



2021 SUMMARY OF BENEFITS

January 1, 2021 – December 31, 2021

The Health Plan SecureCare - Option II (HMO), H3672-020

The Health Plan SecureCare (HMO) is an HMO plan with a Medicare contract. Enrollment in The Health Plan SecureCare (HMO) depends on contract renewal.

Our service area includes the following counties in **Ohio**: Belmont, Guernsey, Harrison, Jefferson, Monroe, Muskingum, Noble, and Washington; and **West Virginia**: Barbour, Berkeley, Braxton, Brooke, Cabell, Calhoun, Doddridge, Gilmer, Grant, Greenbrier, Hampshire, Hancock, Hardy, Harrison, Jefferson, Lewis, Lincoln, Logan, Marion, Marshall, Mason, McDowell, Mercer, Mineral, Mingo, Monongalia, Monroe, Morgan, Nicholas, Ohio, Pendleton, Pleasants, Pocahontas, Preston, Raleigh, Randolph, Ritchie, Roane, Summers, Taylor, Tucker, Tyler, Upshur, Wayne, Webster, Wetzel, Wirt, Wood, and Wyoming.

To join The Health Plan SecureCare - Option II (HMO) you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage" or access it online at healthplan.org/medicare.

The Health Plan SecureCare - Option II (HMO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

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 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. Call **1.877.847.7907** (current members) or **1.877.847.7915** (prospective members) for more information. **TTY users should call 711.**

Hours of operation:

- **October 1 to March 31, 8:00 a.m. to 8:00 p.m. Eastern, 7 days a week.**
- **April 1 to September 30, 8:00 a.m. to 8:00 p.m. Eastern, Monday through Friday.**

Or visit us at healthplan.org/medicare.

This document is available in other formats such as Braille, large print or audio. For additional information, call us at **1.877.847.7915**.

All copays and coinsurance are per visit unless otherwise stated.



Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1.877.847.7915 (TTY 711)**.

Understanding the Benefits

- Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit healthplan.org/medicare or call **1.877.847.7915 (TTY 711)** to view a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copayments/co-insurance may change on January 1, 2022.
- Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE OPTION II (HMO) H3672-020	MAY REQUIRE PRIOR APPROVAL*
Monthly Plan Premium	\$65 You must continue to pay your Medicare Part B premium.	
Deductible	This plan does not have a deductible for medical services.	
Maximum Out-of-Pocket Responsibility (does not include Part D prescription drugs)	\$6,700 annually This is the most that you may pay for copays, co- insurance, and other costs for medical services for the year.	
Hospital Services		
Inpatient Hospital Coverage (per admission)	Days 1-5: \$250 copay per day Days 6-90: \$0 copay Days 91 and beyond: \$0 copay Our plan covers an unlimited number of days for an inpatient hospital stay.	<input checked="" type="checkbox"/>
Outpatient Hospital Coverage	\$0 or \$250 copay \$0 copay for observation visits; \$0 copay for colonoscopy; \$250 copay for outpatient surgeries.	<input checked="" type="checkbox"/>
Doctor Visits		
Primary Care Provider	\$10 copay	<input type="checkbox"/>
Specialist	\$45 copay	<input checked="" type="checkbox"/>
Preventive Care (Medicare-covered zero cost sharing preventive services)	\$0 copay	<input checked="" type="checkbox"/>
Emergency Care (worldwide)	\$90 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. Covered emergency services outside of U.S. have a \$25,000 annual plan maximum.	<input type="checkbox"/>
Urgently Needed Services	\$45 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services.	<input type="checkbox"/>

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE OPTION II (HMO) H3672-020	MAY REQUIRE PRIOR APPROVAL*
Diagnostic Services/Labs/Imaging		
Diagnostic Radiology Service (such as MRIs, CT scans)	\$0 or \$150 copay \$150 for CT scans, MRI, MRA, PET and SPECT scans; \$0 copay for all diagnostic mammograms and diagnostic bone density exams.	<input checked="" type="checkbox"/>
Therapeutic Radiology Services (such as radiation treatment for cancer)	20% coinsurance	<input checked="" type="checkbox"/>
Lab Services	\$0 copay	<input type="checkbox"/>
Diagnostic Tests and Procedures	\$50 copay	<input type="checkbox"/>
Outpatient X-rays	\$0 or \$50 copay \$50 copay for Medicare-covered X-ray services. \$0 copay will apply to X-ray services that are part of a scheduled outpatient surgery, ER visit, or inpatient hospital stay. One copay per date of services.	<input checked="" type="checkbox"/>
Hearing Services Medicare-covered Exam	\$45 copay	<input type="checkbox"/>
Dental Services		
Medicare-covered Services	\$45 copay This does not include services in connection with care, treatment, filling, removal, or replacement of teeth.	<input checked="" type="checkbox"/>
Routine Dental Services	\$0 copay for preventive: 2 exams, 2 cleanings, one set of bitewing X-rays every year. One full mouth x-ray every 3 years. Non-Medicare covered routine dental is provided through plan participating providers. Contact the plan for more details.	<input type="checkbox"/>
Optional Supplemental Dental	Comprehensive dental benefits are available with a separate monthly premium. See the "Optional Supplemental Benefits" section in the back of this book.	<input type="checkbox"/>

