

# Summary of Benefits



## Thank you for your interest in our Medicare Advantage plans

Anthem Blue Cross and Blue Shield offers benefits to help you stay healthy while protecting you from unexpected costs. This plan includes your hospital, medical, and drug benefits in one plan.

### Medicare Advantage and Part D

**Plan year:** January 1 – December 31, 2026

**Ohio**

All counties in Ohio

**Anthem Extra Help (HMO-POS)**

# Anthem Extra Help (HMO-POS)

## Anthem Extra Help (HMO-POS)

Our service area includes these counties in OH: Adams, Allen, Ashland, Ashtabula, Athens, Auglaize, Belmont, Brown, Butler, Carroll, Champaign, Clark, Clermont, Clinton, Columbiana, Coshocton, Crawford, Cuyahoga, Darke, Defiance, Delaware, Erie, Fairfield, Fayette, Franklin, Fulton, Gallia, Geauga, Greene, Guernsey, Hamilton, Hancock, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Knox, Lake, Lawrence, Licking, Logan, Lorain, Lucas, Madison, Mahoning, Marion, Medina, Meigs, Mercer, Miami, Monroe, Montgomery, Morgan, Morrow, Muskingum, Noble, Ottawa, Paulding, Perry, Pickaway, Pike, Portage, Preble, Putnam, Richland, Ross, Sandusky, Scioto, Seneca, Shelby, Stark, Summit, Trumbull, Tuscarawas, Union, Van Wert, Vinton, Warren, Washington, Wayne, Williams, Wood, Wyandot.

### Do you have questions?

You can learn more on our website, **[shop.anthem.com/medicare](https://shop.anthem.com/medicare)**. Or call us toll-free **1-844-612-7171** (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 Extra Help (HMO-POS) is a Medicare Advantage 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 live in our service area.

# Anthem Extra Help (HMO-POS)

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.

## 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 (HMO-POS) plan. 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.

# 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. Or you can give us a call and we'll send you the directory.

## 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 **1-844-612-7171** (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 Extra Help (HMO-POS)

### How much is my premium (monthly payment)?

**\$31.40** per month

You must continue to pay your Medicare Part B premium.

If you receive Extra Help from Medicare, your monthly plan premium will be lower or you might pay nothing.

### How much is my deductible?

This plan does not have a medical deductible.

**\$390.00** deductible per year for Part D prescription drugs.

Drugs listed on Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, Tier 5: Specialty Tier are included in the Part D deductible.

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.

The Part D deductible does not apply to Insulin drugs.

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

**\$7,350.00** 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 Extra Help (HMO-POS)

### Inpatient Hospital<sup>1</sup>

Facilities in our plan: Days 1-7: **\$310.00** 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<sup>1</sup>

