Anthem BlueCross

Anthem MediBlue Plus (HMO)
Offered by Anthem Blue Cross

Annual Notice of Changes for 2016

Next year, there will be some changes to the plan's costs and benefits. This booklet tells about the changes.

Customer Service: 1-888-230-7338 TTY: 711

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Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-230-7338. Someone who speaks English/ Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-888-230-7338. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin:
我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-888-230-7338。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese:
您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-888-230-7338。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-888-230-7338. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-888-230-7338. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-888-230-7338 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-888-230-7338. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-888-230-7338 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-888-230-7338. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:
إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-888-032-8337. سيقوم شخص بمساعدتك. هذه خدمة مجانية ما يتحدث العربية.

Hindi: हमारे सवासथय या दवा की योजना के बारे में आपके किसी भी पशन के जवाब देने के लिए हमारे पास मुफत दुभाषिया सेवाएँ उपलबध हैं. एक दुभायिषा परापत करने के लिए, बस हमें 1-888-230-7338 पर फोन करें. कोई वयकित जो हिनदी बोलता है आपकी मदद कर सकता है. यह एक मुफत सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-888-230-7338. Un nostro incaricato che parla Italiano vi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-888-230-7338. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-888-230-7338. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-888-230-7338. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-888-230-7338 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

Anthem MediBlue Plus (HMO) Offered by Anthem Blue Cross Annual Notice of Changes for 2016

You are currently enrolled as a member of Blue Cross Senior Secure Plan I (HMO). Next year, there will be some changes to the plan's costs and benefits. This booklet tells about the changes.

You have from October 15 until December 7 to make changes to your Medicare coverage for next year.

Additional resources:

- This information is available for free in other languages. Please contact our Customer Service number at 1-888-230-7338 for additional information. (TTY users should call 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30. Customer Service also has free language interpreter services available for non-English speakers.
- Esta información está disponible en otros idiomas de manera gratuita. Comuníquese con el número de nuestro Servicio de Atención al Cliente al 1-888-230-7338 para obtener más información. (Los usuarios de TTY deben llamar al 711). El horario es de 8 a.m. a 8 p.m., los 7 días de la semana (excepto el Día de Acción de Gracias y Navidad) desde el 1.° de octubre hasta el 14 de febrero, y de lunes a viernes (excepto los feriados) desde el 15 de febrero hasta el 30 de septiembre. El Servicio de Atención al Cliente también ofrece los servicios gratuitos de un intérprete para las personas que no hablan inglés.
- This document is available to order in Braille, large print and audio tape. To request this document in an alternate format, please call Customer Service at the phone number printed on the back of this booklet.

About Anthem MediBlue Plus (HMO):

- Anthem Blue Cross is an HMO plan with a Medicare contract. Enrollment in Anthem Blue Cross depends on contract renewal.
- When this booklet says "we," "us" or "our," it means Anthem Blue Cross. When it says "plan" or "our plan," it means Anthem MediBlue Plus (HMO).

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Think about your Medicare coverage for next year

Each fall, Medicare allows you to change your Medicare health and drug coverage during the Annual Enrollment Period. It's important to review your coverage now to make sure it will meet your needs next year.

Important things to do:

- **Check the changes to our benefits and costs to see if they affect you.** Do the changes affect the services you use? It is important to review benefit and cost changes to make sure they will work for you next year. *Look in Section 1.1 and Section 1.5 for information about benefit and cost changes for our plan.*
- **Check the changes to our prescription drug coverage to see if they affect you.** Will your drugs be covered? Are they in a different tier? Can you continue to use the same pharmacies? It is important to review the changes to make sure our drug coverage will work for you next year. *Look in Section 1.6 for information about changes to our drug coverage.*
- **Check to see if your doctors and other providers will be in our network next year.** Are your doctors in our network? What about the hospitals or other providers you use? *Look in Section 1.3 for information about our Provider/Pharmacy Directory.*
- **Think about your overall health care costs.** How much will you spend out of pocket for the services and prescription drugs you use regularly? How much will you spend on your premium? How do the total costs compare to other Medicare coverage options?
- **Think about whether you are happy with our plan.**

