2019 Summary of Benefits

The Health Plan SecureChoice - Option II (PPO) (H8604, Plan 011)

The Health Plan SecureChoice (PPO) is a PPO plan with a Medicare contract. Enrollment in The Health Plan SecureChoice (PPO) depends on contract renewal.

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

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, Pleasants, Pocahontas, Preston, Raleigh, Randolph, Ritchie, Roane, Summers, Taylor, Tucker, Tyler, Upshur, Wayne, Webster, Wetzel, Wirt, Wood, and Wyoming.*

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 SecureChoice - Option II (PPO) has a network of doctors, hospitals, pharmacies, and other providers. You may use providers that are not in our network However, if you use the providers in our network, you may pay less for your covered services.

The formulary, pharmacy and/or provider network(s) may change at any time. You will receive notice when necessary.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at healthplan.org/medicare.

You can see our plan's provider directory at our website at **findadoc.healthplan.org**. You can see our plan's pharmacy directory at our website at **healthplan.org/medicare**.

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 **http://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**.

The Health Plan SecureChoice - Option II (PPO) covers Part D drugs. The Health Plan SecureChoice – Option II (PPO) covers Part B drugs such as chemotherapy and some drugs administered by your provider.

Out-of-network/non-contracted providers are under no obligation to treat SecureChoice (PPO) members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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/co-insurance may change on January 1 of each year.

For more information, please visit us at **healthplan.org/medicare**, or call us toll-free:

- Current members should call **1.877.847.7907 (TTY 711)**
- Prospective members should call **1.877.847.7915 (TTY 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**.

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

H8604_011_SB19_032_M ACCEPTED 9/1/2018

The HealthPlan

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PREMIUMS & BENEFITS	SECURECHOICE - OPTION II (PPO)		WHAT YOU SHOULD KNOW
Monthly Plan Premium	$110		You must continue to pay your Medicare Part B premium.
Deductible	$500 out-of-network deductible.		Applies to all out-of-network covered services except for emergency care, urgently needed services, and emergency ambulance transport.
Maximum Out-of-Pocket Responsibility (does not include Part D prescription drugs)	$6,700 for services you receive from in-network providers. $10,000 for services you receive from any provider. Your limit for services received from in-network providers will count towards this limit.		The most you pay for copays, co-insurance, and other costs for medical services for the year.
Inpatient Hospital Coverage (per admission)	**In-network** Days 1-5: $250 copay per day Days 6 and beyond: $0 copay	**Out-of-network** 20% co-insurance per stay	Our plan covers an unlimited number of days for an inpatient hospital stay.
Outpatient Hospital Coverage	**In-network** $0-$250 copay	**Out-of-network** 30% co-insurance	$0 copay for observation visits; $0 copay for colonoscopy; $250 copay for outpatient surgeries.
Doctor Visits			
•Primary Care Visit	**In-network** $0 copay	**Out-of-network** $20 copay per visit	
•Specialist Visit	**In-network** $35 copay per visit	**Out-of-network** $45 copay per visit	Prior authorization is required for certain specialist visits. $0 copay for Medicare covered vision exam with in-network providers.

PREMIUMS & BENEFITS	SECURECHOICE - OPTION II (PPO)		WHAT YOU SHOULD KNOW
Preventive Care (Medicare-covered)	**In-network** $0 copay	**Out-of-network** 30% co-insurance	
Emergency Care (worldwide)	**In-network** $90 copay per visit	**Out-of-network** $90 copay per visit	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 the U.S. have a $25,000 annual plan maximum.
Urgently Needed Services	**In-network** $65 copay per visit	**Out-of-network** $65 copay per visit	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)**	**In-network** $0-$200 copay	**Out-of-network** 30% co-insurance	**In-network:** $200 for CT Scans, MRI, MRA, PET and SPECT Scans; $0 copay for all diagnostic mammograms and diagnostic bone density exams.
• **Lab Services**	**In-network** $0 copay	**Out-of-network** 30% co-insurance	
• **Diagnostic Tests and Procedures**	**In-network** $0 copay	**Out-of-network** 30% co-insurance	

