Summary of Benefits

Anthem Touch (HMO SNP)

Available in Santa Clara County

Anthem BlueCross

Y0114_18_32747_U_031 CMS Accepted

Introduction

This is a summary of health services and drugs covered by Anthem Touch (HMO SNP) from January 1, 2018 - December 31, 2018.

This Plan is Medicare Advantage HMO-SNP plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the *Evidence of Coverage* by calling Customer Service at (844) 309-6996, TTY: 711 where you will reach a licensed sales representative or going to https://shop.anthem.com/medicare/ca.

Who can join?

To join, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in an institution such as an Assisted Living Community, Assisted Living Home, Board and Care group home, the independent living section of a continued care Medicare community (CCRC), or within the long-term care/custodial nursing home.

Who can join?

To join, you must be entitled to Medicare Part A, and be enrolled in Medicare Part B.

Which doctors, hospitals and pharmacies can I use?

Our plans have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directory at our website https://shop.anthem.com/medicare/ca.

What are my drug costs?

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.

How to find out what your covered drugs will cost:

Step 1: Find your drug on the Formulary on our website at https://shop.anthem.com/medicare/ca. Or you can call us and ask for a copy of the Formulary.

Step 2: Identify the drug tier in the Formulary.

Step 3: Go to the Outpatient Prescription Drugs section within this Summary of Benefits to match the tier.

Need more information?

Call Customer Service at (844) 309-6996, TTY: 711.

Hours are 8 a.m. – 8 p.m., 7 days a week, October 1 to February 14 (except Thanksgiving and Christmas), and Monday through Friday from February 15 to September 30 (except holidays). You will reach a licensed sales representative.

Or visit us at https://shop.anthem.com/medicare/ca.

This information is available for free in other languages.

Esta información esta disponible gratis en otros idiomas.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy 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.

What is our service area?

Our service area includes Santa Clara County.

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. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/co-insurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium. The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. Other Pharmacies/Physicians/Providers are available in our network.

	Anthem Touch (HMO SNP)	What You Should Know
Monthly Plan Premium	$0	In addition, you must keep paying your Medicare Part B premium.
Part B Monthly Premium Reduction	Not Applicable	
Annual Maximum Out-of-Pocket Responsibility	$3,000	This is the most you pay for copays, coinsurance and other costs for in-network medical services during the year. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Inpatient Hospital Coverage	Days 1 - 5: $125 copay/day Days 6 - 90: $0 You are covered for 325 days each benefit period	A benefit period begins the first day you go to a Medicare-covered inpatient hospital. A benefit period ends when you have not been admitted to a Medicare-covered inpatient hospital for 60 days in a row. For inpatient hospital care, the cost-sharing applies each time you are admitted to a network hospital. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital. Prior authorization may be required.
Outpatient Hospital	$125	*Requires prior authorization and referral.* We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to:

	Anthem Touch (HMO SNP)	What You Should Know
		• Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain screenings and preventive services • Certain drugs and biologicals that you can't give yourself
Doctor Visits * Primary Care Physician * Specialist	 $0 $0	Prior authorization or referral from your primary care doctor may be required for specialist visits.
Preventive Care	$0	Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services

	Anthem Touch (HMO SNP)	What You Should Know
		• Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening 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) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	$100 per visit $10,000 annual limit, ER and Urgent Care combined, outside the U.S. and its territories every year	If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs. If you are admitted to the hospital within 24 hours for the same condition, you pay $0 for the emergency room visit.
Urgently Needed Services	$0 Copay $10,000 annual limit, ER and Urgent Care combined, outside the U.S. and its territories every year	
Diagnostic Services/Labs/Imaging		Costs for these services may vary based on place of service.
* Diagnostic radiology services (CT/MRI/PET)	$150	Prior authorization or referral may be required.
* Diagnostic tests and procedures	$0	
* Lab tests	$0	
* X-rays	$0	
* Therapeutic radiology (radiation therapy)	20%	

