Annual Notice of Changes for 2020

Anthem

Changes to benefits and costs for next year

Anthem MediBlue Plus (HMO)

Offered by:

Anthem Blue Cross

Orange and Los Angeles Counties

1-888-230-7338, TTY: 711

Next year, there will be changes

It's important to review your coverage now to make sure it will meet your needs next year

The Annual Notice of Changes gives you a summary of changes in your benefits and costs for 2020.

Look in the sections below for information about changes to our coverage.

- Section 1.1 Changes to the monthly premium
- Section 1.2 Changes to your maximum out-of-pocket amount
- Section 1.3 Changes to the provider network
- Section 1.4 Changes to the pharmacy network
- Section 1.5 Changes to benefits and costs for medical services
- Section 1.6 Changes to Part D prescription drug coverage

If you have any questions, please call Customer Service.

Phone numbers are on the front cover of this booklet.

Anthem

Anthem MediBlue Plus (HMO) Offered by Anthem Blue Cross Annual Notice of Changes for 2020

You are currently enrolled as a member of Anthem MediBlue Plus (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.

What to do now

1. **ASK:** Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.1 and 1.5 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2020 *Drug List* and look in Section 1.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit https://go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.

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Y0114_20_109281_U_M_0059 CMS Accepted OMB Approval 0938-1051 (Expires: December 31, 2021)

- Are your doctors, including specialists you see regularly, 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 and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your *Medicare & You* Handbook.
- Look in Section 3.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan

- If you want to **keep** Anthem MediBlue Plus (HMO), you don't need to do anything. You will stay in Anthem MediBlue Plus (HMO).
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. **ENROLL:** To change plans, join a plan between **October 15 and December 7, 2019**

- If you don't join another plan by **December 7, 2019**, you will stay in Anthem MediBlue Plus (HMO).
- If you join another plan by **December 7, 2019**, your new coverage will start on **January 1, 2020**.

Additional resources:

- This document is available for free in Spanish.
- This document is available for free in Chinese.
- This document is available for free in Korean.
- 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 March 31, and Monday to Friday (except holidays) from April 1 through September 30.
- 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 front cover of this booklet.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the

Internal Revenue Service (IRS) website at https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

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).

Summary of important costs for 2020

The table below compares the 2019 costs and 2020 costs for Anthem MediBlue Plus (HMO) in several important areas. **Please note this is only a summary of changes.** A copy of the *Evidence of Coverage* is located on our website at https://shop.anthem.com/medicare/ca. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Cost	2019 (this year)	2020 (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.)	$6,700.00	$6,700.00
Doctor office visits	Primary care visits: In network $20.00 copay per visit Specialist visits: In network $50.00 copay per visit	Primary care visits: In network $20.00 copay per visit Specialist visits: In network $50.00 copay 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: $350.00 per day, per admission / Days 6 - 90: $0.00 per day, per admission	In network: Days 1 - 5: $350.00 per day, per admission / Days 6 - 90: $0.00 per day, per admission

Summary of important costs for 2020

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

Cost	2019 (this year)	2020 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: N/A Copays during the initial coverage stage: ▪ **Tier 1: Preferred Generic:** $7.00[1] (30-day supply at retail network pharmacies that offer preferred cost sharing) ▪ **Tier 2: Generic:** $15.00[1] (30-day supply at retail network pharmacies that offer preferred cost sharing) ▪ **Tier 3: Preferred Brand:** $42.00[1] (30-day supply at retail network pharmacies that offer preferred cost sharing) ▪ **Tier 4: Nonpreferred Drugs:** $95.00[1] (30-day supply at retail network pharmacies that offer preferred cost sharing) ▪ **Tier 5: Specialty Tier:** 33%[1] (30-day supply at retail network pharmacies that offer preferred cost sharing) ▪ **Tier 6: Select Care Drugs:** $0.00[1] (30-day supply at retail network pharmacies that offer preferred cost sharing)	Deductible: N/A Copays during the initial coverage stage: ▪ **Tier 1: Preferred Generic:** $7.00[1] (30-day supply at retail network pharmacies that offer preferred cost sharing) ▪ **Tier 2: Generic:** $15.00[1] (30-day supply at retail network pharmacies that offer preferred cost sharing) ▪ **Tier 3: Preferred Brand:** $42.00[1] (30-day supply at retail network pharmacies that offer preferred cost sharing) ▪ **Tier 4: Non-Preferred Drug:** $95.00[1] (30-day supply at retail network pharmacies that offer preferred cost sharing) ▪ **Tier 5: Specialty Tier:** 33%[1] (30-day supply at retail network pharmacies that offer preferred cost sharing) ▪ **Tier 6: Select Care Drugs:** $0.00[1] (30-day supply at retail network pharmacies that offer preferred 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*.

