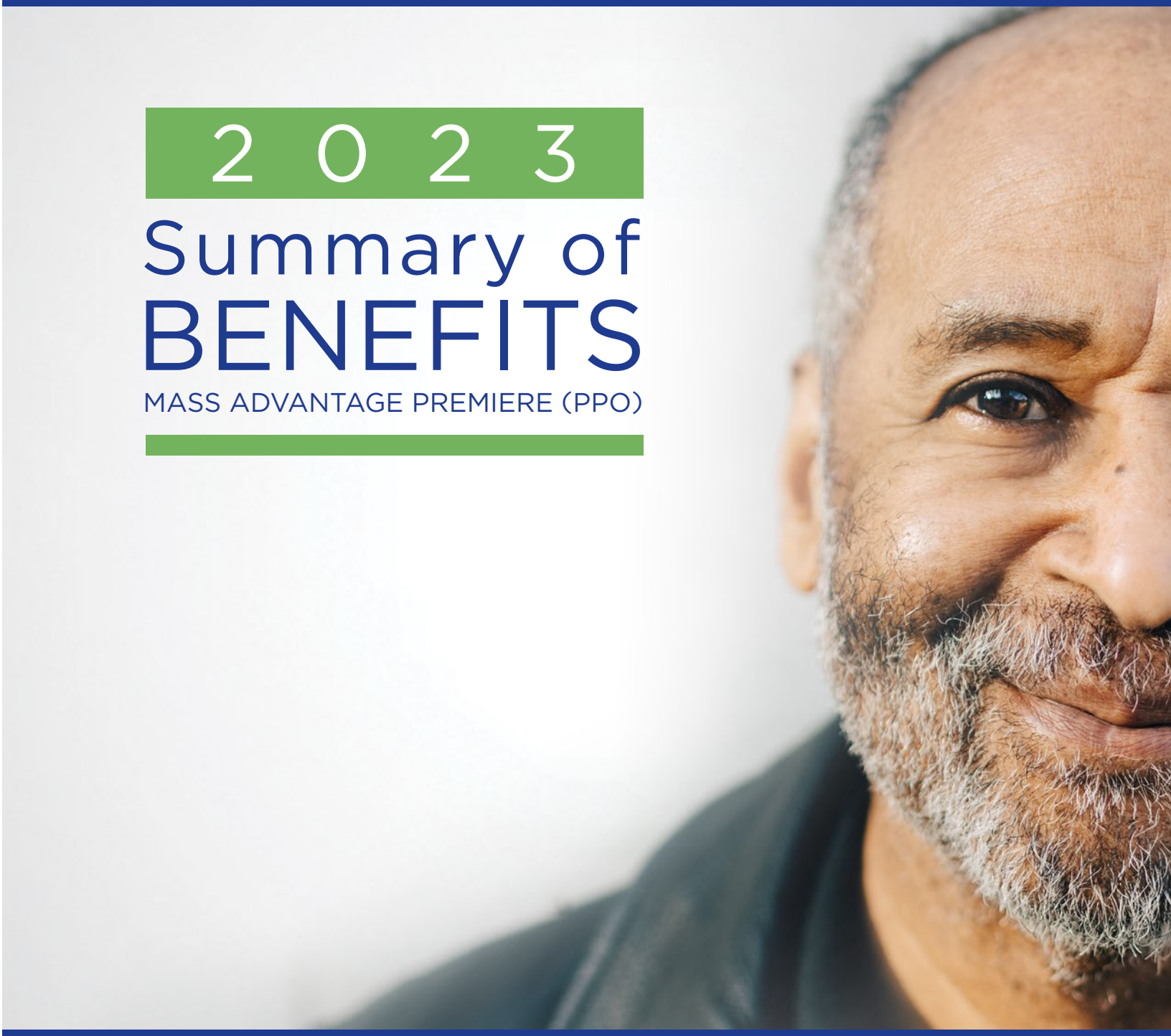
2023

Summary of BENEFITS

MASS ADVANTAGE PREMIERE (PPO)



MASS ADVANTAGE

H9904_23632_M Accepted

MASS ADVANTAGE

2023 Summary of Benefits

Mass Advantage Premiere (PPO)
H9904 001

January 1, 2023 – December 31, 2023

H9904_23632_M Accepted

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 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 www.MassAdvantage.com.