	Anthem Touch (HMO SNP)	What You Should Know
Hearing Services		
* Hearing exam to diagnose & treat hearing & balance issues	$0	
* Routine hearing exam (1 per year)	$0	
* Hearing aid fitting/evaluation (1 per year)	$0	
* Hearing aids (allowance)	$1,500 allowance every 2 years	
Non-routine Dental Services (Medicare-covered)	$0	Limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician. This does not include services in connection with care, treatment, filling, removal, or replacement of teeth. Prior authorization or referral may be required.
Vision Services		
* Exam to diagnose & treat disease & conditions of the eye (including yearly glaucoma screening)	$0	Our plan pays up to $100 every 2 years for eyewear.
* Routine eye exam (1 every year)	$0	
* Eyeglass lenses (1 every 2 years)	$20 copay	
* Contact lenses (1 every 2 years)	$0	
* Eyeglass frames (1 every 2 years)	$0	
* Eyeglasses or contact lenses after cataract surgery	$0	
Mental Health Services		A benefit period begins the first day you go to a Medicare-covered inpatient psychiatric facility. A benefit period ends when you have not been admitted to a Medicare-covered inpatient psychiatric facility for 60 days in a row. For inpatient mental health, the cost-sharing applies each time you are
* Inpatient visit	Days 1 - 5: $125 copay/day Days 6 - 90: $0 You are covered for up to 60 additional days per benefit period	

	Anthem Touch (HMO SNP)	What You Should Know
		admitted to a network hospital. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Prior authorization or referral may be required.
* Outpatient group or individual therapy visit	$0	
* Outpatient group or individual therapy visit at a network psychiatrist's office	$0	
Skilled Nursing Facility	Days 1 - 100: $0	Our plan covers up to 100 days in a SNF. No prior hospital stay required. Prior authorization or referral from your doctor may be required.
Physical Therapy	$0	Prior authorization or referral from your doctor may be required.
Ambulance	$195	Prior authorization may be required.
Medicare Part B Drugs		Prior authorization may be required.
* Part B drugs such as chemotherapy drugs	20% coinsurance	
* Other Part B drugs	20% coinsurance	

Outpatient Prescription Drugs – Initial Coverage Stage Copays for Anthem Touch (HMO SNP)		
Tier	**Standard Retail (30-day supply)**	**What You Should Know**
Tier 1 (Preferred Generic)	$0	You pay these copays until your total yearly drug costs reach $3,750. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. Cost sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost-sharing and the phases of the
Tier 2 (Generic)	$7.50	
Tier 3 (Preferred Brand)	$40	
Tier 4 (Non-Preferred)	$85	
Tier 5 (Specialty)	33%	
Tier 6 (Select Care Drugs)	$0	

		benefit, please call us or refer to the *Evidence of Coverage*. Mail-order prescriptions (90-day supply) cost 2 times the amount of a 30-day supply.

Outpatient Prescription Drugs – Coverage Gap and Catastrophic Coverage Stage Copay		
	Anthem Touch (HMO SNP)	**What You Should Know**
Coverage in the Gap (after prescription costs reach **$3,750**)	All Tier 1 & 2 drugs & selected Tier 6 drugs are covered in the Gap. For other drugs, you pay no more than 35% of the cost for brand drugs & 44% of the cost for generic drugs.	
Catastrophic Coverage (after prescription costs reach $5,000)	$0 for Tier 1 & 6; greater of $3.35 copay or 5% coinsurance for Tier 2; greater of $8.35 copay or 5% coinsurance for Tier 3, 4 & 5	

Additional Medical Benefits		
	Anthem Touch (HMO SNP)	**What You Should Know**
Foot Care (podiatry services)		
* Foot exams & treatment for diabetes-related nerve damage or certain conditions	$0	Prior authorization or referral from your doctor may be required.
* Routine foot care	$0; 4 visits/year	
Medical Equipment Supplies		
* Durable medical equipment (wheelchairs, oxygen, etc.)	0% coinsurance, $0-$499;20% coinsurance, $500 +	Prior authorization may be required
* Prosthetic devices (braces, artificial limbs) and related medical supplies	0% coinsurance, $0-$499; 20% coinsurance, $500+	
Outpatient Rehabilitation Services		
* Cardiac (heart) rehab services (maximum 2 one hour sessions per day for up to 36 sessions up to 36 weeks)	$0	Prior authorization or referral from your doctor may be required.
* Occupational therapy visits	$0	
* Speech & language therapy visits	$0	

You have the following choice(s) for Optional Supplemental Benefits:

Optional Supplemental Benefits - Optional Dental Plan		
Dental Services	Monthly Premium: $9 per month You must keep paying your Medicare Part B premium and your monthly plan premium, if applicable. This package does not have a deductible.	Benefits include: *Preventive Dental *Comprehensive Dental There is no limit to how much our plan will pay for benefits in this package.
Optional Supplemental Benefits - High Option Dental Plan		
Dental Services	Monthly Premium: $35 per month You must keep paying your Medicare Part B premium and your monthly plan premium, if applicable. This package does not have a deductible.	Benefits include: *Preventive Dental *Comprehensive Dental There is a $1,500 maximum limit for benefits per calendar year.

