Summary of Benefits

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Medicare Advantage and Part D

Plan year: January 1 – December 31, 2025

New York

Bronx, Kings, Nassau, New York, Orange, Queens, Richmond, Rockland, Suffolk, Westchester counties

Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP)*

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Introduction

This document is a brief summary of the benefits and services covered by Anthem HealthPlus Full Dual Advantage (LTSS) Long-Term Services and Supports (HMO D-SNP) Dual Special Needs Plan. It includes answers to frequently asked questions, important contact information, an overview of benefits and services offered, and information about your rights as a member of Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP). Key terms and their definitions appear in alphabetical order in the last chapter of the *Evidence of Coverage.*

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A. Disclaimers

This is a summary of health services covered by Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) for January 1 – December 31, 2025. This is only a summary. Read the *Evidence of Coverage* for the full list of benefits. You may contact Member Services at the phone number listed below to request your *Evidence of Coverage*. You can also access your *Evidence of Coverage* at the plan's website listed on the bottom of this page.

- Anthem Blue Cross and Blue Shield is an HMO D-SNP plan with a Medicare contract and either a contract or a coordination of benefits agreement with the New York State Department of Health. Enrollment in Anthem Blue Cross and Blue Shield depends on contract renewal. Anthem Blue Cross and Blue Shield is an HMO D-SNP plan with a Medicare contract and either a contract or a coordination of benefits agreement with the New York State Department of Health. Enrollment in Anthem Blue Cross and Blue Shield depends on contract renewal. Services provided by Anthem HP, LLC licensee of the Blue Cross Blue Shield Association, an association of independent Blue Cross Blue Shield plans. Anthem is a registered trademark of Anthem Insurance Companies, Inc.
- You can get this document for free in other formats, such as large print, braille, or audio.Call **1-877-269-5706** (TTY: **711**), 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free.
- If you call us to request a change to your preferred language or format preference, let us know if you want this to be a standing order. That means we will send the same documents in your requested format and language every year. You can also call us to change or cancel a standing order. You can also find your documents online at **https://shop.anthem.com/medicare**.

- ☐ Contact Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) at the phone number listed at the bottom of this page if there are any changes in your personal information, such as your address or phone number.
- ☐ This document is available for free in Chinese and Spanish.
- ☐ For more information about **Medicare**, you can read the *Medicare & You* 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 access it online at the Medicare website (www.medicare.gov) or request a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- ☐ Members may receive an allowance in the form of a Benefits Prepaid Card to pay for a wide range of approved items like groceries and utilities. Unused amounts do not roll over to the next benefit period (month or quarter) or next plan year. Benefits vary by plan.

B. Frequently asked questions

The following table lists frequently asked questions.

Frequently Asked Questions (FAQs)	Answers
What is a Medicaid Advantage Plus (MAP/ HMO) + Dual Eligible Special Needs Plan (D-SNP) plan?	Our MAP plan is a Health Maintenance Organization (HMO) aligned with a Dual Eligible (Medicaid and Medicare) Special Needs Plan (D-SNP). Our plan combines your Medicaid home care and long-term care services and your Medicare services. It combines your doctors, hospital, pharmacies, home care, nursing home care, behavioral health care (mental health and substance use/addiction services), and other health care providers into one coordinated health care system. It also has care coordinators to help you manage all of your providers and services. They all work together to provide the care you need. Our MAP plan is called Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP).
Will I get the same Medicare and Medicaid benefits in Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) that I get now?	If you are coming to Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) from Original Medicare or another Medicare plan, you may get benefits or services differently. You will get almost all of your covered Medicare and Medicaid benefits directly from Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP). When you enroll in Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) you and your Care Team will work together to develop an individualized Plan of Care to address your health and support needs, reflecting your personal preferences and goals. If you are taking any Medicare Part D prescription drugs that Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) does not normally cover, you can get a temporary supply and we will help you to transition to another drug or get an exception for Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) to cover your drug if medically necessary. For more information, call Member Services at the numbers listed at the bottom of this page.

Frequently Asked Questions (FAQs)	Answers
Can I use the same health care providers I use now?	That is often the case. If your providers (including doctors, therapists, pharmacies, and other health care providers) work with Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) and have a contract with us, you can keep using them. ☐ Providers with an agreement with us are "in-network." **You must use the providers in Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP)'s network.** ☐ If you need urgent or emergency care or behavioral health crisis servicesor out-of-area dialysis services, you can use providers outside of Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP)'s network. To find out if your providers are in the plan's network, call Member Services at the number at the bottom of this page or read Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP)'s *Provider and Pharmacy Directory*. You can also visit our website at **https://shop.anthem.com/medicare** for the most current listing. If Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) is new for you, we will work with you to develop an Individualized Plan of Care (ICP) to address your needs. You can keep using the providers you use now for 90 days or until your ICP is completed. Further, members who enroll on or after January 1, 2025, can continue to use their same behavioral health providers for up to 24 months as part of a continuous episode of care. "Continuous Behavioral Health Episode of Care" means a course of ambulatory behavioral health treatment, other than ambulatory detoxification and withdrawal services, which began prior to the effective date of the behavioral health benefit inclusion into MAP in the geographic service area in which services had been provided to an enrollee at least twice during the six months preceding January 1, 2025 by the same provider for the treatment of the same or related behavioral health condition.

