2018

Summary of Benefits

Allwell Medicare (HMO)

Spokane, WA

H0029 – 004

Benefits effective January 1, 2018

H0029_18_3190SB_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, and ask for the "Evidence of Coverage" (EOC), or you may access the EOC on our website at https://allwell.coordinatedcarehealth.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 service area county). Our service area includes the following counties in Washington: Spokane County.
- You do not have end-stage renal disease (ESRD).

The 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 directory or, for an up-to-date list of network providers, visit https://allwell.coordinatedcarehealth.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 will be responsible for the costs.)

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

This 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, 2018–DECEMBER 31, 2018

Premiums and Benefits	Allwell Medicare (HMO)
Monthly Plan Premium, including Part C and Part D premium.	$0 You must continue to pay your Medicare Part B premium.
Deductible	$200 deductible for Part D prescription drugs The Part D deductible applies to drugs on Tiers 3-5.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$5,900 annually This is the most you will pay in copays and coinsurance for medical services for the year. You will still need to pay your cost-sharing for your Part D prescription drugs.
Inpatient Hospital Coverage	$450 copay per day, days 1 through 4, $0 copay per day, days 5 through 90 *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)	• Hospital Visit (Including Epidural Injections): 25% coinsurance per visit • Ambulatory Surgical Center Visit (Including Epidural Injections): 20% coinsurance per visit *Prior authorization (approval in advance) may be required.* Referral may be required
Doctor Visits	• Primary Care: $0 copay per visit • Specialist: $50 copay per visit *Specialist services may require Prior Authorization (approval in advance).* A referral may be required for specialist visits.
Preventive Care	$0 copay for Medicare-covered zero cost-sharing 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).*

Premiums and Benefits	Allwell Medicare (HMO)
Emergency Care	$80 copay per visit If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care.
Urgently Needed Services	$25 copay per visit
Diagnostic Services/Labs/ Imaging	• Lab services: $10 copay • Diagnostic tests and procedures: 25% coinsurance • EKG: 25% coinsurance • Outpatient x-ray services: $20 copay • Diagnostic radiological services (such as MRI, MRA, CT, PET): 20% 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	• Hearing exam (Medicare-covered): $50 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 (up to 1 every year) • Hearing aid: $0 copay This plan pays up to $1,500 for one hearing aid (for either the left or right ear) every year. *Some services may require Prior Authorization (approval in advance).* Referral may be required.
Dental Services	Dental services (Medicare-covered): $50 copay per visit Medicare-covered services: Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth). **Preventive dental services:** • Cleaning and Oral exam: $0 copay (up to 2 every year) • Dental x-rays: $0 copay (up to 1 every year) Dental x-rays include bitewing series only. *Some services may require Prior authorization (approval in advance).* Referral may be required.

Premiums and Benefits	Allwell Medicare (HMO)
Vision Services	• Vision exam to diagnose and treat diseases and conditions of the eye (Medicare-covered): $50 copay per visit • Annual 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 $200 allowance for contact lenses and/or eyeglasses (frames and lenses) every year. Some services may require Prior Authorization (approval in advance).
Mental Health Services	Outpatient: $40 copay per individual visit $40 copay per group visit Inpatient: $395 copay per day, days 1 through 4 $0 copay per day, days 5 through 90 *Some services may require Prior Authorization (approval in advance).*
Skilled Nursing Facility	For each admission, you pay: • $0 copay per day for days 1 through 20 • $165 copay per day for days 21 through 100 *Some services may require Prior Authorization (approval in advance)*
Physical Therapy	$40 copay per visit *Prior Authorization (approval in advance) may be required.* Referral may be required.
Ambulance	$265 copay Cost is per one-way trip for Medicare-covered Ambulance services. *Prior authorization (approval in advance) is required for non-emergency ambulance services.*
Transportation	Not Covered

Premiums and Benefits	Allwell Medicare (HMO)
Medicare Part B Drugs	Chemotherapy drugs: 20% coinsurance Other Part B drugs: 20% coinsurance *Prior Authorization (approval in advance) may be required.*
Meal Benefits	$0 copay The plan covers home-delivered meals (up to 2 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 non- physician practitioner. Prior authorization (approval in advance) may be required.
Over-the-Counter (OTC) Items	$0 copay The plan covers $50 per calendar quarter for items available via mail order. Any unused plan benefit amounts do not carry forward into the next calendar 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 an 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. Smoking and tobacco use cessation (Medicare-covered) (counseling to stop smoking or tobacco use): $0 copay Additional sessions of smoking and tobacco cessation counseling $0 copay For a detailed list of wellness program benefits offered, please refer to the Evidence of Coverage.

Outpatient Prescription Drugs				
Deductible Phase	$200 Deductible. Deductible does not apply to Tiers 1, 2 and 6.			
Initial Coverage Phase (After you pay your Part D 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 Cost sharing **Rx 30-day supply**	**Standard Retail Cost Sharing** **Rx 30-day supply**	**Mail Order** **90-day supply**
	Tier 1: Preferred Generic	$3 copay	$8 copay	$9 copay
	Tier 2: Generic	$15 copay	$20 copay	$45 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	29% coinsurance	29% coinsurance	N/A
	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 our drugs covered by our plan. For a complete listing, please call 1-855-848-6940 (TTY:711) or visit https://allwell.coordinatedcarehealth.com.			

For more information, please contact:

Allwell Medicare (HMO)
1145 Broadway Tacoma, WA 98402
https://allwell.coordinatedcarehealth.com.

Current members should call: 1-855-848-6940 (TTY: 711)

Prospective members should call: 1-877-893-7277 (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.

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

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

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

- 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 Medicare (HMO) Customer Contact Center at:
1-855-848-6940 (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 Medicare (HMO) 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 Medicare (HMO) 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.

SPANISH	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-848-6940 (HMO) (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 1-855-848-6940 (HMO) (TTY: 711)。
VIETNAMESE	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-848-6940 (HMO) (TTY: 711).
KOREAN	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-848-6940 (HMO) (TTY: 711). 번으로 전화해 주십시오.
RUSSIAN	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-848-6940 (HMO) (TTY: 711).
TAGALOG	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-848-6940 (HMO) (TTY: 711).
UKRAINIAN	**УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером** 1-855-848-6940 (HMO) (TTY: 711).
MON-KHMER, CAMBODIAN	ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-855-848-6940 (HMO) (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。1-855-848-6940 (HMO) (TTY: 711). まで、お電話にてご連絡ください。
AMHARIC	ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-848-6940 (HMO) (TTY: 711).
CUSHITE	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-848-6940 (HMO) (TTY: 711).
ARABIC	تنبيه: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال بالرقم. 1-855-848-6940 (HMO) (مقر فتاه مصلا مكبلاو: 711).
PUNJABI	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਬਿਲਕੁਲ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ 1-855-848-6940 (HMO) (TTY: 711) 'ਤੇ ਕਾੱਲ ਕਰੋ।
GERMAN	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-848-6940 (HMO) (TTY: 711).
LAOTIAN	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ,ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-848-6940 (HMO) (TTY: 711).