## 2023 Medicare Enrollment Guide

# Your partner in wellness

Choose Medicare coverage from WellFirst Health — Provided by SSM Health Plan — with benefits made just for you

SSM Integrity (HMO-POS)
SSM FlexSpend (HMO-POS)
SSM Harmony (HMO-POS) MA-Only

WellFirst Health®
provided by SSM Health Plan

## Contents



## Ready to Enroll?

You can enroll with WellFirst Health — Provided by SSM Health Plan — one of the following ways:

CALL

**By Phone**
Call **833-942-2153 (TTY: 711)** to enroll over the phone with a Medicare sales consultant

CLICK

**Enroll Online**
Visit **wellfirsthealth.com/medicare2023**

Find our upcoming seminars at **wellfirsthealth.com/seminars**

VISIT

**In Person**
Schedule an appointment for an in person or an in-home visit with a licensed, independent Medicare sales consultant by calling **833-942-2153**

**You can also visit one of our Medicare Resource Centers**
Walk-ins welcome during scheduled hours or call to schedule an appointment.

**SSM Health Outpatient Center – Kisker Road**
1475 Kisker Road
St. Charles, MO 63304
**833-942-2153**

**SSM Health DePaul Hospital Campus**
12255 DePaul Drive, 1B
Bridgeton, MO 63044
**833-942-2153**



# Discover the WellFirst Health — Provided by SSM Health Plan — Advantage

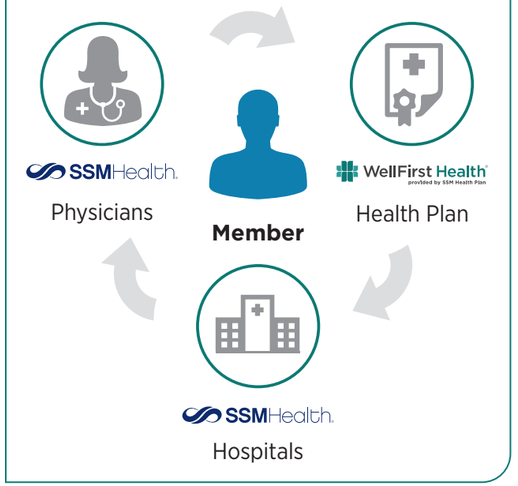
WellFirst Health — Provided by SSM Health Plan — is a trusted partner there to support you on your health care journey. We provide the care you know and trust from SSM Health, along with affordable coverage.

**Our Coordinated Care Network** is a true collaboration between health care experts, hospital partners and your health plan, leading to a more streamlined and simpler experience for members.

**Local:** Our roots are local. Our health plan employees are your friends and neighbors. You'll find your primary care provider just down the road.

**Caring:** Community is important to us. Our employees participate in a variety of volunteer efforts throughout the year to make local life a little better for everyone.

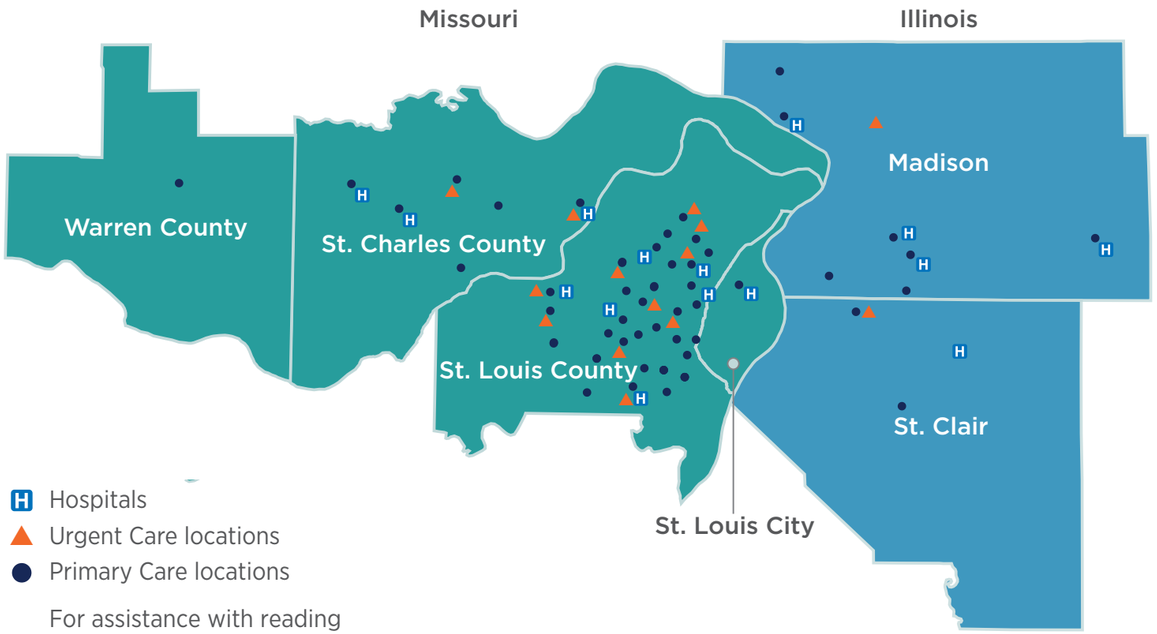
**Premier Benefits:** Our plans offer a suite of premier benefits to give you a Medicare plan that covers your health needs, including dental, over-the-counter benefit and more.



