

2023 Summary of Benefits

Great Plains Medicare Advantage Gold (HMO I-SNP) H7511, Plan 002

This is a summary of drug and health services covered by Great Plains Medicare Advantage (HMO I-SNP) January 1, 2023 - December 31, 2023.

Great Plains Medicare Advantage (HMO I-SNP) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) with a Medicare contract. Enrollment in the Plan depends on contract renewal.

This information is not a complete description of benefits. Call (844) 637-4760, TTY should call (888) 279-1549, for more information.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, visit our website at [GreatPlainsMedicareAdvantage.com](https://www.GreatPlainsMedicareAdvantage.com), or call Member Services and request the *Evidence of Coverage*.

To Reach Our Member Services Representatives:

- Please call (844) 637-4760, TTY (888) 279-1549) for more information. For Medicare Part D drug coverage information can call (855) 800-8872, TTY 711.
- 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.

To join Great Plains Medicare Advantage (HMO I-SNP), you must:

- be entitled to Medicare Part A,
- -- *and* -- be enrolled in Medicare Part B,
- -- *and* -- live in our service area,
- -- *and* -- reside in one of our participating basic care or assisted living communities and meet a nursing facility level of care, or nursing facilities for greater than 90 days. The plan's *Provider Directory* has a list of participating assisted living communities or nursing facilities, you can access this list on our website [GreatPlainsMedicareAdvantage.com](https://www.GreatPlainsMedicareAdvantage.com) or call Member Services and ask us to send you a list.

Our service area includes these counties in Nebraska: Adams, Antelope, Boone, Buffalo, Burt, Butler, Cass, Cedar, Cuming, Custer, Dakota, Dodge, Douglas, Fillmore, Furnas, Gage, Hall, Harlan, Holt, Howard, Jefferson, Kearney, Knox, Lancaster, Madison, Merrick, Nance, Nemaha, Nuckolls, Otoe, Phelps, Platte, Polk, Sarpy, Saunders, Seward, Sherman, Stanton, Washington, Wayne, Webster, and York.

Great Plains Medicare Advantage (HMO I-SNP) has a network of doctors, hospitals, pharmacies, and other providers that can be found on our website at [GreatPlainsMedicareAdvantage.com](https://www.GreatPlainsMedicareAdvantage.com). If you use providers that are not in our network, the plan may not pay for these services.

This document is also available in Braille and in large print.

Benefits, premium, deductible, and/or copayments (copay)/coinsurance may change on January 1 of each year.

Limitations, copays, and restrictions may apply.

You must continue to pay your Medicare Part B premium.

If you want to know more about the coverage and costs of Original Medicare, look in your current “**Medicare & You 2022**” handbook. View it online at <https://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.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

Premiums and Benefits	Great Plains Medicare Advantage (HMO I-SNP)
Monthly Plan Premium	\$50.00 You must continue to pay your Medicare Part B premium.
Deductible	\$0
Maximum Out-of-Pocket Amount (Does Not Include Part D Prescription Drugs)	\$3,000
Doctor Visits Primary Care Providers Specialists <i>Specialist does not include Foot Care (Podiatrist). See Foot Care (Podiatry) section below.</i>	<ul style="list-style-type: none"> • \$0 copay • \$30 copay
Preventive Care	You pay nothing.