Frequently Asked Questions (FAQs)	Answers
What is a Care Manager?	A Care Manager is your main contact person at our plan. This person helps to manage all of your providers and services and make sure you get what you need. Members may have a Care Manager who works for the Plan as well as a specialized Health Home/Health Home Plus Care Manager (refer to section E. *Benefits covered outside of Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP)*.
What are Managed Long Term Care Services and Support (MLTSS)?	Managed Long Term Services and Support (MLTSS) are help for people who need assistance to do everyday tasks like taking a bath, getting dressed, making food, and taking medicine. Often these services are provided at your home or in your community but they could also be provided in a nursing home or hospital when necessary. MLTSS is available to members who meet certain clinical and financial requirements.
What happens if I need a service but no one in Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP)'s network can provide it?	Most services will be provided by our network providers. If you need a service that cannot be provided within our network, such as due to shortage of staff with necessary expertise and/or availability to provide services, Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) will cover services provided by an out-of-network provider.
Where is Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) available?	The service area for this plan includes: Bronx, Kings, Nassau, New York, Orange, Queens, Richmond, Rockland, Suffolk, Westchester counties, New York. You must live in one of these areas to join the plan.

Frequently Asked Questions (FAQs)	Answers
What is prior authorization?	Prior authorization means that you must get approval from Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) before Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) will cover a specific service, item, or drug or out-of-network provider. Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) may not cover the service, item or drug if you don't get prior approval. If you need urgent or emergency care or behavioral health crisis services or out-of-area dialysis services, you don't need to get approval first. Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) can provide you with a list of services or procedures that require you to get prior authorization from Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) before the service is provided. Refer to **Chapter 3** of the *Evidence of Coverage* to learn more about prior authorization. Refer to the Benefits Chart in **Chapter 4** of the *Evidence of Coverage* to learn which services require a prior authorization. If you have questions about whether prior authorization is required for specific services, procedures, items, or drugs, call Member Services at the number listed at the bottom of this page for help.
What is a referral?	A referral means that your Primary Care Provider (PCP) must give you written approval before you can use specialists or other providers in the plan's network. This can be done electronically however if you don't get approval , Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) can provide you with a list of services that require you to get a referral from your PCP before the service is provided. For more information on when a referral is needed, call Member Services at the toll-free number below or refer to Chapter 3, Section 2.2, of the *Evidence of Coverage*.

Frequently Asked Questions (FAQs)	Answers
Do I pay a monthly amount (also called a premium) under Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP)?	No. Because you have Medical Assistance (Medicaid), you will not pay any monthly premiums for your health coverage. However, you must continue to pay your Medicare Part B premium unless your Part B premium is paid for you by Medical Assistance (Medicaid) or another third party.
Do I pay a deductible as a member of Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP)?	No. You do not pay deductibles in Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP).
What is the maximum out-of-pocket amount that I will pay for medical services as a member of Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP)?	There is no cost sharing (copays or deductibles) for medical services in Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP), so your annual out-of-pocket costs will be $0.

C. Overview of services

The following table is a quick overview of what services you may need and rules about the benefits.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need hospital care	Inpatient hospital care	**$0**	Your provider must get an approval from the plan before you are admitted to a hospital for a procedure, rehabilitation or transplant that you and your doctor

