Summary of Benefits

Fully Integrated Dual Eligible

Special Needs Plan (FIDE SNP)

Plan year: January 1 – December 31, 2024

New Jersey

21 counties in New Jersey. Full service area on page 6.

Wellpoint Full Dual Advantage (HMO D-SNP)

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Introduction

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

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A. Disclaimers

This is a summary of health services covered by Wellpoint Full Dual Advantage (HMO D-SNP) for January 1 – December 31, 2024. This is only a summary. Read the *Evidence of Coverage* for the full list of benefits.

- Wellpoint Full Dual Advantage (HMO D-SNP) is a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) with a Medicare contract and a contract with the New Jersey Medicaid program. Enrollment in Wellpoint Full Dual Advantage (HMO D-SNP) depends on contract renewal. This plan is available to anyone who has both Medicare and full New Jersey Medicaid benefits.

- Wellpoint New Jersey, Inc. is a D-SNP plan with a Medicare contract and a contract with the New Jersey Medicaid program. Enrollment in Wellpoint New Jersey, Inc. depends on contract renewal. Coverage provided by Wellpoint New Jersey, Inc.

- When enrolling in Wellpoint Full Dual Advantage (HMO D-SNP)
  1. You must use in-network providers.
  2. You must use an in-network DME (Durable Medical Equipment) supplier.
  3. You must use an in-network pharmacy.
  4. You will be enrolled into Medicaid (NJ FamilyCare) coverage under our plan, and disenrolled from any Medicaid (NJ FamilyCare) plan you are currently enrolled in. All of your Medicaid-covered services, items, and medications will then be covered under our plan, and you must get them from in-network providers.
  5. You will be enrolled into Part D coverage under our plan, and you will be automatically disenrolled from any other Medicare Part D or creditable coverage plan in which you are currently enrolled.
  6. You must understand and follow our plan's rules on referrals.

- You can get this document for free in other formats, such as large print, braille, or audio. Call **1-844-765-5160** (TTY: **711**), 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through

March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free.

- If you call us to request a change to your preferred language or format preference, let us know if you want this to be a standing order. That means we will send the same documents in your requested format and language every year. You can also call us to change or cancel a standing order. You can also find your documents online at **https://shop.wellpoint.com/medicare**.

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

B. Frequently asked questions

The followingchart lists frequently asked questions.

Frequently Asked Questions (FAQs)	Answers
What is a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP)?	A NJ Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) is a managed health care option for NJ FamilyCare members with Medicare. A NJ FIDE SNP covers all of your Medicare, NJ FamilyCare (Medicaid) and prescription drug benefits, including Medicare Part D, and extra benefits, in one health plan, with one Member Identification (ID) Card, and no copays for medical services or prescription drugs. A FIDE SNP coordinates all of your care. If you join a FIDE SNP, you do not lose any of your NJ FamilyCare, Managed Long Term Services and Supports (MLTSS), or Medicare benefits. Every service you have with NJ FamilyCare and Medicare is still available, along with access to some additional services. To be eligible to enroll in a FIDE SNP in New Jersey, you must be entitled to Medicare Parts A and B and eligible for full NJ FamilyCare benefits. You must also live in the plan's "service area" (the counties where that plan is offered). The counties that make up Wellpoint Full Dual Advantage (HMO D-SNP)'s service area are listed on page 7 of this document.

