2022

Summary of BENEFITS

MASS ADVANTAGE PREMIERE (PPO)

MASS ADVANTAGE

H9904_BP22027_M Accepted

2022 Summary of Benefits

Mass Advantage Premiere (PPO)
H9904 001

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

With Mass Advantage Premiere (PPO) plan, you'll enjoy the freedom and flexibility to access your health care where you want it and when you want it. You may seek care from any Medicare provider in the country who agrees to see you as a Medicare member, but you'll generally pay less when you use contracting providers in our network. Either way, doctor visits, hospital stays and many other services have a simple copayment, which helps make health care costs more predictable. You can see our plan's provider and pharmacy directory at our website at https://www.MassAdvantage.com.

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.

Mass Advantage Premiere (PPO)	
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	$0 You must continue to pay your Medicare Part B premium.
Deductible	Medical Deductible: Not Applicable Prescription Drug Deductible: $320 deductible for Tiers 3, 4, and 5
Maximum Out-of-Pocket **Responsibility**	Your yearly limit(s) in this plan: • $7,550 for services you receive from in-network providers • $11,300 combined in and out-of-network annually 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. Not all services apply to the Maximum Out-of-Pocket. Please refer to the Evidence of Coverage for more information.
COVERED MEDICAL AND HOSPITAL BENEFITS	
Inpatient Hospital Coverage*	**In-network:** Days 1 – 6: $335 copay per day Days 7 – beyond: $0 copay per day **Out-of-network:** 40% coinsurance per stay
Outpatient Hospital Coverage*	**In-network:** Outpatient Hospital: $300 copay per stay Observation Services: $300 copay per stay **Out-of-network:** 40% coinsurance per stay
Doctor Visits	**In-network:** Primary Care: $0 copay per visit Specialist: $45 copay per visit

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	Out-of-network: Primary Care: $20 copay per visit Specialist: $65 copay per visit
Preventive Care	**In-network and Out-of-network:** You pay nothing for all preventive services covered under Original Medicare at zero cost sharing.
Emergency Care	**In-network and 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. Worldwide Emergency Coverage: $90 copay per visit $25,000 plan limit per occurrence for the combined unforeseen event outside of the United States.
Urgently Needed Services	**In-network and Out-of-network:** $40 copay per visit
Diagnostic Services/ Labs/Imaging*	**In-network:** Lab services: $5 copay Diagnostic tests and procedures: $20 copay Outpatient X-ray services: $15 copay Diagnostic Radiology services (such as, MRI, MRA, CT, PET): $200 copay **Out-of-network:** Lab services: 40% coinsurance Diagnostic tests and procedures: 40% coinsurance Outpatient X-ray services: 40% coinsurance Diagnostic Radiology services (such as, MRI, MRA, CT, PET): 40% coinsurance
Hearing Services	**In-network:** Hearing exam (Medicare-covered): $45 copay Routine hearing exam: $0 copay (1 every calendar year) Standard Hearing aid: $595 copay per hearing aid

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	Premium Hearing aid: $895 copay per hearing aid 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 **Out-of-network:** Hearing exam (Medicare-covered): $65 copay Routine hearing exam: $65 copay (1 every calendar year)
Dental Services	**In-network:** Dental services (Medicare-covered): $45 copay per visit Preventive Dental Services from a DentaQuest provider: $0 copay • 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) Comprehensive dental services: 20% coinsurance for diagnostic and restorative services, endodontics, periodontics, extractions, prosthodontics, and other oral/maxillofacial surgery. **Out-of-network:** Dental services (Medicare-covered): $65 copay per visit Preventive Dental Services: $0 copay • 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) Comprehensive dental services: 20% coinsurance for diagnostic and restorative services, endodontics, periodontics, extractions, prosthodontics, and other oral/maxillofacial surgery. **There is an in-network and out-of-network combined plan benefit maximum of $2,000 each calendar year for preventive and comprehensive dental services.**
Vision Services	**In-network:** Vision exam (Medicare-covered): $45 copay per visit

