

This is your Summary of Benefits.

2020

Allwell Dual Medicare (HMO D-SNP) H5190: 001
Duval and Volusia counties, FL



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.sunshinehealth.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 Florida: Duval and Volusia.
- 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 Florida 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 Florida 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.sunshinehealth.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) H5190: 001 Premiums / Copays / Coinsurance |
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| 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 - \$28.50 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 deductible for covered medical services • \$435 deductible for Part D prescription drugs (applies to drugs on Tiers 3, 4 and 5) |
| Maximum Out-of-Pocket Responsibility <i>(does not include prescription drugs)</i> | \$3,400 annually This is the most you will pay in copays and coinsurance for 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 | <ul style="list-style-type: none"> • Primary Care: \$0 copay per visit • Specialist: \$0 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 \$120) per visit You do not have to pay the copay if admitted to the hospital immediately. |
| Urgently Needed Services | \$0 copay per visit |
| Diagnostic Services/Labs/Imaging* | <ul style="list-style-type: none"> • 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) H5190: 001 Premiums / Copays / Coinsurance |
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| Hearing Services | <ul style="list-style-type: none"> • 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, every calendar year) |
| Dental Services | <ul style="list-style-type: none"> • 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 \$3,000 every calendar year; it applies to all comprehensive dental benefits. |
| Vision Services | <ul style="list-style-type: none"> • 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 \$350 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* | <ul style="list-style-type: none"> • Ground ambulance services: \$0 or \$100 copay (per one-way trip) • Air ambulance services: 0% or 20% coinsurance (per one-way trip) |
| Transportation* | \$0 copay for each one-way trip Unlimited one-way trips to plan-approved locations each calendar year. Mileage limits may apply. |
| Medicare Part B Drugs* | <ul style="list-style-type: none"> • Chemotherapy drugs: 0% or 20% coinsurance • Other Part B drugs: 0% or 20% coinsurance |

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

Part D Prescription Drugs

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| Deductible Stage | <p>\$435 deductible for Part D prescription drugs (applies to drugs on Tiers 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 | \$0 copay | \$0 copay |
| Tier 3: Preferred Brand | \$47 copay | \$141 copay |
| Tier 4: Non-Preferred Drug | \$100 copay | \$300 copay |
| Tier 5: Specialty | 25% coinsurance | Not available |
| Tier 6: Select Care Drugs | \$0 copay | \$0 copay |

Part D Prescription Drugs

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| Coverage Gap Stage | <p>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.</p> <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 1-877-935-8022 (TTY: 711).</p> |

| Additional Covered Benefits | |
|--|---|
| Benefits | Allwell Dual Medicare (HMO D-SNP) H5190: 001 Premiums / Copays / Coinsurance |
| Opioid Treatment Program Services | <ul style="list-style-type: none"> • Individual setting: \$0 copay per visit • Group setting: \$0 copay per visit |
| Over-the-Counter (OTC) Items | <p>\$0 copay (\$100 allowance per month) for items available via order and at participating CVS retail Pharmacy locations.</p> <p>There is a limit of 5 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> |
| Meals* | <p>\$0 copay</p> <p>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.</p> |
| Chiropractic Care | <ul style="list-style-type: none"> • Chiropractic services (Medicare-covered): \$0 copay per visit • Routine chiropractic services: \$0 copay per visit (12 visits every calendar year.) |
| Medical Equipment/Supplies* | <ul style="list-style-type: none"> • Durable Medical Equipment (e.g., wheelchairs, oxygen): \$0 copay • Prosthetics (e.g., braces, artificial limbs): \$0 copay • Diabetic supplies: 0% or 20% coinsurance |
| Foot Care (Podiatry Services) | <ul style="list-style-type: none"> • Foot exams and treatment (Medicare-covered): \$0 copay per visit • Routine Foot Care: \$0 copay per visit (unlimited visits every calendar year.) |
| 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> |
| Worldwide Emergency Care | <p>\$50,000 plan coverage limit for supplemental urgent/emergent services outside the U.S. and its territories every calendar year.</p> |

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

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 the Florida Agency for Health Care Administration (AHCA) toll-free at 1-888-419-3456 (TTY: 711).

Our source of information for Medicaid benefits is ahca.myflorida.com. All Medicaid covered services are subject to change at any time. For the most current Florida Medicaid coverage information, please visit ahca.myflorida.com or call Member Services for assistance. A detailed explanation of Florida Medicaid benefits can be found in the Florida Summary of Services online at https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/Covered_Services_HCBS_Waivers.shtml

Covered Services

- Allergy Services
- Ambulance Transportation Services
- Ambulatory Surgical Center Services
- Anesthesia Services
- Assistive Care Services
- Behavioral Health Overlay Services
- Cardiovascular Services
- Chiropractic Services
- Community Behavioral Health Services
- Dental Services
- Dialysis Services
- Durable Medical Equipment (DME) and Medical Supplies
- Early Intervention Services
- Evaluation and Management Services
- Family Planning Waiver Services
- Federally Qualified Health Center Clinic Services
- Gastrointestinal Services
- Genitourinary Services
- Hearing Services
- Home Health Services
- Hospice Services
- Inpatient Hospital Services
- Integumentary Services
- Laboratory Services
- Medicaid Forms
- Mental Health Targeted Case Management
- Neurology Services
- Oral and Maxillofacial Surgery Services
- Orthopedic Services
- Outpatient Hospital Services

Covered Services

- Pain Management Services
- Podiatry Services
- Prescribed Drug Services
- Provider Reimbursement Schedules and Billing Codes
- Radiology and Nuclear Medicine Services
- Regional Perinatal Intensive Care Center Services
- Reproductive Services
- Respiratory Services
- Specialized Therapeutic Services
- Statewide Inpatient Psychiatric Program Services
- Therapy Services
- Transplant Services
- Transportation Coverage
- Visual Aid Services
- Visual Care Services

Please note: There may be instances when the Medicaid limit is greater than the Medicare limit. In those instances where the Medicare limit has been exhausted, the Plan shall cover the difference for those eligible recipients.

Additional Medicaid Required Covered Services:

Durable Medical Equipment and Medical Supplies

Notwithstanding the limitations prescribed by the Durable Medical Equipment Services Coverage and Limitations Handbook, the Plan shall provide specialized medical equipment and supplies (e.g., incontinence supplies) to enrollees with a diagnosis of AIDS, and who have had a history of an AIDS-related opportunistic infection. The Plan may place appropriate limits on such services on the basis of medical necessity.

Therapy Services

The Plan shall provide medical massage therapy services to enrollees diagnosed with AIDS, and who have had a history of an AIDS-related opportunistic infection for the treatment of peripheral neuropathy or severe neuromuscular pain and lymphedema. The Plan may place appropriate limits on such services on the basis of medical necessity.

For more information, please contact:

Allwell Dual Medicare (HMO D-SNP)
1301 International Parkway
Suite 400
Sunrise, FL 33323

allwell.sunshinehealth.com

Current members should call: 1-877-935-8022 (TTY: 711)
Prospective members should call: 1-877-826-3692 (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 1-877-935-8022 (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.