Summary of Benefits

2021

Allwell Dual Medicare Harmony P3 (HMO D-SNP) H6446: 014
Clark and Nye counties, NV

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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 Dual Medicare Harmony P3 (HMO D-SNP) 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 Dual Medicare Harmony P3 (HMO D-SNP) service area counties). Our service area includes the following counties in Nevada: Clark and Nye.
- For Allwell Dual Medicare Harmony P3 (HMO D-SNP), you must also be enrolled in the Nevada Medicaid plan. Premiums, copays, coinsurance, and deductibles may vary based on your Medicaid eligibility category and/or the level of Extra Help you receive. Your Part B premium is paid by the State of Nevada for full-dual enrollees. Please contact the plan for further details.

The Allwell Dual Medicare Harmony P3 (HMO D-SNP) 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 Dual Medicare Harmony P3 (HMO D-SNP) will be responsible for the costs.)

This Allwell Dual Medicare Harmony P3 (HMO D-SNP) 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, 2021 – DECEMBER 31, 2021

Benefits	Allwell Dual Medicare Harmony P3 (HMO D-SNP) H6446: 014 Premiums / Copays / Coinsurance
Premiums, copays, coinsurance, and deductibles may vary based on your Medicaid eligibility category and/or the level of Extra Help you receive	
Monthly Plan Premium	$0 (You must continue to pay your Medicare Part B premium, if not otherwise paid for by Medicaid or another third party.)
Deductibles	• $0 deductible for covered medical services • $445 deductible for Part D prescription drugs (applies to drugs on Tiers 2, 3, 4 and 5)
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$3,450 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: $0 copay per visit • Observation Services: $0 copay per visit
Doctor Visits (Primary Care Providers and Specialists)	• 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	$0 copay per visit
Urgently Needed Services	$0 copay per visit

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

Benefits	Allwell Dual Medicare Harmony P3 (HMO D-SNP) H6446: 014 Premiums / Copays / Coinsurance
Diagnostic Services/ Labs/Imaging* (includes diagnostic tests and procedures, labs, diagnostic radiology, and X-rays)	COVID-19 testing and specified testing-related services at any location are $0. • 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): $0 copay
Hearing Services	• Hearing exam (Medicare-covered): $0 copay • Routine hearing exam: $0 copay (1 every calendar year) • Hearing aid: $0 copay (2 hearing aids total, 1 per ear, per calendar year)
Dental Services	• Dental services (Medicare-covered): $0 copay per visit • Preventive Dental Services: $0 copay (including oral exams, cleanings, fluoride treatment, and X-rays). • Comprehensive dental services: Additional comprehensive dental benefits are available. There is a maximum allowance of $4,000 every calendar year; it applies to all comprehensive dental benefits.
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 $300 allowance every calendar year
Mental Health Services	Individual and group therapy: $0 copay per visit
Skilled Nursing Facility*	Days 1-100: $0 copay per stay, per benefit period.
Physical Therapy*	$0 copay per visit
Ambulance	$0 copay (per one-way trip) for ground or air ambulance services
Ambulatory Surgery Center*	Ambulatory Surgery Center: $0 copay per visit

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

Benefits	Allwell Dual Medicare Harmony P3 (HMO D-SNP) H6446: 014 Premiums / Copays / Coinsurance
Transportation	• $0 copay for each one-way trip • Up to 30 one-way trips to plan-approved health-related locations every calendar year. Mileage limits may apply.
Medicare Part B Drugs*	• Chemotherapy drugs: $0 copay • Other Part B drugs: $0 copay

Part D Prescription Drugs		
Deductible Stage	$445 deductible for Part D prescription drugs (applies to drugs on Tiers 2, 3, 4 and 5). The Deductible Stage is the first payment stage for your drug coverage. This stage begins when you fill your first prescription in the year. When you are in this payment stage, you must pay the full cost of your Part D drugs until you reach the plan's deductible amount. Once you have paid the plan's deductible amount for your Part D drugs, you leave the Deductible Stage and move on to the next payment stage (Initial Coverage Stage). If you receive "Extra Help" to pay for your prescription drugs, your deductible amount will be either $0 or $92 depending on the level of "Extra Help" you receive.	
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. "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 $4,130 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 Drugs	$0 copay	$0 copay
Tier 2: Generic Drugs	$20 copay	$60 copay
Tier 3: Preferred Brand Drugs	$47 copay	$141 copay
Tier 4: Non-Preferred Drugs	50% coinsurance	50% coinsurance
Tier 5: Specialty	25% coinsurance	Not available
Coverage Gap Stage	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).	

