2022 SUMMARY OF BENEFITS

January 1, 2022 – December 31, 2022

The Health Plan SecureCare - Option II (HMO)
H3672-013

A Medicare Advantage Plan with Prescription Drugs

Our service area includes the following counties in **Ohio**:

Ashland, Athens, Carroll, Columbiana, Coshocton, Cuyahoga, Delaware, Fairfield, Franklin, Gallia, Geauga, Hocking, Holmes, Jackson, Knox, Lake, Lawrence, Licking, Lorain, Mahoning, Medina, Meigs, Morgan, Morrow, Perry, Pickaway, Portage, Stark, Summit, Trumbull, Tuscarawas, Vinton and Wayne.

This document is available in other formats such as braille, large print and audio CD. For additional information on available formats, call us at **1.877.847.7915 (TTY: 711)**.

INTRODUCTION

The benefit information provided in this booklet is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, access our Evidence of Coverage online at healthplan.org/medicare. Or call us to request a copy.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at medicare.gov or get 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.

The Health Plan SecureCare (HMO) is an HMO plan with a Medicare contract. Enrollment in The Health Plan SecureCare (HMO) depends on contract renewal.

ELIGIBILITY

To join The Health Plan SecureCare - Option II (HMO) you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

WHICH DOCTORS, HOSPITALS AND PHARMACIES CAN I USE?

This is a Health Maintenance Organization (HMO) plan. This means that The Health Plan SecureCare - Option II (HMO) has a network of doctors, hospitals, pharmacies and other providers. You can see current provider lists on our website at healthplan.org/medicare. Or call us and we will send you a copy.

Our plan requires you to choose an in-network doctor to be your primary care provider (PCP). We do not require a referral from your PCP to see network providers, including network specialists, for covered services. However, some services do require prior authorization from the plan. Contact us for additional information. Even though your PCP is not required to refer you, we recommend that they help with coordinating your care. If you use providers that are not in our network, the plan may not pay for these services.

HOW TO REACH US

If you are a member, call toll-free: 1.877.847.7907 (TTY:711)

If you are not a member, call toll-free: 1.877.847.7915 (TTY:711)

Hours of operation:

- October 1 to March 31, 8:00 a.m. to 8:00 p.m. Eastern, 7 days a week.
- April 1 to September 30, 8:00 a.m. to 8:00 p.m. Eastern, Monday through Friday.

Or visit our website: healthplan.org/medicare

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 **1.877.847.7915 (TTY: 711)**.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit healthplan.org/medicare or call **1.877.847.7915 (TTY: 711)** 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 medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ 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, 2023.
- ☐ 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).

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE OPTION II (HMO) H3672-013	MAY REQUIRE PRIOR APPROVAL*
Monthly Plan Premium	$0 You must continue to pay your Medicare Part B premium.	
Annual Medical Deductible	This plan does not have a deductible.	
Maximum Out-of-Pocket Responsibility (Does not include prescription drugs)	$3,900 annually This is the most that you will pay out of pocket for in-network covered Part A and Part B services in 2022. The amounts you pay for copayments and coinsurance for these covered services count towards the maximum out-of-pocket amount.	
MEDICAL AND HOSPITAL SERVICES		
Inpatient Hospital Coverage **(Per admission or stay)**	Days 1-5: $265 copay per day Days 6-90: $0 copay Days 91 and beyond: $0 copay Our plan covers an unlimited number of days for an inpatient hospital stay.	☑
Outpatient Hospital Coverage	$250 copay for outpatient surgeries $0 copay for diagnostic colonoscopies $0 copay for observation visits	☑
Doctor Visit - Primary Care Provider	$0 copay	☐
Doctor Visit - Specialist	$45 copay No referral needed. However, organizational authorization may be required for out-of-network and tertiary specialists.	☑
Preventive Care (Medicare–covered zero cost sharing preventive services)	$0 copay	☑