# WellFirst Health — Provided by SSM Health Plan — Service Area

**The health plan service area is Madison, St. Clair County, IL and St. Charles, St. Louis, Warren County and St. Louis City, MO. You must live in one of these areas to join a WellFirst Health — Provided by SSM Health Plan — Medicare Advantage plan.**


One plan. **One strong network.**




- Hospitals
- Urgent Care locations
- Primary Care locations

For assistance with reading this map or questions about provider locations, plesase call **877-301-3326 (TTY: 711)**.

*Providers are subject to change.*

# Medicare Eligibility and Enrollment Periods

## Who's Eligible For Medicare?

You are eligible for Medicare, the federal health insurance program, if you are a legal U.S. resident and one of the following applies to you:

- You are 65 years old or older
- You are any age and have a qualifying permanent disability
- You are any age and have been diagnosed with end-stage renal disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS, also called Lou Gehrig's disease)

## Medicare Advantage Enrollment Periods

IEP

**Initial Enrollment Period (IEP)**
**This is the seven-month period** during which you may enroll in Medicare for the first time. This includes the three months prior, the month of your birthday and the three months after. If you are enrolling for the first time due to disability, your IEP timing is based on your disability date.

**Your Initial Enrollment Period**
You can enroll before you turn 65, but your coverage may not be effective before your 65th birthday. For your Initial Enrollment Period the earliest effective date can be the first day of the month you turn 65. If you are born on the first of the month, coverage can begin the first of the month before.

If you enroll within the three months after you turn 65, your effective date will be the first day of the next month.

AEP

**Annual Enrollment Period (AEP)**
**Oct. 15–Dec. 7** of every year is the period during which you may make changes to your Medicare Advantage coverage. Your coverage will become effective January 1.

OEP

**Open Enrollment Period (OEP)**
**Jan. 1 – Mar. 31** of every year is the period during which you may switch from one Medicare Advantage plan to another Medicare Advantage plan, or cancel your Medicare Advantage plan and return to Original Medicare.

SEP

**Special Enrollment Period (SEP)**
This is a period during which Medicare recipients may change Medicare Advantage coverage outside of the AEP, if they **meet certain requirements and have a qualifying event**, such as moving to a new service area or leaving an employer-based plan.

# Extra Benefits Not Covered by Original Medicare

**WellFirst Health — Provided by SSM Health Plan — is dedicated to our members' well-being. The benefits listed below are included in all of our Medicare plans.**

**Learn more at...**

Find more information about our extra benefits at **wellfirsthealth.com/extrabenefits23**

### Over-the-Counter

Your over-the-counter benefit includes $60 per quarter to spend on eligible over-the-counter products like bandages, pain relievers and much more.

You can shop:

- In-store at participating retailers including Walgreens, CVS, Walmart and Dollar General stores
- Order online or over the phone
- Mail-order catalog

### In-Home Support from Papa

We partnered with Papa, a company that connects you with screened and trained Papa Pals who provide assistance with organization, light housework, technology and transportation. Your Pal can visit with you in your home or virtually for up to 120 hours per year.

### Dental / Vision / Hearing

Please see page 9 for benefit information.

### Chiropractic Care

We cover additional chiropractic benefits to help you stay healthy and active.

### Transportation

We partnered with Lyft to cover 24 one-way personal rides each year to medical appointments and to the pharmacy.

### Post-Discharge Meals

We cover 14 meals from Mom's Meals delivered to your door after you are discharged from the hospital or a skilled nursing facility.

### Fitness

The One Pass™ program includes:

- Fitness center memberships
- Home fitness kit
- On-demand fitness videos

### Nurse Line

Experienced registered nurses are always available to answer your questions and concerns. Nurses are available 24 hours a day, 365 days a year. Call if you're unsure if you need to see a doctor, or if you have other health related questions.

### Living Healthy Rewards

You can earn up to $150 in rewards for completing healthy activities like receiving a flu shot, going to the dentist and getting an annual physical.

# $0 Benefits

**All of our plans include many benefits at no cost to you.**

# Diabetic Benefits

**WellFirst Health — Provided by SSM Health Plan — understands the special needs of individuals with diabetes. Our Medicare Advantage plans offer specific benefits geared toward those needs.**

# Additional Savings

**Make our additional savings work for you.**

### $0 Benefits

- All Primary Care Visits: In-person and Telehealth
- Routine Vision and Hearing Exams
- Meals Post-Discharge
- Transportation
- In-Home Support
- Dental Exams, Cleanings and X-Ray
- Vaccines
- Mammograms and Pelvic Exams
- Prostate Cancer Screening
- Preventive Colonoscopy Screening
- Diabetes Screenings, Testing Supplies and Self-Management Training
- E-Visit For Eligible Conditions
- Three-month Fill at a Mail Order Pharmacy for Tier 1 and Tier 2 Drugs