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	Routine eye exam: $0 copay per visit (up to 1 every calendar year) Routine eyewear: up to $200 allowance combined in and out-of-network allowance every calendar year You must see a EyeQuest (a product of DentaQuest) vision provider to use this benefit. **Out-of-network:** Vision exam (Medicare-covered): $65 copay per visit Routine eye exam: $65 copay per visit (up to 1 every calendar year) Routine eyewear: up to $200 allowance combined in and out-of-network allowance every calendar year
Mental Health Services*	**In-network:** Outpatient group therapy: $40 copay per visit Outpatient individual therapy: $40 copay per visit Inpatient Mental Health Care: Days 1 – 6: $310 per day Days 7 – 90: $0 per day **Out-of-network:** Outpatient group therapy: $65 copay per visit Outpatient individual therapy: $65 copay per visit Inpatient Mental Health Care: 40% coinsurance per visit
Skilled Nursing Facility (SNF)*	**In-network:** Days 1-20: $0 copay per day Day 21-44: $160 copay per day Day 45-100: $0 copay per day **Out-of-network:** 20% coinsurance per day
Outpatient Rehabilitation*	**In-network:** Occupational therapy: $40 copay per visit Speech and language therapy: $40 copay per visit Physical therapy: $10 copay per visit

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	Out-of-network: Occupational therapy: $65 copay per visit Speech and language therapy: $65 copay per visit Physical therapy: $65 copay per visit
Ambulance	**In-network and Out-of-network:** Ground Ambulance: $250 copay (per one-way trip) Air Ambulance: $250 copay If you are admitted to the hospital, you do not have to pay your share of the cost for ambulance services.
Transportation	Not covered
Medicare Part B Drugs*	**In-network and Out-of-network:** Chemotherapy drugs: 20% coinsurance Other Part B drugs: 20% coinsurance

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

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PART D PRESCRIPTION DRUGS

Deductible Stage

Prescription Drug Deductible: $320 deductible for Tiers 3, 4 and 5

Initial Coverage Stage

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.

Standard Retail Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	$2 copay	$6 copay
Tier 2 (Generic)	$6 copay	$18 copay
Tier 3 (Preferred Brand)	$42 copay	$126 copay
Tier 4 (Non-Preferred Drug)	$95 copay	$285 copay
Tier 5 (Specialty Tier)	27% coinsurance	27% coinsurance

Standard Mail Order

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	$2 copay	$6 copay
Tier 2 (Generic)	$6 copay	$18 copay
Tier 3 (Preferred Brand)	$42 copay	$126 copay
Tier 4 (Non-Preferred Drug)	$95 copay	$285 copay
Tier 5 (Specialty Tier)	27% coinsurance	27% coinsurance

Your cost-sharing may be different if you use a Long-Term Care pharmacy, or an out-of-network pharmacy.

Coverage Gap Stage

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,430.

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	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 generic drugs until your costs total $7,050, which is the end of the coverage gap.
Catastrophic Stage	After your yearly out-of-pocket drug costs reach $7,050, you pay the greater of: • $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	**In-network and Out-of-network:** You have $50 every quarter to spend on plan approved OTC items. OTC items must be ordered through Convey Health Solutions. 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. Please visit https://www.MassAdvantage.com to see the list of covered over-the counter items.
Chiropractic Care	**In-network:** $20 copay per visit **Out-of-network:** $65 copay per visit
Ambulatory Surgical Center*	**In-network:** $275 copay per visit **Out-of-network:** 40% coinsurance per visit
Telehealth Services	**In-network:** Primary Care Physician Services: $0 copay per visit Physician Specialist Services: $0 copay per visit **Out-of-network:** Not covered

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Medical Equipment/ Supplies*	**In-network:** Durable Medical Equipment (e.g., wheelchairs, oxygen): 20% coinsurance Prosthetics (e.g., braces, artificial limbs): 20% coinsurance Diabetic supplies: 20% coinsurance from a preferred manufacturer -Preferred Manufacturers: Abbott and Lifescan **Out-of-network:** Durable Medical Equipment (e.g., wheelchairs, oxygen): 40% coinsurance Prosthetics (e.g., braces, artificial limbs): 40% coinsurance Diabetic supplies: 40% coinsurance
Wellness Programs	**In-network and Out-of-network:** Fitness program: $0 copay **The Silver&Fit® Healthy Aging and Exercise Program** You pay nothing for this benefit. 8,000+ on demand videos through the website and mobile app digital library, including the Silver&Fit Signature Series Classes®. 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 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.

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: 1-844-915-0234 (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 1-844-915-0234 (TTY: 711) for more information.

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