Frequently Asked Questions (FAQs)	Answers
Will I get the same Medicare and NJ FamilyCare benefits in Wellpoint Full Dual Advantage (HMO D-SNP) that I get now?	If you are coming to Wellpoint Full Dual Advantage (HMO D-SNP) from Original Medicare or another Medicare plan, you may get benefits or services differently. You will get almost all of your covered Medicare and NJ FamilyCare benefits directly from Wellpoint Full Dual Advantage (HMO D-SNP). When you enroll in Wellpoint Full Dual Advantage (HMO D-SNP) you and your Care Team will work together to develop an individualized Plan of Care to address your health and support needs, reflecting your personal preferences and goals. If you are taking any Medicare Part D prescription drugs that Wellpoint Full Dual Advantage (HMO D-SNP) does not normally cover, you can get a temporary supply, and we will help you to transition to another drug or get an exception for Wellpoint Full Dual Advantage (HMO D-SNP) to cover your drug if medically necessary.
Can I use the same health care providers I use now?	That is often the case. If your providers (including doctors, therapists, pharmacies, and other health care providers) work with Wellpoint Full Dual Advantage (HMO D-SNP) and have a contract with us, you can keep using them. ☐ Providers with an agreement with us are "in-network." You must use the providers in Wellpoint Full Dual Advantage (HMO D-SNP) network. ☐ If you need urgent or emergency care or out-of-area dialysis services, you can use providers outside of Wellpoint Full Dual Advantage (HMO D-SNP)'s network. To find out if your providers are in the plan's network, call Member Services at the number at the bottom of this page or read Wellpoint Full Dual Advantage (HMO D-SNP)'s *Provider and Pharmacy Directory*. You can also visit our website at **https://shop.wellpoint.com/medicare** for the most current listing. If Wellpoint Full Dual Advantage (HMO D-SNP) is new for you, we will work with you to develop an individualized Plan of Care to address your needs. You can keep using the providers you use now for 90 days or until your individualized Plan of Care is completed.

Frequently Asked Questions (FAQs)	Answers
What is a Care Manager?	A Care Manager is your main contact person at our plan. This person helps to manage all of your providers and services and make sure you get what you need.
What are Managed Long Term Care Services and Support (MLTSS)?	Managed Long Term Services and Support (MLTSS) are help for people who need assistance to do everyday tasks like taking a bath, getting dressed, making food, and taking medicine. Often these services are provided at your home or in your community, but they could also be provided in a nursing home or hospital when necessary. MLTSS is available to members who meet certain clinical and financial requirements.
What happens if I need a service but no one in Wellpoint Full Dual Advantage (HMO D-SNP)'s network can provide it?	Most services will be provided by our network providers. If you need a service that cannot be provided within our network, Wellpoint Full Dual Advantage (HMO D-SNP) will cover services provided by an out-of-network provider.
Where is Wellpoint Full Dual Advantage (HMO D-SNP) available?	The service area for this plan includes: Atlantic, Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Gloucester, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem, Somerset, Sussex, Union, Warren counties, New Jersey. You must live in one of these areas to join the plan.

Frequently Asked Questions (FAQs)	Answers
What is prior authorization?	Prior authorization means that you must get approval from Wellpoint Full Dual Advantage (HMO D-SNP) before Wellpoint Full Dual Advantage (HMO D-SNP) will cover a specific service, item, or drug or out-of-network provider. Wellpoint Full Dual Advantage (HMO D-SNP) may not cover the service, item or drug if you don't get prior approval. If you need urgent or out-of-area dialysis services, you don't need to get approval first. Wellpoint Full Dual Advantage (HMO D-SNP) can provide you with a list of services or procedures that require you to get prior authorization from Wellpoint Full Dual Advantage (HMO D-SNP) before the service is provided. Refer to Chapter 3 of the *Evidence of Coverage* to learn more about prior authorization. Refer to the Benefits Chart in Chapter 4 of the *Evidence of Coverage* to learn which services require a prior authorization.
Do I pay a monthly amount (also called a premium) under Wellpoint Full Dual Advantage (HMO D-SNP)?	No. You will not pay any monthly premiums to Wellpoint Full Dual Advantage (HMO D-SNP) for your health coverage. Additionally, Medicaid will pay your Medicare Part B premium for you.
Do I pay a deductible as a member of Wellpoint Full Dual Advantage (HMO D-SNP)?	No. You do not pay deductibles in Wellpoint Full Dual Advantage (HMO D-SNP).
What is the maximum out-of-pocket amount that I will pay for medical services as a member of Wellpoint Full Dual Advantage (HMO D-SNP)?	There is no cost sharingfor medical services in Wellpoint Full Dual Advantage (HMO D-SNP), so your annual out-of-pocket costs will be $0.

Frequently Asked Questions (FAQs)	Answers
Do I have a coverage gap for drugs?	No. Because you have Medicaid you will not have a coverage gap stage for your drugs.

