Medicare Complementary — Medical Only

Administered by Anthem Blue Cross and Blue Shield

Effective July 1, 2009 or October 1, 2009

The Local Choice is a unique health benefits program managed by the Commonwealth of Virginia Department of Human Resource Management (DHRM). The Medicare Complementary plan may be offered to you if you are eligible for Medicare and to your Medicare-eligible family members by your group.

The Medicare Complementary Health Benefits Plan provides medical benefits that work with Medicare Part A and Part B. In addition, the plan offers benefits for services not covered by the government program, including vision and dental. It does not provide prescription drug coverage. **This guide is only an overview. For a complete description of the benefits, exclusions, limitations, and reductions, please see the Medicare Coordinating Plans Member Handbook.**

Service Area

Wherever retirees live.

How The Plan Works

To receive full benefits you must be enrolled under both Part A and Part B of Medicare. Always show both your Medicare card and your Anthem Blue Cross and Blue Shield identification card when you receive care.

Choose Health Care Providers Carefully

Physicians

Ask your doctor if he or she is a Medicare participating physician. Your benefits cover the patient's share of Part B expenses after you pay the first $1,000 of expenses each calendar year. This $1,000 out-of-pocket expense is made up of your Part B Medicare deductible and copayments. A doctor who participates in Medicare agrees to:

- File claims on your behalf
- Accept Medicare's payment for covered services

This means your copayment is limited to a percentage of the Medicare-approved charge. Your nearest Social Security office can give you additional information about Medicare-participating physicians.

This brochure describes benefits based on Medicare-approved charges. Doctors who do not accept assignments may not charge you any more than 15% above what Medicare considers a reasonable fee. This applies to all doctors and all services.

Hospitals

Hospitals that participate in the Medicare program are covered. Admissions not approved by Medicare are not covered.

Vision Care

Routine vision benefits are available once every 24 months. The 24-month count begins on the month you receive your eye examination or purchase eyeglass frames or lenses. You may purchase lenses and frames from any optician, optometrist or retail setting. You may receive your eye examination by any licensed vision provider. However, if you receive your eye examination from a non-network provider, the provider may bill you for amounts above the allowable charge, and payment is your responsibility. You may view a list of contracting vision providers at **www.anthem.com/tlc**.

If you need medical, non-routine treatment for your eyes, consult your physician or a network eye specialist.

Dental Benefits

Covered Dental Services are available from dentists who contract with Anthem Blue Cross and Blue Shield. You may view a list of contracting dentists on the Web at **www.anthem.com/tlc**. Claims will be handled by the contracting dentist's office and you'll be responsible only for any coinsurance which applies to the covered care you receive. If you go to a non-contracting dentist, you may pay more of the bill.

Medicare Complementary Plan

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What The Plan Covers

		Plan Pays
PART A SERVICES		
Hospital Inpatient	■ Medicare Part A hospital deductible less $100 per benefit period, days 1-60	In full
	■ Medicare Part A daily hospital copayment amount, days 61-90	In full
	■ 100% of hospital's reasonable charges, days 91-120	In full
	■ Copayment amount for Medicare Lifetime Reserve Days (60 days available)	In full
Skilled Nursing Facility	■ Medicare Part A skilled nursing home copayment, days 21-100 (Medicare covers days 1-20 in full.)	In full
	■ A daily amount equal to Medicare skilled nursing home copayment, days 101-180 (Medicare provides no coverage beyond 100 days.)	In full
PART B SERVICES		
Doctors' Care And Medical Services (after $1,000 out-of-pocket expense limit)	Medicare pays 80% and the plan pays 20% of Medicare-approved charges for Part B services. Enrollees are responsible for the first $1,000 in covered expenses for Part B doctors' care and other medical services. Expenses that apply to the $1,000 out-of-pocket expense limit include the Part B $131 calendar year deductible and 20% of Medicare-approved charges for Part B services.	
	After the $1,000 out-of-pocket expense limit is met during a calendar year	
		Plan Pays
	■ Physicians' care	20%*
	■ Diagnostic x-rays and lab tests	20%*
	■ Ambulance service	20%*
	■ Durable medical equipment and supplies	20%*
	■ Chiropractic services—Benefits coordinated with Medicare	20%*
	■ Routine mammography screenings	20%*