If you decide to stay with Anthem MediBlue Plus (HMO):	**If you decide to change plans:**
If you want to stay with us next year, it's easy - you don't need to do anything.	If you decide other coverage will better meet your needs, you can switch plans between October 15 and December 7. If you enroll in a new plan, your new coverage will begin on January 1, 2016. *Look in Section 3.2 to learn more about your choices.*

Summary of important costs for 2016

The table below compares the 2015 costs and 2016 costs for Anthem MediBlue Plus (HMO) in several important areas. **Please note this is only a summary of changes. It is important to read the rest of this *Annual Notice of Changes*** and review the attached *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2015 (this year)	2016 (next year)
Monthly plan premium[1] Your premium may be higher or lower than this amount. *See Section 1.1 for details.*	$0.00	$0.00
Maximum out-of-pocket amount This is the **most** you will pay out of pocket for your covered Part A and Part B services. *See Section 1.2 for details.*	$6,000	$6,700
Doctor office visits	Primary care visits: In network $20.00 per visit Specialist visits: In network $50.00 per visit	Primary care visits: In network $20.00 per visit Specialist visits: In network $50.00 per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term-care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	In network Days 1 - 5: $347.00 per day / Days 6 - 90: $0.00 per day	In network Days 1 - 5: $340.00 per day / Days 6 - 90: $0.00 per day
Part D prescription drug coverage *See Section 1.6 for details.*	Deductible: $50.00 Copays during the initial coverage stage:	Deductible: N/A Copays during the initial coverage stage:

Summary of important costs for 2016

If you have any questions, please call 1-888-230-7338.

Cost	2015 (this year)	2016 (next year)
	▪ **Tier 1: Preferred Generic:** $5.00[1] (30-day supply at retail network pharmacies that offer preferred[2] cost sharing) ▪ **Tier 2: Nonpreferred Generic:** $28.00[1] (30-day supply at retail network pharmacies that offer preferred[2] cost sharing) ▪ **Tier 3: Preferred Brand:** $40.00[1] (30-day supply at retail network pharmacies that offer preferred[2] cost sharing) ▪ **Tier 4: Nonpreferred Brand:** $90.00[1] (30-day supply at retail network pharmacies that offer preferred[2] cost sharing) ▪ **Tier 5: Specialty Tier:** 33%[1] (30-day supply at retail network pharmacies that offer preferred[2] cost sharing) ▪ **Tier 6: Select Care Drugs:** $0.00[1] (30-day supply at retail network pharmacies that offer preferred[2] cost sharing)	▪ **Tier 1: Preferred Generic:** $5.00[1] (30-day supply at retail network pharmacies that offer preferred[2] cost sharing) ▪ **Tier 2: Generic:** $15.00[1] (30-day supply at retail network pharmacies that offer preferred[2] cost sharing) ▪ **Tier 3: Preferred Brand:** $42.00[1] (30-day supply at retail network pharmacies that offer preferred[2] cost sharing) ▪ **Tier 4: Nonpreferred Brand:** $95.00[1] (30-day supply at retail network pharmacies that offer preferred[2] cost sharing) ▪ **Tier 5: Specialty Tier:** 33%[1] (30-day supply at retail network pharmacies that offer preferred[2] cost sharing) ▪ **Tier 6: Select Care Drugs:** $0.00[1] (30-day supply at retail network pharmacies that offer preferred[2] cost sharing)

1 The amount you pay will depend on if you qualify for low-income subsidy (LIS), also known as Medicare's "Extra Help" program. *For more information about the "Extra Help" program, please see Chapter 2, Section 7 of your Evidence of Coverage.*

2 Your costs could be more if you do not use a pharmacy with preferred cost sharing. *Please see the cost-sharing table in Section 1.6 for cost sharing at network pharmacies with standard cost sharing.*

Annual Notice of Changes for 2016
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Section i. We are changing the plan's name

On January 1, 2016, our plan name will change from Blue Cross Senior Secure Plan I (HMO) to Anthem MediBlue Plus (HMO). We are sending you a new membership card due to a slight change in the plan name. Please begin using this new membership card starting January 1, 2016. Your old card should be destroyed. Please check your new card to make sure your information is accurate. If any corrections need to be made, please contact Customer Service at the number listed on your membership card.

