Santa Clara County, CA
2019

Annual Notice of Changes

Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan)

Have questions?
Call us toll free at 1-855-817-5785 (TTY 711),
Monday through Friday from 8 a.m. to 8 p.m.
or visit duals.anthem.com.

Anthem BlueCross

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Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan) offered by Anthem Blue Cross

Annual Notice of Changes for 2019

Introduction

You are currently enrolled as a member of Anthem Blue Cross Cal MediConnect Plan. Next year, there will be some changes to the plan's benefits, coverage, rules and costs. This *Annual Notice of Changes* tells you about the changes and where to find more information about them. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. Disclaimers

❖ Anthem Blue Cross Cal MediConnect Plan is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees.

B. Reviewing Your Medicare and Medi-Cal Coverage for Next Year

It is important to review your coverage now to make sure it will still meet your needs next year. If it does not meet your needs, you may be able to leave the plan. See section F2 for more information.

If you choose to leave Anthem Blue Cross Cal MediConnect Plan, your membership will end on the last day of the month in which your request was made.

If you leave our plan, you will still be in the Medicare and Medi-Cal programs as long as you are eligible.

- You will have a choice about how to get your Medicare benefits (go to page 18 to see your choices).
- You will continue to be enrolled in Anthem Blue Cross for your Medi-Cal benefits, unless you choose a different Medi-Cal only plan (go to page 17 for more information).

NOTE: If you are in a drug management program, you may not be able to join a different plan. See Chapter 5 of your *Member Handbook* for information about drug management programs.

B1. Additional resources

- ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-817-5785 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

ATENCIÓN: Si usted habla español, tiene a su disposición servicios gratuitos de asistencia de idiomas. Llame al 1-855-817-5785 (TTY: 711), de lunes a viernes, de 8:00 a.m. a 8:00 p.m. La llamada es gratuita.	Spanish
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-817-5785 (TTY:771), 週一至週五上午 8：00-晚上 8：00。通話免費。	Chinese
CHU Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ, miễn phí, cho quý vị. Xin gọi số 1-855-817-5785 (TTY: 711), Thứ Hai đến Thứ Sáu từ 8:00 sáng đến 8:00 tối. Cuộc gọi được miễn tính cước phí.	Vietnamese
PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo nang walang bayad ang mga serbisyo ng tulong sa wika. Tumawag sa 1-855-817-5785 (TTY: 711), Lunes hanggang Biyernes, 8:00 a.m. hanggang 8:00 p.m. Libre ang tawag.	Tagalog

- You can get this *Annual Notice of Changes* for free in other formats, such as large print, braille or audio. Call 1-855-817-5785 (TTY 711), Monday through from Friday 8 a.m. to 8 p.m. The call is free.

- You can make a standing request to get this and future information for free in other languages and formats. Call 1-855-817-5785 (TTY 711) Monday through Friday from 8 a.m. to 8 p.m. The call is free.

B2. Information about Anthem Blue Cross Cal MediConnect Plan

- Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees.

- Coverage under Anthem Blue Cross Cal MediConnect Plan qualifies as minimum essential coverage (MEC). It satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.irs.gov/affordable-care-act/individuals-and-families for more information on the individual shared responsibility requirement for MEC.

- Anthem Blue Cross Cal MediConnect Plan is offered by Anthem Blue Cross. When this *Annual Notice of Changes* says "we," "us" or "our," it means Anthem Blue Cross. When it says "the plan" or "our plan," it means Anthem Blue Cross Cal MediConnect Plan.

