Summary of Benefits

Medicare Advantage and Part D

Plan year: January 1 – December 31, 2020

California

Los Angeles, Orange counties

Anthem MediBlue Coordination Plus (HMO)*

20CAH0544072

Thank you for your interest in our Medicare Advantage plans

Anthem Blue Cross offers a variety of benefits designed to help keep you healthy while protecting you from unexpected medical and drug costs. This booklet tells you what we cover, what you may pay and more. If you have questions, please call your agent.

***This plan uses a focused network of providers.**

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Anthem MediBlue Coordination Plus (HMO)

Anthem MediBlue Coordination Plus (HMO)
Our service area includes these counties in CA: Los Angeles, Orange

Have questions?

- If you **are not** a member of our plan, please call us toll-free **1-844-250-2336** (TTY: **711**), and follow the instructions to be connected to a representative.
- If you **are** a member of our plan, please call us toll-free at **1-888-230-7338** (TTY: **711**).
- Hours of operation: 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.

- You can learn more about us on our website at **https://shop.anthem.com/medicare/ca.**

While the Summary of Benefits does not include every service, limit or exclusion, the *Evidence of Coverage* does. Just give us a call to request a copy.

Anthem MediBlue Coordination Plus (HMO) is a Medicare Advantage and prescription drug plan. It includes hospital, medical and prescription drug benefits in one plan. To join this plan, you must:

- Be entitled to Medicare Part A,
- Enrolled in Medicare Part B, and
- Live in our service area.

With this plan, if you're enrolled in the state's Medicaid program, you may pay nothing or get help with your share of the costs (such as monthly payment, coinsurances, copays or deductibles). You must remain enrolled in Medicaid under the state Medicaid plan to get the reduced cost-sharing.

With this plan, you must use doctors and facilities in our plan. If you use a doctor or facility not in our plan, we may not cover the services.

Medicare coverage that goes beyond Original Medicare

- Like all Medicare Advantage health plans, we cover everything that Original Medicare covers — Part A (hospital services) and Part B (medical services), plus more. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less (see benefits section for more details).
- This plan covers Medicare Part D drugs and Part B drugs (such as chemotherapy and some drugs administered by your provider). To see if your prescription drugs are covered, follow the instructions in the "Know Your Drug Plan" section of this booklet.

This is a Health Maintenance Organization (HMO) plan. That means:

- You must choose a primary care provider (PCP) in the plan's network of doctors for covered services.† A PCP is your main doctor who provides most of your medical care, including routine care and hospitalizations. Your PCP will also help coordinate your care after a stay in the hospital.
- Before you get care from a specialist, we highly recommend you talk to your PCP first. Doing so will keep your PCP informed and will help ensure you get the right care. Many specialist services require a referral from your PCP. So if you have a favorite specialist, make sure to ask if the specialist is in the plan's network.

† If you need emergency or urgent care, call 911 or go to the nearest doctor or facility that can help you. Most times, you must use doctors in our plan to get covered medical care, except for emergencies and urgently needed care when doctors in our plan are not available, or dialysis services when you are out of the service area. If you get routine care from doctors outside our plan, neither Medicare nor Anthem Blue Cross will pay for it.

Is your PCP in our plan's network of doctors?

If, for any reason, you need to change your PCP, give us a call – we can help you! A doctor or PCP can join or leave our plan at any time, so be sure to ask if he or she is in our Medicare Advantage plan, taking new patients and accepts Medicare. You can find a PCP in our plan or check their status online. Just follow the steps below.

How to find a doctor/PCP in our plan:

- Go to **https://shop.anthem.com/medicare/ca**
  1. Scroll to the *Useful Tools* section and choose the tab labeled **Find a Doctor**.
  2. Enter your ZIP code, county and the date you want your coverage to begin and select **Continue**.
  3. Fill in the details of your search (city, doctor's name, distance, etc.).
  4. Be sure to check that the doctor displays as "In-Network" for these plans.
- Or you can call us and ask for a copy of the *Provider Directory*. The phone number is on page 2.

Know your drug plan

Prescription drugs are an important part of health and wellness

Our plan gives you access to the drugs you need to get healthy and stay active.

What is a formulary?

The formulary is a list of drugs covered by our plan that tells you:

- Which drugs require prior authorization from your plan before you fill your prescription,
- If there is a quantity limit on the frequency, amount or dosage,
- If you need to try other drugs first (called step therapy),
- And the cost-sharing tier a drug is in.

Our plan groups each drug into "tiers". The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Learn more by going to the "Summary of 2020 prescription drug coverage" section in this guide.

How to find if your drugs (or an acceptable alternative) are covered and what they'll cost:

- Visit **https://shop.anthem.com/medicare/ca**
  1. Scroll to the *Useful Tools* section and choose the tab labeled **Find Your Covered Drugs**.
  2. Enter your ZIP code, county and beginning coverage date; then select **Continue**.
  3. Enter the name of your drug, dosage, quantity and refill frequency, and select **Add Drug**.
  4. Select your pharmacy.
  5. Select **View All Plans**.
  6. Make sure to choose **Show drug cost details** to view what tier your drugs are in, specific costs and coverage details.
- You can also call Customer Service at the number on page 2 to get a copy of the *Formulary*.

