



MEDICARE

Group Plan

Your Medicare Part D Enrollment Guide

LAPD Retiree Part D for HMO and PPO plans
Blue Cross MedicareRx (PDP) with Senior Rx Plus
7/1/2022 - 6/30/2023



Look inside!

How Medicare works
Discounts on products and services
Ways you can save on prescription drugs



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How to qualify and enroll 
Required information for this plan year

The page with this icon lists the steps to take to enroll. It appears after the Benefits Chart.



Plan highlights and enrollment

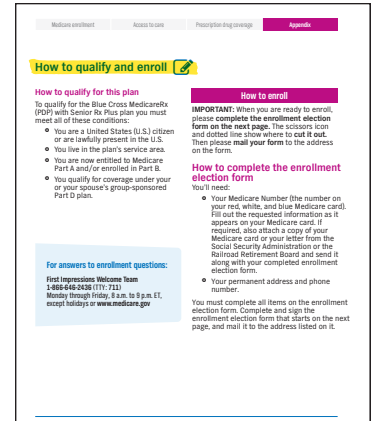
LAPD Retiree offers you this Blue Cross MedicareRx (PDP) with Senior Rx Plus plan. When you enroll in our plan, you are receiving more than prescription drug coverage. Here are some of the things we think you'll appreciate about this plan:

- Coverage on commonly prescribed drugs, plus Extra Covered Drugs
- Plan pharmacies nationwide
- Discounted rates on health products and services

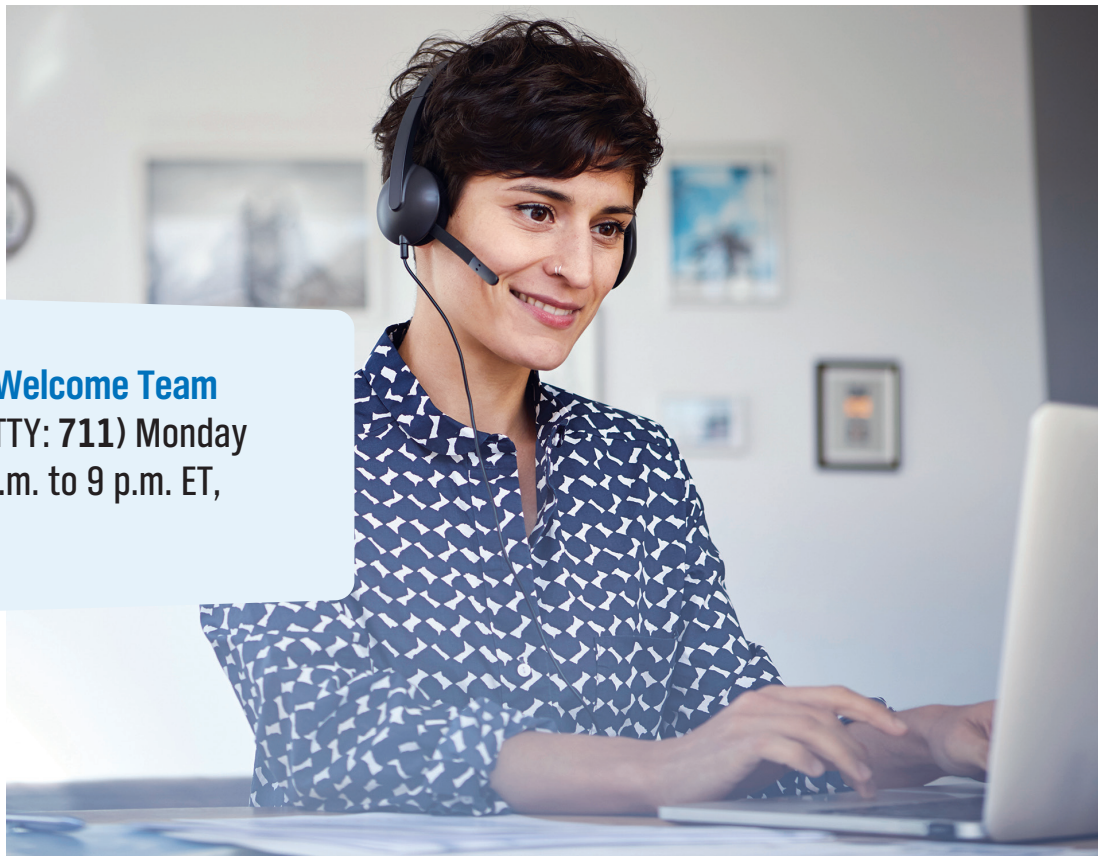
For enrollment assistance from a live person here in the United States, you can call our **First Impressions Welcome Team**. This team can answer your questions, review plan details, and check drug coverage and costs.

If you are ready to enroll, please see the page titled “How to qualify and enroll” that looks like this. It comes after the Benefits Chart.

For a smooth enrollment, please make sure that both the Social Security Administration and LAPD Retiree have your most current information and that their records match.



First Impressions Welcome Team
1-866-646-2436 (TTY: 711) Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays



The ABCDs of Medicare

This is a Part D prescription drug plan.

Medicare is a federal government health insurance program available to people:

- Over age 65.
- Under age 65 with certain disabilities.
- With end-stage renal disease (ESRD).
- With amyotrophic lateral sclerosis (ALS), also called Lou Gehrig's disease.