Part D Prescription Drugs	
	You generally stay in this stage until the amount of your year-to-date “out-of-pocket costs” reaches $6,550. “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 $6,550, you move to the next payment stage (Catastrophic Coverage Stage). If you qualify for “Extra Help” this stage doesn’t apply-If you are not eligible for “Extra Help”, call the plan or refer to the Evidence of Coverage (EOC), Chapter 6, for outpatient prescription drug cost-sharing information.
Catastrophic Coverage 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 ($3.70 for a generic drug or a drug that is treated like a generic, $9.20 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. Low income subsidy (LIS) is extra help you receive from Medicare. To find out if you qualify, visit Medicare.gov or call Member Services at 1-833-717-0806 (TTY: 711).

Additional Covered Benefits	
Benefits	**Allwell Dual Medicare Harmony P3 (HMO D-SNP) H6446: 014 Premiums / Copays / Coinsurance**
Additional Telehealth Services	The cost share of Medicare-covered additional telehealth services with primary care physicians, specialists, individual/group sessions with mental health and psychiatric providers and other health care practitioners within these practices will be equal to the cost share of these individual services' office visits.
Opioid Treatment Program Services	• Individual setting: $0 copay per visit • Group setting: $0 copay per visit
Over-the-Counter (OTC) Items	$0 copay ($185 allowance per quarter) for items available via mail. There is a limit of 9 per item, per order, with the exception of certain products which have additional limits. You are allowed to order once per quarter and any unused money does not carry over to the next quarter. 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 2 meals per day for 14 days) following discharge from an inpatient facility or skilled nursing facility. Services are contingent on medical necessity and Case Management review and prior authorization to the vendor.
Chiropractic Care	Chiropractic services (Medicare-covered): $0 copay per visit
Acupuncture	• Acupuncture services for chronic low back pain (Medicare-covered): $0 copay per visit in a chiropractic setting • Acupuncture services for chronic low back pain (Medicare-covered): $0 copay per visit in a Primary Care Provider's office • Acupuncture services for chronic low back pain (Medicare-covered): $0 copay per visit in a Specialist's office
Medical Equipment/ Supplies*	• Durable Medical Equipment (e.g., wheelchairs, oxygen): $0 copay • Prosthetics (e.g., braces, artificial limbs): $0 copay • Diabetic supplies: $0 copay
Foot Care (Podiatry Services)	Foot exams and treatment (Medicare-covered): $0 copay per visit

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

Additional Covered Benefits	
Benefits	**Allwell Dual Medicare Harmony P3 (HMO D-SNP) H6446: 014 Premiums / Copays / Coinsurance**
Virtual Visit	Teladoc™ plan offers 24 hours a day/7 days 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.
Routine Annual Exam	$0 copay
Additional Services that are covered for the Chronically Ill	The following service is available for members with chronic conditions Nutritional Shakes: $0 copay Supplemental nutritional shakes are formulated to target both situational conditions and disease states such as diabetes, ESRD, cancer and wound care. Upon case management authorization and referral, 24 shakes per month, up to 3 months, will be shipped to the member's home. For a detailed list of benefits offered, please refer to the EOC.

Comprehensive Written Statement for Prospective Enrollees

The benefits described in the Premium and Benefit section of the Summary of Benefits are covered by our Medicare Advantage plan. For each benefit listed, you can see what our plan covers. What you pay for covered services may depend on your level of Medicaid eligibility. Coverage of the benefits described in this Summary of Benefits depends upon your level of Medicaid eligibility. No matter what your level of Medicaid eligibility is,
Allwell Dual Medicare Harmony P3 (HMO D-SNP) will cover the benefits described in the Premium and Benefit section of the Summary of Benefits. If you have questions about your Medicaid eligibility and what benefits you are entitled to, call Nevada Medicaid toll-free at 1-877-638-3472 (TTY: 711).