Can I use any pharmacy to fill my covered prescriptions?

To get the best savings on your covered Part D drugs, you must generally use a pharmacy in our plan. You may get your covered drugs from pharmacies that are **not** in our plan, but only when you are unable to get your prescription drugs from a pharmacy that **is** in our plan.

Save even more money at pharmacies with preferred cost sharing

To help you save even more money on your covered drugs, we work with certain pharmacies *(preferred pharmacies)* to further reduce prices. At preferred pharmacies, your copays and share of the cost may be lower than pharmacies with standard cost sharing. You can use a preferred pharmacy or a pharmacy with standard cost sharing; the choice is yours.

To find a pharmacy in our plan, see our online *Pharmacy Directory* on our website at **https://shop.anthem.com/medicare/ca** (under *Useful Tools*, select **Find a Pharmacy**, and enter your location and search details). Preferred pharmacies are indicated above the pharmacy name. Or you can give us a call and we'll send you a copy.

Don't miss out on some "Extra Help"*

If you qualify for **Medicare's "Extra Help**," you can get help with paying your drug plan's monthly payment (premium), yearly deductible, coinsurance and copays for covered prescription drugs. Plus:

- The coverage gap stage will not apply to you and
- There are no late enrollment penalties.

* You can't get Medicare Coverage Gap Discounts on brand-name drugs if you receive "Extra Help."

To find out if you qualify for "Extra Help," call:

- **1-800-MEDICARE** (TTY **1-877-486-2048**), 24 hours a day/7 days a week.
- The Social Security Administration at **1-800-772-1213** (TTY: **1-800-325-0778**) between 7 a.m. and 7 p.m., Monday through Friday,
- Your state Medicaid office, or
- Our Customer Service number located on page 2.

Summary of 2020 medical benefits

On the following pages, you can review more about our plan benefits to help you choose the right plan for you. If you want to compare our plan with other Medicare health plans, call and ask the other plans for a copy of their Summary of Benefits.

Anthem MediBlue Coordination Plus (HMO)

How much is my premium (monthly payment)?

$25.30 per month

You must continue to pay your Medicare Part B premium.

If you get "Extra Help" from Medicare, your monthly plan premium will be lower or you might pay nothing.

How much is my deductible?

This plan does not have a medical deductible.

$435.00 deductible per year for Part D prescription drugs.

Drugs listed on Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Nonpreferred Drug, Tier 5: Specialty Tier are included in the Part D deductible.

If you receive "Extra Help" from Medicare, your deductible amount depends on the level of "Extra Help" you receive.

If you qualify for low-income subsidy (LIS), also known as Medicare's "Extra Help" program, your annual Part D deductible will be lower or you might pay nothing.

Additionally, if you're enrolled in the state's Medicaid program, you may pay nothing or get help with your share of the costs (such as monthly plan premium,coinsurances, copays or deductibles). You must remain enrolled in Medicaid under the state Medicaid plan to get the reduced cost-sharing.

Some services, procedures or drugs are only covered if your PCP or other provider gets permission from our plan first. This is called prior authorization (pre-approval). Please contact your PCP or refer to the *Evidence of Coverage* (EOC) for services that require prior authorization.

Is there a limit on how much I will pay for my covered medical services? (does not include Part D drugs)

$6,700.00 per year from doctors and facilities in our plan.

Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.

Services you get from doctors or facilities in our plan go toward your yearly limit. If you reach the limit on out-of-pocket costs, you will not have to pay any out-of-pocket costs for covered Part A and Part B services for the rest of the year.

Inpatient Hospital

Facilities in our plan: Medicare-defined Cost Share

Medicare-defined Cost Share

In 2019, the amounts for each benefit period are:

- $1,364 deductible for days 1 through 60.
- $341 copay per day for days 61 through 90.
- $682 copay per day for 60 lifetime reserve days. These are "extra" days we cover once in your lifetime.

These amounts may change for 2020 after this book is printed. Please see your plan's *Evidence of Coverage* for exact amounts for 2020, or ask your agent orbroker.

Your copays for inpatient benefits are based on benefit periods. A benefit period starts on the first day you go into a hospital or skilled nursing facility (SNF) and ends when you haven't had any inpatient hospital care or skilled nursing care for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period starts. There's no limit to the number of benefit periods you can have.

Some services, procedures or drugs are only covered if your PCP or other provider gets permission from our plan first. This is called prior authorization (pre-approval). Please contact your PCP or refer to the *Evidence of Coverage* (EOC) for services that require prior authorization.

Anthem MediBlue Coordination Plus (HMO)

Outpatient Hospital

Doctors and facilities in our plan: 20% coinsurance

What you will pay depends on the service and where you are treated. Please refer to the *Evidence of Coverage* for additional information.