Section 1. Changes to benefits and costs for next year

Section 1.1 Changes to the monthly premium

Cost	2015 (this year)	2016 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0.00	$0.00
Optional supplemental benefits monthly plan premium	Preventive Dental Package - $11.00 Dental and Vision Package - $29.00 Enhanced Dental and Vision Package - $38.00	Preventive Dental Package - $12.00 Dental and Vision Package - $29.00 Enhanced Dental and Vision Package - $37.00

- Your monthly plan premium will be more if you are required to pay a late-enrollment penalty.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs.

Section 1.2 Changes to your maximum out-of-pocket amount

To protect you, Medicare requires all health plans to limit how much you pay out of pocket during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2015 (this year)	2016 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,000	$6,700 Once you have paid $6,700 out of pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 Changes to the provider network

There are changes to our network of providers for next year.

An updated *Provider/Pharmacy Directory* is located on our website at www.anthem.com/ca. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider/Pharmacy Directory*. **Please review the 2016 *Provider/Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but, if your doctor or specialist does leave your plan, you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- When possible, we will provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider, or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

Section 1.4 Changes to the pharmacy network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other pharmacies within the network.

There are changes to our network of pharmacies for next year.

An updated *Provider/Pharmacy Directory* is located on our website at www.anthem.com/ca. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider/Pharmacy Directory*. **Please review the 2016 *Provider/Pharmacy Directory* to see which pharmacies are in our network.**

Section 1.5 Changes to benefits and costs for medical services

We are changing our coverage for certain medical services next year. The information below describes these changes. *For details about the coverage and costs for these services, see Chapter 4, "Medical Benefits Chart (what is covered and what you pay)," in your 2016 Evidence of Coverage.*

Cost	2015 (this year)	2016 (next year)
Ambulance services	**In-Network:** $250 copay for each covered one-way ambulance trip.	**In-Network:** $365 copay for each covered one-way ambulance trip via ground or water. 20% as your portion of the covered charges for each one-way air ambulance trip.
Diabetes self-management training, diabetic services and supplies	**In-Network:** 20% as your portion of the covered charges for therapeutic shoes, including fitting the shoes or inserts. You can buy them from a DME provider.	**In-Network:** $0 copay for therapeutic shoes, including fitting the shoes or inserts. You can buy them from a DME provider.
Emergency care	**In- and Out-of-Network:** $65 copay for each covered emergency room visit.	**In- and Out-of-Network:** $75 copay for each covered emergency room visit.
Inpatient hospital care	**In-Network:** For covered hospital stays: Days 1 - 5: $347 copay per day per admission	**In-Network:** For covered hospital stays: Days 1 - 5: $340 copay per day per admission

	Days 6 - 90: $0 copay per day per admission	Days 6 - 90: $0 copay per day per admission
LiveHealth Online	This plan did not provide coverage for LiveHealth Online services in 2015.	**In-Network:** $0 copay for LiveHealth Online services.
Outpatient diagnostic tests and therapeutic services and supplies	**In-Network:** $10 copay for each covered lab service. $65 copay for covered basic medical diagnostic tests and procedures (Your doctor may refer to these as Tier 1 procedures) or $220 copay for covered complex medical diagnostic procedures and tests (Your doctor may refer to these as Tier 2) when you get them at a network outpatient facility. $220 copay for covered complex medical diagnostic procedures and tests when you get them at a network doctor's office. Your doctor may refer to these as Tier 2. $220 copay for covered diagnostic radiology services to diagnose a condition when you get them at a network doctor's office. These include heart catheterizations, sleep studies, Computed Tomography (CT), Magnetic Resonance tests (MRIs and MRAs) and nuclear medicine studies including PET scans. $220 copay for covered diagnostic radiology services to diagnose a condition when you get them at a network outpatient facility department. These include heart catheterizations, sleep studies, Computed Tomography (CT), Magnetic Resonance tests (MRIs	**In-Network:** $15 copay for each covered lab service. $235 copay for each covered diagnostic procedure or test at a network outpatient facility. $65 copay for each covered diagnostic procedure or test at a network doctor's office. $250 copay for covered radiology to diagnose a condition when you get them at a network doctor's office. $250 copay for covered radiology to diagnose a condition when you get them at a network outpatient facility.

