

Medicare Advantage Group Plan Enrollment Guide

Retired Indiana Public Employees Insurance Trust
Anthem Medicare Preferred (PPO) with Senior Rx Plus
1/1/2026 – 12/31/2026

Anthem | RIPEA

Explore Your Plan Options

We're here to help

There can be a lot to sort through when it comes to selecting a health plan and managing your health. We created this guide to help you understand the basics of our Anthem Blue Cross and Blue Shield group Medicare plans. From choosing a doctor to learning about our convenient online tools and health programs, the important information is all right here at your fingertips. As you read, you will learn that Original Medicare doesn't cover everything. Group-sponsored coverage from your employer, like Medicare Advantage from Anthem, usually offers more.

Understanding Your Plan Options



Retired Indiana Public Employees Insurance Trust gives you plan options. Here's a brief overview:

- These plans offer medical and prescription drug benefits, along with additional features and programs.
- These plans are preferred provider organizations (PPO) plans and use a network of doctors, hospitals, and other healthcare providers. You can see any doctor or visit any hospital that accepts Medicare and the plan. Your benefits will go further if you stay in the plan's network.

We're committed to helping you understand your options so you can choose the plan that best suits your healthcare needs. For more information to help you compare plans, please refer to your Summary of Benefits or call the First Impressions Welcome team at **1-833-848-8729** (TTY: **711**) Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays.

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Medical benefit highlights

This plan covers many medical services, treatments, and tests. Plus, you can protect your health by getting your recommended checkups, shots, and screenings with preventive care services at no cost when you see a doctor that accepts Medicare and the plan. Here are some of the benefits that may be included:

Health and wellness

- Inpatient hospital care and ambulance services
- Emergency and urgent care, including access to emergency care across the U.S. and outside of the country
- Skilled nursing facility benefits
- Complex radiology services and radiation therapy
- Diagnostic procedures and testing services received in a doctor's office
- Lab services and outpatient X-rays
- Tobacco cessation counseling
- Hearing care
- Vision care

Nutrition

- Diabetes services and supplies
- Medical nutrition therapy*
- Obesity screening and therapy*

Preventive care services

- Annual wellness visit and routine physical exam
- Blood pressure and cholesterol tests
- Breast cancer (mammogram) screening
- Colorectal cancer (colonoscopy) screening
- Diabetes (blood sugar, kidney, retinopathy) screening
- Osteoporosis (bone density) screening
- Immunizations like flu and pneumococcal shots

Devices

- Durable medical equipment and related supplies
- Prosthetic devices



See your Summary of Benefits located in the appendix for more details.

* Benefit available if qualifying conditions are met.

Prescription drug benefit highlights

Covered medications

- Find commonly prescribed brand-name and specialty drugs that Medicare Part D allows us to cover.
- Choose from a wide range of generic drugs to save even more money — and without sacrificing effectiveness.

Network pharmacies

- Access to a vast network of pharmacies to save money on your prescriptions.
- Most national chains and many local pharmacies are in our network.

Home delivery through CarelonRx Pharmacy

Save time by not waiting in line at the pharmacy and enjoy the convenience of having your maintenance medications delivered straight to you. With home delivery, you can receive up to 90 days of supplies often at a lower cost than filling your prescription at a regular pharmacy. Set up home delivery through your account online or on the **Sydney℠ Health** app.[1,2]

Generics have the same active ingredients and effects as brand-name drugs, generally without the higher cost share.



1 Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan.

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

Access to care

Discover a wide network of Medicare providers who deliver high-quality care.

Choose the doctors you want

You can see any doctor, specialist, or other care provider in or out of your plan's network who accepts both Medicare and the plan.

You will also benefit from:

- Paying the same copay or coinsurance amount, whether or not you see a care provider in or out of your plan's network.*
- Having your benefits and coverage stay the same, no matter where you travel in the country.

What if a doctor says they don't accept this plan?

Ask the doctor or care provider to call the phone number on the back of your health plan ID card. We'll explain to them how they can submit a claim for your visit.

How to find care

Once you enroll, you'll be able to use our helpful Find Care tool to search for doctors and other care providers in your area.

Are you ready to enroll?

Visit page 13 to get started.



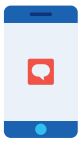
Questions?

Call our First Impressions Welcome team for answers or plan details, and provide this group specific code IN005GRS. **1-833-848-8729** (TTY: **711**) **Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays**.

* Out-of-network or noncontracted care providers are not obligated to treat plan members except in emergency situations. Contact the First Impressions Welcome team for more information.

Perks and programs

This plan includes useful tools and programs to support your health and well-being — at no additional cost. Once you enroll, you'll have access and can begin using these valuable benefits.



Manage your health with our online tools and programs

Sydney Health app[1]

The Sydney℠ Health app offers you ways to stay healthy and manage your health plan, all from the palm of your hand.[2]

After you receive your ID card, you can download the app from the App Store® or Google Play™. Then use the information on the card to set up your account. It only takes a few minutes to register.

Use the app to:

- See a live doctor via a virtual visit.
- Access plan and health resources.
- Check the status of claims.
- Use home delivery for prescription drugs.

MyHealth Advantage[6]

MyHealth Advantage sends you mailed reminders about ways to protect your health. You'll also have access to health specialists who can answer your questions.

LiveHealth Online®[3]

Visit with a doctor, therapist, or psychiatrist through live video on your phone, tablet, or computer with a camera. It's a great way to:

- Access a board-certified doctor in the comfort of your home, 24/7.
- Find help with common conditions like the flu, colds, sinus infections, pink eye, and skin rashes — and even have prescriptions sent to the pharmacy if needed.[4]
- Set up a 45-minute counseling session with a licensed therapist to find help when you feel depressed, anxious, or stressed. You can also meet with a board-certified psychiatrist to get medication management support if talk therapy alone isn't enough.[5]
- With the Anthem plan, video visits using LiveHealth Online are $0.

1 Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan.
2 Online tools are offered to Anthem plan members as extra services. They are not part of the contract and can change or stop.
3 LiveHealth Online is offered through an arrangement with Amwell, a separate company, providing telehealth services on behalf of your health plan.
4 Prescription availability is defined by physician judgment.
5 Prescriptions determined to be a "controlled substance" (as defined by the Controlled Substances Act under federal law) cannot be prescribed using LiveHealth Online. Psychiatrists on LiveHealth Online will not offer counseling or talk therapy. Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it's important that you seek help immediately. Please call 988 (National Suicide Prevention Lifeline) or 911 and ask for help.
6 Carelon Health, Inc. is a separate company providing care management services on behalf of Anthem. In addition to using a telehealth service, you can receive in-person or virtual care from your own doctor or another healthcare provider in your plan's network. If you receive care from a doctor or healthcare provider not in your plan's network, your share of the costs may be higher. You may also receive a bill for any charges not covered by your health plan.

Perks and programs

Convenient care services

The House Call program

Receive an annual in-home or virtual health evaluation from a licensed clinician in the comfort of your own home to support the ongoing care you receive from your doctors.

24/7 NurseLine[7]

24/7 NurseLine puts you in touch with a registered nurse anytime of the day or night. Call **1-800-700-9184** (TTY: **711**) to have your questions answered.

Carelon Health Palliative Care[8]

In the event of a serious illness, Carelon Health Palliative Care is a community-based program that can provide an extra layer of support. A team of doctors, nurse practitioners, nurses, and social workers would work with your primary care provider to coordinate care. The Carelon Health Palliative Care clinical team is available 24/7. They provide extra care and attention, as well as education about illness, your plan of care, and medications. These services are provided through a combination of home-based visits and telehealth support.



Questions?

Call our First Impressions Welcome team for answers or plan details, and provide this group specific code IN005GRS. **1-833-848-8729** (TTY: **711**) **Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays**.

7 The information contained in this program is for general guidance only. Your doctor will be specific regarding recommendations for your individual circumstances. Recommended treatments may not be covered under your health plan.

8 The Carelon companies are separate companies providing behavioral health, care pathways, pharmacy, and value-based care delivery solutions through our digital platforms and technology services and research on behalf of Anthem Blue Cross and Blue Shield.

Perks and programs

Supporting your whole health

SilverSneakers®

SilverSneakers is a fitness and lifestyle benefit that offers the opportunity to connect with your community, make friends, and stay active. Your membership gives you:[9]

- Access to thousands of participating locations with use of basic amenities, plus group exercise classes for all levels at select locations.[10, 11]
- The SilverSneakers GO™ app so you can find locations near you, participate in live classes from your phone, and tailor workouts to your fitness level.
- Access to SilverSneakers LIVE virtual classes and the On-Demand library with hundreds of online videos so you can work out at home.

To find a location near you or join virtual classes, visit **www.silversneakers.com/starthere** or call **1-855-741-4985**, TTY: **711**, Monday to Friday, 8 a.m. to 8 p.m. ET.

9 Always talk with your doctor before starting an exercise program.
10 Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL.
11 Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location.
The SilverSneakers fitness program is provided by Tivity Health, an independent company. SilverSneakers and the SilverSneakers shoe logotype are registered trademarks of Tivity Health, Inc. SilverSneakers On-Demand and SilverSneakers GO are trademarks of Tivity Health, Inc. © 2025 Tivity Health, Inc. All rights reserved.

What is Medicare?

Medicare is a federal government health insurance program for people 65 or older. You may also be eligible if you:

- Are under age 65 with certain disabilities
- Have end-stage renal disease (ESRD)
- Have 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 Advantage 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 Advantage vs. Original Medicare



Compare coverage

The good thing about Medicare Advantage is that it limits how much you'll spend each year on treatment. Plus, the prices are often fixed, so you'll have a better idea of any costs beforehand.

Medicare Advantage can include prescription drug coverage (Part D) — something Original Medicare doesn't offer.

Medicare Advantage	Original Medicare
Plan pays 100% of covered medical costs for rest of plan year after annual out-of-pocket maximum is met*	No limit to medical costs you will pay annually — no annual out-of-pocket maximum
You will often pay copays (fixed dollar amounts)	You will pay percentage of cost (20% of the cost for common services like outpatient surgery and doctor visits)
Can include Part D prescription drug coverage	No Part D prescription drug coverage
Emergency care is covered outside of U.S.	No emergency care coverage outside of U.S.

* Not all medical costs are included in or are subject to the annual out-of-pocket maximum. Call our First Impressions Welcome team if you have questions about plan benefits. 1-833-848-8729 (TTY: 711) Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays.