Ambulatory Surgical Center

Doctors and facilities in our plan: 20% coinsurance

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

Doctor's Office Visits

Primary care physician (PCP) visit:

PCPs in our plan: 20% coinsurance

Specialist visit:

Doctors in our plan: 20% coinsurance

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

Preventive Care Screenings and Annual Physical Exams

Preventive care screenings:

Doctors in our plan: $0.00 copay

Some services, procedures or drugs are only covered if your PCP or other provider gets permission from our plan first. This is called prior authorization (pre-approval). Please contact your PCP or refer to the *Evidence of Coverage* (EOC) for services that require prior authorization.

Anthem MediBlue Coordination Plus (HMO)

Preventive Care Screenings and Annual Physical Exams

Annual physical exam:

Doctors in our plan: $0.00 copay

Covered preventive care screenings:

- Abdominal aortic aneurysm screening
- Annual "wellness" visit
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular screening
- Cervical and vaginal cancer screening
- Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
- Depression screening
- Diabetes prevention program
- Diabetes screenings and monitoring
- Hepatitis C Screening
- High Intensity Behavioral Counseling
- HIV screening
- Lung cancer screenings
- Medical nutrition therapy services
- Obesity screenings and counseling
- Prostate cancer screenings (PSA)
- Sexually transmitted infections screenings and counseling
- Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)
- Vaccines, including flu shots, hepatitis B shots, pneumococcal shots
- "Welcome to Medicare" preventive visit (one-time)

Any extra preventive services approved by Medicare during the contract year will be covered. When you use doctors in this plan, 100% of the cost of preventive care screenings and annual physical exams are covered.

Some services, procedures or drugs are only covered if your PCP or other provider gets permission from our plan first. This is called prior authorization (pre-approval). Please contact your PCP or refer to the *Evidence of Coverage* (EOC) for services that require prior authorization.

Anthem MediBlue Coordination Plus (HMO)

Emergency Care

$90.00 copay

Emergency and Urgent Care Worldwide Coverage

$0.00 copay

This plan covers emergency services when traveling outside of the United States for less than six months. This benefit is limited to $25,000.00 per year for worldwide emergency services.

Urgently Needed Services

$65.00 copay

Diagnostic Radiology Services (such as MRIs, CT scans)

Doctors and facilities in our plan: 20% coinsurance

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

What you pay for these services may vary based on where you are treated.

Diagnostic Tests and Procedures

Doctors and facilities in our plan: 20% coinsurance

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

What you pay for these services may vary based on where you are treated.

Some services, procedures or drugs are only covered if your PCP or other provider gets permission from our plan first. This is called prior authorization (pre-approval). Please contact your PCP or refer to the *Evidence of Coverage* (EOC) for services that require prior authorization.

Anthem MediBlue Coordination Plus (HMO)

Lab Services

Doctors and facilities in our plan: 20% coinsurance

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

What you pay for these services may vary based on where you are treated.

Outpatient X-rays

Doctors and facilities in our plan: 20% coinsurance

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

What you pay for these services may vary based on where you are treated.

Therapeutic Radiology Services (such as radiation treatment for cancer)

Doctors and facilities in our plan: 20% coinsurance

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

What you pay for these services may vary based on where you are treated.

Hearing Services

Medicare-covered hearing services (Exam to diagnose and treat hearing and balance issues):

Doctors in our plan: 20% coinsurance

Some services, procedures or drugs are only covered if your PCP or other provider gets permission from our plan first. This is called prior authorization (pre-approval). Please contact your PCP or refer to the *Evidence of Coverage* (EOC) for services that require prior authorization.

Hearing Services

Routine hearing services:

This plan covers 1 routine hearing exam(s) and hearing aid fitting/ evaluation(s) every year. $3,000.00 maximum plan benefit for hearing aids every year.

Doctors in our plan: $0.00 copay for routine hearing exam(s). $0.00 copay for hearing aids up to the maximum plan benefit amount.

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

Dental Services

Medicare-covered dental services (this does not include services for care, treatment, filling, removal or replacement of teeth):

Doctors and dentists in our plan: 20% coinsurance

Preventive dental services:

This plan covers: 2 oral exam(s), 2 cleaning(s), 1 dental X-ray(s), 1 fluoride treatment(s) every year.

Dentists in our plan: $0.00 copay

Some services, procedures or drugs are only covered if your PCP or other provider gets permission from our plan first. This is called prior authorization (pre-approval). Please contact your PCP or refer to the *Evidence of Coverage* (EOC) for services that require prior authorization.

Anthem MediBlue Coordination Plus (HMO)

Dental Services

Comprehensive dental services:

This plan covers up to a $600.00 allowance for comprehensive dental services every quarter.

Doctors and dentists in our plan: $0.00 copay

We cover more dental care than what Original Medicare covers. You can use our coverage for these services and more: extra exams, cleanings, X-rays, fillings and repairs, root canals (endodontics), dental crowns (caps), bridges and implants, and dentures.

