Part D beneficiary, you have many rights and options put in place to protect you as a consumer.

You may have other options

The important thing to remember is that the choice is yours, keeping in mind that you may be able to join or leave a plan only at certain times. Please note that if you do not take your retiree benefits, it may affect other retiree benefits your group sponsor offers. No matter what you decide, you may still be eligible for the Original Medicare program.

Geographic service areas covered by this plan

This plan offers coverage in our Centers for Medicare & Medicaid Services (CMS) defined geographic service area of all 50 states, Washington, DC, and all United States territories.

Your Medicare protection

The plan must offer Medicare benefits to you for a full calendar year at a time, although benefits and cost sharing may change from year to year. The plan provider can decide each year whether to keep offering Part D plans, or whether or not to continue offering plans in specific geographic areas like yours.

Also, Medicare may decide to end our contract.

If for some reason this plan is discontinued, we will send you a letter at least 90 days before your coverage ends explaining your options for Medicare coverage in your area.

For more information on the options and rights you have as a Medicare Advantage member with this plan, please contact our First Impressions Welcome Team and ask for a copy of the *Evidence of Coverage (EOC)*.

Extra Help from Medicare

You may be able to find help to pay for your prescription drugs and other Medicare costs. If you qualify for Medicare's Extra Help and are enrolled in a Part D plan like this one, Medicare can pay up to 100% of your prescribed drugs. This can help offset your drug plan's monthly premium, plus coinsurance and copays for covered prescription drugs.

Extra Help can also close any drug coverage gaps and stop late enrollment penalties (LEPs). For more information, visit **www.medicare.gov** or **www.ssa.gov**, or call:

- **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.
- The Social Security Administration at **1-800-772-1213**, Monday to Friday, 7 a.m. to 7 p.m. ET. TTY users should call **1-800-325-0778**.
- Your state Medicaid office.

Required information for this plan year

Information about Medicare

To help you make more informed healthcare decisions, we are providing this important information about Medicare to use as a resource. If you have any questions, or you would like to request a benefits chart, please contact our **First Impressions Welcome Team**.

Matching Medicare Advantage (medical) coverage and Part D (prescription drug) coverage for members in group plans

If you are enrolled in a group Medicare Advantage plan, your Part D coverage must also be a group Part D plan. This is important because enrolling in a non-group Part D plan could result in termination of your enrollment in your group Medicare Advantage plan.

Enrolling in other plans

If you decide to enroll in other plans, you will be disenrolled from your current plan.

Notifying your group sponsor

To ensure a smooth enrollment, make sure your group sponsor has your most up-to-date information and that it matches your Social Security information.

What to know about a drug list

A drug list is a list of drugs covered by the plan. We choose our list to provide good prescription coverage and a good value to you, as well.

Your full Benefits Chart will tell you if you have an open or closed drug list plan. Open plans cover almost all Medicare Part D eligible drugs, while closed plans cover most.

When new drugs come to market, we conduct a clinical and cost review and may add them to the drug list. To keep plans affordable, every year we may also remove drugs or change the cost you pay for them the following year. But don't worry; we'll notify you first and send you a new drug list when we make these changes.

Important: Check to see if your drug is on the drug list before you go to the pharmacy.

If the drug you take is not on our drug list, you will have to pay the full price of the drug. If that's the case, or if your drug comes with additional requirements or limits, you may be able to receive a temporary supply. We will notify you once the temporary supply is dispensed. You will have to contact your doctor and ask if you can switch to a different drug listed on our drug list.

About IRMAA and your income level

If your modified adjusted gross income on your IRS tax return from two years ago is above a certain limit, you must pay an income-related monthly adjustment amount (IRMAA) in addition to your monthly plan premium.

The Social Security Administration will contact you if you have to pay an IRMAA, which you must pay to them, not us.

High-income surcharges

If you must pay a high-income surcharge on your Medicare Part B or Part D premium to the Social Security Administration, please be sure to do so to avoid a mandatory disenrollment.

Required information for this plan year

Information about Medicare

We do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age, or disability. For people with disabilities, we offer free aids and services. Our plan has free language interpreter services available to answer questions from non-English-speaking members. Please call the First Impressions Welcome Team at the number listed in this guide to request interpreter services.

Out-of-network/noncontracted providers are under no obligation to treat Anthem Blue Cross and Blue Shield members, except in emergency situations. Please call our First Impressions Welcome Team at **1-866-646-2436, TTY: 711, Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays**, and provide them with this group specific code IN004GRX for more information.

This information is not a complete description of benefits. Contact the plan for more information. Every year, Medicare evaluates plans based on a five-star rating system.

This guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits and exclusions are contained in the *Benefits Chart and Evidence of Coverage (EOC)*, which is received upon enrollment. In the event of a conflict between the *Benefits Chart* and *EOC* and this guide, the terms of the *Benefits Chart* and *EOC* will prevail.

Coordination of Benefits (COB) letter

If we receive Coordination of Benefits (COB) information from CMS, we are required to send a letter to you requesting verification of the other coverage information. The benefit verification letter we send will include information from CMS, including any other coverage that needs to be verified. Separately, we could receive COB information from other reporting sources in addition to CMS.

If the information is not correct in the letter, you can call Member Services or you can fill in the correct information on the letter and return it to the plan for processing.

If a response is not received within 21 days, the information on the letter is considered to be accurate.

If the previous carrier does not notify CMS of the previous plan termination prior to the plan enrollment process, a COB letter could be triggered for the plan that was just terminated.

Late enrollment penalty (LEP)

If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later.

Required information for this plan year

Information about Medicare

Some of the benefits mentioned are part of a special supplement program for the chronically ill. Not all members may qualify for these benefits.

Anthem Blue Cross and Blue Shield is a PDP plan with a Medicare contract. Enrollment in Anthem Blue Cross and Blue Shield depends on contract renewal.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, 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 HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In 17 southeastern counties of New York: Anthem HealthChoice Assurance, Inc., and Anthem HealthChoice HMO, Inc. In these same counties Anthem Blue Cross and Blue Shield HP is the trade name of Anthem HP, LLC. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare Health Services Insurance Corporation (Compcare) or Wisconsin Collaborative Insurance Corporation (WCIC). Compcare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Multi-language Interpreter Services

Form Approved
OMB# 0938-1421

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-866-646-2436 (TTY: 711). Someone who speaks your language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al número mencionado anteriormente (TTY: **711**). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 上述數字 (TTY: **711**)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 上述數字 (TTY: **711**)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa numero na nakasulat sa itaas (TTY: **711**). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au le numéro écrit ci-dessus (TTY: **711**). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi số được viết ở trên (TTY: **711**). Sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter die oben genannte Nummer (TTY: **711**). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 위에 나와있는 번호 (TTY: **711**) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Multi-language Interpreter Services

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Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону номер, указанный выше (TTY: **711**). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية. ليس عليك سوى الاتصال بنا على الرقم المكتوب أعلاه (TTY: **711**)

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें ऊपर लिखा हुआ नंबर (TTY: **711**) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero il numero sopraindicato (TTY: **711**). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número o número escrito acima (TTY: **711**). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa medikaman nou an. Pou jwenn yon entèprèt, jis rele nou nan nimewo ki ekri pi wo a (TTY: **711**). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer numer napisany powyżej (TTY: **711**). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、上記の番号 (TTY: **711**). にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Form CMS-10802
(Expires 12/31/25)