Our source of information for Medicaid benefits is https://www.medicaid.nv.gov/contactinfo.aspx. All Medicaid covered services are subject to change at any time. For the most current Nevada Medicaid coverage information, please visit https://www.medicaid.nv.gov/contactinfo.aspx or call Member Services for assistance. A detailed explanation of Nevada Medicaid benefits can be found in the Nevada Summary of Services online at https://www.medicaid.nv.gov/contactinfo.aspx

What Benefits Are Covered?
• Ambulance/Emergency Transportation
• Birth Control/Family Planning
• Dental (most adults - emergency care only; qualified pregnant women - some periodontal benefits; children - full coverage & limited orthodontia)
• Disposable Medical Supplies
• Durable Medical Equipment
• Doctor Visits
• Emergency Room
• Eye Exams and Eyeglasses
• Healthy Kids (preventive health services for children to age 21)
• Hearing Tests
• Home Health Care
• Hospice Care
• Hospital Care
• Lab and Radiology Services
• Maternity Care
• Mental Health/ Substance Abuse Services
• Midwife Services
• Nursing Home Services
• Nutritionist
• Occupational Therapy Services

What Benefits Are Covered?
• Orthotics & Prosthetics
• Over-the-Counter Drugs with a Prescription
• Personal Care Services
• Physical Therapy Services
• Podiatry
• Prescription Drugs
• Preventive Screenings
• Private Duty Nursing
• Specialists
• Speech and Hearing Services
• Tobacco Cessation
• Transportation Services (Non-emergency transportation is not a NCU benefit.)
• Vaccines
• Waiver Programs - help people with special needs (elderly/people with physical and intellectual disabilities, for example) stay in their communities. Eligibility requirements must be met and services are not an entitlement (not a regular benefit).

This Section gives you more information about benefits.

Ambulance/Emergency Transportation

In you have a medical emergency, call 911 for an ambulance. Medicaid and NCU (Nevada Check Up) will cover air and ground ambulance services in an emergency.

Birth Control & Family Planning

Talk to your doctor or clinic about family planning. You can get family planning services from any provider who accepts Medicaid and NCU. You do not need a referral. You may get some types of birth control in your doctor's office. For others, your doctor will write a prescription. These forms of birth control are covered by Medicaid and NCU:

- Birth control pills
- Condoms
- Creams
- Diaphragms
- Foams
- IUDs
- Shots (ex. Depo-Provera)
- Sponges

Dental Benefits

Adults (Medicaid only): Emergency, palliative, some prosthetic care; qualified pregnant women—adult benefits and some expanded benefits. Children (under 21) get full coverage, with some (limited) orthodontia. Dentists need prior approval from Medicaid or NCU for some of the benefits.

Disposable Medical Supplies, Durable Medical Equipment, Orthotics & Prosthetics

Medicaid and NCU cover many medical supplies that are ordered by your doctor for a medical reason. For example, some supplies which may be covered are:

- Incontinent supplies (adult diapers)
- Wheelchair, canes, crutches and walkers
- Prosthetic orthotic devices
- Wound care supplies
- Insulin pump
- Oxygen

Talk to your doctor if you need medical supplies. Your doctor may write a prescription for you to take to a medical supply company. The medical supplier must get prior approval from Medicaid and NCU for some items.

Doctor Visits

Medicaid and NCU pay for you to see a doctor or visit an Urgent Care Clinic when you are having health problems. It is important for you to see your primary care physician whenever possible for regular treatment so he/she has an updated medical history. If needed, your doctor may refer you to a specialist.

Emergency Room

Call 911 in an emergency, or go to the emergency room right away. You will need to call your doctor when the emergency is over. Your doctor must provide any follow up care you need after the emergency. If it is not an emergency and your primary care provider is not available, go to an urgent care clinic.

Eye Exams and Eyeglasses

Medicaid/NCU covers care for eye diseases, eye surgery that is medically necessary, eye exams and prescription eyeglasses. Medicaid pays for eye exams and eyeglasses only once every 12 months. Your provider will show you frames you may choose from that are covered in full. If you choose more expensive frames, you must pay the difference between what Medicaid and NCU pay and the cost of the frames you've chosen. Make sure you sign an agreement in advance if you are going to pay for more expensive frames. Medicaid/NCU does not cover contact lenses, except under certain cases when they are medically necessary.

Healthy Kids or Early Periodic Screening Diagnosis and Treatment (EPSDT)

Healthy Kids, also known as EPSDT, is a special benefit for children on Medicaid/NCU. Some problems start before your child looks or feels sick. Your doctor can find and treat these problems early, before they become serious, with regular "well-child" exams. Healthy Kids also covers dental check-ups. Almost everyone from birth through age 20 who gets Medicaid/NCU can get Healthy Kids-covered services. These services include:

- Well-child exams by your child's doctor. This is a head-to-toe exam including health history, eating habits, vision and hearing exams, mental health evaluation and a growth and development check;
- Shots (vaccines) to keep your child healthy;
- Dental checkups. A complete exam and cleaning (covered through age 20) twice a year, or more often if your child's dentist recommends it;
- Fluoride treatment and sealants;
- Follow-up treatment and care if a health problem is found during an exam;
- Lead testing and other laboratory tests; and
- If needed, free transportation to any Medicaid-approved medical appointments. (Does not apply to NCU recipients.)