Medicare comes in parts, known as A, B, C, and D

Part A (hospital insurance) comes from the government.

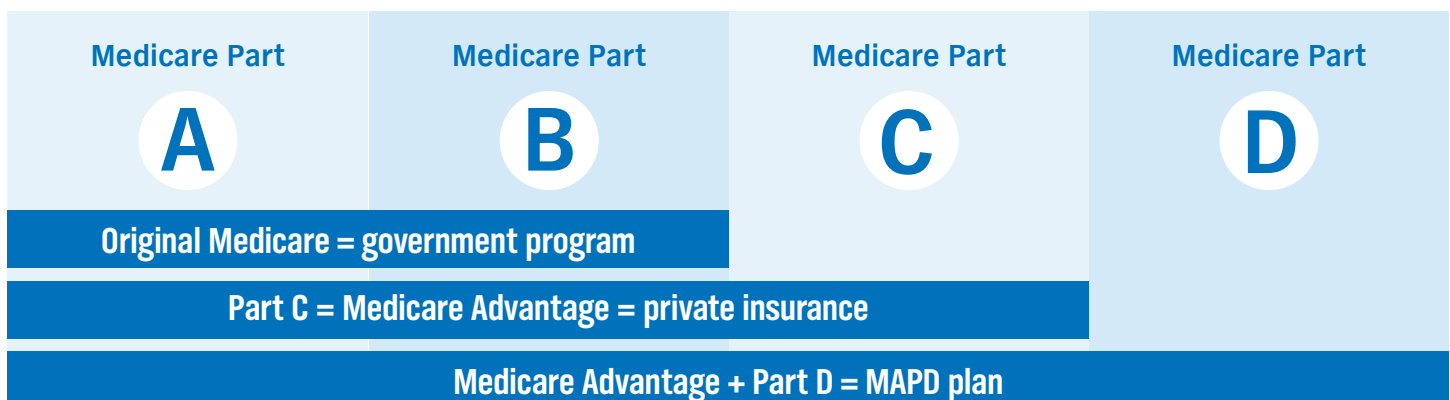
Part B (medical insurance) comes from the government.

Together they are called **Original Medicare**, the government program.

Part C (Medicare Advantage) covers Parts A and B, plus offers additional benefits. It only comes from private insurance companies like ours.

Part D (prescription drug coverage) covers drugs and only comes from private insurance companies like ours. When combined with Part C, it is known as a Medicare Advantage plan with prescription drug coverage (MAPD).

You can learn more about Medicare at www.medicare.gov or **1-800-MEDICARE (1-800-633-4227)**, TTY: **1-877-486-2048**, 24/7.



Frequently asked questions



Whom can I call if I have questions about this plan?

Call the **First Impressions Welcome Team** at **1-866-646-2436**, TTY: **711**, Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays.

What is a deductible?

When applicable, a deductible is the amount of money you pay for healthcare services before your plan starts paying. After you reach your deductible, you will still have to pay toward your cost share for services. Certain plans have no deductible and will cover your healthcare services from the start. Other services will be covered by your plan before you reach the deductible. For more details, please see the Benefits Chart included in this guide.

What is a copay?

When applicable, a copay is a fixed dollar amount that you pay for covered services. A copay is often charged to you after your appointment.

What is coinsurance?

When applicable, coinsurance is the percentage of a covered health care cost that you would pay after you meet your deductible, while the plan pays the rest of the covered cost. If you have not yet met your deductible, you pay the full allowed amount.

What is a true out-of-pocket (TrOOP) limit?

It is an annual out-of-pocket limit that includes payments made by you and the discount you receive on covered brand name drugs in the coverage gap. Once you reach this limit, you may pay a lower copay or coinsurance for your covered drugs until the start of the next plan year. The amount paid by your plan does not count toward your TrOOP costs. Not all of your costs add to the TrOOP. For more details, please see the Benefits Chart included in this guide.

Before enrolling, what do I need to provide my 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.

Health and savings with SpecialOffers

Our members receive discounts on these products and services.



Fitness and healthy living

The Active&Fit Direct™ program*

- Choose from 10,000+ participating fitness centers nationwide
- \$25/month membership (plus \$25 enrollment fee and applicable taxes)
- No long-term contracts

The ChooseHealthy® program*

- Discounts on services such as acupuncture, chiropractic care, therapeutic massage, and more from a nationwide network of healthcare providers.
- Discounts on fitness and wellness products such as activity trackers, equipment, and more. Obtain access to online health and wellness classes at no additional cost.

Fitbit

Save up to 22% on select Fitbit trackers and smartwatches.

Garmin

20% off select Garmin wellness devices

GlobalFit™

Discounts on gym memberships, fitness equipment, coaching, and more

Jenny Craig®

Free three-month program (food not included), plus \$120 in food savings (purchase required) or save 50% off our premium programs (food costs separate)

Puritan's Pride

10% off vitamins, supplements, and minerals

SelfHelpWorks

Choose one of the online Living programs and save 15% on coaching to help you lose weight, stop smoking, manage stress or diabetes, restore sound sleep, or face an alcohol problem.



Dental

ProClear™ Aligners

Improving your smile shouldn't cost a fortune. You can save 50% off the cost of a beautiful, professional smile in the comfort of your own home. There are no metal braces, no time-consuming dentist visits, and no hidden fees. When you order, you can receive a free whitening kit, along with a great-looking smile.