Annual Notice of Changes for 2020
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Section 1. Changes to benefits and costs for next year

Section 1.1 Changes to the monthly premium

Cost	2019 (this year)	2020 (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 - $12.00 Dental and Vision Package - $32.00 Enhanced Dental and Vision Package - $47.00	Preventive Dental Package - $12.00 Dental and Vision Package - $31.00 Enhanced Dental and Vision Package - $51.00

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late-enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- 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	2019 (this year)	2020 (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.	$6,700.00	$6,700.00 Once you have paid $6,700.00 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

Our network has changed more than usual for 2020.

An updated *Provider/Pharmacy Directory* is located on our website at https://shop.anthem.com/medicare/ca. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider/ Pharmacy Directory*. **We strongly suggest that you review our current *Provider/Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are still 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, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to 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 network pharmacies for some drugs.

There are changes to our network of pharmacies for next year. An updated *Provider/Pharmacy Directory* is located on our website at https://shop.anthem.com/medicare/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 2020 *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 2020 *Evidence of Coverage.*

Cost	2019 (this year)	2020 (next year)
Emergency Care	Emergency Room copay is not waived if admitted.	Emergency Room copay is waived if admitted within 24 hours.
Skilled nursing facility (SNF) care	Preferred Participating SNF: Days 1 - 20: $0 per day / Days 21 - 100: $142 per day; All Other Participating SNF: Days 1 - 20: $0 per day / Days 21 - 100: $172 per day	SNF Days 1 - 20: $0.00 per day / Days 21 - 100: $140.00 per day
Urgently needed services	$50.00 copay	$35.00 copay
Routine Eyewear	This plan covers up to $100.00 for eyeglasses or contact lenses every year.	This plan covers up to $50.00 for eyeglasses or contact lenses every year.
Opioid Treatment Services	Not covered.	Covered.

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 provided electronically.

Certain drugs may be covered for some medical conditions, but are considered non-formulary for other medical conditions. Drugs that are covered for only select medical conditions will be identified on our *Drug List* and in Medicare Plan Finder, along with the specific medical conditions that they cover.

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 temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy.

If we approve your request for an exception, our approval usually is valid until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.

Most of the changes in the *Drug List* are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to the *Drug List* during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online *Drug List* as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the *Drug List*, see Chapter 5, Section 6 of the *Evidence of Coverage*.)

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 receive "Extra Help" and haven't received this insert by September 30, 2019, 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, Sections 6 and 7, in the *Evidence of Coverage*, which is located on our website at https://shop.anthem.com/medicare/ca. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.)

Changes to the deductible stage

Stage	2019 (this year)	2020 (next year)
Stage 1: Yearly deductible stage	Because we have no deductible, this payment stage does not apply to you.	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	2019 (this year)	2020 (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 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*.	Your cost for a one-month supply at a network pharmacy: **Tier 1: Preferred Generic** *Standard cost sharing:* You pay $12.00* per prescription. *Preferred cost sharing:* You pay $7.00* per prescription. **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 Drugs** *Standard cost sharing:* You pay $100.00* per prescription. *Preferred cost sharing:* You pay $95.00* per prescription.	Your cost for a one-month supply at a network pharmacy: **Tier 1: Preferred Generic** *Standard cost sharing:* You pay $12.00* per prescription. *Preferred cost sharing:* You pay $7.00* per prescription. **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: Non-Preferred Drug** *Standard cost sharing:* You pay $100.00* per prescription. *Preferred cost sharing:* You pay $95.00* per prescription.

Stage	2019 (this year)	2020 (next year)
	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 $3,500, you will move to the next stage (the Coverage Gap Stage).	**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 $4,020, 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. Administrative changes

Cost	2019 (this year)	2020 (next year)
Optional supplemental package 3 – Enhanced dental and vision package As a Supplemental Benefit, these services are not routinely covered under Original Medicare. They are offered for an additional premium through this Optional supplemental package 3 – Enhanced dental and vision package. For more information about optional supplemental packages, refer to your *Evidence of Coverage (EOC)* in Chapter 4, Section 2.2.	**In-network:** **The plan will pay up to** $2,000 for dental benefits each year (benefit maximum). Dental implants not covered.	**In-network:** **The plan will pay up to** $2,000 for dental benefits each year (benefit maximum). **You pay 50%** as your portion of the covered charges for dental implants.
Pharmacy benefit manager (PBM)	Your plan works with Express Scripts to process all of your pharmacy claims.	Your plan will work with the new PBM, IngenioRx, to process all of your pharmacy claims. It is important for you to know that the information on your member ID card will change and you will need to give your new ID card to your pharmacist when you make your first visit to the pharmacy in