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
			planned ahead. This is called getting prior authorization. You do not need approval for emergency or urgently needed services. Except in an emergency, your health care provider must tell the plan of your hospital admission.
	Outpatient hospital services (including outpatient treatment by a doctor or a surgeon)	**$0**	
	Ambulatory surgical center (ASC) services	**$0**	
You want to use an outpatient health care provider	Doctor visits (including visits to Primary Care Providers and specialists)	**$0**	Prior authorization and referral may be required.
	Visits to treat an injury or illness	**$0**	Prior authorization and referral may be required.
	Preventive care (care to keep you from getting sick, such as flu shots and other immunizations)	**$0**	Influenza, Hepatitis B, pneumococcal vaccinations, and other vaccinations recommended for adults are covered. The full childhood immunization schedule is covered for members under the age of 21.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
	Wellness visits, such as a physical	**$0**	
	"Welcome to Medicare" preventive visit (one time only)	**$0**	
You need emergency care	Emergency room services, including mental health emergencies at Comprehensive Psychiatric Emergency Programs (CPEPs)	**$0**	You may use any emergency room or CPEP if you reasonably believe you need emergency care. You do not need prior authorization and you do not have to be in-network. Emergency room services are NOT covered outside of the U.S. and its territories except under limited circumstances. In addition to the Medicare-covered emergency room services, this plan offers worldwide emergency care services when traveling outside of the United States and its territories for less than six months. Coverage is limited to **$100,000** per year for worldwide emergency services and urgent care. Contact the plan for details.
	Urgent care	**$0**	Urgent care is not emergency care. You do not need prior authorization and you do not have to be in-network. Urgent care is NOT covered outside the U.S. and its territories except under limited circumstances. Contract the plan for details.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
			In addition to the Medicare-covered urgent care services, this plan offers urgently needed services when traveling outside of the United States and its territories for less than six months. Coverage is limited to **$100,000** per year for worldwide emergency services and urgent care. Contact the plan for details.
You need medical tests	Lab tests, such as blood work	**$0**	Prior authorization and referral may be required.
	X-rays or other pictures, such as CAT scans	**$0**	Your provider must refer you and get an approval from the plan before you get high-tech imaging or certain diagnostic and therapeutic radiology and lab services
	Screenings, such as tests to check for cancer	**$0**	
You need hearing/ auditory services	Hearing screenings (including routine hearing exams)	**$0**	This plan offers Medicare-covered hearing evaluations to determine if you need medical treatment for a hearing condition. In addition to the Medicare-covered hearing evaluations, this plan offers one (1) supplemental routine hearing exam. Prior authorization and referral may be required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
			Additional services may be covered in accordance with your Medicaid benefits and guidelines.
	Hearing aids (as well as fittings and associated accessories and supplies)	**$0**	In addition to the Medicare-covered hearing evaluations, this plan offers up to **$4,000** toward the purchase of one pair of supplemental prescribed hearing aid(s) or up to **$300** towards the purchase of one pair of over-the-counter hearing aid(s) and one (1) supplemental hearing aid fitting/ evaluation every year. Prior authorization and referral may be required. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
You need dental care	Dental services (including, but not limited to, routine exams and cleanings, X-rays, fillings, crowns, extractions, dentures, and endodontic and periodontal care)	**$0**	In addition to the Medicare covered dental services, this plan covers 2 periodic oral exams every 6 months, 1 cleaning every 6 months, and certain dental x-rays up to the plan's limitations. This plan covers comprehensive dental including Restorative Services, Crown Services, Endodontics, Periodontics, Implants, and other comprehensive dental services up to the plan's limitations. Please reference the Dental Services section of your *Evidence of Coverage* for additional benefit information, limitations, and exclusions.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
			Many dental services require prior authorization. Please note that dental crown and implant services require prior authorization. Please refer to the *Evidence of Coverage* for a full list of the dental benefits, limitations, and exclusions.
You need eye care	Vision services (including annual eye exams)	**$0**	This plan offers Medicare-covered exam to treat an eye condition. In addition to the Medicare-covered eye exam, this plan offers one (1) routine eye exam every calendar year. Prior authorization may be required. Additional services may be covered in accordance with your Medicaid benefits and guidelines.
	Glasses or contact lenses	**$0**	In addition to Medicare-covered eye wear, this plan covers up to **$350** for supplemental eyeglasses or contact lenses every year.
	Other vision care (including diagnosis and treatment for diseases and conditions of the eye)	**$0**	
You have a mental	Inpatient mental health care (long-term mental health	**$0**	All members are covered by the plan for acute inpatient hospitalization in

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
health condition	services, including inpatient services in a psychiatric hospital, general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF), State Operated Addiction Treatment Center's (ATC), Inpatient addition rehabilitation, Inpatient Medically Supervised Detox, or critical access hospital)		a general hospital, regardless of the admitting diagnosis or treatment. Except in an emergency, your health care provider must tell the plan of your hospital admission.
	Adult outpatient mental health care Continuing Day Treatment (CDT) Partial hospitalization Adult outpatient rehabilitative mental health care Assertive Community Treatment (ACT) Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS)	**$0**	

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
	Personalized Recovery Oriented Services (PROS) Adult outpatient rehabilitative mental health and addiction services for members who meet clinical requirements These are also known as Community Oriented Recovery and Empowerment (CORE) services. CORE services: Psychosocial Rehabilitation (PSR) Community Psychiatric Supports and Treatment (CPST) Empowerment services – peer supports Family Support and Training (FST) Adult mental health crisis services Comprehensive Psychiatric Emergency Program (CPEP) Mobile Crisis and Telephonic Crisis Services		

