Summary of Benefits

Healthy Blue

Medicare Advantage and Part D

Plan year: January 1 – December 31, 2021

Missouri

Christian, Dade, Greene, Jasper, Lawrence, Newton, Polk, Stone, Taney, Webster

Healthy Blue Dual (HMO D-SNP)

21MOH6316002

Thank you for your interest in our Medicare Advantage plans

Healthy Blue offers a variety of benefits designed to help keep you healthy while protecting you from unexpected costs. This plan includes your hospital, medical and drug benefits in one plan.

Healthy Blue Dual (HMO D-SNP)

Healthy Blue Dual (HMO D-SNP)

Our service area includes these counties in MO: Christian, Dade, Greene, Jasper, Lawrence, Newton, Polk, Stone, Taney, Webster

Have questions?

- Please call us toll-free **1-855-430-7698** (TTY: **711**), and follow the instructions to be connected to a representative.
- Hours of operation: 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.
- You can learn more about us on our website at **https://shop.healthybluemo.com/medicare**.

While the Summary of Benefits does not include every service, limit or exclusion, the *Evidence of Coverage* does. Just give us a call to request a copy.

This is a Dual Eligible Special Needs Plan (D-SNP)

Healthy Blue Dual (HMO D-SNP) is a Medicare Advantage and prescription drug plan. It includes hospital, medical and prescription drug benefits in one plan. To join this plan, you must[1]:

- Be entitled to Medicare Part A,
- Be enrolled in Medicare Part B and MO HealthNet (the state's Medicaid program) and
- Live in our service area.

Eligibility

Healthy Blue Dual (HMO D-SNP) is available to anyone with both Medicare Parts A and B and who receives some level of Medical Assistance from MO HealthNet (the state Medicaid program) as described below:

Healthy Blue Dual (HMO D-SNP)

- Plan members with **full Medicaid coverage (Full Benefit Dual Eligible (FBDE))** status are eligible for the MO HealthNet program, which may be responsible for payment of their Medicare cost sharing. These members are also eligible to receive the full Medicaid benefits.
- Plan members with **Qualified Medicare Beneficiary (QMB)** status are eligible for the MO HealthNet program, which is responsible for payment of their Medicare premiums, deductibles, and cost sharing. Some QMB members are also eligible to receive full Medicaid benefits (QMB+).
- Plan members with **Specified Low-Income Medicare Beneficiary Plus (SLMB+)** status are eligible for the MO HealthNet program, which is responsible for payment of their Medicare Part B premium. Members are also eligible to receive full Medicaid benefits.

Cost sharing and cost-sharing protections for all members

In our plan, the state Medicaid program pays the cost sharing for Medicare-covered medical services you receive. You pay no cost sharing for the Medicare-covered benefits described later in this Summary of Benefits. You will pay no or small copayments for prescriptions covered under the Medicare Part D prescription drug benefit. When you receive health

[1] This plan is available to anyone who has both Medical Assistance from the State and Medicare.

services, the provider should only bill the plan for the cost of those services and cost-sharing amounts. The provider should not bill you for services or cost sharing.

If you receive care from a non-contracted provider, the provider may not understand the plan or these billing rules. If you receive a bill from a provider for Medicare-covered services, please notify Customer Service so we can help you. Please see Chapter 7 of your plan's *Evidence of Coverage* for more information.

Medicare coverage that goes beyond Original Medicare

- Like all Medicare Advantage health plans, we cover everything that Original Medicare covers — Part A (hospital services) and Part B (medical services). Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are covered in this Summary of Benefits.
- This plan covers Medicare Part D drugs and Part B drugs (such as chemotherapy and some drugs administered by your provider). To see if your prescription drugs are covered, follow the instructions in the "Know Your Drug Plan" section of this booklet.

Is your PCP in our plan's network of doctors?

You must choose a **P**rimary **C**are **P**rovider (PCP) in our network (plan) for covered services.[1] A PCP is your main doctor who provides most of your medical care, including routine care and hospitalizations. Your PCP will also help coordinate your care after a stay in the hospital. If you use a doctor or facility that is not in our plan, we may not cover the services.

