

Summary of Benefits



Thank you for your interest in our Medicare Advantage plans

Anthem Chronic Care (HMO-POS C-SNP) is a special type of Medicare Advantage plan called a Chronic Condition Special Needs Plan (C-SNP). This C-SNP is designed for people living with diabetes mellitus, a cardiovascular disorder, and/or chronic heart failure. This plan offers extra benefits and services to support you.

Medicare Advantage and Part D

Plan year: January 1 – December 31, 2026

Missouri

St. Louis, St. Louis City counties

Anthem Chronic Care (HMO-POS C-SNP)*

*** This plan uses a focused network of doctors and hospitals.**

Anthem Chronic Care (HMO-POS C-SNP)

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Our service area includes these counties in MO: St. Louis, St. Louis City.

Do you have questions?

You can learn more on our website, **shop.anthem.com/medicare**. Or call us toll-free **1-844-604-0335** (TTY: **711**). Hours of operation: 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 Summary of Benefits does not include every service, limit, or exclusion, but the Evidence of Coverage does. Just give us a call to request a copy.

Anthem Chronic Care (HMO-POS C-SNP) is a Medicare Advantage Special Needs Plan. It includes hospital, medical, and prescription drug benefits. To join this plan, the following must apply to you:

- ☐ You're entitled to Medicare Part A.
- ☐ You're enrolled in Medicare Part B.
- ☐ You're diagnosed with diabetes mellitus, a cardiovascular disorder, and/or chronic heart failure.
- ☐ You live in our service area.

You can use doctors and facilities outside this plan's network for certain services. You can use either network or out-of-network providers for non-Medicare dental services covered by the plan. If you go outside the network, your out-of-pocket cost may be higher.

Anthem Chronic Care (HMO-POS C-SNP)

Medicare coverage that goes beyond Original Medicare

- ❑ Medicare Advantage plans cover everything Original Medicare covers — Part A (hospital services) and Part B (medical services) — plus more.
- ❑ Medicare Advantage Prescription Drug Plans cover Medicare Part D drugs and Part B drugs.

This is a Health Maintenance Organization Point of Service Special Needs Plan (HMO-POS SNP). That means:

- ❑ You will choose a primary care physician (PCP) in the plan's network of doctors for covered services. Your PCP provides most of your medical care, including routine care and hospitalizations. They can help you save time and money by directing you to specialists when needed.
- ❑ Before you visit a specialist, we recommend you talk to your PCP first. They know your health history and can help you find the right care. You can use doctors who aren't in the plan for a limited number of services, but your costs may be higher.

If you choose a PCP that is part of an independent practice/physician association (IPA) or medical group, the specialists, ancillary providers, and hospitals available to you may be limited to only those contracted with the PCP's IPA or medical group.

Is your PCP in our plan's network of doctors?

If you need to change your primary care physician (PCP), give us a call and we'll help. Doctors can join or leave the network at any time, so check if they're in-network with our Find a Doctor tool online. Just follow the steps listed.

How to find a doctor/PCP in our plan:

- ☐ Go to **shop.anthem.com/medicare**
 1. Select **Useful Tools** and choose **Find a Doctor**.
 2. Enter your ZIP code, county, and the date you want your coverage to begin.
 3. Fill in the details (city, doctor's name, distance, etc.).
 4. Be sure to check that the doctor is listed as "In-Network" for this plan.
- ☐ Or you can ask us for the Provider Directory. The phone number is on page 2.



Find a pharmacy

Our plans include the majority of pharmacies in America, so you're likely to find one near you. If your pharmacy is not in this plan, you could end up paying more for your drugs.

To confirm your pharmacy is in the plan (or find a new one), see the Pharmacy Directory on our website at **shop.anthem.com/medicare**. Under **Useful Tools**, choose **Find a Pharmacy** to enter your location and search details. Preferred pharmacies are noted to the right of the pharmacy name. Or you can give us a call and we'll send you the directory.

Our plan offers preferred and standard pharmacies. You may go to either type of pharmacy to fill your covered prescription drugs.

How to check if your prescriptions (or an acceptable alternative) are covered and what they'll cost:



- ☐ Visit **shop.anthem.com/medicare**
 1. Select **Useful Tools** and choose **Find Your Covered Drugs**.
 2. Enter your ZIP code, county, and beginning coverage date.
 3. Enter your drug name, dosage, quantity, and refill frequency, and select **Add Drug** or **Next**.
 4. Select your pharmacy, and then select **View All Plans**.
 5. Choose **Plan Details** and then **Drug Cost** to view the drug's tier, specific cost, and coverage details.
- ☐ You can also call us at the number on page 2 for a copy of the Formulary.

Don't miss out on some Extra Help

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty.

To find out if you qualify for Extra Help, call:

- Our helpful representatives at **1-844-604-0335** (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.
- 1-800-MEDICARE (1-800-633-4227) (TTY: 1-877-486-2048), 24 hours a day/7 days a week.
- The Social Security Administration at 1-800-772-1213 (TTY: 1-800-325-0778) Monday to Friday, 8 a.m. to 7 p.m.
- Your state Medicaid office.

For more information about Medicare, you can read the Medicare & You handbook. If you don't have a copy of this booklet, you can access it online at the Medicare website ([medicare.gov/medicare-and-you](https://www.medicare.gov/medicare-and-you)) 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.

Optional supplemental dental and/or vision benefits

You can add an Optional Supplemental Benefits (OSB) package to the plan for an additional monthly premium. Optional Supplemental Benefits may not be available with every Medicare Advantage plan. See the Optional Supplemental Dental and Vision Plans section of the medical benefits chart for more details.



Summary of 2026 medical benefits

Anthem Chronic Care (HMO-POS C-SNP)

How much is my premium (monthly payment)?

\$0.00 per month

You must continue to pay your Medicare Part B premium.

How much is my deductible?

This plan does not have a medical deductible.

This plan does not have a Part D deductible.

Is there a limit on how much I will pay for my covered medical services? (does not include Part D drugs)

\$3,500.00 per year from doctors and facilities in our plan

Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.