**Percent of Medicare charges*

Plan Deductibles And Copayments

You are responsible for these amounts:

- $100 deductible per benefit period for the first 60 days of hospital inpatient care
- $131 calendar year Part B deductible (included in the $1,000 out-of-pocket expense limit)
- 20% of Medicare-approved charges for Part B services (not to exceed the $1,000 out-of-pocket expense limit each calendar year)
- Copayment equal to any balance between the allowance paid for vision services and the provider's charge for the covered service
- 20% copayment for dental services paid at 80% of the allowable amount

Dental Benefits

Plan Pays $1,200 Maximum Per Person Per Calendar Year		In-Network You Pay
Diagnostic And Preventive Services	Twice-a-year visits to the dentist for oral examinations, x-rays, and cleanings	$0
Primary Services	Fillings, oral surgery, periodontal services, scaling, repair of dentures, root canals and other endodontic services, and recementing of existing crowns and bridges	20% AC**
Out-Of-Network Care	For services by a non-network dentist, you pay the applicable coinsurance plus any amounts above the allowable charge.	

Using Your Dental Benefits

To reduce your out-of-pocket expense, choose an Anthem network dentist. View the Provider Directory on the Web at **www.anthem.com/tlc**.

Claims will be handled by the dentist's office and you will be responsible only for any coinsurance, which applies to the covered care you receive. If you go to a non-network dentist, you may pay more of the bill.

Vision Benefits

	Plan Pays
Routine vision examination (once every 24 months)	Provider's charge up to a maximum of $40 per routine exam
Frames (one pair every 24 months)	Provider's charge up to a a maximum of $75 per pair
Lenses (one pair of eyeglass lenses or any type of contact lenses every 24 months)	Provider's charge up to the maximum amounts specified below for the types of lenses provided:
• Single lenses	$50 per pair
• Bifocal lenses	$75 per pair
• Trifocal lenses	$100 per pair
• Contact lenses (hard, soft, or disposable)	$100

Remember that you are responsible for paying any costs above the amounts listed for eyeglass frames and lenses. Providers may require payment from you for the difference between this fixed amount and their charges. The provider may choose to file the claim for you, or you may use the Anthem claim form to file your claim.

** ***Allowable Charge (AC)*** *— The term has two meanings, depending on whether the service is provided by a doctor (or other health care professional) or a hospital. For care by a doctor or other health care professional, the allowable charge is the lesser amount of your plan's allowance for that service, or the provider's charge for that service. For hospital services the allowable charge is the amount of the negotiated compensation to the facility for the covered service, or the facility's charge for that service, whichever is less. For complete information about the allowable charge, please see the Medicare Coordinating Plans Member Handbook.*

Options For Prescription Drug Coverage

If you want prescription drug coverage, you may enroll in a separate Medicare Part D prescription drug plan.

Several Medicare Part D plan options are being offered. To determine what drug coverage option best meets your needs, consult the "Medicare & You 2009" handbook, call **1-800-MEDICARE (1-800-633-4227)** or visit the Medicare Web site at **www.medicare.gov**.

If You Need Assistance

Anthem Blue Cross and Blue Shield

Medical, Dental and Vision Care
1-800-552-2682
Monday through Friday 8:00 a.m. – 6:00 p.m.
Saturday 9:00 a.m. – 1:00 p.m.

On the Web at **www.anthem.com/tlc**

The Local Choice

The Local Choice Health Benefits Program
Commonwealth of Virginia
Department of Human Resource Management
101 North 14th Street – 13th Floor
Richmond, VA 23219
(804) 786-6460

On the Web at **www.thelocalchoice.virginia.gov**

This is not a policy. This is a brief summary of the Medicare Complementary health benefits plan. For a complete description of the benefits, exclusions, terms, and conditions, please see the Medicare Coordinating Plans Member Handbook.