* The ChooseHealthy program is provided by ChooseHealthy, Inc. and the Active&Fit Direct program is provided by American Specialty Health Fitness, Inc. (ASH Fitness). ChooseHealthy, Inc. and ASH Fitness are subsidiaries of American Specialty Health Incorporated (ASH). ChooseHealthy and Active&Fit Direct are trademarks of ASH and used with permission herein. The ChooseHealthy program is a discount program; it is not insurance. You can access services from any ChooseHealthy participating provider; referral from a primary care physician is not required. You are responsible for paying the discounted fee directly to the contracted provider.

More health and savings with SpecialOffers



Family and home offerings

Allergy Control and National Allergy

Save up to 25% on select products. Free shipping on all orders over \$59 when shipping ground within the contiguous United States.

23andMe

- \$40 off each Health + Ancestry Service kit
- 20% off one 23andMe kit — learn about your wellness, ancestry, and more



Vision

1-800 CONTACTS® or Glasses.com™

- \$20 off orders of \$100 or more for the latest contact lenses or brand name frames
- Free shipping

Premier LASIK

- Save \$800 on LASIK when you choose any featured Premier LASIK Network provider.
- Save 15% with all other in-network providers.

TruVision

- Save up to 40% on LASIK eye surgery at over 1,000+ locations
- Over 6.5 million procedures performed in the network



Hearing

Amplifon®

- 25% off Amplifon hearing aids for qualified members, plus an extra \$50 off one hearing aid or \$125 off two hearing aids
- A three-year repair/loss/damage warranty
- A free two-year supply of batteries

Hearing Care Solutions (HCS)*

- Digital instruments starting at \$500
- Free hearing exam
- 3,100 locations and eight manufacturers
- Three-year warranty
- Two years of batteries
- Unlimited visits for one year

NationsHearing

Big savings on top-quality hearing aids from major manufacturers with a 60-day, 100% money-back guarantee, plus a three-year repair warranty, batteries included for three years, and replacement coverage

* Hearing benefit management administered by Hearing Care Solutions, an independent company.

SpecialOffers is a discount program that is not part of your drug plan coverage. It is a value-added online service we provide to give our Part D members access to discounts offered by different vendors. Vendors and offers are subject to change without prior notice. Anthem does not endorse and is not responsible for the products, services, or information provided by SpecialOffers vendors. Arrangements and discounts were negotiated between vendors and Anthem for the benefit of our members. The products and services described are not part of our contract with Medicare. They are not subject to the Medicare appeals process. Any disputes about these products or services may be subject to the Anthem grievance process.

IMPORTANT: SpecialOffers vendors and discounts are subject to change without notice

Plan onboarding after you join

After you enroll, you will receive:

- **Proof of your enrollment request**, with your membership start date listed.
- **Your plan membership card**. Begin using this card on your membership start date.

You'll also receive a **plan welcome guide** with ways to:

- Make the most of your benefits.
- Find pharmacies.
- Access information online.



Perks of our website and app

As a member, you can find information online without needing to call or sort through papers.

Once you receive your plan membership card, you can register at www.anthem.com/ca to:

- **Access plan and health resources.** You can check the status of claims and review plan documents. If you need to, you can request a replacement plan membership card or print a temporary one. There is also an online library of medical articles and videos. If you choose, you can opt in to receive paperless communications.
- **Search** covered drugs and pharmacies.
- **Use mail order** for prescription drugs.
- **Message us** securely.

Online tools are offered to Anthem plan members as extra services. They are not part of the contract and can change or stop.

Drug highlights and savings

Using covered medications and plan pharmacies can save you money.



Covered medications

We cover generic, brand name, and specialty drugs that Medicare Part D allows us to cover, plus even more than Medicare lets us. These additional drugs are called our Extra Covered Drugs. You can call our **First Impressions Welcome Team** to receive a full list of covered drugs and plan pharmacies. We can also check coverage of specific drugs and pharmacies over the phone.

Choosing covered generic drugs may save you money without sacrificing effectiveness. Generics have the same active ingredients and effects as brand name drugs, generally without the higher cost share.



Plan pharmacies

You have options and savings with our pharmacy network and mail-order pharmacy.

You'll save by filling prescriptions at any of our 65,000 plan pharmacies. Most national chains and many local pharmacies are in our National Discount Network.

Our mail-order pharmacy service can save you both time and money by mailing supplies of up to 90 days, often for less than if you were to fill a 90-day supply from a retail pharmacy.

For a complete list of covered drugs and plan pharmacies:

First Impressions Welcome Team

1-866-646-2436 (TTY: 711)

Monday through Friday, 8 a.m. to 9 p.m. ET,
except holidays



Please see the Benefits Chart in this guide for the complete details.

