



# 2023

## Summary of Benefits

### Health Advantage Blue Classic (HMO) H9699-004-003

The service area for **Health Advantage Blue Classic (HMO)** includes the following Arkansas counties: Faulkner, Perry, Pope, and Yell.

## 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 **1-877-349-9335** (TTY: **711**).

## Understanding the Benefits

- The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **www.hamedicare.com** or call **1-877-349-9335** (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 medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- Review the Formulary to make sure your drugs are covered.

## 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/coinsurance may change on January 1, 2024.
- Except in emergency or urgent situations, we do not cover services from out-of-network providers (doctors who are not listed in the Provider Directory).

The benefit information provided is a summary of what we cover and what you pay. To get a complete list of services we cover, call us, and ask for the “Evidence of Coverage.” You may also view the “Evidence of Coverage” for this plan on our website at **www.hamedicare.com**.

If you want to know more about the coverage and costs of Original Medicare, look in the 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, seven days a week. TTY users should call **1-877-486-2048**.

## Who can join?

To join, you must be entitled to Medicare Part A, enrolled in Medicare Part B, and live in our service area.

The service area for **Health Advantage Blue Classic (HMO)** includes the following Arkansas counties: Faulkner, Perry, Pope, and Yell.

## Which doctors, hospitals, and pharmacies can I use?

We have a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, the plan may not pay for these services.

You can see our plan's Provider and Pharmacy Directories and Formulary (Drug List) on our website at [www.hamedicare.com](http://www.hamedicare.com), or you can call us, and we will send you a copy of the Provider and Pharmacy Directories and Formulary.

## Have questions? Call us.

If you are not a member of this plan, call us at **1-855-591-9795** (TTY: **711**).

If you are a member of this plan, call us at **1-877-349-9335** (TTY: **711**).

October 1 to March 31: We are available seven days a week from 8:00 a.m. to 8:00 p.m. Central, except for Thanksgiving and Christmas.

April 1 to September 30: We are available Monday through Friday, 8:00 a.m. to 8:00 p.m. Central.

You can visit our website at [www.hamedicare.com](http://www.hamedicare.com).

<b>Monthly Premium, Deductible, and Limits</b>	
<b>Monthly Plan Premium</b> You must continue to pay your Medicare Part B premium.	<b>\$0</b>
<b>Medical Deductible</b>	This plan does not have a deductible.
<b>Pharmacy (Part D) Deductible</b>	<b>\$250</b> for Tier 3, Tier 4, and Tier 5
<b>Maximum Out-of-Pocket Responsibility</b> The most you pay for copays, coinsurance, and other costs for medical services for the year.	<b>\$5,800</b>

<b>Covered Medical and Hospital Benefits</b>	
<b>Acute Inpatient Hospital Coverage</b>	<b>\$365</b> copay per day for days 1–5 <b>\$0</b> copay per day for days 6–90 <b>\$0</b> copay per day for days 91 and beyond  Prior authorization may be required. See the Evidence of Coverage (EOC) for details.
<b>Outpatient Hospital Coverage</b>  Outpatient surgery/non-surgery at an outpatient hospital:  Outpatient observation:	<b>\$285</b> copay  <b>\$285</b> copay  Prior authorization may be required. See the EOC for details.
<b>Ambulatory Surgical Center (ASC) Services</b>	<b>\$0</b> copay for a diagnostic colonoscopy at an ASC  <b>\$285</b> copay for all other services

<b>Covered Medical and Hospital Benefits</b>	
<p><b>Doctor Visits</b></p> <p>Primary care provider (PCP):</p> <p>Specialist:</p>	<p><b>\$0</b> copay</p> <p><b>\$40</b> copay</p>
<p><b>Preventive Care</b></p> <p>Abdominal aortic aneurysm screening, alcohol misuse counseling, the Annual Wellness Visit, barium enema, bone mass measurement, breast cancer screening (mammogram), cardiovascular disease (behavioral therapy), cardiovascular screening, cervical and vaginal cancer screening, colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy), depression screening, diabetes screening, diabetes self-management training, digital rectal exam, electrocardiogram (EKG), glaucoma screening, HIV screening, lung cancer screening, medical nutrition therapy services, Medicare diabetes prevention program, obesity screening and counseling, prostate cancer screening (PSA), sexually transmitted infections screening and counseling, tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease), vaccines (including flu shots, hepatitis B shots, and pneumococcal shots), and the "Welcome to Medicare" preventive visit (one-time)</p> <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>	<p><b>\$0</b> copay</p>