	and MRAs) and nuclear medicine studies including PET scans.	
Outpatient hospital services	**In-Network:** $250 copay for each covered surgery or observation room service in an outpatient hospital or outpatient surgery center.	**In-Network:** $300 copay for each covered surgery or observation room service in an outpatient hospital or outpatient surgery center.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	**In-Network:** $200 copay for each covered surgery in an ambulatory surgical center. $250 copay for each covered surgery or observation room service in an outpatient hospital or outpatient surgery center.	**In-Network:** $265 copay for each covered surgery in an ambulatory surgical center. $300 copay for each covered surgery or observation room service in an outpatient hospital.
Podiatry services	**In-Network:** $50 copay for each routine podiatry visit. Your plan covers up to 12 routine foot care visit(s) every year.	**In-Network:** $50 copay for each routine podiatry visit. Your plan covers up to 10 routine foot care visit every year.
Skilled nursing facility (SNF) care	**In-Network:** For covered SNF stays: Days 1 - 20: $0 copay per day Days 21 - 100: $152 copay per day	**In-Network:** For covered SNF stays: Days 1 - 20: $0 copay per day Days 21 - 100: $160 copay per day
Optional Supplemental Benefit Package 1	Package: 1 - Preventive Dental Package **In-Network:** Dental X-rays include one full-mouth or panoramic X-ray and one set/series of bitewing X-rays each year. Fluoride treatments were not offered in 2015.	Package: 1 - Preventive Dental Package **In-Network:** Dental X-rays include one full-mouth or panoramic X-ray and one set/series of bitewing X-rays each year and up to seven Periapical images per calendar year. Two fluoride treatments each year. Please see Optional Supplemental Benefits in Chapter 4, Section 2.2 of the EOC for additional information.

Optional Supplemental Benefit Package 2	Package: 2 - Dental and Vision Package: **In-Network:** Dental X-rays include one full-mouth or panoramic X-ray and one set/series of bitewing X-rays each year. Fluoride treatments were not offered in 2015. Restorative dental services include (amalgam and/or anterior composite restorations). The applicable In-Network costshare will apply. **In-Network:** $130 reimbursement allowance toward the purchase of eyeglasses (lenses and frames) each year or $80 reimbursement allowance toward the purchase of contact lenses each year.	Package: 2 - Dental and Vision Package: **In-Network:** Dental X-rays include one full-mouth or panoramic X-ray and one set/series of bitewing X-rays each year and up to seven Periapical images per calendar year. Two fluoride treatments each year. Restorative dental services include (amalgam and/or anterior/posterior composite restorations). The applicable In-Network costshare will apply. **In-Network:** $150 reimbursement allowance toward the purchase of Eyewear. The benefit applies to corrective (prescription) glasses, lenses, frames and/or contact lenses purchased from a participating provider. Please see Optional Supplemental Benefits in Chapter 4, Section 2.2 of the EOC for additional information.
Optional Supplemental Benefit Package 3	Package: 3 – Enhanced Dental and Vision Package: **In-Network:** Dental X-rays include one full-mouth or panoramic X-ray and one set/series of bitewing X-rays each year. Fluoride treatments were not offered in 2015. Restorative dental services include (amalgam and/or anterior composite restorations). The applicable In-Network costshare will apply. **In-Network:**	Package: 3 – Enhanced Dental and Vision Package: **In-Network:** Dental X-rays include one full-mouth or panoramic X-ray and one set/series of bitewing X-rays each year and up to seven Periapical images per calendar year. Two fluoride treatments each year. Restorative dental services include (amalgam and/or anterior/posterior composite restorations). The applicable In-Network costshare will apply.

	$200 reimbursement allowance toward the purchase of eyeglasses (lenses and frames) each year or $80 reimbursement allowance toward the purchase of contact lenses each year.	**In-Network:** $200 reimbursement allowance toward the purchase of Eyewear. The benefit applies to corrective (prescription) glasses, lenses, frames and/or contact lenses purchased from a participating provider. Please see Optional Supplemental Benefits in Chapter 4, Section 2.2 of the EOC for additional information.

Section 1.6 Changes to Part D prescription drug coverage

Changes to our Drug List

Our *List of Covered Drugs* is called a *"Formulary"* or *"Drug List."* A copy of our *Drug List* is in this envelope.

