Get to know the plan

We're here to help

There can be a lot to sort through when it comes to selecting a health plan and managing your health. We created this guide to help you understand the basics of our Anthem Blue Cross group Medicare plan. From choosing a doctor to learning about our convenient online tools and health programs, the important information is all right here at your fingertips. As you read, you will learn that Original Medicare doesn't cover everything. Group-sponsored coverage from your employer, like Medicare Advantage from Anthem, usually offers more.

You will also find step-by-step instructions on how to enroll. If you have more questions or need help, call our First Impressions Welcome Team for answer or plan details, and provide this group specific code CAEGR020. **1-833-848-8729** (TTY: **711**) Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays.

The plan at a glance

The Aerospace Corporation offers you the Senior Secure (HMO) with Senior Rx Plus plan. It's both a Medicare Advantage plan and a health maintenance organization (HMO) plan. You can receive care and services only from doctors, hospitals, and other care providers in the plan's network.

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Medical benefit highlights

This plan covers many medical services, treatments, and tests. Plus, you can protect your health by getting your recommended checkups, shots, and screenings with preventive care services at no cost when you see a doctor that accepts Medicare and the plan. Here are some of the benefits that may be included:

Health and wellness

- Inpatient hospital care and ambulance services
- Emergency and urgent care, including access to emergency care across the U.S. and outside of the country
- Skilled nursing facility benefits
- Complex radiology services and radiation therapy
- Diagnostic procedures and testing services received in a doctor's office
- Lab services and outpatient X-rays
- Tobacco cessation counseling
- Routine hearing exams and hearing aid coverage
- Routine vision care
- Routine dental care

Nutrition

- Diabetes services and supplies
- Healthy Meals program*
- Medical nutrition therapy*
- Obesity screening and therapy*

Preventive care services

- $0 copay for an annual wellness visit and routine physical exam
- Blood pressure and cholesterol tests
- Breast cancer (mammogram) screening
- Colorectal cancer (colonoscopy) screening
- Diabetes (blood sugar, kidney, retinopathy) screening
- Osteoporosis (bone density) screening
- Immunizations like flu and pneumococcal shots

Devices

- Durable medical equipment and related supplies
- Prosthetic devices

See your *Summary of Benefits* located in the appendix for more details.

* Benefit available if qualifying conditions are met.

Prescription drug benefit highlights

There are many ways to save on prescription drugs with the Senior Secure (HMO) with Senior Rx Plus plan.

Covered medications

- Find commonly prescribed brand-name and specialty drugs that Medicare Part D allows us to cover, plus more drugs beyond what Original Medicare covers called "extra covered drugs."
- Choose from a wide range of generic drugs to save even more money — and without sacrificing effectiveness.

Network pharmacies

- Access to over 64,000 network pharmacies to save money on your prescriptions.
- Most national chains and many local pharmacies are in our National Discount Network.

Home Delivery through CarelonRx Pharmacy

Save time by not waiting in line at the pharmacy and enjoy the convenience of having your maintenance medications delivered straight to you. With home delivery, you can receive up to 90 days of supplies often at a lower cost than filling your prescription at a regular pharmacy. Set up home delivery through your account online or on the **Sydney[SM] Health** app.

Generics have the same active ingredients and effects as brand-name drugs, generally without the higher cost share. Generic drugs on our select generics list have a $0 copay.

$0 copay for select generics

These select generics have the same active ingredients and effects as brand-name drugs for a $0 copay. If you don't see one of your drugs here, you can call us to check the full list for you.[1]

Use	Name
Cardiovascular	Amlodipine/benazepril capsule Atenolol/chlorthalidone tablet Atenolol tablet Benazepril/hydrochlorothiazide tablet Benazepril tablet Bisoprolol fumarate tablet Bisoprolol/hydrochlorothiazide tablet Carvedilol tablet Chlorthalidone tablet Enalapril/hydrochlorothiazide tablet Enalapril maleate tablet Fosinopril tablet Furosemide tablet Hydrochlorothiazide capsule/tablet Irbesartan/hydrochlorothiazide tablet Irbesartan tablet Lisinopril/hydrochlorothiazide tablet Lisinopril tablet Losartan potassium/hydrochlorothiazide tablet Losartan potassium tablet Metoprolol tartrate tablet Olmesartan tablet Quinapril tablet Ramipril tablet Trandolapril tablet Valsartan/hydrochlorothiazide tablet Valsartan tablet
Cholesterol	Atorvastatin tablet Lovastatin tablet Pravastatin sodium tablet Rosuvastatin tablet Simvastatin tablet[2]
Diabetes	Glimepiride tablet Glipizide ER tablet Glipizide/metformin tablet Glipizide tablet Metformin ER tablet[2] Metformin tablet Pioglitazone tablet
Osteoporosis	Alendronate sodium tablet

1 This list is current as of May 2024 and is subject to change. It is not a complete list of covered drugs.
2 Not all dosages are covered at the select generics cost share.

Top 50 most prescribed drugs we cover

If you don't see one of your drugs here, you can call us to check the full list for you.[1]

albuterol sulfate HFA	furosemide	omeprazole
alendronate sodium	hydrochlorothiazide	OZEMPIC
allopurinol	hydrocodone-acetaminophen	pantoprazole sodium
amlodipine besylate	JARDIANCE	potassium chloride
atenolol	latanoprost	pravastatin sodium
atorvastatin calcium	levothyroxine sodium	prednisone
carvedilol[2]	lisinopril	rosuvastatin calcium
clopidogrel	lisinopril-hydrochlorothiazide	sertraline
donepezil	losartan potassium	simvastatin[2]
duloxetine	losartan-hydrochlorothiazide	spironolactone
ELIQUIS[2]	meloxicam	SYNTHROID
escitalopram oxalate	metformin	tamsulosin
ezetimibe	metformin ER	tramadol
famotidine	metoprolol succinate	trazodone
FARXIGA	metoprolol tartrate	valsartan
finasteride	montelukast sodium	XARELTO
fluticasone propionate		

Generic drugs appear in lowercase (lisinopril, for example), while brand-name drugs are in uppercase (ELIQUIS, for example).

1 This list is current as of May 2024 and is subject to change. It is not a complete list of covered drugs.
2 Not all dosages are covered at the select generics cost share.

Access to care

Discover a wide network of Medicare providers who deliver high-quality care.