Services you receive from doctors or facilities in our plan go toward your yearly limit. If you reach the limit on out-of-pocket costs, you will not have to pay any out-of-pocket costs for covered Part A and Part B services for the rest of the year.

Anthem Chronic Care (HMO-POS C-SNP)

Inpatient Hospital¹

Facilities in our plan: Days 1-7: **\$295.00** per day, per admission / Days 8-90: **\$0.00** per day, per admission

Our plan covers an unlimited number of days for an inpatient hospital stay.

Per-day cost sharing applies to each new inpatient admission (Note: transfers to an inpatient rehabilitation hospital are considered a new admission and cost sharing per day applies).

Outpatient Hospital^{1,2}

Doctors and facilities in our plan: **\$295.00** copay

What you will pay may depend on the service and where you are treated.

Ambulatory Surgical Center^{1,2}

Doctors and facilities in our plan: **\$245.00** copay

Doctor's Office Visits

Primary care physician (PCP) visit:

PCPs in our plan: **\$0.00** copay

Specialist visit:^{1,2}

Doctors in our plan: **\$0.00** copay - **\$30.00** copay

You pay nothing for Cardiologists or Endocrinologists services. For all other specialists' services, you pay the higher amount shown above.

Anthem Chronic Care (HMO-POS C-SNP)

Preventive Care Screenings and Annual Physical Exams

Preventive care screenings:

Doctors in our plan: **\$0.00** copay

Annual physical exam:

Doctors in our plan: **\$0.00** copay

Anthem Chronic Care (HMO-POS C-SNP)

Preventive Care Screenings and Annual Physical Exams

Covered preventive care screenings:

- ☐ Abdominal aortic aneurysm screening
- ☐ Annual wellness visit
- ☐ Bone mass measurement
- ☐ Breast cancer screening (mammogram)
- ☐ Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)
- ☐ Cardiovascular disease screening tests
- ☐ Cervical and vaginal cancer screening
- ☐ Colorectal cancer screenings
- ☐ Depression screening
- ☐ Diabetes screening
- ☐ Diabetes self-management training, diabetic services, and supplies
- ☐ Health and wellness education programs
- ☐ HIV screening
- ☐ Immunizations
- ☐ Medical nutrition therapy
- ☐ Medicare Diabetes Prevention Program (MDPP)
- ☐ Obesity screening and therapy to promote sustained weight loss
- ☐ Pre-exposure prophylaxis (PrEP) for HIV prevention
- ☐ Prostate cancer screening exams
- ☐ Screening and counseling to reduce alcohol misuse
- ☐ Screening for Hepatitis C Virus infection
- ☐ Screening for lung cancer with low dose computed tomography (LDCT)
- ☐ Screening for sexually transmitted infections (STIs) and counseling to prevent STIs
- ☐ Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)
- ☐ Vision care
- ☐ “Welcome to Medicare” preventive visit (one-time)

Any extra preventive services approved by Medicare during the contract year will be covered. When you use doctors in our plan, **100%** of the cost of preventive care screenings and annual physical exams is covered.

Anthem Chronic Care (HMO-POS C-SNP)

Emergency Care

\$150.00 copay

Emergency and Urgent Care Worldwide Coverage

\$150.00 copay

This plan covers urgent care and emergency services, including emergency transportation, when traveling outside of the United States for less than six months. This benefit is limited to **\$100,000** per year.

Your emergency room copay will be waived if you receive care from a primary care provider, urgent care provider, or LiveHealth Online 24 hours prior to the emergency room visit.

Urgently Needed Services

\$45.00 copay

Anthem Chronic Care (HMO-POS C-SNP)

Diagnostic Services, Labs, and Imaging ^{1,2}	
Diagnostic Radiology Services CT scans, MRI, MRA, PET at a physician's office or free-standing provider facilities in our plan: CT scans, MRI, MRA, PET at hospital outpatient facilities in our plan: Ultrasounds at a physician's office or free-standing provider facilities in our plan: Ultrasounds at hospital outpatient facilities in our plan:	 \$55.00 copay \$195.00 copay \$50.00 copay \$50.00 copay
Diagnostic Tests and Procedures Physician's office or free-standing provider facilities in our plan: Hospital outpatient facilities in our plan:	 \$55.00 copay \$65.00 copay
Lab Services Physician's office or free-standing provider facilities in our plan: Hospital outpatient facilities in our plan:	 \$0.00 copay \$0.00 copay
Outpatient X-rays Physician's office in our plan: Hospital outpatient facilities in our plan:	 \$90.00 copay \$110.00 copay

Anthem Chronic Care (HMO-POS C-SNP)

Diagnostic Services, Labs, and Imaging^{1,2}

Free-standing facility or at-home portable X-ray services in our plan:	\$90.00 copay
Therapeutic Radiology Services (such as radiation treatment for cancer) Physician’s office, free-standing provider or hospital outpatient facilities in our plan:	20% coinsurance

Hearing Services

Medicare-covered hearing services (Exam to diagnose and treat hearing and balance issues):^{1,2}

Doctors in our plan: \$30.00 copay

Routine hearing services:^{1,2}

This plan covers 1 routine hearing exam every year. \$300 maximum plan benefit for over-the-counter hearing aids OR 1 routine hearing aid fitting evaluation and a \$3,000 maximum plan benefit for prescribed hearing aids every year.

Doctors in our plan: \$0.00 copay for routine hearing exam(s). \$0.00 copay for hearing aids up to the maximum plan benefit amount.

Anthem Chronic Care (HMO-POS C-SNP)

Dental Services

Medicare-covered dental services (this does not include services for care, treatment, filling, removal or replacement of teeth):¹

Doctors and dentists in our plan: **\$20.00** copay

Preventive and Comprehensive¹ Dental Combined Allowance:

This plan covers up to a **\$3,000** allowance for covered preventive and comprehensive dental services every year.

Any amount not used at the end of the plan year will expire.