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 drug 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

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.

Drug type	Description	Possible tier coverage[2]	Cost
Generic[1,2]	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	$$$$

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.

How to qualify and enroll

Qualifications for enrolling in Anthem Medicare Preferred (PPO) 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 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.

To enroll, please complete the enrollment election form on the next page. The scissors icon and dotted line show where to cut it out. Don't forget to include your signature and mail to the address listed on the form.

To complete the form, you'll need:

- **Your Medicare number.** Fill out the requested information as it appears on your red, white, and blue 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.**
- **To complete all items on the enrollment election form.** Double check that you've filled out the form entirely and included your signature.

Understanding the Medicare Prescription Payment Plan:

This is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for Part D covered drugs by spreading them across the calendar year (January - December). It does not apply to Part B drugs. It also does not apply to Extra Covered Drugs if your plan includes this benefit. Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.

"Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option. To learn more about this option, call us at 1-833-246-7717 (TTY users call 711) or visit **www.medicare.gov**.

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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: **Retired Indiana Public Employees Insurance Trust**	Group #: **IN005GRS**
Plan you will join (check ONE box only): Anthem Medicare Preferred (PPO) with Senior Rx Plus ☐ 10PL- 4/12/42/95/250 ($115.80 per month) ☐ 10PL- 15/40/75/25% ($162.32 per month) ☐ 15PD- 4/12/42/95/250 ($168.71 per month) ☐ 20PD- 5/10/45/40%/250 ($237.25 per month)	Requested effective date of coverage: (__ __/__ __/__ __ __ __) (MM/DD/YYYY) 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 or phone with Important Plan Information.

In addition, may we also contact you about additional products and services that might interest you by email.

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

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 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. Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No
3. Do you have other medical insurance? ☐ Yes ☐ No If "yes," what is the name of the health plan (e.g., Aetna, Humana, Cigna)? _____ What are the effective dates of coverage? _____
4. 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:_____ _____
5. 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: _____ _____ _____
This document may be available in an alternate format, such as large print. Please call the First Impressions Welcome team at **1-833-848-8729**, 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:

By completing this enrollment application, I agree to the following:

- I must keep Medicare Part A and Part B to stay in the plan I have selected.
- **Release of information:** By joining this Medicare Advantage with (Part D) prescription drug plan, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment, and healthcare 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 Anthem Medicare Preferred (PPO) with Senior Rx Plus coverage begins, I must get all of my medical and 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 Anthem Medicare Preferred (PPO) 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 as a member of this plan, I have the right to ask about the plan's decision regarding payments or coverage for services I receive. I also have the right to appeal plan decisions about payment or services if I disagree.
- I understand that by enrolling in this Medicare Advantage plan, I will automatically be disenrolled by CMS from any other Medicare Advantage plan or Medicare Part D prescription drug plan. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform the plan of any other prescription drug coverage that I have or may obtain in the future.
- 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:

HIPAA authorization
If you would like to authorize an individual to have the ability to speak with us and/or obtain protected health information (PHI) on your account, please complete the HIPAA (Health Insurance Portability and Accountability Act) Member Authorization Form located at **www.anthem.com/forms**. This form is valid for one year from the signature date. • A printed form can be requested by contacting Member Services at the telephone number on the back of your ID card. **Sign and return it to the address on the form.** • If you wish to continue having the authorized representative on your account, a new form is required annually. • If you have a durable healthcare power of attorney document, it can also be returned with the HIPAA form.

Please return this enrollment election form to:

IN005GRS
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 an PPO 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 is the trade name of Anthem HP, LLC and Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield Retiree Solutions. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia with its affiliate Healthkeepers, Inc., 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.

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Anthem

Please check one of the boxes below to indicate premium payment method for your Anthem Medicare Preferred (PPO) with Senior Rx Plus plan:

☐ Deduct premium from pension fund

☐ Bill me directly (This is the default if no selection is made)

Pension deduction option is available for Medicare eligible retirees, spouse and dependents. If you are the spouse and would like to select the pension deduction as your payment method, please have retiree sign below to authorize.

REQUIRED INFORMATION IF PENSION DEDUCTION IS SELECTED ABOVE:

TRF/Pension Identification Number (PID)* _____

Retiree signature_____ **Today's date**_____

* If you are unable to locate your PID, or your PID was not provided, please contact **Indiana Public Retirement System (INPRS) at 1-844-464-6777**.

Note: If Pension deduction is selected and not available, Direct Billing will apply and an invoice including any retroactive premiums due will be sent to the address on file.

INTERNAL ANTHEM USE ONLY:
PID must be entered to EEID with enrollment processing for billing processes.

Please return this form with your enrollment election form

Anthem

Chronic Condition Verification Form
Special Supplemental Benefits for the Chronically Ill (SSBCI)

If you have a chronic health condition, and think that you qualify for Special Supplemental Benefits for the Chronically Ill (SSBCI) based on the requirements found on the next page of this form, please follow the instructions below:

1. Fill out the **Member Information** section.
2. Take this form to your healthcare provider to fill out the **Provider Information** section.
3. Submit the completed form by faxing it to **800-833-8554**, uploading it to your secure online account at **www.anthem.com**, or mailing it to P.O. Box 659403, San Antonio, TX 78265-9714.

Member Information	
Member first name:	Member last name:
Date of birth:	
Medicare beneficiary ID:	
Member ID:	

Provider Information	
By signing below, I certify that the above referenced patient meets the defined criteria to receive Special Supplemental Benefits for the Chronically Ill as outlined on the following page of this form.	
Provider first name:	Provider last name:
Street address:	City:
State:	ZIP:
Phone number:	
Fax number:	
NPI:	
I certify that the patient meets the defined criteria. Signature:	Date:

Supplemental Benefits for the Chronically Ill Qualifying Conditions

Per CMS guidelines, members must have one of the eligible chronic conditions listed and have a condition that:

- Is life-threatening or significantly limits overall health or function,
- Has a high risk of hospitalization or other adverse health outcomes,
- And requires intensive care coordination.

Meeting these conditions must be demonstrated by one or more of the following:

- One or more inpatient admissions (inclusive of behavioral health) related to the chronic condition in the last 12 months, OR
- One or more urgent care or emergency room visits related to the chronic condition in the last 12 months, OR
- Two or more outpatient visits related to the chronic condition (including primary care or specialty care visits) in the last 12 months, OR
- Is a patient who requires home health visits related to the chronic condition, OR
- Is a patient who has an impairment in daily living activities related to the chronic condition (bathing, dressing, toileting, transferring, and eating) or cognitive impairments, OR
- Is a patient with a chronic condition and a need for one or more durable medical equipment (DME) in the outpatient setting (including but not limited to): group 3 power / manual wheelchair, non-invasive ventilation (NIV), wound vacuums, bipap machines, mechanical in-exsufflation devices, group 2 or group 3 mattresses.

Eligible conditions include:

- Chronic alcohol use disorder and other substance use disorders
- Autoimmune disorders:
  - Polyarteritis nodosa
  - Polymyalgia rheumatica
  - Polymyositis
  - Dermatomyositis
  - Rheumatoid arthritis
  - Systemic lupus erythematosus
  - Psoriatic arthritis
  - Scleroderma
- Cancer
- Cardiovascular disorders:
  - Cardiac arrhythmias
  - Coronary artery disease
  - Peripheral vascular disease
  - Valvular heart disease
- Chronic heart failure
- Dementia
- Diabetes mellitus:
  - Pre-diabetes (Fasting blood glucose: 100-125 mg/dl or Hgb A1C:5.7-6.4%)
- Overweight, obesity, and metabolic syndrome
- Chronic gastrointestinal disease:
  - Chronic liver disease
  - Non-alcoholic fatty liver disease (NAFLD)
  - Hepatitis B
  - Hepatitis C
  - Pancreatitis
  - Irritable bowel syndrome
  - Inflammatory bowel disease

- Chronic kidney disease (CKD):
  - CKD requiring dialysis/ End-stage renal disease (ESRD)
  - CKD not requiring dialysis
- Severe hematologic disorders:
  - Aplastic anemia
  - Hemophilia
  - Immune thrombocytopenic purpura
  - Myelodysplastic syndrome
  - Sickle-cell disease (excluding sickle-cell trait)
  - Chronic venous thromboembolic disorder
- HIV/AIDS
- Chronic lung disorders:
  - Asthma
  - Chronic bronchitis
  - Cystic fibrosis
  - Emphysema
  - Pulmonary fibrosis
  - Pulmonary hypertension
  - Chronic obstructive Pulmonary disease (COPD)
- Chronic and disabling mental health conditions:
  - Bipolar disorders
  - Major depressive disorders
  - Paranoid disorder
  - Schizophrenia
  - Schizoaffective disorder
  - Post-traumatic stress disorder (PTSD)
  - Eating disorders
  - Anxiety disorders
- Neurologic disorders:
  - Amyotrophic lateral sclerosis (ALS)
  - Cerebral palsy
  - Epilepsy
  - Extensive paralysis (hemiplegia, quadriplegia, paraplegia, monoplegia)
  - Huntington's disease
  - Multiple sclerosis
  - Parkinson's disease
  - Polyneuropathy
  - Fibromyalgia
  - Chronic fatigue syndrome
  - Spinal cord injuries
  - Spinal stenosis
  - Stroke-related neurologic deficit
  - Traumatic brain injury
- Stroke
- Post-organ transplantation care
- Immunodeficiency and immunosuppressive disorders
- Conditions that may cause cognitive impairment:
  - Alzheimer's disease
  - Intellectual and developmental disabilities
  - Traumatic brain injuries
  - Disabling mental illness associated with cognitive impairment
  - Mild cognitive impairment
- Conditions that may cause similar functional challenges and require similar services:
  - Spinal cord injuries
  - Paralysis
  - Limb loss
  - Stroke
  - Arthritis
- Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell
- Conditions that require continued therapy services in order for individuals to maintain or retain functioning
- Other:
  - Hypertension
  - Osteoporosis
  - Chronic back pain

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 and Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield Retiree Solutions. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia with its affiliate Healthkeepers, Inc., 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.

What to expect after you enroll



How to give others access to your health records

Fill out your Member Authorization Form at **www.anthem.com/forms** to give people that you choose access to your health records.



Keep an eye on your mailbox

After you enroll, you can sit back and relax. Once your enrollment is processed, you will receive:

- Proof of your enrollment request with your membership start date listed.
- Your ID card. You can begin using this card on your membership start date.
- A health survey to help us understand and address your needs. Within your first 90 days, we will call you to answer a simple health survey to help keep your care and services up to date.