Doctors and facilities in our plan: **\$310.00** copay

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

### Ambulatory Surgical Center<sup>1</sup>

Doctors and facilities in our plan: **\$210.00** copay

### Doctor's Office Visits

#### Primary care physician (PCP) visit:

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

#### Specialist visit:<sup>1</sup>

Doctors in our plan: **\$40.00** copay

# Anthem Extra Help (HMO-POS)

## 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

### 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 Extra Help (HMO-POS)

## Emergency Care

**\$115.00** copay

### Emergency and Urgent Care Worldwide Coverage

**\$115.00** 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

**\$35.00** copay

## Anthem Extra Help (HMO-POS)

| Diagnostic Services, Labs, and Imaging <sup>1</sup>                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Diagnostic Radiology Services</b><br><br>CT scans, MRI, MRA, PET at a physician's office or free-standing provider facilities in our plan:<br><br>CT scans, MRI, MRA, PET at hospital outpatient facilities in our plan:<br><br>Ultrasounds at a physician's office or free-standing provider facilities in our plan:<br><br>Ultrasounds at hospital outpatient facilities in our plan: | <br><br><b>\$90.00 copay</b><br><br><br><br><b>\$310.00 copay</b><br><br><br><br><b>\$50.00 copay</b><br><br><br><br><b>\$90.00 copay</b> |
| <b>Diagnostic Tests and Procedures</b><br><br>Physician's office or free-standing provider facilities in our plan:<br><br>Hospital outpatient facilities in our plan:                                                                                                                                                                                                                      | <br><br><b>\$45.00 copay</b><br><br><br><br><b>\$90.00 copay</b>                                                                          |
| <b>Lab Services</b><br><br>Physician's office or free-standing provider facilities in our plan:<br><br>Hospital outpatient facilities in our plan:                                                                                                                                                                                                                                         | <br><br><b>\$10.00 copay</b><br><br><br><br><b>\$10.00 copay</b>                                                                          |
| <b>Outpatient X-rays</b><br><br>Physician's office in our plan:<br><br>Hospital outpatient facilities in our plan:                                                                                                                                                                                                                                                                         | <br><br><b>\$50.00 copay</b><br><br><br><br><b>\$90.00 copay</b>                                                                          |

Anthem Extra Help (HMO-POS)

Diagnostic Services, Labs, and Imaging<sup>1</sup>

|                                                                                                                                                                          |                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|
| Free-standing facility or at-home portable X-ray services in our plan:                                                                                                   | \$50.00 copay   |
| Therapeutic Radiology Services (such as radiation treatment for cancer)<br><br>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):<sup>1</sup>

Doctors in our plan: \$40.00 copay

Routine hearing services:<sup>1</sup>

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 Extra Help (HMO-POS)

### Dental Services

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

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

#### **Preventive and Comprehensive<sup>1</sup> Dental Combined Allowance:**

This plan covers up to a **\$1,000** 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: **25%** coinsurance

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 Extra Help (HMO-POS)

### Vision Services

---

#### Medicare-covered vision services:

---

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

Doctors in our plan: **\$40.00** copay

##### Eyeglasses or contact lenses after cataract surgery:

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

---

#### 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 **\$125** 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 Extra Help (HMO-POS)

### Mental Health Care

#### Inpatient visit:<sup>1</sup>

Doctors and facilities in our plan: Days 1-6: **\$310.00** per day, per admission /  
Days 7-90: **\$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:<sup>1</sup>

Doctors and facilities in our plan: **\$40.00** copay

### Skilled Nursing Facility (SNF)<sup>1</sup>

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<sup>1</sup>

Doctors and facilities in our plan: **\$35.00** copay

## Anthem Extra Help (HMO-POS)

### Ambulance<sup>1</sup>

#### Ground/Water Ambulance:

Emergency transportation services in our plan: **\$325.00** copay per trip

#### Air Ambulance:

Emergency transportation services in our plan: **\$325.00** copay per trip

### Transportation

#### Plan approved health related locations

You pay a **\$0.00** copay. This plan offers coverage for 12, 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:<sup>1</sup>

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

## Anthem Extra Help (HMO-POS)

### Medicare Part B Drugs

#### Chemotherapy drugs:<sup>1</sup>

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 Extra Help (HMO-POS)

### Acupuncture

#### Medicare-covered acupuncture services:<sup>1</sup>

Providers in our plan: **\$15.00** copay

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

### Chiropractic Care<sup>1</sup>

#### Medicare-covered chiropractic services:

Providers in our plan: **\$15.00** 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).

### Foot Care (podiatry services)<sup>1</sup>

#### Medicare-covered podiatry:

Doctors in our plan: **\$0.00** copay - **\$40.00** 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.

## Anthem Extra Help (HMO-POS)

### Foot Care (podiatry services)<sup>1</sup>

#### Routine foot care:

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

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

### Healthy Meals - Post Discharge

**\$0.00** copay for up to 2 meals a day for 10 days following your discharge from the hospital or skilled nursing facility (SNF).

You must use network providers.