Choosing your doctor

You will first select a PCP from your group plan's network. Your PCP can be a family practitioner, general practitioner, or internal medicine doctor. Keep in mind:

- You will coordinate most of your care through your PCP, but you may need a referral from them to see a specialist. In most cases, covered services need to come from doctors and other care providers in your plan's network.
- If you decide to go outside the plan's network for care, your plan won't cover those costs unless it's a it's for urgent care, a medical emergency, or for out-of-area dialysis.
- If you receive routine care from care providers not in your plan's network, neither Medicare nor the Senior Secure (HMO) with Senior Rx Plus plan will pay for the costs.

Independent medical groups

Some doctors in your plan are part of an independent practice association (IPA) or medical group. That means you can only see a PCP and specialists within that IPA or medical group. If your doctor is part of this arrangement, be sure to check first with your doctor about using other doctors or facilities that are not part of the same IPA or medical group.

Specialist care

If you need specialized care, your PCP or medical group may refer you to other doctors who are also in plan's network. In most cases, covered services need to come from doctors and facilities in your plan's network.

Referrals

When services require a referral from your PCP, referrals are for one or two visits. PCPs can make referrals that last for a longer duration (called "standing referrals") to doctors in your plan's network if you need cancer pain management or have special conditions (life-threatening, degenerative, or disabling conditions that need ongoing, specialized treatment).

How to find care

Once you enroll, you'll be able to use our helpful Find Care tool to select your PCP and search for other care providers in your plan's network.

Are you ready to enroll?

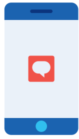
Visit page 14 to get started.

Questions?

Call our First Impressions Welcome Team for answers or plan details, and provide this group specific code CAEGR020. **1-833-848-8729** (TTY: **711**) Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays.

Perks and programs

This plan includes useful tools and programs to support your health and well-being — at no additional cost. Once you enroll, you'll have access and can begin using these valuable benefits.



Manage your health with our online tools and programs

Sydney Health app[1]

The Sydney℠ Health app offers you ways to stay healthy and manage your health plan, all from the palm of your hand.[2]

After you receive your ID card, you can download the app from the App Store® or Google Play™. Then use the information on the card to set up your account. It only takes a few minutes to register.

Use the app to:

- See a live doctor via a virtual visit.
- Access plan and health resources.
- Check the status of claims.
- Use home delivery for prescription drugs.

MyHealth Advantage[6]

This program sends you personalized reminders about preventive care, medical tests, and ways to stay healthy. MyHealth Advantage also gives you access to health specialists who can answer your questions.

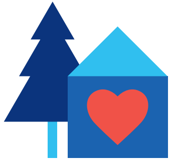
LiveHealth Online®[3]

Visit with a doctor, therapist, or psychiatrist through live video on your phone, tablet, or computer with a camera. It's a great way to:

- Access a board-certified doctor in the comfort of your home, 24/7.
- Find help with common conditions like the flu, colds, sinus infections, pink eye, and skin rashes — and even have prescriptions sent to the pharmacy if needed.[4]
- Set up a 45-minute counseling session with a licensed therapist to find help when you feel depressed, anxious, or stressed. You can also meet with a board-certified psychiatrist to get medication management support if talk therapy alone isn't enough.[5]
- With the Anthem plan, video visits using LiveHealth Online are $0.

1 Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan.
2 Online tools are offered to Anthem plan members as extra services. They are not part of the contract and can change or stop.
3 LiveHealth Online is offered through an arrangement with Amwell, a separate company, providing telehealth services on behalf of your health plan.
4 Prescription availability is defined by physician judgment.
5 Prescriptions determined to be a "controlled substance" (as defined by the Controlled Substances Act under federal law) cannot be prescribed using LiveHealth Online. Psychiatrists on LiveHealth Online will not offer counseling or talk therapy.
Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it's important that you seek help immediately. Please call 988 (National Suicide Prevention Lifeline) or 911 and ask for help.
6 Carelon Health, Inc. is a separate company providing care management services on behalf of Senior Secure (HMO) with Senior Rx Plus.

Perks and programs



Convenient care services

The House Call program[7]

Receive an annual in-home health evaluation from a licensed clinician in the comfort of your own home to support the ongoing care you receive from your doctors.

24/7 NurseLine[8]

24/7 NurseLine puts you in touch with a registered nurse anytime of the day or night. Call **1-800-700-9184** (TTY: **711**) to have your questions answered.

Carelon Health Palliative Care[9]

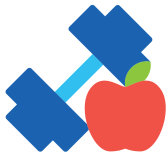
In the event of a serious illness, Carelon Health Palliative Care is a community-based program that can provide an extra layer of support. A team of doctors, nurse practitioners, nurses, and social workers would work with your primary care provider to coordinate care. The Carelon Health Palliative Care clinical team is available 24/7. They provide extra care and attention, as well as education about illness, your plan of care, and medications. These services are provided through a combination of home-based visits and telehealth support.

Questions?

Call our First Impressions Welcome Team for answers or plan details, and provide this group specific code CAEGR020. **1-833-848-8729** (TTY: **711**) Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays.

7 The House Call program is administered by an independent contracted vendor.
8 The information contained in this program is for general guidance only. Your doctor will be specific regarding recommendations for your individual circumstances. Recommended treatments may not be covered under your health plan.
9 The Carelon companies are separate companies providing behavioral health, care pathways, pharmacy and value-based care delivery solutions through our digital platforms and technology services and research on behalf of Anthem Blue Cross.

Perks and programs



Programs and services to support your whole health

SilverSneakers®

SilverSneakers is a fitness and lifestyle benefit that offers the opportunity to connect with your community, make friends, and stay active. Your membership gives you:[10]

- Access to thousands of participating locations with use of basic amenities, plus group exercise classes for all levels at select locations.[11, 12]
- The SilverSneakers GO™ app so you can find locations near you, participate in live classes from your phone, and tailor workouts to your fitness level.
- Access to SilverSneakers LIVE virtual classes and the On-Demand library with hundreds of online videos so you can work out at home.

To find a location near you or join virtual classes, visit **www.silversneakers.com/starthere** or call **1-855-741-4985**, TTY: **711**, Monday to Friday, 8 a.m. to 8 p.m. ET.

Healthy meals

If you have a chronic illness or live with diabetes, you can have nutritious, balanced meals delivered to your home after a hospital stay.[13]

Anthem Health Guide

Whatever questions you might have, our Anthem Health Guide concierge service has answers.

Once you enroll, you can contact us by calling the number on the back of your ID card, logging in to **www.anthem.com/ca**, or using the Sydney Health app.