Top 50 most commonly prescribed drugs we cover

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

*atorvastatin calcium**amlodipine besylate**levothyroxine sodium**lisinopril**losartan potassium**metoprolol succinate**metformin hydrochloride*²*rosuvastatin calcium**omeprazole**hydrochlorothiazide**simvastatin*²*tamsulosin hydrochloride**pantoprazole sodium**gabapentin**furosemide*ELIQUIS²*metoprolol tartrate**carvedilol*²*pravastatin sodium**hydrocodone/acetaminophen**clopidogrel bisulfate**montelukast sodium**albuterol sulfate**amoxicillin**prednisone**allopurinol**sertraline hydrochloride**escitalopram oxalate**fluticasone propionate**tramadol hydrochloride**meloxicam**atenolol**trazodone hydrochloride**famotidine**latanoprost**alprazolam**finasteride**potassium chloride*²*ezetimibe**cephalexin**duloxetine hydrochloride*

SHINGRIX

*azithromycin**triamcinolone acetonide**spironolactone*

XARELTO

*bupropion hydrochloride**lisinopril/hydrochlorothiazide**zolpidem tartrate**alendronate sodium*

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

¹ This list is current as of April 2021 and is subject to change. It is not a complete list of covered drugs.

² Not all dosages are covered at the generic cost share.



Prescription drug coverage with Part D

This plan is for prescription drug coverage, also called Medicare Part D. All of our covered drugs appear on a drug list, called the *Part D Formulary*. This plan also covers drugs beyond those that Medicare allows, which appear on a separate list called *Extra Covered Drugs*.

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

1. Ask your doctor to switch you to a covered drug.
2. Request an exception.
3. Request a temporary supply while discussing other drug options with your doctor.

Our **First Impressions Welcome Team** is available to check the drug list and estimate costs.

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**. All of the tiers contain 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	\$ \$
Nonpreferred brand name	Less commonly used brand name drugs that usually have a generic alternative	Tier 3	\$ \$ \$
Specialty	Cost over \$830 for 30 days. 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.

Complete Benefits Chart

The Benefits Chart describes the plan's prescription drug benefits, including:

- What we cover
- Any copay or coinsurance amounts
- Any out-of-pocket costs

Prescription drug benefits start on the next page.

To discuss benefit details:

First Impressions Welcome Team

1-866-646-2436 (TTY: 711)

Monday through Friday, 8 a.m. to 9 p.m.
ET, except holidays



We are happy to review your benefits with you. Call our First Impressions Welcome Team.

Your 2022 Prescription Drug Benefits Chart
Premier 15/25/40/20% to \$150 (with Senior Rx Plus)
Los Angeles Police Relief Association, Inc. (HMO)

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	Premier
Deductible	None
Covered Services	What you pay
Part D Initial Coverage	
Below is your payment responsibility until the amount paid by you and the Coverage Gap Discount Program for covered Part D prescriptions reaches your True Out of Pocket limit of \$4,850.	
Retail Pharmacy	per 30-day supply
• Generics	\$15 copay
• Preferred Brands	\$25 copay
• Non-Preferred Drugs and Non-Formulary Drugs	\$40 copay
• Specialty Drugs	20% coinsurance with a maximum of \$150
• Diabetic Supplies - Insulin Syringes, Pen Needles and Alcohol Swabs up to 90-day supply	\$15 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 only pay the mail-order copay below.	
Mail-Order Pharmacy	per 90-day supply
• Generics	\$30 copay
• Preferred Brands	\$50 copay
• Non-Preferred Drugs and Non-Formulary Drugs	\$80 copay
• Specialty Drugs	20% coinsurance with a maximum of \$300
• Diabetic Supplies - Insulin Syringes, Pen Needles and Alcohol Swabs	\$30 copay

Covered Services	What you pay
Part D Catastrophic Coverage	
Your payment responsibility changes after the cost you and the Coverage Gap Discount Program have paid for covered drugs reaches your True Out of Pocket limit of \$4,850.	
Retail and Mail-Order Pharmacies	Up to a 90-day supply
• Generic Drugs	\$2 copay
• Brand-Name Drugs	\$5 copay

- 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. Other common vaccines are also covered under Medicare drug coverage for Medicare-eligible individuals under 65. You can fill 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 pay its share of the cost. 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 and the Coverage Gap Discount. The copay or coinsurance shown in this benefits chart is the amount you pay for covered drugs filled at network pharmacies.

Your 2022 Extra Covered Drugs Benefits Chart

Covered Services	What you pay
Extra Covered Drugs	
<p>These are drugs that are covered by your retiree drug plan that are often excluded from Part D coverage. These 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 True Out of Pocket expenses. They do not qualify for lower Catastrophic copays.</p>	
Retail Pharmacy	per 30-day supply
Cough and Cold DESI Vitamins and Minerals	See Drug List for complete list of drugs covered
• Generics	\$15 copay
• Preferred Brands	\$25 copay
• Non-Preferred Drugs	\$40 copay
Erectile Dysfunction (ED)	Immediate and Daily dose ED drugs Immediate dose formats are limited to 6 per 30 days. Daily dose formats are limited to 6 per 30 days.
• Generics	\$15 copay
• Preferred Brands	\$25 copay
• Non-Preferred Drugs	\$40 copay
Other Non-Part D Coverage	Copay or coinsurance
• Non-Part D Diabetic Supplies – Lancets, Blood Sugar Diagnostics and Calibration Solutions up to 90-day supply	\$0 copay
• Non-Part D Diabetic Supplies – Glucometers	\$15 copay per Covered Device
• Contraceptive Devices	Limit 1 per year; \$0 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	\$30 copay
• Preferred Brands	\$50 copay
• Non-Preferred Drugs	\$80 copay
Erectile Dysfunction (ED)	Immediate and Daily dose ED drugs Immediate dose formats are limited to 6 per 30 days. Daily dose formats are limited to 6 per 30 days.
• Generics	\$30 copay
• Preferred Brands	\$50 copay
• Non-Preferred Drugs	\$80 copay
Other Non-Part D Coverage	Copay or coinsurance
• Non-Part D Diabetic Supplies - Lancets, Blood Sugar Diagnostics and Calibration Solutions	\$0 copay
• Non-Part D Diabetic Supplies - Glucometers	\$15 copay per Covered Device
• Contraceptive Devices	Limit 1 per year; \$0 copay per Covered Device

