This is your Summary of Benefits.

2020

Allwell Medicare (HMO) H6446: 001

Clark and Nye counties, NV

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allwell. FROM silversummit healthplan

This booklet provides you with a summary of what we cover and the cost-sharing responsibilities. 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, and ask for the "Evidence of Coverage" (EOC), or you may access the EOC on our website at allwell.silversummithealthplan.com.

You are eligible to enroll in Allwell Medicare (HMO) 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 the Allwell Medicare (HMO) service area counties). Our service area includes the following counties in Nevada: Clark and Nye.
- You do not have End-Stage Renal Disease (ESRD). (Exceptions may apply for individuals who develop ESRD while enrolled in an Allwell commercial or group health plan, or a Medicaid plan.)

The Allwell Medicare (HMO) plan gives you access to our network of highly skilled medical providers in your area. You can look forward to choosing a Primary Care Provider (PCP) to work with you and coordinate your care. You can ask for a current provider and pharmacy directory or, for an up-to-date list of network providers, visit allwell.silversummithealthplan.com. (Please note that, except for emergency care, urgently needed care when you are out of the network, out-of-area dialysis services, and cases in which our plan authorizes use of out-of-network providers, if you obtain medical care from out-of-plan providers, neither Medicare nor Allwell Medicare (HMO) will be responsible for the costs.)

This Allwell Medicare (HMO) plan also includes Part D coverage, which provides you with the ease of having both your medical and prescription drug needs coordinated through a single convenient source

Summary of Benefits

JANUARY 1, 2020–DECEMBER 31, 2020

Benefits	Allwell Medicare (HMO) H6446: 001 Premiums / Copays / Coinsurance
Monthly Plan Premium	$0 You must continue to pay your Medicare Part B premium.
Deductible	No deductible
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	$2,150 annually This is the most you will pay in copays and coinsurance for covered medical services for the year.
Inpatient Hospital Coverage*	$0 copay per stay
Outpatient Hospital Coverage*	Outpatient Hospital (includes ambulatory surgical center and observation services: $0 copay per visit
Doctor Visits	• Primary Care: $0 copay per visit • Specialist: $0 copay per visit
Preventive Care *(e.g. flu vaccine, diabetic screening)*	$0 copay for most Medicare-covered preventive services Other preventive services are available.
Emergency Care	$90 copay per visit You do not have to pay the copay if admitted to the hospital immediately.
Urgently Needed Services	$20 copay per visit
Diagnostic Services/ Labs/Imaging*	• Lab services: $0 copay • Diagnostic tests and procedures: $0 copay • Outpatient X-ray services: $0 copay • Diagnostic Radiology Services (such as, MRI, MRA, CT, PET): – CT Scan: $50 copay – MRIs, MRAs, and SPECT scans: $50 copay – PET Scans/Nuclear radiology: $150 copay

Services with an * (asterisk) may require prior authorization from your doctor.

Benefits	Allwell Medicare (HMO) H6446: 001 Premiums / Copays / Coinsurance
Hearing Services	• Hearing exam (Medicare-covered): $0 copay • Routine hearing exam: $0 copay (1 every calendar year) • Hearing aid: $0 to $1,580 copay (2 hearing aids total, 1 per ear every calendar year)
Dental Services	• Dental services (Medicare-covered): $0 copay per visit • Preventive Dental Services: $0 copay (including oral exams, cleanings, and X-rays) • Additional comprehensive dental benefits are available for an extra premium. See optional supplemental benefits section.
Vision Services	• Vision exam (Medicare-covered): $0 copay per visit • Routine eye exam: $0 copay per visit (up to 1 every calendar year) • Routine eyewear: up to $150 allowance every calendar year
Mental Health Services	Individual and group therapy: $10 copay per visit
Skilled Nursing Facility*	For each benefit period, you pay: • $0 copay per day, days 1 through 20 • $125 copay per day, days 21 through 100
Physical Therapy*	$10 copay per visit
Ambulance*	$200 copay (per one-way trip) for ground or air ambulance services
Transportation*	$0 copay (per one-way trip) Up to 30 one-way trips to plan-approved locations
Medicare Part B Drugs*	• Chemotherapy drugs: 20% coinsurance • Other Part B drugs: 20% coinsurance

Services with an * (asterisk) may require prior authorization from your doctor.