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE OPTION II (HMO) H3672-013	MAY REQUIRE PRIOR APPROVAL*
Emergency Care (Worldwide)	$90 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. Covered emergency services outside of U.S. have a $25,000 annual plan maximum.	☐
Urgently Needed Services	$45 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services.	☐
Diagnostic Radiological Service (such as MRIs, CT scans)	$0 or $150 copay $150 for CT scans, MRI, MRA, PET and SPECT scans. $0 copay for all diagnostic mammograms and diagnostic bone density exams.	☑
Therapeutic Radiological Services (such as radiation treatment for cancer)	20% co-insurance	☑
Lab Services	$0 copay	☐
Diagnostic Tests and Procedures	$50 copay	☐
Outpatient X-rays	$50 copay for Medicare-covered X-ray services	☑

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE OPTION II (HMO) H3672-013	MAY REQUIRE PRIOR APPROVAL*
Hearing Services	Medicare-covered hearing exam: $45 copay <u>Routine Hearing</u> Hearing exam: $0 copay for one exam every year Hearing aids: Hearing aids are covered up to one per ear, every two years - $599 copayment for Advanced level hearing aid - $899 copayment for Premium level hearing aid - Includes 2-year supply of batteries per aid (non-rechargeable models only) after purchase - $0 copay for provider visits for fittings and adjustments, covered for 12 months after hearing aid purchase TruHearing provider must be used.	☐
Medicare-Covered Dental Services	$45 copay This does not include services in connection with care, treatment, filling, removal, or replacement of teeth.	☑

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE OPTION II (HMO) H3672-013	MAY REQUIRE PRIOR APPROVAL*
Routine Dental Services	This plan covers preventive and comprehensive dental services You pay a $0 copay for: • 2 oral exams every year • 2 cleanings and 1 set of bitewing X-rays every year • 1 full mouth X-ray every 3 years This plan also covers up to a $1,000 allowance for covered comprehensive dental services every year. You pay $0 for covered diagnostic service charges, 20%-50% for covered restorative dental service charges and 50% for covered endodontic, periodontic, prosthodontic and oral surgery service charges. This includes but is not limited to: • Fillings • Root canal • Periodontal scaling and root planing • Extractions • Crowns • Dentures Not every covered dental service is listed here. Also, most services have limits that are not included above. Contact us for more details. You must use participating providers for routine dental services. You can find the dental directory on our website at healthplan.org/medicare, or by calling us at 1.877.847.7915 (TTY: 711).	☑

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE OPTION II (HMO) H3672-013	MAY REQUIRE PRIOR APPROVAL*
Optional Supplemental Dental	Additional comprehensive dental benefits are available for purchase, with a separate monthly premium. See the "Optional Supplemental Benefits" section in the back of this book.	☐
Vision Services: Medicare-covered exam to diagnose and treat conditions of the eye	$0 copay	☐
Vision Services: Medicare-covered eyewear	$0 copay Limited coverage of eyewear related to cataract surgery.	☐
Vision Services: Routine eye exam	$0 copay for one exam every year Routine vision services are provided through plan participating providers. Contact the plan for more details.	☐
Vision Services: Routine eyewear	$0 copay This plan has a coverage limit for routine eyewear. We will cover up to $100 toward glasses (lens and frames) or contacts (including fitting exam) every two years if purchased at a participating provider.	☐
Inpatient Mental Health Services **(Per admission or stay)**	Days 1-5: $265 copay per day Days 6-90: $0 copay	☑
Outpatient Individual or Group Mental Health Therapy Visit	$40 copay for Medicare-covered sessions	☑
Skilled Nursing Facility (Per benefit period, as defined by Original Medicare)	Days 1-20: $0 copay Days 21-100: $160 copay per day This plan covers up to 100 days in a skilled nursing facility during each benefit period.	☑
Physical Therapy	$40 copay	☑