Premiums and Benefits	Great Plains Medicare Advantage (HMO I-SNP)
<p>Inpatient Hospital Coverage</p>	<ul style="list-style-type: none"> • Days 1-5: \$185 copay each day • Days 6-90: \$0 copay each day • Days 91-150: \$0 copay per each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime) • Each day after lifetime reserve days: All costs <p><i>Prior Authorization is required.</i></p>
<p>Outpatient Hospital Coverage</p> <p>Outpatient Hospital Services</p> <p>Outpatient Hospital Observation Services</p>	<ul style="list-style-type: none"> • \$50 copay • \$50 copay for surgery at outpatient hospital <p><i>Prior Authorization is required for certain surgeries.</i></p> <ul style="list-style-type: none"> • \$100 copay per stay
<p>Mental Health Services</p> <p>Inpatient Visit</p> <p>Outpatient Group Therapy Visit</p> <p>Outpatient Individual Therapy Visit</p>	<ul style="list-style-type: none"> • Days 1-5: \$185 copay each day • Days 6-90: \$0 copay each day • Days 91-150: \$0 copay per each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime) • Each day after lifetime reserve days: All costs <p><i>Prior Authorization is required</i></p> <ul style="list-style-type: none"> • \$30 copay • \$30 copay

Premiums and Benefits	Great Plains Medicare Advantage (HMO I-SNP)
Ambulatory Surgical Center (ASC) Services	<ul style="list-style-type: none"> \$50 copay <i>Prior Authorization is required for certain surgeries.</i>
Emergency Care	\$90 copay Copay is waived if you are admitted to a hospital within 3 days.
Urgently Needed Services	\$30 copay Coinsurance is waived if you are admitted to a hospital within 3 days.
Ambulance Services Ground or Air Ambulance	20% coinsurance \$150.00 minimum for MC-covered ambulance services
Diagnostic Services / Labs / Imaging* Diagnostic and Therapeutic Radiology Services (e.g. MRI, CT Scan) Outpatient X-rays Lab Services Other Diagnostic Tests and Procedures <i>*If a member receives multiple services at the same location on the same day, only the maximum copay apply.</i>	<ul style="list-style-type: none"> \$50 copay \$10 copay for Medicare-covered services <i>No Prior Authorization is needed except for High-End Imaging.</i> <ul style="list-style-type: none"> \$0 copay <i>No Prior Authorization required for lab services rendered in any place of service, except for Genetic Testing, which does require Prior Authorization.</i> <ul style="list-style-type: none"> \$20% coinsurance for Medicare-covered services

Premiums and Benefits	Great Plains Medicare Advantage (HMO I-SNP)
<p>Hearing Services</p> <p>Hearing Exam</p> <p><i>Supplemental Benefits</i></p> <p>Routine Hearing Exam, Fitting and Evaluation for Hearing Aids</p> <p>Hearing Aids</p>	<p>\$30 copay for Medicare-covered hearing services.</p> <p>\$0 copay for one routine hearing exam, fitting, and evaluation for hearing aids every year.</p> <p>Up to \$2,000 in credit for both ears combined every two years.</p>
<p>Dental Services</p> <p>Medicare-covered Dental</p> <p><i>Supplemental Benefits</i></p> <p>Preventive and Comprehensive</p>	<p>20% coinsurance for Medicare-covered dental services.</p> <p>\$0 copay for the following Preventive dental services:</p> <ul style="list-style-type: none"> • 2 Oral Exams every year • 2 Prophylaxis (Cleanings) every year • 1 set of bitewing x-rays annually • 1 full mouth (Panoramic) x-ray every 5 years <p>A maximum amount of \$2,000 is to be divided out between a set of dentures and other Comprehensive dental services every year.</p> <p>\$500 limit for the following Comprehensive dental benefits:</p> <ul style="list-style-type: none"> • Non-routine services, • Diagnostic services, • Restorative services, • Endodontics, • Periodontics, • Extractions, • Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services. <p>\$1,500 limit for services related to the provision of dentures, covering one set of dentures every two years.</p>