B3. Important things to do

- **Check if there are any changes to our benefits and costs that may affect you.**
  - Are there any changes that affect the services you use?
  - It is important to review benefit and cost changes to make sure they will work for you next year.
  - Look in section D for information about benefit and cost changes for our plan.
- **Check if there are any changes to our prescription drug coverage that may affect you.**
  - Will your drugs be covered? Are they in a different cost-sharing tier? Can you continue to use the same pharmacies?
  - It is important to review the changes to make sure our drug coverage will work for you next year.
  - Look in section D2 for information about changes to our drug coverage.
  - Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices, visit https://go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.
- **Check to see if your providers and pharmacies will be in our network next year.**
  - Are your doctors in our network? What about your pharmacy? What about the hospitals or other providers you use?
  - Look in section C for information about our *Provider and Pharmacy Directory.*

- **Think about your overall costs in the plan.**
  - How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
  - How do the total costs compare to other coverage options?
- **Think about whether you are happy with our plan.**

If you decide to stay with Anthem Blue Cross Cal MediConnect Plan:	If you decide to change plans:
If you want to stay with us next year, it's easy – you don't need to do anything. If you don't make a change, you will automatically stay enrolled in our plan.	If you decide other coverage will better meet your needs, you may be able to switch plans (see section F2 for more information). If you enroll in a new plan, your new coverage will begin on the first day of the following month. Look in section F, page 15 to learn more about your choices.

C. Changes to the network providers and pharmacies

Our provider and pharmacy networks have changed for 2019.

We strongly encourage you to **review our current *Provider and Pharmacy Directory*** to see if your providers or pharmacy are still in our network. An updated *Provider and Pharmacy Directory* is located on our website at duals.anthem.com. You may also call Member Services at 1-855-817-5785 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*.

It is important that you know that we may also make changes to our network during the year. If your provider does leave the plan, you have certain rights and protections. For more information, see Chapter 3 of your *Member Handbook*.

D. Changes to benefits and costs for next year

D1. Changes to benefits and costs for medical services

We are changing our coverage for certain medical services and what you pay for these covered medical services next year. The following table describes these changes.

	2018 (this year)	2019 (next year)
Eyewear	$200 maximum benefit coverage amount every two years for contact lenses and/or eyewear.	$100 maximum benefit coverage amount every two years for contact lenses and/or eyewear.
Fitness Benefit	Membership to a contracted fitness center is covered.	Membership to a contracted fitness center is **not** covered.
LiveHealth Online	LiveHealth Online is **not** covered.	LiveHealth Online is covered. It's an easy way to interact with a doctor via live, two-way video on a computer or mobile device using a free application.
Personal Emergency Response System (PERS)	A PERS is covered.	A PERS is **not** covered.
Routine Foot Care Visits	Up to 1 visit every 3 months is covered.	Up to 12 visits every year are covered.
Worldwide Emergency/ Urgent Coverage	Worldwide Emergency/ Urgent Coverage is **not** covered.	$10,000 for combined Worldwide Emergency Care and Urgently Needed Care is covered.

D2. Changes to prescription drug coverage

Changes to our Drug List

An updated *List of Covered Drugs* is located on our website at duals.anthem.com. You may also call Member Services at 1-855-817-5785 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. for updated drug information or to ask us to mail you a *List of Covered Drugs*.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs.

Review the Drug List to **make sure your drugs will be covered next year** and to see if there will be any restrictions.

If you are affected by a change in drug coverage, we encourage you to:

- Work with your doctor (or other prescriber) to find a different drug that we cover.
    - You can call Member Services at 1-855-817-5785 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. to ask for a list of covered drugs that treat the same condition.
    - This list can help your provider find a covered drug that might work for you.
- Work with your doctor (or other prescriber) and ask the plan to make an exception to cover the drug.
    - You can ask for an exception before next year and we will give you an answer within 72 hours after we get your request (or your prescriber's supporting statement).
    - To learn what you must do to ask for an exception, see Chapter 9 of the *2019 Member Handbook* or call Member Services at 1-855-817-5785 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m.
    - If you need help asking for an exception, you can contact Member Services. See Chapter 2 and Chapter 3 of the *Member Handbook* to learn more about how to contact your case manager.
- Ask the plan to cover a temporary supply of the drug.
    - In some situations, we will cover a **temporary** supply of the drug during the first 90 days of the calendar year.
    - This temporary supply will be for up to 31 days. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5 of the *Member Handbook*.)
    - When you get a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

Formulary exceptions are granted until the end of the plan year. Any formulary exceptions granted during the current plan year would need to be resubmitted for the 2019 plan year.

