allwell. FROM mhs

2018

Summary of Benefits

Allwell Medicare (PPO)

Allen, Elkhart, and St. Joseph Counties, Indiana

H6348-002

Benefits effective January 1, 2018

H6348_18_3220SB Accepted 09302017

This booklet provides you with a summary of what we cover and your cost-sharing. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call us at the number listed on the last page of this booklet, and ask for the "Evidence of Coverage" (EOC), or you may access the EOC on our website at https://allwell.mhsindiana.com

You are eligible to enroll in Allwell Medicare (PPO) if:

- You are entitled to Medicare Part A and enrolled in Medicare Part B. Members must continue to pay their Medicare Part B premium if not otherwise paid for under Medicaid or by another third party.
- You must be a United States citizen, or are lawfully present in the United States and permanently reside in the service area of the plan (in other words, your permanent residence is within one of the Allwell Medicare (PPO) service area counties). Our service area includes the following counties in Indiana: Allen, Elkhart, and St. Joseph.
- You do not have end-stage renal disease (ESRD).

With Allwell Medicare (PPO) plans, you'll enjoy the freedom and flexibility to access your health care where you want it and when you want it. You may seek care from any Medicare provider in the country who agrees to see you as a Medicare member, but you'll generally pay less when you use contracting providers in our network. Either way, doctor visits, hospital stays and many other services have a simple copayment, which helps make health care costs more predictable.

You can see our plan's provider directory at our website at https://allwell.mhsindiana.com.

This Allwell Medicare (PPO) plan also includes prescription drug coverage and access to our large network of pharmacies. Our drug plan is designed specifically for Medicare beneficiaries and includes a comprehensive selection of affordable generic and brand-name drugs.

Summary of Benefits

JANUARY 1, 2018–DECEMBER 31, 2018

Premiums and Benefits	Allwell Medicare (PPO)
Monthly Plan Premium, including Part C and Part D premium	$0 You must continue to pay your Medicare Part B premium.
Deductible	This plan does not have a medical deductible. This plan does not have a Part D deductible.
Maximum Out-of-Pocket Responsibility ***(does not include prescription drugs)***	$5,000 in-network annually $7,750 combined in-network and out-of-network annually This is the most you will pay in copays and coinsurance for medical services for the year. Not all covered services count towards the maximum out-of-pocket amount. For more information, please see the plan's Evidence of Coverage (EOC). You will still need to pay your cost sharing for your Part D prescription drugs.
Inpatient Hospital Coverage	In-network $285 copay per day, days 1 through 6, $0 copay per day, days 7 through 90. Out-of-network 40% coinsurance *Prior authorization (approval in advance) may be required.* Referral may be required.
Outpatient Hospital (including services provided at hospital outpatient facilities and ambulatory surgical centers)	In-network • Hospital Visit (including Epidural Injections): $275 per visit • Ambulatory Surgical Center Visit (Including Epidural Injections): $250 per visit Out-of-network • Hospital Visit (including Epidural Injections): 40% coinsurance per visit • Ambulatory Surgical Center Visit (Including Epidural Injections): 40% coinsurance per visit Prior authorization (approval in advance) may be required. Referral may be required.

<table>
<tr><th>Premiums and Benefits</th><th>Allwell Medicare (PPO)</th></tr>
<tr><td>Doctor Visits</td><td><u>In-network</u>
• Primary care: $5 copay
• Specialist: $35 copay
<u>Out-of-network</u>
• Primary care: 40% coinsurance
• Specialist: 40% coinsurance

Specialist services may require Prior Authorization (approval in advance).

Referral may be required for specialist services.</td></tr>
<tr><td>Preventive Care</td><td>$0 copay for Medicare-covered preventive services

For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. Cost-sharing may apply when other services are received in addition to the preventive service.

Some services may require Prior Authorization (approval in advance).</td></tr>
<tr><td>Emergency Care</td><td><u>In-network</u>
$80 copay per visit

<u>Out-of-network</u>
$80 copay per visit

If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.</td></tr>
<tr><td>Urgently Needed Services</td><td><u>In-network</u>
$25 copay per visit

<u>Out-of-network</u>
$25 copay per visit</td></tr>
<tr><td>Diagnostic Services/Labs/ Imaging</td><td><u>In-network</u>
• Lab services: $5 copay
• Diagnostic tests and procedures: $5 copay
• Outpatient x-ray services: $50 copay
• Diagnostic Radiological services: 20% coinsurance
• Therapeutic radiological services: 20% coinsurance</td></tr>
</table>

