Health Advantage
An Independent Licensee of the Blue Cross and Blue Shield Association

2023
Summary of Benefits

Health Advantage Blue Premier (HMO) H9699-006

The service area for **Health Advantage Blue Premier (HMO)** includes the following Arkansas counties: Cleburne, Conway, Faulkner, Grant, Lonoke, Perry, Pope, Pulaski, Saline, Van Buren, White, 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 Premier (HMO)** includes the following Arkansas counties: Cleburne, Conway, Faulkner, Grant, Lonoke, Perry, Pope, Pulaski, Saline, Van Buren, White, 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**, 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**.

Monthly Premium, Deductible, and Limits	
Monthly Plan Premium You must continue to pay your Medicare Part B premium.	**$0**
Medical Deductible	This plan does not have a deductible.
Pharmacy (Part D) Deductible	**$250** for Tier 3, Tier 4, and Tier 5
Maximum Out-of-Pocket Responsibility The most you pay for copays, coinsurance, and other costs for medical services for the year.	**$6,200**

Covered Medical and Hospital Benefits	
Acute Inpatient Hospital Coverage	**$375** copay per day for days 1–5 **$0** copay per day for days 6–90 **$0** copay per day for days 91 and beyond Prior authorization may be required. See the Evidence of Coverage (EOC) for details.
Outpatient Hospital Coverage Outpatient surgery/non-surgery at an outpatient hospital: Outpatient observation:	 **$285** copay **$285** copay Prior authorization may be required. See the EOC for details.
Ambulatory Surgical Center (ASC) Services	**$0** copay for a diagnostic colonoscopy at an ASC **$275** copay for all other services

Covered Medical and Hospital Benefits	
Doctor Visits	
Primary care provider (PCP):	**$0** copay
Specialist:	**$40** copay
Preventive Care 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) Any additional preventive services approved by Medicare during the contract year will be covered.	**$0** copay

Covered Medical and Hospital Benefits	
Emergency Care 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). Worldwide emergency or urgent care services:	**$95** copay **20%** coinsurance **$15,000** annual coverage limit
Urgently Needed Services Worldwide emergency or urgent care services:	**$30** copay **20%** coinsurance **$15,000** annual coverage limit
Diagnostic Services/Labs/Imaging Diagnostic tests and procedures: Lab services: Diagnostic radiology: Therapeutic (radiation) radiology: X-rays:	 **0%** coinsurance for a spirometry test **0%** coinsurance for a home-based sleep study **20%** coinsurance for all other tests and procedures **$0** copay **$0** copay for a diagnostic mammogram **$0** copay for a DEXA scan **$30** copay for services at an urgent care location **$40** copay for services in a professional office or freestanding radiology clinic **$285** copay for services in an outpatient location **20%** coinsurance **$0** copay Prior authorization may be required. See the EOC for details.

Covered Medical and Hospital Benefits	
Hearing Services	
Medicare-covered hearing exam:	**$40** copay
Routine hearing exam:	**$0** copay (1 per year)
Hearing aid fittings/evaluation:	**$0** copay (includes first year of follow-up provider visits)
Hearing aids:	Up to **$1,000** every 3 years towards the cost of 2 non-implantable hearing aids (limit 1 hearing aid per ear) 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
Hearing Services – More Information TruHearing providers and hearing aids must be used.	
Dental Services – Preventive Dental	
Comprehensive oral evaluation:	**$0** copay (1 per lifetime per dentist)
Oral exams:	**$0** copay (2 per year)
Cleanings:	**$0** copay (2 per year)
X-rays:	**$0** copay (limits vary per service)
Fluoride treatments:	**$0** copay (2 per year)

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

Covered Medical and Hospital Benefits	
Dental Services – Dental Xtra[SM] 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.	**$0** copay
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**.	

Covered Medical and Hospital Benefits	
Vision Services	
Medicare-covered diabetic retinopathy:	**$0** copay (for the 1st exam, then the specialist copay will apply for additional exams)
Medicare-covered glaucoma screening:	**$0** copay
All other Medicare-covered eye exams:	**$40** copay
Routine eye exam:	**$0** copay (1 per year)
Medicare-covered eyewear:	**$0** copay
Routine eyewear – contact lenses:	**$0** copay (1 per year)
Routine eyewear – eyeglasses (lenses and frames):	**$0** copay (1 per year)
Routine eyewear – upgrades:	**$0** copay (included in coverage amount) The plan covers up to **$100** combined for contact lenses, eyeglasses (lenses and frames), and upgrades per year.
Vision Services – More Information To find an in-network vision provider, please visit **www.hamedicare.com**.	
Mental Health Services	
Inpatient psychiatric hospital coverage:	**$360** 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