### Diabetic Benefits:

- $30 Insulin Fills at Preferred Pharmacy Locations
- $35 Insulin Fills at Standard Retail Pharmacies
- $0 Continuous Glucose Monitors
- $0 PCP
- $0 Diabetic Testing and Insulin Supplies
- 20% Coinsurance for Insulin Pumps
- Two Additional Dental Cleanings Per Year
- Over-the-Counter Benefit Includes Coverage for Products Like Diabetic Socks and Glucose Tablets

| | SSM Integrity (HMO-POS) | SSM FlexSpend (HMO-POS) | SSM Harmony (HMO-POS) MA-Only |
|---|---|---|---|
| **Part B Premium Reduction**<br>We lower the Part B premium you pay - giving you money back into your Social Security check | **$35** monthly | Not Included | **$50** monthly |
| **FlexSpend Benefit**<br>Prepaid allowance on your WellFirst Wallet Card to be used towards additional dental services, vision services, eyewear, hearing services and hearing aids. Your FlexSpend benefit can be spent at any free-standing dental, vision or hearing facility. You are not restricted to in-network providers. | Not Included | **$500** yearly | |
| **Dental**<br>We partnered with Delta Dental to provide you dental benefits with no waiting periods or deductibles | **$1000 of dental** services per year<br>• Preventive and diagnostic services: **$0 copay**<br>• Comprehensive services: **50% coinsurance** | **$1000 of dental** services per year<br>• Preventive and diagnostic services: **$0 copay**<br>• Comprehensive services: **50% coinsurance**<br>**+ FlexSpend Benefit** | |
| **Eyeglasses**<br>Eyeglasses, frames, lenses or contact lenses from a freestanding vision center | Not Included | **FlexSpend Benefit** | |
| **Hearing Aids**<br>Hearing aids when purchased from an in-network hearing aid provider | $750 In-Network Only | **$750** In-Network Only<br>**+ FlexSpend Benefit** | **$750** In-Network Only<br>**+ FlexSpend Benefit** |

# Plan Options

**Choose the plan that is right for you.**
**SSM Integrity (HMO-POS)**
**SSM FlexSpend (HMO-POS)**
**SSM Harmony (HMO-POS) MA-Only**

| Cost Sharing at a Glance | | SSM Integrity (HMO-POS) | SSM FlexSpend (HMO-POS) | SSM Harmony (HMO-POS) MA-Only |
|---|---|---|---|---|
| **Maximum Out-of-Pocket** | In-Network | $2,500 | $2,750 | $3,250 |
| | Out-of-Network | $5,000 | $5,000 | $10,000 |
| **Hospital Copay per Day; Days 1-7** | In-Network | $325 | $325 | $325 |
| | Out-of-Network | $500 | $500 | $750 |
| **Primary Care** | In-Network | $0 | $0 | $0 |
| | Out-of-Network | $50 | $50 | $75 |
| **Specialist** | In-Network | $35 | $35 | $35 |
| | Out-of-Network | $50 | $50 | $75 |
| **Emergency Room** | In- and Out-of-Network | $100 | $100 | $125 |
| **Urgent Care** | In- and Out-of-Network | $35 | $35 | $35 |
| **Ambulance** | In- and Out-of-Network | $300 | $300 | $300 |
| **Therapy: Physical, Occupational, Speech** | In-Network | $35 | $35 | $40 |
| | Out-of-Network | $60 | $60 | $75 |
| **Outpatient Surgery** | In-Network | $300 | $300 | $300 |
| | Out-of-Network | 40% | 40% | 40% |

See Summary of Benefits for additional plan details.

# Part D Prescription Drug Coverage

**SSM Integrity and SSM FlexSpend** provide comprehensive prescription drug coverage. Our drug formulary covers a wide-ranging list of generic, brand name and specialty drugs, with manageable copays and no deductibles.

**Members save money by filling prescriptions in our preferred retail pharmacy network and through our mail order pharmacy.**

- All SSM Pharmacies, Walgreens, Walmart and select community pharmacies, such as Medicine Shoppe
- Costco retail and mail order pharmacies – no Costco membership required
- **$0 100-day fills at a mail order pharmacy for Tier 1 and Tier 2 drugs**

**Members have access to standard retail pharmacy network that includes:**

- Most national pharmacy chains including CVS
- Many retail and grocery store pharmacies
- Many independent, local community pharmacies

## Maintenance Drugs Savings

**Save time and money by purchasing a three-month supply of maintenance drugs** in one transaction via the Costco mail-order pharmacy.

## $0 Part D Vaccines

You pay $0 in all stages for all covered Part D vaccines – including Shingles and Tdap. These $0 vaccines are listed in our formulary as Tier 6.

## Insulin Savings

You will pay a $30 copay per fill at a preferred pharmacy or a $35 copay per fill at a standard pharmacy. These savings apply through the deductible and copay stages and the donut hole.

WellFirst Health's — Provided by SSM Health Plan — Drug Formulary and Pharmacy Directory are available at **wellfirsthealth.com/medicaremember**

**SSM Integrity** (HMO-POS)
**SSM FlexSpend** (HMO-POS)

## Part D Prescription Drug Coverage at a Glance

| | | | | | |
|---|---|---|---|---|---|
| **Stage 1: Initial Coverage Deductible You pay:** | **No Part D Deductible** | | | | |
| **Stage 2: Initial Coverage Copay and Coinsurance You pay:** | | **1 Month/30 Day** | | **3 Month/100 Day** | |
| | | **Preferred Retail and Mail Order** | **Standard Retail** | **Mail Order** | **Preferred Retail** | **Standard Retail** |
| | **Tier 1** | $2 | $7 | $0 | $2 | $7 |
| | **Tier 2** | $8 | $13 | $0 | $16 | $26 |
| | **Tier 3** | $42 | $47 | $117.50 | $117.50 | $130 |
| | **Tier 4** | $95 | $100 | $285 | $285 | $300 |
| | **Tier 5** | 33% | 33% | Not applicable | Not applicable | Not applicable |
| **Stage 3: Coverage Gap (Donut Hole) You pay:** | **25% coinsurance** | | | | |
| **Stage 4: Catastrophic Coverage You pay:** | Generic: 5% or $4.15<br>Brand: 5% or $10.35 | | | | |
| *Drug dispensing fees may apply.* | | | | | |

**SSM Harmony** (HMO-POS) MA-Only

SSM Harmony does not offer Part D Prescription Drug coverage. This is an excellent choice if you already have prescription drug coverage through a State Prescription Drug Assistance Program, TRICARE for Life, the VA or an employer plan. You cannot have a Medicare Part D Prescription Drug plan if you enroll in the SSM Harmony plan.