When should your child have a well-child exam?

- Newborns – as soon as possible after birth
- Infants – at one, two, four, six, nine and 12, 15, 18, 24, and 30 months
- Toddlers to young adults (3-20 years old) every year

Hearing Tests

Newborn hearing tests are included in the newborn hospital stay. Childhood hearing tests are part of a Healthy Kids/EPSDT exam. Other hearing tests are covered for both children and adults, if they are medically necessary.

Home- and Community-based Services

These services help you receive the medical care you need so you can stay in your home. They include adult day health care, personal care services, home health care, private-duty nursing and partial hospitalization. These services are for people who need assistance because they have ongoing mental health illnesses. If you need these services, you will need to have an evaluation to make sure you or your loved one meets the eligibility requirements and that they are medically necessary.

Home Health Care

Home health care is for people who need special, in-home services like skilled nursing, physical therapy, occupational therapy or speech therapy. If you think you need home health care, talk to your doctor. Your doctor will submit an order to a home health agency of your choice who is enrolled with Medicaid. The home health agency will contact Medicaid or NCU for prior approval.

Hospice Care

Hospice services can give you or a family member support and comfort when someone is at the end of their life. The hospice takes care of your physical, emotional and spiritual needs in a specialized hospice facility, a nursing facility, an Intermediate Care Facility (ICF) or in your home. Different kinds of specialists can help your family deal with the final stages of illness, dying and grieving.

Hospital Care

Both inpatient and outpatient hospital care are covered. Before you use hospital services, get a referral from your doctor.

Lab and Radiology Services

Lab and radiology (X-ray) services are covered; they may be done in your doctor's office, or your doc-tor may refer you to another clinic, lab or hospital.

Maternity Care

If you think you are pregnant, see a doctor as soon as possible. Early maternity care will help you give birth to a healthy baby. You may choose to see a specialist such as an Obstetrical/ Gynecological (OB/GYN) physician or a certified nurse midwife. Medicaid covers medically necessary Caesarian-sections but does not pay for C-sections done for the convenience of the mother or the physician. Covered services include:

- Prenatal visits, lab work and necessary tests (such as ultrasound)
- The hospital stay
- Labor and delivery
- The second- and/or sixth-week checkup after the birth
- Anesthesia (pain treatment)
- Birth control/family planning

You can stay in the hospital up to 72 hours after a normal birth and up to 96 hours after a C-section. You can choose a shorter stay if you and your doctor agree. Your baby may be covered by Medicaid for the first year of life if you are able to get Medicaid when your baby is born. Contact your DWSS caseworker as soon as possible to report the birth of your baby.
For your baby to be covered for NCU services from their birth, you must notify DWSS within 14 days of the delivery. If you have temporary coverage for the newborn and they are qualified for NCU, coverage will begin the first day of the next administrative month. For example, if your baby is born on September 15, and the mother has other insurance coverage for 30 days (until October 15), the newborn would not be enrolled in NCU until November 1. Your newborn cannot receive coverage which predates another family member's earliest current enrollment. Your child can stay covered by NCU if the parent meets the income requirement yearly, keeps premium payments current and the child meets other eligibility requirements.

Midwife Services

You may choose to use a midwife during your pregnancy. You must choose a certified and licensed midwife who is a Medicaid or NCU provider. Some certified midwives can deliver babies in a birthing center or in the hospital, in case of an emergency during delivery.

Mental Health/Substance Abuse Services

These are benefits you may receive to treat an acute (short-term) or chronic (continuing for a long time) behavioral health disorder. Some of these services include:

- Inpatient/Outpatient services
- Psychiatric evaluations
- Medication management
- Psychological testing
- Inpatient alcohol/substance abuse detoxification services
- Individual and group therapy
- Emergency hospital care
- Crisis intervention
- Outpatient alcohol/substance abuse detoxification services

Nursing Home Services

Nursing facilities provide health care services on a 24-hour basis to people who have medical problems or injuries that cannot be managed at home. If you or a family member has cognitive impairments (problems with things like memory, perception, judgment and reasoning) or behavioral impairments, a nursing facility can provide help. This assistance can help you with medical care, nursing care, rehabilitative services and psychosocial management or a combination of those services.

