Summary of Benefits

2021

Allwell Medicare Boost (HMO) H2134: 002
Bernalillo, Dona Ana, Sandoval and Santa Fe counties, NM

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This booklet provides you with a summary of what we cover and the cost-sharing responsibilities. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call us at the number listed on the last page, and ask for the "Evidence of Coverage" (EOC), or you may access the EOC on our website at allwell.westernskycommunitycare.com.

You are eligible to enroll in Allwell Medicare Boost (HMO) if:

- You are entitled to Medicare Part A and enrolled in Medicare Part B. Members must continue to pay their Medicare Part B premium if not otherwise paid for under Medicaid or by another third party.
- You must be a United States citizen, or are lawfully present in the United States and permanently reside in the service area of the plan (in other words, your permanent residence is within the Allwell Medicare Boost (HMO) service area counties). Our service area includes the following counties in New Mexico: Bernalillo, Dona Ana, Sandoval and Santa Fe.

The Allwell Medicare Boost (HMO) plan gives you access to our network of highly skilled medical providers in your area. You can look forward to choosing a primary care provider (PCP) to work with you and coordinate your care. You can ask for a current provider and pharmacy directory or, for an up-to-date list of network providers, visit allwell.westernskycommunitycare.com. (Please note that, except for emergency care, urgently needed care when you are out of the network, out-of-area dialysis services, and cases in which our plan authorizes use of out-of-network providers, if you obtain medical care from out-of-plan providers, neither Medicare nor Allwell Medicare Boost (HMO) will be responsible for the costs.)

This Allwell Medicare Boost (HMO) plan also includes Part D coverage, which provides you with the ease of having both your medical and prescription drug needs coordinated through a single convenient source.

Summary of Benefits

JANUARY 1, 2021 – DECEMBER 31, 2021

Benefits	Allwell Medicare Boost (HMO) H2134: 002 Premiums / Copays / Coinsurance
Monthly Plan Premium	$0 This plan offers a $30 give back every month in your Social Security check. You must continue to pay your Medicare Part B premium.
Deductibles	• $0 deductible for covered medical services • $150 deductible for Part D prescription drugs (applies to drugs on Tiers 4 and 5).
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$7,550 annually This is the most you will pay in copays and coinsurance for covered medical services for the year.
Inpatient Hospital Coverage*	For each admission, you pay: • $403 copay per day, for days 1 through 5 • $0 copay per day, for days 6 and beyond
Outpatient Hospital Coverage*	• Outpatient hospital: $403 copay per visit • Observation Services: $403 copay per visit
Doctor Visits (Primary Care Providers and Specialists)	• Primary Care: $20 copay per visit • Specialist: $40 copay per visit
Preventive Care (e.g. flu vaccine, diabetic screening)	$0 copay for most Medicare-covered preventive services Other preventive services are available.
Emergency Care	$90 copay per visit You do not have to pay the copay if admitted to the hospital immediately.
Urgently Needed Services	$65 copay per visit Copay is not waived if admitted to hospital.

Services with an * (asterisk) may require prior authorization from your doctor.

Benefits	Allwell Medicare Boost (HMO) H2134: 002 Premiums / Copays / Coinsurance
Diagnostic Services/ Labs/Imaging* (includes diagnostic tests and procedures, labs, diagnostic radiology, and X-rays)	COVID-19 testing and specified testing-related services at any location are $0. • Lab services: $0 to $15 copay • Diagnostic tests and procedures: $0 to $15 copay • Outpatient X-ray services: $20 copay • Diagnostic Radiology Services (such as, MRI, MRA, CT, PET): 20% coinsurance (up to $270)
Hearing Services	• Hearing exam (Medicare-covered): $40 copay • Routine hearing exam: $0 copay (1 every calendar year) • Hearing aid: $0 to $1,580 copay (2 hearing aids total, 1 per ear, per calendar year)
Dental Services	Dental services (Medicare-covered): $40 copay per visit Additional preventive and comprehensive dental benefits are available for an extra premium. See optional supplemental benefits section.
Vision Services	Vision exam (Medicare-covered): $0 to $40 copay per visit Routine eye exam and eyewear are available for an additional premium. See optional supplemental benefits section.
Mental Health Services	Individual and group therapy: $40 copay per visit
Skilled Nursing Facility*	For each admission, you pay: • $0 copay per day, days 1 through 20 • $184 copay per day, days 21 through 100
Physical Therapy*	$40 copay per visit
Ambulance	$300 copay (per one-way trip) for ground or air ambulance services
Ambulatory Surgery Center*	Ambulatory Surgery Center: $350 copay per visit
Transportation	Not covered
Medicare Part B Drugs*	• Chemotherapy drugs: 20% coinsurance • Other Part B drugs: 20% coinsurance

Services with an * (asterisk) may require prior authorization from your doctor.