10 Always talk with your doctor before starting an exercise program.
11 Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL.
12 Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location.
SilverSneakers and the SilverSneakers shoe logotype are registered trademarks of Tivity Health, Inc. © 2024 Tivity Health, Inc. All rights reserved.
13 The benefits mentioned are Special Supplemental Benefits for the Chronically Ill (SSBCI). You may qualify for SSBCI if you have a high risk for hospitalization and require intensive care coordination to manage chronic conditions such as Chronic Kidney Diseases, Chronic Lung Disorders, Cardiovascular Disorders, Chronic Heart Failure, or Diabetes. For a full list of chronic conditions or to learn more about other eligibility requirements needed to qualify for SSBCI benefits, please refer to Chapter 4 in the plan's Evidence of Coverage.

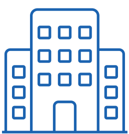
What is Medicare?

Medicare is a federal government health insurance program for people 65 or older. You may also be eligible if you:

- Are under age 65 with certain disabilities
- Have end-stage renal disease (ESRD)
- Have amyotrophic lateral sclerosis (ALS), also called Lou Gehrig's disease

More information is available at medicare.gov, or you can call **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Medicare is available as follows:



Original Medicare

- Part A provides coverage for hospital benefits.
- Part B provides medical benefits.

Medicare Advantage

- Also called Part C.
- Bundles Parts A and B.
- Offers supplemental benefits and a first-class member service experience.
- Can include Part D, the prescription drug plan.

Medicare Advantage is a Medicare-approved plan available only through private insurance companies. The added benefits it offers are listed throughout this guide.

Original Medicare = government program		Offered by private insurance companies	
Medicare Part A	Medicare Part B	Medicare Part C	Medicare Part D
Original Medicare + Part C = Medicare Advantage			
Medicare Advantage + Part D = MAPD plan			

Medicare Advantage vs. Original Medicare

Compare coverage

The good thing about Medicare Advantage is that it limits how much you'll spend each year on treatment. Plus, the prices are often fixed, so you'll have a better idea of any costs beforehand.

Medicare Advantage can include prescription drug coverage (Part D) — something Original Medicare doesn't offer.

Medicare Advantage	Original Medicare
Plan pays 100% of covered medical costs for rest of plan year after annual out-of-pocket maximum is met*	No limit to medical costs you will pay annually — no annual out-of-pocket maximum
You will often pay copays (fixed dollar amounts)	You will pay percentage of cost (20% of the cost for common services like outpatient surgery and doctor visits)
Can include Part D prescription drug coverage	No Part D prescription drug coverage
Emergency care is covered outside of U.S.	No emergency care coverage outside of U.S.

* Not all medical costs are included in or are subject to the annual out-of-pocket maximum. Call our First Impressions Welcome Team if you have questions about The Aerospace Corporation Senior Secure (HMO) with Senior Rx Plus plan benefits. 1-833-848-8729 (TTY: 711) Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays.

Medicare Part D

The prescription drug plan described in this guide is also known as a Medicare Part D plan. All of our covered drugs appear on a drug list called the Part D formulary. This plan also covers drugs beyond those that Original Medicare covers, which appear on a separate list called extra covered drugs.

If you take a drug that is not covered, you have three options:

- Ask your doctor to switch you to a covered drug
- Request an exception
- Request a temporary supply while discussing other drug options

Covered drugs are divided into levels or tiers. Drugs on the lowest-numbered tier generally cost less, while drugs on the highest-numbered tier generally cost the most. Each tier contains drugs that we cover based on their safety and effectiveness. This chart provides an overview of how the tiers and pricing generally work.

Drug type	Description	Possible tier coverage[2]	Cost
Generic[1]	Same active ingredients and effects as brand-name drug without the brand-name	Tier 1	$
Preferred brand-name	Safe and effective brand-name drugs that may not have a generic alternative	Tier 2	$$
Non-preferred brand-name	Less commonly used brand-name drugs that usually have a generic alternative	Tier 3	$$$
Specialty	Cost $950 or more for a 30-day supply. May require special handling.	Highest tier	$$$$

1 High-cost generic medications may also appear on the same tiers as brand-name medications. Please consult the formulary for specific tier details.
2 Some drug lists divide generic drugs into two tiers. For those lists, the tier number increases by one for all tiers after the first. For example, Tier 1 becomes Tier 1 and Tier 2, and the numbering continues up the tiers.

How to qualify and enroll

Qualifications for enrolling in Senior Secure (HMO) with Senior Rx Plus:

- You are a United States (U.S.) citizen or are lawfully present in the U.S.
- You live in the plan's service area.
- You are now entitled to Medicare Part A and enrolled in Part B.
- You keep paying your Medicare Part B premiums, unless they are paid by Medicaid or through another third party.
- You qualify for coverage under your or your spouse's group-sponsored health plan.

To enroll, please complete the enrollment election form on the next page. The scissors icon and dotted line show where to cut it out. Don't forget to include your signature and mail to the address listed on the form.

To complete the form, you'll need:

- **Your Medicare number.** Fill out the requested information as it appears on your red, white, and blue Medicare card. If required, also attach a copy of your Medicare card, or your [letter from the Social Security Administration, or the Railroad Retirement Board] and send it along with your completed enrollment election form.
- **Your permanent address and phone number.**
- **To complete all items on the enrollment election form.** Double check that you've filled out the form entirely and included your signature.

Understanding the Medicare Prescription Payment Plan:

The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket Part D prescription drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your Part D prescription drug costs by spreading them across monthly payments that vary throughout the year (January – December). This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. This program does not apply to Part B. It also does not apply to Extra Covered Drugs if your plan includes this benefit.

"Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please contact **1-833-848-8729** or visit **Medicare.gov**.

What to expect after you enroll

How to give others access to your health records

Fill out your Member Authorization Form at www.anthem.com/ca/forms to give people that you choose access to your health records. You can also contact Member Services to request this form.

Keep an eye on your mailbox

After you enroll, you can sit back and relax. Once your enrollment is processed, you will receive:

- Proof of your enrollment request with your membership start date listed.
- Your ID card. You can begin using this card on your membership start date.
- A health survey to help us understand and address your needs. We'll call you within 90 days to talk about your experience to understand how we can better serve you.

Look out for your plan Welcome Guide

This guide can help you:

- Understand and make the most of your benefits.
- Find plan doctors and facilities in your health plan's network.
- Access information online.
- Find ways to connect with our team of personal advocates to answer any questions.