Before you get care from a specialist, we highly recommend you talk to your PCP first. Doing so will keep your PCP informed and will help ensure you get the right care. Many specialist services require a referral from your PCP. So if you have a favorite specialist, make sure to ask if the specialist is in the plan's network.

A PCP can join or leave the plan's network at any time, so be sure to ask the PCP if he or she is in the plan's network, taking new patients and accepts Medicare and Medicaid. You can find a PCP in the plan's network or check the PCP status online. Just follow the steps below. If, for any reason, you need to change your PCP, give us a call – we can help you.

[1] If you need emergency or urgent care, call 911 or go to the nearest doctor or facility that can help you. Most times, you must use doctors in our plan to get covered medical care, except for emergencies and urgently needed care when doctors in our plan are not available, or dialysis services when you are out of the service area. If you get routine care from doctors outside our plan, neither Medicare nor Healthy Blue will pay for it.

How to find a doctor/PCP in our plan:

- ☐ Go to **https://shop.healthybluemo.com/medicare**
  1. Scroll to the *Useful Tools* section and choose the tab labeled **Find a Doctor**.
  2. Enter your ZIP code, county and the date you want your coverage to begin and select **Continue**.
  3. Fill in the details of your search (city, doctor's name, distance, etc.).
  4. Be sure to check that the doctor displays as "In-Network" for these plans.
- ☐ Or you can call us and ask for a copy of the *Provider Directory*. The phone number is on page 2.

Know your drug plan

Prescription drugs are an important part of health and wellness

Our plan gives you access to the drugs you need to get healthy and stay active.

What is a formulary?

The formulary is a list of drugs covered by our plan that tells you:

- ☐ Which drugs require prior authorization from your plan before you fill your prescription,
- ☐ If there is a quantity limit on the frequency, amount or dosage,
- ☐ If you need to try other drugs first (called step therapy),
- ☐ And the cost-sharing tier a drug is in.

Our plan groups each drug into "tiers." The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Learn more by going to the "Summary of 2021 prescription drug coverage" section in this guide.

How to find if your drugs (or an acceptable alternative) are covered and what they'll cost:

- ☐ Visit **https://shop.healthybluemo.com/medicare**
  1. Scroll to the *Useful Tools* section and choose the tab labeled **Find Your Covered Drugs**.
  2. Enter your ZIP code, county and beginning coverage date; then select **Continue**.
  3. Enter the name of your drug, dosage, quantity and refill frequency, and select **Add Drug**.
  4. Select your pharmacy.
  5. Select **View All Plans**.
  6. Make sure to choose **Show drug cost details** to view what tier your drugs are in, specific costs and coverage details.
- ☐ You can also call us at the number on page 2 to get a copy of the *Formulary*.

Can I use any pharmacy to fill my covered prescriptions?

To get the best savings on your covered Part D drugs, you must generally use a pharmacy in our plan. You may get your covered drugs from pharmacies that are not in our plan, but only when you are unable to get your prescription drugs from a pharmacy that is in our plan.

Our plan offers preferred and standard pharmacies. You may go to either type of pharmacy to fill your covered prescription drugs. Your costs will be the same if you use a preferred or standard pharmacy.

To find a pharmacy in our plan, see our online *Pharmacy Directory* on our website at **https://shop.healthybluemo.com/medicare** (under *Useful Tools*, select **Find a Pharmacy**, and enter your location and search details). Preferred pharmacies are indicated above the pharmacy name. Or you can give us a call and we'll send you a copy.

Summary of 2021 medical benefits

On the following pages, you can review more about our plan benefits to help you choose the right plan for you. If you want to compare our plan with other Medicare health plans, call and ask the other plans for a copy of their Summary of Benefits.

Are there any restrictions on my coverage?

Prior Authorization:

Healthy Blue requires you or your physician to get prior authorization (pre-approval) for certain services. This means that you will need to get approval from our plan before you receive some covered services. Services that may require prior approval are noted with a * in the benefit title.

Healthy Blue Dual (HMO D-SNP)

How much is my premium (monthly payment)**?**

$0.00 per month

Part B premium is covered by your state's Medicaid agency for D-SNP enrollees.

How much is my deductible?

This plan does not have a medical deductible.