- **Erectile Dysfunction (ED) Drugs - Cialis** 2.5mg and 5mg medication is covered when used to treat Benign Prostatic Hyperplasia (BPH). These drugs are covered 30 per 30 days when used to treat BPH.
- **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 a pharmacist.

Your 2022 Prescription Drug Benefits Chart
Premier 15/25/40/20% to \$150 (with Senior Rx Plus)
Los Angeles Police Relief Association, Inc. (PPO)

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	Premier
Deductible	None
Covered Services	What you pay
Part D Initial Coverage	
Below is your payment responsibility until the amount paid by you and the Coverage Gap Discount Program for covered Part D prescriptions reaches your True Out of Pocket limit of \$4,850.	
Retail Pharmacy	per 30-day supply
• Generics	\$15 copay
• Preferred Brands	\$25 copay
• Non-Preferred Drugs and Non-Formulary Drugs	\$40 copay
• Specialty Drugs	20% coinsurance with a maximum of \$150
• Diabetic Supplies - Insulin Syringes, Pen Needles and Alcohol Swabs up to 90-day supply	\$15 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 only pay the mail-order copay below.	
Mail-Order Pharmacy	per 90-day supply
• Generics	\$30 copay
• Preferred Brands	\$50 copay
• Non-Preferred Drugs and Non-Formulary Drugs	\$80 copay
• Specialty Drugs	20% coinsurance with a maximum of \$300
• Diabetic Supplies - Insulin Syringes, Pen Needles and Alcohol Swabs	\$30 copay

Covered Services	What you pay
Part D Catastrophic Coverage	
Your payment responsibility changes after the cost you and the Coverage Gap Discount Program have paid for covered drugs reaches your True Out of Pocket limit of \$4,850.	
Retail and Mail-Order Pharmacies	Up to a 90-day supply
• Generic Drugs	\$2 copay
• Brand-Name Drugs	\$5 copay

- **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. Other common vaccines are also covered under Medicare drug coverage for Medicare-eligible individuals under 65. You can fill 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 pay its share of the cost. 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 and the Coverage Gap Discount. The copay or coinsurance shown in this benefits chart is the amount you pay for covered drugs filled at network pharmacies.

Your 2022 Extra Covered Drugs Benefits Chart

Covered Services	What you pay
Extra Covered Drugs	
<p>These are drugs that are covered by your retiree drug plan that are often excluded from Part D coverage. These 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 True Out of Pocket expenses. They do not qualify for lower Catastrophic copays.</p>	
Retail Pharmacy	per 30-day supply
Cough and Cold DESI Vitamins and Minerals	See Drug List for complete list of drugs covered
<ul style="list-style-type: none"> • Generics 	\$15 copay
<ul style="list-style-type: none"> • Preferred Brands 	\$25 copay
<ul style="list-style-type: none"> • Non-Preferred Drugs 	\$40 copay
Erectile Dysfunction (ED)	Immediate and Daily dose ED drugs Immediate dose formats are limited to 6 per 30 days. Daily dose formats are limited to 6 per 30 days.
<ul style="list-style-type: none"> • Generics 	\$15 copay
<ul style="list-style-type: none"> • Preferred Brands 	\$25 copay
<ul style="list-style-type: none"> • Non-Preferred Drugs 	\$40 copay
Other Non-Part D Coverage	Copay or coinsurance
<ul style="list-style-type: none"> • Non-Part D Diabetic Supplies – Lancets, Blood Sugar Diagnostics and Calibration Solutions up to 90-day supply 	\$15 copay
<ul style="list-style-type: none"> • Non-Part D Diabetic Supplies - Glucometers 	\$15 copay per Covered Device
<ul style="list-style-type: none"> • LifeScan/Roche Non-Part D Diabetic Supplies – Blood Sugar Diagnostics and Glucometers 	\$0 copay
<ul style="list-style-type: none"> • Contraceptive Devices 	Limit 1 per year; \$0 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	\$30 copay
• Preferred Brands	\$50 copay
• Non-Preferred Drugs	\$80 copay
Erectile Dysfunction (ED)	Immediate and Daily dose ED drugs Immediate dose formats are limited to 6 per 30 days. Daily dose formats are limited to 6 per 30 days.
• Generics	\$30 copay
• Preferred Brands	\$50 copay
• Non-Preferred Drugs	\$80 copay
Other Non-Part D Coverage	Copay or coinsurance
• Non-Part D Diabetic Supplies – Lancets, Blood Sugar Diagnostics and Calibration Solutions	\$30 copay
• Non-Part D Diabetic Supplies - Glucometers	\$15 copay per Covered Device
• LifeScan/Roche Non-Part D Diabetic Supplies – Blood Sugar Diagnostics and Glucometers	\$0 copay
• Contraceptive Devices	Limit 1 per year; \$0 copay per Covered Device

- **Erectile Dysfunction (ED) Drugs - Cialis** 2.5mg and 5mg medication is covered when used to treat Benign Prostatic Hyperplasia (BPH). These drugs are covered 30 per 30 days when used to treat BPH.
- **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 a pharmacist.