<b>Covered Medical and Hospital Benefits</b>	
<p><b>Emergency Care</b></p> <p>If you are admitted to the hospital within 24 hours, you do not have to pay your ER copay (does not apply to worldwide ER or worldwide urgent care services).</p> <p>Worldwide emergency or urgent care services:</p>	<p><b>\$110</b> copay</p> <p><b>20%</b> coinsurance <b>\$15,000</b> annual coverage limit</p>
<p><b>Urgently Needed Services</b></p> <p>Worldwide emergency or urgent care services:</p>	<p><b>\$40</b> copay</p> <p><b>20%</b> coinsurance <b>\$15,000</b> annual coverage limit</p>
<p><b>Diagnostic Services/Labs/Imaging</b></p> <p>Diagnostic tests and procedures:</p> <p>Lab services:</p> <p>Diagnostic radiology:</p> <p>Therapeutic (radiation) radiology:</p> <p>X-rays:</p>	<p><b>0%</b> coinsurance for a spirometry test <b>20%</b> coinsurance for all other tests and procedures</p> <p><b>\$0</b> copay</p> <p><b>\$0</b> copay for a diagnostic mammogram <b>\$0</b> copay for a DEXA scan <b>\$40</b> copay for services in a professional office <b>\$285</b> copay for services in an outpatient location</p> <p><b>20%</b> coinsurance</p> <p><b>\$0</b> copay</p> <p>Prior authorization may be required. See the EOC for details.</p>

<b>Covered Medical and Hospital Benefits</b>	
<b>Hearing Services</b>	
Medicare-covered hearing exam:	<b>\$40</b> copay
Routine hearing exam:	<b>\$0</b> copay (1 per year)
Hearing aid fittings/evaluation:	<b>\$0</b> copay (includes first year of follow-up provider visits)
Hearing aids:	<p><b>\$699</b> copay per hearing aid for Advanced hearing aids (up to 1 hearing aid per ear per year)</p> <p><b>\$999</b> copay per hearing aid for Premium hearing aids (up to 1 hearing aid per ear per year)</p> <p>Included with hearing aids: First year of provider follow-up visits, 80 batteries per hearing aid for non-rechargeable models, 60-day trial period, and 3-year warranty</p>
<b>Hearing Services – More Information</b>	
TruHearing providers and hearing aids must be used.	
<b>Dental Services – Preventive Dental</b>	
Comprehensive oral evaluation:	<b>\$0</b> copay (1 per lifetime per dentist)
Oral exams:	<b>\$0</b> copay (2 per year)
Cleanings:	<b>\$0</b> copay (2 per year)
X-rays:	<b>\$0</b> copay (limits vary per service)
Fluoride treatments:	Not covered

## Covered Medical and Hospital Benefits

### Dental Services – Comprehensive Dental

Medicare-covered dental services:	<b>\$40</b> copay
Fillings (white and silver):	<b>50%</b> coinsurance (1 per year)
Extractions:	<b>\$20</b> copay (2 per year)
Root canals:	Not covered
Crowns:	Not covered
Re-cementation of crowns:	Not covered
Deep cleanings:	<b>50%</b> coinsurance (1 per quadrant every 2 years, not to exceed 4 unique quadrants every 2 years)
Periodontal maintenance:	<b>50%</b> coinsurance (2 per year)
Complete or partial dentures:	Not covered
Complete or partial denture adjustments:	<b>\$20</b> copay (2 per year)
Complete or partial denture relines:	<b>50%</b> coinsurance (1 upper and 1 lower every 3 years)
Complete or partial denture rebase:	Not covered
Denture repairs (after 6 months of placement):	<b>50%</b> coinsurance (2 per year with up to 5 total in 5 years)
	The plan covers up to <b>\$2,000</b> combined for preventive and comprehensive dental per year.



## Covered Medical and Hospital Benefits

### Dental Services – Dental Xtra<sup>SM</sup>

**\$0** copay

A program for members who have diabetes, coronary artery disease (CAD), have suffered a stroke, or have been diagnosed with oral cancer, head and neck cancers, or Sjögren's syndrome that provides qualifying members with enhanced dental benefits.

The benefits mentioned here are part of a special supplemental program for the chronically ill. Not all members qualify for them.

### Dental Services – More Information

Covered dental services are subject to conditions, limitations, exclusions, and maximums. Please see the EOC for details. Network dentists have agreed to provide services at a negotiated rate. If you see a network dentist, you cannot be billed more than that rate. Benefits received out-of-network are not covered.

To find an in-network dental provider, please visit [www.hamedicare.com](http://www.hamedicare.com).