Changes to prescription drug costs

There are two payment stages for your Medicare Part D prescription drug coverage under Anthem Blue Cross Cal MediConnect Plan. How much you pay depends on which stage you are in when you get a prescription filled or refilled. These are the two stages:

Stage 1 Initial Coverage Stage	Stage 2 Catastrophic Coverage Stage
During this stage, the plan pays part of the costs of your drugs, and you pay your share. Your share is called the copay. You begin this stage when you fill your first prescription of the year.	During this stage, the plan pays all of the costs of your drugs through December 31, 2019. You begin this stage when you have paid a certain amount of out-of-pocket costs.

The Initial Coverage Stage ends when your total out-of-pocket costs for prescription drugs reaches **$5,100**. At that point, the Catastrophic Coverage Stage begins. The plan covers all your drug costs from then until the end of the year. See Chapter 6 of your *Member Handbook* for more information on how much you will pay for prescription drugs.

D3. Stage 1: "Initial Coverage Stage"

During the Initial Coverage Stage, the plan pays a share of the cost of your covered prescription drugs, and you pay your share. Your share is called the copay. The copay depends on what cost-sharing tier the drug is in and where you get it. You will pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you will pay the lower price.

We moved some of the drugs on the Drug List to a lower or higher drug tier. If your drugs move from tier to tier, this could affect your copay. To see if your drugs will be in a different tier, look them up in the Drug List.

The following table shows your costs for drugs in each of our four (4) drug tiers. These amounts apply **only** during the time when you are in the Initial Coverage Stage.

	2018 (this year)	2019 (next year)
Drugs in Tier 1 (Medicare Part D preferred generic and brand-name) Cost for a one-month supply of a drug in Tier 1 that is filled at a network pharmacy	Your copay for a one-month (31-day) supply is **$0 per prescription**.	Your copay for a one-month (31-day) supply is **$0 per prescription**.
Drugs in Tier 2 (Part D preferred and non-preferred brand and generic) Cost for a one-month supply of a drug in Tier 2 that is filled at a network pharmacy	Your copay for a one-month (31-day) supply is **$0-$8.35 per prescription**.	Your copay for a one-month (31-day) supply is **$0-$8.50 per prescription**.
Drugs in Tier 3 (Non-Medicare Medi-Cal – State approved prescription generic and brand name drugs) Cost for a one-month supply of a drug in Tier 3 that is filled at a network pharmacy	Your copay for a one-month (31-day) supply is **$0 per prescription**.	Your copay for a one-month (31-day) supply is **$0 per prescription**.
Drugs in Tier 4 (Non-Medicare Medi-Cal approved over-the-counter (OTC) drugs that require a prescription from your provider) Cost for a one-month supply of a drug in Tier 4 that is filled at a network pharmacy	Your copay for a one-month (31-day) supply is **$0 per prescription**.	Your copay for a one-month (31-day) supply is **$0 per prescription**.

The Initial Coverage Stage ends when your total out-of-pocket costs reach **$5,100.** At that point the Catastrophic Coverage Stage begins. The plan covers all your drug costs from then until the end of the year. See Chapter 6 of your *Member Handbook* for more information on how much you will pay for prescription drugs.

D4. Stage 2: "Catastrophic Coverage Stage"

When you reach the out-of-pocket limit of **$5,100** for your prescription drugs, the Catastrophic Coverage Stage begins. You will stay in the Catastrophic Coverage Stage until the end of the calendar year.

The following table shows your costs for drugs in each of our four (4) drug tiers.