The Part D deductible does not apply to you because you get "Extra Help" from Medicare.

Is there a limit on how much I will pay for my covered medical services?

(does not include Part D drugs)

$4,800.00 per year from doctors and facilities in our plan.

Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.

Services you get from doctors or facilities in our plan go toward your yearly limit. If you reach the limit on out-of-pocket costs, you will not have to pay any out-of-pocket costs for covered Part A and Part B services for the rest of the year.

Inpatient Hospital*

Facilities in our plan: **$0.00** copay per stay

Our plan covers 90 days for an inpatient hospital stay.

Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.

Healthy Blue Dual (HMO D-SNP)

Outpatient Hospital*

Doctors and facilities in our plan: **$0.00** copay

Ambulatory Surgical Center*

Doctors and facilities in our plan: **$0.00** copay

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

Doctor's Office Visits

Primary care physician (PCP) visit:

PCPs in our plan: **$0.00** copay

Specialist visit:*

Doctors in our plan: **$0.00** copay

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

Preventive Care Screenings and Annual Physical Exams

Preventive care screenings:

Doctors in our plan: **$0.00** copay

Annual physical exam:

Doctors in our plan: **$0.00** copay

Healthy Blue Dual (HMO D-SNP)

Preventive Care Screenings and Annual Physical Exams

Covered preventive care screenings:

- ☐ Abdominal aortic aneurysm screening
- ☐ Annual "wellness" visit
- ☐ 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 prevention program
- ☐ Diabetes screenings and monitoring
- ☐ Hepatitis C Screening
- ☐ High Intensity Behavioral Counseling
- ☐ HIV screening
- ☐ Lung cancer screenings
- ☐ Medical nutrition therapy services
- ☐ Obesity screenings and counseling
- ☐ Prostate cancer screenings (PSA)
- ☐ Sexually transmitted infections screenings and counseling
- ☐ Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)
- ☐ Vaccines, including flu shots, hepatitis B shots, pneumococcal shots
- ☐ "Welcome to Medicare" preventive visit (one-time)

Any extra preventive services approved by Medicare during the contract year will be covered. When you use doctors in our plan, **100%** of the cost of preventive care screenings and annual physical exams are covered.

Healthy Blue Dual (HMO D-SNP)

Emergency Care

$0.00 copay

Emergency and Urgent Care Worldwide Coverage

$0.00 copay

This plan covers urgent care and emergency services when traveling outside of the United States for less than six months. This benefit is limited to **$100,000.00** per year.

Urgently Needed Services

$0.00 copay

Diagnostic Radiology Services (such as MRIs, CT scans)*

Doctors and facilities in our plan: **$0.00** copay

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

Diagnostic Tests and Procedures*

Doctors and facilities in our plan: **$0.00** copay

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

Lab Services*

Doctors and facilities in our plan: **$0.00** copay

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

Healthy Blue Dual (HMO D-SNP)

Outpatient X-rays*

Doctors and facilities in our plan: **$0.00** copay

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

Therapeutic Radiology Services (such as radiation treatment for cancer)*

Doctors and facilities in our plan: **$0.00** copay

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

Hearing Services

Medicare-covered hearing services (Exam to diagnose and treat hearing and balance issues):*

Doctors in our plan: **$0.00** copay

Routine hearing services:*

This plan covers 1 routine hearing exam(s) and hearing aid fitting/evaluation(s) every year. **$3,000.00** maximum plan benefit for hearing aids every year.

Doctors in our plan: **$0.00** copay for routine hearing exam(s). **$0.00** copay for hearing aids up to the maximum plan benefit amount.

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

Dental Services

Medicare-covered dental services (this does not include services for care, treatment, filling, removal or replacement of teeth):

Doctors and dentists in our plan: **$0.00** copay

Dental Services

Preventive dental services:

This plan covers: 2 oral exam(s), 2 cleaning(s), 1 dental X-ray(s), 1 fluoride treatment(s) every year.

Dentists in our plan: **$0.00** copay

Comprehensive dental services:

This plan covers up to a **$3,500.00** allowance for covered comprehensive dental services every year.