Part D Prescription Drugs			
Deductible Stage	$150 deductible for Part D prescription drugs (applies to drugs on Tiers 4 and 5). The Deductible Stage is the first payment stage for your drug coverage. This stage begins when you fill your first prescription in the year. When you are in this payment stage, you must pay the full cost of your Part D drugs until you reach the plan's deductible amount. Once you have paid the plan's deductible amount for your Part D drugs, you leave the Deductible Stage and move on to the next payment stage (Initial Coverage Stage).		
Initial Coverage Stage (after you pay your Part D deductible, if applicable)	After you have met your deductible (if applicable), the plan pays its share of the cost of your drugs and you pay your share of the cost. You generally stay in this stage until the amount of your year-to-date "total drug costs" reaches $4,130. "Total drug costs" is the total of all payments made for your covered Part D drugs. It includes what the plan pays and what you pay. Once your "total drug costs" reach $4,130 you move to the next payment stage (Coverage Gap Stage).		
	Preferred Retail Rx 30-day supply	**Standard Retail Rx 30-day supply**	**Mail Order Rx 90-day supply**
Tier 1: Preferred Generic Drugs	$0 copay	$5 copay	$0 copay
Tier 2: Generic Drugs	$9 copay	$14 copay	$27 copay
Tier 3: Preferred Brand Drugs	$37 copay	$47 copay	$111 copay
Tier 4: Non-Preferred Drugs	$90 copay	$100 copay	$270 copay
Tier 5: Specialty	30% coinsurance	30% coinsurance	Not available
Tier 6: Select Care Drugs	$0 copay	$0 copay	$0 copay
Coverage Gap Stage	During this payment stage, you receive a 70% manufacturer's discount on covered brand name drugs and the plan will cover another 5%, so you will pay 25% of the negotiated price and a portion of the dispensing fee on brand-name drugs. In addition the plan will pay 75% and you pay 25% for generic drugs. (The amount paid by the plan does not count towards your out-of-pocket costs). You generally stay in this stage until the amount of your year-to-date "out-of-pocket costs" reaches $6,550. "Out of pocket costs" includes what you pay when you fill or refill a prescription for a covered Part D drug and payments made for your drugs by any of the following programs or organizations: "Extra Help" from Medicare; Medicare's Coverage Gap Discount Program; Indian Health Service; AIDS drug assistance programs; most charities; and most State Pharmaceutical Assistance Programs (SPAPs). Once your "out-of-pocket costs" reach $6,550, you move to the next payment stage (Catastrophic Coverage Stage).		

Part D Prescription Drugs	
Catastrophic Coverage Stage	During this payment stage, the plan pays most of the cost for your covered drugs. For each prescription, you pay whichever of these is greater: a payment equal to 5% coinsurance of the drug, or a copayment ($3.70 for a generic drug or a drug that is treated like a generic, $9.20 for all other drugs).
Important Info:	Cost-sharing may change depending on the level of help you receive, the pharmacy you choose (such as Standard Retail, Preferred Retail, Mail Order, Long-Term Care, or Home Infusion) and when you enter any of the four stages of the Part D benefit. For more information about the costs for Long-Term Supply, Home Infusion, or additional pharmacy-specific cost-sharing and the stages of the benefit, please call us or access our EOC online.