## Stages of Part D Coverage

| | |
|---|---|
| **Stage 1: Initial Coverage Deductible** | Plans from WellFirst Health — Provided by SSM Health Plan — do not have a drug deductible. Our plans begin in Stage 2 |
| **Stage 2: Initial Coverage Copay and Coinsurance** | You pay copays or a percentage of the drug's total cost (coinsurance)<br>You stay in this stage until you and WellFirst Health — Provided by SSM Health Plan — have paid $4,660 within a plan year |
| **Stage 3: Coverage Gap (Donut Hole)** | Once your total drug costs reach $4,660 you pay 25% of the cost of the drug<br>You stay in this stage until your total out-of-pocket costs reaches $7,400 (not counting the amount that WellFirst Health — Provided by SSM Health Plan — has also paid) within a plan year |
| **Stage 4: Catastrophic Coverage** | After your total out-of-pocket costs reach $7,400 you pay a small copay or 5% coinsurance, whichever amount is larger<br>You stay in this stage for the remainder of the plan year |



# Summary of Benefits Plan Year 2023

**SSM Integrity (HMO-POS)**
**SSM FlexSpend (HMO-POS)**
**SSM Harmony (HMO-POS) MA-Only**

**January 1, 2023 – December 31, 2023**
This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. See the Evidence of Coverage to get a complete list of services we cover. The Evidence of Coverage is available to view on wellfirsthealth.com/medicaremember. You can also request a printed copy of any of these materials by calling our Customer Care Center.

If you want to know more about the coverage and costs of Original Medicare, look in the current "Medicare & You" handbook. View it online at 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.

Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year. You must continue to pay your Part B premium.

This document is available in other formats such as Braille and large print. This document may be available in a non-English language. For additional information, call us at 1-877-301-3326 (TTY: 711).

SSM Health Plan is an HMO/HMO-POS with a Medicare contract. Enrollment in SSM Health Plan depends on contract renewal. SSM Health Plan markets under the name WellFirst Health.

**Hours of Operation**

- From October 1 to March 31, you can call us 7 days a week from 8 am – 8 pm Central time.
- From April 1 to September 30, you can call us Monday through Friday from 8 am – 8 pm Central time.

**Phone Numbers and Website**

- If you are a member of this plan, call toll-free 1-877-301-3326 (TTY: 711).
- If you are not a member of this plan, call toll-free 1-833-551-0565 (TTY: 711).
- Our website: wellfirsthealth.com/medicare

**Who can join?**

To join a Medicare Advantage plan, you must be enrolled in Medicare Part A and Medicare Part B and live in our service area.

**What is the Service Area?**

Our service area includes the following:
**St. Charles County (MO), St. Louis City (MO), St Louis County (MO), Warren (MO), St. Claire (IL), Madison (IL)**

**Which doctors, hospitals and pharmacies can I use?**

We have a network of doctors, hospitals, pharmacies and other providers. For some services you can use providers that are not in our network.

- Provider directory website: wellfirsthealth.com/doctors
- Pharmacy directory website: wellfirsthealth.com/medicaremember

## Monthly Premium, Deductibles, and Limits on How Much You Pay for Covered Services

| | SSM Integrity (HMO-POS) | SSM FlexSpend (HMO-POS) | SSM Harmony (HMO-POS) |
|---|---|---|---|
| **Monthly Premium**<br>You must continue to pay your Medicare Part B premium | **$0** | **$0** | **$0** |
| **Part B Buy Back**<br>WellFirst Health provides a credit that will automatically be applied towards your Medicare Part B premium | $35 | Not Applicable | $50 |
| **Medical Deductible** | Not Applicable | Not Applicable | Not Applicable |
| **Maximum Out-of-Pocket Responsibility**<br>If you reach the limit on out-of-pocket costs, you will keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.<br>(Does not include prescription drugs) | $2,500 for in-network services<br>$5,000 for in-network and out-of-network services combined | $2,750 for in-network services<br>$5,000 for in-network and out-of-network services combined | $3,250 for in-network services<br>$10,000 for in-network and out-of-network services combined |