Doctors and dentists in our plan: **$0.00** copay

We cover more dental care than what Original Medicare covers. You can use our coverage for these services and more: extra exams, cleanings, X-rays, fillings and repairs, root canals (endodontics), dental crowns (caps), bridges and implants, and dentures.

Any amount not used at the end of the calendar year will expire.

To find a dental provider in our plan, follow the same steps as the "How to find a doctor/PCP in our plan" box at the beginning of this booklet. Then select **Dental Provider** under **Provider Type**.

Vision Services

Medicare-covered vision services:

Exam to diagnose and treat diseases and conditions of the eye

Doctors in our plan: **$0.00** copay

Eyeglasses or contact lenses after cataract surgery

Doctors in our plan: **$0.00** copay

Vision Services

Routine vision services:

Routine vision exam

This plan covers 1 routine eye exam(s) every year.

Doctors in our plan: **$0.00** copay

Routine eyewear (lenses and frames)

This plan covers up to **$500.00** for eyeglasses or contact lenses every year.

Doctors in our plan: **$0.00** copay

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

To find a vision provider in our plan, follow the same steps as the "How to find a doctor/PCP in our plan" box at the beginning of this booklet. Then select **Vision Provider** under **Provider Type**.

Mental Health Care

Inpatient visit:*

Doctors and facilities in our plan: **$0.00** copay per stay

Our plan has a lifetime limit of 190 days for inpatient mental health care in a psychiatric hospital. This limit does not apply to inpatient mental health services provided in a general hospital.

Our plan covers 90 days for an inpatient hospital stay.

Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.

Outpatient individual and group therapy services:*

Doctors and facilities in our plan: **$0.00** copay

Healthy Blue Dual (HMO D-SNP)

Skilled Nursing Facility (SNF)*

Doctors and facilities in our plan: **$0.00** copay per stay

Our plan covers up to 100 days in a Skilled Nursing Facility (SNF).

Physical Therapy*

Doctors and facilities in our plan: **$0.00** copay

Ambulance*

Ground/Water Ambulance:

Emergency transportation services in our plan: **$0.00** copay per trip

Air Ambulance:

Emergency transportation services in our plan: **$0.00** copay per trip

Transportation*

$0.00 copay. This plan offers coverage for 150, one-way, routine transportation services every year. Trips are limited to 60 miles.

Routine transportation coverage is limited to plan-approved locations (within the local service area) provided by contracted transportation vendors in our plan. If you need a ride, call us at least 48 hours ahead of time.

This plan allows you to select additional transportation benefits as part of the Essential Extras benefit. See that benefit description for more information.

Healthy Blue Dual (HMO D-SNP)

Medicare Part B Drugs*

Other Part B Drugs:

Drugs in our plan: **$0.00** copay

Chemotherapy drugs:

Drugs in our plan: **$0.00** copay

Additional benefits

Essential Extras*

Healthy Blue Dual (HMO D-SNP): Offered

We want you to have not just the best possible health, but comfort in your daily life. Choose any one of the following innovative benefits as part of a comprehensive plan that we will help you create.

Transportation

If you need a ride to plan-approved health- or fitness-related appointments, this benefit gives you 60 one-way trips per year.

Personal Home Helper

Provides up to 31 visits (up to 4 four hours each visit) of home health aide services, if you need help with two or more activities of daily living such as mobility help around the home, bathing and dressing, meal prep, light chores like laundry or dishes, or to provide respite care.

Assistive Devices

You could get an annual allowance of **$500** for assistive and safety devices, such as hand rails, shower stools, raised toilet seats and temporary mobility ramps.

Healthy Meals

Enjoy healthy meals delivered directly to your home. You could get up to 16 meals, 4 times per year, for qualifying events. Qualifying events include a body mass index (BMI) of 18.5 or lower, a BMI of 25 or higher, or an A1C level higher than 9.0, or discharge from the hospital.

Day Center Visits

You could visit a licensed adult day center once a week (up to 8 hours per visit) and be reimbursed up to **$80** if you need help with 2 or more activities of daily living. This benefit includes rides to and from the center. You'll experience supervised care and the chance to socialize, and your caregiver will gain a respite.

Service Dog Support

You could get up to **$500** per year to help pay for items used to care for your ADA service dog, such as food, leashes or vests.