Additional Covered Benefits	
Benefits	**Allwell Medicare Boost (HMO) H2134: 002 Premiums / Copays / Coinsurance**
Additional Telehealth Services	The cost share of Medicare-covered additional telehealth services with primary care physicians, specialists, individual/group sessions with mental health and psychiatric providers and other health care practitioners within these practices will be equal to the cost share of these individual services' office visits.
Opioid Treatment Program Services	• Individual setting: $40 copay per visit • Group setting: $40 copay per visit
Over-the-Counter (OTC) Items	$0 copay ($20 allowance per quarter) for items available via mail. There is a limit of 9 per item, per order, with the exception of certain products, which have additional limits. You are allowed to order once per quarter and any unused money does not carry over to the next quarter. Please visit the plan's website to see the list of covered over-the-counter items.
Chiropractic Care	Chiropractic services (Medicare-covered): $20 copay per visit
Acupuncture	• Acupuncture services for chronic low back pain (Medicare-covered): $20 copay per visit in a chiropractic setting • Acupuncture services for chronic low back pain (Medicare-covered): $20 copay per visit in a Primary Care Provider's office • Acupuncture services for chronic low back pain (Medicare-covered): $40 copay per visit in a Specialist's office
Medical Equipment/ Supplies*	• Durable Medical Equipment (e.g., wheelchairs, oxygen): 20% coinsurance • Prosthetics (e.g., braces, artificial limbs): 20% coinsurance • Diabetic supplies: $0 copay
Foot Care (Podiatry Services)	Foot exams and treatment (Medicare-covered): $40 copay
Virtual Visit	Teladoc™ plan offers 24 hours a day/7days a week/365 days a year virtual visit access to board certified doctors to help address a wide variety of health concerns/questions.

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Additional Covered Benefits	
Benefits	**Allwell Medicare Boost (HMO) H2134: 002 Premiums / Copays / Coinsurance**
Wellness Programs	• Fitness program: $0 copay • 24-hour Nurse Connect: $0 copay • Supplemental smoking and tobacco use cessation (counseling to stop smoking or tobacco use): $0 copay For a detailed list of wellness program benefits offered, please refer to the EOC.
Worldwide Emergency Care	$50,000 plan coverage limit for urgent/emergent services outside the U.S. and its territories every calendar year.
Routine Annual Exam	$0 Copay

Optional Supplemental Benefits
(you must pay an extra premium each month for these benefits)

Allwell Wellbeing	
Monthly Premium This additional monthly premium is in addition to your monthly plan premium and the monthly Medicare Part B premium.	$18.10 per month

Dental Care Benefits

Preventive/Comprehensive Dental Care
You must select a dentist from our list of network providers to use the benefits of the Dental HMO plan. Additional service limits apply.

	In-network
Annual benefit maximum	$1,000, applies to preventive and comprehensive services
Preventive services:	
Oral exams – 2 per year	You pay a $0 copay
Cleanings (prophylaxis) - 2 per year	You pay a $0 copay
Fluoride treatment – 1 per year	You pay a $0 copay
Dental x-rays – 1 set of preventive x-rays	You pay a $0 copay
Comprehensive services:	
Non-routine services	You pay a $0 copay
Diagnostic services	You pay a $0 copay
Restorative services	You pay 20%
Endodontic services	You pay 50%
Periodontics	You pay 50%
Extractions	You pay 50%
Prosthodontics (dentures, oral/maxillofacial surgery and other services)	You pay 50%

Vision Care Benefits

Vision hardware (eyeglasses or contact lenses) covered every calendar year.

	In-network	
Eye exam (available once every year)	You pay a $0 copay	You pay a $0 copay
Eyewear - Eyeglasses (Frames and Lenses) or contact lenses	You pay nothing up to the $250 annual benefit maximum.	
Annual benefit maximum	$250 combined benefit maximum for eyeglasses (frames and lenses) or contacts. You are responsible for amounts over the annual benefit maximum.	

For more information, please contact:

Allwell Medicare Boost (HMO)
5300 Homestead Road NE
Albuquerque, NM 87110

allwell.westernskycommunitycare.com

Current members should call: 1-833-543-0246 (TTY: 711)

Prospective members should call: 1-866-445-1088 (TTY: 711)

From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

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 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.

This information is not a complete description of benefits. Call 1-833-543-0246 (TTY: 711) for more information.

“Coinsurance” is the percentage you pay of the total cost of certain medical and/or prescription drug services.

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

This document is available in other formats such as Braille, large print or audio.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-833-543-0246 (TTY: 711)

Allwell is contracted with Medicare for HMO plans. Enrollment in Allwell depends on contract renewal.

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