Anthem

Anthem Blue Cross Group-Sponsored Health Plan Enrollment Election Form

All fields on this form are required unless noted with an asterisk*	
Group sponsor name: **The Aerospace Corporation**	Group #: **CAEGR020**
Plan you will join: Senior Secure (HMO) with Senior Rx Plus	Requested effective date of coverage: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y) Generally the effective date of enrollment will be the first of the month following the enrollment receipt date, unless a future date is requested and is allowed.

FIRST name:	LAST name:	MIDDLE initial:

Birthdate: (MM/DD/YYYY) (__ __/__ __/__ __ __ __)	Sex: ☐ M ☐ F	Phone number: ( ) ☐ Cell ☐ Other

Permanent residence street address (Do not enter a P.O. Box):

City:	State:	ZIP code:

Mailing address, if different from your permanent address (P.O. Box allowed):

Street address: City: State: ZIP code:

Email address:______________________________

Your email address will be used for communications only from Anthem Blue Cross. We will not share your email address. Thank you for providing your email address and phone number. We will only use this information to occasionally contact you by email or phone with Important Plan Information.

In addition, may we also contact you about additional products and services that might interest you by email.

Please know you can change your preference at any time by visiting www.anthem.com/ca or contacting customer service.

Your PCP information:

Please choose a primary care physician (PCP), clinic, or health center, and write the name and address below.

____

____

Your Medicare information:

Medicare Number: ______________________________

Note: The Medicare Number is required to complete your enrollment. If you do not provide your Medicare Beneficiary ID from your ID card, your enrollment into the plan may be delayed.

Please read and answer these important questions
1. Are you the retiree? ☐ Yes ☐ No If "yes," retirement date (month/date/year): ____________ If "no," name of retiree:________________________ Retiree Medicare ID #:__________
2. Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No
3. Do you have other medical insurance? ☐ Yes ☐ No If "yes," what is the name of the health plan (e.g., Aetna, Humana, Cigna)? ____________ What are the effective dates of coverage? ____________________
4. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No If "yes," please provide the following information: Name of institution:________________________________ Address (number and street) and phone number of institution:____________________ ____
5. Will you have other prescription drug coverage (like VA or TRICARE) in addition to this plan? ☐ Yes ☐ No Name of other coverage: ____________ Member number for this coverage: ____________ Group number for this coverage: ____________
This document may be available in an alternate format, such as large print. Please call the First Impressions Welcome Team at **1-833-848-8729**, TTY: **711**, Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays, for additional information or questions you may have.

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Race*		Ethnicity*
☐ White	☐ Vietnamese	☐ Not of Hispanic, Latino/a, or Spanish Origin
☐ Black or African American	☐ Other Asian	☐ Puerto Rican
☐ American Indian or Alaska Native	☐ Native Hawaiian	☐ Another Hispanic, Latino/a, or Spanish Origin
☐ Asian Indian	☐ Samoan	☐ Mexican, Mexican American, Chicano/a
☐ Chinese	☐ Guamanian or Chamorro	☐ Cuban
☐ Filipino	☐ Other Pacific Islander	☐ I choose not to answer
☐ Japanese	☐ I choose not to answer	
☐ Korean		

What is your gender? Select one.*	**Which of the following best represents how you think of yourself?** Select one.*
☐ Woman	☐ Lesbian or gay
☐ Man	☐ Straight, that is, not gay or lesbian
☐ Non-binary	☐ Bisexual
☐ I use a different term:________	☐ I use a different term:________
☐ I choose not to answer	☐ I don't know
	☐ I choose not to answer

IMPORTANT: Read and sign below:

- I must keep Medicare Part A and Part B to stay in the plan I have selected.
- **Release of information:** By joining this Medicare Advantage (Part D) prescription drug plan, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment, and healthcare operations. I also acknowledge that Anthem Blue Cross will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations.
- The information on this enrollment election form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Senior Secure (HMO) with Senior Rx Plus coverage begins, I must get all of my medical and prescription drug benefits from Anthem Blue Cross. Benefits and services authorized by Anthem Blue Cross and contained in my Senior Secure (HMO) with Senior Rx Plus *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, neither Medicare nor Anthem Blue Cross will pay for benefits or services.**
- I understand that as a member of this plan, I have the right to ask about the plan's decision regarding payments or coverage for services I receive. I also have the right to appeal plan decisions about payment or services if I disagree.
- I understand that by enrolling in this Medicare Advantage plan, I will automatically be disenrolled by CMS from any other Medicare Advantage plan or Medicare Part D prescription drug plan. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform the plan of any other prescription drug coverage that I have or may obtain in the future.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this enrollment election form means that I have read and understand the contents of this enrollment election form. If signed by an authorized representative (as described above), this signature certifies that:

  1. This person is authorized under state law to complete this enrollment election form, and
  2. Documentation of this authority is available upon request by Medicare.

Signature:	**Today's date:**
If you are the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone number:	Relationship to enrollee:

Please read this important information:

If you are a member of a Medicare Advantage plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage plan that will meet your needs. By joining Senior Secure (HMO) with Senior Rx Plus, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage, as well as your prescription drug coverage. Read the information that your Medicare Advantage plan sends you, and if you have questions, contact your Medicare Advantage plan.

If you currently have health coverage from a group sponsor, joining Senior Secure (HMO) with Senior Rx Plus could affect your group sponsor health benefits. You could lose your group-sponsored health coverage if you join Blue Cross MedicareRx (PDP) with Senior Rx Plus. Please read the communications your group sponsor sends you. If you have questions, visit their website or contact the office listed in their communications. If there isn't information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

HIPAA authorization

If you would like to authorize an individual to have the ability to speak with us and/or obtain protected health information (PHI) on your account, please complete the HIPAA (Health Insurance Portability and Accountability Act) Member Authorization Form located at www.anthem.com/ca/forms. This form is valid for one year from the signature date.

- A printed form can be requested by contacting Member Services at the telephone number on the back of your ID card. **Sign and return it to the address on the form.**
- If you wish to continue having the authorized representative on your account, a new form is required annually.
- If you have a durable healthcare power of attorney document, it can also be returned with the HIPAA form.

Please return this enrollment election form to:

The Aerospace Corporation

P.O. Box 92957 M3/433

Los Angeles, CA 90009-2957

Please refer to the Anthem Blue Cross *Evidence of Coverage* for a complete listing of all plan benefits, conditions, limitations, and exclusions of coverage.

Our plan has free language interpreter services available to answer questions from non-English-speaking members. Please call the First Impressions Welcome Team number listed in this document to request interpreter services.

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.