Health and Fitness Tracker

You could enjoy a fitness tracking device (every other year) plus access to online programs to help you achieve your mental acuity and fitness goals.

Pest Control

If you have a diagnosed chronic condition, you could have your home treated every three months for standard pests or a 1-time treatment for certain infestations, if they are having a direct impact on your health.

Healthy Pantry

If you have a diagnosed chronic condition, you could receive monthly nutritional counseling sessions and monthly delivery of non-perishable pantry staples to help you make important changes to your diet.

Chiropractic Care*

Medicare-covered chiropractic services:

Providers in our plan: **$0.00** copay

Medicare coverage includes manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position).

Foot Care (podiatry services)*

Medicare-covered podiatry:

Doctors in our plan: **$0.00** copay

Foot exams and treatment are covered if you have diabetes-related nerve damage and/or meet certain conditions.
Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

Routine foot care:

Doctors in our plan: **$0.00** copay

This plan covers: Unlimited routine foot care visits each year.

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

Healthy Meals-Post Discharge*

$0.00 copay for up to 2 meals a day for 21 days following your discharge from the hospital.

Requires a referral.

Home Health Care*

Doctors and facilities in our plan: **$0.00** copay

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

Healthy Blue Dual (HMO D-SNP)

LiveHealth Online

Lets you talk to a board-certified doctor, or licensed psychiatrist, psychologist or therapist, by live, two-way video on a computer, smartphone or tablet.

LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of our plan.

Medical Equipment/Supplies

Durable Medical Equipment (wheelchairs, oxygen, etc.):*

Suppliers in our plan: **$0.00** copay

Medical supplies and prosthetic devices (braces, artificial limbs, etc.):*

Suppliers in our plan: **$0.00** copay

Diabetic supplies and services:*

Suppliers in our plan: **$0.00** copay

Medicare Community Resource Support

We assist you right over the phone by providing you with health-related information and by connecting you to local community-based services and support programs. We'll help you coordinate these services based on your unique needs. Call us at the number listed on your plan ID card and ask for the Medicare Community Resource Support team for more details.

Outpatient Rehabilitation

Cardiac (heart) rehab services (with a limit of two, one-hour sessions per day and a maximum of 36 sessions within a 36-week period):*

Doctors and facilities in our plan: **$0.00** copay

Outpatient Rehabilitation

Pulmonary (lung) rehab services (with a limit of two, one-hour sessions per day and a maximum of 36 sessions):*

Doctors and facilities in our plan: **$0.00** copay

Occupational therapy visit:*

Doctors and facilities in our plan: **$0.00** copay

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

Outpatient Substance Abuse*

Individual & Group therapy visit:

Doctors and facilities in our plan: **$0.00** copay

Note: We highly recommend you talk to your PCP first, before you get care from a specialist.

Over-the-Counter Items

This plan covers certain approved, non-prescription, over-the-counter drugs and health-related items, up to **$360** every quarter. Unused OTC amounts do roll over to the next quarter. Unused OTC amounts do not roll over to the next calendar year.

There are many ways to access your benefit:

- Shop online or use the mobile app and have items sent to your home or to a store location near you for pickup
- Shop at more than 4,600 Walmart and Neighborhood Market stores and other participating retailers
- Call to place an order and have items sent to your home

Personal Emergency Response System (PERS) coverage*

Includes the monitoring device and monitoring service. To start and install services, give us a call. We can help you.

Healthy Blue Dual (HMO D-SNP)

Renal Dialysis

Doctors and facilities in our plan: **$0.00** copay

SilverSneakers®† Fitness program

When you become our member, you can sign up for SilverSneakers. It's included in our plan. To learn more details, go to **www.silversneakers.com** or call SilverSneakers at 1-855-741-4985 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. ET.

†The SilverSneakers Fitness Program is provided by Tivity Health, an independent company. SilverSneakers and the SilverSneakers shoe logotype are registered trademarks of Tivity Health, Inc. © 2020 Tivity Health, Inc. All rights reserved.

24/7 NurseLine

24-hour access to a nurse helpline, 7 days a week, 365 days a year.

Summary of Medicaid-covered benefits

Services available through Missouri Department of Social Services:

The following services are not covered or may not be fully covered by Healthy Blue Dual (HMO D-SNP) but are available through Medicaid.