Cost	2019 (this year)	2020 (next year)
		2020. The address for claims reimbursement and customer service numbers for drug-related questions will also change, so please make sure to check your *Evidence of Coverage (EOC)*.
Mail order	Your mail-order vendor is Express Scripts.	Your new mail-order vendor will be IngenioRx Home Delivery. If you elect to use mail order to receive your prescriptions, you will need to use IngenioRx Home Delivery. More information on the mail-order process and changes to the auto-refill process can be found in Chapter 5 of the *Evidence of Coverage (EOC)*.
100-day supply	Your plan covers up to a 90-day supply for certain drugs on your formulary.	Tier 6 drugs are available in a 100-day supply at retail/mail-order.
Opioid coverage change	If you are taking an opioid drug and are allowed refills, you are allowed to get a 30, 60 or 90-day supply.	You cannot get more than a 30-day opioid supply.
Hyaluronic acids	The plan covers hyaluronic acids when clinical requirements are met.	Plan covers preferred hyaluronic acids, DUROLANE, EUFLEXXA, SUPARTZ, and Gel-SYN-3 hyaluronic acids, when clinical requirements are met. Other brands are only covered if deemed medically necessary by your doctor.
Continuous glucose monitors (CGMS)	You may purchase your CGMS through a durable medical equipment (DME) provider or at the pharmacy.	You must purchase your CGMS at the pharmacy.

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 2020.

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 2020, follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- *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. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late-enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2020*, 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 https://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Anthem Blue Cross offers other Medicare health plans and Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

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, seven 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, 2020.

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, those who have or are leaving employer coverage, and those who move out of the service area, may be 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, 2020, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch

to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2020. 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 http://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/seven days a week;
  - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, 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
  Call: 1-844-421-7050
  TTY users should call 711.

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 March 31, and Monday to Friday (except holidays) from April 1 through September 30. Calls to these numbers are free.

Read your 2020 *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 2020. For details, look in the 2020 *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 located on our website at https://shop.anthem.com/medicare/ca. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Visit our website

You can also visit our website at https://shop.anthem.com/medicare/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, seven days a week. TTY users should call 1-877-486-2048.

Visit the Medicare website

You can visit the Medicare website (https://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 https://www.medicare.gov and click on "Find health & drug plans").

Read *Medicare & You 2020*

You can read the *Medicare & You 2020* 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 (https://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

It's important we treat you fairly
That's why we follow Federal civil rights laws in our health programs and activities. We don't 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. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call Customer Service for help (TTY: 711).

If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, 4361 Irwin Simpson Rd, Mailstop: OH0205-A537; Mason, Ohio 45040-9498. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TTY: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Get help in your language
Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Customer Service number on the back of your ID card.

English: You have the right to get this information and help in your language for free. Call Customer Service for help.

Spanish: Tiene el derecho de obtener esta información y ayuda en su idioma de forma gratuita. Llame al número de Servicios para Miembros para obtener ayuda.

Arabic:
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجاناً. اتصل بخدمة العملاء للمساعدة.

Armenian: Դուք իրավունք ունեք Ձեր լեզվով ստանալու այս տեղեկատվությունը և ցանկացած օգնություն՝ անվճար: Օգնություն ստանալու համար զանգահարեք հաճախորդների սպասարկման կենտրոն:

Chinese: 您有權使用您的語言免費獲得該資訊和協助。請致電客戶服務部尋求協助。

Farsi:
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید.
برای دریافت کمک با مرکز خدمات مشتریان تماس بگیرید.

French: Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour obtenir de l'aide, veuillez appeler le service client.

Haitian: Ou gen dwa resevwa enfòmasyon sa a ak asistans nan lang ou pale a pou gratis. Rele nimewo Sèvis Kliyan an pou jwenn èd.

Italian: Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il Servizio clienti.

Japanese: この情報と支援を希望する言語で無料で受けることができます。サポートが必要な場合はカスタマー サービスにお電話ください。

Korean: 귀하께는 본 정보와 도움을 비용없이 귀하의 언어로 받으실 권리가 있습니다. 도움을 받으시려면 고객 서비스부로 연락해 주십시오.

Polish: Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. Zadzwoń pod numer Działu Obsługi Klienta w celu uzyskania pomocy.

Portuguese: Você tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o Atendimento ao Cliente para obter ajuda.

Russian: Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания клиентов.

Tagalog: May karapatan kang makuha ang impormasyon at tulong na ito sa sarili mong wika ng walang kabayaran. Tumawag sa Serbisyo para sa mga Kustomer para matulungan ka.

Vietnamese: Bạn có quyền được biết về thông tin này và được hỗ trợ bằng ngôn ngữ của bạn miễn phí. Hãy liên hệ với Dịch vụ khách hàng để được hỗ trợ.

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