### Vision Services

Medicare-covered diabetic retinopathy:	<b>\$0</b> copay (for the 1 <sup>st</sup> exam, then the specialist copay will apply for additional exams)
Medicare-covered glaucoma screening:	<b>\$0</b> copay
All other Medicare-covered eye exams:	<b>\$40</b> copay
Routine eye exam:	Not covered
Medicare-covered eyewear:	<b>\$40</b> copay
Routine eyewear – contact lenses:	Not covered
Routine eyewear – eyeglasses (lenses and frames):	Not covered
Routine eyewear – upgrades:	Not covered

## Covered Medical and Hospital Benefits

### Vision Services – More Information

To find an in-network vision provider, please visit [www.hamedicare.com](http://www.hamedicare.com).

### Mental Health Services

Inpatient psychiatric hospital coverage:

**\$330** copay per day for days 1–5  
**\$0** copay per day for days 6–90

Partial hospitalization:

**\$55** copay

Outpatient mental health specialty and psychiatry individual sessions:

**\$35** copay

Outpatient mental health specialty and psychiatry group sessions:

**\$35** copay

Prior authorization may be required. See the EOC for details.

### Skilled Nursing Facility (SNF)

**\$0** copay per day for days 1–20  
**\$196** copay per day for days 21–100

Prior authorization may be required. See the EOC for details.

### Rehabilitation/Therapy Services

Cardiac rehabilitation:

**\$40** copay

Intensive cardiac rehabilitation:

**\$60** copay

Pulmonary rehabilitation:

**\$20** copay

Supervised exercise therapy (SET) for peripheral artery disease (PAD):

**\$30** copay

Occupational therapy:

**\$40** copay

Physical therapy:

**\$40** copay

Speech therapy:

**\$40** copay

<b>Covered Medical and Hospital Benefits</b>	
Opioid treatment services:	<b>\$40</b> copay  Prior authorization may be required. See the EOC for details.
<b>Ambulance Services</b>	
Ground ambulance:	<b>\$265</b> copay
Air ambulance:	<b>20%</b> coinsurance
<b>Transportation</b>	Not covered
<b>Medicare Part B Drugs</b>	
Chemotherapy/Radiation drugs:	<b>20%</b> coinsurance
Other Medicare Part B drugs:	<b>20%</b> coinsurance  Prior authorization may be required. See the EOC for details.

**Prescription Drug Benefits**

**Deductible Stage**

**\$250** deductible for Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug), and Tier 5 (Specialty Tier) drugs

You begin in this stage when you fill your first Tier 3, Tier 4, or Tier 5 prescription of the year. You pay the full cost of these drugs until you reach \$250. After that, you only pay your share of the total cost.

There is no deductible for insulin products. During the Deductible Stage, your out-of-pocket cost for each insulin product will be \$35 for a one-month supply.

**Initial Coverage Stage** (after you pay your deductible, if applicable)

During this stage, the plan pays its share of the total cost of your drugs, and you pay your share of the total cost.

You remain in this stage until your total yearly drug costs (total drug costs paid by you and our plan) reach \$4,660. Once you reach this amount, you will enter the Coverage Gap.

**Standard Retail and Mail-Order Pharmacy Cost Shares**

	Standard Retail Pharmacy		Mail-Order Pharmacy	
	30-Day Supply	100-Day Supply	30-Day Supply	100-Day Supply
Tier 1 (Preferred Generic):	<b>\$3</b> copay	<b>\$6</b> copay	<b>\$3</b> copay	<b>\$6</b> copay
Tier 2 (Generic):	<b>\$13</b> copay	<b>\$26</b> copay	<b>\$13</b> copay	<b>\$26</b> copay
Tier 3 (Preferred Brand):	<b>\$40</b> copay Insulin products will have a \$35 copay.	<b>\$80</b> copay	<b>\$40</b> copay Insulin products will have a \$35 copay.	<b>\$80</b> copay