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE OPTION II (HMO) H3672-013	MAY REQUIRE PRIOR APPROVAL*
Ambulance Authorization required for non-emergency Medicare services	$200 copay for all other ambulance services $500 copay for air ambulance services The above cost shares are for Medicare-covered ambulance services only. Emergency transportation is covered worldwide. Covered emergency transportation services outside of the U.S. have a $25,000 annual plan maximum.	☐
Transportation (Routine)	$0 copay Covered up to 35 round trips to any health-related location, with a plan coverage maximum of $1,000 per year. Services must be arranged with our approved vendor.	☑
Medicare Part B Drugs Part B drugs may be subject to step therapy. See Evidence of Coverage for details.	20% co-insurance	☑
Ambulatory Surgery Center	$250 copay	☑
ADDITIONAL BENEFITS		
Medicare-Covered Foot Exams and Treatment (Podiatry)	$45 copay	☑
Routine Foot Care (Podiatry)	$45 copay Routine foot care is covered for up to 2 visits every year.	☑
Durable Medical Equipment (like wheelchairs and oxygen) and Prosthetics (like braces and artificial limbs)	20% co-insurance Must meet certain criteria to be covered. Contact the plan for more details.	☑

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Diabetic Monitoring Supplies	$7.50 copay for a 30-day supply of test strip/lancet items. Coverage is limited to 100 strips for a 30-day supply. Additional quantity requires coverage review. 0% co-insurance for preferred blood glucose monitors. Diabetic monitoring devices and test strips are limited to LifeScan products.	☑
Medicare-Covered Diabetes Self-Management	$0 copay Diabetes self-management training is covered under certain conditions. Contact the plan for details.	☐
Diabetic Therapeutic Shoes or Inserts	20% co-insurance	☑
Health/Wellness Programs (e.g., fitness, tobacco cessation, etc.)	$0 copay SilverSneakers is the fitness program covered by this plan.	☐
Home Health Services	$0 copay	☑
Cardiac/Pulmonary Rehabilitation Services	$0 copay	☑
Chiropractic Services	$20 copay Medicare covered chiropractic services only	☑
Over-the-Counter Items (OTC)	$60 allowance every 3 months The unused quarterly allowance amount will not carry over to the next quarter. Unused amounts will not carry over to the next calendar year. Services must be accessed through our contracted vendor.	☐

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE OPTION II (HMO) H3672-013	MAY REQUIRE PRIOR APPROVAL*
Telehealth Services	$0 copay This applies to phone or virtual visits with our telehealth vendor providers: • Primary Care Physician Services • Physician Specialist Services • Individual Sessions for Mental Health Specialty Services • Individual Sessions for Psychiatric Services • Individual Sessions for Outpatient Substance Abuse Services must be accessed through our contracted vendor.	☐
Meals	$0 copay for meals provided through the approved vendor. When you get home after an inpatient hospital stay or immediately following surgery, we cover up to 2 home delivered meals per day for 7 days after discharge. Covered up to 4 times per year.	☑
Personal Emergency Response System (PERS)	$0 copay Includes the monitoring device and monthly monitoring fees. Services must be accessed through our contracted vendor.	☐

*SERVICES WITH ☑ MAY REQUIRE YOUR PROVIDER TO OBTAIN PRIOR AUTHORIZATION FROM THE PLAN.

Prescription Coverage

THE HEALTH PLAN SECURECARE – OPTION II (HMO) H3672- 013				
Outpatient Prescription Drugs	This plan provides Part D Rx coverage.			
Cost Sharing	Costs may differ based on pharmacy type/status (i.e., preferred/non-preferred, mail order, long term care, home infusion) and prescription day supply. There are preferred retail pharmacies in our network. You will generally pay a lower copay at a preferred network pharmacy. **If you qualify for low-income subsidy (LIS), also known as Medicare's "Extra Help" program, the amount you pay in some stages may be different than what is listed** For more information, please call us or access our Evidence of Coverage or formulary online at healthplan.org/medicare.			
Stage 1: **Annual Prescription (Part D) Deductible**	$0 per year for Tier 1 and Tier 2 Part D prescription drugs $100 per year for Tier 3, Tier 4, and Tier 5 Part D prescription drugs			
Stage 2: **Initial Coverage**	After you pay your yearly deductible, you pay the amount listed in the table(s) until your total yearly drug costs reach **$4,430** Total yearly drug costs are the total drug costs paid by both you and our Part D plan			
	Preferred Retail Pharmacy 30-day supply	**Standard Retail Pharmacy 30-day supply**	**Preferred Mail Order Pharmacy 30-day supply**	**Standard Mail Order Pharmacy 30-day supply**
Tier 1: Preferred Generic	$3	$13	$3	$13
Tier 2: Generic	$10	$20	$10	$20
Tier 3: Preferred Brand	$47	$47	$47	$47
Tier 4: Non-Preferred Drug	$100	$100	$100	$100
Tier 5: Specialty (Extended day supply not available in this Tier)	31%	31%	31%	31%