We made changes to our *Drug List*, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the *Drug List* to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception to cover the drug.** We encourage current members to ask for an exception before next year.
  - *To learn what you must do to ask for an exception, see Chapter 9 of your Evidence of Coverage, "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)," or call Customer Service.*
- **Work with your doctor (or other prescriber) to find a different drug that we cover.** You can call Customer Service to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a **one-time**, temporary supply of a nonformulary drug in the first 90 days of coverage of the plan year or coverage. *To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the Evidence of Coverage.* During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

Formulary exceptions are granted for a 12-month period. If you are granted a formulary exception, you and your doctor will receive a letter with the termination date of the exception. If you wish to continue the exception, a new request is required.

Changes to prescription drug costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the *"Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs"* (also called the "*Low-Income Subsidy Rider"* or the *"LIS Rider"*), which tells you about your drug costs. If you get "Extra Help" and haven't received

this insert by September 30, 2015, please call Customer Service and ask for the *LIS Rider.* Phone numbers for Customer Service are in Section 7.1 of this booklet.

There are four drug payment stages. How much you pay for a Part D drug depends on which drug payment stage you are in. *You can look in Chapter 6, Section 2 of your Evidence of Coverage for more information about the stages.*

The information below shows the changes for next year to the first two stages – the yearly deductible stage and the initial coverage stage. Most members do not reach the other two stages – the coverage gap stage or the catastrophic coverage stage. *To get information about your costs in these stages, look at Chapter 6, Section 6 and Section 7, in the attached Evidence of Coverage.*

Changes to the deductible stage

Stage	2015 (this year)	2016 (next year)
Stage 1: Yearly deductible stage	The deductible is $50.00. During this stage, **you pay the copays listed under Stage 2: Initial coverage stage** of your Tier 1: Preferred Generic, Tier 2: Nonpreferred Generic, Tier 5: Specialty Tier and Tier 6: Select Care Drugs and **the full cost** of your Tier 3: Preferred Brand and Tier 4: Nonpreferred Brand until you have reached the yearly deductible.	Because we have no deductible, this payment stage does not apply to you.

Changes to your cost sharing in the initial coverage stage

To learn how copayments and coinsurance work, look at *Chapter 6, Section 1.2*, "*Types of out-of-pocket costs you may pay for covered drugs"* in your *Evidence of Coverage*.

Stage	2015 (this year)	2016 (next year)
Stage 2: Initial coverage stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. *For information*	Your cost for a one-month supply at a network pharmacy: **Tier 1: Preferred Generic** *Standard cost sharing:* You pay $10.00* per prescription. *Preferred cost sharing:* You pay $5.00* per prescription.	Your cost for a one-month supply at a network pharmacy: **Tier 1: Preferred Generic** *Standard cost sharing:* You pay $10.00* per prescription. *Preferred cost sharing:* You pay $5.00* per prescription.

Stage	2015 (this year)	2016 (next year)
about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your Evidence of Coverage. We changed the tier for some of the drugs on our *Drug List*. To see if your drugs will be in a different tier, look them up on the *Drug List*.	**Tier 2: Nonpreferred Generic** *Standard cost sharing:* You pay $33.00* per prescription. *Preferred cost sharing:* You pay $28.00* per prescription. **Tier 3: Preferred Brand** *Standard cost sharing:* You pay $45.00* per prescription. *Preferred cost sharing:* You pay $40.00* per prescription. **Tier 4: Nonpreferred Brand** *Standard cost sharing:* You pay $95.00* per prescription. *Preferred cost sharing:* You pay $90.00* per prescription. **Tier 5: Specialty Tier** *Standard cost sharing:* You pay 33%* of the total cost. *Preferred cost sharing:* You pay 33%* of the total cost. **Tier 6: Select Care Drugs** *Standard cost sharing:* You pay $0.00* per prescription. *Preferred cost sharing:* You pay $0.00* per prescription. Once your total drug costs have reached $2,960.00, you will move to the next stage (the coverage gap stage).	**Tier 2: Generic** *Standard cost sharing:* You pay $20.00* per prescription. *Preferred cost sharing:* You pay $15.00* per prescription. **Tier 3: Preferred Brand** *Standard cost sharing:* You pay $47.00* per prescription. *Preferred cost sharing:* You pay $42.00* per prescription. **Tier 4: Nonpreferred Brand** *Standard cost sharing:* You pay $100.00* per prescription. *Preferred cost sharing:* You pay $95.00* per prescription. **Tier 5: Specialty Tier** *Standard cost sharing:* You pay 33%* of the total cost. *Preferred cost sharing:* You pay 33%* of the total cost. **Tier 6: Select Care Drugs** *Standard cost sharing:* You pay $0.00* per prescription. *Preferred cost sharing:* You pay $0.00* per prescription. Once your total drug costs have reached $3,200.00, you will move to the next stage (the coverage gap stage).