Out-of-state nursing facility services are offered to residents when:

- You cannot be placed in a Nevada nursing facility;
- You live on or near a Nevada border and it is more practical for you to receive medical service from an out-of-state provider.

Occupational Therapy

Occupational therapy helps improve your medical condition or helps you learn or relearn a task after serious illnesses, injuries or disabilities. Your doctor’s order must be submitted to an occupational therapist who accepts Medicaid or NCU.

Over-the-counter Drugs

If your doctor prescribes them, you can get over-the-counter medicines, like antacids, aspirin, acetaminophen, and medicine for coughs, colds and allergies. Take the prescription to the pharmacy and Nevada Medicaid will pay for the medicine.

Personal Care Services

The Personal Care Services program helps people with disabilities or long-lasting illnesses live independently in their home. These services are for people who do not have someone legally responsible to help them. A Personal Care Attendant (PCA) helps people with tasks like bathing, dressing and toileting, and may also help with making meals, shopping for essential things like food, laundry and light housekeeping. The type of service and number of hours allowed are based on medical need. A physical or occupational therapist will do an evaluation.

Physical Therapy

You can get physical therapy for some serious illnesses, injuries or disabilities if it will improve your medical condition. It must be ordered by your doctor, who will authorize a physical therapist who accepts Medicaid or NCU.

Prescription Drugs

Medicaid and NCU cover many prescription drugs. Some prescriptions require prior authorization. There is a list of preferred drugs for your physician to choose from. Prescriptions for weight loss and drugs you use for cosmetic and experimental reasons are not covered. If you are on Medicare and Medicaid, most of your prescriptions must be provided by Medicare. Medicaid will cover the items Medicare may not cover, including some over-the-counter medications.

Private Duty Nursing

Private duty nursing can help you get more individual and continuous care than you would from a visiting nurse. The program helps you stay safely at home rather than in a facility like a nursing home. You must have a doctor's order for private duty nursing.

Speech & Hearing Services

If you have serious speech or hearing problems, see your doctor. Your doctor may refer you to a speech therapist or an audiologist. Some services covered by Medicaid or NCU are:

- Hearing tests
- Hearing aids
- Hearing aid batteries
- Speech therapy

Tobacco Cessation

Products to help you stop using tobacco are covered. You must get a prescription from your doctor and take it to a pharmacy. Prescription and over-the-counter medication like patches and lozenges are covered. So is tobacco-cessation counseling, as part of an office visit to your doctor.

Transportation Services (non-emergency)

Medicaid provides rides to medical appointments, called Non-Emergency Transportation (NET). This service is provided through a transportation company that Medicaid contracts with. Transportation is not covered for NCU recipients. You can get rides to be treated for a Medicaid-covered service. You should arrange for rides at least five days in advance. The company may help you get public transportation. For urgent care trips, the transportation company must provide you with a ride on the same day you call. If you have to cancel your doctor's appointment, please remember to cancel your transportation. The doctor's office will not cancel it for you.
Prior Authorization by the transportation company is required.

Vaccines

All medically recommended childhood and adult vaccines are covered.

Waiver Programs

If you have special needs, you may qualify for more benefits through waiver programs. Waivers allow Medicaid to pay for support and services to help you, and as a result may enable you to live safely in your own home or community rather than in a nursing facility or other institution. Waiver services include:

- Emergency response systems
- Homemaker services
- Group homes
- Day treatment centers
- Adult day care
- Family support
- Home-delivered meals
- Respite care for family members who need a break from caring for disabled or elderly family members

These programs are for people who meet the program requirements, like those who are aged or who have physical or intellectual disabilities. There is a set number of people who can be on these programs. For information about how to apply for one of the waiver programs, call the Medicaid District Office in your area.

For more information, please contact:

Allwell Dual Medicare Harmony P3 (HMO D-SNP)
2500 N. Buffalo Drive, Suite 250
Las Vegas, NV 89128

allwell.silversummithealthplan.com

Current members should call: 1-833-717-0806 (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 plan is available to anyone who has both Medical Assistance from the State and Medicare.

This information is not a complete description of benefits. Call 1-833-717-0806 (TTY: 711) for more information.

“Coinsurance” is the percentage you pay of the total cost of certain medical and/or prescription drug 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 1-833-717-0806 (TTY: 711)

Allwell is contracted with Medicare for HMO D-SNP plans and with the state Medicaid program. Enrollment in Allwell depends on contract renewal.

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