### Home Health Care<sup>1</sup>

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

### LiveHealth<sup>®</sup> 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.

## Anthem Extra Help (HMO-POS)

### Medical Equipment/Supplies

#### **Durable Medical Equipment** (wheelchairs, oxygen, etc.):<sup>1</sup>

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

#### **Medical supplies and prosthetic devices** (braces, artificial limbs, etc.):<sup>1</sup>

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.

### 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):<sup>1</sup>

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

## Anthem Extra Help (HMO-POS)

### Outpatient Rehabilitation

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

Doctors and facilities in our plan: **\$15.00** copay

**Occupational therapy visit:**<sup>1</sup>

Doctors and facilities in our plan: **\$35.00** copay

### Outpatient Substance Abuse<sup>1</sup>

**Individual & Group therapy visit:**

Doctors and facilities in our plan: **\$40.00** copay

### Over-the-Counter Products

This benefit provides a spending allowance of **\$125** every quarter on your Benefits Mastercard® Prepaid Card for over-the-counter (OTC) health and wellness products like vitamins, first aid supplies, pain-relievers, and more.

You have a variety of convenient ways to use the benefit:

- ☐ Shop in-store at participating retailers near you
- ☐ Shop online on the approved vendor website
- ☐ Shop on the approved vendor's mobile app
- ☐ Call to place an order
- ☐ Order by mail

Unused amounts expire at the end of every quarter.

# Anthem Extra Help (HMO-POS)

## Personal Emergency Response System (PERS) coverage

Includes the monitoring device and monitoring service. To start and install services, give us a call. We can help you.

## Renal Dialysis

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

## 24/7 Nurseline

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

## Footnote

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



## Summary of 2026 prescription drug coverage

### Ways to save

1. Choose generic drugs on tiers 1 and 2 when available.
2. Use mail order.

## Anthem Extra Help (HMO-POS)

### Stage 1: Yearly Deductible

**\$390.00** deductible per year for Part D prescription drugs.

Drugs listed on Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, Tier 5: Specialty Tier are included in the Part D deductible.

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.

The Part D deductible does not apply to Insulin drugs.

### 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 Extra Help (HMO-POS) |
| <b>Tier 1: Preferred Generic</b>             |                             |
| Standard retail one-month supply             | <b>\$0.00*</b>              |
| Mail order three-month supply                | <b>\$0.00*</b>              |
| <b>Tier 2: Generic</b>                       |                             |
| Standard retail one-month supply             | <b>25%</b>                  |
| Mail order three-month supply                | <b>25%</b>                  |
| <b>Tier 3: Preferred Brand</b>               |                             |
| Standard retail one-month supply             | <b>25%</b>                  |
| Mail order three-month supply                | <b>25%</b>                  |
| <b>Tier 4: Non-Preferred Drug</b>            |                             |
| Standard retail one-month supply             | <b>25%</b>                  |
| Mail order three-month supply                | <b>25%</b>                  |
| <b>Tier 5: Specialty Tier</b>                |                             |
| Standard retail one-month supply             | <b>28%</b>                  |
| Mail order three-month supply                | <b>Not available</b>        |
| <b>Tier 6: Select Care Drugs</b>             |                             |
| Standard retail one-month supply             | <b>\$0.00*</b>              |
| Mail order three-month supply <sup>100</sup> | <b>\$0.00*</b>              |

\* Your deductible will not apply for these drugs.