Look out for your plan Welcome Guide

This guide can help you:

- Learn how to contact us.
- Access plan documents online.
- Find the right resources for more information.

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 this group specific code IN005GRS. **1-833-848-8729** (TTY: **711**) Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays.

Retired Indiana Public Employees Insurance Trust (RIPEA)

2026 Summary of Benefits

PPO Plan 10PL

About this Plan:

For comprehensive information about all the services and any limitations or exclusions, please refer to your Evidence of Coverage (EOC). Upon enrolling in the plan, you'll receive guidance on accessing your plan details online. You can conveniently view your EOC by logging into the member portal at **www.anthem.com**, or you can call Member Services with any questions you may have.

Doctor and hospital choice: You may go to doctors, specialists, and hospitals in or out of the network. You do not need a referral.

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

How much is the monthly premium?
Contact your group plan sponsor/union for more information on your plan premium.

Anthem Medicare Preferred (PPO) Benefits Effective: 01/01/2026 – 12/31/2026

Plan Features	In-network:	Out-of-network:
Annual medical deductible:	$0 combined in-network and out-of-network	
Maximum out-of-pocket responsibility: (Does not include Part D prescription drugs)	$6,000 combined in-network and out-of-network	

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Inpatient hospital care* No limit to the number of days covered by the plan	$275 copay per day for days 1-7 per admission	$275 copay per day for days 1-7 per admission
Outpatient hospital facility or ambulatory surgical center visit for surgery*	$225 copay per visit	$225 copay per visit
Outpatient hospital services observation room	$225 copay per visit	$225 copay per visit
Primary care office visit	$10 copay per visit	$10 copay per visit
Specialty care office visit	$40 copay per visit	$40 copay per visit
Preventive care, screenings, and tests	$0 copay per visit	$0 copay per visit
Emergency care	$90 copay per visit $90 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.	
Urgently needed services	$35 copay per visit $35 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.	
X-ray visit and/or simple diagnostic test*	$40 copay per visit	$40 copay per visit
Complex diagnostic test and/or radiology visit*	$125 copay per visit	$125 copay per visit
Radiation therapy treatment*	20% coinsurance per visit	20% coinsurance per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Clinical/diagnostic lab test*	$0 copay per visit	$0 copay per visit
Medicare-covered basic hearing and balance exams performed by your specialist*	$40 copay per visit	$40 copay per visit
Routine hearing services We have partnered with TruHearing to bring you these discounts and services.	Must use a TruHearing participating provider. **Hearing exams** $0 copay for routine hearing exams 1 exam every calendar year combined in-network and out-of-network **Hearing aids fitting evaluation** $0 copay for hearing aid fitting evaluations 1 evaluation per covered hearing aid combined in-network and out-of-network **Routine hearing exams and fitting evaluations limit** $70 maximum benefit every calendar year combined in-network and out-of-network **Hearing aids** $0 copay for hearing aids $500 maximum benefit every calendar year	Out-of-network providers must order hearing aids through TruHearing. **Hearing exams** $0 copay for routine hearing exams 1 exam every calendar year combined in-network and out-of-network **Hearing aids fitting evaluation** $0 copay for hearing aid fitting evaluations 1 evaluation per covered hearing aid combined in-network and out-of-network **Routine hearing exams and fitting evaluations limit** $70 maximum benefit every calendar year combined in-network and out-of-network **Hearing aids** $0 copay for hearing aids through TruHearing $500 maximum benefit every calendar year
Medicare-covered dental is non-routine care performed by your specialist*	$40 copay per visit	$40 copay per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Routine dental services	Must use a LIBERTY Dental participating provider. $0 copay for routine dental services $75 maximum benefit per year combined in-network and out-of-network	$0 copay for routine dental services $75 maximum benefit per year combined in-network and out-of-network
Medicare-covered exams performed by your specialist to diagnose and treat eye diseases and conditions	$40 copay per visit	$40 copay per visit
Medicare-covered glaucoma screening	$0 copay per visit	$0 copay per visit
Medicare-covered eyewear following cataract surgery	$0 copay per surgery	$0 copay per surgery
Routine vision services	Must use a Blue View Vision provider. **Exams** $0 copay for routine vision exams 1 exam every calendar year combined in-network and out-of-network **Eyewear** $0 copay for eyewear $100 maximum benefit every two calendar years combined in-network and out-of-network **Non-elective contact lenses** $0 copay for non-elective contact lenses 1 pair every two calendar years combined in-network and out-of-network	Member must submit a claim form for reimbursement **Exams** $70 reimbursement for routine vision exams 1 exam every calendar year combined in-network and out-of-network **Eyewear** $100 reimbursement for eyewear, maximum benefit every two calendar years combined in-network and out-of-network **Non-elective contact lenses** 100% reimbursement for non-elective contact lenses 1 pair every two calendar years combined in-network and out-of-network
Inpatient services in a psychiatric hospital* No limit to the number of days covered by the plan	$235 copay per day for days 1-6 per admission	$235 copay per day for days 1-6 per admission

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Mental health professional individual therapy visit	$40 copay per visit	$40 copay per visit
Substance use disorder professional individual therapy visit	$40 copay per visit	$40 copay per visit
Skilled nursing facility (SNF) care*	$0 copay for days 1-20 per benefit period $172 copay per day for days 21-100 per benefit period 100-day limit per benefit period	$0 copay for days 1-20 per benefit period $172 copay per day for days 21-100 per benefit period 100-day limit per benefit period
Outpatient rehabilitation services*	$40 copay per visit	$40 copay per visit
Ambulance services	Your provider must get an approval from the plan before you get ground, air, or water transportation that is not an emergency. $265 copay per one-way trip for ambulance services	
Medicare Part B drugs*	20% coinsurance for Part B drugs	20% coinsurance for Part B drugs
Chiropractic services Medicare-covered	$15 copay per visit	$15 copay per visit
Acupuncture for chronic low back pain Medicare-covered	$10 copay per visit	$10 copay per visit
Cardiac rehabilitation services*	$0 copay per visit	$0 copay per visit
Pulmonary rehabilitation services*	$15 copay per visit	$15 copay per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Blood glucose test strips, lancets, lancet devices, and glucose control solutions For a 30 day supply	**If purchased through a pharmacy:** $0 copay per purchase for FreeStyle® (made by Abbott) and ACCU-CHEK® (made by Roche Diagnostics) $10 copay per purchase for all other brands when purchased through the pharmacy	**If purchased through a pharmacy:** $0 copay per purchase for FreeStyle® (made by Abbott) and ACCU-CHEK® (made by Roche Diagnostics) $10 copay per purchase for all other brands when purchased through the pharmacy
Blood glucose monitors	**If purchased through a pharmacy:** $0 copay per purchase for FreeStyle® (made by Abbott) and ACCU-CHEK® (made by Roche Diagnostics) $10 copay per purchase for all other brands when purchased through the pharmacy	**If purchased through a pharmacy:** $0 copay per purchase for FreeStyle® (made by Abbott) and ACCU-CHEK® (made by Roche Diagnostics) $10 copay per purchase for all other brands when purchased through the pharmacy
Therapeutic shoes	$0 copay per purchase	$0 copay per purchase
Diabetes self-management training	$0 copay per visit	$0 copay per visit
Continuous glucose monitors (CGMs)*	$0 copay per purchase for FreeStyle Libre® (made by Abbott) and Dexcom	$0 copay per purchase for FreeStyle Libre® (made by Abbott) and Dexcom
Durable medical equipment (DME) and related supplies*	20% coinsurance per purchase	20% coinsurance per purchase
Opioid treatment program services*	$40 copay per visit	$40 copay per visit
Podiatry services*	$10 copay per visit	$10 copay per visit
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.	$10 copay per visit 12 visits per year combined in-network and out-of-network	$10 copay per visit 12 visits per year combined in-network and out-of-network

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Home health agency care*	$0 copay per visit	$0 copay per visit
Hospice care	$40 copay for the one time only consultation 1 visit per lifetime When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan.	$40 copay for the one time only consultation 1 visit per lifetime When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan.

Additional covered benefits and services	Member pays unless specified:
Video doctor visits LiveHealth Online†	$0 copay for video doctor visits using LiveHealth Online
Health and wellness education programs SilverSneakers® Membership† Take fitness classes virtually or visit a participating location.	$0 copay for the SilverSneakers fitness benefit
24/7 NurseLine†	$0 copay for 24/7 NurseLine
Foreign travel (outside U.S. and its territories) Emergency care Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Emergency care** $90 copay for emergency care $90 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.
Foreign travel (outside U.S. and its territories) Urgently Needed Services Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Urgently needed services** $35 copay for urgently needed services $35 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.
Foreign travel (outside U.S. and its territories) Emergency Inpatient Care Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Inpatient care** $275 copay per day for days 1-7 per admission 60 days per lifetime
Healthy Meals†§* Meals delivered after being discharged from inpatient hospital visit or for members living with a chronic condition and qualify under Special Supplemental Benefits for the Chronically Ill	$0 copay for Healthy Meals 14 meals per qualifying event, allows up to four (4) events each year (56 meals in total).
Medicare Community Resource Support	$0 copay for Medicare Community Resource Support

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

This document reflects cost shares only.

†Must use the plan approved provider

§ The benefits mentioned are Special Supplemental Benefits for the Chronically Ill (SSBCI). You may qualify for SSBCI if you have a high risk for hospitalization and require intensive care coordination to manage chronic conditions such as Chronic Kidney Diseases, Chronic Lung Disorders, Cardiovascular Disorders, Chronic Heart Failure, or Diabetes. For a full list of chronic conditions or to learn more about other eligibility requirements needed to qualify for SSBCI benefits, please refer to Chapter 4 in the plan's Evidence of Coverage (EOC).

Some of the benefits and limitations listed above are combined in-network and out-of-network.

This information is not a complete description of the benefits. Contact the plan for more information. Limitations, copayments, coinsurance, and restrictions may apply. If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

Benefits, premiums and/or copayments/coinsurance may change upon renewal or on January 1 of each year.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our member service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service.

Medicare & You 2026 resource: For more information, we encourage you to read Medicare & You 2026. This booklet is mailed to people with Medicare every year in the fall. It has a summary of Medicare benefits, rights, and protections. It also includes answers to the most frequently asked questions. If you don't have a copy of this booklet, request one at **www.medicare.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**.