Any amount not used at the end of a quarter will carry over to the next quarter.

Any amount not used at the end of the calendar year will expire.

To find a dental provider in our plan, follow the same steps as the "How to find a doctor/PCP in our plan" box at the beginning of this booklet. Then select **Dental Provider** under **Provider Type**.

Vision Services

Medicare-covered vision services:

Exam to diagnose and treat diseases and conditions of the eye

Doctors in our plan: 20% coinsurance

Eyeglasses or contact lenses after cataract surgery

Doctors in our plan: 20% coinsurance

Routine vision services:

Routine vision exam

This plan covers 1 routine eye exam(s) every year.

Some services, procedures or drugs are only covered if your PCP or other provider gets permission from our plan first. This is called prior authorization (pre-approval). Please contact your PCP or refer to the *Evidence of Coverage* (EOC) for services that require prior authorization.

Vision Services

Doctors in our plan: $0.00 copay

Routine eyewear (lenses and frames)

This plan covers up to $300.00 for eyeglasses or contact lenses every year.

Doctors in our plan: $0.00 copay

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

To find a vision provider in our plan, follow the same steps as the "How to find a doctor/PCP in our plan" box at the beginning of this booklet. Then select **Vision Provider** under **Provider Type**.

Some services, procedures or drugs are only covered if your PCP or other provider gets permission from our plan first. This is called prior authorization (pre-approval). Please contact your PCP or refer to the *Evidence of Coverage* (EOC) for services that require prior authorization.

Mental Health Care

Inpatient visit:

Doctors and facilities in our plan: Medicare-defined Cost Share

Medicare-defined Cost Share

In 2019, the amounts for each benefit period are:

- $1,364 deductible for days 1 through 60.
- $341 copay per day for days 61 through 90.
- $682 copay per day for 60 lifetime reserve days. These are "extra" days we cover once in your lifetime.

These amounts may change for 2020 after this book is printed. Please see your plan's *Evidence of Coverage* for exact amounts for 2020, or ask your agent orbroker.

Our plan has a lifetime limit of 190 days for inpatient mental health care in a psychiatric hospital. This limit does not apply to inpatient mental health services provided in a general hospital.

Your copays for inpatient benefits are based on benefit periods. A benefit period starts on the first day you go into a hospital or skilled nursing facility (SNF) and ends when you haven't had any inpatient hospital care or skilled nursing care for 60 days in a row. If you go into a hospital after one benefit period has ended, a new benefit period starts. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods you can have.

Outpatient individual and group therapy services:

Doctors and facilities in our plan: 20% coinsurance

Some services, procedures or drugs are only covered if your PCP or other provider gets permission from our plan first. This is called prior authorization (pre-approval). Please contact your PCP or refer to the *Evidence of Coverage* (EOC) for services that require prior authorization.

Skilled Nursing Facility (SNF)

Doctors and facilities in our plan: Medicare-defined Cost Share

Medicare-defined Cost Share

In 2019, the amounts for each benefit period are:

- $0 copay per day for days 1 through 20.
- $170.50 copay per day for days 21 through 100.

These amounts may change for 2020 after this book is printed. Please see your plan's *Evidence of Coverage* for exact amounts for 2020, or ask your agent or broker.

Our plan covers up to 100 days in a Skilled Nursing Facility (SNF).

Your copays for SNF benefits are based on benefit periods. A benefit period starts on the first day you go into a hospital or SNF and ends when you haven't had any inpatient hospital care or skilled nursing care for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period starts. There's no limit to the number of benefit periods you can have.

Physical Therapy

Doctors and facilities in our plan: 20% coinsurance

Ambulance

Ground/Water Ambulance:

Emergency transportation services in our plan: 20% coinsurance per trip

Air Ambulance:

Emergency transportation services in our plan: 20% coinsurance per trip

Some services, procedures or drugs are only covered if your PCP or other provider gets permission from our plan first. This is called prior authorization (pre-approval). Please contact your PCP or refer to the *Evidence of Coverage* (EOC) for services that require prior authorization.

Transportation

Transportation services in our plan: $0.00 copay. This plan offers coverage for 48, one-way, routine transportation services every year. Trips are limited to 60 miles.

Routine transportation coverage is limited to plan-approved locations (within the local service area) provided by contracted transportation vendors in our plan. If you need a ride, call us at least 48 hours ahead of time.

Medicare Part B Drugs

Other Part B Drugs:

Drugs in our plan: 20% coinsurance

Chemotherapy drugs:

Drugs in our plan: 20% coinsurance

Some services, procedures or drugs are only covered if your PCP or other provider gets permission from our plan first. This is called prior authorization (pre-approval). Please contact your PCP or refer to the *Evidence of Coverage* (EOC) for services that require prior authorization.

Additional benefits

Anthem MediBlue Coordination Plus (HMO)

Acupuncture

Providers in our plan: $0.00 copay per visit. This plan offers coverage for unlimited visits every year.

