Annual Notice of Changes for 2019

Anthem

Anthem Diabetes (HMO SNP)

Offered by BLUE CROSS OF CALIFORNIA

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

1-800-499-2793, 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 2019.

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 Diabetes (HMO SNP) Offered by BLUE CROSS OF CALIFORNIA Annual Notice of Changes for 2019

You are currently enrolled as a member of Anthem Diabetes (HMO SNP). 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 2019 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.

- Are your doctors in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our *Provider/Pharmacy Directory.*

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?

- How much will you spend on your premium 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 Diabetes (HMO SNP), you don't need to do anything. You will stay in Anthem Diabetes (HMO SNP).
- 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, 2018**

- If you **don't join another plan by December 7, 2018,** you will stay in Anthem Diabetes (HMO SNP).
- If you **join another plan by December 7, 2018,** your new coverage will start on January 1, 2019.

Additional resources:

- ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-499-2793 (TTY: 711).
- Please contact our Customer Service number at 1-800-499-2793 for additional information. (TTY users should 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.
- This document is available to order in Braille, large print and audio tape. To request this document in an alternate format, please call Customer Service at the phone number printed on the back of this booklet.
- **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 Diabetes (HMO SNP):

- Anthem Blue Cross is an HMO CSNP plan with a Medicare contract. Enrollment in Anthem Blue Cross depends on contract renewal.
- When this booklet says "we," "us" or "our," it means BLUE CROSS OF CALIFORNIA. When it says "plan" or "our plan," it means Anthem Diabetes (HMO SNP).

Summary of important costs for 2019

The table below compares the 2018 costs and 2019 costs for Anthem Diabetes (HMO SNP) in several important areas. **Please note this is only a summary of changes. It is important to read the rest of this *Annual Notice of Changes*** and review the *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2018 (this year)	2019 (next year)
Monthly plan premium* *Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0.00 monthly plan premium	$0.00 monthly plan premium
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.)	$1,900	$1,500
Doctor office visits	Primary care visits: $0.00 copayment per visit Specialist visits: $0.00 copayment per visit	Primary care visits: $0.00 copayment per visit Specialist visits: $0.00 copayment 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: You pay a $0.00 copayment for Medicare-covered stays at a network hospital.	In-network: You pay a $0.00 copayment for Medicare-covered stays at a network hospital.

Summary of important costs for 2019

If you have any questions, please call 1-800-499-2793.

Cost	2018 (this year)	2019 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: N/A Copayments or Coinsurance during the initial coverage stage: ▪ **Tier 1: Preferred Generic:** *Standard cost-sharing:* $0.00[1] (30-day supply at retail network pharmacies) ▪ **Tier 2: Generic:** *Standard cost-sharing:* $7.50[1] (30-day supply at retail network pharmacies) ▪ **Tier 3: Preferred Brand:** *Standard cost-sharing:* $37.50[1] (30-day supply at retail network pharmacies) ▪ **Tier 4: Nonpreferred Drugs:** *Standard cost-sharing:* $85.00[1] (30-day supply at retail network pharmacies) ▪ **Tier 5: Specialty Tier:** *Standard cost-sharing:* 33%[1] (30-day supply at retail network pharmacies) ▪ **Tier 6: Select Care Drugs:** *Standard cost-sharing:* $0.00[1] (30-day supply at retail network pharmacies)	Deductible: N/A Copayments or Coinsurance during the initial coverage stage: ▪ **Tier 1: Preferred Generic:** *Standard cost-sharing:* $0.00[1] (30-day supply at retail network pharmacies) ▪ **Tier 2: Generic:** *Standard cost-sharing:* $7.50[1] (30-day supply at retail network pharmacies) ▪ **Tier 3: Preferred Brand:** *Standard cost-sharing:* $37.50[1] (30-day supply at retail network pharmacies) ▪ **Tier 4: Nonpreferred Drugs:** *Standard cost-sharing:* $85.00[1] (30-day supply at retail network pharmacies) ▪ **Tier 5: Specialty Tier:** *Standard cost-sharing:* 33%[1] (30-day supply at retail network pharmacies) ▪ **Tier 6: Select Care Drugs:** *Standard cost-sharing:* $0.00[1] (30-day supply at retail network pharmacies)

[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.*

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Section 1. Changes to benefits and costs for next year

Section 1.1 Changes to the monthly premium

Cost	2018 (this year)	2019 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0.00 monthly plan premium	$0.00 monthly plan premium

- 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	2018 (this year)	2019 (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.	$1,900	$1,500 Once you have paid $1,500 out of pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 Changes to the provider network

There are changes to our network of providers for next year. An updated *Provider/Pharmacy Directory* is located on our website at 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 2019 *Provider/ Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

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

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- 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.

