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Summary of **BENEFITS**

MASS ADVANTAGE PLUS (HMO)



MASS **ADVANTAGE**

2022 Summary of Benefits

Mass Advantage Plus (HMO)
H7670 002

January 1, 2022 – December 31, 2022

INTRODUCTION TO SUMMARY OF BENEFITS

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 <https://www.MassAdvantage.com>.

You are eligible to enroll in Mass Advantage 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 Mass Advantage service area counties). Our service area includes the following counties in Massachusetts: Worcester

The Mass Advantage Medicare 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 <https://www.MassAdvantage.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 Mass Advantage Medicare will be responsible for the costs.)

This Mass Advantage Medicare 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.

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MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

Monthly Plan Premium	<p>\$102</p> <p>You must continue to pay your Medicare Part B premium.</p>
Deductible	<p>Medical Deductible: Not Applicable</p> <p>Prescription Drug Deductible: \$225 deductible for Tiers 3, 4, and 5</p>
Maximum Out-of-Pocket Responsibility	<p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none"> \$3,450 for services you receive from in-network providers <p>This is the most you will pay in copays and coinsurance for covered medical services for the year. Please note that you will still need to pay your monthly premiums and cost-sharing for Part D prescription drugs.</p> <p>Not all services apply to the Maximum Out-of-Pocket. Please refer to the Evidence of Coverage for more information.</p>

COVERED MEDICAL AND HOSPITAL BENEFITS

Inpatient Hospital Coverage*	<p>Days 1 – 5: \$200 copay per day</p> <p>Days 6 – beyond: \$0 copay per day</p>
Outpatient Hospital Coverage*	<p>Outpatient Hospital: \$150 copay per stay</p> <p>Observation Services: \$150 copay per stay</p>
Doctor Visits	<p>Primary Care: \$10 copay per visit</p> <p>Specialist: \$20 copay per visit</p>
Preventive Care	<p>You pay nothing for all preventive services covered under Original Medicare at zero cost sharing.</p>
Emergency Care	<p>\$120 copay per visit</p> <p>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.</p> <p>Worldwide Emergency Coverage: \$120 copay per visit</p> <p>\$25,000 plan limit per occurrence for the combined unforeseen event outside of the United States.</p>

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Urgently Needed Services	\$15 copay per visit
Diagnostic Services/ Labs/Imaging*	<p>Lab services: \$0 copay</p> <p>Diagnostic tests and procedures: \$5 copay</p> <p>Outpatient X-ray services: \$15 copay</p> <p>Diagnostic Radiology services (such as, MRI, MRA, CT, PET): \$250 copay</p>
Hearing Services	<p>Hearing exam (Medicare-covered): \$20 copay</p> <p>Routine hearing exam: \$0 copay (1 every calendar year)</p> <p>Standard Hearing aid: \$595 copay per hearing aid</p> <p>Premium Hearing aid: \$895 copay per hearing aid</p> <p>Limit of 2 hearing aids per calendar year, 1 per ear. You must see an Amplifon Hearing Health Care provider to use this benefit. Call Member Services for additional information about the network or visit https://www.MassAdvantage.com</p>
Dental Services	<p>Dental services (Medicare-covered): \$20 copay per visit</p> <p>Preventive Dental Services from a DentaQuest provider: \$0 copay</p> <ul style="list-style-type: none"> • Oral exam (up to 2 visits every year) • Cleaning (up to 2 visits every year) • Fluoride treatment (up to 2 visits per year) • Dental X-rays (1 per year) <p>Comprehensive dental services: 20% coinsurance for diagnostic and restorative services, endodontics, periodontics, extractions, prosthodontics, and other oral/maxillofacial surgery.</p> <p>There is a maximum allowance of \$1,000 every calendar year; it applies to all comprehensive dental benefits.</p>
Vision Services	<p>Vision exam (Medicare-covered): \$20 copay per visit</p> <p>Routine eye exam: \$0 copay per visit (up to 1 every calendar year)</p> <p>Routine eyewear: up to \$200 allowance every calendar year</p> <p>You must see a EyeQuest (a product of DentaQuest) vision provider to use this benefit.</p>
Mental Health Services*	Outpatient group therapy: \$20 copay per visit

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	<p>Outpatient individual therapy: \$20 copay per visit</p> <p>Inpatient Mental Health Care:</p> <p>Days 1 – 5: \$200 per day</p> <p>Days 6 – 90: \$0 per day</p>
Skilled Nursing Facility (SNF)*	<p>Days 1-20: \$15 copay per day</p> <p>Day 21-44: \$75 copay per day</p> <p>Day 45-100: \$0 copay per day</p>
Outpatient Rehabilitation*	<p>Occupational therapy: \$35 copay per visit</p> <p>Speech and language therapy: \$20 copay per visit</p> <p>Physical therapy: \$10 copay per visit</p>
Ambulance	<p>Ground Ambulance: \$200 copay (per one-way trip)</p> <p>Air Ambulance: \$200 copay</p> <p>If you are admitted to the hospital, you do not have to pay your share of the cost for ambulance services.</p>
Transportation	Not covered
Medicare Part B Drugs*	<p>Chemotherapy drugs: 20% coinsurance</p> <p>Other Part B drugs: 20% coinsurance</p>