# Covered Medical and Hospital Benefits

*Benefit may require prior authorization

| | SSM Integrity (HMO-POS) | | SSM FlexSpend (HMO-POS) | | SSM Harmony (HMO-POS) | |
|---|---|---|---|---|---|---|
| | In Network | Out-of-Network | In Network | Out-of-Network | In Network | Out-of-Network |
| **Inpatient Hospital Coverage*** For Medicare-covered stays | $325 copay each day for days 1 - 7<br>$0 each day for days 8 to discharge | $500 copay each day for days 1 - 7<br>$0 each day for days 8 to discharge | $325 copay each day for days 1 - 7<br>$0 each day for days 8 to discharge | $500 copay each day for days 1 - 7<br>$0 each day for days 8 to discharge | $325 copay each day for days 1 - 7<br>$0 each day for days 8 to discharge | $750 copay each day for days 1 - 7<br>$0 each day for days 8 to discharge |
| **Outpatient Hospital Coverage*** | | | | | | |
| Outpatient Hospital: | $300 copay | 40% coinsurance | $300 copay | 40% coinsurance | $300 copay | 40% coinsurance |
| Ambulatory Surgery Center: | $175 copay | 40% coinsurance | $200 copay | 40% coinsurance | $200 copay | 40% coinsurance |
| Procedure performed during office visit: | $0 - $35 copay | $50 - $50 copay | $0 - $35 copay | $50 - $50 copay | $0 - $35 copay | $75 - $75 copay |
| **Doctor Visits** | | | | | | |
| Primary Care Providers: | $0 copay | $50 copay | $0 copay | $50 copay | $0 copay | $75 copay |
| Specialists: | $35 copay | $50 copay | $35 copay | $50 copay | $35 copay | $75 copay |
| Palliative Care: | $0 copay | $0 copay | $0 copay | $0 copay | $0 copay | $0 copay |
| **Preventive Care** | $0 copay | $30 copay | $0 copay | $30 copay | $0 copay | $30 copay |
| **Emergency Care** In the U.S.<br>(Waived if admitted) | $100 copay | $100 copay | $100 copay | $100 copay | $125 copay | $125 copay |
| **Urgently Needed Services** In the U.S. | $35 copay<br>Your cost may be reduced based on level of treating provider | $35 copay | $35 copay<br>Your cost may be reduced based on level of treating provider | $35 copay | $35 copay<br>Your cost may be reduced based on level of treating provider | $35 copay |

| | SSM Integrity (HMO-POS) | | SSM FlexSpend (HMO-POS) | | SSM Harmony (HMO-POS) | |
|---|---|---|---|---|---|---|
| | In Network | Out-of-Network | In Network | Out-of-Network | In Network | Out-of-Network |
| **Diagnostic Services / Labs / Imaging*** | | | | | | |
| Outpatient X-ray: | $20 copay | 40% coinsurance | $20 copay | 40% coinsurance | $10 copay | 40% coinsurance |
| Laboratory Tests: | $0 copay | 20% coinsurance | $0 copay | 20% coinsurance | $0 copay | 40% coinsurance |
| Radiation Therapy: | $65 copay | 40% coinsurance | 20% coinsurance | 40% coinsurance | $65 copay | 40% coinsurance |
| Diagnostic Procedures/Tests: | $10 copay | 20% coinsurance | $10 copay | 20% coinsurance | $15 copay | 40% coinsurance |
| Diagnostic Mammograms: | $0 copay | 40% coinsurance | $0 copay | 40% coinsurance | $0 copay | 40% coinsurance |
| Diagnostic Radiology: | $120 copay | 40% coinsurance | $120 copay | 40% coinsurance | $120 copay | 40% coinsurance |
| **Hearing Services** Medicare-covered-exam to diagnose and treat hearing and balance issues: | $35 copay | $60 copay | $35 copay | $60 copay | $35 copay | $75 copay |

| | SSM Integrity (HMO-POS) | | SSM FlexSpend (HMO-POS) | | SSM Harmony (HMO-POS) | |
|---|---|---|---|---|---|---|
| | In Network | Out-of-Network | In Network | Out-of-Network | In Network | Out-of-Network |
| Routine hearing exam: | $0 copay per exam for 1 exam every calendar year | Not Covered | $0 copay per exam for 1 exam every calendar year | Not Covered | $0 copay per exam for 1 exam every calendar year | Not Covered |
| Hearing aid fitting / evaluation: | $0 copay per fitting for 1 fitting every calendar year | Not Covered | $0 copay per fitting for 1 fitting every calendar year | Not Covered | $0 copay per fitting for 1 fitting every calendar year | Not Covered |
| Hearing aid allowance: | $0 copay<br><br>Our plan pays up to $750 both ears combined every calendar year for hearing aids<br><br>You are responsible for costs beyond the plan limit | Not Covered | $0 copay<br><br>Our plan pays up to $750 both ears combined every calendar year for hearing aids<br><br>Additional allowance included in FlexSpend benefit<br><br>You are responsible for costs beyond the plan limit | Included in FlexSpend benefit | $0 copay<br><br>Our plan pays up to $750 both ears combined every calendar year for hearing aids<br><br>Additional allowance included in FlexSpend benefit<br><br>You are responsible for costs beyond the plan limit | Included in FlexSpend benefit |