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
	Crisis Residential Programs		
	Outpatient mental health care (including, but not limited to, clinical counseling and therapy, peer support, psychosocial rehabilitation, medication management, family psychoeducation, and intensive outpatient models of care) (**Note**: This is not a complete list of the plan's expanded outpatient mental health services. Call Member Services at the number listed at the bottom of this page or read the *Evidence of Coverage*, Chapter 4, for more information.)	**$0**	Services may be provided by any OMH licensed, designated, or approved provider agency, or a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, Independent Practitioner Network (IPN) Psychiatrist, Psychologist or Advanced Practice Nurse (APN), or other qualified mental health care professional as allowed under applicable state laws. A member may self-refer for one assessment from a network provider in a twelve (12) month period. Prior authorization and referral may be required.
You are having a mental health or	Mobile Crisis services (assessment by telephone or	**$0**	Any approved mobile crisis or licensed crisis residence provider in New York State

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
substance use crisis	mobile crisis team response); short-term residential crisis stabilization (for mental health crises)		
You have a mental health condition or a substance use disorder	CORE Services (which are person-centered, recovery-oriented mobile behavioral health supports. CORE Services build skills and self-efficacy that promote and facilitate community participation and independence). (**Note**: For more information about CORE Services and to determine whether you are eligible for them, call Member Services at the numbers at the bottom of this page or read the *Evidence of Coverage*.)	**$0**	CORE services are available to members who meet certain clinical requirements. Anyone can refer or self-refer to CORE Services.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a substance use disorder	Inpatient and outpatient substance use disorder treatment services (including, but not limited to, detoxification and withdrawal management, short-term residential services, residential treatment center services, and methadone Medication Assisted Treatment) (**Note:** This is not a complete list of the plan's expanded substance use disorder services. Call Member Services at the number listed at the bottom of this page or read the *Evidence of Coverage,* Chapter 4, for more information.)	**$0**	Your provider must refer you and get an approval from the plan before you are admitted to a hospital for a mental condition, drug or alcohol abuse or rehab. A member may self-refer for one assessment from a network provider in a twelve (12) month period.
You need a place to live with people available to help you	Skilled nursing care	**$0**	Your provider must get an approval from the plan before you get skilled nursing facility care.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
	Nursing home	**$0**	
	Custodial care (long-term care in a Nursing Facility)	**$0**	Services are covered for those who meet nursing facility level of care and whose rehabilitation goals have been met or discontinued with no plan to discharge to the community within 180 days of admission.
You need therapy after a stroke or accident	Occupational, physical, or speech therapy (outpatient or in-home)	**$0**	In addition to Medicare coverage, the plan provides 40 outpatient physical therapy visits, occupational and speech therapy limited to 20 visits each per calendar year. Limits do not apply to Enrollees under age 21, Enrollees who are developmentally disabled, and Enrollees with traumatic brain injury. You may need a referral and an approval from the plan before you get physical therapy, occupational therapy and speech/language therapy.
You need help getting to health services	Emergency transportation	**$0**	
You need drugs to treat your illness or condition	Medicare Part B prescription drugs (including those given by your provider in their office, some oral	**$0**	Your plan currently may require step therapy for any Part B drugs. Step Therapy is a utilization tool that requires you to first try another drug to treat your medical condition

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
	anti-cancer drugs, and some drugs used with certain medical equipment)		before we will cover the drug your doctor may have initially prescribed. You may also be required to try a Part B drug before using a Part D drug and in some cases you may be required to try a Part D drug before getting a Part B drug. You can contact Member Services for more information. Read the *Evidence of Coverage*, Chapter 4, Section 2, for more information on these drugs.
	Medicare Part D prescription drugs Generic and/or Brand name drugs	**$0** for a 30-day supply.	There may be limitations on the types of drugs covered. Refer to Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP)'s list of covered drugs (formulary) at the website listed at the bottom of the page for more information. Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) for certain drugs.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
			You must use certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These specialty drugs are listed on the plan's website, list of covered drugs (formulary), and printed materials, as well as on the Medicare Prescription Drug Plan Finder on www.medicare.gov/plan-compare.
	Over-the-counter (OTC) drugs	**$0**	There may be limitations on the types of drugs covered. Please refer to Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP)'s *Formulary* for more information.
You need foot care	Podiatry services (including routine exams)	**$0**	In addition to the Medicare-covered podiatry services, this plan offers six (6) routine foot care visits each year. Prior authorization and referral may be required.
	Orthotic services	**$0**	
You need durable medical equipment (DME) or supplies	Wheelchairs, nebulizers, crutches, rollabout knee walkers, walkers, and oxygen equipment and supplies, for example	**$0**	Therapeutic Continuous Glucose Monitors (CGMs) and related supplies are covered by Medicare when they meet Medicare National Coverage Determination (NCD) and Local Coverage Determinations (LCD) criteria. In addition, where there is not NCD/ LCD criteria, therapeutic CGM must meet any plan benefit