PREMIUMS & BENEFITS	SECURECHOICE - OPTION II (PPO)		WHAT YOU SHOULD KNOW
Diagnostic Services Labs/Imaging (continued)			
• **Outpatient X-rays**	**In-network** $0-$50 copay	**Out-of-network** 30% co-insurance	In-network a $50 copay will apply to X-ray services. One copay per date of service. A $0 copay will apply to X-ray services that are part of a scheduled outpatient surgery, ER visit, or inpatient hospital stay.
• **Therapeutic Radiology Services (such as radiation treatment for cancer)**	**In-network** 20% co-insurance	**Out-of-network** 30% co-insurance	
Hearing Services			
•**Medicare-covered Exam**	**In-network** $35 copay	**Out-of-network** $45 copay	Exam to diagnose and treat hearing and balance issues.
Dental Services			
•**Medicare-covered Services**	**In-network** $35 copay	**Out-of-network** $45 copay	This does not include services in connection with care, treatment, filling, removal, or replacement of teeth.
• **Routine Dental Services**	**In-network** $0 copay for preventive: 2 exams, 2 cleanings, one set of bitewing X-rays	**Out-of-network** 30% co-insurance for preventive: 2 exams, 2 cleanings, one set of bitewing X-rays	Non-Medicare covered routine dental is provided through the plan's participating providers. Please contact the plan for more details.

PREMIUMS & BENEFITS	SECURECHOICE - OPTION II (PPO)		WHAT YOU SHOULD KNOW
Vision Services			
• **Medicare-covered exam to diagnose and treat conditions of the eye (including yearly glaucoma screening)**	**In-network** $0 copay	**Out-of-network** $20-$45 copay	
• **Medicare-covered Eyewear**	**In-network** $0 copay	**Out-of-network** 30% co-insurance	
• **Routine Eye Exam (for up to 1 every year)**	**In-network** $0 copay	**Out-of-network** $45 copay	Non-Medicare covered routine vision is provided through the plan's participating providers. Please contact the plan for more details.
• **Routine Eyewear**	**In-network** $0 copay	**Out-of-network** $15 copay	For plans with routine eyewear coverage, 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)**	**In-network** Days 1-5: $250 copay per day Days 6-90: $0 copay	**Out-of-network** 20% co-insurance	
• **Outpatient Individual Therapy Visit** • **Outpatient Group Therapy Visit**	**In-network** $35 copay per outpatient/ individual or group therapy visit	**Out-of-network** $45 copay per outpatient/ individual or group therapy visit	

PREMIUMS & BENEFITS	SECURECHOICE - OPTION II (PPO)		WHAT YOU SHOULD KNOW
Skilled Nursing Facility	**In-network** Days 1-20: $0 copay Days 21-100 $150 copay per day	**Out-of-network** 20% co-insurance	Our plan covers up to 100 days in a skilled nursing facility.
Physical Therapy	**In-network** $35 copay per visit	**Out-of-network** $45 copay per visit	
Ambulance (worldwide)	**In-network** $200 copay Air ambulance: 20% co-insurance	**Out-of-network** $200 copay Air ambulance: 20% co-insurance	Covered emergency services outside of U.S. have a $25,000 annual plan maximum. Cost-sharing applies to each one way trip.
Transportation (routine)	Not covered	Not covered	
Medicare Part B Drugs	**In-network** 20% co-insurance	**Out-of-network** 30% co-insurance	
Foot Care (podiatry services)			
• **Medicare-covered Foot Exams and Treatment**	**In-network** $35 copay per visit	**Out-of-network** $45 copay per visit	Foot exams and treatments if you have diabetes-related nerve damage and/or meet certain conditions.
• **Routine Foot Care**	**In-network** $35 copay per visit	**Out-of-network** $45 copay per visit	Routine foot care covered for up to 2 visits every year.

PREMIUMS & BENEFITS	SECURECHOICE - OPTION II (PPO)		WHAT YOU SHOULD KNOW
Medical Equipment Supplies			
• **Durable Medical Equipment (e.g., wheelchairs, oxygen)**	**In-network** 20% co-insurance	**Out-of-network** 40% co-insurance	Durable medical equipment must meet certain criteria to be covered. Please contact the plan for more details.
• **Prosthetics (e.g., braces, artificial limbs)**	**In-network** 20% co-insurance	**Out-of-network** 40% co-insurance	
Diabetes Supplies			
• **Diabetes Monitoring Supplies**	**In-network** $7.50 copay	**Out-of-network** 40% co-insurance	For monitoring supplies, coverage is limited to LifeScan preferred monitoring devices and test strips. Coverage is limited to 100 test strips for a 30-day supply. Additional quantity requires coverage review.
• **Medicare-Covered Diabetes Self-Management**	**In-network** $0 copay	**Out-of-network** 40% co-insurance	Diabetes self-management training is covered under certain condition. Contact the plan for details.
• **Therapeutic Shoes or Inserts**	**In-network** 20% co-insurance	**Out-of-network** 40% co-insurance	
Health/Wellness Programs (e.g., fitness, tobacco cessation, etc.)	**In-network** $0 copay	**Out-of-network** 30% co-insurance	SilverSneakers is the fitness program covered by this plan.
Home Health	**In-network** $0 copay	**Out-of-network** 30% co-insurance	
Cardiac/Pulmonary Rehabilitation Services	**In-network** $0 copay	**Out-of-network** 30% co-insurance	
Chiropractic Services	**In-network** $20 copay	**Out-of-network** $45 copay	Covers only manual manipulation of the spine to correct subluxation.