Anthem Blue Cross — H0544

2018 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 2018, Anthem Blue Cross received the following Overall Star Rating from Medicare.

4.5 Stars

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

Health Plan Services: 4.5 Stars

Drug Plan Services: 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 Stars - poor

Learn more about our plan and how we are different from other plans at www.medicare.gov. You may also contact us 7 days a week from 8:00 a.m. to 8:00 p.m. Pacific time at 844-309-6996 (toll-free) or 711 (TTY), from October 1 to February 14. Our hours of operation from February 15 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Pacific time. Current members please call 800-499-2793 (toll-free) or 711 (TTY).

Anthem Blue Cross is an HMO plan with a Medicare contract. Enrollment in Anthem Blue Cross depends on contract renewal. 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. ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-844-309-6996 (TTY: 711). ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-309-6996 (TTY:771). 注意：如果 您使用繁體中文ㄉ，您可以免費獲l得語言援助服務。請致電 1-844-309-6996 (TTY/TDD: 711).

*Star Ratings are based on 5 Stars. Star Ratings are assessed each year and may change from one year to the next.

NOTICE OF NON-DISCRIMINATION

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Services. If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Member Services, Appeals & Grievances, 12900 Park Plaza Drive, Suite 150, Mailstop 6150, Cerritos, CA 90703, 1-800-499-2793, TTY 711. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Member Services Representative is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Amharic ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-499-2793 (መስማት ለተሳናቸው: 711).

Arabic ملحوظة: إذا كنت تتحدث بلغة أخرى، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل على الرقم 1-800-499-2793 (للصم والبكم: 711)

Armenian ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-499-2793 (TTY: 711).

Bengali লক্ষ্য করুনঃ যদি আপনি অন্য ভাষায় কথা বলেন, তাহলে আপনার জন্য নিঃখরচায় ভাষা সহায়তা পরিষেবাউপলব্ধ রয়েছে। ফোন করুন 1-800-499-2793 (TTY: 711).

Chinese 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-499-2793 (TTY: 711)。

English ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-499-2793 (TTY: 711).

French ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-499-2793 (ATS : 711).

German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-499-2793 (TTY: 711).
Hindi	धान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए मुफ्त में, भाषा सहायता सेवाएं उपलब्ध है। 1-800-499-2793 (TTY: 711) पर कॉल करें।
Hmong	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-499-2793 (TTY: 711).
Ilocano	PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-800-499-2793 (TTY: 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-499-2793 (TTY: 711)まで、お電話にてご連絡ください。
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-499-2793 (TTY: 711)번으로 전화해 주십시오.
Kru (Bassa)	Kru PO NƆKÙN+ TI: Ɛ yemâ wlu bɛ̀ɛ̀ n̂ a po win tê, bò mȧyɔ+ ne-ȯ kȯ dɔ̇-dɔ̀ win poyɔ+bò, ɛ se pɛnȯ kɔn. Dȧ 1-800-499-2793 (TTY: 711)
Mon-Khmer, Cambodian	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-499-2793 (TTY: 711) ។
Navajo	Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-499-2793 (TTY: 711)
Persian (Farsi)	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-499-2793 (TTY: 711) تماس بگیرید.
Punjabi	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-499-2793 (TTY:711) 'ਤੇ ਕਾਲ ਕਰੋ।
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-499-2793 (телетайп: 711).
Samoan	MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1-800-499-2793 (TTY: 711).
Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-499-2793 (TTY: 711)
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-499-2793 (TTY: 711).
Syriac	ܙܘܗܪܐ : ܐܢ ܐܢܬܘܢ ܟܐ ܗܡܙܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ ، ܡܨܝܬܘܢ ܕܡܩܒܠܝܬܘܢ ܚܕܡܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܐܝܬ (ܕܠܐ ܕܡܝܐ). ܩܪܘܢ ܥܠ ܡܢܝܢܐ : 1-800-499-2793 (TTY: 711)
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, makakakuha ka ng mga libreng serbisyo ng tulong sa wika. Tumawag sa 1-800-499-2793 (TTY: 711)
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-499-2793 (TTY: 711).
Urdu	خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں - کال کریں 1-800-499-2793 (TTY: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-499-2793 (TTY: 711).