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

Chiropractic Care

Medicare-covered chiropractic services:

Providers in our plan: 20% coinsurance

Medicare coverage includes manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position).

Enhanced Drug Coverage

Our plan offers additional coverage of some prescription drugs not normally covered in a Medicare prescription drug plan. Covered drugs include:

- Sildenafil. Limit 4 tablets per month.

Please refer to your Tier 1: Preferred Generic copay later in this Summary of Benefits for how much you will pay. Your plan's *Formulary* includes additional information about all drugs covered under this benefit.

Some services, procedures or drugs are only covered if your PCP or other provider gets permission from our plan first. This is called prior authorization (pre-approval). Please contact your PCP or refer to the *Evidence of Coverage* (EOC) for services that require prior authorization.

Anthem MediBlue Coordination Plus (HMO)

Foot Care (podiatry services)

Medicare-covered podiatry:

Doctors in our plan: 20% coinsurance

Foot exams and treatment are covered if you have diabetes-related nerve damage and/or meet certain conditions.

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

Routine foot care:

Doctors in our plan: $0.00 copay

This plan covers: Unlimited routine foot care visits each year.

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

Home Health Care

Doctors and facilities in our plan: $0.00 copay

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

In-Home Support

Upon discharge from a hospital or nursing facility, receive up to 4 four-hour shifts of assistance in performing activities of daily living (ADLs). Activities include support such as light cleaning or help obtaining groceries outside the home.

Requires prior authorization and referral. You must use network providers.

Some services, procedures or drugs are only covered if your PCP or other provider gets permission from our plan first. This is called prior authorization (pre-approval). Please contact your PCP or refer to the *Evidence of Coverage* (EOC) for services that require prior authorization.

Anthem MediBlue Coordination Plus (HMO)

LiveHealth Online

Lets you talk to a board-certified doctor, or licensed psychologist or therapist, by live, two-way video on a computer, smartphone or tablet.

Please refer to the *Evidence of Coverage* for additional information.

Meals Benefit

Post Hospitalization Meals

$0.00 copay for up to 2 meals a day for 7 days following your discharge from the hospital.

Medical Equipment/Supplies

Durable Medical Equipment (wheelchairs, oxygen, etc.)**:**

Suppliers in our plan: 20% coinsurance

Medical supplies and prosthetic devices (braces, artificial limbs, etc.):

Suppliers in our plan: 20% coinsurance

Diabetic supplies and services:

Suppliers in our plan: $0.00 copay

Some services, procedures or drugs are only covered if your PCP or other provider gets permission from our plan first. This is called prior authorization (pre-approval). Please contact your PCP or refer to the *Evidence of Coverage* (EOC) for services that require prior authorization.

Anthem MediBlue Coordination Plus (HMO)

Medicare Community Resource Support

We assist you right over the phone by providing you with health-related information and by connecting you to local community-based services and support programs. We'll help you coordinate these services based on your unique needs. Call us at the number listed on page 2 of this booklet and ask for the Medicare Community Resource team for more details.

Outpatient Rehabilitation

Cardiac (heart) rehab services (with a limit of two, one-hour sessions per day and a maximum of 36 sessions within a 36-week period):

Doctors and facilities in our plan: 20% coinsurance

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

Pulmonary (lung) rehab services (with a limit of two, one-hour sessions per day and a maximum of 36 sessions):

Doctors and facilities in our plan: 20% coinsurance

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

Occupational therapy visit:

Doctors and facilities in our plan: 20% coinsurance

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

Some services, procedures or drugs are only covered if your PCP or other provider gets permission from our plan first. This is called prior authorization (pre-approval). Please contact your PCP or refer to the *Evidence of Coverage* (EOC) for services that require prior authorization.

Outpatient Substance Abuse

Individual & Group therapy visit:

Doctors and facilities in our plan: 20% coinsurance

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

Over-the-Counter Items

This plan covers certain approved, non-prescription, over-the-counter drugs and health-related items, up to $200 every quarter. Unused OTC amounts do roll over to the next quarter. Unused OTC amounts do not roll over to the next calendar year.

There are many ways to access your benefit:

- Shop online or use the mobile app and have items sent to your home or to a store location near you for pickup
- Shop at more than 4,600 Walmart and Neighborhood Market stores and other participating retailers
- Call to place an order and have items sent to your home

Personal Emergency Response System (PERS) coverage

Includes the monitoring device and monitoring service. To start and install services, give us a call. We can help you. Please refer to the *Evidence of Coverage* for additional information.

Some services, procedures or drugs are only covered if your PCP or other provider gets permission from our plan first. This is called prior authorization (pre-approval). Please contact your PCP or refer to the *Evidence of Coverage* (EOC) for services that require prior authorization.

Pest Control

Based on qualifying clinical criteria, you could have your home treated every three months to control pests, if they are having a direct impact on your health.

Requires prior authorization and referral.