This Mass Advantage Premiere (PPO) 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. You can access information about how the coverage works, including covered drugs as well as coverage limitations on our website at www.MassAdvantage.com.

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	This plan does not have a deductible.
Pharmacy (Part D) Deductible	$250 deductible for Tiers 3, 4 and 5
Maximum Out-of-Pocket Responsibility	**In-network:** $6,550 **In-network and Out-of-network combined:** $11,300 This is the most you will pay for copays, coinsurance, and other costs for Medicare-covered medical services, supplies, and Part B-covered medication for the plan year. What you pay out-of-pocket for Part D prescription drugs and certain supplemental benefits (dental, hearing aids) do not apply to this amount. Please refer to the Evidence of Coverage for more information.
COVERED MEDICAL AND HOSPITAL BENEFITS	
Inpatient Hospital Coverage*	**In-network:** Days 1-5: $350 copay per day Days 6-beyond: $0 copay per day **Out-of-network:** 35% 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
Ambulatory Surgical Center*	**In-network:** $300 copay per visit **Out-of-network:** 40% coinsurance per visit

Mass Advantage Premiere (PPO)	
Doctor Visits	**In-network:** Primary Care: $0 copay per visit Specialist: $45 copay per visit **Out-of-network:** Primary Care: $0 copay per visit Specialist: $65 copay per visit
Preventive Care	**In-network and Out-of-network:** There is no coinsurance, copayment, or deductible for Medicare-covered preventive services.
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 emergency care copay. Worldwide Emergency Coverage: $90 copay per visit
Urgently Needed Services	**In-network and Out-of-network:** $40 copay per visit
Diagnostic Services/ Labs/Imaging*	**In-network:** Lab services: $0 copay Diagnostic tests and procedures: $20 copay Outpatient X-ray services: $0 copay Diagnostic Radiology services (such as, MRI, MRA, CT, PET): $150 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

Mass Advantage Premiere (PPO)	
Hearing Services	**In-network:** Routine and Hearing Aids services outlined below must be received from a NationsBenefits Hearing Health Care provider. • Routine hearing exam: $0 copay (1 every calendar year) • Entry Hearing Aids: $500 per hearing aid • Basic Hearing Aids: $675 per hearing aid • Prime Hearing Aids: $975 per hearing aid • Preferred Hearing Aids: $1,275 per hearing aid • Advanced Hearing Aids: $1,575 per hearing aid • Premium Hearing Aids: $1,975 per hearing aid Limit of 2 hearing aids per calendar year, (one per ear). Medicare-covered Hearing care: $45 copay for each Medicare-covered hearing care service if required for another medical procedure and deemed medically necessary by a physician. **Out-of-network:** Routine and Hearing Aids services outlined below must be received from a NationsBenefits Hearing Health Care provider. • Routine hearing exam: $65 copay (1 every calendar year) • Hearing Aids: The same as in-network copays for the different types of hearing aids (as indicated above). Medicare-covered Hearing care: $65 copay for each Medicare-covered hearing care service if required for another medical procedure and deemed medically necessary by a physician.
Dental Services	**In-network:** Preventive and Comprehensive dental services outlined below must be received from a DentaQuest provider. Preventive Dental Services include the following: $0 copay • Oral exam (2 per calendar year) • Cleaning (2 per calendar year) • Fluoride treatment (2 per calendar year)

- Dental X-rays (1 set per calendar year)
  - One vertical bitewing imaging, and one panoramic imaging is covered once every 36 months
  - Intraoral occlusal imaging is covered twice every 24 months
  - Intraoral-complete series is covered once every 36 months
- Comprehensive oral exam is covered once every 36 months

Comprehensive dental services include the following: 20% coinsurance for each service outlined below

- Diagnostic services (1 per calendar year)
- Restorative services (1 every two years)
- Endodontics*
- Periodontics (1 visit every three years)
- Extractions*
- Prosthodontics, including dentures, other oral/maxillofacial surgery, and other services*

Medicare-covered Dental Care: $45 copay for each Medicare-covered dental care service if required for another medical procedure and deemed medically necessary by a physician.