Preventive dental services:

Dentists in our plan: **\$0.00** copay

Dentists not in our plan: **20%** coinsurance

This plan covers 2 oral exams, 2 cleanings, 2 fluoride treatments, and 2 dental X-rays every year.

Comprehensive dental services:

Doctors and dentists in our plan: **\$0.00** copay

Doctors and dentists not in our plan: **50%** coinsurance

Please refer to Chapter 4 in the plan's Evidence of Coverage for more details on prior authorizations, covered dental services, limitations, and exclusions.

To find a dental provider in our plan, follow the same steps as the "How to find a doctor/PCP in our plan" box at the beginning of this booklet. Then select **Dental Provider** under **Provider Type**.

Anthem Chronic Care (HMO-POS C-SNP)

Vision Services

Medicare-covered vision services:

Exam to diagnose and treat diseases and conditions of the eye:

Doctors in our plan: **\$30.00** copay

Eyeglasses or contact lenses after cataract surgery:

Doctors in our plan: **20%** coinsurance

Routine vision services:

Routine vision exam:

This plan covers 1 routine eye exam(s) every year.

Doctors in our plan: **\$0.00** copay

Routine eyewear (lenses and frames):

This plan covers up to **\$400** for eyeglasses or contact lenses every year.

Doctors in our plan: **\$0.00** copay

To find a vision provider in our plan, follow the same steps as the "How to find a doctor/PCP in our plan" box at the beginning of this booklet. Then select **Vision Provider** under **Provider Type**.

Anthem Chronic Care (HMO-POS C-SNP)

Mental Health Care

Inpatient visit:¹

Doctors and facilities in our plan: Days 1-7: **\$295.00** per day, per admission /
Days 8-90: **\$0.00** per day, per admission

Our plan covers unlimited inpatient days.

Per day cost sharing applies to each new inpatient admission. (Note: transfers to an inpatient rehabilitation hospital is considered a new admission and cost sharing per day applies).

Outpatient individual and group therapy services:^{1,2}

Doctors and facilities in our plan: **\$20.00** copay

Skilled Nursing Facility (SNF)¹

Doctors and facilities in our plan: Days 1 - 20: **\$0.00** per day / Days 21 - 100:
\$218.00 per day

Our plan covers up to 100 days in a Skilled Nursing Facility (SNF).

Your copays for SNF benefits are based on benefit periods. A benefit period starts on the first day you go into a hospital or SNF and ends when you haven't had any inpatient hospital care or skilled nursing care for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period starts. There's no limit to the number of benefit periods you can have.

Physical Therapy^{1,2}

Doctors and facilities in our plan: **\$20.00** copay

Anthem Chronic Care (HMO-POS C-SNP)

Ambulance¹

Ground/Water Ambulance:

Emergency transportation services in our plan: **\$244.00** copay per trip

Air Ambulance:

Emergency transportation services in our plan: **\$244.00** copay per trip

Transportation

Plan approved health related locations

You pay a **\$0.00** copay. This plan offers coverage for 26, one-way, routine transportation services every year. Trips are limited to 60 miles.

Routine transportation coverage is limited to plan-approved locations (within the local service area) provided by contracted transportation vendors in our plan. If you need a ride, call us at least 48 hours ahead of time (excluding weekends).

Medicare Part B Drugs

Insulin furnished through an insulin pump:

Drugs obtained from doctors and facilities in our plan: **\$35.00** copay

Other Part B Drugs:¹

Drugs obtained from doctors and facilities in our plan: **\$0.00** copay - **20%** coinsurance

Anthem Chronic Care (HMO-POS C-SNP)

Medicare Part B Drugs

Chemotherapy drugs:¹

Drugs obtained from doctors and facilities in our plan: **\$0.00** copay - **20%** coinsurance

You may pay less than the maximum coinsurance for certain Part B and chemotherapy rebatable drugs. The list and the cost of each rebatable drug changes every quarter.

Additional benefits

Anthem Chronic Care (HMO-POS C-SNP)

Acupuncture

Medicare-covered acupuncture services:^{1,2}

Providers in our plan: **\$20.00** copay

Available for people with chronic low back pain under certain circumstances. Please see the Evidence of Coverage for more information.

Chiropractic Care^{1,2}

Medicare-covered chiropractic services:

Providers in our plan: **\$20.00** copay

Medicare coverage includes manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position).

Everyday Options Allowance

This plan offers a spending allowance of **\$40 each month** for:

- ☐ **Over-the-Counter (OTC) products:** Health and wellness items like vitamins, first aid supplies, pain-relievers, and more.

If you are eligible for Special Supplemental Benefits for the Chronically Ill (SSBCI), you can also use the allowance for:

- ☐ **Healthy Foods:**⁶ Healthy food items that assist in meeting your nutritional needs such as dairy products, fresh fruits, vegetables, meat, seafood, and other healthy pantry staples.

Unused amounts expire at the end of each month.

Anthem Chronic Care (HMO-POS C-SNP)

Foot Care (podiatry services)^{1,2}

Medicare-covered podiatry:

Doctors in our plan: **\$0.00** copay - **\$30.00** copay

Foot exams and treatment are covered if you have diabetes-related nerve damage and/or meet certain conditions.

You pay nothing for Medicare-covered *routine* podiatry services. For all other Medicare-covered podiatry services, you pay the higher amount shown above.

Routine foot care:

Doctors in our plan: **\$0.00** copay

This plan covers: Unlimited routine foot care visits each year.

Healthy Meals - Chronic Condition

\$0.00 copay for up to 3 meals a day for 10 days to support your chronic condition nutritional needs.

This benefit requires the diagnosis of a chronic condition.

You must use network providers.

Healthy Meals - Post Discharge

\$0.00 copay for up to 2 meals a day for 5 days following your discharge from the hospital or skilled nursing facility (SNF).

You must use network providers.

Anthem Chronic Care (HMO-POS C-SNP)

Home Health Care^{1,2}

Doctors and facilities in our plan: **\$0.00** copay

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.