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE OPTION II (HMO) H3672-020	MAY REQUIRE PRIOR APPROVAL*
Vision Services		
Medicare-covered exam to diagnose and treat conditions of the eye (including yearly glaucoma screening)	\$0 copay	<input type="checkbox"/>
Medicare-covered Eyewear	\$0 copay	<input type="checkbox"/>
Routine Eye Exam (1 every year)	\$0 copay Non-Medicare covered routine vision is provided through plan participating providers. Contact the plan for more details.	<input type="checkbox"/>
Routine Eyewear (Every two years)	\$0 copay The plan coverage limit for non-Medicare covered/routine eyewear: \$100 toward glasses (lens and frames) or contacts (including fitting exam).	<input type="checkbox"/>
Mental Health Services		
Inpatient Services (per admission)	Days 1-5: \$250 copay per day Days 6-90: \$0 copay	<input checked="" type="checkbox"/>
Outpatient Individual Therapy Visit	\$40 copay	<input checked="" type="checkbox"/>
Outpatient Group Therapy Visit		<input checked="" type="checkbox"/>
Skilled Nursing Facility (Per benefit period)	Days 1-20: \$0 copay Days 21-100: \$178 copay per day Our plan covers up to 100 days in a skilled nursing facility.	<input checked="" type="checkbox"/>
Physical Therapy	\$40 copay	<input checked="" type="checkbox"/>
Ambulance (worldwide)	\$250 copay Air ambulance: \$500 copay Covered emergency services outside of U.S. have a \$25,000 annual plan maximum. Cost-sharing applies to each one-way trip.	<input type="checkbox"/>
Transportation (routine)	Not covered	<input type="checkbox"/>

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PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE OPTION II (HMO) H3672-020	MAY REQUIRE PRIOR APPROVAL*
Medicare Part B Drugs	20% co-insurance	<input checked="" type="checkbox"/>
Ambulatory Surgery Center	\$250 copay	<input checked="" type="checkbox"/>
Foot Care (podiatry services)		
Medicare-covered Foot Exams and Treatment	\$45 copay Foot exams and treatments if you have diabetes-related nerve damage and/or meet certain conditions.	<input checked="" type="checkbox"/>
Routine Foot Care	\$45 copay Routine foot care covered for up to 2 visits every year.	<input checked="" type="checkbox"/>
Medical Equipment Supplies		
Durable Medical Equipment (e.g., wheelchairs, oxygen)	20% co-insurance Durable medical equipment must meet certain criteria to be covered. Contact the plan for more details.	<input checked="" type="checkbox"/>
Prosthetics (e.g., braces, artificial limbs)	20% co-insurance	<input checked="" type="checkbox"/>
Diabetes Supplies		
Diabetes Monitoring Supplies	\$7.50 copay for diabetes supply of test strip/lancet items. 0% coinsurance for preferred blood glucose monitors. 20% coinsurance for all other covered diabetic supplies. Coverage limited to 100 strips for a 30-day supply. Additional quantity requires coverage review. Diabetic monitoring devices and test strips are limited to LifeScan products.	<input checked="" type="checkbox"/>
Medicare-Covered Diabetes Self-Management	\$0 copay Diabetes self- management training is covered under certain condition. Contact the plan for details.	<input type="checkbox"/>
Therapeutic Shoes or Inserts	20% co-insurance	<input checked="" type="checkbox"/>
Health/Wellness Programs (e.g., fitness, tobacco cessation, etc.)	\$0 copay SilverSneakers is the fitness program covered by this plan.	<input type="checkbox"/>

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE OPTION II (HMO) H3672-020	MAY REQUIRE PRIOR APPROVAL*
Home Health	\$0 copay	<input checked="" type="checkbox"/>
Cardiac/Pulmonary Rehabilitation Services	\$0 copay	<input checked="" type="checkbox"/>
Chiropractic Services	\$20 copay Covers only manual manipulation of the spine to correct subluxation.	<input checked="" type="checkbox"/>
Over the Counter Items (OTC)	\$60 Allowance Per Quarter The quarterly credit may be carried over from month to month but must be used by December 31.	<input type="checkbox"/>
Additional Telehealth Services	\$0 copay This applies to: <ul style="list-style-type: none"> • Primary Care Physician Services • Physician Specialist Services (call plan for details) • Individual Sessions for Mental Health Specialty Services • Individual Sessions for Psychiatric Services • Individual Sessions for Outpatient Substance Abuse Services must be accessed through our contracted vendor.	<input type="checkbox"/>

*SERVICES WITH MAY REQUIRE YOUR PROVIDER TO OBTAIN PRIOR AUTHORIZATION FROM THE PLAN.