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Summary of Benefits

We've provided a *Summary of Benefits* so you can have a better understanding of what's covered and what's not, including:

- Costs you are responsible for
- What we cover under the plan
- Any copays or percentage of the cost
- Any out-of-pocket costs

Questions?
Call our First Impressions Welcome Team for answers or plan details, and provide this group specific code CAEGR020. **1-833-848-8729** (TTY: **711**) Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays.

Anthem

The Aerospace Corporation

2025 Summary of Benefits

HMO Plan 4

About this Plan:

Anthem BC Health Insurance Company gives you the tools and resources to make the best decisions for your health, like this summary of benefits. It's a snapshot of your plan's covered benefits and services and what they cost. This Summary of Benefits doesn't list every service we cover or every limitation or exclusion. For more details about your benefits and services, please review your *Evidence of Coverage* (EOC). You can access your EOC online by logging into the member portal, or you can call Member Services with any questions you may have.

Doctor and hospital choice: It is important to know which providers are part of our network because, with limited exceptions, you must use in-network providers while you are a member of our plan.

How much is the monthly premium?:
Contact your group plan benefit administrator to determine your actual premium amount, if applicable.

Questions?

Call our **Member Services Team** for answers or plan details and provide them with this group specific code CAEGR020.

Prospective Members, please contact your benefit administrator. When you enroll in the plan you will receive information that tells you where to go online to view your *Evidence of Coverage*.

Anthem Medicare Advantage Plan (HMO) Benefits Effective: 01/01/2025 – 12/31/2025

Plan Features	In-network:
Annual medical deductible:	$0
Maximum out-of-pocket responsibility: (Does not include Part D prescription drugs)	$3,400

Covered benefits	In-network, members pay:
Inpatient hospital care* No limit to the number of days covered by the plan	$0 copay per admission
Outpatient hospital facility or ambulatory surgical center visit for surgery*	$0 copay per visit
Outpatient hospital services observation room	$0 copay per visit
Primary care office visit	$10 copay per visit
Specialty care office visit	$10 copay per visit
Preventive care, screenings, and tests	$0 copay per visit
Emergency care	$20 copay per visit $20 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.
Urgently needed services	$10 copay per visit $10 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.
X-ray visit and/or simple diagnostic test*	$0 copay per visit
Complex diagnostic test and/or radiology visit*	$0 copay per visit
Radiation therapy treatment*	$0 copay per visit

Covered benefits	In-network, members pay:
Clinical/diagnostic lab test*	$0 copay per visit
Medicare-covered basic hearing and balance exams performed by your specialist*	$10 copay per visit
Routine hearing services We have partnered with Hearing Care Solutions to bring you these discounts and services.	Must use a Hearing Care Solutions participating provider. **Hearing Exams** $0 copay for routine hearing exams 1 exam every calendar year **Hearing Aids Fitting Evaluations** $0 copay for hearing aid fitting evaluations 1 evaluation per covered hearing aid **Hearing Aids** $0 copay for hearing aids $500 maximum benefit every calendar year
Medicare-covered dental is non-routine care performed by your specialist*	$10 copay per visit
Routine dental services	$0 copay for an oral evaluation, one every year $0 copay for first cleaning $40 copay for second cleaning Cleanings are one every six months. $10 copay for full mouth/panoramic X-rays, one every five year $0 copay for bitewing X-rays, one every year
Medicare-covered exams performed by your specialist to diagnose and treat eye diseases and conditions	$10 copay per visit
Medicare-covered glaucoma screening	$0 copay per visit
Medicare-covered eyewear following cataract surgery	$0 copay per surgery

Covered benefits	In-network, members pay:
Routine vision services	Must use a Blue View Vision provider. **Exams** $0 copay for routine vision exams 1 exam every calendar year **Frames** $100 allowance towards the purchase of frames 1 pair of eyeglass frames, once every two calendar years **Eyeglass lenses in lieu of contact lenses** $0 copay for single vision, bifocal or trifocal eyeglass lenses 1 pair of standard plastic prescription lenses, once every calendar year **Contact lenses in lieu of eyeglass lenses** $100 allowance towards the purchase of elective contact lenses $0 copay for non-elective contact lenses 1 every calendar year
Inpatient services in a psychiatric hospital* No limit to the number of days covered by the plan	$0 copay per admission
Mental health professional individual therapy visit	$10 copay per visit
Substance use disorder professional individual therapy visit	$10 copay per visit
Skilled nursing facility (SNF) care*	$0 copay for days 1-100 per benefit period 100-day limit per benefit period
Outpatient rehabilitation services*	$10 copay per visit

Covered benefits	In-network, members pay:
Ambulance services	Your provider must get an approval from the plan before you get ground, air, or water transportation that is not an emergency. All nonemergent ambulance services must be coordinated by your Primary Care Physician (PCP). $0 copay per one-way trip for ambulance services
Medicare Part B prescription drugs*	$0 copay for Part B drugs
Chiropractic services* Medicare-covered	$10 copay per visit
Additional chiropractic services*	$10 copay per visit 20 visits per year $0 copay for appliances $50 maximum benefit per year for appliances prescribed by an ASH Plans participating chiropractor
Acupuncture for chronic low back pain* Medicare-covered	$10 copay per visit
Cardiac rehabilitation services*	$0 copay per visit
Pulmonary rehabilitation services*	$0 copay per visit
Blood glucose test strips, lancets, lancet devices, and glucose control solutions For a 30 day supply	**If purchased through a pharmacy:** $0 copay per purchase of OneTouch® (made by LifeScan, Inc.) and ACCU-CHECK® (made by Roche Diagnostics) $10 for all other brands when purchased through the pharmacy
Blood glucose monitors	**If purchased through a pharmacy:** $0 copay per purchase of OneTouch® (made by LifeScan, Inc.) and ACCU-CHECK® (made by Roche Diagnostics) $10 for all other brands when purchased through the pharmacy
Therapeutic shoes	$0 copay per purchase

Covered benefits	In-network, members pay:
Diabetes self-management training	$0 copay per visit
Continuous glucose monitors (CGMs)*	$0 copay per purchase
Durable medical equipment (DME) and related supplies*	$0 copay per purchase
Opioid treatment program services*	$10 copay per visit
Podiatry services*	$10 copay per visit
Routine foot care	$10 copay per visit 12 visits per year
Home health agency care*	$0 copay per visit
Hospice care When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan.	$10 copay for the one time only consultation 1 visit per lifetime