- ☐ Ambulance (emergency only)
- ☐ Ambulatory surgical center
- ☐ Applied behavior analysis
- ☐ Certified nurse practitioner
- ☐ Community psychiatric rehabilitation services
- ☐ Comprehensive day rehabilitation
- ☐ Comprehensive substance treatment and rehab (CSTAR)
- ☐ Dental
- ☐ Diabetes self-management
- ☐ Durable medical equipment
- ☐ Environmental lead assessments
- ☐ Family planning
- ☐ Hearing aids
- ☐ Home health
- ☐ Hospice
- ☐ Inpatient hospital
- ☐ Intermediate care facility, intellectual disabilities (ICF-ID)
- ☐ Lab and radiology
- ☐ Licensed clinical social worker (LCSW)
- ☐ Licensed professional counselor (LPC)
- ☐ Non-emergency medical transportation
- ☐ Nurse midwife
- ☐ Nursing facility
- ☐ Optical

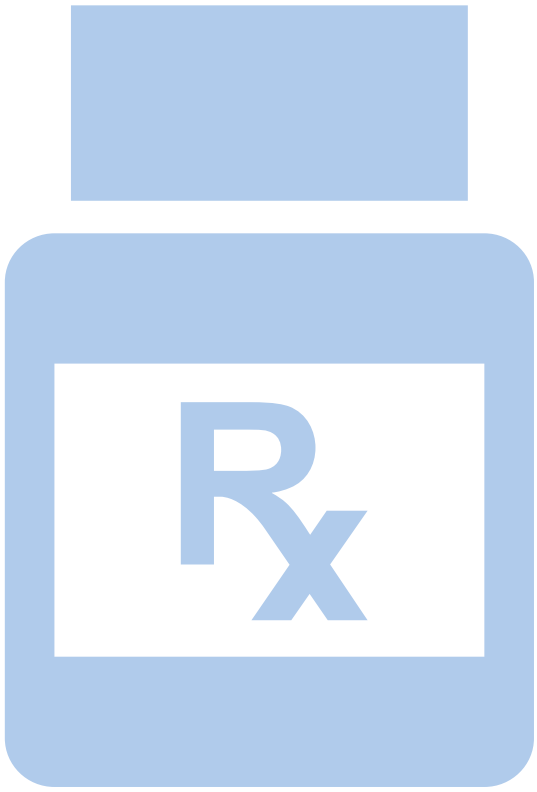
- ☐ Outpatient hospital
- ☐ Personal care
- ☐ Pharmacy
- ☐ Physician-certified nurse practitioner - FQHC/RHC
- ☐ Podiatry
- ☐ Private duty nursing
- ☐ Psychologist
- ☐ Therapies - occupational, physical, and speech
- ☐ Transplants

Medicaid coverage is based on your eligibility. Please check your Medicaid contract for a full list of services.

Have Questions?

What you pay for covered services may depend on your level of Medicaid eligibility. If you have questions about your Medicaid eligibility and what benefits you are entitled to, please call: **1-855-373-4636**.

Summary of 2021 prescription drug coverage



Know where to go:

Once you become a member of our plan, Chapters 5 and 6 of your *Evidence of Coverage* include many important details about your pharmacy benefit.

To find a pharmacy in our plan:

- Visit **https://shop.healthybluemo.com/medicare** (under *Useful Tools*, select **Find a Pharmacy**, and enter your location and search details).
- Give us a call and we will send you a copy of the Pharmacy Directory.

Healthy Blue Dual (HMO D-SNP)

Stage 1: How much is my deductible?

The Part D deductible does not apply to you because you get "Extra Help" from Medicare.

Stage 2: Initial Coverage

After you pay your yearly deductible (if your plan has one), you pay the amount listed in the table on the following pages, until your total yearly drug costs reach **$4,130**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

You may get your covered drugs at retail pharmacies and mail-order pharmacies in our plan. Generally, you may get your covered drugs from pharmacies not in our plan only when you are unable to get your prescription drugs from a pharmacy that is in our plan.

