

This is your Summary of Benefits.

2020

Allwell Dual Medicare (HMO D-SNP) H7173: 001

Butts, Chattahoochee, Clayton, Cobb, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Greene, Gwinnett, Harris, Heard, Henry, Lumpkin, Marion, Morgan, Muscogee, Oconee, Paulding, Pickens, Rabun, Rockdale, Spalding, Taliaferro, Towns, Troup, Union, and White counties, GA



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.pshpgeorgia.com.

You are eligible to enroll in Allwell Dual Medicare (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 (HMO D-SNP) service area counties). Our service area includes the following counties in Georgia: Butts, Chattahoochee, Clayton, Cobb, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Greene, Gwinnett, Harris, Heard, Henry, Lumpkin, Marion, Morgan, Muscogee, Oconee, Paulding, Pickens, Rabun, Rockdale, Spalding, Taliaferro, Towns, Troup, Union, and White.
- 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.)
- For Allwell Dual Medicare (HMO D-SNP), you must also be enrolled in the Georgia 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 Georgia for full-dual enrollees. Please contact the plan for further details.

The Allwell Dual Medicare (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.pshpgeorgia.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 (HMO D-SNP) will be responsible for the costs.) This Allwell Dual Medicare (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, 2020–DECEMBER 31, 2020

| Benefits | Allwell Dual Medicare (HMO D-SNP) H7173: 001 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 | You pay \$0 - \$25.30 based on your level of Medicaid eligibility (You must continue to pay your Medicare Part B premium, if not otherwise paid for by Medicaid or another third party.) |
| Deductible | <ul style="list-style-type: none"> • \$0 or \$185 deductible for covered medical services. \$185 is the 2019 Part B deductible. This amount may change for 2020. • \$345 deductible for Part D prescription drugs (applies to drugs on Tiers 2, 3, 4 and 5. • \$0 or \$1,364 deductible for inpatient hospital stay (may change in 2020) |
| Maximum Out-of-Pocket Responsibility <i>(does not include prescription drugs)</i> | \$6,700 annually This is the most you will pay in copays and coinsurance for medical services for the year. |
| Inpatient Hospital Coverage* | In 2019, the amounts for each benefit period were: \$0 or <ul style="list-style-type: none"> • \$1,364 hospital deductible each benefit period • \$0 copay per day for days 1 through 60 • \$341 copay per day for days 61 through 90 • \$682 copay per day per lifetime reserve day (may change in 2020) |
| Outpatient Hospital Coverage* | Outpatient Hospital (includes ambulatory surgical center and observation services): 0% or 20% coinsurance per visit |
| Doctor Visits | <ul style="list-style-type: none"> • Primary Care: \$0 copay per visit • Specialist: \$0 or \$15 copay per visit |
| Preventive Care <i>(e.g. flu vaccine, diabetic screening)</i> | \$0 copay for most Medicare-covered preventive services Other preventive services are available. |
| Emergency Care | 0% or 20% coinsurance (up to \$90) per visit You do not have to pay the copay if admitted to the hospital immediately. |
| Urgently Needed Services | 0% or 20% coinsurance (up to \$65) per visit |
| Diagnostic Services/Labs/Imaging* | <ul style="list-style-type: none"> • Lab services: \$0 copay • Diagnostic tests and procedures: 0% or 20% coinsurance • Outpatient X-ray services: 0% or 20% coinsurance • Diagnostic Radiology services (such as, MRI, MRA, CT, PET): 0% or 20% coinsurance |

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

| Benefits | Allwell Dual Medicare (HMO D-SNP) H7173: 001 Premiums / Copays / Coinsurance |
|----------------------------------|---|
| Hearing Services | <ul style="list-style-type: none"> • Hearing exam (Medicare-covered): 0% or 20% coinsurance • 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 | <ul style="list-style-type: none"> • Dental services (Medicare-covered): 0% or 20% coinsurance per visit • Preventive Dental Services: \$0 copay (including oral exams, cleanings, and X-rays) • Comprehensive dental services: Additional comprehensive dental benefits are available. • There is a maximum allowance of \$1,500 every calendar year; it applies to all comprehensive dental benefits. |
| Vision Services | <ul style="list-style-type: none"> • Vision exam (Medicare-covered): 20% coinsurance per visit • Routine eye exam: \$0 copay per visit (up to 1 every calendar year) • Routine eyewear: up to \$250 allowance every calendar year |
| Mental Health Services | <ul style="list-style-type: none"> • Individual and group therapy: 0% or 20% coinsurance per visit |
| Skilled Nursing Facility* | <p>In 2019, the amounts for each benefit period were: \$0 or,</p> <ul style="list-style-type: none"> • \$0 copay per day, days 1 through 20 • \$170.50 copay per day, days 21 through 100 (may change for 2020) |
| Physical Therapy* | 0% or 20% coinsurance per visit |
| Ambulance* | 0% or 20% coinsurance (per one-way trip) for ground or air ambulance services |
| Transportation* | <p>\$0 copay for each one-way trip</p> <p>Up to 24 one-way trips to plan-approved locations each calendar year. Mileage limits may apply.</p> |
| Medicare Part B Drugs* | <ul style="list-style-type: none"> • Chemotherapy drugs: 0% or 20% coinsurance • Other Part B drugs: 0% or 20% coinsurance |