Out-of-network:

Preventive Dental Services include the following: 20% coinsurance for each service outlined below

- Oral exam (2 per calendar year)
- Cleaning (2 per calendar year)
- Fluoride treatment (2 per calendar year)
- Dental X-rays (1 set per calendar year)
  - One vertical bitewing imaging, and one panoramic imaging is covered once every 36 months
  - Intraoral occlusal imaging is covered twice every 24 months
  - Intraoral-complete series is covered once every 36 months
- Comprehensive oral exam is covered once every 36 months

Mass Advantage Premiere (PPO)	
	Comprehensive dental services include the following: 20% coinsurance for each service outlined below • Diagnostic services (1 per calendar year) • Restorative services (1 every two years) • Endodontics* • Periodontics (1 visit every three years) • Extractions* • Prosthodontics, including dentures, other oral/maxillofacial surgery, and other services* *You should review your Evidence of Coverage (EOC) for additional details and coverage limits. Medicare-covered Dental Care: $65 copay for each Medicare-covered dental care service if required for another medical procedure and deemed medically necessary by a physician. There is an in-network and out-of-network combined plan benefit maximum of $2,000 each calendar year for comprehensive dental services.
Vision Services	**In-network:** Routine and vision services outlined below must be received by an EyeQuest provider. • Routine eye exam: $0 copay per visit (up to 1 every calendar year) Medicare-covered Vision Care: $45 copay for each Medicare-covered eye exam related to the diagnosis and treatment of diseases and conditions of the eye. **Out-of-network:** Routine eye exam: $65 copay per visit (up to 1 every calendar year) Medicare-covered Vision Care: $65 copay for each Medicare-covered eye exam related to the diagnosis and treatment of diseases and conditions of the eye. $200 combined in and out-of-network allowance every calendar year to use towards the purchase of contact lenses, eyeglass lenses, and eyeglass frames.

Mass Advantage Premiere (PPO)	
Mental Health Services*	**In-network:** Outpatient group therapy: $30 copay per visit Outpatient individual therapy: $30 copay per visit Inpatient Mental Health Care: • Days 1-5: $350 per day • Days 6-90: $0 per day **Out-of-network:** Outpatient group therapy: 40% copay per visit Outpatient individual therapy: 40% 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 21-51: $196 copay per day Day 52-100: $0 copay per day **Out-of-network:** 20% coinsurance per day
Outpatient Rehabilitation*	**In-network:** Occupational therapy: $30 copay per visit Speech and language therapy: $30 copay per visit Physical therapy: $30 copay per visit **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: $275 copay (per one-way trip) Air Ambulance: $275 copay (per one-way trip) If you are admitted to the hospital, you do not have to pay your ambulance services copay.

Mass Advantage Premiere (PPO)	
Transportation*	**In-network and Out-of-network:** $0 copay for 6 one-way rides per year for plan approved health-related locations. Members can use taxi, ridesharing, and medical transportation services under this benefit.
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 a referral and/or prior authorization from your doctor.

Mass Advantage Premiere (PPO)

PART D PRESCRIPTION DRUGS

Deductible Stage

Prescription Drug Deductible: $250 deductible for Tiers 3, 4 and 5

**Select Insulins: Cost-sharing is applicable in the Initial Coverage, and Coverage Gap phases of the Part D benefit, and only apply to beneficiaries who are not eligible for Low Income Subsidy cost-sharing.

Part D Vaccines: Cost-sharing of $0 is applicable in the Deductible, Initial Coverage, and Coverage Gap phases of the Part D benefit

Initial Coverage Stage

You pay the following until your total yearly drug costs reach $4,660. 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	$4 copay
Tier 2 (Generic)	$6 copay	$12 copay
Tier 3 (Preferred Brand)	$42 copay Select Insulins: $35** Part D Vaccines: $0	$84 copay Select Insulins: $70**
Tier 4 (Non-Preferred Brand)	$95 copay	$190 copay
Tier 5 (Specialty)	29% coinsurance	29% coinsurance

Standard Mail Order

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	$2 copay	$4 copay
Tier 2 (Generic)	$6 copay	$12 copay
Tier 3 (Preferred Brand)	$42 copay Select Insulins: $35**	$84 copay Select Insulins: $70**

Tier 4 (Non-Preferred Brand)	$95 copay	$190 copay
Tier 5 (Specialty)	29% coinsurance	29% coinsurance

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

**Select Insulins: Cost-sharing is applicable in the Initial Coverage, and Coverage Gap phases of the Part D benefit, and only apply to beneficiaries who are not eligible for Low Income Subsidy cost-sharing.