Prescription Coverage

THE HEALTH PLAN SECURECARE – OPTION II (HMO) H3672-020			
Outpatient Prescription Drugs	This plan provides Part D Rx coverage		
Cost Sharing	<p>Cost sharing may change when you enter a new stage of the Part D benefit. Costs may differ based on pharmacy type and status (e.g. preferred/non-preferred, mail order, long term care (LTC), home infusion) and days supply.</p> <p>There are preferred retail pharmacies in our network. You will generally pay a lower copay at a preferred network pharmacy. Cost sharing may be different than listed if you receive Medicare Part D Rx Extra Help.</p> <p>For more information, please call us or access our Evidence of Coverage or formulary online at healthplan.org/medicare.</p>		
Deductible	<p>\$100</p> <p>Deductible applies to drugs in Tier 3, Tier 4, and Tier 5 only.</p>		
Initial Coverage	<p>In the initial coverage “phase,” you pay the cost share amount indicated until your total yearly drug costs reach \$4,130. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.</p>		
	Preferred Retail Pharmacy 30-day supply	Standard Retail Pharmacy 30-day supply	Mail Order Pharmacy 30-day supply
Tier 1: Preferred Generic	\$3	\$13	N/A
Tier 2: Generic	\$10	\$20	N/A
Tier 3: Preferred Brand	\$47	\$47	N/A
Tier 4: Non-Preferred Drug	\$100	\$100	N/A
Tier 5: Specialty (Extended day supply not available in this Tier)	31%	31%	31%
	Preferred Retail Pharmacy 90-day supply	Standard Retail Pharmacy 90-day supply	Mail Order Pharmacy 90-day supply
Tier 1: Preferred Generic	\$9	\$39	\$0
Tier 2: Generic	\$30	\$60	\$0
Tier 3: Preferred Brand	\$141	\$141	\$94
Tier 4: Non-Preferred Drug	\$300	\$300	\$200
Tier 5: Specialty (Extended day supply not available in this Tier)	N/A	N/A	N/A

THE HEALTH PLAN SECURECARE – OPTION II (HMO) H3672-020	
Coverage Gap	Most Medicare drug plans have a coverage gap. This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,130. After you enter the coverage gap, you pay 25% of the price for brand name drugs plus a portion of the drug dispensing fee, and 25% of the price for generic drugs until your costs total \$6,550.
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,550, you pay the greater of 5% of the cost, or \$3.70 copay for generic (or a preferred multi-source drug) and a \$9.20 copayment for all other drugs.

Optional Supplemental Benefits - Dental

This coverage is available to you for an additional monthly cost of **\$23.60**. This will be in addition to your The Health Plan SecureCare HMO monthly premium.

Our plan will cover up to \$1,500 for dental services per plan year. You will be responsible for a portion of the cost for services, as indicated below. The benefit is administered through Liberty Dental providers.

This is not a complete description of benefits. There are covered services that are not listed here. In addition, some of the following services have limitations, exclusions, and maximums. Please contact the plan for complete details.

Monthly Premium	\$23.60
Maximum Benefit – Plan Coverage Limit	\$1,500 per year

Covered Dental Benefits	In-Network You Pay
Basic Benefits	
Fillings	20%
Resin-based Composite	20%
Endodontics	50%
Scaling and Root Planning	50%
Periodontal Maintenance	50%
General Anesthesia/Intravenous Sedation	50%
Major Benefits	
Crown	50%
Extractions	50%
Complete and Partial Dentures	50%
Denture Adjustment	50%
Denture Repair	50%
Denture Reline/Rebase	50%

How to add this additional Optional Supplemental dental coverage to your plan: Mark the appropriate section on your initial Medicare Advantage plan enrollment form. You can also add this coverage: Up to 60 days after your effective date or during the Annual Enrollment Period (AEP). This coverage will have an additional monthly cost. Your options are listed on the enrollment form. Please contact the plan for complete details.



Discrimination is Against the Law

The Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact The Health Plan Customer Service Department.

If you believe that The Plan 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 with: The Health Plan Appeals Coordinator, 1110 Main Street, Wheeling, WV 26003, Phone: 1.877.847.7907, TTY: 711, Fax 740.699.6163, Email: info@healthplan.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance The Health Plan Customer Service Department 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, D.C. 20201
1.800.368.1019, 1.800.537.7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-847-7907 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-847-7907 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877- 847-7907 (TTY : 711)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-847-7907 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.877.847.7907 (رقم هاتف الصم والبكم: 711).

Wann du Deutsch (Pennsylvania German / Dutch) schwetztscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-847-7907 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-847-7907 (телетайп: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-847-7907 (ATS: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-847-7907 (TTY: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-877-847-7907 (TTY: 711).

주의: 한국어어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-847-7907 (TTY: 711).번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-847-7907 (TTY: 711).

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。1-877-847-7907 (TTY: 711) まで、お電話にてご連絡ください。

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-877-847-7907 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-877-847-7907 (телетайп: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-877-847-7907 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877- 847-7907 (TTY : 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาไทยได้ฟรี โทร 1-877-847-7907 (TTY: 711).

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-877- 847-7907 (टिटीवाइ: 711)।

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای تماس بگیرد. 1-877- 847-7907 (TTY: 711) شما فراهم می باشد. با

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں 1-877- 847-7907 (TTY: 711) دستیاب ہیں۔ کال کریں