LiveHealth Online is offered through an arrangement with Amwell, a separate company, providing telehealth services on behalf of your health plan.

SilverSneakers is a registered trademark of Tivity Health. All rights reserved Tivity Health, Inc. is an independent company providing a fitness program on behalf of this plan.

Hearing benefit management administered by TruHearing, an independent company.

Prescription Drug Summary of Benefits: 01/01/2026 – 12/31/2026
Formulary B5, 4/12/42/95/250 (with Senior Rx Plus)

Retired Indiana Public Employees Insurance Trust (RIPEA)

About this Plan:

For comprehensive information about all the services and any limitations or exclusions, please refer to your Evidence of Coverage (EOC). Upon enrolling in the plan, you'll receive guidance on accessing your plan details online. You can conveniently view your EOC by logging into the member portal at **www.anthem.com**, or you can call Member Services with any questions you may have.

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

How much is the monthly premium?
Contact your group plan sponsor/union for more information on your plan premium.

Prescription Drug Summary of Benefits: 01/01/2026 – 12/31/2026

Stage 1 Annual Deductible Stage

In this stage, you pay a set amount. Once you reach this amount, your plan begins to pay its share of the cost.

Deductible: $0

Stage 2 Initial Coverage Stage

Below is your payment responsibility for covered prescriptions until you reach the **CMS defined drug out-of-pocket limit** of $2,100.

Retail Pharmacy	Standard Network Pharmacy		Mail-Order Pharmacy
	per 30-day supply (Specialty limited to a 30-day supply)	per 90-day supply	per 90-day supply (Specialty limited to a 30-day supply)
Tier 1: Select Generics	$0	$0	$0
Tier 1: Preferred Generics	$4	$12	$0
Tier 2: Generics	$12	$36	$24
Tier 3: Preferred Drugs	$42	$126	$84
Tier 4: Non-Preferred Drugs	$95	$285	$190
Tier 5: Specialty Drugs	$250	N/A	$250

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 pay one copay for each full or partial 30-day supply filled. For example, if you order a 90-day supply, you will pay three 30-day supply copays. If you get a 45-day or 50-day supply, you will pay two 30-day copays.

Stage 3 Catastrophic Coverage Stage

Your payment responsibility changes after the amount you have paid for covered drugs reaches your **CMS defined drug out-of-pocket limit** of $2,100.

Retail and Mail-Order Pharmacies	Up to a 90-day supply (Specialty limited to a 30-day supply)
All Part D Covered Prescription Drugs	$0

- **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.

- **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 Part B medical coverage. Vaccines for Chicken Pox, Shingles, Tetanus, Diphtheria, Meningitis, Rabies, Polio, Yellow Fever and Hepatitis A are covered under Medicare Part D drug coverage. Hepatitis B is covered under Medicare Part D drug coverage unless you fall into a high risk category, then it is covered under Medicare Part B medical coverage. Other common vaccines are also covered under Medicare Part D drug coverage for Medicare-eligible individuals under 65. You can fill 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 pay its share of the cost. 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. The copay or coinsurance shown in this benefits chart is the amount you pay for covered drugs filled at network pharmacies.

This document reflects cost shares only.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, coinsurance, and restrictions may apply. If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

Benefits, premiums and/or copayments/coinsurance may change upon renewal or on January 1 of each year.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Medicare & You 2026 resource: For more information, we encourage you to read Medicare & You 2026. This booklet is mailed to people with Medicare every year in the fall. It has a summary of Medicare benefits, rights, and protections. It also includes answers to the most frequently asked questions. If you don't have a copy of this booklet, request one at www.medicare.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**.

Retired Indiana Public Employees Insurance Trust (RIPEA)

2026 Summary of Benefits

PPO Plan 10PL

About this Plan:

For comprehensive information about all the services and any limitations or exclusions, please refer to your Evidence of Coverage (EOC). Upon enrolling in the plan, you'll receive guidance on accessing your plan details online. You can conveniently view your EOC by logging into the member portal at **www.anthem.com**, or you can call Member Services with any questions you may have.

Doctor and hospital choice: You may go to doctors, specialists, and hospitals in or out of the network. You do not need a referral.

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

How much is the monthly premium?
Contact your group plan sponsor/union for more information on your plan premium.

Anthem Medicare Preferred (PPO) Benefits Effective: 01/01/2026 – 12/31/2026

Plan Features	In-network:	Out-of-network:
Annual medical deductible:	$0 combined in-network and out-of-network	
Maximum out-of-pocket responsibility: (Does not include Part D prescription drugs)	$6,000 combined in-network and out-of-network	

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Inpatient hospital care* No limit to the number of days covered by the plan	$275 copay per day for days 1-7 per admission	$275 copay per day for days 1-7 per admission
Outpatient hospital facility or ambulatory surgical center visit for surgery*	$225 copay per visit	$225 copay per visit
Outpatient hospital services observation room	$225 copay per visit	$225 copay per visit
Primary care office visit	$10 copay per visit	$10 copay per visit
Specialty care office visit	$40 copay per visit	$40 copay per visit
Preventive care, screenings, and tests	$0 copay per visit	$0 copay per visit
Emergency care	$90 copay per visit $90 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.	
Urgently needed services	$35 copay per visit $35 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.	
X-ray visit and/or simple diagnostic test*	$40 copay per visit	$40 copay per visit
Complex diagnostic test and/or radiology visit*	$125 copay per visit	$125 copay per visit
Radiation therapy treatment*	20% coinsurance per visit	20% coinsurance per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Clinical/diagnostic lab test*	$0 copay per visit	$0 copay per visit
Medicare-covered basic hearing and balance exams performed by your specialist*	$40 copay per visit	$40 copay per visit
Routine hearing services We have partnered with TruHearing to bring you these discounts and services.	Must use a TruHearing participating provider. **Hearing exams** $0 copay for routine hearing exams 1 exam every calendar year combined in-network and out-of-network **Hearing aids fitting evaluation** $0 copay for hearing aid fitting evaluations 1 evaluation per covered hearing aid combined in-network and out-of-network **Routine hearing exams and fitting evaluations limit** $70 maximum benefit every calendar year combined in-network and out-of-network **Hearing aids** $0 copay for hearing aids $500 maximum benefit every calendar year	Out-of-network providers must order hearing aids through TruHearing. **Hearing exams** $0 copay for routine hearing exams 1 exam every calendar year combined in-network and out-of-network **Hearing aids fitting evaluation** $0 copay for hearing aid fitting evaluations 1 evaluation per covered hearing aid combined in-network and out-of-network **Routine hearing exams and fitting evaluations limit** $70 maximum benefit every calendar year combined in-network and out-of-network **Hearing aids** $0 copay for hearing aids through TruHearing $500 maximum benefit every calendar year
Medicare-covered dental is non-routine care performed by your specialist*	$40 copay per visit	$40 copay per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Routine dental services	Must use a LIBERTY Dental participating provider. $0 copay for routine dental services $75 maximum benefit per year combined in-network and out-of-network	$0 copay for routine dental services $75 maximum benefit per year combined in-network and out-of-network
Medicare-covered exams performed by your specialist to diagnose and treat eye diseases and conditions	$40 copay per visit	$40 copay per visit
Medicare-covered glaucoma screening	$0 copay per visit	$0 copay per visit
Medicare-covered eyewear following cataract surgery	$0 copay per surgery	$0 copay per surgery
Routine vision services	Must use a Blue View Vision provider. **Exams** $0 copay for routine vision exams 1 exam every calendar year combined in-network and out-of-network **Eyewear** $0 copay for eyewear $100 maximum benefit every two calendar years combined in-network and out-of-network **Non-elective contact lenses** $0 copay for non-elective contact lenses 1 pair every two calendar years combined in-network and out-of-network	Member must submit a claim form for reimbursement **Exams** $70 reimbursement for routine vision exams 1 exam every calendar year combined in-network and out-of-network **Eyewear** $100 reimbursement for eyewear, maximum benefit every two calendar years combined in-network and out-of-network **Non-elective contact lenses** 100% reimbursement for non-elective contact lenses 1 pair every two calendar years combined in-network and out-of-network
Inpatient services in a psychiatric hospital* No limit to the number of days covered by the plan	$235 copay per day for days 1-6 per admission	$235 copay per day for days 1-6 per admission

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Mental health professional individual therapy visit	$40 copay per visit	$40 copay per visit
Substance use disorder professional individual therapy visit	$40 copay per visit	$40 copay per visit
Skilled nursing facility (SNF) care*	$0 copay for days 1-20 per benefit period $172 copay per day for days 21-100 per benefit period 100-day limit per benefit period	$0 copay for days 1-20 per benefit period $172 copay per day for days 21-100 per benefit period 100-day limit per benefit period
Outpatient rehabilitation services*	$40 copay per visit	$40 copay per visit
Ambulance services	Your provider must get an approval from the plan before you get ground, air, or water transportation that is not an emergency. $265 copay per one-way trip for ambulance services	
Medicare Part B drugs*	20% coinsurance for Part B drugs	20% coinsurance for Part B drugs
Chiropractic services Medicare-covered	$15 copay per visit	$15 copay per visit
Acupuncture for chronic low back pain Medicare-covered	$10 copay per visit	$10 copay per visit
Cardiac rehabilitation services*	$0 copay per visit	$0 copay per visit
Pulmonary rehabilitation services*	$15 copay per visit	$15 copay per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Blood glucose test strips, lancets, lancet devices, and glucose control solutions For a 30 day supply	**If purchased through a pharmacy:** $0 copay per purchase for FreeStyle® (made by Abbott) and ACCU-CHEK® (made by Roche Diagnostics) $10 copay per purchase for all other brands when purchased through the pharmacy	**If purchased through a pharmacy:** $0 copay per purchase for FreeStyle® (made by Abbott) and ACCU-CHEK® (made by Roche Diagnostics) $10 copay per purchase for all other brands when purchased through the pharmacy
Blood glucose monitors	**If purchased through a pharmacy:** $0 copay per purchase for FreeStyle® (made by Abbott) and ACCU-CHEK® (made by Roche Diagnostics) $10 copay per purchase for all other brands when purchased through the pharmacy	**If purchased through a pharmacy:** $0 copay per purchase for FreeStyle® (made by Abbott) and ACCU-CHEK® (made by Roche Diagnostics) $10 copay per purchase for all other brands when purchased through the pharmacy
Therapeutic shoes	$0 copay per purchase	$0 copay per purchase
Diabetes self-management training	$0 copay per visit	$0 copay per visit
Continuous glucose monitors (CGMs)*	$0 copay per purchase for FreeStyle Libre® (made by Abbott) and Dexcom	$0 copay per purchase for FreeStyle Libre® (made by Abbott) and Dexcom
Durable medical equipment (DME) and related supplies*	20% coinsurance per purchase	20% coinsurance per purchase
Opioid treatment program services*	$40 copay per visit	$40 copay per visit
Podiatry services*	$10 copay per visit	$10 copay per visit
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.	$10 copay per visit 12 visits per year combined in-network and out-of-network	$10 copay per visit 12 visits per year combined in-network and out-of-network

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Home health agency care*	$0 copay per visit	$0 copay per visit
Hospice care	$40 copay for the one time only consultation 1 visit per lifetime When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan.	$40 copay for the one time only consultation 1 visit per lifetime When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan.