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 2019 *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 *2019 Evidence of Coverage.*

Cost	2018 (this year)	2019 (next year)
Inpatient hospital care	You are covered for 345 days each benefit period.	You are covered for 260 days each benefit period.

Adult Day Care Services	Adult day care services are not covered.	You pay a $0.00 copayment. In order to be eligible for adult day care services, you must require assistance with 2 or more activities of daily living (ADLs). You may receive adult day care services up to 1 day per week. Requires prior authorization and referral. You must obtain the covered service through a network provider.
Health and wellness education program	SilverSneakers is not covered.	You pay a $0.00 copayment for SilverSneakers.
In-Home Support	In-home support is not covered.	You pay a $0.00 copayment. After you are discharged from an inpatient hospital stay and/or nursing facility, you may qualify to receive up to 4 four-hours shifts of assistance in performing activities of daily living (ADLs) provided by a plan approved vendor. Requires prior authorization and referral. You must obtain the covered service through a network provider.
Outreach Support Program	Outreach support program is not covered.	You pay a $0.00 copayment. The outreach support program addresses senior loneliness and encourages meaningful conversations among seniors, caregivers, and health care professionals. You may be eligible to receive a regular outreach call from a “connector” who will talk with you and connect you to social services. Rules and limitations may apply.
Pain Management	Pain management is not covered.	You pay a $0.00 copayment. Medically necessary, non-opioid pain management alternatives are available to you. This plan covers up to 24 combined visits for the following pain management services: Acupuncture/Acupressure, Chiropractic services, and/or

		Therapeutic massages. Requires prior authorization and referral. Rules and limitations may apply. You must obtain the covered service through a network provider.
Meals Program - Post-Hospitalization	Post-hospitalization meal benefit is not covered.	You pay a $0.00 copayment for up to 14 fully-prepared, nutritious home-delivered meals (2 meals per day for 7 days) per discharge. Once you are discharged, a case manager and/or clinical team member will help coordinate the benefit. Requires prior authorization and referral. You must obtain the covered service through a network provider.
Prescribed Meals	Prescribed meals are not covered.	You pay a $0.00 copayment for 3 fully-prepared, nutritious home-delivered meals per day for up to 42 days. Periodic appointments will be arranged with a registered dietician to monitor and discuss your health conditions. Requires prior authorization and referral. Rules and limitations apply. You must obtain the covered service through a network provider.
Respite Care	Respite care is not covered.	You pay a $0.00 copayment. If you have been diagnosed with a chronic debilitating medical condition and an unpaid primary caregiver provides care assistance to you 24 hours a day, we will arrange and cover up to 40 hours (minimum of four 4 hours shifts) of respite care per calendar year for you to relieve your primary caregiver from the daily routine caregiving. Requires prior authorization and referral. Rules and limitations may apply. You must obtain the covered service through a network provider.

Over the Counter supplemental coverage	Over-the-Counter supplemental coverage is not covered.	This plan covers up to $125 every quarter. Purchases can be made online or through a smartphone app, in stores using your OTC benefit card at more than 4,600 Walmart and Neighborhood Market stores and other participating retailers.
Medicare Part B prescription drugs	Your plan currently does not require step therapy for any Part B drugs. Step Therapy is a utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.	There are some Medicare Part B Drugs that will now require this step in addition to obtaining prior authorization. You can contact the plan for more information.

Section 1.6 Changes to Part D prescription drug coverage

Changes to our *Drug List*

Our list of covered drugs is called a *Formulary* or *"Drug List."* A copy of our *Drug List* is provided electronically.

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. For 2019, members in long term care (LTC) facilities will now receive a temporary supply that is the same amount of temporary days supply provided in all other cases: 31 days of medication rather than the amount provided in 2018 (98 days of medication). (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

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.