C. Overview of services

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

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need hospital care (This service is continued on the next page)	Inpatient hospital care	**$0**	Your provider must get an approval from the plan before you are admitted to a hospital for a procedure, rehabilitation or transplant that you and your doctor planned ahead. This is called getting prior authorization. You do not need approval for emergency or urgently needed services. Except in an emergency, your health care provider must tell the plan of your hospital admission.
	Outpatient hospital services (including outpatient treatment by a doctor or a surgeon)	**$0**	

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need hospital care (continued)	Ambulatory surgical center (ASC) services	**$0**	
You want to use a health care provider	Doctor visits (including visits to Primary Care Providers and specialists)	**$0**	
	Visits to treat an injury or illness	**$0**	
	Preventive care (care to keep you from getting sick, such as flu shots and other immunizations)	**$0**	Influenza, Hepatitis B, pneumococcal vaccinations, and other vaccinations recommended for adults are covered. The full childhood immunization schedule is covered for members under the age of 21.
	Wellness visits, such as a physical	**$0**	
	"Welcome to Medicare" preventive visit (one time only)	**$0**	
You need emergency care (This service is continued on the next page)	Emergency room services	**$0**	You may use any emergency room if you reasonably believe you need emergency care. You do not need prior authorization and you do not have to be in-network.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need emergency care (continued)	Emergency room services (cont'd)		In addition to the Medicare-covered emergency room services, this plan offers worldwide emergency care services when traveling outside of the United States and its territories for less than six months. Coverage is limited to **$100,000** per year for worldwide emergency services and urgent care. Contact the plan for details.
	Urgently needed services	**$0**	Urgently needed services are not emergency care. You do not need prior authorization and you do not have to be in-network. In addition to the Medicare-covered urgent care services, this plan offers urgently needed services when traveling outside of the United States and its territories for less than six months. Coverage is limited to **$100,000** per year for worldwide emergency services and urgent care. Contact the plan for details.
You need medical tests (This service is continued on the next page)	Lab tests, such as blood work	**$0**	

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need medical tests (continued)	X-rays or other pictures, such as CAT scans	**$0**	Your provider must get an approval from the plan before you get high-tech imaging or certain diagnostic and therapeutic radiology and lab services.
	Screenings, such as tests to check for cancer	**$0**	
You need hearing/ auditory services	Hearing screenings (including routine hearing exams)	**$0**	
	Hearing aids (as well as fittings and associated accessories and supplies)	**$0**	Prior authorization required.
You need dental care	Dental services (including, but not limited to, routine exams and cleanings, X-rays, fillings, crowns, extractions, dentures, and endodontic and periodontal care)	**$0**	Contact the plan or see the *Evidence of Coverage* for details.
You need eye care (continued on the next page)	Vision services (including annual eye exams)	**$0**	

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need eye care (continued)	Glasses or contact lenses	**$0**	Replacement glasses and frames are covered once every 24 months unless medically necessary or unless the glasses are lost, damaged or destroyed.
	Other vision care (including diagnosis and treatment for diseases and conditions of the eye)	**$0**	
You have a mental health condition (This service is continued on the next page)	Inpatient mental health care (long-term mental health services, including inpatient services in a psychiatric hospital, general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF), or critical access hospital)	**$0**	All members are covered by the plan for acute inpatient hospitalization in a general hospital, regardless of the admitting diagnosis or treatment.
	Outpatient mental health care (including, but not limited to, clinical counseling and therapy, peer support, psychosocial rehabilitation,	**$0**	Services may be provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, Independent Practitioner Network (IPN) Psychiatrist, Psychologist or Advanced Practice Nurse (APN), or other qualified mental health care

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a mental health condition (continued)	medication management, family psychoeducation, and intensive outpatient models of care) (**Note**: This is not a complete list of the plan's expanded outpatient mental health services. Call Member Services or read the Evidence of Coverage, Chapter 4, for more information.)		professional as allowed under applicable state laws.
You have a substance use disorder (This service is continued on the next page)	Inpatient and outpatient substance use disorder treatment services (including, but not limited to, detoxification and withdrawal management, short-term residential services, residential treatment center services, and Methadone Medication Assisted Treatment)	**$0**	