| | SSM Integrity (HMO-POS) | | SSM FlexSpend (HMO-POS) | | SSM Harmony (HMO-POS) | |
|---|---|---|---|---|---|---|
| | In Network | Out-of-Network | In Network | Out-of-Network | In Network | Out-of-Network |
| **Preventive Dental** | | | | | | |
| Preventive Exams: | $0 copay per visit for 2 visits every calendar year | $0 copay per visit for 2 visits every calendar year | $0 copay per visit for 2 visits every calendar year | $0 copay per visit for 2 visits every calendar year | $0 copay per visit for 2 visits every calendar year | $0 copay per visit for 2 visits every calendar year |
| Cleanings: | $0 copay per visit for 2 visits every calendar year | $0 copay per visit for 2 visits every calendar year | $0 copay per visit for 2 visits every calendar year | $0 copay per visit for 2 visits every calendar year | $0 copay per visit for 2 visits every calendar year | $0 copay per visit for 2 visits every calendar year |
| X-Ray: | $0 copay per visit for 1 visit every calendar year | $0 copay per visit for 1 visit every calendar year | $0 copay per visit for 1 visit every calendar year | $0 copay per visit for 1 visit every calendar year | $0 copay per visit for 1 visit every calendar year | $0 copay per visit for 1 visit every calendar year |
| **Comprehensive Dental** | | | | | | |
| Diagnostic services: | 0% coinsurance | 50% coinsurance | 0% coinsurance | 50% coinsurance | 0% coinsurance | 50% coinsurance |
| Gum disease maintenance and bridge/implants/dentures repairs: | 50% coinsurance | 50% coinsurance | 50% coinsurance | 50% coinsurance | 50% coinsurance | 50% coinsurance |
| Fillings, gum disease treatment, and extractions: | 50% coinsurance | 50% coinsurance | 50% coinsurance | 50% coinsurance | 50% coinsurance | 50% coinsurance |
| Root canals, bridges, implants, dentures, and crowns: | 50% coinsurance | 50% coinsurance | 50% coinsurance | 50% coinsurance | 50% coinsurance | 50% coinsurance |
| **Dental Maximum** Annual limit that WellFirst Health will pay for preventive and comprehensive dental services<br><br>You are responsible for costs beyond the plan limit | $1,000 every calendar year for dental services | | $1,000 every calendar year for dental services<br><br>Additional allowance included in FlexSpend benefit | | $1,000 every calendar year for dental services<br><br>Additional allowance included in FlexSpend benefit | |

| | SSM Integrity (HMO-POS) | | SSM FlexSpend (HMO-POS) | | SSM Harmony (HMO-POS) | |
|---|---|---|---|---|---|---|
| | In Network | Out-of-Network | In Network | Out-of-Network | In Network | Out-of-Network |
| **Vision Services**<br>Medicare-covered exam to treat to diagnose and treat diseases and conditions of the eye: | $35 copay | $60 copay | $35 copay | $60 copay | $35 copay | $75 copay |
| Medicare-covered eyewear after cataract surgery: | $0 copay | Not Covered | $0 copay | Not Covered | $0 copay | Not Covered |
| Routine eye exam: | $0 copay per exam for 1 exam every calendar year | Not Covered | $0 copay per exam for 1 exam every calendar year | Not Covered | $0 copay per exam for 1 exam every calendar year | Not Covered |
| Eyewear: (eyeglasses, frames, lenses or contact lenses) | Not Covered | Not Covered | Included in FlexSpend benefit | Included in FlexSpend benefit | Included in FlexSpend benefit | Included in FlexSpend benefit |
| **Mental Health Services: Hospital Care***<br>For Medicare-covered stays | $325 copay each day for days 1 - 7<br>$0 each day for days 8 - 90 | $500 copay each day for days 1 - 7<br>$0 each day for days 8 - 90 | $325 copay each day for days 1 - 7<br>$0 each day for days 8 - 90 | $500 copay each day for days 1 - 7<br>$0 each day for days 8 - 90 | $325 copay each day for days 1 - 7<br>$0 each day for days 8 - 90 | $750 copay each day for days 1 - 7<br>$0 each day for days 8 - 90 |
| **Mental Health Services: Outpatient Care*** | | | | | | |
| Outpatient Individual Therapy: | $0 copay | $30 copay | $0 copay | $30 copay | $0 copay | $75 copay |
| Outpatient Group Therapy: | $0 copay | $30 copay | $0 copay | $30 copay | $0 copay | $75 copay |
| **Skilled Nursing Facility***<br>Our plan covers up to 100 day per benefit period in a SNF:<br>A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row | $0 each day for days 1 - 20<br>$196 each day for days 21 - 100 | $150 each day for days 1 - 100 | $0 each day for days 1 - 20<br>$196 each day for days 21 - 100 | $150 each day for days 1 - 100 | $0 each day for days 1 - 20<br>$196 each day for days 21 - 100 | $150 each day for days 1 - 100 |
| **Therapy***<br>Outpatient physical therapy, speech language pathology, and occupational therapy: | $35 copay per visit | $60 copay per visit | $35 copay per visit | $60 copay per visit | $40 copay per visit | $75 copay per visit |
| **Ambulance**<br>For each one-way Medicare-covered trip | $300 copay | $300 copay | $300 copay | $300 copay | $300 copay | $300 copay |
| **Transportation**<br>For rides to medical appointments | $0 copay per ride for 24 one-way rides every calendar year | Not Covered | $0 copay per ride for 24 one-way rides every calendar year | Not Covered | $0 copay per ride for 24 one-way rides every calendar year | Not Covered |

| | SSM Integrity (HMO-POS) | | SSM FlexSpend (HMO-POS) | | SSM Harmony (HMO-POS) | |
|---|---|---|---|---|---|---|
| | In Network | Out-of-Network | In Network | Out-of-Network | In Network | Out-of-Network |
| **Medicare Part B Drugs*** | | | | | | |
| Part B Drugs: | 20% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance |
| Part B prescription drugs received in the pharmacy: | | | | | | |
| Beneficiary coinsurance for certain Part B rebatable drugs may be subject to a lower coinsurance beginning on April 1, 2023. | $2 copay - $47 copay | 20% coinsurance | $2 copay - $47 copay | 20% coinsurance | $2 copay - $47 copay | 20% coinsurance |
| For Part B insulin furnished through an insulin pump, you will pay no more than a $35 copay for a one-month supply, effective July 1, 2023. | | | | | | |