Additional covered benefits and services	Member pays unless specified:
Video doctor visits LiveHealth Online†	$0 copay for video doctor visits using LiveHealth Online
Health and wellness programs SilverSneakers® Membership† Take fitness classes virtually or visit a participating location.	$0 copay for the SilverSneakers fitness benefit
24/7 NurseLine†	$0 copay for 24/7 NurseLine
Foreign travel emergency (outside U.S. territories) **Emergency care** Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Emergency care** $20 copay for emergency care $20 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.
Foreign Travel - Urgently Needed Services Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Urgently needed services** $10 copay for urgently needed services $10 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.
Foreign Travel - Inpatient Care Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Inpatient care** $0 copay per admission 90 days per lifetime
Healthy Meals†§* Meals delivered after being discharged from inpatient hospital visit or for members living with a chronic condition	$0 copay for Healthy Meals 14 meals per qualifying event, allows up to four (4) events each year (56 meals in total).
Compression stockings	$0 copay for compression stockings 8 compression stockings per year
Medicare Community Resource Support	$0 copay for Medicare Community Resource Support

*Some services that fall within this benefit category require prior authorization. Based on the service you are receiving, your provider will know if prior authorization is needed. This means an approval in advance is needed, by your plan, to get covered services. Benefit categories that include services that require prior authorization are marked with an asterisk in the benefits chart.

This document reflects cost shares only.

†Must use the plan approved provider

§ The benefits mentioned are Special Supplemental Benefits for the Chronically Ill (SSBCI). You may qualify for SSBCI if you have a high risk for hospitalization and require intensive care coordination to manage chronic conditions such as Chronic Kidney Diseases, Chronic Lung Disorders, Cardiovascular Disorders, Chronic Heart Failure, or Diabetes. For a full list of chronic conditions or to learn more about other eligibility requirements needed to qualify for SSBCI benefits, please refer to Chapter 4 in the plan's *Evidence of Coverage*.

All services below must be coordinated by your Primary Care Physician (PCP).

- Inpatient hospital care
- Inpatient services in a psychiatric hospital
- Skilled nursing facility (SNF) care
- Home health agency care
- Specialty care office visit
- Mental health professional individual therapy visit
- Substance use disorder professional individual therapy visit
- Outpatient hospital facility or ambulatory surgical center visit for surgery
- Outpatient hospital services observation room
- X-ray visit and/or simple diagnostic test
- Complex diagnostic test and/or radiology visit
- Radiation therapy treatment
- Clinical/diagnostic lab test
- Medicare-covered basic hearing and balance exams performed by your specialist
- Medicare-covered dental is non-routine care performed by your specialist
- Medicare-covered exams performed by your specialist to diagnose and treat eye diseases and conditions
- Medicare-covered glaucoma screening
- Medicare-covered eyewear following cataract surgery
- Podiatry services
- Outpatient rehabilitation services
- Chiropractic services
- Acupuncture for chronic low back pain
- Opioid treatment program services
- Medicare Part B prescription drugs
- Blood glucose test strips, lancets, lancet devices, and glucose control solutions
- Blood glucose monitors
- Therapeutic shoes
- Diabetes self-management training
- Continuous glucose monitors (CGMs)
- Cardiac rehabilitation services
- Pulmonary rehabilitation services
- Durable medical equipment (DME) and related supplies

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, coinsurance, and restrictions may apply. If there is a difference between this document and the *Evidence of Coverage* (EOC), the EOC is considered correct.

Benefits, premiums, and/or copayments/coinsurance may change upon renewal or on January 1 of each year.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our member service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.

Medicare & You 2025 resource: For more information, we encourage you to read Medicare & You 2025. This booklet is mailed to people with Medicare every year in the fall. It has a summary of Medicare benefits, rights, and protections. It also includes answers to the most frequently asked questions. If you don't have a copy of this booklet, request one at **www.medicare.gov**. Or call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.

LiveHealth Online is offered through an arrangement with Amwell, a separate company, providing telehealth services on behalf of your health plan.

The SilverSneakers fitness program is provided by Tivity Health, an independent company. SilverSneakers is a registered trademark of Tivity Health, Inc.© 2024 Tivity Health, Inc. All rights reserved

Your 2025 Prescription Drug Benefits Chart
Formulary P3, 10/20/40 (with Senior Rx Plus)
The Aerospace Corporation

Your retiree drug coverage includes Medicare Part D drug benefits and non-Medicare supplemental drug benefits. The cost shown below is what you pay after all benefits under your retiree drug coverage have been provided.

Formulary	P3
Deductible	$0
Covered Services	What you pay
Part D Initial Coverage	
Below is your payment responsibility until the amount paid by you reaches your Drug Plan Maximum Out of Pocket of $2,000	
Retail Pharmacy	per 30-day supply
• Select Generics • Generics	$0 copay $10 copay
• Preferred Drugs	$20 copay
• Non-Preferred Drugs, including Specialty Drugs and Non-Formulary Drugs	$40 copay
Retail Pharmacy	per 90-day supply
• Select Generics • Generics	$0 copay $30 copay
• Preferred Drugs	$60 copay
• Non-Preferred Drugs, including Specialty Drugs and Non-Formulary Drugs	$120 copay

Many of our retail pharmacies can dispense more than a 30-day supply of medication. If you purchase more than a 30-day supply at these retail pharmacies, you will need to pay one copay for each full or partial 30-day supply filled. For example, if you order a 90-day supply, you will need to pay three 30-day supply copays. If you get a 45-day or 50-day supply, you will need to pay two 30-day copays.

Covered Services	What you pay
Mail-Order Pharmacy	per 90-day supply
• Select Generics • Generics	$0 copay $20 copay
• Preferred Drugs	$40 copay
• Non-Preferred Drugs, including Specialty Drugs and Non-Formulary Drugs	$80 copay

Covered Services	What you pay
Part D Catastrophic Coverage	
Your responsibility for payment of covered drugs changes once you reach your Drug Plan Maximum Out of Pocket of $2,000.	
Retail and Mail-Order Pharmacies	Up to a 90-day supply (Specialty limited to a 30-day supply)
• All Part D Covered Prescription Drugs	$0 copay

- **Important Message About What You Pay for Vaccines:** All Advisory Committee on Immunization Practices (ACIP) recommended Part D vaccines are covered at no cost to you.

- **Important Message About What You Pay for Insulin:** You won't pay more than $35 for a one month supply of each insulin product covered by your plan, no matter what cost-sharing tier it is on.