How to qualify and enroll

How to qualify for this plan

To qualify for the Blue Cross MedicareRx (PDP) with Senior Rx Plus plan you must meet all of these conditions:

- 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/or enrolled in Part B.
- You qualify for coverage under your or your spouse's group-sponsored Part D plan.

For answers to enrollment questions:

First Impressions Welcome Team

1-866-646-2436 (TTY: 711)

Monday through Friday, 8 a.m. to 9 p.m. ET,
except holidays or www.medicare.gov

How to enroll

IMPORTANT: When you are ready to enroll, please **complete the enrollment election form on the next page**. The scissors icon and dotted line show where to **cut it out**. Then please **mail your form** to the address on the form.

How to complete the enrollment election form

You'll need:

- Your Medicare Number (the number on your red, white, and blue Medicare card). Fill out the requested information as it appears on your 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.

You must complete all items on the enrollment election form. Complete and sign the enrollment election form that starts on the next page, and mail it to the address listed on it.

Anthem Blue Cross Group-Sponsored Health Plan Enrollment Election Form

All fields on this form are required		
Group sponsor name: LAPD Retiree	Group #: CA014GRX	
Plan you will join: <input checked="" type="checkbox"/> Blue Cross MedicareRx (PDP)	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: <input type="checkbox"/> M <input type="checkbox"/> F	Phone number: () <input type="checkbox"/> Cell <input type="checkbox"/> 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.		
Your Medicare information:		
Medicare Number:		
Please read and answer these important questions		
1. Are you the retiree? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," retirement date (month/date/year): _____ If "no," name of retiree: _____ Retiree Medicare ID #: _____		
2. Are you a resident in a long-term care facility, such as a nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," please provide the following information: Name of institution: _____ Address (number and street) and phone number of institution: _____		
3. Will you have other prescription drug coverage (like VA or TRICARE) in addition to this plan? <input type="checkbox"/> Yes <input type="checkbox"/> 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 **1-866-646-2436**, TTY: **711**, Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays, for additional information or questions you may have.



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 Blue Cross MedicareRx (PDP) 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 Blue Cross MedicareRx (PDP) 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.

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 prescription drug plan, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care 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 Blue Cross MedicareRx (PDP) with Senior Rx Plus coverage begins, I must get all of my prescription drug benefits from Anthem Blue Cross. Benefits and services authorized by Anthem Blue Cross and contained in my Blue Cross MedicareRx (PDP) 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 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:

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 on the next page, and **sign and return it with this form**. This form is valid for one year from the signature date.

- If you don't complete the HIPAA form at this time, a future request for this form can be made by contacting Member Services at the telephone number on the back of your membership card.
- If you wish to continue having the authorized representative on your account, a new form is required annually.
- If you have a durable health care power of attorney document, it can also be returned with the HIPAA form.

Please return this enrollment election form to:

Anthem Blue Cross
Los Angeles Police Relief Association, Inc.
600 North Grand Avenue
Los Angeles, CA 90012-2212

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 Life and Health Insurance Company is a PDP plan with a Medicare contract. Enrollment in Anthem Blue Cross Life and Health Insurance Company depends on contract renewal. Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Instructions for completing the Pre-member/member authorization form



If you have any questions, please call the First Impressions Welcome Team.

Please read the following for help completing page one of the form.

Part A: pre-member/member information

This section applies to the pre-member/member who is asking for the release of their information to another person or company.

- 1 Print your last name, first name and middle initial.
- 2 Write your date of birth in this format: MM/DD/YYYY. (If you were born on October 5, 1960, you would write 10/05/1960.)
- 3 Write your full street address, city, state and ZIP code.
- 4 Write your daytime phone number (including area code).
- 5 Write your cell/mobile phone number (including area code).
- 6 Write your identification number (issued when enrolled as a member). You will find this number on your membership card.
- 7 Write your group number. You will find this number on the enrollment election form. If your enrollment election form does not have a group number, leave this blank.

Part B: person or company who will receive this information

- 8 Write the full name of the person or company that you want us to give your information to. Please don't use a general term like "my daughter" or "my son," as it will not be accepted. You need to be specific.
- 9 If you check "Other," give the first and last name (if available), the name of the company (if applicable) and how they relate to you.

Part C: information that can be released

This section tells us what information you would like us to release: all or just some.

- 10 For all of your information, check the first box.
- 11 For limited information, check the second box and the boxes that apply to you.
- 12 Some topics may be very personal or sensitive to you. If you wish to approve the release of this type of information, check the box(es) that apply to you.

Pre-member/member authorization form

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This form is to be filled out by a pre-member/member if there is a request to release the pre-member/member's health information to another person or company. Please include as much information as you can.

Part A: pre-member/member information

Pre-member/member last name 1	Pre-member/member first name	Middle initial	Pre-member/member date of birth (MM/DD/YYYY) 2
Pre-member/member street address 3		City	State
Daytime phone number (with area code) 4	Cell/mobile phone number (with area code) 5	Identification number (see membership card) 6	Group number (see membership card) 7

Part B: person or company who will receive this information

The following people or companies have the right to receive my information. (They must be 18 years of age or older.) Please enter first and last name. By entering first/last name below, that person may receive my information.

