Summary of Benefits

2021

Allwell Dual Medicare (HMO D-SNP) H2915: 002
Bucks, Chester, Delaware, Montgomery and Philadelphia counties, PA

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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.pahealthwellness.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 Pennsylvania: Bucks, Chester, Delaware, Montgomery and Philadelphia.
- For Allwell Dual Medicare (HMO D-SNP), you must also be enrolled in the Pennsylvania 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 Pennsylvania 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.pahealthwellness.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, 2021 – DECEMBER 31, 2021

Benefits	Allwell Dual Medicare (HMO D-SNP) H2915: 002 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
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 (includes 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
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

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

Benefits	Allwell Dual Medicare (HMO D-SNP) H2915: 002 Premiums / Copays / Coinsurance
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 $550 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
Transportation	• $0 copay for each one-way trip • Unlimited 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

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

Part D Prescription Drugs		
Deductible Stage	\$445 deductible for Part D prescription drugs. 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	\$5 copay	\$15 copay
Tier 3: Preferred Brand Drugs	\$40 copay	\$120 copay
Tier 4: Non-Preferred Drugs	45% coinsurance	45% 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). 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).	

Part D Prescription Drugs	
	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 1-866-330-9368 (TTY: 711).

Additional Covered Benefits	
Benefits	**Allwell Dual Medicare (HMO D-SNP) H2915: 002 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 ($360 allowance per quarter) for items available via mail and at participating CVS retail Pharmacy locations. 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. You can also purchase OTC products at participating CVS locations. Participating locations vary by area. Refer to the Store Locator link on cvs.com/otchs/allwell for a list of participating locations. 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

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Additional Covered Benefits	
Benefits	**Allwell Dual Medicare (HMO D-SNP) H2915: 002 Premiums / Copays / Coinsurance**
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 For a detailed list of wellness program benefits offered, please refer to the EOC.
Routine Annual Exam	$0 copay
Special Supplemental Benefits for the Chronically Ill	The following service is available for members with chronic conditions • Additional 20 one-way trips are covered to approved non-medical locations for members with chronic conditions per calendar year. Such locations would include banking, grocery shopping, fitness, community centers and other social events. Mileage limits may apply. 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 (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 Pennsylvania Medical Assistance toll free at 1-800-692-7462 (TTY: 711).

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

Pennsylvania's Current Medicaid State Plan Benefits and Home and Community Based Services	
Adult Benefit Package*	
Services	**Adult Benefit Package**
Category 1: Ambulatory Services	
Primary Care Provider	No limits
Physician Services and Medical and Surgical Services provided by a Dentist	No limits
Certified Registered Nurse Practitioner	No limits
Federally Qualified Health Center/Rural Health Clinic	No limits except for Dental Care Services as described below
Independent Clinic	No limits
Outpatient Hospital Clinic	No limits
Podiatrist Services	No limits
Chiropractic Services	No limits
Optometrist Services	2 visits (exams) per calendar year
Hospice Care	The only key limitation is related to respite care, which may not exceed a total of 5 consecutive days in a 60-day certification period.
Radiology (For example: X-Rays, MRIs, and CTs)	No limits

Dental Care Services	Diagnostic, preventive, restorative, surgical dental procedures, prosthodontics and sedation. **Key Limitations:** Dentures – 1 upper arch (complete or partial) and 1 lower arch (complete or partial) per lifetime. Denture relines – either full or partial, limited to 1 arch every 2 calendar years. Oral exams – 1 per 180 days Dental prophylaxis – 1 per 180 days Panoramic maxilla or mandible single film Is limited to 1 per 5 calendar years. Crowns, Periodontics and Endodontics only via approved benefit limit exception.
Outpatient Hospital Short Procedure Unit (SPU)	No limits
Outpatient Ambulatory Surgical Center (ASC)	No limits
Non-Emergency Medical Transport	Only to and from Medicaid covered services.
Family Planning Clinic, Services and Supplies	No limits
Renal Dialysis	Initial training for home dialysis is limited to 24 sessions per patient per calendar year. Backup visits to the facility limited to no more than 75 per calendar year.
Category 2: Emergency Services	
Emergency Room	No limits
Ambulance	No limits
Category 3: Hospitalization	
Inpatient Acute Hospital	No limits
Inpatient Rehab Hospital	No limits
Inpatient Psychiatric Hospital	No limits
Inpatient Drug & Alcohol	No limits
Category 4: Maternity and Newborn	
Maternity – Physician, Certified Nurse Midwives, Birth Centers	No limits