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a substance use disorder (continued	(**Note:** This is not a complete list of the plan's expanded substance use disorder services. Call Member Services or read the *Evidence of Coverage,* Chapter 4, for more information.)		
You need a place to live with people available to help you	Skilled nursing care	**$0**	Your provider must get an approval from the plan before you get skilled nursing facility care. This is called getting prior authorization.
	Nursing home	**$0**	
	Custodial care (long-term care in a Nursing Facility)	**$0**	Services are covered for those who meet nursing facility level of care and whose rehabilitation goals have been met or discontinued with no plan to discharge to the community within 180 days of admission.
You need therapy after a stroke or accident	Occupational, physical, or speech therapy	**$0**	You may need an approval from the plan before you get physical therapy, occupational therapy and speech/ language therapy.
You need help getting to health services (This service is continued on the next page)	Ambulance services	**$0**	Your provider must get an approval from the plan before you get ground, air or water transportation that is not an emergency.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need help getting to health services (continued)	Emergency transportation	**$0**	
You need drugs to treat your illness or condition (This service is continued on the next page)	Medicare Part B prescription drugs (including those given by your provider in their office, some oral anti-cancer drugs, and some drugs used with certain medical equipment)	**$0**	This plan requires step therapy for some Part B drugs. Step Therapy is a utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your doctor may have initially prescribed. You may also be required to try a Part B drug before using a Part D drug and in some cases you may be required to try a Part D drug before getting a Part B drug. You can contact Member Services at the number at the bottom of the page for more information. Read the *Evidence of Coverage*, Chapter 4, for more information on these drugs.
	Medicare Part D prescription drugs Tiers 1-6: Generic and brand name drugs	**$0**	There may be limitations on the types of drugs covered. Refer to Wellpoint Full Dual Advantage (HMO D-SNP)'s list of covered drugs (formulary) at the website listed at the bottom of the page for more information.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued)	Medicare Part D prescription drugs Tiers 1-6: Generic and brand name drugs (cont'd)		Wellpoint Full Dual Advantage (HMO D-SNP) may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from Wellpoint Full Dual Advantage (HMO D-SNP) for certain drugs. You must use certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, *List of Covered Drugs* (formulary), and printed materials, as well as on the Medicare Prescription Drug Plan Finder on www.medicare.gov/plan-compare. Extended day supplies are available through retail pharmacies and mail-order. **Important Message About What You Pay for Vaccines** – Some vaccines are considered medical benefits. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's List of Covered

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued)			Drugs (Formulary). Our plan covers Part D vaccines at no cost to you.
	Over-the-counter (OTC) drugs	**$0**	There may be limitations on the types of drugs covered.
	Diabetes medications	**$0**	
You need foot care	Podiatry services (including routine exams)	**$0**	Excludes routine hygienic care of the feet, including the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, in the absence of a pathological condition.
	Orthotic services	**$0**	
You need durable medical equipment (DME) or supplies (This service is continued on the next page)	Wheelchairs, nebulizers, crutches, rollabout knee walkers, walkers, and oxygen equipment and supplies, for example (**Note:** This is not a complete list of covered DME or supplies. Call Member Services at the number at the bottom of this page or read the *Evidence of*	**$0**	Therapeutic Continuous Glucose Monitors (CGMs) and related supplies are covered by Medicare when they meet Medicare National Coverage Determination (NCD) and Local Coverage Determinations (LCD) criteria. In addition, where there is not NCD/ LCD criteria, therapeutic CGM must meet any plan benefit limits, and the plan's evidence based clinical practice guidelines. This plan only covers FreeStyle Libre Continuous Glucose Monitors (CGMs). We will not cover other brands unless your provider tells us it is medically necessary. CGMs MUST be purchased