<sup>100</sup> 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 Extra Help (HMO-POS)

### How much is the monthly payment?

An extra **\$14.00** per month. You must keep paying your Medicare Part B monthly payment and your **\$31.40** monthly plan 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 Extra Help (HMO-POS)

### 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 Extra Help (HMO-POS)

### How much is the monthly payment?

An extra **\$27.00** per month. You must keep paying your Medicare Part B monthly payment and your **\$31.40** monthly plan 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 Extra Help (HMO-POS)

### 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 Extra Help (HMO-POS)

### 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 Extra Help (HMO-POS)

### How much is the monthly payment?

An extra **\$34.00** per month. You must keep paying your Medicare Part B monthly payment and your **\$31.40** monthly plan 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 Extra Help (HMO-POS)

### 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 Extra Help (HMO-POS)

### 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.

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 plan with a Medicare contract. Enrollment in Anthem Blue Cross and Blue Shield depends on contract renewal. Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company. Independent licensee 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 **1-844-612-7171** (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。

**Dari** - توجه: اگر شما به دری، صحبت می کنید، خدمات کمک زبان رایگان برای شما در دسترس است. کمک ها و خدمات کمکی مناسب برای ارائه معلومات در نمونه های قابل دسترس نیز به صورت رایگان در دسترس هستند. با شماره تلفون ذکر شده در بالا تماس بگیرید یا با ارائه دهنده خود صحبت کنید. ساعات کاری از 8 صبح تا 8 شب به وقت محلی، هفت روز در هفته (به جز روز شکرگزاری و کریسمس) از 1 اکتوبر تا 31 مارچ و از دوشنبه تا جمعه (به جز ایام رخصتی) از 1 اپریل تا 30 سپتمبر می باشد.

**Dutch** – LET OP: Als u Nederlands spreekt, kunt u gratis gebruikmaken van taalhulpdiensten. Ook zijn er gratis hulpmiddelen en diensten beschikbaar om informatie in toegankelijke formaten te verstrekken. Bel het bovenstaande telefoonnummer of neem contact op met uw provider. De openingstijden zijn van 8 a.m. tot 8 p.m. uur lokale tijd, zeven dagen per week (behalve Thanksgiving en kerstmis) vanaf 1 oktober tot en met 31 maart, en van maandag tot en met vrijdag (behalve feestdagen) vanaf 1 april tot en met 30 september.

**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.

**Gujarati** – ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે વનિ મૂલ્યે ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. સુવલ ફોર્મેટમાં માહિતી પ્રદાન કરવા માટે યોગ્ય સહાયક સહાય અને સેવાઓ પણ વનિ મૂલ્યે ઉપલબ્ધ છે. ઉપર દર્શાવેલ ફોન નંબર પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો. કામકાજના કલાકો સ્થાનકિ સમય મુજબ સવારે 8 વાગ્યાથી સાંજના 8 વાગ્યા સુધી, ઓક્ટોબર 1 થી માર્ચ

31 સુધી અઠવાડિયાના સાતેય દવિસ (થેક્સગવિગિ અને ફ્રસિમસ સવાિય) અને સોમવારથી શુક્રવાર (રજાઓ સવાિય) એપ્રિલ 1 થી સપ્ટેમ્બર 30 સુધી છે.

**Haitian Creole** – ATANSYON: Si w pale kreyòl ayisyen, sèvis asistans linguistik gratis disponib pou ou. Èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòm ki aksesib disponib tou san w p ap peye. Rele nimewo telefòn yo bay anwo a oswa pale ak founisè w la. Orè fonksyònman yo se 8 a.m. rive 8 p.m., sèt jou sou sèt (eksepte Jou Thanksgiving ak Nwèl) soti 1ye Oktòb rive 31 Mas, ak Lendi pou rive Vandredi (eksepte jou ferye) soti 1ye Avril rive 30 Septanm.

**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 (थैंकसगविंग और फ्रसिमस 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।

**Italian** – ATTENZIONE: sono disponibili servizi di assistenza linguistica gratuita in italiano. Sono inoltre disponibili gratuitamente adeguati supporti e servizi per ottenere informazioni in formato accessibile. Chiamare il numero di telefono riportato sopra o rivolgersi al proprio fornitore. Il servizio è attivo dalle 8.00 alle 20.00 ora locale, sette giorni su sette (eccetto il Giorno del Ringraziamento e Natale) dal 1° ottobre al 31 marzo, e dal lunedì al venerdì (eccetto i giorni festivi) dal 1° aprile al 30 settembre.