Stage 2: Initial Coverage	
Retail and Mail Order Cost Sharing	
Cost Sharing	**Healthy Blue Dual (HMO D-SNP)**
Tier 1: Preferred Generic, **Tier 2: Generic**, **Tier 6: Select Care Drugs**	**$0 copay**
Generic drugs (including brand drugs treated as generic) on all other Tiers not referenced above	**$0 - $3.70 copay, depending on the level of "Extra Help" you receive**
All other brand drugs on all other Tiers not referenced above	**$0 - $9.20 copay, depending on the level of "Extra Help" you receive**

Cost sharing is the same for 30-day or long-term supply.
You can determine which covered drugs are generic by reading the plan's Formulary.

Plan Tiers
Tier 1: Preferred Generic
Tier 2: Generic
Tier 3: Preferred Brand
Tier 4: Nonpreferred Brand
Tier 5: Specialty Tier
Tier 6: Select Care Drugs

Stage 3: Coverage Gap

After you enter the coverage gap, you will pay your low income subsidy (LIS) level cost-sharing for generic and brand name drugs unless your plan has extra generic gap coverage.
For drugs on Tier 1, Tier 2, Tier 6, you will pay: **$0.00**.
You will stay in the gap until your costs total **$6,550,** which is the end of the coverage gap. Note - not everyone will enter the coverage gap.

Stage 4: Catastrophic Coverage

After your yearly out-of-pocket drug costs reach **$6,550,** the plan will pay all of your Medicare covered Part D drugs for the rest of the calendar year.

Ways we support your health

MyAdvocate

The MyAdvocate® program helps you find local discounts and services such as home repair, nutrition and assistance with your copays. In addition - once you become a member of our D-SNP plan (dual-eligible for Medicare and Medicaid), we will help you keep your Medicaid benefits.

Services this program provides:

- **Medicare Saving Complete (Eligibility & Enrollment Assistance):** We help you enroll and keep your Medicaid benefits. An advocate will contact you to help you renew your Medicaid benefits. Or you can contact us at **1-866-705-8732** (TTY: **1-855-368-9643**) and an advocate will walk you through the process.
- **Recertification Assistance:** RECERT Complete acts on your behalf by helping you make sure you don't miss the annual deadline and advocate on your behalf to re-enroll or maintain your Medicaid status.
- **Community Connect:** We help you with social advocacy by connecting you with public and private benefits for which you may qualify.
- **Part D:** We assist you with the Part D or Low Income Subsidy (LIS) resources that will help you with prescription drug costs and expenses while you are in the coverage gap.

An overview of how Medicare works

If you're new to Medicare, this information can help you decide what option is right for you.

ORIGINAL MEDICARE (PARTS A and B) is offered by the federal government. It helps cover the costs for:

A + B

- ☐ Inpatient care in hospitals and skilled nursing facilities (not custodial or long-term care)
- ☐ Hospice and some home health care services
- ☐ Doctors' services, hospital outpatient care and some home health care services, as well as lab tests, medical equipment and supplies
- ☐ Most preventive services, including a yearly wellness exam

But Original Medicare doesn't cover everything. Parts A and B don't cover:

- ☐ Prescription drugs
- ☐ Routine vision, dental or hearing care

Here are your options:

OPTION 1 - Choose all your coverage in one Medicare Advantage Plan:	OPTION 2 - Choose one or both of the following:
Medicare Part C **C+D+Extras** ☐ Includes all of Part A (hospital) and Part B (medical) coverage ☐ Usually includes Part D prescription drug coverage ☐ Often offers extra services and benefit options ☐ Has yearly limits on your out-of-pocket costs for medical services	**Medicare Supplement** ☐ Medicare Part A or Part B deductibles, coinsurance or copayments ☐ Medicare Part B excess charges ☐ Skilled Nursing Facility care coinsurance ☐ Foreign Travel Emergencies **Prescription Drug Coverage** **Part D** ☐ Helps pay for many of your prescribed drugs ☐ Gives you access to mail-order options and retail drugstores across the country

When you can enroll

Initial coverage period

You can sign up for a D-SNP when you are first eligible for Medicare. Your initial enrollment phase is a 7-month period that includes the 3 months before you turn 65, the month you turn 65 and the 3 months after you turn 65. You must be eligible for both Medicare and Medicaid to join a D-SNP.