## Medicare Part D Prescription Drug Coverage

| | SSM Integrity (HMO-POS) | SSM FlexSpend (HMO-POS) | SSM Harmony (HMO-POS) |
|---|---|---|---|
| **Part D Deductible** | $0 | $0 | Not Covered |
| **PREFERRED RETAIL 30 day supply** | | | |
| Tier 1 Preferred Generic | $2 copay | $2 copay | Not Covered |
| Tier 2 Generic | $8 copay | $8 copay | Not Covered |
| Tier 3 Preferred Brand | $42 copay | $42 copay | Not Covered |
| Tier 4 Non-Preferred Drugs | $95 copay | $95 copay | Not Covered |
| Tier 5 Specialty Drugs | 33% coinsurance | 33% coinsurance | Not Covered |
| Tier 6 Part D Vaccines | $0 copay | $0 copay | Not Covered |
| **STANDARD RETAIL 30 day supply** | | | |
| Tier 1 Preferred Generic | $7 copay | $7 copay | Not Covered |
| Tier 2 Generic | $13 copay | $13 copay | Not Covered |
| Tier 3 Preferred Brand | $47 copay | $47 copay | Not Covered |
| Tier 4 Non-Preferred Drugs | $100 copay | $100 copay | Not Covered |
| Tier 5 Specialty Drugs | 33% coinsurance | 33% coinsurance | Not Covered |
| Tier 6 Part D Vaccines | $0 copay | $0 copay | Not Covered |
| **LONG TERM CARE 31 day supply** | See Standard Retail Pharmacy (30 Day) | | Not Covered |
| **OUT-OF-NETWORK 29 day supply** | See Standard Retail Pharmacy (30 Day) | | Not Covered |
| **PREFERRED RETAIL 100 day supply** | | | |
| Tier 1 Preferred Generic | $2 copay | $2 copay | Not Covered |
| Tier 2 Generic | $16 copay | $16 copay | Not Covered |
| Tier 3 Preferred Brand | $117.50 copay | $117.50 copay | Not Covered |

| | SSM Integrity (HMO-POS) | SSM FlexSpend (HMO-POS) | SSM Harmony (HMO-POS) |
|---|---|---|---|
| Tier 4 Non-Preferred Drugs | $285 copay | $285 copay | Not Covered |
| Tier 5 Specialty Drugs | Not Applicable | Not Applicable | Not Covered |
| Tier 6 Part D Vaccines) | Not Applicable | Not Applicable | Not Covered |
| **STANDARD RETAIL 100 day supply** | | | |
| Tier 1 Preferred Generic | $7 copay | $7 copay | Not Covered |
| Tier 2 Generic | $26 copay | $26 copay | Not Covered |
| Tier 3 Preferred Brand | $130 copay | $130 copay | Not Covered |
| Tier 4 Non-Preferred Drugs | $300 copay | $300 copay | Not Covered |
| Tier 5 Specialty Drugs | Not Applicable | Not Applicable | Not Covered |
| Tier 6 Part D Vaccines | Not Applicable | Not Applicable | Not Covered |
| **Part D Coverage Stages** | | | |
| **Stage 1 Deductible** | There is no deductible. You begin in the initial coverage stage. | There is no deductible. You begin in the initial coverage stage. | Not Covered |
| **Stage 2 Initial Coverage** | You pay copays or coinsurance, and we pay the remainder until together our spending reaches **$4,660** | You pay copays or coinsurance, and we pay the remainder until together our spending reaches **$4,660** | Not Covered |
| **Stage 3 Coverage Gap** | Above **$4,660** , you pay 25% of the cost for generics and brand drugs until your expenses reach **$7,400** | Above **$4,660** , you pay 25% of the cost for generics and brand drugs until your expenses reach **$7,400** | Not Covered |
| **Stage 4 Catastrophic** | Above **$7,400** you pay the greater of **5%** or **$4.15** for generics and **$10.35** for all other drugs and we pay the remainder | Above **$7,400** you pay the greater of **5%** or **$4.15** for generics and **$10.35** for all other drugs and we pay the remainder | Not Covered |

| | SSM Integrity (HMO-POS) | SSM FlexSpend (HMO-POS) | SSM Harmony (HMO-POS) |
|---|---|---|---|
| **Tier 1 Gap Coverage** | You will continue to pay Initial Coverage Stage cost-sharing for Tier 1 drugs until you reach the Catastrophic Stage. | | Not Covered |
| **100 day fills at mail order pharmacies** | $0 Tier 1 and Tier 2 three-month supplies through Costco mail-order pharmacy. You do not need to be a Costco member to access the pharmacy | | Not Covered |