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
	(**Note:** This is not a complete list of covered DME or supplies. Call Member Services at the number at the bottom of this page or read the *Evidence of Coverage* for more information.)		limits, and the plan's evidence based clinical practice guidelines. This plan only covers FreeStyle Libre Continuous Glucose Monitors (CGMs). We will not cover other brands unless your provider tells us it is medically necessary. CGMs MUST be purchased at a network retail or our mail-order pharmacy to be covered. If you purchase these supplies through a Durable Medical Equipment (DME) provider these items will not be covered. Coverage limitations: ☐ 2 Sensors per month ☐ One receiver every 2 years Insulin pumps are different than a CGM and can be purchased through a DME provider. This plan covers only DUROLANE, EUFLEXXA, SUPARTZ, and Gel-SYN-3 Hyaluronic Acids. We will not cover other brands unless your provider tells us it is medically necessary. Prior authorization may be required.
You need interpreter services	Spoken language interpreter	**$0**	
	Sign language interpreter	**$0**	

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Other covered services	Acupuncture	**$0**	This plan offers twelve (12) acupuncture visits each year to treat lower back pain not related to a systemic cause, pregnancy, or surgery. In addition to the Medicare-covered acupuncture visits, this plan offers up to twenty-four (24) supplemental acupuncture visits as an alternative to treat illness or to numb pain. Prior authorization may be required.
	Plan Care coordination	**$0**	
	Chiropractic services	**$0**	This plan offers Medicare-covered visits for manual manipulation of the spine to correct subluxation. In addition to the Medicare-covered chiropractic visits, this plan offers up to twelve (12) supplemental routine chiropractic visits. Prior authorization and referral may be required.
	Diabetic supplies	**$0**	This plan covers only OneTouch® (made by LifeScan, Inc.) and ACCU-CHECK® (made by Roche Diagnostics) blood glucose test strips and glucometers. We will not cover other brands unless your provider tells us it is medically

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
			necessary. Blood glucose test strips and glucometers MUST be purchased at a network retail or our mail-order pharmacy to be covered. If you purchase these supplies through a Durable Medical Equipment (DME) provider these items will NOT be paid for. Lancets are limited to the following manufacturers: LifeScan / Delica, Roche, Kroger and its affiliates which include Fred Meyer, King Soopers, City Market, Fry's Food Stores, Smith's Food and Drug Centers, Dillon Companies, Ralphs, Quality Food Centers, Baker, Scott's, Owen, Payless, Gerbes, Jay-C, Prodigy, and Good Neighbor.
	Early and Periodic Screening Diagnosis and Treatment (EPSDT) (including preventive screenings, medical examinations, vision and hearing screenings and services, immunizations, lead screening, and private duty nursing services)	**$0**	EPSDT is for members under 21 years of age.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
	Family planning	**$0**	Family planning services furnished by out-of-network providers are covered directly by Medicaid fee-for-service. Services primarily related to the diagnosis and treatment of infertility are not covered.
	Hospice care	**$0**	
	Mammograms	**$0**	
	Managed Long Term Services and Supports (MLTSS) (including, but not limited to, assisted living services; cognitive, speech, occupational, and physical therapy; chore services; home-delivered meals; residential modifications (such as the installation of ramps or grab bars); social adult day care)	**$0**	MLTSS provides services for members that need the level of care typically provided in a Nursing Facility, and allows them to get necessary care in a residential or community setting. MLTSS is available to all members; specific service authorization, including amount, is indicated in the member's individualized approved Plan of Care.
	Medical day care (including preventive, diagnostic, therapeutic, and rehabilitative	**$0**	Medical day care is provided to meet the needs of individuals with physical and/or cognitive impairments in order to support their community living.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
	services under medical and nursing supervision in an ambulatory care setting)		
	Personal Care Assistance (PCA) (assistance with daily activities such as bathing, dressing, using the bathroom, shopping, cooking, including health-related tasks performed by a qualified individual in a member's home, under the supervision of a registered professional nurse, as certified by a physician in accordance with a member's written plan of care)	**$0**	
	Prosthetic services	**$0**	Prior authorization required.
	Services to help manage your disease	**$0**	

The above summary of benefits is provided for informational purposes only. For more information about your benefits, you can read Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP)'s Evidence of Coverage. If you have questions, you can also call Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) Member Services at the number at the bottom of this page.

D. Additional services and programs Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) covers

This is not a complete list. Call Member Services at the number at the bottom of this page or read the *Evidence of Coverage* to find out about other covered services.