*The amount you pay will depend on if you qualify for low-income subsidy (LIS), also known as Medicare's "Extra Help" program. *For more information about the "Extra Help" program, please see Chapter 2, Section 7 of the Evidence of Coverage.*

Changes to the coverage gap and catastrophic coverage stages

The other two drug coverage stages – the coverage gap stage and the catastrophic coverage stage – are for people with high drug costs. **Most members do not reach the coverage gap stage or the catastrophic coverage stage.** *For information about your costs in these stages, look at Chapter 6, Section 6 and Section 7, in your Evidence of Coverage.*

Section 2. Other changes

Cost	2015 (this year)	2016 (next year)
Effective date for PCP change	PCP changes are effective on the day that you call or date requested.	If your request to change your PCP is made on days 1-14 of the month, the effective date of your PCP change will default to the first of the current month in which you have requested your PCP change. If your request to change your PCP is made on days 15-31 of the month, the effective date of your PCP change will default to the first of the following month.
Changes in Diabetic supplies (lancets)	Any lancet brand may be used. There are no limits to the number of lancets you may get in a month.	Lancets are limited to the following manufacturers: Lifescan / Delica, Roche, Kroger and its affiliates which include Fred Meyer, King Soopers, City Market, Fry's Food Stores, Smith's Food and Drug Centers, Dillon Companies, Ralphs, Quality Food Centers, Baker, Scott's, Owen, Payless, Gerbes, Jay-C, Prodigy, and Good Neighbor. Up to 100 lancets per month are covered.
Pharmacy network	Our pharmacies with preferred cost sharing include CVS/pharmacy, Food Lion, Giant Eagle Pharmacy, Hannaford, Harris Teeter Pharmacy, Kroger, Target and Walmart. CVS/pharmacy participating pharmacies that offer preferred cost sharing include CVS/pharmacy and Longs Drug Stores. Hannaford participating pharmacies that offer preferred cost sharing include Hannaford and Food Lion.	For 2016 we will continue to have the same preferred pharmacies as 2015 but we have additional preferred pharmacies. We have added Navarro Discount Pharmacy as well as other independent pharmacies in the network. Please check the *Provider/ Pharmacy Directory* to determine if your pharmacy is a preferred pharmacy.

Cost	2015 (this year)	2016 (next year)
	Kroger participating pharmacies that offer preferred cost sharing include Kroger, Fred Meyer, King Soopers, City Market, Fry's Food Stores, Smith's Food & Drug Centers, Dillon Companies, Ralphs, Quality Food Centers, Baker, Scott's, Owen, Payless, Gerbes and Jay-C. Walmart participating pharmacies that offer preferred cost sharing include Walmart, Neighborhood Market and Sam's Club. You can fill a prescription at a network retail pharmacy with standard cost sharing, but your cost sharing amount may be higher.	
Coverage gap	Your plan has the CMS mandated gap coverage benefits.	Your plan has additional gap coverage for Tier 6 drugs that will allow you to continue to pay a $0 copay for those drugs through the gap stage.
Durable medical equipment – oxygen-related equipment	You will not own oxygen-related equipment rentals no matter how many copayments you make for the item while a member of our plan. Your cost share (deductible, coinsurance and/or copayments) will continue for the time you have possession of the item.	Ownership of oxygen-related equipment transfers to the member after 36 months of rental. Your cost share (deductible, coinsurance and/or copayments) for durable medical equipment will end when you obtain ownership of the item.
Durable medical equipment – non-oxygen-related equipment	In Original Medicare, people who rent certain types of durable medical equipment own the equipment after paying copayments for the item for 13 months. As a member of our plan, however, you will not acquire ownership of rented durable medical equipment items no matter how many copayments you make for the item while a member of our plan. Even if you made up to 12 consecutive payments for the durable medical equipment item under Original Medicare before you joined our	In Original Medicare, people who rent certain types of durable medical equipment own the equipment after paying copayments for the item for 13 months. As a member of our plan, you will acquire ownership of the durable medical equipment items following a rental period not to exceed 13 months from an in-network provider. Your copayments will end when you obtain ownership of the item.