Prescribed Meals

Based on qualifying clinical criteria, enjoy 2 home-delivered meals per day for up to 90 consecutive days alongside a nutrition education.

Requires prior authorization and referral. You must use network providers.

Renal Dialysis

Doctors and facilities in our plan: 20% coinsurance

Respite Care

You could receive up to 40 hours (minimum of 4 four-hour shifts) of respite care per calendar year through a network provider if you have a chronic debilitating medical condition and your 24/7 primary caregiver is unpaid, for you to relieve your primary caregiver from the daily routine caregiving such as walking, bathing, getting in/out of bed/chair, dressing, toileting, and eating.

Requires prior authorization and referral. You must use network providers.

Some services, procedures or drugs are only covered if your PCP or other provider gets permission from our plan first. This is called prior authorization (pre-approval). Please contact your PCP or refer to the *Evidence of Coverage* (EOC) for services that require prior authorization.

SilverSneakers®* Fitness program

When you become our member, you can sign up for SilverSneakers. It's included in our plan. To learn more details, go to **www.silversneakers.com** or call SilverSneakers at 1-855-741-4985 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. ET.

* The SilverSneakers Fitness Program is provided by Tivity Health, an independent company. Tivity Health and SilverSneakers are registered trademarks or trademarks of Tivity Health, Inc., and/or its subsidiaries and/or affiliates in the USA and/or other countries.

24/7 NurseLine

24-hour access to a nurse helpline, 7 days a week, 365 days a year.

Please refer to the *Evidence of Coverage* for additional information.

Some services, procedures or drugs are only covered if your PCP or other provider gets permission from our plan first. This is called prior authorization (pre-approval). Please contact your PCP or refer to the *Evidence of Coverage* (EOC) for services that require prior authorization.

Summary of 2020 prescription drug coverage

Know where to go:

Once you become a member of our plan, Chapters 5 and 6 of your *Evidence of Coverage* include lots of important details about your pharmacy benefit.

To find a pharmacy in our plan:

- Visit **https://shop.anthem.com/medicare/ca** (under *Useful Tools*, select **Find a Pharmacy**, and enter your location and search details).
- Give us a call and we'll send you a copy of the *Pharmacy Directory.*

The four stages of drug coverage

What you pay for your covered drugs depends, in part, on which coverage stage you are in.

Stage 1	Stage 2	Stage 3	Stage 4
Deductible	**Initial Coverage**	**Coverage Gap**	**Catastrophic Coverage**
If you have a deductible, you will pay 100% of your drug cost until you meet your deductible. (If you have no deductible, or if a specific drug tier does not apply to the deductible, you will skip to Stage 2.)	You will pay a copay or a percentage of the cost, and your plan pays the rest for your covered drugs.	In this stage, you pay a greater share of the costs. It begins after you and your plan have paid a certain amount on covered drugs during Stages 1 and 2 (this can vary by plan). See Stage 2: Initial Coverage below for the exact amount. After you enter the coverage gap, you pay **25%** of the plan's cost for covered brand-name drugs and **25%** of the plan's cost for covered generic drugs until your costs total **$6,350**. Some plans have extra coverage. See the Coverage Gap section for more details.	In this stage, after your yearly out-of-pocket drug costs (including drugs purchased through mail order and your retail pharmacy) reach **$6,350**, the plan pays most, or in some cases all, of the cost of your covered Part D prescription drugs. See the Catastrophic Coverage section below for what you pay with this plan.

Which coverage stage am I in?

You will get an **Explanation of Benefits** (EOB) each month you fill a prescription. It will show which coverage stage you're in and how close you are to entering the next one.

Anthem MediBlue Coordination Plus (HMO)

Stage 1: How much is my deductible?

$435.00 deductible per year for Part D prescription drugs.

Drugs listed on Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Nonpreferred Drug, Tier 5: Specialty Tier are included in the Part D deductible.

If you receive "Extra Help" from Medicare, your deductible amount depends on the level of "Extra Help" you receive.

Stage 2: Initial Coverage

After you pay your yearly deductible (if your plan has one), you pay the amount listed in the table on the following pages, until your total yearly drug costs reach $4,020. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

You may get your covered drugs at retail pharmacies and mail-order pharmacies in our plan. Generally, you may get your covered drugs from pharmacies not in our plan only when you are unable to get your prescription drugs from a pharmacy that is in our plan. If you live in a long-term care facility, you pay the same as at a standard retail pharmacy.

If you qualify for low-income subsidy (LIS), also known as Medicare's "Extra Help" program, the amount you pay may be different in this Stage.

Stage 2: Initial Coverage	
Preferred Retail and Mail Order Cost Sharing	
Cost Sharing	**Anthem MediBlue Coordination Plus (HMO)**
Tier 1: Preferred Generic	
Preferred retail one-month supply	**$0.00***
Mail order three-month supply	**$0.00*** [100]
Tier 2: Generic	
Preferred retail one-month supply	**$15.00**
Mail order three-month supply	**$45.00**
Tier 3: Preferred Brand	
Preferred retail one-month supply	**$47.00**
Mail order three-month supply	**$141.00**
Tier 4: Non-Preferred Drug	
Preferred retail one-month supply	**$95.00**
Mail order three-month supply	**$285.00**
Tier 5: Specialty Tier	
Preferred retail one-month supply	**25%**
Mail order three-month supply	**Not available**

*Your deductible will not apply for these drugs.