Medical Equipment/Supplies

Durable Medical Equipment (wheelchairs, oxygen, etc.):¹

Suppliers in our plan: **20%** coinsurance

Medical supplies and prosthetic devices (braces, artificial limbs, etc.):¹

Suppliers in our plan: **20%** coinsurance

Diabetic supplies and services:

Suppliers in our plan: **\$0.00** copay

Covered diabetic supplies include: glucose monitors, test strips, and lancets. See your Evidence of Coverage for all supplies covered.

Anthem Chronic Care (HMO-POS C-SNP)

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.

Outpatient Rehabilitation

Cardiac (heart) rehab services (with a limit of two, one-hour sessions per day and a maximum of 36 sessions within a 36-week period):¹

Doctors and facilities in our plan: **\$0.00** copay

Pulmonary (lung) rehab services (with a limit of two, one-hour sessions per day and a maximum of 36 sessions):¹

Doctors and facilities in our plan: **\$0.00** copay

Occupational therapy visit:^{1,2}

Doctors and facilities in our plan: **\$20.00** copay

Outpatient Substance Abuse^{1,2}

Individual & Group therapy visit:

Doctors and facilities in our plan: **\$20.00** copay

Anthem Chronic Care (HMO-POS C-SNP)

Renal Dialysis

Doctors and facilities in our plan: **20%** coinsurance

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 **silversneakers.com** or call SilverSneakers at 1-855-741-4985 (TTY: 711), Monday to Friday, 8 a.m. to 8 p.m. ET.

^{††}SilverSneakers is a registered trademark of Tivity Health, Inc. All rights reserved. Tivity Health, Inc. is an independent company providing a fitness program on behalf of this plan.

24/7 Nurseline

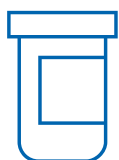
24-hour access to a nurse line, seven days a week, 365 days a year

Footnotes

Services with a 1 may need prior authorization (preapproval) from the plan.

Services with a 2 may need a referral from your doctor or Primary Care Physician (PCP).

Benefits with a 6: The benefits mentioned are Special Supplemental Benefits for the Chronically Ill (SSBCI). You may qualify for SSBCI if you have a high risk for hospitalization and require intensive care coordination to manage chronic conditions such as Chronic Kidney Diseases, Chronic Lung Disorders, Cardiovascular Disorders, Chronic Heart Failure, or Diabetes. For a full list of chronic conditions or to learn more about other eligibility requirements needed to qualify for SSBCI benefits, please refer to Chapter 4 in the plan's Evidence of Coverage.



Summary of 2026 prescription drug coverage

Ways to save

1. Choose generic drugs on tiers 1 and 2 when available.
2. Use mail order.
3. Use a preferred pharmacy. To find a preferred pharmacy in this plan:
 - ☐ Visit **shop.anthem.com/medicare** (select **Useful Tools** and choose **Find a Pharmacy**). Preferred pharmacies are noted to the right of the pharmacy name.
 - ☐ Give us a call and we will send you a copy of the Pharmacy Directory.

Anthem Chronic Care (HMO-POS C-SNP)

Stage 1: Yearly Deductible

This plan does not have a Part D deductible.

Stage 2: Initial Coverage

After you pay your yearly deductible (if your plan has one), you move to the Initial Coverage Stage. In this stage, you pay the amounts listed in the table on the following pages, until your total year-to-date out-of-pocket costs reach **\$2,100**.

The amount you pay is determined by the covered Part D prescription and if you receive Extra Help low-income subsidy coverage. Please refer to your 2026 LIS Rider for the specific amount if you receive Extra Help.

You may get your covered drugs at retail pharmacies and mail-order pharmacies in our plan. Generally, you may get your covered drugs from pharmacies not in our plan only when you are unable to get your prescription drugs from a pharmacy that is in our plan. If you live in a long-term care facility, you pay the same as at a standard retail pharmacy.

Important message about what you pay for vaccines and insulin:

This plan covers most Part D vaccines at no cost to you and you will not pay more than **\$35** for a one-month supply for any covered Insulin.

Stage 2: Initial Coverage

Cost Sharing	Anthem Chronic Care (HMO-POS C-SNP)
Tier 1: Preferred Generic	
Preferred retail one-month supply	\$0.00
Standard retail one-month supply	\$0.00
Mail order three-month supply	\$0.00
Tier 2: Generic	
Preferred retail one-month supply	\$0.00
Standard retail one-month supply	\$10.00
Mail order three-month supply	\$0.00
Tier 3: Preferred Brand	
Preferred retail one-month supply	20%
Standard retail one-month supply	25%
Mail order three-month supply	20%
Tier 4: Non-Preferred Drug	
Preferred retail one-month supply	30%
Standard retail one-month supply	30%
Mail order three-month supply	30%
Tier 5: Specialty Tier	
Preferred retail one-month supply	33%
Standard retail one-month supply	33%
Mail order three-month supply	Not available

Stage 2: Initial Coverage

Cost Sharing

Anthem Chronic Care (HMO-POS C-SNP)

Tier 6: Select Care Drugs

Preferred retail one-month supply	\$0.00
Standard retail one-month supply	\$0.00
Mail order three-month supply ¹⁰⁰	\$0.00

¹⁰⁰ The three-month supply for this tier on this plan is 100 days.

Stage 3: Catastrophic Coverage

During this stage, you pay nothing for your covered Part D drugs.



Optional supplemental dental and vision plans

Package 1: Preventive Dental Package

Anthem Chronic Care (HMO-POS C-SNP)

How much is the monthly payment?

An extra **\$19.00** per month. You must keep paying your Medicare Part B monthly payment.

How much is the deductible?

This package does not have a deductible.

Is there a limit on how much the plan will pay?

Doctors in our plan:

- ☐ The plan will pay up to **\$500** for the following preventive dental benefits each year (benefit maximum).

Talk to your doctor and confirm all coverage, costs, and codes before you receive services.