Cost	2015 (this year)	2016 (next year)
	plan, you will not acquire ownership no matter how many copayments you make for the item while a member of our plan.	

Section 3. Deciding which plan to choose

Section 3.1 If you want to stay in Anthem MediBlue Plus (HMO)

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2016.

Section 3.2 If you want to change plans

We hope to keep you as a member next year, but if you want to change for 2016, follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *--or--* You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan and whether to buy a Medicare supplement (Medigap) policy.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2016*, call your State Health Insurance Assistance Program *(see Section 5)*, or call Medicare *(see Section 7.2)*.

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.medicare.gov and click *"Find health & drug plans."* **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

Step 2: Change your coverage

- To **change to a different Medicare health plan,** enroll in the new plan. You will automatically be disenrolled from Anthem MediBlue Plus (HMO).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Anthem MediBlue Plus (HMO).
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this. *Phone numbers are in Section 7.1 of this booklet.*
  - *--or--* Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

Section 4. Deadline for changing plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2016.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, and those who move out of the service area, are allowed to make a change at other times of the year. *For more information, see Chapter 10, Section 2.3 of the Evidence of Coverage.*

If you enrolled in a Medicare Advantage plan for January 1, 2016, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2016. *For more information, see Chapter 10, Section 2.2 of the Evidence of Coverage.*

Section 5. Programs that offer free counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state.

SHIPs are independent (not connected with any insurance company or health plan). SHIPs are state programs that get money from the federal government to give **free** local health insurance counseling to people with Medicare.

SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans.

You can call the SHIP in your state at the phone number listed below. You can learn more about the SHIP in your state by visiting their website www.aging.ca.gov/HICAP.

In California:

California Health Insurance Counseling & Advocacy Program (HICAP) – contact information

Call: 1-800-434-0222

TTY: 1-800-735-2929

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Write: California Health Insurance Counseling & Advocacy Program (HICAP)
1300 National Drive
Suite 200
Sacramento, CA 95834-1992

Section 6. Programs that help pay for prescription drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify will not have a coverage gap or late-enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
  - The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
  - Your State Medicaid Office (applications).

- **Help from your state's pharmaceutical assistance program.** Many states have a program called State Pharmaceutical Assistance Program (SPAP) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program. *The name and phone numbers for this organization are in Section 5 of this booklet.*

  — **In California**:
  A full-service SPAP is not available in this state.

- **Prescription cost-sharing assistance for persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the ADAP in your state. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the ADAP in your state.

  — **In California:**
  California Office of AIDS
  1-916-558-1784
  TTY users should call 1-800-735-2929.

Section 7. Questions?

Section 7.1 Getting help from Anthem MediBlue Plus (HMO)

Questions? We're here to help. Please call Customer Service at 1-888-230-7338. (TTY only, call 711.) We are available for phone calls from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from

October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30. Calls to these numbers are free.

Read your 2016 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2016. For details, look in the 2016 *Evidence of Coverage* for Anthem MediBlue Plus (HMO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is included in this envelope.

Visit our website

You can also visit our website at www.anthem.com/ca. As a reminder, our website has the most up-to-date information about our provider network *(Provider/Pharmacy Directory)* and our *List of Covered Drugs (Formulary/ Drug List)*.

Section 7.2 Getting help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

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.

Visit the Medicare website

You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. To view the information about plans, go to www.medicare.gov and click on *"Find health & drug plans."*

Read *Medicare & You 2016*

You can read the *Medicare & You 2016* Handbook. Every year, in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Anthem Blue Cross is an HMO plan with a Medicare contract. Enrollment in Anthem Blue Cross depends on contract renewal. Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.