Annual election period - October 15 to December 7

This is the time frame each year that you can enroll in or change your Medicare Advantage or Part D plan. You may also switch to Original Medicare (Parts A and B). New coverage begins January 1 of each year, after you've enrolled.

Special enrollment period - January 1 to September 30

As a D-SNP member, you can change plans one time per calendar quarter. This option is known as a special enrollment period. For more help, call your agent or call us (toll-free number is listed on page 2).

Medicare ID cards

The Medicare plan option you choose will determine the plan ID card or cards you will need to carry with you at all times.

If you choose one of our Dual-Eligible Special Needs (D-SNP) plans:

You should put away your red, white and blue Medicare ID card because all you'll need to carry is one card. Just present your D-SNP plan ID card for all your covered medical and drug benefits. We recommend that you also carry your state Medicaid ID card just in case your doctor may need to see it.

Avoid late-enrollment penalties

It's important to enroll in a Medicare plan when you're first eligible. If you don't, you may have to pay the following penalties:

Medicare Part A: Your monthly premium, if you have one, may increase by 10% per year for twice the number of years you could have had Part A but didn't sign up.

Medicare Part B: Your monthly premium may increase 10% for each 12-month period that you could have had Part B but didn't sign up. You'll have to pay this penalty for as long as you have Part B.

Medicare Part D: If you don't sign up when you're first eligible, you may have to pay this penalty for as long as you are enrolled in Part D, and it may increase every year. (You may not have to pay if you receive "Extra Help" or can provide proof of other creditable coverage.)

How can I learn more about Medicare?

Medicare & You – a helpful tool

We strongly recommend you obtain a copy of the official U.S. government's *Medicare & You* handbook to get the answers to all of your questions about Medicare. If you do not have a copy, you can view it online at **www.medicare.gov** or call Medicare for a copy at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users can call **1-877-486-2048**.

Healthy Blue Dual is a Medicare plan with a Medicare contract and a contract with the state Medicaid plan. Enrollment in Healthy Blue Essential depends on contract renewal.

Healthy Blue is the trade name of Missouri Care, Inc., an independent licensee of the Blue Cross Blue Shield Association.

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Healthy Blue - H6316
2020 Medicare Star Ratings*

The Medicare Program rates all health and prescription drug plans each year, based on a plan's quality and performance. Medicare Star Ratings help you know how good a job our plan is doing. You can use these Star Ratings to compare our plan's performance to other plans. The two main types of Star Ratings are:

1. An Overall Star Rating that combines all of our plan's scores.
2. Summary Star Rating that focuses on our medical or our prescription drug services.

Some of the areas Medicare reviews for these ratings include:

- How our members rate our plan's services and care;
- How well our doctors detect illnesses and keep members healthy;
- How well our plan helps our members use recommended and safe prescription medications.

For 2020, Healthy Blue received the following Overall Star Rating from Medicare.

Plan too new to be measured

We received the following Summary Star Rating for Healthy Blue's health/drug plan services:

Health Plan Services:	Plan too new to be measured
Drug Plan Services:	Plan too new to be measured

The number of stars shows how well our plan performs.

★★★★★	5 stars - excellent
★★★★	4 stars - above average
★★★	3 stars – average
★★	2 stars - below average
★	1 star - poor

Learn more about our plan and how we are different from other plans at www.medicare.gov.

We do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability in our health programs and activities.

You may also contact us at 1-855-430-7698 (toll-free) or 711 (TTY), 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

Current members please call 1-833-557-0952 (toll-free) or 711 (TTY).

*Medicare evaluates plans based on a 5-star rating system. Star Ratings are calculated each year and may change from one year to the next.

This plan is available to anyone who has both Medical Assistance from the State and Medicare.

Healthy Blue Dual is a Medicare plan with a Medicare contract and a contract with the state Medicaid plan. Enrollment in Healthy Blue Essential depends on contract renewal.

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 **1-855-430-7698** TTY: **711**, 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit **https://shop.healthybluela.com/medicare** or call **1-855-430-7698** 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 medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, 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/co-insurance may change on January 1, 2022.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.