Benefits included:

Doctors in our plan:

You pay no copay for:

- ☐ Two exams
- ☐ Two cleanings
- ☐ Dental X-rays: include one full-mouth **or** panoramic X-ray **and** one set/series of bitewing X-rays each year **and** up to seven periapical images per calendar year

Anthem Chronic Care (HMO-POS C-SNP)

Benefits included:

- ☐ Two fluoride treatments

Doctors not in our plan:

You pay **20%** of the covered charges for:

- ☐ Two exams
- ☐ Two cleanings
- ☐ Dental X-rays include one full-mouth *or* panoramic X-ray *and* one set/series of bitewing X-rays each year *and* up to seven periapical images per calendar year
- ☐ Two fluoride treatments

Exclusions & Limits for this benefit package:

- ☐ In-network coverage is only available from network providers.

Since these services are not normally covered under Original Medicare, we offer them as a Supplemental Benefit for an extra monthly payment through this Optional Supplemental Package.

Package 2: Dental and Vision Package

Anthem Chronic Care (HMO-POS C-SNP)

How much is the monthly payment?

An extra **\$29.00** per month. You must keep paying your Medicare Part B monthly payment.

How much is the deductible?

This package does not have a deductible.

Is there a limit on how much the plan will pay?

Doctors in our plan:

- ☐ The plan will pay up to **\$1,000** for the following preventive and comprehensive dental benefits each year (benefit maximum).

Talk to your doctor and confirm all coverage, costs, and codes before you receive services.

Benefits included:

Dental:

Doctors in our plan:

You pay no copay for:

- ☐ Two exams
- ☐ Two cleanings

Anthem Chronic Care (HMO-POS C-SNP)

Benefits included:

- ☐ Dental X-rays: include one full-mouth **or** panoramic X-ray **and** one set/series of bitewing X-rays each year **and** up to seven periapical images per calendar year
- ☐ Two fluoride treatments

You pay **20%** of the covered charges for certain restorative dental services (fillings).

You pay **50%** of the covered charges for certain endodontic, periodontic, and oral surgery dental services which include, but are not limited to, the following:

- ☐ Root canal treatment
- ☐ Periodontal scaling and root planing
- ☐ Simple and surgical extractions

Exclusions & Limits for this benefit package:

- ☐ Dentures and crowns are excluded.
- ☐ Coverage is only available from network providers.

Doctors not in our plan:

You pay **30%** of the covered charges for:

- ☐ Two exams
- ☐ Two cleanings
- ☐ X-rays include one full-mouth **or** panoramic X-ray **and** one set/series of bitewing X-rays each year **and** up to seven periapical images per calendar year.
- ☐ Two fluoride treatments.

You pay **60%** of the covered charges for certain restorative dental services (fillings). You pay **75%** of the covered charges for certain endodontic, periodontic, and oral surgery dental services which include, but are not limited to, the following:

- ☐ Root canal treatment
- ☐ Periodontal scaling and root planning
- ☐ Simple and surgical extractions

Exclusions & limits for this benefit package:

Anthem Chronic Care (HMO-POS C-SNP)

Benefits included:

- ☐ Dentures and crowns are excluded.
- ☐ In-network coverage is only available from network dental providers.

Vision:

This package offers a **\$150** reimbursement allowance toward the purchase of eyewear. The benefit applies to corrective (prescription) glasses, lenses, frames, and/or contact lenses.

Talk to your provider and confirm all coverage, costs, and codes prior to services being rendered.

Exclusions & limits for this benefit package:

- ☐ Safety eyewear, non-prescription sunglasses, glass lenses, non-prescription lenses or contacts are not covered.
- ☐ Coverage is only available from network providers.

Since these services are not normally covered under Original Medicare, we offer them as a Supplemental Benefit for an extra monthly payment through this Optional Supplemental Package.

Package 3: Enhanced Dental and Vision Package

Anthem Chronic Care (HMO-POS C-SNP)

How much is the monthly payment?

An extra **\$49.00** per month. You must keep paying your Medicare Part B monthly payment.

How much is the deductible?

This package does not have a deductible.

Is there a limit on how much the plan will pay?

Doctors in our plan:

- ☐ The plan will pay up to **\$2,000** for the following preventive and comprehensive dental benefits each year (benefit maximum).

Talk to your doctor and confirm all coverage, costs, and codes before you receive services.

Benefits included:

Dental:

Doctors in our plan:

You pay no copay for:

- ☐ Two exams
- ☐ Two cleanings
- ☐ Dental X-rays: include one full-mouth **or** panoramic X-ray **and** one set/series of bitewing X-rays each year **and** up to seven periapical images per calendar year

Anthem Chronic Care (HMO-POS C-SNP)

Benefits included:

- ☐ Two fluoride treatments

You pay **20%** of the covered charges for certain restorative dental services (fillings).

You pay **50%** of the covered charges for certain endodontic, periodontic, prosthodontic, and oral surgery dental services which include, but are not limited to, the following:

- ☐ Root canal treatment
- ☐ Periodontal scaling and root planing
- ☐ Simple and surgical extractions
- ☐ Crowns (once per tooth every five years)
- ☐ Complete denture, immediate denture, or partial denture (one set of dentures every five years)
- ☐ Denture adjustment, repair, replacement, rebasing, and relining
- ☐ Local anesthesia (a drug to numb a part of the body) or regional block anesthesia

Doctors not in our plan:

You pay **30%** of the covered charges for:

- ☐ Two exams
- ☐ Two cleanings
- ☐ Dental X-rays include one full-mouth **or** panoramic X-ray **and** one set/series of bitewing X-rays each year **and** up to seven periapical images per calendar year.
- ☐ Two fluoride treatments.

You pay **60%** of the covered charges for certain restorative dental services (fillings).