Premiums and Benefits	Allwell Medicare (PPO)
Diagnostic Services/Labs/ Imaging *(continued)*	Out-of-network • Lab services: 40% coinsurance • Diagnostic tests and procedures: 40% coinsurance • Outpatient x-ray: 40% coinsurance • Diagnostic Radiological services: 40% coinsurance • Therapeutic radiological services (such as radiation treatment for cancer): 20% coinsurance *Some services may require Prior Authorization (approval in advance).* Referral may be required.
Hearing Services	In-network • Hearing exam (Medicare-covered): $35 copay per visit Medicare-covered services include an exam to diagnose and treat hearing and balance issues. • Routine hearing exam (non Medicare-covered): $0 copay per visit • Hearing aid: $0 copay Out-of-network • Hearing exam (Medicare-covered): 40% coinsurance Medicare-covered services include an exam to diagnose and treat hearing and balance issues. • Routine hearing exam (non Medicare-covered): 40% coinsurance • Hearing aid: 40% coinsurance This plan pays up to $1,500 for one hearing aid (for either left or right ear) every year.
Dental Services	In-network Dental services (Medicare-covered): $35 copay Medicare-covered services: Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth). Preventive Services: • Cleaning: $0 copay (up to 2 every year) • Oral exam: $0 copay (up to 2 every year) • Dental x-ray: $0 copay (up to 1 every year) Out-of-network Dental services (Medicare-covered): 40% coinsurance Medicare-covered services: Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).

Premiums and Benefits	Allwell Medicare (PPO)
Dental Services ***(continued)***	Preventive Services: • Cleaning: $0 copay (up to 2 every year) • Oral exam: $0 copay (up to 2 every year) • Dental x-ray: $0 copay (up to 1 every year) Dental x-rays include one set of preventive x-rays (up to 4 bitewing x-rays) during a single visit.
Vision Services	<u>In-network</u> • Vision exam to diagnose and treat diseases and conditions of the eye (Medicare-covered): $35 copay • Yearly Glaucoma screening (Medicare-covered): $0 copay • Eyeglasses or contact lenses after cataract surgery (Medicare-covered): $0 copay • Routine eye exam (non Medicare-covered): $0 copay per visit (up to 1 every calendar year) • Routine (non Medicare-covered) eyewear: up to $100 allowance for contact lenses and/or eyeglasses (frames and lenses) every calendar year <u>Out-of-network</u> • Vision exam to diagnose and treat diseases and conditions of the eye (Medicare-covered): 40% coinsurance • Yearly Glaucoma screening (Medicare-covered): 40% coinsurance • Eyeglasses or contact lenses after cataract surgery (Medicare-covered): 40% coinsurance • Routine eye exam (non Medicare-covered): 40% coinsurance per visit (up to 1 every calendar year) • Routine (non Medicare-covered) eyewear: up to $100 allowance for contact lenses and/or eyeglasses (frames and lenses) every calendar year Our plan pays up to $100 every calendar year for routine (non-Medicare-covered) eyewear for in-network and out-of-network services combined.
Mental Health Services	<u>In-network</u> • Outpatient group therapy: $35 copay per visit • Outpatient individual therarpy: $ 35 copay per visit • Inpatient Psychiatric Services: $285 copay per day, days 1 through 5, $0 copay per day, days 6-90

Premiums and Benefits	Allwell Medicare (PPO)
Mental Health Services ***(continued)***	Out-of-network • Outpatient group therapy: 40% of the total cost • Outpatient individual therarpy: 40% of the total cost • Inpatient Psychiatric Services: 40% of the total cost *Some services may require Prior Authorization (approval in advance).* Referral may be required.
Skilled Nursing Facility	In-network $0 copay per day, days 1 through 20, $160 copay per day, days 21 through 100 Out-of-network 40% coinsurance Our plan covers up to 100 days in a skilled nursing facility each benefit period. You pay all costs for each day after day 100 in the benefit period. *Prior authorization (approval in advance) may be required.* Referral may be required.
Physical Therapy	In-network Physical Therapy: $35 copay per visit Out-of-network Physical Therapy: 40% coinsurance per visit *Prior authorization (approval in advance) may be required.* Referral may be required.
Ambulance	In-network • $250 copay Out-of-network • 40% coinsurance Cost is per one-way trip for Medicare-covered Ambulance services. *Prior authorization (approval in advance) is required for non-emergency ambulance services.*

Premiums and Benefits	Allwell Medicare (PPO)
Transportation	Not covered
Medicare Part B Drugs	In-network • Chemotherapy drugs: 20% coinsurance • Other Part B drugs: 20% coinsurance Out-of-network • Chemotherapy drugs: 20% coinsurance • Other Part B drugs: 20% coinsurance *Prior Authorization (approval in advance) may be required.*
Over-the-Counter (OTC) Items	$65 every three months The plan covers up to $65 per quarter for items available via mail order. Any unused plan benefit amounts do not carry forward into the next quarter. Please visit the plan's website to see the list of covered over-the-counter items.
Wellness Programs	• Fitness program: $0 copay The plan covers a basic fitness membership at participating fitness facilities, Members can also request in-home fitness program. • 24-hour nurse advice line: $0 copay You can call the nursing hotline 24 hours a day, 365 days a year with questions about your health.