Premiums and Benefits	Great Plains Medicare Advantage (HMO I-SNP)
<p>Vision Care</p> <p>Eye Exams</p> <p><i>Supplemental Benefits</i></p> <p>Routine Eye Exam</p> <p>Eyewear: eyeglasses (lenses and frames), upgrades, contacts</p>	<p>\$30 copay for Medicare-covered services.</p> <p>\$0 copay for one routine eye exam every year.</p> <p>\$275 limit for eyeglasses (lenses and frames) every year.</p> <ul style="list-style-type: none"> • \$0 copay for one routine eye exam every year. • Eyeglass lenses (single vision, lined bifocal, lined trifocal and lenticular) are covered in full. \$275 frame allowance is provided. • Standard progressives are covered in full. • \$100 limit to cover fitting evaluation and 1 pair of contact lenses every year in lieu of eyeglasses (lenses and frames)
<p>Foot Care (Podiatry Services)</p> <p>Foot Exams and Treatment</p> <p><i>Supplemental Benefits</i></p> <p>Routine Foot Care</p>	<p>This cost-sharing applies to Diabetic Foot Care also.</p> <p>20% coinsurance for Medicare-covered services.</p> <p>\$0 copay for 6 routine foot care visits per year</p>
<p>Cardiac Rehab</p>	<p>\$30 copay</p>
<p>Pulmonary Rehab</p>	<p>\$20 copay</p>
<p>Occupational Therapy</p> <p>Physical Therapy</p> <p>Speech Therapy</p>	<p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p>
<p>Transportation (Additional Routine)</p>	<p>\$0 copay</p> <p>Routine transportation for up to 32 trips per year.</p> <p>A trip is considered one-way transportation by taxi, bus/subway, van, or medical transport to a plan approved health-related location</p>

Premiums and Benefits	Great Plains Medicare Advantage (HMO I-SNP)
<p>Skilled Nursing Facility (SNF) Care</p>	<p>You pay the 2023 Original Medicare cost-sharing amounts.</p> <ul style="list-style-type: none"> • Days 1-20: \$0 copay per day • Days 21-100: Up to \$200 copay per day • Days 101 and beyond: All costs <p>Original Medicare benefit period.</p>
<p>Medicare Part B Prescription Drugs</p> <p>Chemotherapy Drugs</p> <p>Other Part B Drugs</p>	<ul style="list-style-type: none"> • 20% coinsurance <p><i>Prior Authorization is required for some medications.</i></p> <ul style="list-style-type: none"> • 20% coinsurance <p><i>Prior Authorization is required for some medications.</i></p>

Great Plains Medicare Advantage (HMO I-SNP) Outpatient Prescription Drugs		
	Standard Retail Cost-Sharing (In-network) (30 day supply, 60 day supply, or 90 day supply)	Long-Term Care (LTC) Cost-sharing (31 day supply)
Deductible	This plan has no deductible for Part D drugs; this payment stage does not apply.	
Tier 1 (Preferred Generic)	30 day supply: \$4 copay 60 day supply: \$8 copay 90 day supply: \$12 copay	\$4 copay
Tier 2 (Generic)	30 day supply: \$10 copay 60 day supply: \$20 copay 90 day supply: \$30 copay	\$10 copay
Tier 3 (Preferred Brand)	30 day supply: \$45 copay 60 day supply: \$90 copay 90 day supply: \$135 copay	\$45 copay
Tier 4 (Non-Preferred Drug)	30 day supply: \$95 copay 60 day supply: \$190 copay 90 day supply: \$285 copay	\$95 copay
Tier 5 (Specialty Tier)	30 day supply: 33% coinsurance 60 day supply: 33% coinsurance 90 day supply: 33% coinsurance	33% coinsurance
Coverage Gap	After your total drug costs (including what our plan has paid and what you have paid) reach \$4,660, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap.	
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through retail pharmacy or mail order) reach \$7,400, you pay the greater of: <ul style="list-style-type: none"> • 5% coinsurance, or • \$4.15 copay for generic (including brand drugs treated as generic) and a \$10.35 copay for all other drugs. 	
Cost-sharing may differ based on point-of-service (retail, Long Term Care (LTC)), home infusion, whether the pharmacy is in our standard network, or whether the prescription is a short-term supply (30-days) or long-term supply (90-days).		

Our plan covers most Part D vaccines at no cost to you.

You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.