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need durable medical equipment (DME) or supplies (continued	*Coverage* for more information.)		at a network retail or our mail-order pharmacy to be covered. If you purchase these supplies through a Durable Medical Equipment (DME) provider these items will not be covered. Coverage limitations (unless otherwise medically necessary): • 2 Sensors per month • One receiver every 2 years Insulin pumps are different than a CGM and can be purchased through a DME provider. This plan covers only DUROLANE, EUFLEXXA, SUPARTZ, and Gel-SYN-3 Hyaluronic Acids. We will not cover other brands unless your provider tells us it is medically necessary.
You need interpreter services	Spoken language interpreter	**$0**	
	Sign language interpreter	**$0**	
Other covered services (This service is continued on	Acupuncture	**$0**	
	Care coordination	**$0**	

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Other covered services (continued)	Chiropractic services	**$0**	You may need an approval from the plan before you get chiropractic services.
	Diabetic supplies	**$0**	This plan covers only OneTouch® (made by LifeScan, Inc.) and ACCU-CHECK® (made by Roche Diagnostics) blood glucose test strips and glucometers. We will not cover other brands unless your provider tells us it is medically necessary. Blood glucose test strips and glucometers MUST be purchased at a network retail or our mail-order pharmacy to be covered. If you purchase these supplies through a Durable Medical Equipment (DME) provider these items will NOT be paid for. Lancets are limited to the following manufacturers: LifeScan / Delica, Roche, Kroger and its affiliates which include Fred Meyer, King Soopers, City Market, Fry's Food Stores, Smith's Food and Drug Centers, Dillon Companies, Ralphs, Quality Food Centers, Baker, Scott's, Owen, Payless, Gerbes, Jay-C, Prodigy, and Good Neighbor.
	Early and Periodic Screening Diagnosis and Treatment (EPSDT)	**$0**	EPSDT is for members under 21 years of age.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Other covered services (continued)	(including preventive screenings, medical examinations, vision and hearing screenings and services, immunizations, lead screening, and private duty nursing services)		
	Family planning	**$0**	Family planning services furnished by out-of-network providers are covered directly by Medicaid fee-for-service. Services primarily related to the diagnosis and treatment of infertility are not covered.
	Hospice care	**$0**	
	Mammograms	**$0**	
	Managed Long Term Services and Supports (MLTSS) (including, but not limited to, assisted living services; cognitive, speech, occupational, and physical therapy; chore services; home-delivered	**$0**	MLTSS provides services for members that need the level of care typically provided in a Nursing Facility, and allows them to get necessary care in a residential or community setting. MLTSS is available to members who meet certain clinical requirements.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Other covered services (continued)	meals; residential modifications (such as the installation of ramps or grab bars); vehicle modifications; social adult day care; and non-medical transportation)		
	Medical day care (including preventive, diagnostic, therapeutic, and rehabilitative services under medical and nursing supervision in an ambulatory care setting)	**$0**	Medical day care is provided to meet the needs of individuals with physical and/or cognitive impairments in order to support their community living.
	Personal Care Assistance (PCA) (including health-related tasks performed by a qualified individual in a member's home, under the supervision of a registered professional nurse, as certified by a physician in	**$0**	

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Other covered services (continued)	accordance with a member's written plan of care)		
	Prosthetic services	**$0**	
	Services to help manage your disease	**$0**	

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

D. Additional services Wellpoint Full Dual Advantage (HMO D-SNP) covers

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

Additional services Wellpoint Full Dual Advantage (HMO D-SNP) covers	Your costs
24/7 NurseLine 24-hour access to a nurse helpline, 7 days a week, 365 days a year: **1-855-658-9249**.	**$0**
Advanced Directives Program As a member of our plan, you will have access to an online advance care planning resource to create an advance directive where you can combine the elements of a: ☐ Living will. ☐ Medical power of attorney. ☐ Do not attempt resuscitation form. ☐ Organ donation form. You can create your own digital care plan and even include video and audio files. If you already have these documents prepared, you can store them and ensure they are shared with your doctors and care providers 24 hours a day, seven days a week. You can add new information at any time as your health status or wishes change.	**$0**