Outpatient Prescription Drugs

Deductible Phase	$0 Deductible. Because you do not have a Part D deductible, this payment phase does not apply to you.
Initial Coverage Phase (After you pay your deductible, if applicable)	Cost-Sharing may change depending on the pharmacy you choose (such as Preferred Retail, Standard Retail, mail-order, Long Term Care or Home Infusion) and when you enter another of the four phases of the Part D benefit.

	Preferred Retail Rx 30-day supply	Standard Retail Rx 30-day supply	Mail Order 90-day supply
Tier 1: Preferred Generic	$0 copay	$5 copay	$0 copay
Tier 2: Generic	$5 copay	$10 copay	$15 copay
Tier 3: Preferred Brand	$37 copay	$47 copay	$111 copay
Tier 4: Non-Preferred Drug	$90 copay	$100 copay	$270 copay
Tier 5: Specialty	33% coinsurance	33% coinsurance	Not Available
Tier 6: Select Care Drugs	$0 copay	$0 copay	$0 copay

Important Info:	For more information about the costs for Long Term Supply, Home Infusion or additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online. This is not a complete list of drugs covered by our plan. For a complete listing, please call 1-855-766-1541 (TTY: 711) or visit https://allwell.mhsindiana.com.

For more information, please contact:

Allwell Medicare (PPO)
550 N. Meridian Street Suite 101
Indianapolis, IN 46204

https://allwell.mhsindiana.com

Current members should call: 1-855-766-1541 (TTY: 711)

Prospective members should call: 1-877-891-6093 (TTY: 711)

From October 1 to February 14, you can call us 7 days a week from 8 a.m. to 8 p.m. From February 15 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

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 www.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.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/ coinsurance may change on January 1 of each year. "Coinsurance" is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat Allwell Medicare (PPO) members, except in emergency situations. If you receive care from an out-of-network/non-contracted provider, we will pay for the same services we cover in-network, as long as the services are medically necessary. For a decision about whether we will cover an out-of-network service, you or your provider can ask us for a pre-service organization determination before you receive the service. Please call our member services number or see Chapter 3 section 2.3of your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Allwell is a PPO plan with a Medicare contract. Enrollment in Allwell depends on contract renewal.

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

Allwell:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).

- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Allwell's Customer Contact Center at: 1-855-766-1541 (TTY: 711). From October 1 to February 14, you can call us 7 days a week from 8 a.m. to 8 p.m. From February 15 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. On weekends and holidays, an automated system will handle your call.

If you believe that Allwell 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 by calling the number above and telling them you need help filing a grievance; Allwell Customer Contact Center 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, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

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

Language	Notice
SPANISH	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-766-1541 (HMO and PPO) (TTY: 711).
CHINESE	注意：如果您說中文，您可以免費獲得語言援助服務。請致電 1-855-766-1541 (HMO and PPO) (TTY: 711)。
GERMAN	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-766-1541 (HMO and PPO) (TTY: 711).
PENNSYLVANIAN DUTCH	AADACHT: Wann du Deitsch Schwetze kann, kannscht du frei Schprooch aushilfe griege. Ruf Nummer Call 1-855-766-1541 (HMO and PPO) (TTY: 711).
BURMESE	သတိထားပါ- သင့် ဗမာစကား (Burmese) ပြောဆိုလျှင်၊ ဘာသာစကားအကူအညီ ဝန်ဆောင်မှုများ အခမဲ့ရနိုင်သည်။ ကျေးဇူးပြု၍ 1-855-766-1541 (HMO and PPO) (TTY: 711) ကို ခေါ်ပါ။
ARABIC	تنبيه: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال بالرقم 1-855-766-1541 (HMO and PPO) (رقم هاتف الصم والبكم: 711).
KOREAN	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-766-1541 (HMO and PPO) (TTY: 711) 번으로 전화해 주십시오.
VIETNAMESE	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-766-1541 (HMO and PPO) (TTY: 711).
FRENCH	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposes gratuitement. Appelez le 1-855-766-1541 (HMO and PPO) (TTY: 711).
JAPANESE	**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。**1-855-766-1541 (HMO and PPO) (TTY: 711) **まで、お電話にてご連絡ください。**
DUTCH	AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-855-766-1541 (HMO and PPO) (TTY: 711).
TAGALOG	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-766-1541 (HMO and PPO) (TTY: 711).
RUSSIAN	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-766-1541 (HMO and PPO) (TTY: 711).
PUNJABI	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਬਿਲਕੁਲ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ 1-855-766-1541 (HMO and PPO) (TTY: 711) 'ਤੇ ਕਾੱਲ ਕਰੋ।
HINDI	ध्यान दें: यदि आप हिंदी बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया 1-855-766-1541 (HMO and PPO) (TTY: 711) पर कॉल करें।