Additional services Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) covers	Your costs
24/7 NurseLine 24-hour access to a nurse helpline, 7 days a week, 365 days a year: **1-855-658-9249**.	**$0**
Advance Directives Program As a member of our plan, you will have access to an online advance care planning resource to create an advance directive where you can combine the elements of a: ☐ Living will. ☐ Medical power of attorney. ☐ Do not attempt resuscitation form. ☐ Organ donation form. You can create your own digital care plan and even include video and audio files. If you already have these documents prepared, you can store them and ensure they are shared with your doctors and care providers 24 hours a day, seven days a week. You can add new information at any time as your health status or wishes change.	**$0**
Dental In addition to the Medicare covered dental services, this plan covers 2 periodic oral exams every 6 months, 1 cleaning every 6 months, and certain dental x-rays up to the plan's limitations. This plan covers comprehensive dental including Restorative Services, Crown Services, Endodontics, Periodontics, Implants, and other comprehensive dental services up to the plan's limitations. Please reference the Dental Services section of your *Evidence of Coverage* for additional benefit information, limitations, and exclusions.	**$0**

Additional services Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) covers	Your costs
Many dental services require prior authorization. Please note that dental crown and implant services require prior authorization. Please refer to the *Evidence of Coverage* for a full list of the dental benefits, limitations, and exclusions.	
Everyday Options Allowance This benefit provides a monthly combined spending allowance of **$260 each month** on a Benefits Mastercard® Prepaid Card for assistive devices, eligible food items, over-the-counter (OTC) health and wellness products, and utilities. You have a variety of convenient ways to use the benefit: ☐ Shop in-store at participating retailers near you (Groceries and OTC only). ☐ Shop online on the approved vendor website. ☐ Shop on the approved vendor mobile app. ☐ Call to place an order. ☐ Order by mail (OTC and Assistive Devices only). ☐ With your utility provider. Unused amounts expire at the end of each month.	**$0**
LiveHealth Online Lets you talk to a board-certified doctor, or licensed psychiatrist, psychologist or therapist, by live, two-way video on a computer, smartphone or tablet. LiveHealth Online is offered through an arrangement with Amwell, a separate company, providing telehealth services on behalf of your health plan.	**$0**

Additional services Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) covers	Your costs
Medicare Community Resource Support We assist you right over the phone by providing you with health-related information and by connecting you to local community-based services and support programs. We'll help you coordinate these services based on your unique needs. Call us at the number listed on your plan ID card and ask for the Medicare Community Resource Support team for more details.	**$0**
SilverSneakers*® Fitness program When you become our member, you can sign up for SilverSneakers. It's included in our plan. To learn more details, go to **www.silversneakers.com** or call SilverSneakers at 1-855-741-4985 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. ET. * SilverSneakers is a registered trademark of Tivity Health, Inc. © 2024 Tivity Health, Inc. All rights reserved. Tivity Health, Inc. is an independent company providing a fitness program on behalf of this plan.	**$0**
Transportation This plan offers up to forty-eight (48), one-way, routine supplemental transportation services every year. Trips are limited to 60 miles. To schedule transportation, call Modivcare at **1-866-481-9488**. You can also ask your PCP or Care Manager to help you to arrange this service. Additional services may be covered in accordance with your Medicaid benefits and guidelines.	**$0**

E. Benefits covered outside of Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP)

This is not a complete list. Call the Member Services number at the bottom of this page to find out about other services not covered by Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) but available through Medicaid fee-for-service.

Other services covered directly by Medicaid fee-for-service	Your costs
CSS (Community Support Services)	**$0**
Health Home (HH) and Health Home Plus (HH+) Care Management services	**$0**
Certified Community Behavioral Health Clinics (CCBHC)	**$0**
Crisis Intervention Services for Youth ages 18-20	**$0**

F. Services that Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP), Medicare, and Medicaid do not cover .

The following services are not covered by our plan. This is not a complete list. Call Member Services at the number listed at the bottom of this page to find out about other excluded services.

Services that Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP), Medicare, and Medicaid do not cover
Personal and comfort items
Cosmetic surgery if not medically necessary
Services of a provider that is not part of the plan, unless the plan sends you to that provider
Services not considered "reasonable and necessary" according to standards of Medicare and New York State Department of Health
Experimental medical and surgical treatments, items, or drugs unless covered by Medicare or under a Medicare-approved clinical study
Surgical treatment for morbid obesity except when medically necessary
Elective or voluntary enhancement procedures
LASIK surgery

G. Your rights and responsibilities as a member of the plan

As a member of Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP), you have certain rights concerning your health care. You also have certain responsibilities to the health care providers who are taking care of you. Regardless of your health condition, you cannot be refused medically necessary treatment. You can use these rights without losing your health care services. We will tell you about your rights at least once a year. For more information on your rights, read the *Evidence of Coverage.*

Your rights include, but are not limited to, the following:

- **You have a right to respect, fairness, and dignity.** This includes the right to:
    - Get covered services without concern about race, ethnicity, national origin, color, religion, creed, sex (including sex stereotypes and gender identity), age, health status, mental, physical, or sensory disability, sexual orientation, genetic information, ability to pay, or ability to speak English. No health care provider should engage in any practice, with respect to any member that constitutes unlawful discrimination under any state or federal law or regulation.
    - Ask for and get information in other formats (for example, large print, braille, audio) free of charge
    - Be free from any form of physical restraint or seclusion
    - Not be billed by network providers
    - Have your questions and concerns answered completely and courteously
    - Apply your rights freely without any negative effect on the way Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) or your provider treats you
- **You have the right to get information about your health care.** This includes information on treatment and your treatment options, regardless of cost or benefit coverage. This information should be in a format and language you can understand. These rights include getting information on:
    - Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP)
    - Description of the services we cover
    - How to get services
    - How much services will cost you
    - Names of health care providers and Care Managers
    - Your rights and responsibilities

- **You have the right to make decisions about your care, including refusing treatment.** This includes the right to:
    - Choose a primary care provider (PCP) and change your PCP at any time during the year. You can call **1-877-269-5706** if you want to change your PCP.
    - Use a women's health care provider without a referral
    - Get your covered services and drugs quickly
    - Know about all treatment options, no matter what they cost or whether they are covered
    - Refuse treatment as far as the law allows, even if your health care provider advises against it
    - Stop taking medicine, even if your health care provider advises against it
    - Ask for a second opinion about any health care that your PCP or your Care Team advises you to have. Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) will pay for the cost of your second opinion visit.
    - Make your health care wishes known in an advance directive
- **You have the right to timely access to care that does not have any communication or physical access barriers.** This includes the right to:
    - Get timely medical care
    - Get in and out of a health care provider's office. This means barrier-free access for people with disabilities, in accordance with the Americans with Disabilities Act.
    - Have interpreters to help with communication with your doctors, other providers, and your health plan. Call **1-877-269-5706** if you need help with this service.
    - Have your *Evidence of Coverage* and any printed materials from Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) translated into your primary language, and/or have these materials read out loud to you if you have trouble seeing or reading. Oral interpretation services will be made available upon request and free of charge.

- Be free of any form of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience, or retaliation

- **You have the right to emergency and urgent care when you need it**. This means you have the right to:
  - Get emergency and urgent care services, 24 hours a day, 7 days a week, without prior approval
  - Use an out-of-network urgent or emergency care provider, when necessary

- **You have a right to confidentiality and privacy.** This includes the right to:
  - Ask for and get a copy of your medical records in a way that you can understand and to ask for your records to be changed or corrected
  - Have your personal health information kept private. No personal health information will be released to anyone without your consent, unless required by law.
  - Have privacy during treatment

- **You have the right to make complaints about your covered services or care.** This includes the right to:
  - Access an easy process to voice your concerns, and to expect follow-up by Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP)
  - File a complaint or grievance against us or our providers. You also have the right to appeal certain decisions made by us or our providers.
  - Ask for a State Appeal (State Fair Hearing)
  - Get a detailed reason why services were denied

For more information about your rights, you can read Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP)'s *Evidence of Coverage*. If you have questions, you can also call Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) Member Services at the number listed at the bottom of this page.

Your responsibilities include, but are not limited to, the following:

- **You have a responsibility to treat others with respect, fairness, and dignity.** You should:
    - Treat your health care providers with dignity and respect
    - Keep appointments, be on time, and call in advance if you're going to be late or have to cancel
- **You have the responsibility to give information about you and your health.** You should:
    - Tell your health care provider your health complaints clearly and provide as much information as possible
    - Tell your health care provider about yourself and your health history
    - Tell your health care provider that you are an Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) member
    - Talk to your PCP, Care Manager, or other appropriate person about using the services of a specialist before you go to a hospital (except in cases of emergency)
    - Tell your PCP, Care Manager, or other appropriate person within 24 hours of any emergency or out-of-network treatment
    - Notify Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) Member Services if there are any changes in your personal information, such as your address or phone number
- **You have the responsibility to make decisions about your care, including refusing treatment.** You should:
    - Learn about your health problems and any recommended treatment, and consider the treatment before it's performed
    - Partner with your Care Team and work out treatment plans and goals together
    - Follow the instructions and plans for care that you and your health care provider have agreed to, and remember that refusing treatment recommended by your health care provider might harm your health

- **You have the responsibility to obtain your services from Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP).** You should:
    - Get all your health care from Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP), except in cases of emergency, urgent care, behavioral health crisis services, out-of-area dialysis services, or family planning services, unless Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) provides a prior authorization for out-of-network care
    - Not allow anyone else to use your Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) Member ID Card to obtain healthcare services
    - Notify Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) when you believe that someone has purposely misused Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) benefits or services

H. How to file a complaint or appeal a denied service

If you have a complaint or think Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) should cover something we denied, call Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) at **1-877-269-5706** (TTY: **711**), 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. You can file a complaint or appeal our decision.