Additional services Wellpoint Full Dual Advantage (HMO D-SNP) covers	Your costs
Everyday Options Allowance for Assistive Devices, Groceries, Over-the-Counter (OTC), and Utilities: This benefit provides a monthly combined spending allowance of **$269.00 each month** for assistive devices, eligible food items, over-the-counter (OTC) health and wellness products, and utilities. You have a variety of convenient ways to use the benefit: ☐ Shop in-store at participating retailers near you (Groceries and OTC only). ☐ Shop online on the approved vendor website. ☐ Shop on the approved vendor mobile app. ☐ Call to place an order. ☐ Order by mail (OTC and Assistive Devices only). ☐ With your utility provider. Unused amounts do not roll over to the next month or calendar year. Please call Member Services at the number at the bottom of the page for more information.	**$0**
Healthy Meals Enjoy healthy meals delivered directly to your home. You could receive up to two meals a day for up to 90 days to support your nutritional needs. Depending on your specific conditions and healthcare needs, you may be eligible. Please reach out to Member services at the number at the bottom of the page so it can be coordinated for you. For more information, please refer to your *Evidence of Coverage*.	**$0**
LiveHealth Online Lets you talk, 24/7, to a board-certified doctor, or licensed psychiatrist, psychologist or therapist, by live, two-way video on a computer, smartphone or tablet.	**$0**

Additional services Wellpoint Full Dual Advantage (HMO D-SNP) covers	Your costs
Medicare Community Resource Support We assist you right over the phone by providing you with health-related information and by connecting you to local community-based services and support programs. We'll help you coordinate these services based on your unique needs. For more details, call Member Services at the number listed on the bottom of the page and ask for the Medicare Community Resource Support team.	**$0**
Personal Emergency Response System (PERS) Includes the monitoring device and monitoring service. To start and install services, give us a call. We can help you. For more details, please call the Member Services phone number listed at the bottom of this page.	**$0**
SilverSneakers*® Fitness program When you become our member, you can sign up for SilverSneakers. It's included in our plan. To learn more details, go to **www.silversneakers.com** or call SilverSneakers at 1-855-741-4985 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. ET. * The SilverSneakers Fitness Program is provided by Tivity Health, an independent company. SilverSneakers and the SilverSneakers shoe logotype are registered trademarks of Tivity Health, Inc. © 2023 Tivity Health, Inc. All rights reserved.	**$0**
Transportation: Non-Health Related This plan provides 24 one-way transportation trips to grocery stores, SilverSneakers classes, religious services, community centers, banks, and Medicare or other government offices (including DMV).	**$0**

E. Benefits covered outside of Wellpoint Full Dual Advantage (HMO D-SNP)

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

Other services covered directly by Medicaid fee-for-service	Your costs
Non-Emergency (Routine) Transportation (including mobile assistance vehicles (MAVs)); non-emergency basic life support (BLS) ambulance (stretcher); and livery transportation services (such as bus and train fare or passes, or car service and reimbursement for mileage)	**$0**
Targeted case management (chronic mental illness)	**$0**
Behavioral Health Home (Care Management)	**$0**
PACT (Program in Assertive Community Treatment)	**$0**
CSS (Community Support Services)	**$0**
Psychiatric Emergency Services (PES)/Affiliated Emergency Services (AES)	**$0**

F. Services not covered by Wellpoint Full Dual Advantage (HMO D-SNP) (exclusions)

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

Services not covered by Wellpoint Full Dual Advantage (HMO D-SNP) (exclusions)
Services not considered "reasonable and necessary" according to standards of Medicare and NJ FamilyCare
Experimental medical and surgical treatments, items, or drugs unless covered by Medicare or under a Medicare-approved clinical study
Surgical treatment for morbid obesity except when medically necessary
Elective or voluntary enhancement procedures
Cosmetic surgery or other cosmetic work unless required criteria are met
LASIK surgery

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

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

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

- **You have a right to respect, fairness, and dignity.** This includes the right to:
    - Get covered services without concern about race, ethnicity, national origin, color, religion, creed, sex (including sex stereotypes and gender

identity), age, health status, mental, physical, or sensory disability, sexual orientation, genetic information, ability to pay, or ability to speak English. No health care provider should engage in any practice, with respect to any member that constitutes unlawful discrimination under any state or federal law or regulation.