Covered Medical and Hospital Benefits	
	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:	**$10** copay
Intensive cardiac rehabilitation:	**$10** copay
Pulmonary rehabilitation:	**$20** copay
Supervised exercise therapy (SET) for peripheral artery disease (PAD):	**$10** copay
Occupational therapy:	**$35** copay
Physical therapy:	**$40** copay
Speech therapy:	**$40** copay
Opioid treatment services:	**$40** copay Prior authorization may be required. See the EOC for details.
Ambulance Services	
Ground ambulance:	**$265** copay
Air ambulance:	**20%** coinsurance
Transportation	Not covered

Covered Medical and Hospital Benefits	
Medicare Part B Drugs	
Chemotherapy/Radiation drugs:	**20%** coinsurance
Other Medicare Part B drugs:	**20%** 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. During this stage, your out-of-pocket cost for Select Insulin will be a $0 copay. (If you receive Extra Help, your Extra Help cost sharing will apply.)				
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. During this stage, your out-of-pocket cost for Select Insulin will be a $0 copay. (If you receive Extra Help, your Extra Help cost sharing will apply.)				
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):	**$3** copay	**$6** copay	**$3** copay	**$6** copay
Tier 2 (Generic):	**$10** copay	**$20** copay	**$10** copay	**$20** copay

Prescription Drug Benefits				
Tier 3 (Preferred Brand):	**$47** copay Select Insulin will have a $0 copay.	**$94** copay Select Insulin will have a $0 copay.	**$47** copay Select Insulin will have a $0 copay.	**$94** copay Select Insulin will have a $0 copay.
Tier 4 (Non-Preferred Drug):	**36%** coinsurance Select Insulin will have a $0 copay.	**36%** coinsurance Select Insulin will have a $0 copay.	**36%** coinsurance Select Insulin will have a $0 copay.	**36%** coinsurance Select Insulin will have a $0 copay.
Tier 5 (Specialty Tier):	**29%** coinsurance	Not covered	**29%** coinsurance	Not covered
Tier 6 (Select Care Drugs):	**$0** copay	**$0** copay	**$0** copay	**$0** copay
Coverage Gap Stage				
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. 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. During this stage, your out-of-pocket cost for Select Insulin will be a $0 copay. (If you receive Extra Help, your Extra Help cost sharing will apply.)				
Catastrophic Coverage Stage				
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: • **5%** coinsurance, or • a **$4.15** copay for generics (including brand drugs treated as generic) and a **$10.35** copay for all other drugs.				

Prescription Drug Benefits

Prescription Drug Benefits – More Information

Important Message About What You Pay for Vaccines – 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.

Important Message About What You Pay for Insulin – You won't pay more than $0 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.

Tier 6 includes coverage of certain excluded drugs for erectile dysfunction and weight loss (generics), which are not covered by Medicare. Please see the Formulary and EOC for more details.

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).

Additional Benefits	
Chiropractic Services	**$20** copay
Medical Equipment/Supplies	
Durable medical equipment (DME):	**20%** coinsurance
Prosthetics:	**20%** coinsurance
Medical supplies:	**20%** coinsurance
Diabetic supplies:	**$0** 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):	**$0** copay (Dexcom and Freestyle are our preferred manufacturers for CGMs)
Diabetic therapeutic shoes or inserts:	**20%** coinsurance Prior authorization may be required. See the EOC for details.
Outpatient Substance Abuse Services	
Individual sessions:	**$40** copay
Group sessions:	**$40** copay
Podiatry	
Medicare-covered care:	**$35** copay
Routine care:	**$35** copay (6 visits per year)
Home Health Services	**$0** copay Prior authorization may be required. See the EOC for details.

Additional Benefits	
Telehealth Services	
PCP, urgently needed, and mental health (individual or group sessions) services:	**$0** copay
Specialist services:	**$40** copay
Wellness Programs	
Additional physical exam:	**$0** copay (1 per year)
SilverSneakers® fitness program:	**$0** copay 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.
Nurse24:	**$0** copay 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.
Over-the-Counter (OTC) Items	**$0** copay **$25** per calendar quarter We have three easy ways to order your items from the convenience and comfort of your home.
Meals Benefit	**$0** copay (14 meals per year) Immediately following surgery or discharge from an inpatient hospital stay, you can get two nutritious meals per day for seven days delivered to your home.

Additional Benefits	
In-Home Support Services	**$0** copay (40 hours per year) Get in-person or virtual help with making medical appointments, transportation, chores, meal prep, companionship, etc.

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**).

Notes