2021 SUMMARY OF BENEFITS

January 1, 2021 – December 31, 2021

The Health Plan SecureCare - Option I, MA Only (HMO), H3672- 021

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 I, MA Only (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 I, MA Only (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

- ☐ 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 I MA ONLY (HMO) H3672-021	MAY REQUIRE PRIOR APPROVAL*
Monthly Plan Premium	$0 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 The most you 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.	☑
Outpatient Hospital Coverage	$0 or $250 copay $0 copay for observation visits; $0 copay for colonoscopy; $250 copay for outpatient surgeries.	☑
Doctor Visits		
Primary Care Provider	$10 copay	☐
Specialist	$45 copay	☑
Preventive Care **(Medicare-covered zero cost sharing preventive services)**	$0 copay	☑
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.	☐

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE OPTION I MA ONLY (HMO) H3672-021	MAY REQUIRE PRIOR APPROVAL*
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.	☐
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.	☑
Therapeutic Radiology Services (such as radiation treatment for cancer)	20% coinsurance	☑
Lab Services	$0 copay	☐
Diagnostic Tests and Procedures	$50 copay	☐
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.	☑
Hearing Services Medicare-covered Exam	$45 copay	☐
Dental Services		
Medicare-covered Services	$45 copay This does not include services in connection with care, treatment, filling, removal, or replacement of teeth.	☑
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.	☐

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE OPTION I MA ONLY (HMO) H3672-021	MAY REQUIRE PRIOR APPROVAL*
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.	☐
Vision Services		
Medicare-covered exam to diagnose and treat conditions of the eye (including yearly glaucoma screening)	$0 copay	☐
Medicare-covered Eyewear	$0 copay	☐
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.	☐
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).	☐
Mental Health Services		
Inpatient Services (per admission)	Days 1-5: $250 copay per day Days 6-90: $0 copay	☑
Outpatient Individual Therapy Visit	$40 copay	☑
Outpatient Group Therapy Visit		
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.	☑
Physical Therapy	$40 copay	☑
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.	☐

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE OPTION I MA ONLY (HMO) H3672-021	MAY REQUIRE PRIOR APPROVAL*
Transportation (routine)	Not covered	☐
Medicare Part B Drugs	20% co-insurance	☑
Ambulatory Surgery Center	$250 copay	☑
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.	☑
Routine Foot Care	$45 copay Routine foot care covered for up to 2 visits every year.	☑
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.	☑
Prosthetics (e.g., braces, artificial limbs)	20% co-insurance	☑
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. Prior authorization may be required.	☑
Medicare-Covered Diabetes Self- Management	$0 copay Diabetes self- management training is covered under certain condition. Contact the plan for details.	☐
Therapeutic Shoes or Inserts	20% co-insurance	☑

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE OPTION I MA ONLY (HMO) H3672-021	MAY REQUIRE PRIOR APPROVAL*
Health/Wellness Programs (e.g., fitness, tobacco cessation, etc.)	$0 copay SilverSneakers is the fitness program covered by this plan.	☐
Home Health	$0 copay	☑
Cardiac/Pulmonary Rehabilitation Services	$0 copay	☑
Chiropractic Services	$20 copay Covers only manual manipulation of the spine to correct subluxation.	☑
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.	☐
Additional Telehealth Services	$0 copay. This applies to: • 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.	☐
Part D Prescription	This plan does NOT include Part D Rx drug coverage.	

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

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.

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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 Deitsch (Pennsylvania German / Dutch) schwetzscht, 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: 한국어를 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 lingüística 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: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี 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 (टिटिवाइ: 711).।

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

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

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TheHealthPlan