Additional covered benefits and services	Member pays unless specified:
Video doctor visits LiveHealth Online†	$0 copay for video doctor visits using LiveHealth Online
Health and wellness education programs SilverSneakers® Membership† Take fitness classes virtually or visit a participating location.	$0 copay for the SilverSneakers fitness benefit
24/7 NurseLine†	$0 copay for 24/7 NurseLine
Foreign travel (outside U.S. and its territories) Emergency care Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Emergency care** $90 copay for emergency care $90 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.
Foreign travel (outside U.S. and its territories) Urgently Needed Services Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Urgently needed services** $35 copay for urgently needed services $35 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.
Foreign travel (outside U.S. and its territories) Emergency Inpatient Care Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Inpatient care** $275 copay per day for days 1-7 per admission 60 days per lifetime
Healthy Meals†§* Meals delivered after being discharged from inpatient hospital visit or for members living with a chronic condition and qualify under Special Supplemental Benefits for the Chronically Ill	$0 copay for Healthy Meals 14 meals per qualifying event, allows up to four (4) events each year (56 meals in total).
Medicare Community Resource Support	$0 copay for Medicare Community Resource Support

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

This document reflects cost shares only.

†Must use the plan approved provider

§ The benefits mentioned are Special Supplemental Benefits for the Chronically Ill (SSBCI). You may qualify for SSBCI if you have a high risk for hospitalization and require intensive care coordination to manage chronic conditions such as Chronic Kidney Diseases, Chronic Lung Disorders, Cardiovascular Disorders, Chronic Heart Failure, or Diabetes. For a full list of chronic conditions or to learn more about other eligibility requirements needed to qualify for SSBCI benefits, please refer to Chapter 4 in the plan's Evidence of Coverage (EOC).

Some of the benefits and limitations listed above are combined in-network and out-of-network.

This information is not a complete description of the benefits. Contact the plan for more information. Limitations, copayments, coinsurance, and restrictions may apply. If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

Benefits, premiums and/or copayments/coinsurance may change upon renewal or on January 1 of each year.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our member service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service.

Medicare & You 2026 resource: For more information, we encourage you to read Medicare & You 2026. This booklet is mailed to people with Medicare every year in the fall. It has a summary of Medicare benefits, rights, and protections. It also includes answers to the most frequently asked questions. If you don't have a copy of this booklet, request one at **www.medicare.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**.

LiveHealth Online is offered through an arrangement with Amwell, a separate company, providing telehealth services on behalf of your health plan.

SilverSneakers is a registered trademark of Tivity Health. All rights reserved Tivity Health, Inc. is an independent company providing a fitness program on behalf of this plan.

Hearing benefit management administered by TruHearing, an independent company.

Prescription Drug Summary of Benefits: 01/01/2026 – 12/31/2026
Formulary E4, 15/40/75/25% (with Senior Rx Plus)

Retired Indiana Public Employees Insurance Trust (RIPEA)

About this Plan:

For comprehensive information about all the services and any limitations or exclusions, please refer to your Evidence of Coverage (EOC). Upon enrolling in the plan, you'll receive guidance on accessing your plan details online. You can conveniently view your EOC by logging into the member portal at **www.anthem.com**, or you can call Member Services with any questions you may have.

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

How much is the monthly premium?
Contact your group plan sponsor/union for more information on your plan premium.

Prescription Drug Summary of Benefits: 01/01/2026 – 12/31/2026

Stage 1 Annual Deductible Stage

In this stage, you pay a set amount. Once you reach this amount, your plan begins to pay its share of the cost.

Deductible: $0

Stage 2 Initial Coverage Stage

Below is your payment responsibility for covered prescriptions until you reach the **CMS defined drug out-of-pocket limit** of $2,100.

Retail Pharmacy	Standard Network Pharmacy		Mail-Order Pharmacy
	per 30-day supply (Specialty limited to a 30-day supply)	per 90-day supply	per 90-day supply (Specialty limited to a 30-day supply)
Tier 1: Select Generics	$0	$0	$0
Tier 1: Generics	$15	$45	$30
Tier 2: Preferred Drugs	$40	$120	$80
Tier 3: Non-Preferred Drugs	$75	$225	$150
Tier 4: Specialty Drugs	25%	N/A	25%

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 pay one copay for each full or partial 30-day supply filled. For example, if you order a 90-day supply, you will pay three 30-day supply copays. If you get a 45-day or 50-day supply, you will pay two 30-day copays.

Stage 3 Catastrophic Coverage Stage

Your payment responsibility changes after the amount you have paid for covered drugs reaches your **CMS defined drug out-of-pocket limit** of $2,100.

Retail and Mail-Order Pharmacies	Up to a 90-day supply (Specialty limited to a 30-day supply)
All Part D Covered Prescription Drugs	$0

- **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.

- **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 Part B medical coverage. Vaccines for Chicken Pox, Shingles, Tetanus, Diphtheria, Meningitis, Rabies, Polio, Yellow Fever and Hepatitis A are covered under Medicare Part D drug coverage. Hepatitis B is covered under Medicare Part D drug coverage unless you fall into a high risk category, then it is covered under Medicare Part B medical coverage. Other common vaccines are also covered under Medicare Part D drug coverage for Medicare-eligible individuals under 65. You can fill 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 pay its share of the cost. 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. The copay or coinsurance shown in this benefits chart is the amount you pay for covered drugs filled at network pharmacies.

This document reflects cost shares only.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, coinsurance, and restrictions may apply. If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

Benefits, premiums and/or copayments/coinsurance may change upon renewal or on January 1 of each year.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Medicare & You 2026 resource: For more information, we encourage you to read Medicare & You 2026. This booklet is mailed to people with Medicare every year in the fall. It has a summary of Medicare benefits, rights, and protections. It also includes answers to the most frequently asked questions. If you don't have a copy of this booklet, request one at www.medicare.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**.

Retired Indiana Public Employees Insurance Trust (RIPEA)

2026 Summary of Benefits

PPO Plan 15PD

About this Plan:

For comprehensive information about all the services and any limitations or exclusions, please refer to your Evidence of Coverage (EOC). Upon enrolling in the plan, you'll receive guidance on accessing your plan details online. You can conveniently view your EOC by logging into the member portal at **www.anthem.com**, or you can call Member Services with any questions you may have.

Doctor and hospital choice: You may go to doctors, specialists, and hospitals in or out of the network. You do not need a referral.

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

How much is the monthly premium?
Contact your group plan sponsor/union for more information on your plan premium.

Anthem Medicare Preferred (PPO) Benefits Effective: 01/01/2026 – 12/31/2026

Plan Features	In-network:	Out-of-network:
Annual medical deductible:	$150 combined in-network and out-of-network	
Maximum out-of-pocket responsibility: (Does not include Part D prescription drugs)	$2,900 combined in-network and out-of-network	