Category 5: Mental Health and Substance Abuse (Behavioral Health)	
Outpatient Psychiatric Clinic	No limits
Mobile Mental Health Treatment	No limits
Outpatient Drug And Alcohol Treatment	No limits
Methadone Maintenance	No limits
Clozapine	No limits
Psychiatric Partial Hospital	No limits
Peer Support	No limits
Crisis	No limits
Targeted Case Management – other than Behavioral Health	Limited to Individuals Identified in the target group (No limits).
Targeted Case Management – Behavioral Health Only	Limited to individuals with Serious Mental illness (SMI) only (No limits).
Category 6: Prescription Drugs	
Prescription Drugs	No limits
Nutritional Supplements	No limits
Category 7: Rehabilitation and Habilitation Services and Devices	
Skilled Nursing Facility	365 days per calendar year
Home Health Care includes nursing, aide and therapy services.	Unlimited for the first 28 days; limited to 15 days every month thereafter.
ICF/IID and ICF/ORC	Requires and institutional level of care (No limits).
Durable Medical Equipment	No limits
Prosthetics and Orthotics	Orthopedic Shoes and Hearing Aids are not covered. Coverage of molded shoes is limited to molded shoes for severe foot and ankle conditions and deformities of such a degree that the beneficiary is unable to wear ordinary shoes without corrections and modifications. Coverage of modifications to orthopedic shoes are molded shoes is limited to only modifications necessary for the application of a brace or splint. Coverage for low vision aids and eye protheses is limited to 1 per 2 calendar years. Coverage for an eye ocular is limited to 1 per calendar year.

Eyeglass Lenses	Limited to individuals diagnosed with aphakia – 4 lenses per calendar year.
Eyeglass Frames	Limited to individuals diagnosed with aphakia – 2 frames per calendar year. Deluxe frames not included.
Contact Lenses	Limited to individuals diagnosed with aphakia – 4 lenses per calendar year.
Medical Supplies	No limits
Therapy (Physical, occupational, speech) – Rehabilitative	Only when provided by a hospital, outpatient clinic or home health provider.
Therapy (Physical, occupational, speech) – Habilitative	Only when provided by a hospital, outpatient clinic or home health provider.
Category 8: Laboratory Services	
Laboratory	No limits
Category 9: Preventive/Wellness Services and Chronic Care	
Tobacco Cessation**	70, 15-minute units per calendar year

All units of service, age, gender, diagnosis, and other procedure code related limits still apply as indicated on the Medical Assistance Fee Schedule.

*Children's benefit plan will include all medically necessary services without limitation.

**Tobacco cessation is one of the preventive services as recommended by the US Preventive Services Task Force. For a full listing of preventive services beyond tobacco cessation, please contact your MCO.

Home and Community-Based Services (HCBS)	
Services	**Limits**
• Adult Daily Living Services • Assistive Technology • Behavior Therapy • Benefits Counseling • Career Assessment • Cognitive Rehabilitation Therapy • Community Integration • Community Transition Services • Counseling • Employment Skills Development • Home Adaptations • Home Delivered Meals • Home Health Aide	**Under Community Integration:** Each distinct goal may not be more than twenty-six (26) weeks. No more than 32 units per week for one goal will be approved. If the participant has multiple goals, no more than 48 units per week will be approved. However, the Office of Long Term Living retains the discretion to authorize more than 48 units (12 hours) of Community Integration In one week for up to 21 hours per week and for periods longer than 26 weeks. Community Transition Services are limited to an aggregate of $4,000 per participant, per lifetime, as pre-authorized by the State Medicaid Agency program office.

• Home Health -Nursing • Home Health -Occupational Therapy • Home Health -Physical Therapy • Home Health -Speech and Language Therapy • Job Coaching • Job Finding • Non-Medical Transportation • Nutritional Counseling • Participant-Directed Community Supports • Participant-Directed Goods and Services • Personal Assistance Services • Personal Emergency Response System (PERS) • Pest Eradication • Residential Habilitation • Respite • Service Coordination • Specialized Medical Equipment and Supplies • Structured Day Habilitation • Telecare • Vehicle Modifications	Total combined hours for Employment Skills Development, or Job Coaching services are limited to 50 hours in a calendar week. A participant whose needs exceed 50 hours a week must obtain prior approval. **Under Specialized Medical Equipment and Supplies non-covered Items include:** All prescription and over-the-counter medications, compounds and solutions (except wipes and barrier cream) Items covered under third party payer liability Items that do not provide direct medical or remedial benefit to the participant and/or are not directly related to a participant's disability Food, food supplements, food substitutes (including formulas), and thickening agents Eyeglasses, frames, and lenses Dentures Any Item labeled as experimental that has been denied by Medicare and/or Medicaid Recreational or exercise equipment and adaptive devices for such

For all HCBS services that are also offered under the State Plan, the State Plan benefit must be exhausted before HCBS services can be accessed. Additionally, Medicare and other third party resources such as private Insurance limitations must also have been exhausted. Lastly, some HCBS services may not be accessed at the same time.

For more information, please contact:

Allwell Dual Medicare (HMO D-SNP)
300 Corporate Center Drive
Camp Hill, PA 17011

allwell.pahealthwellness.com

Current members should call: 1-866-330-9368 (TTY: 711)

Prospective members should call: 1-877-891-6103 (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 1-866-330-9368 (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 D-SNP plans and with the state Medicaid program. Enrollment in Allwell depends on contract renewal.

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