- Ask for and get information in other formats (for example, large print, braille, audio) free of charge
- Be free from any form of physical restraint or seclusion
- Not be billed by network providers
- Have your questions and concerns answered completely and courteously
- Apply your rights freely without any negative effect on the way Wellpoint Full Dual Advantage (HMO D-SNP) or your provider treats you

- **You have the right to get information about your health care.** This includes information on treatment and your treatment options, regardless of cost or benefit coverage. This information should be in a format and language you can understand. These rights include getting information on:
  - Wellpoint Full Dual Advantage (HMO D-SNP)
  - The services we cover
  - How to get services
  - How much services will cost you
  - Names of health care providers and Care Managers
  - Your rights and responsibilities
- **You have the right to make decisions about your care, including refusing treatment.** This includes the right to:
  - Choose a primary care provider (PCP) and change your PCP at any time during the year. You can call **1-844-765-5160** if you want to change your PCP.
  - Use a women's health care provider without a referral

- Get your covered services and drugs quickly
- Know about all treatment options, no matter what they cost or whether they are covered
- Refuse treatment as far as the law allows, even if your health care provider advises against it
- Stop taking medicine, even if your health care provider advises against it
- Ask for a second opinion about any health care that your PCP or your Care Team advises you to have. Wellpoint Full Dual Advantage (HMO D-SNP) will pay for the cost of your second opinion visit.
- Make your health care wishes known in an advance directive

- **You have the right to timely access to care that does not have any communication or physical access barriers.** This includes the right to:
  - Get timely medical care
  - Get in and out of a health care provider's office. This means barrier-free access for people with disabilities, in accordance with the Americans with Disabilities Act.
  - Have interpreters to help with communication with your doctors, other providers, and your health plan. Call **1-844-765-5160** if you need help with this service.
  - Have your *Evidence of Coverage* and any printed materials from Wellpoint Full Dual Advantage (HMO D-SNP) translated into your primary language, and/or have these materials read out loud to you if you have trouble seeing or reading. Oral interpretation services will be made available upon request and free of charge.
  - Be free of any form of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience, or retaliation

- **You have the right to use emergency and urgent care when you need it**. This means you have the right to:
  - Get emergency and urgent care services, 24 hours a day, 7 days a week, without prior approval

- Use an out-of-network urgent or emergency care provider, when necessary

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

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

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

- **You have a responsibility to treat others with respect, fairness, and dignity.** You should:
  - Treat your health care providers with dignity and respect
  - Keep appointments, be on time, and call in advance if you're going to be late or have to cancel

- **You have the responsibility to give information about you and your health.** You should:
  - Tell your health care provider your health complaints clearly and provide as much information as possible
  - Tell your health care provider about yourself and your health history

- Tell your health care provider that you are an Wellpoint Full Dual Advantage (HMO D-SNP) member
- Talk to your PCP, Care Manager, or other appropriate person about using the services of a specialist before you go to a hospital (except in cases of emergency)
- Tell your PCP, Care Manager, or other appropriate person within 24 hours of any emergency or out-of-network treatment
- Notify Wellpoint Full Dual Advantage (HMO D-SNP) if there are any changes in your personal information, such as your address or phone number

- **You have the responsibility to make decisions about your care, including refusing treatment.** You should:
  - Learn about your health problems and any recommended treatment, and consider the treatment before it's performed
  - Partner with your Care Team and work out treatment plans and goals together
  - Follow the instructions and plans for care that you and your health care provider have agreed to, and remember that refusing treatment recommended by your health care provider might harm your health

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

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

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

If you have a complaint or think Wellpoint Full Dual Advantage (HMO D-SNP) should cover something we denied, call Wellpoint Full Dual Advantage (HMO D-SNP) at **1-844-765-5160** (TTY: **711**), 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. You can file a complaint or appeal our decision.

For questions about complaints and appeals, you can read Chapter 9 of Wellpoint Full Dual Advantage (HMO D-SNP)'s *Evidence of Coverage*. You can also call Wellpoint Full Dual Advantage (HMO D-SNP) Member Services at **1-844-765-5160** (TTY: **711**).

I. What to do if you suspect fraud

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

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

- Call us at Wellpoint Full Dual Advantage (HMO D-SNP) Member Services. The phone number is at the bottom of each page of this summary.
- Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users may call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- You can also contact New Jersey's Medicaid Fraud Division (of the Office of the State Comptroller) by calling 1-609-292-1272 Control Division by calling (800) 771-7755. Calls to this number are free.