You pay **75%** of the covered charges for certain endodontic, periodontic, prosthodontic, and oral surgery dental services which include, but are not limited to, the following:

- ☐ Root canal treatment

Anthem Chronic Care (HMO-POS C-SNP)

Benefits included:

- ☐ Periodontal scaling and root planing
- ☐ Simple and surgical extractions
- ☐ Crowns (once per tooth every five years)
- ☐ Complete denture, immediate denture, or partial denture (one set of dentures every five years)
- ☐ Denture adjustment, repair, replacement, rebasing, and relining
- ☐ Local anesthesia (a drug to numb a part of the body) or regional block anesthesia

Exclusions & Limits for this benefit package:

- ☐ In-network coverage is only available from network providers.

Vision

This package offers a **\$200** reimbursement allowance toward the purchase of eyewear. The benefit applies to corrective (prescription) glasses, lenses, frames, and/or contact lenses.

Talk to your provider and confirm all coverage, costs, and codes prior to services being rendered.

Exclusions & limits for this benefit package:

- ☐ Safety eyewear, non-prescription sunglasses, glass lenses, non-prescription lenses or contacts are not covered.
- ☐ Coverage is only available from network providers.

Since these services are not normally covered under Original Medicare, we offer them as a Supplemental Benefit for an extra monthly payment through this Optional Supplemental Package.

If you need emergency or urgent care, call 911 or go to the nearest doctor or facility that can help you. Most times, you must use doctors in our plan to receive covered medical care, except for emergencies and urgently needed care when doctors in our plan are not available or dialysis services when you are out of the service area. If you receive routine care from doctors outside our plan, neither Medicare nor Anthem Blue Cross and Blue Shield will pay for it.

Benefits with a 6: The benefits mentioned are Special Supplemental Benefits for the Chronically Ill (SSBCI). You may qualify for SSBCI if you have a high risk for hospitalization and require intensive care coordination to manage chronic conditions such as Chronic Kidney Diseases, Chronic Lung Disorders, Cardiovascular Disorders, Chronic Heart Failure, or Diabetes. For a full list of chronic conditions or to learn more about other eligibility requirements needed to qualify for SSBCI benefits, please refer to Chapter 4 in the plan's Evidence of Coverage.

The Benefits Mastercard® Prepaid Card is issued by The Bancorp Bank N.A., Member FDIC, pursuant to license by Mastercard International Incorporated and card can be used for eligible expenses wherever Mastercard is accepted. Valid only in the U.S. No cash access. This is not a gift card or gift certificate. You have received this card as a gratuity without the payment of any monetary value or consideration.

Anthem Blue Cross and Blue Shield is an HMO-POS C-SNP plan with a Medicare contract and a contract with the Missouri Medicaid program. Enrollment in Anthem Blue Cross and Blue Shield depends on contract renewal. In Missouri (excluding 30 counties in the Kansas City area): Anthem Blue Cross and Blue Shield is the trade name of RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensees of the Blue Cross Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call **1-844-604-0335** (TTY: **711**) or speak to your provider. Hours of operation are 8 a.m. to 8 p.m. local time, 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.

Spanish – ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia en otros idiomas. También puede obtener ayudas y servicios auxiliares adecuados gratuitos para proporcionar información en formatos accesibles. Llame al número de teléfono indicado anteriormente o hable con su proveedor. El horario de atención es de 8 a.m. a 8 p.m. hora local, los siete días de la semana (excepto el Día de Acción de Gracias y Navidad) desde el 1.o de octubre hasta el 31 de marzo, y de lunes a viernes (excepto los días feriados) desde el 1.o de abril hasta el 30 de septiembre.

Amharic – ያስተውሉ:- አማርኛ የሚናገሩ ከሆነ፣ነጻ የቋንቋ እርዳታ አገልግሎቶች ለእርስዎ ይገኛሉ። መረጃን በተደራሽ ቅርጾች ለማቅረብ አግባብ የሆኑ ረዳት መርጃዎች እና አገልግሎቶችም በነጻ ይገኛሉ። ከላይ በተጠቀሰው ስልክ ቁጥር ይደውሉ ወይም አቅራቢዎን ያነጋግሩ። የስራ ሰዓቶች ከጠዋቱ 8 ሰዓት እስከ ከሰዓት 8 ሰዓት የአካባቢ ሰዓት፣ በሳምንት ሰዓት ቀናት (ከምስጋና እና የገና በዓላት በስተቀር) ከአክቶበር 1 እስከ ማርች 31፣ እና ከሰኞ እስከ አርብ (ከበዓላት በስተቀር) ከሚያዝያ 1 እስከ ሴፕቴምበር 30 ናቸው።

Arabic - تنبيه: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية المجانية متاحة لك. كما تتوفر مساعدات وخدمات مساعدة مناسبة لتوفير المعلومات بأشكال يسهل الوصول إليها مجاناً. اتصل برقم الهاتف المذكور أعلاه أو تحدث إلى مقدم الخدمة الخاص بك. ساعات العمل من الساعة 8 صباحاً حتى الساعة 8 مساءً على مدار الأسبوع (ما عدا أيام عيد الشكر وعيد الميلاد) بدايةً من 1 أكتوبر حتى 31 مارس، ومن الاثنين حتى الجمعة (ما عدا أيام العطلات) من 1 أبريل حتى 30 سبتمبر.

Chinese Simplified – 注意：如果您说简体中文，我们可以为您提供免费的语言协助服务。我们还免费提供适当的辅助工具和服务，以可访问的格式提供信息。请拨打上面列出的电话号码或与您的提供者交谈。营业时间：10月1日至3月31日，每周七天（感恩节和圣诞节除外），4月1日至9月30日，周一至周五（节假日除外），当地时间上午8时至晚上8时。

Chinese Traditional – 注意：如果您說繁體中文，我們可以為您提供免費的語言協助服務。我們還免費提供適當的輔助工具和服務，以無障礙格式提供資訊。請撥打上面列出的電話號碼或與您的提供者交談。營業時間：10月1日至3月31日，每週七天（感恩節和耶誕節除外），4月1日至9月30日，週一至週五（節假日除外），當地時間上午8時至晚上8時。

Farsi - توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات کمک زبانی رایگان قابل ارائه به شما است. وسایل و خدمات کمکی مناسب برای ارائه اطلاعات در قالب های مناسب معلولان نیز به صورت رایگان قابل ارائه است. با شماره تلفن بالا تماس بگیرید یا با ارائه دهنده تماس صحبت کنید. ساعات کاری: از 8 صبح تا 8 شب به وقت محلی از 1 اکتبر تا 31 مارس (به جز کریسمس و روز شکرگزاری) در هفت روز هفته و از 1 آوریل تا 30 سپتامبر از دوشنبه تا جمعه (به جز تعطیلات).