	2018 (this year)	2019 (next year)
Drugs in Tier 1 (Medicare Part D preferred generic and brand-name) Cost for a one-month supply of a drug in Tier 1 that is filled at a network pharmacy	Your copay for a one-month (31-day) supply is **$0 per prescription**.	Your copay for a one-month (31-day) supply is **$0 per prescription**.
Drugs in Tier 2 (Medicare Part D preferred and non-preferred brand and generic) Cost for a one-month supply of a drug in Tier 2 that is filled at a network pharmacy	Your copay for a one-month (31-day) supply is **$0 per prescription**.	Your copay for a one-month (31-day) supply is **$0 per prescription**.
Drugs in Tier 3 (Non-Medicare Medi-Cal - State approved drugs) Cost for a one-month supply of a drug in Tier 3 that is filled at a network pharmacy	Your copay for a one-month (31-day) supply is **$0 per prescription**.	Your copay for a one-month (31-day) supply is **$0 per prescription**.
Drugs in Tier 4 (Non-Medicare Over-the-counter (OTC) drugs. Covered OTC drugs require a prescription from your provider) Cost for a one-month supply of a drug in Tier 4 that is filled at a network pharmacy	Your copay for a one-month (31-day) supply is **$0 per prescription**.	Your copay for a one-month (31-day) supply is **$0 per prescription**.

E. Administrative changes

	2018 (this year)	2019 (next year)
Barium Enemas	Prior authorization is not required.	Prior authorization is required.
Durable Medical Equipment (DME)	There are preferred vendors/ manufacturers for DME. A separate insert listing these vendors is provided with your *Member Handbook*.	There are **not** preferred vendors/manufacturers for DME. See your provider directory for a list of all DME vendors in our network.
Inpatient Hospital	A referral is not required.	Except in an emergency a referral is required.
Occupational Therapy Services	A referral is not required.	Prior authorization and a referral are required.
Outpatient Observation Services	Prior authorization and a referral are not required.	Prior authorization and a referral are required.
Routine Hearing Exams	A referral is not required.	Prior authorization and a referral are required.
Transportation Service	To schedule a ride call 1-855-608-5172.	To schedule a ride call 1-888-325-1024.
Changing Your PCP	If you request to change your PCP on the 15th of the month or sooner, your change will be effective the first day of the current month. If you request to change your PCP on the 16th of the month or later, your change will be effective the first day of the following month.	If you request to change your PCP you can start seeing your PCP on the first day of the month after your request.

	2018 (this year)	2019 (next year)
Long Term Care Transition	Beneficiaries in Long Term Care that are new to the plan may obtain up to a 93-day temporary supply of a drug that is not on the drug list, or is limited in some way, during the first 90 days of enrollment.	Beneficiaries that are in Long Term Care and that are new to the plan may obtain up to a 31-day temporary supply of a drug that is not on the drug list, or is limited in some way, during the first 90 days of enrollment.
Drug Tier Exceptions	You may request to have the copay of a Tier 2 drug lowered to the Tier 1 copay.	Tier 2 drugs are **not** eligible to be lowered to a Tier 1 copay.

F. How to choose a plan

F1. How to stay in our plan

We hope to keep you as a member next year.

You do not have to do anything to stay in your health plan. If you do not sign up for a different Cal MediConnect plan, change to a Medicare Advantage Plan, or change to Original Medicare, you will automatically stay enrolled as a member of our plan for 2019.

F2. How to change plans

You can end your membership at any time during the year by enrolling in another Medicare Advantage Plan, enrolling in another Cal MediConnect plan, or moving to Original Medicare.

NOTE: Effective January 1, 2019, if you're in a drug management program, you may not be able to change plans. If you are in a drug management program, you may not be able to join a different plan. See Chapter 5 of your Member Handbook for information about drug management programs.

How you will get Medicare services

You will have three options for getting your Medicare services. By choosing one of these options, you will automatically end your membership in our Cal MediConnect plan:

1. You can change to:	**Here is what to do:**
A Medicare health plan, such as a Medicare Advantage plan or, if you meet eligibility requirements, a Program of All-inclusive Care for the Elderly (PACE)	Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048 to enroll in the new Medicare-only health plan. For PACE inquiries, call 1-855-921-PACE (7223). If you need help or more information: • Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit https://www.aging.ca.gov/HICAP/. You will automatically be disenrolled from Anthem Blue Cross Cal MediConnect Plan when your new plan's coverage begins.