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

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PART D PRESCRIPTION DRUGS

Deductible Stage	Prescription Drug Deductible: \$225 deductible for Tiers 3, 4 and 5																																				
Initial Coverage Stage	<p>You pay the following until your total yearly drug costs reach \$4,430. Total yearly drug costs are the drug costs paid by both you and our Part D plan.</p> <p>Standard Retail Cost-Sharing</p> <table border="1" data-bbox="446 615 1507 989"> <thead> <tr> <th>Tier</th> <th>One-month supply</th> <th>Three-month supply</th> </tr> </thead> <tbody> <tr> <td>Tier 1 (Preferred Generic)</td> <td>\$0 copay</td> <td>\$0 copay</td> </tr> <tr> <td>Tier 2 (Generic)</td> <td>\$4 copay</td> <td>\$12 copay</td> </tr> <tr> <td>Tier 3 (Preferred Brand)</td> <td>\$47 copay</td> <td>\$141 copay</td> </tr> <tr> <td>Tier 4 (Non-Preferred Drug)</td> <td>\$100 copay</td> <td>\$300 copay</td> </tr> <tr> <td>Tier 5 (Specialty Tier)</td> <td>29% coinsurance</td> <td>29% coinsurance</td> </tr> </tbody> </table> <p>Standard Mail Order</p> <table border="1" data-bbox="446 1104 1507 1478"> <thead> <tr> <th>Tier</th> <th>One-month supply</th> <th>Three-month supply</th> </tr> </thead> <tbody> <tr> <td>Tier 1 (Preferred Generic)</td> <td>\$0 copay</td> <td>\$0 copay</td> </tr> <tr> <td>Tier 2 (Generic)</td> <td>\$4 copay</td> <td>\$12 copay</td> </tr> <tr> <td>Tier 3 (Preferred Brand)</td> <td>\$47 copay</td> <td>\$141 copay</td> </tr> <tr> <td>Tier 4 (Non-Preferred Drug)</td> <td>\$100 copay</td> <td>\$300 copay</td> </tr> <tr> <td>Tier 5 (Specialty Tier)</td> <td>29% coinsurance</td> <td>29% coinsurance</td> </tr> </tbody> </table> <p>Your cost-sharing may be different if you use a Long-Term Care pharmacy, or an out-of-network pharmacy.</p>	Tier	One-month supply	Three-month supply	Tier 1 (Preferred Generic)	\$0 copay	\$0 copay	Tier 2 (Generic)	\$4 copay	\$12 copay	Tier 3 (Preferred Brand)	\$47 copay	\$141 copay	Tier 4 (Non-Preferred Drug)	\$100 copay	\$300 copay	Tier 5 (Specialty Tier)	29% coinsurance	29% coinsurance	Tier	One-month supply	Three-month supply	Tier 1 (Preferred Generic)	\$0 copay	\$0 copay	Tier 2 (Generic)	\$4 copay	\$12 copay	Tier 3 (Preferred Brand)	\$47 copay	\$141 copay	Tier 4 (Non-Preferred Drug)	\$100 copay	\$300 copay	Tier 5 (Specialty Tier)	29% coinsurance	29% coinsurance
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Coverage Gap Stage	<p>The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,430.</p> <p>After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered</p>																																				

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	generic drugs until your costs total \$7,050, which is the end of the coverage gap.
Catastrophic Stage	<p>After your yearly out-of-pocket drug costs reach \$7,050, you pay the greater of:</p> <ul style="list-style-type: none"> • \$3.95 copay for generic (including brand drugs treated as generic) and a \$9.85 copay for all other drugs, or • 5% of the cost

ADDITIONAL BENEFITS

Over-the-Counter (OTC) Items	<p>You have \$100 every quarter to spend on plan approved OTC items. OTC items must be ordered through Convey Health Solutions.</p> <p>You are allowed to order once per quarter. Any unused money will carry over to the next quarter but will not carry over to the next benefit year.</p> <p>Please visit https://www.MassAdvantage.com to see the list of covered over-the counter items.</p>
Chiropractic Care	\$20 copay per visit
Ambulatory Surgical Center*	\$150 copay per visit
Telehealth Services	<p>Primary Care Physician Services: \$0 copay per visit</p> <p>Physician Specialist Services: \$0 copay per visit</p>
Medical Equipment/Supplies*	<p>Durable Medical Equipment (e.g., wheelchairs, oxygen): 20% coinsurance</p> <p>Prosthetics (e.g., braces, artificial limbs): 20% coinsurance</p> <p>Diabetic supplies: 20% coinsurance from a preferred manufacturer</p> <p>-Preferred Manufacturers: Abbott and Lifescan</p>
Wellness Programs	<p>Fitness program: \$0 copay</p> <p>The Silver&Fit® Healthy Aging and Exercise Program</p> <p>You pay nothing for this benefit.</p> <p>8,000+ on demand videos through the website and mobile app digital library, including the Silver&Fit Signature Series Classes®.</p> <p>Fitness Center Membership: You can visit participating fitness centers or YMCAs near you that takes part in the program. Many participating fitness centers may also offer low-impact classes focused on improving</p>

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and increasing muscular strength and endurance, mobility, flexibility, range of motion, balance, agility, and coordination.

One Home Fitness Kits per benefit year

Healthy Aging Coaching sessions by telephone with a trained coach

The Silver&Fit Connected™ tool for tracking your activity

Online Healthy Aging classes.

Online quarterly newsletter.

***Non-standard services that call for an added fee are not part of the Silver&Fit program and will not be reimbursed.

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

NOTES

NOTES

For more information, please contact:

Mass Advantage
PO Box 830059
Birmingham AL 35283
<https://www.MassAdvantage.com>

This document is available in other formats such as large print.

Mass Advantage is a Medicare Advantage organization with a Medicare contract offering HMO and PPO plans. Enrollment in Mass Advantage depends on contract renewal.

Current members should call: 1-844-918-0114 (TTY: 711)

Prospective members should call: 1-844-614-0745 (TTY: 711)

Calls to this number are free. From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m EST. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m EST. 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.

You must continue to pay your Medicare Part B premium.

This information is not a complete description of benefits. Call 1-844-918-0114 (TTY: 711) for more information.

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