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

CALL: 1-844-765-5160

Calls to this number are free.

8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

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

TTY: 711

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

If you have questions about your health:

- ☐ Call your primary care provider (PCP). Follow your PCP's instructions for getting care when the office is closed.
- ☐ If your PCP's office is closed, you can also call Wellpoint Full Dual Advantage (HMO D-SNP)'s 24/7 NurseLine at **1-855-658-9249** (TTY: **711**). A nurse will listen to your problem and tell you how to get care.

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Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at **1-844-765-5160** (TTY: **711**). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al **1-844-765-5160** (TTY: **711**). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险計劃的任何疑 问。如果您需要此翻译服务，请致电 **1-844-765-5160** (TTY: **711**)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險計劃可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 **1-844-765-5160** (TTY: **711**)。我們講粵語的工作人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa **1-844-765-5160** (TTY: **711**). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au **1-844-765-5160** (TTY: **711**). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi **1-844-765-5160** (TTY: **711**) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter **1-844-765-5160** (TTY: **711**). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

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Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 **1-844-765-5160** (TTY: **711**) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону **1-844-765-5160 (TTY: 711)**. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات الترجمة الفورية المجانية للإجابة عن أي أسئلة تتعلق بالخطة الصحية أو الأدوية. للحصول على مترجم فوري، ما عليك سوى الاتصال بنا على الرقم **1-844-765-5160 (TTY: 711)** يمكن لشخص يتحدث الإنجليزية أن يساعدك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें**1-844-765-5160**(TTY: **711**) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero **1-844-765-5160** (TTY: **711**). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número **1-844-765-5160** (TTY: **711**). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan **1-844-765-5160** (TTY: **711**). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer **1-844-765-5160** (TTY: **711**). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、**1-844-765-5160** (TTY: **711**) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

IMPORTANT INFORMATION:
2023 Medicare Star Ratings

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Amerigroup Community Care - H3240

For 2023, Amerigroup Community Care - H3240 received the following Star Ratings from Medicare:

Overall Star Rating: ★★★½☆

Health Services Rating: ★★★½☆

Drug Services Rating: ★★★☆☆

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

Plan Star Ratings

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

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

Star Ratings are based on factors that include:

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

The number of stars show how well a plan performs.

★★★★★ EXCELLENT

★★★★☆ ABOVE AVERAGE

★★★☆☆ AVERAGE

★★☆☆☆ BELOW AVERAGE

★☆☆☆☆ POOR

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

Get More Information on Star Ratings Online

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

Questions about this plan?

Contact Amerigroup Community Care 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 1-877-470-4131 (toll-free) or 711 (TTY). Current members please call 1-844-765-5160 (toll-free) or 711 (TTY).

This plan is available to anyone who has both Medicare and full Medicaid benefits.

Amerivantage Dual Coordination (HMO D-SNP) is a D-SNP plan with a Medicare contract and a contract with the New Jersey Medicaid program. Enrollment in Amerivantage Dual Coordination (HMO D-SNP) 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 **1-877-470-4131** (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.wellpoint.com/medicare** or call **1-877-470-4131** to view a copy of the EOC.
- ☐ Review the *Provider and Pharmacy 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 *Provider and 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.
- ☐ Your Medicare Part B premium will be covered for you by NJ FamilyCare (Medicaid).
- ☐ Benefits may change on January 1, 2025.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the *Provider and Pharmacy Directory*).
- ☐ This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid. To be eligible for this plan, you must be eligible for Medicare and full Medicaid benefits.
- ☐ If you are currently enrolled in a NJ FamilyCare (Medicaid) plan, you will be automatically disenrolled. Wellpoint Full Dual Advantage (HMO D-SNP) will cover your Medicaid benefits.

- [ ] You will automatically be disenrolled from any Medicare Advantage and/or Medicare Part D plans you are currently enrolled in. Wellpoint Full Dual Advantage (HMO D-SNP) will cover your Medicare Part A and Part B benefits, as well as all of your Medicare Part D prescription drugs.