- **Vaccines:** Medicare covers some vaccines under Medicare Part B medical coverage and other vaccines under Medicare Part D drug coverage. Vaccines for Flu, including H1N1, and Pneumonia are covered under Medicare medical coverage. Vaccines for Chicken Pox, Shingles, Tetanus, Diphtheria, Meningitis, Rabies, Polio, Yellow Fever and Hepatitis A are covered under Medicare drug coverage. Hepatitis B is covered under drug coverage unless you fall into a high risk category, then it is covered under medical coverage. All other Advisory Committee on Immunization Practices (ACIP) recommended Part D vaccines are also covered under Medicare drug coverage for Medicare-eligible individuals under 65. You can fill and receive your vaccines at a network pharmacy or they can be administered at a physician's office. However, the physician will only submit a claim for a Part B vaccine. If you want to get a Part D vaccine at your physician's office you will pay for the entire cost of the vaccine and its administration and then ask your drug plan to reimburse you the cost of the vaccine and it's administration. Please see your Evidence of Coverage for complete details on what you pay for vaccines.

- **Senior Rx Plus:** Your supplemental drug benefit is non-Medicare coverage that reduces the amount you pay, after your Group Part D benefits. The copay or coinsurance shown in this benefits chart is the amount you pay for covered drugs filled at network pharmacies.

Your 2025 Extra Covered Drugs Benefits Chart

Covered Services	What you pay
Extra Covered Drugs	
These are prescription drugs that are covered by your retiree drug plan that are often excluded from Part D coverage. These prescription drugs are covered by your Senior Rx Plus benefits. Some of these drugs may be required on your retiree drug plan by state regulations. These drugs do not count towards your Drug Plan Maximum Out of Pocket expenses. They do not qualify for lower Catastrophic copays.	
Retail Pharmacy	per 30-day supply
Cough and Cold **DESI** **Vitamins and Minerals**	See Drug List for complete list of drugs covered
• Generics	$10 copay
• Preferred Drugs	$20 copay
• Non-Preferred Drugs	$40 copay
Erectile Dysfunction (ED)	Immediate dose ED drugs Immediate dose formats are limited to 6 per 30 days.
• Generics	$10 copay
• Preferred Drugs	$20 copay
• Non-Preferred Drugs	$40 copay
Other Non-Part D Coverage	Copay or coinsurance
• Contraceptive Devices	$20 copay per Covered Device

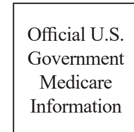
Covered Services	What you pay
Mail-Order Pharmacy	per 90-day supply
Cough and Cold **DESI** **Vitamins and Minerals**	See Drug List for complete list of drugs covered
• Generics	$20 copay
• Preferred Drugs	$40 copay
• Non-Preferred Drugs	$80 copay
Erectile Dysfunction (ED)	Immediate dose ED drugs Immediate dose formats are limited to 6 per 30 days.
• Generics	$20 copay
• Preferred Drugs	$40 copay
• Non-Preferred Drugs	$80 copay
Other Non-Part D Coverage	Copay or coinsurance
• Contraceptive Devices	$20 copay per Covered Device

- **Over the Counter Drugs:** To get over the counter drugs listed as covered under your drug plan, you must have a prescription from your provider and have the prescribed drug filled by the pharmacist.

IMPORTANT INFORMATION:

2025 Medicare Star Ratings

Anthem Blue Cross - H0544



For 2025, Anthem Blue Cross - H0544 received the following Star Ratings from Medicare:

Overall Star Rating:	★★★☆☆
Health Services Rating:	★★★☆☆
Drug Services Rating:	★★★☆☆

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings are important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care.
- The number of members who left or stayed with the plan.
- The number of complaints Medicare got about the plan.
- Data from doctors and hospitals that work with the plan.

More stars mean a better plan – for example, members may get better care and better, faster customer service.

The number of stars show how well a plan performs.

★★★★★	EXCELLENT
★★★★☆	ABOVE AVERAGE
★★★☆☆	AVERAGE
★★☆☆☆	BELOW AVERAGE
★☆☆☆☆	POOR

Get more information on Star Ratings online

Compare Star Ratings for this and other plans online at **www.medicare.gov/plan-compare**.

Questions about this plan?

Contact Anthem Blue Cross Monday through Friday, 8 a.m. to 9 p.m. ET at **1-833-848-8729** (toll free) or **711** (TTY). Current members please call **1-833-848-8730** or **711** (TTY).

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

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Common health plan terms

Here are terms you'll come across in this guide and what they mean.

Care

Facility – A location for receiving care. Examples: hospital, skilled nursing facility (SNF), or imaging center.

Inpatient care – Medical treatment for someone formally admitted to a facility with a doctor's order. Without a doctor's order, it may be considered outpatient care, even if you stay overnight.

Outpatient care – Medical treatment for someone not admitted to a facility. It may take place in a doctor's office, clinic, or hospital outpatient department.

Preventive care – Services that help you stay healthy and detect health problems early when treatment works best. Examples: exams, shots, lab tests, screenings, and programs for health monitoring, counseling, and education.

Primary care provider (PCP) – A general practice doctor, nurse practitioner, or physician assistant who treats basic medical conditions and is often the first person you'll see for health concerns. PCPs provide checkups, vaccinations, and screenings. They help diagnose conditions and refer you to specialists when needed. You are not required to select a PCP.

Care provider – A doctor, nurse, clinician, hospital, health system, licensed healthcare facility, program, agency, or healthcare professional that delivers healthcare services.

Cost

Annual out-of-pocket maximum (or max OOP) – The maximum amount you pay for medical costs each plan year. After paying the max OOP, you pay nothing for covered services until the next plan year. Copays, coinsurance, and deductibles count toward the max OOP, but not all costs do.*

Summary of Benefits – A summarized list of medical care and drugs the plan covers.

Coinsurance – A percentage you may be required to pay for covered services or drugs after paying your deductible.

Copay – A fixed dollar amount you may be required to pay for covered services or drugs after paying your deductible.

Cost share – Also called "cost-sharing amount" or "your share of the costs." It is usually a deductible, copay, or coinsurance. This is the amount you pay for covered services or drugs.

Covered services and drugs – Medical care and drugs your plan pays for under the plan terms.

Deductible – If applicable, the fixed dollar amount you pay for medical care or drugs before the plan begins to pay.

* Not all medical costs or services are included in or subject to the annual out-of-pocket maximum.

Required information for this plan year

Your rights, protections, and Medicare options

As a Medicare beneficiary, you have many rights and options put in place to protect you as a consumer. You have choices.

As a Medicare beneficiary, you can choose between:

- The Original (Fee-for-Service) Medicare plan.
- A Medicare health plan like the one offered in this guide.