My spouse (enter first and last name) 8	My parents (if you are over 18 – enter first and last name(s))
My domestic partner (enter first and last name)	My insurance broker or agent (enter the name of the company and first and last name, if you have it)
My adult children (enter first and last name(s))	Other (enter first and last name (if you have it), name of company and how they are related to you) 9

Part C: information that can be released

I allow the following information to be used or released by Anthem Blue Cross (Anthem) on my behalf.
Check only one box.

10 All my information. This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

OR

11 Only limited information may be released (check all boxes below that apply to you).

<input type="checkbox"/> Appeal	<input type="checkbox"/> Doctor and hospital	<input type="checkbox"/> Pre-certification and pre-authorization (for treatment approvals)
<input type="checkbox"/> Benefits and coverage	<input type="checkbox"/> Eligibility and enrollment	<input type="checkbox"/> Referral
<input type="checkbox"/> Billing	<input type="checkbox"/> Financial	<input type="checkbox"/> Treatment
<input type="checkbox"/> Claims and payment	<input type="checkbox"/> Medical records	<input type="checkbox"/> Vision
<input type="checkbox"/> Dental	<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Diagnosis (name of illness or condition) and procedure (treatment)		

12 I also approve the release of the following types of sensitive information by Anthem (check all boxes that apply to you):

All sensitive information²

OR

Just information about topics checked below.

<input type="checkbox"/> Abortion	<input type="checkbox"/> HIV or AIDS	<input type="checkbox"/> Sexually transmitted illness
<input type="checkbox"/> Abuse (sexual/physical/mental)	<input type="checkbox"/> Maternity	<input type="checkbox"/> Substance use disorder ^{1,2}
<input type="checkbox"/> Genetic testing	<input type="checkbox"/> Mental health	<input type="checkbox"/> Other: _____

1. Specify time period of records to be disclosed: _____
Description of records that may be disclosed: _____

2. Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by Anthem about me. I understand that my substance use disorder records are protected under federal and state confidentiality laws and regulations and cannot be disclosed without my written consent, unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time or as described in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

Please read the following for help completing page two of the form.

Part D: purpose of this approval

This section tells us the reason you've asked for the release of your information.

- 1 Check the first box to let us know to give out this information as shown on this form.
- 2 Check the second box for a specific reason. An example might be to settle a life insurance claim.

Part E: date your approval expires

You have two choices of when you would like this approval to end.

- 3 Check the first box for the approval to end after one year, which is standard.
- 4 Check the second box for an earlier date (other than one year), and give the date you wish this approval to end. Your authorization/approval can't be granted for more than one year.

Part F: review and approval

- 5 **Sign your name and put the date on the form.** Your name and signature **must** match the information in Part A.
- 6 **If you are signing this form on behalf of another person, or if you have power of attorney for health care or are a legal guardian/conservator, you must do the following:**
 - o You must complete the designated legal representative/guardian section.
 - o You must also provide us with a copy of the legal document showing that you are approved and include it with this form.

Examples of legal documents:

- o **Health care, general or durable power of attorney.** This document gives someone you trust the legal power to act on your behalf and make health care decisions for you.
- o **Legal guardianship.** This is when the court appoints someone to care for another person.
- o **Conservatorship.** This happens when a judge appoints a responsible person to make decisions for someone who can't make responsible decisions for themselves.
- o **Executor of estate.** This type of document would be used when the person who is being represented has died.

Part D: purpose of this approval – check only one box			
1	<input type="checkbox"/> To give out the information as shown on this form.		
	OR		
2	<input type="checkbox"/> For this/these reason(s): _____		
Part E: date your approval expires – check only one box			
3	<input type="checkbox"/> If this document has not already been withdrawn, this approval will end on the earlier of the following dates:		
	OR		
4	<input type="checkbox"/> Earlier than one year and upon the date, event or condition described below: _____		
Part F: review and approval			
I have read the contents of this form. I understand, agree and allow Anthem to use and release my information as I have stated above or as required by applicable law. I also understand that signing this form is done of my own free will. I understand that Anthem does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.			
I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Anthem. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. I am entitled to a copy of this form.			
Pre-member/member signature or designated legal representative/guardian signature			5
X			Date (MM/DD/YYYY)
6 Designated legal representative/guardian – complete this section only if you have documentation supporting legal representation			
If this form is signed by someone other than the pre-member/member or parent, such as a personal representative, legal representative or guardian on behalf of the pre-member/member, please submit the following:			
o A copy of a health care, general or durable power of attorney			
OR			
o A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the pre-member/member's behalf			
Please complete the following:			
Legal representative (print full name)		Legal relationship to pre-member/member	
Legal representative street address	City	State	ZIP code
Signature		Date (MM/DD/YYYY)	
X			
Please return with enrollment election form.			
Be sure to keep a copy of this form for your records.			
For recipient of substance use disorder information:			
This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any patient with a diagnosis of substance use disorder.			
Anthem Blue Cross is the trade name of Blue Cross California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.			
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Pre-member/member authorization form



Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This form is to be filled out by a pre-member/member if there is a request to release the pre-member/member's health information to another person or company. Please include as much information as you can.