[100] The three-month supply for this tier on this plan is 100 days.

Cost sharing shown above applies to prescriptions obtained at Preferred Retail Pharmacies and through Mail Order. Cost may differ when obtained at Standard Retail Pharmacies.

Stage 3: Coverage Gap

Anthem MediBlue Coordination Plus (HMO)

For drugs on Tier 1, you pay the same cost-sharing that is listed in Stage 2 above.

For all other drugs, you pay **25%** of the plan's cost for covered brand name drugs and **25%** of the plan's cost for covered generic drugs until your costs total **$6,350**, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Stage 4: Catastrophic Coverage

Anthem MediBlue Coordination Plus (HMO)

After your yearly out-of-pocket drug costs reach $6,350, you pay the greater of: a $3.60 copay for generic (including brand drugs treated as generic) and a $8.95 copay for all other drugs, or 5% coinsurance.

Ways we support your health

Get fit and be healthy with SilverSneakers®

We offer the SilverSneakers[1] fitness program as a plan benefit at no cost to you. SilverSneakers includes:

- In-home SilverSneakers On-Demand™ video classes.
- All basic amenities at participating locations nationwide.
- Group exercise classes at some sites.
- Fun social activities.
- Access to a secure, members-only online community.

How to get started:

When you become our member, you have SilverSneakers. Go to **www.silversneakers.com** to find over 16,000+ nationwide fitness locations and SilverSneakers FLEX classes, and get your unique SilverSneakers ID number. Just show your ID number at the fitness location front desk or to the SilverSneakers FLEX instructor to start working out! You can use more than one location at a time. If you already have a gym membership, SilverSneakers does not replace it or your gym privileges. For more details, visit **www.silversneakers.com** or call SilverSneakers Customer Service at **1-855-741-4985** (TTY: **711**), Monday through Friday, 8 a.m. to 8 p.m. Eastern Time.

[1] The SilverSneakers fitness program is provided by Tivity Health, an independent company. SilverSneakers and the SilverSneakers shoe logotype are registered trademarks of Tivity Health, Inc. SilverSneakers On-Demand and SilverSneakers GO are trademarks of Tivity Health, Inc.

LiveHealth® † ONLINE

Using LiveHealth Online, you can visit with a board-certified doctor or licensed psychologist or therapist from the comfort and privacy of your home using your smartphone, tablet or computer for a $0 copay. Doctors are available 24 hours a day, 7 days a week to assess common health conditions like the flu, a cold, sinus infection, pink eye, sore throat and more.

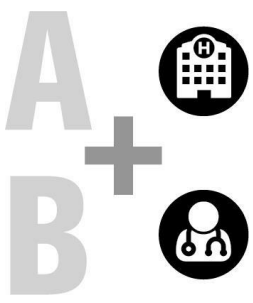
When you're having a tough time coping or feeling stressed, you can make an appointment and visit with a therapist in four days or less. Getting started is easy. You can sign up at **https://livehealthonline.com** or by downloading our free mobile app.

† LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of our plan.

An overview of how Medicare works

If you're new to Medicare, this information can help you decide what option is right for you.

ORIGINAL MEDICARE (PARTS A and B) is offered by the federal government. It helps cover the costs for:



- Inpatient care in hospitals and skilled nursing facilities (not custodial or long-term care).
- Hospice and some home health care services.
- Doctors' services, hospital outpatient care and some home health care services, as well as lab tests, medical equipment and supplies.
- Most preventive services, including a yearly wellness exam.

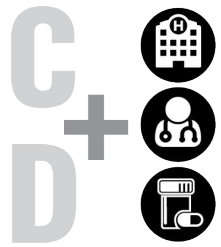
But Original Medicare doesn't cover everything. Parts A and B don't cover:

- Prescription drugs.
- Routine vision, dental or hearing care.

HERE ARE YOUR OPTIONS

Option 1 Choose all your coverage in one plan

Medicare PART C (offered by private insurers) can also be called a "Medicare Advantage" plan and:



- Includes all of Part A (hospital) and Part B (medical) coverage.
- Usually includes Part D prescription drug coverage.
- Often offers extra services and benefit options.
- Has yearly limits on your out-of-pocket costs for medical services.

How Medicare works - continued

- OR -

Option 2	Choose one or both of the following

MEDICARE PART D (offered by private insurers) is stand-alone prescription drug coverage and

- Helps pay for many of your prescribed drugs.
- Gives you access to mail-order options and retail drug stores across the country.