THE HEALTH PLAN SECURECARE – OPTION II (HMO) H3672- 013				
	Preferred Retail Pharmacy 90-day supply	**Standard Retail Pharmacy 90-day supply**	**Preferred Mail Order Pharmacy 90-day supply**	**Standard Mail Order Pharmacy 90-day supply**
Tier 1: Preferred Generic	$9	$39	$0	$39
Tier 2: Generic	$30	$60	$0	$60
Tier 3: Preferred Brand	$141	$141	$94	$141
Tier 4: Non-Preferred Drug	$300	$300	$200	$300
Tier 5: Specialty (Extended day supply not available	N/A	N/A	N/A	N/A
Stage 3: **Coverage Gap**	Most Medicare drug plans have a coverage gap. This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,430. After you enter the coverage gap, you pay 25% of the price for brand name drugs plus a portion of the drug dispensing fee, and 25% of the price for generic drugs until your costs total $7,050			
Stage 4: **Catastrophic Coverage**	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,050, you pay the greater of 5% of the cost, or $3.95 copay for generic (or a preferred multi-source drug) and a $9.85 copayment for all other drugs			

Optional Supplemental Benefits – Dental

This coverage is available to you for an additional monthly cost of **$21.30**. This will be in addition to your The Health Plan SecureCare – Option II (HMO) monthly premium.

Our plan will cover up to $1,500 for dental services per plan year. You will be responsible for a portion of the cost for services, as indicated below. The benefit is administered through Liberty Dental providers.

This is not a complete description of benefits. There are covered services that are not listed here. In addition, some of the following services have limitations, exclusions, and maximums. Please contact the plan for complete details.

Monthly Premium	**$21.30**
Maximum Benefit – Plan Coverage Limit	**$1,500 per year**

Covered Dental Benefits	**In-Network You Pay**
Basic Benefits	
Fillings	20%
Resin-based Composite	20%
Endodontics	50%
Scaling and Root Planing	50%
Periodontal Maintenance	50%
General Anesthesia/Intravenous Sedation	50%
Major Benefits	
Crown	50%
Extractions	50%
Complete and Partial Dentures	50%
Denture Adjustment	50%
Denture Repair	50%
Denture Reline/Rebase	50%

How to add this additional Optional Supplemental dental coverage to your plan: Mark the appropriate section on your initial Medicare Advantage plan enrollment form. You can also add this coverage: Up to 60 days after your effective date or during the Annual Enrollment Period (AEP). This coverage will have an additional monthly cost. Your options are listed on the enrollment form. Please contact the plan for complete details.

Discrimination is Against the Law

The Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact The Health Plan Customer Service Department.

If you believe that The Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: The Health Plan Appeals Coordinator, 1110 Main Street, Wheeling, WV 26003, Phone: 1.877.847.7907, TTY: 711, Fax 740.699.6163, Email: info@healthplan.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance The Health Plan Customer Service Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 1.800.537.7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-847-7907 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-847-7907 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877- 847-7907（TTY：711）

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-847-7907 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.877.847.7907 (رقم هاتف الصم والبكم: 711).

Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-847-7907 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-847-7907 (телетайп: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-847-7907 (ATS: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-847-7907 (TTY: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-877-847-7907 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-847-7907 (TTY: 711).번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza lingüística gratuiti. Chiamare il numero 1-877-847-7907 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-847-7907 (TTY: 711) まで、お電話にてご連絡ください。

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-877-847-7907 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-877-847-7907 (телетайп: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-877-847-7907 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877- 847-7907 （TTY：711）.

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-877-847-7907 (TTY: 711).

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-877- 847-7907 (टिटिवाइ: 711).।

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.1-877- 847-7907 (TTY: 711). با تماس بگیرید

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں 1-877- 847-7907 (TTY: 711).

Revised 5/2020


TheHealthPlan