Part A: pre-member/member information

Pre-member/member last name	Pre-member/member first name	Middle initial	Pre-member/member date of birth (MM/DD/YYYY)
Pre-member/member street address		City	State
ZIP code	Daytime phone number (with area code)	Cell/mobile phone number (with area code)	Identification number (see membership card)
		Group number (see membership card)	

Part B: person or company who will receive this information

The following people or companies have the right to receive my information. (They must be 18 years of age or older.) Please enter first and last name. By entering first/last name below, that person may receive my information.

My spouse (enter first and last name)	My parents (if you are over 18 – enter first and last name[s])
My domestic partner (enter first and last name)	My insurance broker or agent (enter the name of the company and first and last name, if you have it)
My adult children (enter first and last name[s])	Other (enter first and last name [if you have it], name of company and how they are related to you)

Part C: information that can be released

I allow the following information to be used or released by Anthem Blue Cross (Anthem) on my behalf.

Check only one box.

All my information. This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

OR

Only limited information may be released (check all boxes below that apply to you).

<input type="checkbox"/> Appeal	<input type="checkbox"/> Doctor and hospital	<input type="checkbox"/> Pre-certification and pre-authorization (for treatment approvals)
<input type="checkbox"/> Benefits and coverage	<input type="checkbox"/> Eligibility and enrollment	<input type="checkbox"/> Referral
<input type="checkbox"/> Billing	<input type="checkbox"/> Financial	<input type="checkbox"/> Treatment
<input type="checkbox"/> Claims and payment	<input type="checkbox"/> Medical records	<input type="checkbox"/> Vision
<input type="checkbox"/> Dental	<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Diagnosis (name of illness or condition) and procedure (treatment)		

I also approve the release of the following types of sensitive information by Anthem (check all boxes that apply to you):

All sensitive information²

OR

Just information about topics checked below.

<input type="checkbox"/> Abortion	<input type="checkbox"/> HIV or AIDS	<input type="checkbox"/> Sexually transmitted illness
<input type="checkbox"/> Abuse (sexual/physical/mental)	<input type="checkbox"/> Maternity	<input type="checkbox"/> Substance use disorder ^{1,2}
<input type="checkbox"/> Genetic testing	<input type="checkbox"/> Mental health	<input type="checkbox"/> Other: _____

- Specify time period of records to be disclosed: _____
Description of records that may be disclosed: _____
- Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by Anthem about me. I understand that my substance use disorder records are protected under federal and state confidentiality laws and regulations and cannot be disclosed without my written consent, unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time or as described in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

Part D: purpose of this approval – check only one box

To give out the information as shown on this form.

OR

For this/these reason(s): _____

Part E: date your approval expires – check only one box

If this document has not already been withdrawn, this approval will end on the earlier of the following dates:

One year from the signature date in Part F.

OR

Earlier than one year and upon the date, event or condition described below: _____

Part F: review and approval

I have read the contents of this form. I understand, agree and allow Anthem to use and release my information as I have stated above or as required by applicable law. I also understand that signing this form is done of my own free will. I understand that Anthem does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Anthem. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. I am entitled to a copy of this form.

Pre-member/member signature or designated legal representative/guardian signature

Date (MM/DD/YYYY)

X

Designated legal representative/guardian – complete this section only if you have documentation supporting legal representation

If this form is signed by someone other than the pre-member/member or parent, such as a personal representative, legal representative or guardian on behalf of the pre-member/member, please submit the following:

- A copy of a health care, general or durable power of attorney

OR

- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the pre-member/member's behalf

Please complete the following:

Legal representative (print full name)		Legal relationship to pre-member/member	
Legal representative street address	City	State	ZIP code
Signature		Date (MM/DD/YYYY)	
X			

Please return with enrollment election form.

Be sure to keep a copy of this form for your records.

For recipient of substance use disorder information:

This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any patient with a diagnosis of substance use disorder.

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Required information for this plan year

Your rights, protections, and Medicare options

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

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 protections

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 Part D 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 Part D 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**.

Matching Medicare Advantage (medical) coverage and Part D (prescription drug) coverage for members in group plans

If you are enrolled in a group Medicare Advantage plan, your Part D coverage must also be a group Part D plan. This is important because enrolling in a non-group Part D plan could result in termination of your enrollment in your group Medicare Advantage plan.

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.

Required information for this plan year

Information about Medicare

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.

Late enrollment penalty (LEP)

If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later.

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 **1-866-646-2436**, 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/*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

Anthem Blue Cross Life and Health Insurance Company is a PDP plan with a Medicare contract. Enrollment in Anthem Blue Cross Life and Health Insurance Company depends on contract renewal. Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

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IMPORTANT INFORMATION:

2022 Medicare Star Ratings

Blue Cross MedicareRx - S5596



For 2022, Blue Cross MedicareRx - S5596 received the following Star Ratings from Medicare:

Overall Star Rating: ★★★★★☆
Health Services Rating: Not offered
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 Blue Cross MedicareRx seven days a week from Monday to Friday from 8 a.m. to 9 p.m. ET at **1-866-646-2436** (toll free) or **711**. Current members please call **1-855-871-5489** or **711**.

Anthem Blue Cross Life and Health Insurance Company is a PDP plan with a Medicare contract. Enrollment in Anthem Blue Cross Life and Health Insurance Company depends on contract renewal.