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Inpatient hospital care* No limit to the number of days covered by the plan	$500 copay per admission $1,500 out-of-pocket maximum per year combined with inpatient mental health care and combined in-network and out-of-network	$500 copay per admission $1,500 out-of-pocket maximum per year combined with inpatient mental health care and combined in-network and out-of-network
Outpatient hospital facility or ambulatory surgical center visit for surgery*	$150 copay per visit	$150 copay per visit
Outpatient hospital services observation room	$150 copay per visit	$150 copay per visit
Primary care office visit	$15 copay per visit	$15 copay per visit
Specialty care office visit	$30 copay per visit	$30 copay per visit
Preventive care, screenings, and tests	$0 copay per visit	$0 copay per visit
Emergency care	$75 copay per visit $75 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.	
Urgently needed services	$30 copay per visit $30 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.	
X-ray visit and/or simple diagnostic test*	$30 copay per visit	$30 copay per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Complex diagnostic test and/or radiology visit*	$75 copay per visit	$75 copay per visit
Radiation therapy treatment*	$30 copay per visit	$30 copay per visit
Clinical/diagnostic lab test*	$0 copay per visit	$0 copay per visit
Medicare-covered basic hearing and balance exams performed by your specialist*	$30 copay per visit	$30 copay per visit
Routine hearing services We have partnered with TruHearing to bring you these discounts and services.	Must use a TruHearing participating provider. **Hearing exams** $0 copay for routine hearing exams 1 exam every calendar year combined in-network and out-of-network **Hearing aids fitting evaluation** $0 copay for hearing aid fitting evaluations 1 evaluation per covered hearing aid combined in-network and out-of-network **Routine hearing exams and fitting evaluations limit** $70 maximum benefit every calendar year combined in-network and out-of-network **Hearing aids** $0 copay for hearing aids $500 benefit per ear with a $1,000 maximum benefit every three calendar years	Out-of-network providers must order hearing aids through TruHearing. **Hearing exams** $0 copay for routine hearing exams 1 exam every calendar year combined in-network and out-of-network **Hearing aids fitting evaluation** $0 copay for hearing aid fitting evaluations 1 evaluation per covered hearing aid combined in-network and out-of-network **Routine hearing exams and fitting evaluations limit** $70 maximum benefit every calendar year combined in-network and out-of-network **Hearing aids** $0 copay for hearing aids through TruHearing $500 benefit per ear with a $1,000 maximum benefit every three calendar years
Medicare-covered dental is non-routine care performed by your specialist*	$30 copay per visit	$30 copay per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Medicare-covered exams performed by your specialist to diagnose and treat eye diseases and conditions	$30 copay per visit	$30 copay per visit
Medicare-covered glaucoma screening	$0 copay per visit	$0 copay per visit
Medicare-covered eyewear following cataract surgery	20% coinsurance per surgery	20% coinsurance per surgery
Routine vision services	Must use a Blue View Vision provider. **Exams** $0 copay for routine vision exams 1 exam every calendar year combined in-network and out-of-network **Eyewear** $0 copay for eyewear $100 maximum benefit every two calendar years combined in-network and out-of-network **Non-elective contact lenses** $0 copay for non-elective contact lenses 1 pair every two calendar years combined in-network and out-of-network	Member must submit a claim form for reimbursement **Exams** $70 reimbursement for routine vision exams 1 exam every calendar year combined in-network and out-of-network **Eyewear** $100 reimbursement for eyewear, maximum benefit every two calendar years combined in-network and out-of-network **Non-elective contact lenses** 100% reimbursement for non-elective contact lenses 1 pair every two calendar years combined in-network and out-of-network
Inpatient services in a psychiatric hospital* No limit to the number of days covered by the plan	$500 copay per admission $1,500 out-of-pocket maximum per year combined with inpatient hospital care and combined in-network and out-of-network	$500 copay per admission $1,500 out-of-pocket maximum per year combined with inpatient hospital care and combined in-network and out-of-network
Mental health professional individual therapy visit	$30 copay per visit	$30 copay per visit
Substance use disorder professional individual therapy visit	$30 copay per visit	$30 copay per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Skilled nursing facility (SNF) care*	$0 copay for days 1-20 per benefit period $25 copay per day for days 21-100 per benefit period 100-day limit per benefit period	$0 copay for days 1-20 per benefit period $25 copay per day for days 21-100 per benefit period 100-day limit per benefit period
Outpatient rehabilitation services*	$30 copay per visit	$30 copay per visit
Ambulance services	Your provider must get an approval from the plan before you get ground, air, or water transportation that is not an emergency. $75 copay per one-way trip for ambulance services	
Medicare Part B drugs*	20% coinsurance for Part B drugs	20% coinsurance for Part B drugs
Chiropractic services Medicare-covered	$20 copay per visit	$20 copay per visit
Acupuncture for chronic low back pain Medicare-covered	$15 copay per visit	$15 copay per visit
Cardiac rehabilitation services*	$0 copay per visit	$0 copay per visit
Pulmonary rehabilitation services*	$20 copay per visit	$20 copay per visit
Blood glucose test strips, lancets, lancet devices, and glucose control solutions For a 30 day supply	**If purchased through a pharmacy:** $0 copay per purchase for FreeStyle® (made by Abbott) and ACCU-CHEK® (made by Roche Diagnostics) $10 copay per purchase for all other brands when purchased through the pharmacy	**If purchased through a pharmacy:** $0 copay per purchase for FreeStyle® (made by Abbott) and ACCU-CHEK® (made by Roche Diagnostics) $10 copay per purchase for all other brands when purchased through the pharmacy

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Blood glucose monitors	**If purchased through a pharmacy:** $0 copay per purchase for FreeStyle® (made by Abbott) and ACCU-CHEK® (made by Roche Diagnostics) $10 copay per purchase for all other brands when purchased through the pharmacy	**If purchased through a pharmacy:** $0 copay per purchase for FreeStyle® (made by Abbott) and ACCU-CHEK® (made by Roche Diagnostics) $10 copay per purchase for all other brands when purchased through the pharmacy
Therapeutic shoes	$0 copay per purchase	$0 copay per purchase
Diabetes self-management training	$0 copay per visit	$0 copay per visit
Continuous glucose monitors (CGMs)*	$0 copay per purchase for FreeStyle Libre® (made by Abbott) and Dexcom	$0 copay per purchase for FreeStyle Libre® (made by Abbott) and Dexcom
Durable medical equipment (DME) and related supplies*	10% coinsurance per purchase	10% coinsurance per purchase
Opioid treatment program services*	$30 copay per visit	$30 copay per visit
Podiatry services*	$15 copay per visit	$15 copay per visit
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.	$15 copay per visit 12 visits per year combined in-network and out-of-network	$15 copay per visit 12 visits per year combined in-network and out-of-network
Home health agency care*	$0 copay per visit	$0 copay per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Hospice care	$30 copay for the one time only consultation 1 visit per lifetime When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan.	$30 copay for the one time only consultation 1 visit per lifetime When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan.

Additional covered benefits and services	Member pays unless specified:
Video doctor visits LiveHealth Online†	$0 copay for video doctor visits using LiveHealth Online
Health and wellness education programs SilverSneakers® Membership† Take fitness classes virtually or visit a participating location.	$0 copay for the SilverSneakers fitness benefit
24/7 NurseLine†	$0 copay for 24/7 NurseLine
Foreign travel (outside U.S. and its territories) Emergency care Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Emergency care** $75 copay for emergency care $75 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.
Foreign travel (outside U.S. and its territories) Urgently Needed Services Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Urgently needed services** $30 copay for urgently needed services $30 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.
Foreign travel (outside U.S. and its territories) Emergency Inpatient Care Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Inpatient care** $500 copay per admission 60 days per lifetime
Healthy Meals†§* Meals delivered after being discharged from inpatient hospital visit or for members living with a chronic condition and qualify under Special Supplemental Benefits for the Chronically Ill	$0 copay for Healthy Meals 14 meals per qualifying event, allows up to four (4) events each year (56 meals in total).
Medicare Community Resource Support	$0 copay for Medicare Community Resource Support

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

This document reflects cost shares only.

†Must use the plan approved provider

§ The benefits mentioned are Special Supplemental Benefits for the Chronically Ill (SSBCI). You may qualify for SSBCI if you have a high risk for hospitalization and require intensive care coordination to manage chronic conditions such as Chronic Kidney Diseases, Chronic Lung Disorders, Cardiovascular Disorders, Chronic Heart Failure, or Diabetes. For a full list of chronic conditions or to learn more about other eligibility requirements needed to qualify for SSBCI benefits, please refer to Chapter 4 in the plan's Evidence of Coverage (EOC).

Some of the benefits and limitations listed above are combined in-network and out-of-network.

This information is not a complete description of the benefits. Contact the plan for more information. Limitations, copayments, coinsurance, and restrictions may apply. If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

Benefits, premiums and/or copayments/coinsurance may change upon renewal or on January 1 of each year.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our member service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service.

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SilverSneakers is a registered trademark of Tivity Health. All rights reserved Tivity Health, Inc. is an independent company providing a fitness program on behalf of this plan.

Hearing benefit management administered by TruHearing, an independent company.

Prescription Drug Summary of Benefits: 01/01/2026 – 12/31/2026
Formulary B5, 4/12/42/95/250 (with Senior Rx Plus)

Retired Indiana Public Employees Insurance Trust (RIPEA)

About this Plan:

For comprehensive information about all the services and any limitations or exclusions, please refer to your Evidence of Coverage (EOC). Upon enrolling in the plan, you'll receive guidance on accessing your plan details online. You can conveniently view your EOC by logging into the member portal at **www.anthem.com**, or you can call Member Services with any questions you may have.

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

How much is the monthly premium?
Contact your group plan sponsor/union for more information on your plan premium.

Prescription Drug Summary of Benefits: 01/01/2026 – 12/31/2026

Stage 1 Annual Deductible Stage

In this stage, you pay a set amount. Once you reach this amount, your plan begins to pay its share of the cost.

Deductible: $0

Stage 2 Initial Coverage Stage

Below is your payment responsibility for covered prescriptions until you reach the **CMS defined drug out-of-pocket limit** of $2,100.

Retail Pharmacy	Standard Network Pharmacy		Mail-Order Pharmacy
	per 30-day supply (Specialty limited to a 30-day supply)	per 90-day supply	per 90-day supply (Specialty limited to a 30-day supply)
Tier 1: Select Generics	$0	$0	$0
Tier 1: Preferred Generics	$4	$12	$0
Tier 2: Generics	$12	$36	$24
Tier 3: Preferred Drugs	$42	$126	$84
Tier 4: Non-Preferred Drugs	$95	$285	$190
Tier 5: Specialty Drugs	$250	N/A	$250

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 pay one copay for each full or partial 30-day supply filled. For example, if you order a 90-day supply, you will pay three 30-day supply copays. If you get a 45-day or 50-day supply, you will pay two 30-day copays.

Stage 3 Catastrophic Coverage Stage

Your payment responsibility changes after the amount you have paid for covered drugs reaches your **CMS defined drug out-of-pocket limit** of $2,100.

Retail and Mail-Order Pharmacies	Up to a 90-day supply (Specialty limited to a 30-day supply)
All Part D Covered Prescription Drugs	$0

- **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.

- **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 Part B medical coverage. Vaccines for Chicken Pox, Shingles, Tetanus, Diphtheria, Meningitis, Rabies, Polio, Yellow Fever and Hepatitis A are covered under Medicare Part D drug coverage. Hepatitis B is covered under Medicare Part D drug coverage unless you fall into a high risk category, then it is covered under Medicare Part B medical coverage. Other common vaccines are also covered under Medicare Part D drug coverage for Medicare-eligible individuals under 65. You can fill 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 pay its share of the cost. 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. The copay or coinsurance shown in this benefits chart is the amount you pay for covered drugs filled at network pharmacies.

This document reflects cost shares only.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, coinsurance, and restrictions may apply. If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

Benefits, premiums and/or copayments/coinsurance may change upon renewal or on January 1 of each year.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Medicare & You 2026 resource: For more information, we encourage you to read Medicare & You 2026. This booklet is mailed to people with Medicare every year in the fall. It has a summary of Medicare benefits, rights, and protections. It also includes answers to the most frequently asked questions. If you don't have a copy of this booklet, request one at www.medicare.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**.

Retired Indiana Public Employees Insurance Trust (RIPEA)

2026 Summary of Benefits

PPO Plan 20PD

About this Plan:

For comprehensive information about all the services and any limitations or exclusions, please refer to your Evidence of Coverage (EOC). Upon enrolling in the plan, you'll receive guidance on accessing your plan details online. You can conveniently view your EOC by logging into the member portal at **www.anthem.com**, or you can call Member Services with any questions you may have.

Doctor and hospital choice: You may go to doctors, specialists, and hospitals in or out of the network. You do not need a referral.

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

How much is the monthly premium?
Contact your group plan sponsor/union for more information on your plan premium.