Prescription Coverage

	SECURECHOICE - OPTION II (PPO)	WHAT YOU SHOULD KNOW
Outpatient Prescription Drugs	This plan **provides** Part D Rx coverage	
Cost Sharing		Cost-sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on a pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage or formulary online at healthplan.org/medicare.
Deductible	$100	Deductible applies to drugs in Tier 3, Tier 4, and Tier 5 only.
Initial Coverage	$3,820	In the initial coverage "phase," you pay the cost share amount indicated until your total yearly drug costs reach $3,820. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

	SECURECHOICE - OPTION II (PPO)		WHAT YOU SHOULD KNOW
Tier 1: Preferred Generic	You pay:		Cost-sharing may differ relative to the pharmacy's status as preferred or non-preferred, mail-order, Long Term Care (LTC) or home infusion, and if a 30- or 90-day supply of prescription medication is ordered. For more information please call us or access our Evidence of Coverage or formulary online at healthplan.org/medicare.
	Preferred Retail Pharmacy		
	Up to 30-day supply	$3	
	Up to 90-day supply	$9	
	Other Network Retail Pharmacy		
	Up to 30-day supply	$13	
	Up to 90-day supply	$39	
	Mail Order Pharmacy		
	Up to 90-day supply	$0	
Tier 2: Generic	You pay:		
	Preferred Retail Pharmacy		
	Up to 30-day supply	$10	
	Up to 90-day supply	$30	
	Other Network Retail Pharmacy		
	Up to 30-day supply	$20	
	Up to 90-day supply	$60	
	Mail Order Pharmacy		
	Up to 90-day supply	$20	

	SECURECHOICE - OPTION II (PPO)		WHAT YOU SHOULD KNOW
Tier 3: Preferred Brand	You pay:		
	Preferred Retail Pharmacy		
	Up to 30-day supply	$35	
	Up to 90-day supply	$105	
	Other Network Retail Pharmacy		
	Up to 30-day supply	$45	
	Up to 90-day supply	$135	
	Mail Order Pharmacy		
	Up to 90-day supply	$70	
Tier 4: Non-Preferred Drug	You pay:		
	Preferred Retail Pharmacy		
	Up to 30-day supply	$85	
	Up to 90-day supply	$255	
	Other Network Retail Pharmacy		
	Up to 30-day supply	$95	
	Up to 90-day supply	$285	
	Mail Order Pharmacy		
	Up to 90-day supply	$170	

	SECURECHOICE - OPTION II (PPO)		WHAT YOU SHOULD KNOW
Tier 5: Specialty (Extended day supply not available in this Tier)	You pay:		
	Preferred Retail Pharmacy		
	Up to 30-day supply	31% of the cost	
	Up to 90-day supply	N/A	
	Other Network Retail Pharmacy		
	Up to 30-day supply	31% of the cost	
	Up to 90-day supply	N/A	
	Mail Order Pharmacy		
	Up to 30-day supply	31% of the cost	
Coverage Gap	Most Medicare drug plans have a coverage gap (also called the "donut hole"). 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 $3,820. 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 37% of the price for generic drugs until your costs total $5,100.		
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,100, you pay the greater of 5% of the cost, or $3.40 copay for generic (or a preferred multi-source drug) and a $8.50 copayment for all other drugs.		

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 that 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, 2020.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

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）

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).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 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.

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

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-847-7907 (TTY: 711) पर कॉल करें।

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).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-847-7907 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-847-7907 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 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。

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).

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

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 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).

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

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1110 Main Street, Wheeling, WV 26003 | 1.800.624.6961