Starting in 2019, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. This means if you are taking the brand name drug that is being replaced by the new generic (or the tier or restriction on the brand name drug changes), you will no longer always get notice of the change 60 days before we make it or get a 60-day refill of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

Also, starting in 2019, before we make other changes during the year to our Drug List that require us to provide you with advance notice if you are taking a drug, we will provide you with notice 30, rather than 60, days before we make the change. Or we will give you a 30 day, rather than a 60-day, refill of your brand name drug at a network pharmacy.

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 the 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, 2018, please call Customer Service and ask for the "*LIS Rider."* Phone numbers for Customer Service are in Section 7.1 of this booklet.

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

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

Changes to the deductible stage

Stage	2018 (this year)	2019 (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	2018 (this year)	2019 (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 that provides standard cost-sharing. 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 filled at a network pharmacy with standard cost-sharing. **Tier 1: Preferred Generic** *Standard cost-sharing*: You pay $0.00 per prescription. **Tier 2: Generic** *Standard cost-sharing:* You pay $7.50 per prescription. **Tier 3: Preferred Brand** *Standard cost-sharing:* You pay $37.50 per prescription. **Tier 4: Nonpreferred Drugs** *Standard cost-sharing:* You pay $85.00 per prescription. **Tier 5: Specialty Tier** *Standard cost-sharing:* You pay 33% of the total cost. **Tier 6: Select Care Drugs** *Standard cost-sharing:* You pay $0.00 per prescription.	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing. **Tier 1: Preferred Generic** *Standard cost-sharing:* You pay $0.00 per prescription. **Tier 2: Generic** *Standard cost-sharing:* You pay $7.50 per prescription. **Tier 3: Preferred Brand** *Standard cost-sharing:* You pay $37.50 per prescription. **Tier 4: Nonpreferred Drugs** *Standard cost-sharing:* You pay $85.00 per prescription. **Tier 5: Specialty Tier** *Standard cost-sharing:* You pay 33% of the total cost. **Tier 6: Select Care Drugs** *Standard cost-sharing:* You pay $0.00 per prescription.

Stage	2018 (this year)	2019 (next year)
	Once your total drug costs have reached $3,750, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $3,820, you will move to the next stage (the Coverage Gap Stage).

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

Below are a few changes to our Drug list. Please review the Drug list to make sure your drugs will be covered next year and if there will be any changes.

Drug/Other	2018 (this year)	2019 (next year)
Fenofibrate 160mg tablet	Tier 2 - Generic	Tier 3 – Preferred Brand
Eliquis	Tier 4 - Non-Preferred Drug	Tier 3 – Preferred Brand
Xarelto	Tier 4 - Non-Preferred Drug	Tier 3 – Preferred Brand
Restasis	Tier 4 - Non-Preferred Drug	Not Covered
Ezetimibe	Tier 2 - Generic	Tier 3 – Preferred Brand
Dexilant	Tier 4 - Non-Preferred Drug	Not Covered
Xiidra	Not Covered	Tier 3 – Preferred Brand
Compound Drug	Compound drugs may be covered under this benefit.	All compound drugs (except for home infusion drugs) will not be covered without a formulary exception request review and approval.

Section 3. Deciding which plan to choose

Section 3.1 If you want to stay in Anthem Diabetes (HMO SNP)

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 2019.

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 2019 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2019*, 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, BLUE CROSS OF CALIFORNIA, offers other Medicare health 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 Diabetes (HMO SNP).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Anthem Diabetes (HMO SNP).
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
  - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

Section 4. Deadline for changing plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2019.

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, 2019, 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, 2019. 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. In California, the SHIP is called California Health Insurance Counseling & Advocacy Program (HICAP).

California Health Insurance Counseling & Advocacy Program (HICAP) is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. California Health Insurance Counseling & Advocacy Program (HICAP) 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 California Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222. You can learn more about California Health Insurance Counseling & Advocacy Program (HICAP) by visiting their website http://www.aging.ca.gov/HICAP.

Section 6. Programs that help pay for prescription drugs

You may qualify for help paying for prescription drugs.

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

- The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications).

- **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 California Office of AIDS. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-916-558-1784 (TTY: 711).

Section 7. Questions?

Section 7.1 Getting help from Anthem Diabetes (HMO SNP)

Questions? We're here to help. Please call Customer Service at 1-800-499-2793. (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 2019 *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 2019. For details, look in the 2019 *Evidence of Coverage* for Anthem Diabetes (HMO SNP). 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* will be separately mailed to you upon request.

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 2019*

You can read the *Medicare & You 2019* 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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