**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。こちらで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。

**Kinyarwanda** – ICYITONDERWA: Niba uvuga niba ukoresha Ikiyinyarwanda, serivisi y'ubufasha mu ndimi uyihabwa ku buntu. Amakuru yose arebana na serivisi aboneka mu buryo bwose wifuzza kandi ku buntu. Hamagara numero iri ku karita yawe ikurunga nk'umunyamuryango cyangwa uvugishe uguha serivisi. Amasaha y'akazi ni 8:00 za mugitondo kugera 8:00 za ni mugoroba ku isaha isanzwe, iminsi irindwi mu cy'umweru (uretse ku munsu w'umuganura [Thanksgiving] na Noheli) guhera tariki 1 Ukwakira kugeza tariki 31 Werurwe, ku wa Mbere kugera ku wa Gatanu (uretse ku munsu y'ikiruhuko) guhera tariki 1 Mata kugera tariki 30 Nzeri.

**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.

**Nepali** - ध्यान दनुहोस्: तपाईं नेपाली बोल्नुहुन्छ भने तपाईंका लागुनिःशुल्क भाषा सहायता सेवाहरू उपलब्ध छन्। प्रयोग गर्न मलिन ढाँचामा जानकारी प्रदान गर्न उपयुक्त ढङ्गको सहयोगी यन्त्र र सेवाहरू पनि निःशुल्क रूपमा उपलब्ध छन्। माथि उल्लेख गरिएको फोन नम्बरमा कल गर्नुहोस् वा आफ्नो प्रदायकसँग कुराकानी गर्नुहोस्। कार्य सञ्चालन गरिने समय स्थानीय समयअनुसार बहिन 8 बजेदेखि साँझ 8 बजेसम्म हप्ताको सातै दिन (थ्याङ्क्सगभिडि र क्रसिमसबाहेक) अक्टोबर 1 देखि मार्च 31 सम्म र सोमवारदेखि शुक्रवार (बदिबाहेक) अप्रिल 1 देखि सेप्टेम्बर 30 सम्म हो।

**Pashto** - پاملرنه: که تاسو په پښتو، خبرې کوئ، نو د ژبې د وړیا مرستې خدمات ستاسو لپاره شتون لري. اړوند مرستندویه وسایل او خدمتونه چې معلومات په لاسرسي وړ بن و کي وړاندې کوي، همداراز د لگښت پرته موجود دي. د پورته ذکر شوي تلیفون شمیرې ته زنگ ووهئ یا له خپل چمتو کوونکي سره خبرې وکړئ. د فعالیت ساعتونه د محلي وخت له مخې له سهار 8 بجو څخه د ماښام تر 8 بجو پورې، اووه ورځې په اونۍ کې (پرته د مننه کولو او کرسمس ورځې) د اکتوبر له 1 نېټې څخه تر مارچ 31 پورې، او له اپریل 1 څخه تر سپټمبر 30 پورې د دوشنبې څخه تر جمعي پورې (پرته له رخصتیو) څخه دی.

**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 срpsки, 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.

**Somali** – FIIRO GAAR AH: Haddii aad ku hadashid Soomaali, adeegyada caawinta luuqada oo bilaash ah ayaa lagu heli karaa. Gargaarada maqalka ku haboon iyo adeegyo lagu bixiyo warbixin qaabab la heli karo ayaa sidoo kale lagu helayaa si bilaash ah. Soo wac lambarka taleefonka kor ku qoran ama la hadal adeeg bixiyahaaga. Saacadaha shaqada waa 8 a.m. illaa 8 p.m. saacadaha maxaliga, todoba maalmood isbuucii (marka laga reebo fasaxa Mahadnaqa iyo Kirismaska) laga bilaabo Oktoobar 1 illaa Maarso 31, iyo Isniin illaa Jimcaha (marka laga reebo fasaxyada) laga bilaabo Abriil 1 illaa Sebteembar 30.