<b>Prescription Drug Benefits</b>				
Tier 4 (Non-Preferred Drug):	<b>31%</b> coinsurance  Insulin products will have a \$35 copay.	<b>31%</b> coinsurance	<b>31%</b> coinsurance  Insulin products will have a \$35 copay.	<b>31%</b> coinsurance
Tier 5 (Specialty Tier):	<b>29%</b> coinsurance	Not covered	<b>29%</b> coinsurance	Not covered
Tier 6 (Select Care Drugs):	<b>\$0</b> copay	<b>\$0</b> copay	<b>\$0</b> copay	<b>\$0</b> copay
<b>Coverage Gap Stage</b>				
<p>Most Medicare drug plans have a Coverage Gap (also called the "donut hole"). In the Coverage Gap, there is a temporary change in what you will pay for your drugs. The Coverage Gap begins after your total yearly drug costs (including what you have paid and what our plan has paid) reach \$4,660. You stay in this stage until your total yearly drug costs reach \$7,400.</p> <p>During the Coverage Gap, you pay the same copays you paid in the Initial Coverage Stage for Tier 6 drugs and 25% coinsurance for generic and brand drugs on all other tiers.</p>				
<b>Catastrophic Coverage Stage</b>				
<p>After your yearly out-of-pocket drug costs (including drugs purchased through retail pharmacies and mail order) reach \$7,400, you pay the greater of:</p> <ul style="list-style-type: none"> <li>• <b>5%</b> coinsurance, or</li> <li>• a <b>\$4.15</b> copay for generics (including brand drugs treated as generic) and a <b>\$10.35</b> copay for all other drugs.</li> </ul>				
<b>Prescription Drug Benefits – More Information</b>				
<p><b>Important Message About What You Pay for Vaccines</b> – Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Customer Service for more information.</p> <p><b>Important Message About What You Pay for Insulin</b> – You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.</p>				

## **Prescription Drug Benefits**

Cost sharing may differ based on pharmacy type (e.g., retail, mail-order, long-term care (LTC)) or by fill amount (i.e., 30- or 100-day supply).

<b>Additional Benefits</b>	
<b>Chiropractic Services</b>	<b>\$15</b> copay
<b>Medical Equipment/Supplies</b>	
Durable medical equipment (DME):	<b>20%</b> coinsurance
Prosthetics:	<b>20%</b> coinsurance
Medical supplies:	<b>20%</b> coinsurance
Diabetic supplies:	<b>\$0</b> copay for preferred supplies at a network pharmacy (Lifescan (i.e., OneTouch) and Ascensia (i.e., Contour) are our preferred manufacturers for diabetic supplies)
Continuous glucose monitors (CGMs):	<b>\$0</b> copay (Dexcom and Freestyle are our preferred manufacturers for CGMs)
Diabetic therapeutic shoes or inserts:	<b>20%</b> coinsurance
	Prior authorization may be required. See the EOC for details.
<b>Outpatient Substance Abuse Services</b>	
Individual sessions:	<b>\$40</b> copay
Group sessions:	<b>\$40</b> copay
<b>Podiatry</b>	
Medicare-covered care:	<b>\$40</b> copay
Routine care:	<b>\$40</b> copay (6 visits per year)
<b>Home Health Services</b>	<b>\$0</b> copay
	Prior authorization may be required. See the EOC for details.

<b>Additional Benefits</b>	
<p><b>Telehealth Services</b></p> <p>PCP, urgently needed, and mental health (individual or group sessions) services:</p> <p>Specialist services:</p>	<p><b>\$0</b> copay</p> <p><b>\$40</b> copay</p>
<p><b>Wellness Programs</b></p> <p>Additional physical exam:</p> <p>SilverSneakers® fitness program:</p> <p>Nurse24:</p>	<p><b>\$0</b> copay (1 per year)</p> <p><b>\$0</b> copay</p> <p>You'll have access to a fitness benefit virtually and at participating SilverSneakers facilities, giving you access to instructor-led group exercise classes, exercise equipment, and options to get active outside of traditional gyms, as well as virtual options.</p> <p><b>\$0</b> copay</p> <p>You'll have access to the Nurse24 nurse advice line 24 hours a day, seven days a week, 365 days a year. Registered nurses can provide information on home treatment of minor illnesses and injuries, how to prepare for doctor visits, how to understand your prescription drugs, and much more.</p>
<p><b>In-Home Support Services</b></p>	<p><b>\$0</b> copay (40 hours per year)</p> <p>Get in-person or virtual help with making medical appointments, transportation, chores, meal prep, companionship, etc.</p>



Health Advantage is the trade name for HMO Partners, Inc. Health Advantage offers HMO plans with a Medicare contract. Enrollment in Health Advantage depends on contract renewal.

If you have any questions, please contact our Customer Service at **1-877-349-9335** (TTY users should call **711**). Hours are 8:00 a.m.–8:00 p.m. Central, seven days a week, from October 1–March 31, except for Thanksgiving and Christmas. From April 1 to September 30, we are open Monday–Friday, 8:00 a.m.–8:00 p.m. Central.

**ATTENTION:** If you speak Spanish, language assistance services, free of charge, are available to you. Call **1-877-349-9335** (TTY: **711**).