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Part D Prescription Drugs

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| Deductible Stage | <p>\$345 deductible for Part D prescription drugs (applies to drugs on Tiers 2, 3, 4 and 5).</p> <p>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.</p> <p>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 \$89 depending on the level of "Extra Help" you receive.</p> | |
| Initial Coverage Stage <i>(after you pay your Part D deductible, if applicable)</i> | <p>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).</p> | |
| | Standard Retail Rx 30-day supply | Mail Order Rx 90-day supply |
| Tier 1: Preferred Generic | \$0 copay | \$0 copay |
| Tier 2: Generic | \$7 copay | \$21 copay |
| Tier 3: Preferred Brand | \$47 copay | \$141 copay |
| Tier 4: Non-Preferred Drug | \$100 copay | \$300 copay |
| Tier 5: Specialty | 26% coinsurance | Not Available |
| Tier 6: Select Care Drugs | \$0 copay | \$0 copay |

Part D Prescription Drugs

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| Coverage Gap Stage | <p>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).</p> <p>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).</p> <p>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.</p> |
| Catastrophic Stage | <p>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).</p> |
| Important Info: | <p>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 another of the four stages of the Part D benefit.</p> <p>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.</p> <p>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 1-877-725-7748 (TTY: 711).</p> |

| Additional Covered Benefits | |
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| Benefits | Allwell Dual Medicare (HMO D-SNP) H7173: 001 Premiums / Copays / Coinsurance |
| Opioid Treatment Program Services | <ul style="list-style-type: none"> • Individual setting: 0% or 20% coinsurance per visit • Group setting: 0% or 20% coinsurance per visit |
| Over-the-Counter (OTC) Items | <p>\$0 copay (\$200 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.</p> <p>Please visit the plan's website to see the list of covered over-the-counter items.</p> |
| Chiropractic Care | Chiropractic services (Medicare-covered): 0% or 20% coinsurance per visit |
| Medical Equipment/Supplies* | <ul style="list-style-type: none"> • Durable Medical Equipment (e.g., wheelchairs, oxygen): 0% or 20% coinsurance • Prosthetics (e.g., braces, artificial limbs): 0% or 20% coinsurance • Diabetic supplies: 0% or 20% coinsurance |
| Foot Care (Podiatry Services) | Foot exams and treatment (Medicare-covered): 0% or 20% coinsurance |
| Wellness Programs | <ul style="list-style-type: none"> • Fitness program: \$0 copay • 24-hour Nurse Connect: \$0 copay <p>For a detailed list of wellness program benefits offered, please refer to the EOC.</p> |

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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 (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 Georgia Medicaid toll free at 1-866-211-0950 (TTY: 711)

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

LIST OF MEDICAID COVERED BENEFITS FOR ELIGIBLES OVER THE AGE OF 21 (Benefits for Eligibles under 21 include EPDST benefits)

SERVICES COVERED BY GEORGIA DEPARTMENT OF COMMUNITY HEALTH ("OCH")
The following are the major services covered by Georgia's Medicaid Program, if the services are not covered by Medicare or other insurance and if the Georgia Medicaid Program's specific requirements are met for the service. OCH retains responsibility of Medicaid Covered Benefits. The Medicare Advantage ("MA") Health Plan helps to coordinate these benefits:

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| Prescriptions that are not covered by Part D but that are covered under the Medicaid Plan |
| Doctor Visits |
| Inpatient and Outpatient Hospital Services |
| Diagnostic Tests including Labs and X-rays |
| Home Health Services |
| Hospice Care |
| Durable Medical Equipment, Prosthetics, and Supplies |
| Emergency Transportation (Medically Necessary) |
| Non-emergency Transportation |
| Emergency Dental (Adults) |
| Hearing Services (Limited to EPSDT) |
| Limited Vision |
| EPDST |
| Waivered Services |
| Transplants (Heart and lung are limited to EPDST) |
| Nursing Facility |
| ICF-MR |
| Pregnancy-Related Services |
| Targeted Case Management |

LIST OF MEDICAID COVERED BENEFITS FOR ELIGIBLES OVER THE AGE OF 21
(Benefits for Eligibles under 21 include EPDST benefits)

SERVICES COVERED BY GEORGIA DEPARTMENT OF COMMUNITY HEALTH ("OCH")
The following are the major services covered by Georgia's Medicaid Program, if the services are not covered by Medicare or other insurance and if the Georgia Medicaid Program's specific requirements are met for the service. OCH retains responsibility of Medicaid Covered Benefits. The Medicare Advantage ("MA") Health Plan helps to coordinate these benefits:

Outpatient Mental Health Clinic Services

Colorectal Screening (Medicare age 50 and older)

Bone Mass Measurements

Cardiac and Pulmonary Rehabilitation

Diabetic Supplies and Programs

Immunizations

Mammograms (Women with Medicare age 40 and older)

Pap Smears and Pelvic Exams (Women with Medicare)

Prostate Cancer Screening (Men age 50 and older)

Kidney Disease and Conditions

Private Duty Nursing (Limited to EPDST)

Swing Bed Services

Rural Health Clinic Services

Federal Qualified Health Center Services

Family Planning Services

Health/Wellness Education

Urgently Needed Care

Outpatient Rehabilitation Services (EPDST under a written service plan) or the Mental Health Rehabilitation Option

Outpatient substance Abuse (Under a written service plan)

Podiatry (Limited)

In addition, the MA Health Plan remains responsible for any Medicare covered benefits in their annual bids and any supplemental benefits approved by CMS through the approval process.

For more information, please contact:

Allwell Dual Medicare (HMO D-SNP)
1100 Circle 75 Parkway
Suite 1100
Atlanta, GA 30339

allwell.pshpgeorgia.com

Current members should call: 1-877-725-7748 (TTY: 711)
Prospective members should call: 1-877-826-3693 (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 1-877-725-7748 (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.

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