French – ATTENTION : Si vous parlez français, des services gratuits d'assistance linguistique sont disponibles. Des aides et services auxiliaires appropriés permettant de fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le numéro de téléphone mentionné ci-dessus ou appelez votre prestataire. Les heures d'ouverture sont de 8 a.m à 8 p.m., heure locale, sept jours sur sept (sauf Thanksgiving et Noël) du 1er octobre au 31 mars, et du lundi au vendredi (sauf jours fériés) du 1er avril au 30 septembre.

German – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Dienste zur sprachlichen Unterstützung zur Verfügung. Außerdem sind kostenlose Hilfsmittel und Dienste verfügbar, um Informationen in zugänglichen Formaten bereitzustellen. Rufen Sie die oben aufgeführte Telefonnummer an oder wenden Sie sich an Ihren Anbieter. Die Geschäftszeiten sind 8 Uhr bis 20 Uhr lokaler Zeit an sieben Tagen in der Woche (außer Thanksgiving und Weihnachten) vom 1. Oktober bis zum 31. März, und Montag bis Freitag (außer an Feiertagen) vom 1. April bis zum 30. September.

Hindi – ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए नशिल्क भाषा सहायता सेवाएं उपलब्ध हैं। पहुँच योग्य प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी नशिल्क उपलब्ध हैं। ऊपर दिए गए फ़ोन नंबर पर कॉल करें या अपने प्रदाता से बात करें। कामकाज के घंटे, 1 अक्टूबर से 31 मार्च तक सप्ताह के सातों दिनों (थैंकसगिविंग और क्रिसमस को छोड़कर), और 1 अप्रैल से 30 सितंबर तक सोमवार से शुक्रवार (छुट्टियों को छोड़कर), स्थानीय समय अनुसार सुबह 8 बजे से रात 8 बजे तक हैं।

Japanese – 注意：日本語を話せる方向けに、無料の言語支援サービスをご提供しています。適切な補助器具・サービスも、利用者がアクセスしやすい方法でご提供しています。こちらも無料でご利用いただけます。必要な情報取得にお役立てください。上記の電話番号にお電話いただくか、プロバイダーにお問い合わせください。営業時間は、10月1日から3月31日までは現地時間午前8時から午後8時まで週7日（感謝祭とクリスマスを除く）、および4月1日から9月30日まで（祝日を除く）は月曜日から金曜日までです。

Khmer – សូមយកចិត្តទុកដាក់៖ បុរសិនបើអ្នកនិយាយភាសា ខ្មែរវ័សវេជ្ជន្តយភាសាភក្តិ គិតថូលមែនផ្ទុដល់ជូនអ្នក។ មានផ្ទុដល់ជូនដោយ ភក្តិគិតថូលន្ទែរសរោគមុម និងឧបករណ៍ជំនួយសមស្របដើម្បីបិទត្រង់ ព័ត៌មានកុនុងទម្រង់បែបបទដ៏អាចចូលបុរីហា នផងដែរ។ ហៅទូរសព្ទទទេលខេត្តសព្ទទទេលមាននរោខាងលើ ឬនិយាយជាមួយអ្នកផ្ទុត្រង់សរោបសំអ្នក។ ម៉ោងធ្វើការចាប់ម៉ោង 8 ព្រឹក ដល់ម៉ោង 8 យប់ ម៉ោងកុនុងស្រុក បុរីពីរថ្ងៃក្នុងមួយសប្តាហ៍ (លើកលែងតែថ្ងៃបុណ្យចូលឆ្នាំអំណរគុណ និងបុណ្យឈូអែល) ចាប់ពីថ្ងៃទី 1 ខែតុលា ដល់ថ្ងៃទី 31 ខែមីនា និងថ្ងៃចន្ទ ដល់ថ្ងៃសុក្រ (លើកលែងតែថ្ងៃឈប់សម្រាក) ចាប់ពីថ្ងៃទី 1 ខែមេសា ដល់ថ្ងៃទី 30 ខែកញ្ញា។

Korean – 주의: 한국어를 구사하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 대체 형식으로 정보를 제공하기 위한 적절한 보조 장치 및 서비스도 무료로 제공됩니다. 위의 전화 번호로 전화하시거나 담당 의료 제공자에게 문의해 주십시오.
운영 시간은 현지 시간 오전 8시부터 오후 8시까지이며 10월 1일부터 3월 31일까지는 주 7일(추수 감사절과 성탄절은 제외) 내내, 4월 1일부터 9월 30일까지는 월요일부터 금요일까지(휴일은 제외)입니다.

Oromo – XIYYEEFFANNOO: Afaan Oromoo dubbattu yoo ta'e, deeggarsi afaanii bilisaan jira. Gargaarsi fi tajaajilootni odeeffannoo kennuu namoota arguufi dhagahuu hin dandeenyeef kaffaltii tokko malee bifa garaagaraan ni jiru. Lakkoofsa bilbilaa armaan olitti kaa'ame irratti bilbilaa yookiin dhiyeessaa keessan haasofsiisaa. Sa'aatiiwwan hojii 8 a.m. hanga 8 p.m. akka sa'aatii naannootti, torbanitti guyyaa torba (guyyaa ayyaana Guyyaa Galateffannoofi Dhaloota Kiristoosiin alatti) Onkoloolessa 1 hanga Bitootessa 31 tti, akkasumas Wiixataa hanga Jimaataa (guyyoota ayyaana waggaaatiin alatti) Ebla 1 hanga Fulbaana 30 tti dha.