For questions about complaints and appeals, you can read **Chapter 9** of Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP)'s *Evidence of Coverage*. You can also call Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) Member Services at **1-877-269-5706** (TTY: **711**).

I. What to do if you suspect fraud

Most health care professionals and organizations that provide services are honest. Unfortunately, there may be some who are dishonest.

If you think a doctor, hospital or other pharmacy is doing something wrong, contact us.

- Call us at Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) Member Services. The phone number is listed in the footer of each page of this document.
- Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users may call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- Or, call the New York State Medicaid Fraud Hotline 1-877-87 FRAUD.

If you have general questions or questions about our plan, services, service area, billing, Member ID Cards, or need immediate behavioral health services, call Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) Member Services:

CALL: 1-877-269-5706
Calls to this number are free.
8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

Member Services also has free language interpreter services available for people who do not speak English.

TTY: 711

This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.

If you have questions about your health:

- ☐ Call your primary care provider (PCP). Follow your PCP's instructions for getting care when the office is closed.
- ☐ If your PCP's office is closed, you can also call Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP)'s 24/7 NurseLine at **1-855-658-9249** (TTY: **711**). A nurse will listen to your problem and tell you how to get care.
- ☐ Calls to this number are free. 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.
- ☐ Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) also has free language interpreter service available for non-English speakers.
- ☐ TTY: **711.** Calls to this number are free. 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

Form Approved
OMB# 0938-1421

Multi-Language Insert
Multi-Language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at **1-877-269-5706** (TTY: **711**). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al **1-877-269-5706** (TTY: **711**). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险 的任 何疑问。 如果您需要此翻译服务，请致电 **1-877-269-5706** (TTY: **711**)。
我们的中文工作人员很乐意帮 助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有 疑問，為此我們提供免 費的 翻譯服務。 如需翻譯服務， 請致 **1-877-269-5706** (TTY: **711**)。 我們講中文的人員將樂意為您提供幫助。 這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa **1-877-269-5706** (TTY: **711**). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au **1-877-269-5706** (TTY: **711**). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi **1-877-269-5706** (TTY: **711**) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter **1-877-269-5706** (TTY: **711**). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제 공하고 있습니다. 통역 서비스를 이용하려면 전화 **1-877-269-5706** (TTY: **711**) 번으로 문의해 주십시오. 한국 어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону **1-877-269-5706** (TTY: **711**). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم, فوري ليس عليك سوى الاتصال بنا على (TTY: **711**) **1-877-269-5706**.
سيقوم شخص ما يتحدثالعربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें **1-877-269-5706** (TTY: **711**) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero **1-877-269-5706** (TTY: **711**). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número **1-877-269-5706** (TTY: **711**). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan **1-877-269-5706** (TTY: **711**). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer **1-877-269-5706** (TTY: **711**). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関 するご質問にお答えするため に、無料の通訳サービスがあり ますございます。 通訳をご 用命になるには、 **1-877-269-5706** (TTY: **711**) にお電話ください。 日本語を話す人 者 が支援いたします。
これは無料のサービスです。

IMPORTANT INFORMATION:
2024 Medicare Star Ratings

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Anthem BlueCross BlueShield - H8432

For 2024, Anthem BlueCross BlueShield - H8432 received the following Star Ratings from Medicare:

Overall Star Rating: ★★★☆☆

Health Services Rating: ★★★☆☆

Drug Services Rating: ★★★☆☆

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

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

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

Star Ratings are based on factors that include:

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

The number of stars show how well a plan performs.

★★★★★ EXCELLENT

★★★★☆ ABOVE AVERAGE

★★★☆☆ AVERAGE

★★☆☆☆ BELOW AVERAGE

★☆☆☆☆ POOR

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

Get More Information on Star Ratings Online

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

Questions about this plan?

Contact Anthem BlueCross BlueShield 7 days a week from 8 a.m. to 8 p.m., (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30 at 1-844-248-6098 (toll-free) or 711 (TTY). Current members please call 1-844-469-1762 (toll-free) or 711 (TTY).

This plan is available to anyone who has both Medical Assistance from the State and Medicare.

Anthem Blue Cross and Blue Shield is an HMO D-SNP plan with a Medicare contract and either a contract or a coordination of benefits agreement with the New York State Department of Health. Enrollment in Anthem Blue Cross and Blue Shield depends on contract renewal.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-800-809-7328** TTY: **711**, 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **https://shop.anthem.com/medicare** or call **1-800-809-7328** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2026.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.