**Swahili** – ANGALIZO: Ikiwa unazungumza Swahili, huduma za usaidizi wa lugha zinapatikana kwako bila malipo. Vifaa na huduma saidizi vinavyofaa kwa ajili ya kutoa taarifa katika miundo inayopatikana kwa urahisi zinapatikana pia bila malipo. Piga nambari ya simu iliyoorodheshwa hapo juu au zungumza na mtoa huduma wako. Saa za kazi ni 8 a.m. hadi 8 p.m. kwa saa za eneo lako, siku saba kwa wiki (isipokuwa Sikukuu ya Shukrani na Krismasi) kuanzia Oktoba 1 hadi Machi 31, na Jumatatu hadi Ijumaa (isipokuwa likizo) kuanzia Aprili 1 hadi Septemba 30.

**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 పరికరాలు, సేవలు కూడ ఉచితంగా లభిస్తయి. వైన జబితలో తలీవిన ఫోన్ నంబర్కు కల్ చేయండి లేదా మేీ వోర్షిడర్తో మాట్లాడండి. పని వేళలు అక్టోబర్ 1 నుండి మార్చి 31 వరకు వరనికి ఏడు రేజులు (థంక్స్ గివింగ్, క్రిస్మస్ మినహా) వటు, ఏప్రిల్ 1 నుండి సెప్టెంబర్ 30 వరకు సోమవారం నుండి శుక్రవారం వరకు (సెలమలు మినహా) న్ధనిక సమయం ఉదయం 8 గంటల నుండి రత్రి 8 గంటల వరకు.

**Turkish** – DİKKAT: Türkçe konuşuyorsanız, ücretsiz dil destek hizmetlerimizi kullanabilirsiniz. Erişilebilir formatlarda bilgi sağlamak için uygun yardımcı destek ve hizmetler de ücretsiz olarak sunulmaktadır. Yukarıdaki telefon numarasını arayın veya sağlayıcınızla konuşun. Çalışma saatleri 1 Ekim'den 31 Mart'a kadar haftanın yedi günü (Şükran Günü ve Noel hariç) ve 1 Nisan'dan 30 Eylül'e kadar Pazartesi'den Cuma'ya (tatiller hariç) 08:00 ö.ö. ile 08:00 ö.s. arasındır.

**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.

**Uzbek** – DIQQAT: Agar siz o'zbek tilini bilsangiz, siz uchun bepul til yordam xizmatlari mavjud. Axborotni ochiq shakllarda taqdim etish uchun tegishli yordamchi vositalar va xizmatlar ham bepul taqdim etiladi. Yuqorida keltirilgan telefon raqamiga chaqiruv qiling yoki provayder bilan gaplashing. Ish vaqti: 1-oktabrdan 31-martgacha haftaning yetti kuni (Shukronalik kuni va Rojdestvo bayramidan tashqari) mahalliy vaqt bilan 8 a.m. dan 8 p.m. gacha va 1-apreldan 30-sentabrgacha dushanbadan jumagacha (bayram kunlaridan tashqari).

**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.

## IMPORTANT INFORMATION: 2025 Medicare Star Ratings

Official U.S.  
Government  
Medicare  
Information



Anthem Blue Cross and Blue Shield - H3655

**For 2025, Anthem Blue Cross and Blue Shield - H3655 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](https://www.medicare.gov/plan-compare).

### Questions about this plan?

Contact Anthem Blue Cross and Blue Shield 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 1-866-803-5169 (toll-free) or 711 (TTY). Current members please call 1-855-690-7796 (toll-free) or 711 (TTY).

Anthem Blue Cross and Blue Shield is an HMO-POS plan with a Medicare contract. 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 **1-844-612-7171** 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 **1-844-612-7171** 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.