Pennsylvania Dutch – BEACHTUNG: Wann Sie Pennsilfaanisch Deitsch schwetze, sin fer Sie gratis Schproochhilfsdiener verfügbar. Geeignet Hilfsmittel un Hilfsdiensch, fer Wiss in barrierefreie Formate bereitzustelle, sin aa gratis verfügbar. Rufe Sie die telefunnummer wu dobaue gennant is odder schwetze Sie mit Ihrem Versorger. Die Bedienungszeite sin vun 8:00 Owends bis 8:00 Moies Ortszeit, sieben Daag in der Woch (ausser Danksagungsdaag un Weihnachten) vum 1. Oktober bis 31. März, un vum 1. April bis 30. September Montag bis Freidaag (ausser Feiertag).

Portuguese – ATENÇÃO: Se fala português, tem à sua disposição serviços de assistência linguística gratuitos. Estão também disponíveis, a título gratuito, ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para o número de telefone acima indicado ou fale com o seu fornecedor. Horário de expediente: das 8h às 20h, (hora local), sete dias por semana (exceto Dia de Ação de Graças e Natal) de 1 de outubro até 31 de março, e de segunda a sexta-feira (exceto feriados) de 1 de abril até 30 de setembro.

Russian – ВНИМАНИЕ: Если вы говорите на русском языке, вам могут предоставить бесплатные услуги переводчика. Также бесплатно предоставляются вспомогательные средства и услуги, позволяющие получать информацию в доступных форматах. Позвоните по вышеуказанному номеру телефона или обсудите этот вопрос с вашим поставщиком услуг. Часы работы: с 08:00 до 20:00 в любой день недели (кроме Дня благодарения и Рождества) с 1 октября по 31 марта и с понедельника по пятницу (кроме праздничных дней) с 1 апреля по 30 сентября.

Serbian – ПАЖЊА: Ако говорите српски, доступне су вам бесплатне услуге помоћи за ваш језик. Бесплатно су вам доступна и одговарајућа помагала и услуге у доступним форматима како бисте добили информације које су вам потребне. Позовите број телефона наведен изнад или поразговарајте са својим пружаоцем услуга. Радно време је од 8 до 20 часова по локалном времену, седам дана у недељи (осим Дана захвалности и Божића) од 1. октобра до 31. марта, односно од понедељка до петка (осим празника) од 1. априла до 30. септембра.

Tagalog – PAUNAWA: Kung nagsasalita ka Tagalog, mayroong available na mga libreng serbisyo sa tulong sa wika para sa iyo. Ang naaangkop na mga karagdagang tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format ay available rin nang walang bayad. Tawagan ang numero ng telepono na nakalista sa itaas o makipag-usap sa iyong provider. Ang mga oras ng opisina ay 8 a.m. hanggang 8 p.m., lokal na oras, pitong araw sa isang linggo (maliban sa Thanksgiving at Pasko) mula Oktubre 1 hanggang Marso 31, at Lunes hanggang Biyernes (maliban sa mga holiday) mula Abril 1 hanggang Setyembre 30.

Telugu – గమనిక: మేీరు తేలుగులో మాట్లాడదలచుకుంటే కనుక, మేీకు ఉచిత భష సహాయ సేవలు అందుబాటులో ఉన్నయి. అందుబాటులో ఉన్న ఫర్మాట్లలో సమాచరణని అందించడనికి తగిన సహాయక పరికరలు, సేవలు కూడ ఉచితంగ లభిస్తయి. వైన జబితలో తలీవిన ఫోన్ నంబర్కు కల్ చేయండి లేద మేీ వోరైవైడర్తో మాట్లాడండి. పని వేళలు అక్టోబర్ 1 నుండి మార్చి 31 వరకు వరనికి ఏడు రేజులు (థంక్స్ గివింగ్, క్రిస్మస్ మినహ) వటు, ఏప్రిల్ 1 నుండి సెప్టెంబర్ 30 వరకు సోమవరం నుండి శుక్రవరం వరకు (సెలమలు మినహ) నోథనీక సమయం ఉదయం 8 గంటల నుండి రత్రి 8 గంటల వరకు.

Ukrainian – УВАГА. Якщо ви розмовляєте українською, вам доступні безкоштовні послуги мовної допомоги. Відповідні допоміжні засоби й послуги для надання інформації в доступних форматах також можна отримати безкоштовно. Зателефонуйте за вказаним вище номером або зверніться до свого постачальника. Графік роботи: з 08:00 до 20:00 за місцевим часом, без вихідних (крім Дня подяки й Різдва) з 1 жовтня по 31 березня, і з понеділка по п'ятницю (крім святкових днів) з 1 квітня по 30 вересня.

Urdu - توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون آلات اور خدمات بھی مفت دستیاب ہیں۔ اوپر درج فون نمبر پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔ کام کے اوقات مقامی وقت کے مطابق صبح 8 بجے تا شام 8 بجے، ہفتے کے سات دن (سوائے تھینکس گیونگ اور کرسمس کے) 1 اکتوبر سے 31 مارچ تک، اور پیر تا جمعہ (چھٹیوں کے علاوہ) 1 اپریل تا 30 ستمبر ہیں۔

Vietnamese – CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí luôn sẵn sàng phục vụ quý vị. Các dịch vụ và hỗ trợ phụ trợ thích hợp cung cấp thông tin ở các định dạng có thể truy cập cũng được cung cấp miễn phí. Gọi số điện thoại nêu trên hoặc nói chuyện với nhà cung cấp của quý vị. Giờ làm việc từ 8 giờ sáng đến 8 giờ tối, giờ địa phương, bảy ngày một tuần (Trừ Lễ Tạ ơn và Giáng sinh) từ ngày 1 Tháng Mười đến 31 Tháng Ba, và Thứ Hai đến Thứ Sáu (trừ các ngày lễ), từ ngày 1 Tháng Tư đến 30 Tháng Chín.

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 **1-844-604-0335** 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 **1-844-604-0335** 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, 2027.
- ☐ 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).
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

☐

This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.