2. You can change to:	**Here is what to do:**
Original Medicare with a separate Medicare prescription drug plan	Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit https://www.aging.ca.gov/HICAP/. You will automatically be disenrolled from Anthem Blue Cross Cal MediConnect Plan when your Original Medicare coverage begins.

3. You can change to: **Original Medicare without a separate Medicare prescription drug plan** **NOTE**: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop prescription drug coverage if you get drug coverage from an employer, union or other source. If you have questions about whether you need drug coverage, call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit https://www.aging.ca.gov/HICAP/.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit https://www.aging.ca.gov/HICAP/. You will automatically be disenrolled from Anthem Blue Cross Cal MediConnect Plan when your Original Medicare coverage begins.

How you will get Medi-Cal services

If you leave our Cal MediConnect plan, you will continue to get your Medi-Cal services through Anthem Blue Cross unless you select a different plan for your Medi-Cal services. Your Medi-Cal services include most long-term services and supports and behavioral health care.

If you want to choose a different plan for your Medi-Cal services, you need to tell Health Care Options. You can call Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 am to 6:00 pm. TTY users should call 1-800-430-7077.

G. How to get help

G1. Getting help from Anthem Blue Cross Cal MediConnect Plan

Questions? We're here to help. Please call Member Services at 1-855-817-5785 (TTY only, call 711). We are available for phone calls Monday through Friday from 8 a.m. to 8 p.m. Calls to these numbers are free.

Your *2019 Member Handbook*

The *2019 Member Handbook* is the legal, detailed description of your plan benefits. It has details about next year's benefits and costs. It explains your rights and the rules you need to follow to get covered services and prescription drugs.

The *2019 Member Handbook* will be available by October 15. An up-to-date copy of the *2019 Member Handbook* is always available on our website at duals.anthem.com. You may also call Member Services at 1-855-817-5785 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. to ask us to mail you a *2019 Member Handbook*.

Our website

You can also visit our website at duals.anthem.com. As a reminder, our website has the most up-to-date information about our provider and pharmacy network (*Provider and Pharmacy Directory*) and our Drug List (*List of Covered Drugs*).

G2. Getting help from the state enrollment broker

You can call Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 am to 6:00 pm. TTY users should call 1-800-430-7077.

G3. Getting help from the Cal MediConnect Ombuds Program

The Cal MediConnect Ombuds Program can help you if you are having a problem with Anthem Blue Cross Cal MediConnect Plan. The ombudsman’s services are free. The Cal MediConnect Ombuds Program:

- Works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do.
- Makes sure you have information related to your rights and protections and how you can get your concerns resolved.
- Is not connected with us or with any insurance company or health plan. The phone number for the Cal MediConnect Ombuds Program is 1-855-501-3077.

G4. Getting help from the Health Insurance Counseling and Advocacy Program

You can also call the State Health Insurance Assistance Program (SHIP). In California, the SHIP is called Health Insurance Counseling and Advocacy Program (HICAP). HICAP counselors can help you understand your Cal MediConnect plan choices and answer questions about switching plans. HICAP is not connected with us or with any insurance company or health plan. HICAP has trained counselors in every county, and services are free. HICAP’s phone number is 1-800-434-0222. For more information or to find a local HICAP office in your area, please visit https://www.aging.ca.gov/HICAP/.

G5. Getting help from Medicare

To get information directly from Medicare, 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's Website

You can visit the Medicare website (https://www.medicare.gov/). If you choose to disenroll from your Cal MediConnect plan and enroll in a Medicare Advantage plan, the Medicare website has information about costs, coverage, and quality ratings to help you compare Medicare Advantage plans. You can find information about Medicare Advantage plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to https://www.medicare.gov/ and click on "Find health & drug plans.")

Medicare & You 2019

You can read the *Medicare & You 2019* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (https://www.medicare.gov/) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

G6. Getting help from the California Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-855-817-5785 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you.

If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance.

You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

The Department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

Have questions?

Call us toll free at 1-855-817-5785 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. or visit duals.anthem.com.

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