Part D Prescription Drugs		
Deductible Stage	This plan does not have a Part D deductible.	
Initial Coverage Stage *(after you pay your Part D deductible, if applicable)*	After you have met your deductible (if applicable), the plan pays its share of the cost of your drugs and you pay your share of the cost. You generally stay in this stage until the amount of your year-to-date "total drug costs" reaches $4,020. "Total drug costs" is the total of all payments made for your covered Part D drugs. It includes what the plan pays and what you pay. Once your "total drug costs" reach $4,020 you move to the next payment stage (Coverage Gap Stage).	
	Standard Retail Rx 30-day supply	**Mail Order Rx 90-day supply**
Tier 1: Preferred Generic Drug	$0 copay	$0 copay
Tier 2: Generic Drug	$10 copay	$30 copay
Tier 3: Preferred Brand Drug	$47 copay	$141 copay
Tier 4: Non-Preferred Drug	$100 copay	$300 copay
Tier 5: Specialty Tier	33% coinsurance	Not Available
Tier 6: Select Care Drugs	$0 copay	$0 copay
Coverage Gap Stage	Because our plan offers additional gap coverage during the Coverage Gap Stage, your out-of-pocket costs will sometimes be lower than the cost described above. For more information, refer to the Evidence of Coverage (EOC), Chapter 6. During this payment stage, you receive a 70% manufacturer's discount on covered brand name drugs and the plan will cover another 5%, so you will pay 25% of the negotiated price and a portion of the dispensing fee on brand-name drugs. In addition, the plan will pay 75% and you pay 25% for generic drugs. (The amount paid by the plan does not count towards your out-of-pocket costs.) You generally stay in this stage until the amount of your year-to-date "out-of-pocket costs" reaches $6,350. "Out of pocket costs" includes what you pay when you fill or refill a prescription for a covered Part D drug and payments made for your drugs by any of the following programs or organizations: "Extra Help" from Medicare; Medicare's Coverage Gap Discount Program; Indian Health Service; AIDS drug assistance programs; most charities; and most State Pharmaceutical Assistance Programs (SPAPs). Once your "out-of-pocket costs" reach $6,350, you move to the next payment stage (Catastrophic Coverage Stage).	

Part D Prescription Drugs	
Catastrophic Stage	During this payment stage, the plan pays most of the cost for your covered drugs. For each prescription, you pay whichever of these is greater: a payment equal to 5% coinsurance of the drug, or a copayment ($3.60 for a generic drug or a drug that is treated like a generic, $8.95 for all other drugs).
Important Info:	Cost-sharing may change depending on the level of help you receive, the pharmacy you choose (such as Standard Retail, Mail Order, Long-Term Care, or Home Infusion) and when you enter any of the four stages of the Part D benefit. For more information about the costs for Long-Term Supply, Home Infusion, or additional pharmacy-specific cost-sharing and the stages of the benefit, please call us or access our EOC online.

Additional Covered Benefits	
Benefits	Allwell Medicare (HMO) H6446: 001 Premiums / Copays / Coinsurance
Opioid Treatment Program Services	• Individual setting: $10 copay per visit • Group setting: $10 copay per visit
Over-the-Counter (OTC) Items	$0 copay ($75 allowance per quarter) for items available via order There is a limit of 15 per item, per order, with the exception of blood pressure monitors which are limited to one per year. Please visit the plan's website to see the list of covered over-the-counter items.
Meals*	$0 copay Plan covers home-delivered meals (up to 3 meals per day for 14 days) following discharge from an inpatient facility or skilled nursing facility provided the meals are medically necessary and ordered by a physician or practitioner.
Medical Equipment/ Supplies*	• Durable Medical Equipment (e.g., wheelchairs, oxygen): 20% coinsurance • Prosthetics (e.g., braces, artificial limbs): 20% coinsurance • Diabetic supplies: 0% to 20% coinsurance
Foot Care (Podiatry Services)	Foot exams and treatment (Medicare-covered): $0 copay
Virtual Visit	Teladoc plan offers 24 hours a day/7days a week/365 days a year virtual visit access to board certified doctors to help address a wide variety of health concerns/questions.
Wellness Programs	• Fitness program: $0 copay • 24-hour Nurse Connect: $0 copay • Supplemental smoking and tobacco use cessation (counseling to stop smoking or tobacco use): $0 copay • Coverage for one Personal Emergency Medical Response Device per lifetime. $0 copay For a detailed list of wellness program benefits offered, please refer to the EOC.
Worldwide Emergency Care	Your plan has coverage for supplemental urgent/emergent services outside the U.S. and its territories.

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Optional Supplemental Benefits

(you must pay an extra premium each month for these benefits)

Allwell Dental Option	
Monthly Premium This additional monthly premium is in addition to your monthly plan premium and the monthly Medicare Part B premium.	$16 per month

Dental Care Benefits

Comprehensive Dental Care

You must select a dentist from our list of network providers to use the benefits of the Dental HMO plan. Additional service limits apply.

	What you pay at an in-network provider
Annual benefit maximum	$1000 applies to comprehensive services
Comprehensive services	
Non-routine services	You pay 50%
Diagnostic services	You pay a $0 copay
Restorative services	You pay 20%
Endodontic services	You pay 50%
Periodontics	You pay 50%
Extractions	You pay 50%
Prosthodontics (dentures, oral/maxillofacial surgery and other services)	You pay 50%

For more information, please contact:

Allwell Medicare (HMO)
2500 N. Buffalo Drive, Suite 250
Las Vegas, Nevada 89128

allwell.silversummithealthplan.com

Current members should call: 1-833-854-4766 (TTY: 711)
Prospective members should call: 1-800-606-3604 (TTY: 711)

From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 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. Call 1-833-854-4766 (TTY: 711) for more information.

"Coinsurance" is the percentage you pay of the total cost of certain medical and/or prescription services.

The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

This document is available in other formats such as Braille, large print or audio.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-833-854-4766 (TTY: 711).

Allwell is contracted with Medicare for HMO plans. Enrollment in Allwell depends on contract renewal.

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