You may have other options

The important thing to remember is that the choice is yours, keeping in mind that you may be able to join or leave a plan only at certain times. Please note that if you do not take your retiree benefits, it may affect other retiree benefits your group sponsor offers. No matter what you decide, you may still be eligible for the Original Medicare program.

Geographic service areas covered by this plan

This plan offers coverage in our Centers for Medicare & Medicaid Services (CMS) defined geographic service area of all 50 states, Washington, DC, and all United States territories.

Your Medicare protection

The plan must offer Medicare benefits to you for a full calendar year at a time, although benefits and cost sharing may change from year to year. The plan provider can decide each year whether to keep offering Medicare Advantage plans, or whether or not to continue offering plans in specific geographic areas like yours.

Also, Medicare may decide to end our contract.

If for some reason this plan is discontinued, we will send you a letter at least 90 days before your coverage ends explaining your options for Medicare coverage in your area.

For more information on the options and rights you have as a Medicare Advantage member with this plan, please contact our First Impressions Welcome Team and ask for a copy of the *Evidence of Coverage* (EOC).

Extra Help from Medicare

You may be able to find help to pay for your prescription drugs and other Medicare costs. If you qualify for Medicare's Extra Help and are enrolled in a Part D plan like this one, Medicare can pay up to 100% of your prescribed drugs. This can help offset your drug plan's monthly premium, plus coinsurance and copays for covered prescription drugs.

Extra Help can also close any drug coverage gaps and stop late enrollment penalties (LEPs). For more information, visit **www.medicare.gov** or **www.ssa.gov**, or call:

- **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.
- The Social Security Administration at **1-800-772-1213**, Monday to Friday, 7 a.m. to 7 p.m. ET. TTY users should call **1-800-325-0778**.
- Your state Medicaid office.

Required information for this plan year

Information about Medicare

To help you make more informed healthcare decisions, we are providing this important information about Medicare to use as a resource. If you have any questions, please contact our First Impressions Welcome Team.

Pay your Medicare Part B premiums

Once you enroll in this plan, you must still pay your Medicare Part B premiums. If you don't, Medicare will terminate your coverage and then you may have to pay a late enrollment penalty if you decide to reenroll.

Enrolling in other plans

If you decide to enroll in other plans, you will be disenrolled from your current plan.

Notifying your group sponsor

To ensure a smooth enrollment, make sure your group sponsor has your most up-to-date information and that it matches your Social Security information.

What to know about a drug list

A drug list is a list of drugs covered by the plan. We choose our list to provide good prescription coverage and a good value to you, as well.

Your full *Benefits Chart* will tell you if you have an open or closed drug list plan. Open plans cover almost all Medicare Part D eligible drugs, while closed plans cover most.

When new drugs come to market, we conduct a clinical and cost review and may add them to the drug list. To keep plans affordable, every year we may also remove drugs or change the cost you pay for them the following year. But don't worry; we'll notify you first and send you a new drug list when we make these changes.

Important: Check to see if your drug is on the drug list before you go to the pharmacy.

If the drug you take is not on our drug list, you will have to pay the full price of the drug. If that's the case, or if your drug comes with additional requirements or limits, you may be able to receive a temporary supply. We will notify you once the temporary supply is dispensed. You will have to contact your doctor and ask if you can switch to a different drug listed on our drug list.

About IRMAA and your income level

If your modified adjusted gross income on your IRS tax return from two years ago is above a certain limit, you must pay an income-related monthly adjustment amount (IRMAA) in addition to your monthly plan premium.

The Social Security Administration will contact you if you have to pay an IRMAA, which you must pay to them, not us.

High-income surcharges

If you must pay a high-income surcharge on your Medicare Part B or Part D premium to the Social Security Administration, please be sure to do so to avoid a mandatory disenrollment.

Required information for this plan year

Information about Medicare

We do not 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. Our plan has free language interpreter services available to answer questions from non-English-speaking members. Please call the First Impressions Welcome Team at the number listed in this guide to request interpreter services.

Out-of-network/noncontracted providers are under no obligation to treat Anthem Blue Cross members, except in emergency situations. Please call our First Impressions Welcome Team at **1-833-848-8729**, TTY: **711**, **Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays**, for more information.

This information is not a complete description of benefits. Contact the plan for more information. Every year, Medicare evaluates plans based on a five-star rating system.

This guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits and exclusions are contained in the *Benefits Chart and Evidence of Coverage (EOC),* which is received upon enrollment. In the event of a conflict between the *Benefits Chart* and *EOC* and this guide, the terms of the *Benefits Chart* and *EOC* will prevail.

Coordination of Benefits (COB) letter

If we receive Coordination of Benefits (COB) information from CMS, we are required to send a letter to you requesting verification of the other coverage information. The benefit verification letter we send will include information from CMS, including any other coverage that needs to be verified. Separately, we could receive COB information from other reporting sources in addition to CMS.

If the information is not correct in the letter, you can call Member Services or you can fill in the correct information on the letter and return it to the plan for processing.

If a response is not received within 21 days, the information on the letter is considered to be accurate.

If the previous carrier does not notify CMS of the previous plan termination prior to the plan enrollment process, a COB letter could be triggered for the plan that was just terminated.

Required information for this plan year

Information about Medicare

Some of the benefits mentioned are part of a special supplement program for the chronically ill. Not all members may qualify for these benefits

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.

Out-of-network/noncontracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your *Evidence of Coverage* for more information, including the cost sharing that applies to out-of-network services.

Form Approved
OMB# 0938-1421

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at **1-833-848-8730** (TTY: **711**). Someone who speaks your language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al número mencionado anteriormente (TTY: **711**). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 上述數字 (TTY: **711**)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 上述數字 (TTY: **711**)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa numero na nakasulat sa itaas (TTY: **711**). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au le numéro écrit ci-dessus (TTY: **711**). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi số được viết ở trên (TTY: **711**). Sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter die oben genannte Nummer (TTY: **711**). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 위에 나와있는 번호 (TTY: **711**) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

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Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону номер, указанный выше (TTY: **711**). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم ليس عليك سوى الاتصال بنا على الرقم المكتوب أعلاه (TTY: **711**) فوري سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें ऊपर लिखा हुआ नंबर (TTY: **711**) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero il numero sopraindicato (TTY: **711**). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número o número escrito acima (TTY: **711**). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa medikaman nou an. Pou jwenn yon entèprèt, jis rele nou nan nimewo ki ekri pi wo a (TTY: **711**). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer numer napisany powyżej (TTY: **711**). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、上記の番号 (TTY: **711**). にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。