Anthem Medicare Preferred (PPO) Benefits Effective: 01/01/2026 – 12/31/2026

Plan Features	In-network:	Out-of-network:
Annual medical deductible:	$200 combined in-network and out-of-network	
Maximum out-of-pocket responsibility: (Does not include Part D prescription drugs)	$500 combined in-network and out-of-network	

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Inpatient hospital care* No limit to the number of days covered by the plan	$0 copay per admission	$0 copay per admission
Outpatient hospital facility or ambulatory surgical center visit for surgery*	$0 copay per visit	$0 copay per visit
Outpatient hospital services observation room	$0 copay per visit	$0 copay per visit
Primary care office visit	$20 copay per visit	$20 copay per visit
Specialty care office visit	$20 copay per visit	$20 copay per visit
Preventive care, screenings, and tests	$0 copay per visit	$0 copay per visit
Emergency care	$50 copay per visit $50 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.	
Urgently needed services	$20 copay per visit $20 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.	
X-ray visit and/or simple diagnostic test*	$20 copay per visit	$20 copay per visit
Complex diagnostic test and/or radiology visit*	$20 copay per visit	$20 copay per visit
Radiation therapy treatment*	$20 copay per visit	$20 copay per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Clinical/diagnostic lab test*	$0 copay per visit	$0 copay per visit
Medicare-covered basic hearing and balance exams performed by your specialist*	$20 copay per visit	$20 copay per visit
Routine hearing services We have partnered with TruHearing to bring you these discounts and services.	Must use a TruHearing participating provider. **Hearing exams** $0 copay for routine hearing exams 1 exam every calendar year combined in-network and out-of-network **Hearing aids fitting evaluation** $0 copay for hearing aid fitting evaluations 1 evaluation per covered hearing aid combined in-network and out-of-network **Routine hearing exams and fitting evaluations limit** $70 maximum benefit every calendar year combined in-network and out-of-network **Hearing aids** $0 copay for hearing aids $500 maximum benefit every calendar year	Out-of-network providers must order hearing aids through TruHearing. **Hearing exams** $0 copay for routine hearing exams 1 exam every calendar year combined in-network and out-of-network **Hearing aids fitting evaluation** $0 copay for hearing aid fitting evaluations 1 evaluation per covered hearing aid combined in-network and out-of-network **Routine hearing exams and fitting evaluations limit** $70 maximum benefit every calendar year combined in-network and out-of-network **Hearing aids** $0 copay for hearing aids through TruHearing $500 maximum benefit every calendar year
Medicare-covered dental is non-routine care performed by your specialist*	$20 copay per visit	$20 copay per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Routine dental services	Must use a LIBERTY Dental participating provider. $0 copay for routine dental services $75 maximum benefit per year combined in-network and out-of-network	$0 copay for routine dental services $75 maximum benefit per year combined in-network and out-of-network
Medicare-covered exams performed by your specialist to diagnose and treat eye diseases and conditions	$20 copay per visit	$20 copay per visit
Medicare-covered glaucoma screening	$0 copay per visit	$0 copay per visit
Medicare-covered eyewear following cataract surgery	$0 copay per surgery	$0 copay per surgery
Routine vision services	Must use a Blue View Vision provider. **Exams** $0 copay for routine vision exams 1 exam every calendar year combined in-network and out-of-network **Eyewear** $0 copay for eyewear $100 maximum benefit every two calendar years combined in-network and out-of-network **Non-elective contact lenses** $0 copay for non-elective contact lenses 1 pair every two calendar years combined in-network and out-of-network	Member must submit a claim form for reimbursement **Exams** $70 reimbursement for routine vision exams 1 exam every calendar year combined in-network and out-of-network **Eyewear** $100 reimbursement for eyewear, maximum benefit every two calendar years combined in-network and out-of-network **Non-elective contact lenses** 100% reimbursement for non-elective contact lenses 1 pair every two calendar years combined in-network and out-of-network
Inpatient services in a psychiatric hospital* No limit to the number of days covered by the plan	$0 copay per admission	$0 copay per admission

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Mental health professional individual therapy visit	$20 copay per visit	$20 copay per visit
Substance use disorder professional individual therapy visit	$20 copay per visit	$20 copay per visit
Skilled nursing facility (SNF) care*	$0 copay for days 1-100 per benefit period 100-day limit per benefit period	$0 copay for days 1-100 per benefit period 100-day limit per benefit period
Outpatient rehabilitation services*	$20 copay per visit	$20 copay per visit
Ambulance services	Your provider must get an approval from the plan before you get ground, air, or water transportation that is not an emergency. $0 copay per one-way trip for ambulance services	
Medicare Part B drugs*	$0 copay for Part B drugs	$0 copay for Part B drugs
Chiropractic services Medicare-covered	$20 copay per visit	$20 copay per visit
Acupuncture for chronic low back pain Medicare-covered	$15 copay per visit	$15 copay per visit
Cardiac rehabilitation services*	$0 copay per visit	$0 copay per visit
Pulmonary rehabilitation services*	$20 copay per visit	$20 copay per visit
Blood glucose test strips, lancets, lancet devices, and glucose control solutions For a 30 day supply	**If purchased through a pharmacy:** $0 copay per purchase for FreeStyle® (made by Abbott) and ACCU-CHEK® (made by Roche Diagnostics) $10 copay per purchase for all other brands when purchased through the pharmacy	**If purchased through a pharmacy:** $0 copay per purchase for FreeStyle® (made by Abbott) and ACCU-CHEK® (made by Roche Diagnostics) $10 copay per purchase for all other brands when purchased through the pharmacy

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Blood glucose monitors	**If purchased through a pharmacy:** $0 copay per purchase for FreeStyle® (made by Abbott) and ACCU-CHEK® (made by Roche Diagnostics) $10 copay per purchase for all other brands when purchased through the pharmacy	**If purchased through a pharmacy:** $0 copay per purchase for FreeStyle® (made by Abbott) and ACCU-CHEK® (made by Roche Diagnostics) $10 copay per purchase for all other brands when purchased through the pharmacy
Therapeutic shoes	$0 copay per purchase	$0 copay per purchase
Diabetes self-management training	$0 copay per visit	$0 copay per visit
Continuous glucose monitors (CGMs)*	$0 copay per purchase for FreeStyle Libre® (made by Abbott) and Dexcom	$0 copay per purchase for FreeStyle Libre® (made by Abbott) and Dexcom
Durable medical equipment (DME) and related supplies*	$0 copay per purchase	$0 copay per purchase
Opioid treatment program services*	$20 copay per visit	$20 copay per visit
Podiatry services*	$20 copay per visit	$20 copay per visit
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.	$20 copay per visit 12 visits per year combined in-network and out-of-network	$20 copay per visit 12 visits per year combined in-network and out-of-network
Home health agency care*	$0 copay per visit	$0 copay per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Hospice care	$20 copay for the one time only consultation 1 visit per lifetime When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan.	$20 copay for the one time only consultation 1 visit per lifetime When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan.

Additional covered benefits and services	Member pays unless specified:
Video doctor visits LiveHealth Online†	$0 copay for video doctor visits using LiveHealth Online
Health and wellness education programs SilverSneakers® Membership† Take fitness classes virtually or visit a participating location.	$0 copay for the SilverSneakers fitness benefit
24/7 NurseLine†	$0 copay for 24/7 NurseLine
Foreign travel (outside U.S. and its territories) Emergency care Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Emergency care** $50 copay for emergency care $50 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.
Foreign travel (outside U.S. and its territories) Urgently Needed Services Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Urgently needed services** $20 copay for urgently needed services $20 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.
Foreign travel (outside U.S. and its territories) Emergency Inpatient Care Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Inpatient care** $0 copay per admission 60 days per lifetime
Healthy Meals†§* Meals delivered after being discharged from inpatient hospital visit or for members living with a chronic condition and qualify under Special Supplemental Benefits for the Chronically Ill	$0 copay for Healthy Meals 14 meals per qualifying event, allows up to four (4) events each year (56 meals in total).
Medicare Community Resource Support	$0 copay for Medicare Community Resource Support

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

This document reflects cost shares only.

†Must use the plan approved provider

§ The benefits mentioned are Special Supplemental Benefits for the Chronically Ill (SSBCI). You may qualify for SSBCI if you have a high risk for hospitalization and require intensive care coordination to manage chronic conditions such as Chronic Kidney Diseases, Chronic Lung Disorders, Cardiovascular Disorders, Chronic Heart Failure, or Diabetes. For a full list of chronic conditions or to learn more about other eligibility requirements needed to qualify for SSBCI benefits, please refer to Chapter 4 in the plan's Evidence of Coverage (EOC).

Some of the benefits and limitations listed above are combined in-network and out-of-network.

This information is not a complete description of the benefits. Contact the plan for more information. Limitations, copayments, coinsurance, and restrictions may apply. If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

Benefits, premiums and/or copayments/coinsurance may change upon renewal or on January 1 of each year.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our member service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service.

Medicare & You 2026 resource: For more information, we encourage you to read Medicare & You 2026. This booklet is mailed to people with Medicare every year in the fall. It has a summary of Medicare benefits, rights, and protections. It also includes answers to the most frequently asked questions. If you don't have a copy of this booklet, request one at **www.medicare.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**.

LiveHealth Online is offered through an arrangement with Amwell, a separate company, providing telehealth services on behalf of your health plan.

SilverSneakers is a registered trademark of Tivity Health. All rights reserved Tivity Health, Inc. is an independent company providing a fitness program on behalf of this plan.

Hearing benefit management administered by TruHearing, an independent company.

Prescription Drug Summary of Benefits: 01/01/2026 – 12/31/2026
Formulary B5, 5/10/45/40%/250 (with Senior Rx Plus)

Retired Indiana Public Employees Insurance Trust (RIPEA)

About this Plan:

For comprehensive information about all the services and any limitations or exclusions, please refer to your Evidence of Coverage (EOC). Upon enrolling in the plan, you'll receive guidance on accessing your plan details online. You can conveniently view your EOC by logging into the member portal at **www.anthem.com**, or you can call Member Services with any questions you may have.

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

How much is the monthly premium?
Contact your group plan sponsor/union for more information on your plan premium.

Prescription Drug Summary of Benefits: 01/01/2026 – 12/31/2026

Stage 1 Annual Deductible Stage

In this stage, you pay a set amount. Once you reach this amount, your plan begins to pay its share of the cost.

Deductible: $150

Stage 2 Initial Coverage Stage

Below is your payment responsibility from the time you meet your deductible, for covered prescriptions until you reach the **CMS defined drug out-of-pocket limit** of $2,100.