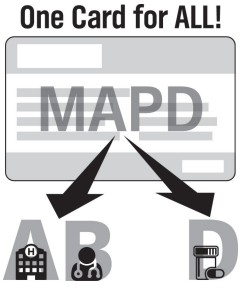
MEDICARE SUPPLEMENT (offered by private insurers) bridges the gap in costs that are not fully covered by Original Medicare, such as:

- Medicare Part A or Part B deductibles, coinsurance or copayments.
- Medicare Part B excess charges.
- Skilled Nursing Facility care coinsurance.
- Foreign Travel Emergencies.

Medicare ID cards

The Medicare plan option you choose will determine the plan ID card or cards you will need to carry with you at all times.

If you choose one of our Medicare Advantage and Prescription Drug (MAPD) plans:



You should put away your red, white and blue Medicare ID card because all you'll need to carry is one card. Just present your MAPD plan ID card for all your covered medical and drug benefits.

How can I learn more about Medicare?

Medicare & You – a helpful tool

We strongly recommend you obtain a copy of the official U.S. government's *Medicare & You* handbook to get the answers to all of your questions about Medicare. If you do not have a copy, you can view it online at **www.medicare.gov** or call Medicare for a copy at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users can call **1-877-486-2048**.

When you can enroll

Initial coverage period

You can sign up for a Medicare Advantage or Part D plan when you are first eligible for Medicare. Your initial enrollment phase is a 7-month period that includes the 3 months before you turn 65, the month you turn 65 and the 3 months after you turn 65.

Annual election period - October 15 to December 7

This is the time frame each year that you can enroll in or change your Medicare Advantage or Part D plan. You may also switch to Original Medicare (Parts A and B). New coverage begins January 1 of each year, after you've enrolled.

Open enrollment period - January 1 to March 31

If you're enrolled in a MA-PD plan, you may switch to another MA-PD plan; an MA-only plan; or Original Medicare with or without a PDP.

Special enrollment period

You can sign up for a Medicare Advantage or Part D plan outside of the time frame above if certain events occur in your life or if you're eligible for low-income subsidy (also called "Extra Help").

Avoid late-enrollment penalties

It's important to enroll in a Medicare plan when you're first eligible. If you don't, you may have to pay the following penalties:

- **Medicare Part A:** Your monthly premium, if you have one, may increase by 10% per year for twice the number of years you could have had Part A but didn't sign up.
- **Medicare Part B:** Your monthly premium may increase 10% for each 12-month period that you could have had Part B but didn't sign up. You'll have to pay this penalty for as long as you have Part B.
- **Medicare Part D:** If you don't sign up when you're first eligible, you may have to pay this penalty for as long as you are enrolled in Part D, and it may increase every year. (You may not have to pay if you receive "Extra Help" or can provide proof of other creditable coverage.)

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.

ATENCIÓN: Si habla español, los servicios de asistencia lingüística están disponibles sin costo alguno para usted. Llame al **1-888-230-7338** (TTY: **711**).

This information is not a complete description of benefits. Call **1-888-230-7338** (TTY: **711**) for more information.

Anthem Blue Cross is an HMO plan with a Medicare contract. Enrollment in Anthem Blue Cross depends on contract renewal.

Anthem Blue Cross - H0544
2020 Medicare Star Ratings*

The Medicare Program rates all health and prescription drug plans each year, based on a plan's quality and performance. Medicare Star Ratings help you know how good a job our plan is doing. You can use these Star Ratings to compare our plan's performance to other plans. The two main types of Star Ratings are:

1. An Overall Star Rating that combines all of our plan's scores.
2. Summary Star Rating that focuses on our medical or our prescription drug services.

Some of the areas Medicare reviews for these ratings include:

- How our members rate our plan's services and care;
- How well our doctors detect illnesses and keep members healthy;
- How well our plan helps our members use recommended and safe prescription medications.

For 2020, Anthem Blue Cross received the following Overall Star Rating from Medicare.

★★★★
4 Stars

We received the following Summary Star Rating for Anthem Blue Cross's health/ drug plan services:

★★★½
Health Plan Services: 3.5 Stars

★★★½
Drug Plan Services: 3.5 Stars

The number of stars shows how well our plan performs.

★★★★★	5 stars - excellent
★★★★	4 stars - above average
★★★	3 stars – average
★★	2 stars - below average
★	1 star - poor

Learn more about our plan and how we are different from other plans at www.medicare.gov.

We do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability in our health programs and activities.

You may also contact us at 1-844-250-2336 (toll-free) or 711 (TTY), 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.

Current members please call 1-888-230-7338 (toll-free) or 711 (TTY).

*Medicare evaluates plans based on a 5-star rating system. Star Ratings are calculated each year and may change from one year to the next.

Anthem Blue Cross is an HMO plan with a Medicare contract. Enrollment in Anthem Blue Cross depends on contract renewal.

Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-844-250-2336 TTY: 711, 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.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC) , especially for those services for which you routinely see a doctor. Visit **https://shop.anthem.com/medicare/ca** or call 1-844-250-2336 to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2021.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).