Part D Vaccines: Cost-sharing of $0 is applicable in the Deductible, Initial Coverage, and Coverage Gap phases of the Part D benefit

Coverage Gap Stage

You will continue to pay the Tier 1 and Tier 2 copay for drugs while in the coverage gap stage.

Tiers 3, 4, and 5 drugs: After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs (plus a portion of the dispensing fee) and 25% of the plan's cost for covered generic drugs until your costs total $7,400 which is the end of the coverage gap.

**Select Insulins: Cost-sharing is applicable in the Deductible, Initial Coverage, and Coverage Gap phases of the Part D benefit, and only applies to beneficiaries who are not eligible for Low Income Subsidy cost-sharing.

Part D Vaccines: Cost-sharing of $0 is applicable in the Deductible, Initial Coverage, and Coverage Gap phases of the Part D benefit

Catastrophic Stage

After your yearly out-of-pocket drug costs reach $7,400, you pay the greater of:

- $4.15 copay for generic (including brand drugs treated as generic) and a $10.35 copay for all other drugs, or
- 5% of the cost

Mass Advantage Premiere (PPO)	
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 www.MassAdvantage.com to see the list of covered over-the counter items.
Chiropractic Care	**In-network:** Chiropractic Care (Medicare-covered): $20 copay per visit **Out-of-network:** Chiropractic Care (Medicare-covered): $65 copay per visit
Telehealth Services	**In-network:** Primary Care Visits: $0 copay per visit Specialist Visits: $45 copay per visit Individual Sessions for Mental Health Specialty Services: $0 Individual Sessions for Outpatient Substance Abuse: $0 **Out-of-network:** Not covered
Medical Equipment/ Supplies*	**In-network:** Durable Medical Equipment (e.g., wheelchairs, oxygen): 20% coinsurance Prosthetics (e.g., braces, artificial limbs): 20% coinsurance Diabetic supplies: • 0% coinsurance for Medicare-covered diabetic monitoring supplies from a preferred manufacturer (Abbott and Lifescan) • 0% coinsurance for Medicare-covered therapeutic shoes or inserts for people with diabetes who have severe diabetic foot disease.

Mass Advantage Premiere (PPO)	
	Out-of-network: Durable Medical Equipment (e.g., wheelchairs, oxygen): 40% coinsurance Prosthetics (e.g., braces, artificial limbs): 40% coinsurance Diabetic supplies: 40% coinsurance
Flex Card	Flex Card: $150 every year The flex card is available to members to pay for: • Eyewear • Fitness benefits • Weight management programs and services • Nutritional / dietary benefits The flex card is preloaded with the full benefit amount and members choose where to use it. Members may pay a portion or the full cost of an item or buy a combination of items up to the allotted limit. Flex card is not eligible for cost sharing for covered benefits.

Services with an * (asterisk) may require a referral and/or prior authorization from your doctor.

For more information, please contact:

Mass Advantage
PO Box 830059
Birmingham, AL 35283
www.MassAdvantage.com

This document is available in Spanish and in other formats such as large print, braille, audio, or other alternate formats.

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: 1-844-514-0674 (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. For more information, call 1-844-915-0234 (TTY: 711).

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-844-915-0234. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-844-915-0234. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-844-915-0234。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-844-915-0234。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-844-915-0234. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-844-915-0234. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-844-915-0234 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-844-915-0234. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-844-915-0234 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-844-915-0234. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على **1-844-915-0234**. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-844-915-0234 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-844-915-0234. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-844-915-0234. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-844-915-0234. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-844-915-0234. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-844-915-0234 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

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