Retail Pharmacy	Standard Network Pharmacy		Mail-Order Pharmacy
	per 30-day supply (Specialty limited to a 30-day supply)	per 90-day supply	per 90-day supply (Specialty limited to a 30-day supply)
Tier 1: Select Generics Deductible waived	$0	$0	$0
Tier 1: Preferred Generics	$5	$15	$5
Tier 2: Generics	$10	$30	$10
Tier 3: Preferred Drugs	$45	$135	$90
Tier 4: Non-Preferred Drugs	40% $250 Max	40% $750 Max	40% $500 Max
Tier 5: Specialty Drugs	$250	N/A	$250

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 pay one copay for each full or partial 30-day supply filled. For example, if you order a 90-day supply, you will pay three 30-day supply copays. If you get a 45-day or 50-day supply, you will pay two 30-day copays.

Stage 3 Catastrophic Coverage Stage

Your payment responsibility changes after the amount you have paid for covered drugs reaches your **CMS defined drug out-of-pocket limit** of $2,100.

Retail and Mail-Order Pharmacies	Up to a 90-day supply (Specialty limited to a 30-day supply)
All Part D Covered Prescription Drugs	$0

- **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.

- **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 Part B medical coverage. Vaccines for Chicken Pox, Shingles, Tetanus, Diphtheria, Meningitis, Rabies, Polio, Yellow Fever and Hepatitis A are covered under Medicare Part D drug coverage. Hepatitis B is covered under Medicare Part D drug coverage unless you fall into a high risk category, then it is covered under Medicare Part B medical coverage. Other common vaccines are also covered under Medicare Part D drug coverage for Medicare-eligible individuals under 65. You can fill 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 pay its share of the cost. 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. The copay or coinsurance shown in this benefits chart is the amount you pay for covered drugs filled at network pharmacies.

This document reflects cost shares only.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, coinsurance, and restrictions may apply. If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

Benefits, premiums and/or copayments/coinsurance may change upon renewal or on January 1 of each year.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Medicare & You 2026 resource: For more information, we encourage you to read Medicare & You 2026. This booklet is mailed to people with Medicare every year in the fall. It has a summary of Medicare benefits, rights, and protections. It also includes answers to the most frequently asked questions. If you don't have a copy of this booklet, request one at www.medicare.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**.

IMPORTANT INFORMATION:

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

2026 Medicare Star Ratings

Anthem Blue Cross and Blue Shield - H4036

For 2026, Anthem Blue Cross and Blue Shield - H4036 received the following Star Ratings from Medicare:

Overall Star Rating:	★★★★☆
Health Services Rating:	★★★★☆
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 Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays at **1-833-848-8729** (toll free) or **711** (TTY). Current members please call **1-833-848-8730** or **711** (TTY).

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

Common health plan terms

Here are terms you'll come across in this guide and what they mean.



Care

Facility – A location for receiving care. Examples: hospital, skilled nursing facility (SNF), or imaging center.

Inpatient care – Medical treatment for someone formally admitted to a facility with a doctor's order. Without a doctor's order, it may be considered outpatient care, even if you stay overnight.

Outpatient care – Medical treatment for someone not admitted to a facility. It may take place in a doctor's office, clinic, or hospital outpatient department.

Preventive care – Services that help you stay healthy and detect health problems early when treatment works best. Examples: exams, shots, lab tests, screenings, and programs for health monitoring, counseling, and education.

Primary care provider (PCP) – A general practice doctor, nurse practitioner, or physician assistant who treats basic medical conditions and is often the first person you'll see for health concerns. PCPs provide checkups, vaccinations, and screenings. They help diagnose conditions and refer you to specialists when needed. You are not required to select a PCP.

Care provider – A doctor, nurse, clinician, hospital, health system, licensed healthcare facility, program, agency, or healthcare professional that delivers healthcare services.



Cost

Annual out-of-pocket maximum (or max OOP) – The maximum amount you pay for medical costs each plan year. After paying the max OOP, you pay nothing for covered services until the next plan year. Copays, coinsurance, and deductibles count toward the max OOP, but not all costs do. Not all medical costs or services are included in or subject to the annual out-of-pocket maximum.

Summary of Benefits – A summarized list of medical care and drugs the plan covers.

Coinsurance – A percentage you may be required to pay for covered services or drugs after paying your deductible.

Copay – A fixed dollar amount you may be required to pay for covered services or drugs after paying your deductible.

Cost share – Also called "cost-sharing amount" or "your share of the costs." It is usually a deductible, copay, or coinsurance. This is the amount you pay for covered services or drugs.

Covered services and drugs – Medical care and drugs your plan pays for under the plan terms.

Deductible – If applicable, the fixed dollar amount you pay for medical care or drugs before the plan begins to pay.

Required information for this plan year

Your rights, protections, and Medicare options

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

As a Medicare beneficiary, you can choose between:

- The Original (Fee-for-Service) Medicare plan.
- A Medicare health plan like the one offered in this guide.

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 Medicare Advantage 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.

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, please contact our First Impressions Welcome team.

Pay your Medicare Part B premiums

Once you enroll in this plan, you must continue to pay your Medicare Part B premiums. If you don't, Medicare will terminate your coverage and then you may have to pay a late enrollment penalty if you decide to reenroll.

Enrolling in other plans

If you decide to enroll in other plans, you may 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.

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 number listed in this guide to request interpreter services.

Out-of-network/noncontracted providers are under no obligation to treat Anthem members, except in emergency situations. Please call our First Impressions Welcome team at **1-833-848-8729**, TTY: **711**, **Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays**, 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 available 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 at the number listed on your ID card 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.

Required information for this plan year

Information about Medicare

Anthem Blue Cross and Blue Shield is an PPO 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 is the trade name of Anthem HP, LLC and Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield Retiree Solutions. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia with its affiliate Healthkeepers, Inc., 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/noncontracted 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.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-833-848-8729 (TTY: 711) or speak to your provider.

Spanish – ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia en otros idiomas. También puede obtener ayudas y servicios auxiliares adecuados gratuitos para proporcionar información en formatos accesibles. Llame al número de teléfono indicado anteriormente o hable con su proveedor.

Arabic – تنبيه: إذا كنت تتحدث العربية ، فإن خدمات المساعدة اللغوية المجانية متاحة لك. كما تتوفر مساعدات وخدمات مساعدة مناسبة لتوفير المعلومات بأشكال يسهل الوصول إليها مجانا. اتصل على رقم الهاتف المذكور أعلاه أو تحدث إلى مقدم الخدمة الخاص بك.

Armenian – ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե խոսում եք հայերեն, ձեզ հասանելի են անվճար լեզվական աջակցության ծառայություններ: Մատչելի ձևաչափերով տեղեկատվություն տրամադրելու համար համապատասխան օժանդակ միջոցներն ու ծառայությունները նույնպես հասանելի են անվճար: Զանգահարեք վերը նշված հեռախոսահամարով կամ խոսեք ձեր մատակարարի հետ:

Chinese – 注意：注意：如果您說中文，我們可以為您提供免費的語言協助服務。我們還免費提供適當的輔助工具和服務，以無障礙格式提供資訊。請撥打上面列出的電話號碼或與您的提供者交談。

Farsi – توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات کمک زبانی رایگان در دسترس شما است. وسایل و خدمات کمکی مناسب برای ارائه اطلاعات در قالب‌های مناسب معلولان نیز به‌صورت رایگان قابل ارائه است. با شماره تلفن بالا تماس بگیرید یا با ارائه‌دهنده‌تان صحبت کنید.

French – ATTENTION : Si vous parlez français, des services gratuits d'assistance linguistique sont disponibles. Des aides et services auxiliaires appropriés permettant de fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le numéro de téléphone mentionné ci-dessus ou appelez votre prestataire.

Haitian Creole – ATANSYON: Si w pale kreyòl ayisyen, gen sèvis asistans lang gratis disponib pou ou. Èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib tou gratis. Rele nimewo telefòn ki endike anwo a oswa pale ak founisè w la.

Italian – ATTENZIONE: sono disponibili servizi di assistenza linguistica gratuita in italiano. Sono inoltre disponibili gratuitamente adeguati supporti e servizi per ottenere informazioni in formato accessibile. Chiamare il numero di telefono riportato sopra o rivolgersi al proprio fornitore.

Japanese – 注意：日本語を話せる方向けに、無料の言語支援サービスをご提供していま。適切な補助器具・サービスも、利用者がアクセスしやすい方法でご提供しています。こちらも無料でご利用いただけます。必要な情報取得にお役立てください。上記の電話番号にお電話いただくか、プロバイダーにお問い合わせください。

Korean – 주의: 한국어를 사용하는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 장치 및 서비스도 무료로 이용하실 수 있습니다. 위에 기재된 전화 번호로 전화하거나 담당 의료 제공자에게 문의하십시오.

Polish – UWAGA: Jeśli mówisz po polsku, możesz skorzystać z bezpłatnych usług pomocy językowej. Dostępne są również nieodpłatnie odpowiednie pomoce i usługi zapewniające informacje w dostępnych formatach. Zadzwoń pod numer telefonu podany powyżej lub porozmawiaj ze swoim dostawcą.

Portuguese – ATENÇÃO: Se fala português, tem à sua disposição serviços de assistência linguística gratuitos. Estão também disponíveis, a título gratuito, ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para o número de telefone acima indicado ou fale com o seu fornecedor.

Russian – ВНИМАНИЕ: Если вы говорите на русском языке, вам могут предоставить бесплатные услуги переводчика. Также бесплатно предоставляются вспомогательные средства и услуги, позволяющие получать информацию в доступных форматах. Позвоните по вышеуказанному номеру телефона или обсудите этот вопрос с вашим поставщиком услуг.

Tagalog – PAUNAWA: Kung nagsasalita ka ng Tagalog, may available na mga libreng serbisyong tulong sa wika para sa iyo. Available rin nang libre ang mga naaangkop na auxiliary aid at serbisyo para maibigay ang impormasyon sa alternatibong mga format. Tawagan ang numero ng telepono na nakalista sa itaas o makipag-usap sa iyong provider.

Vietnamese – CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí luôn sẵn sàng phục vụ quý vị. Các dịch vụ và hỗ trợ phụ trợ thích hợp cung cấp thông tin ở các định dạng có thể truy cập cũng được cung cấp miễn phí. Gọi số điện thoại nêu trên hoặc nói chuyện với nhà cung cấp của quý vị.

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