## Additional Benefits

| | SSM Integrity (HMO-POS) | | SSM FlexSpend (HMO-POS) | | SSM Harmony (HMO-POS) | |
|---|---|---|---|---|---|---|
| | In Network | Out-of-Network | In Network | Out-of-Network | In Network | Out-of-Network |
| **FlexSpend Benefit**<br>Allowance on a prepaid debit card to spend on dental services, vision services, eyewear, hearing services and hearing aids<br><br>You can use your FlexSpend allowance at:<br>• In-network and out-of-network dental offices<br>• In-network eyeglass locations and freestanding vision centers<br>• In-network hearing aid locations and freestanding hearing centers | Not Covered | Not Covered | $500 yearly | | $500 yearly | |
| **In-Home Support**<br>We partnered with Papa, a company that connects you with screened and trained Papa Pals who provide assistance with organization, light housework, technology and transportation. | $0 copay per visit for 120 visits yearly | Not Covered | $0 copay per visit for 120 visits yearly | Not Covered | $0 copay per visit for 120 visits yearly | Not Covered |
| **Over-the-Counter Allowance for Health and Wellness Products**<br>Shop online, in-store, or by catalog. | $60 quarterly allowance | Not Covered | $60 quarterly allowance | Not Covered | $60 quarterly allowance | Not Covered |
| **Post Discharge Meals**<br>Mom's Meals delivered to your door after you are discharged from the hospital or a skilled nursing facility. | Two meals per day for 7 days after an inpatient stay at no cost to you | Not Covered | Two meals per day for 7 days after an inpatient stay at no cost to you | Not Covered | Two meals per day for 7 days after an inpatient stay at no cost to you | Not Covered |

| | SSM Integrity (HMO-POS) | | SSM FlexSpend (HMO-POS) | | SSM Harmony (HMO-POS) | |
|---|---|---|---|---|---|---|
| | In Network | Out-of-Network | In Network | Out-of-Network | In Network | Out-of-Network |
| **Fitness Benefit**<br>One Pass™ Fitness Program | $0 copay | Not Covered | $0 copay | Not Covered | $0 copay | Not Covered |
| **Routine Chiropractic** | $20 copay for an additional 12 routine chiropractic visits every calendar year | $50 copay for an additional combined 12 routine chiropractic visits every calendar year | $20 copay for an additional 12 routine chiropractic visits every calendar year | $50 copay for an additional combined 12 routine chiropractic visits every calendar year | $0 copay for an additional 12 routine chiropractic visits every calendar year | $75 copay for an additional combined 12 routine chiropractic visits every calendar year |
| **Living Healthy**<br>Rewards for completing healthy activities like receiving a flu shot, going to the dentist and getting an annual physical | $150 every calendar year | Not Applicable | $150 every calendar year | Not Applicable | $150 every calendar year | Not Applicable |
| **Worldwide Emergency and Urgent Care**<br>Outside the US | $100 copay<br><br>No Limit | $100 copay<br><br>No Limit | $100 copay<br><br>No Limit | $100 copay<br><br>No Limit | $125 copay<br><br>No Limit | $125 copay<br><br>No Limit |
| **Nurse Line**<br>Nurses are available 24 hours a day, 365 days a year. | $0 copay | Not Covered | $0 copay | Not Covered | $0 copay | Not Covered |
| **Virtual Visits**<br>See conditions treated and complete an online health interview at wellfirsthealth.com/virtualvisit. | $0 copay | Not Covered | $0 copay | Not Covered | $0 copay | Not Covered |
| **Smoking and tobacco use cessation – Quit for Life Program**<br>This supplemental program is designed to help you overcome physical, psychological, and behavioral addictions using a seamlessly integrated mix of medication, one-on-one coaching, group video sessions and digital tools for support. | $0 copay | Not Covered | $0 copay | Not Covered | $0 copay | Not Covered |

SSM Health Plan is an HMO/HMO-POS with a Medicare contract. Enrollment in SSM Health Plan depends on contract renewal. SSM Health Plan markets under the name WellFirst Health. This information is not a complete description of benefits. Call **833-942-2153 (TTY: 711)** for more information. You must continue to pay your Medicare Part B premium.



WellFirst Health®
provided by SSM Health Plan

WellFirst Health — Provided by SSM Health Plan | 12312 Olive Blvd. | St. Louis, MO 63141
877-301-3326 (TTY: 711) | wellfirsthealth.com

## Non-Discrimination & Language Assistance Access

For assistance understanding these materials in a language other than English, call 1-877-317-2410 (TTY: 711), and a Customer Care Center representative will assist you.

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, or religion. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, or religion.

We provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, or other formats).

We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, or religion, you can file a grievance with the organization's Civil Rights Coordinator. If you need help filing a grievance, the Civil Rights Coordinator for the Health Plan is available to help you. You can file a written grievance in person, by mail, or by email at:

Civil Rights Coordinator
1277 Deming Way
Madison, Wisconsin 53717
1-608-828-2216 (TTY: 711)
civilrightscoordinator@deancare.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, by mail, or phone at:
U.S. Department of Health and Human Services
200 Independence Ave, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 or 1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

**For help to translate or understand this or other documents, please call 1-877-317-2410 (TTY: 711).**

**Español**: tenemos servicios gratuitos de interpretación para responder a cualquier consulta sobre nuestro plan de atención médica o de cobertura de medicamentos. Para solicitar un intérprete, llame al 1-877-317-2410 (TTY:711). Un hablante de español puede ayudarle. Este servicio es gratuito.

**Somali-** Waxaan bixinaa adeegyada bilaashka ah si looga jawaabo su'aalo kasta ood ka qabi karto caymiskaaga caafimaadka ama daawada. Si aad u hesho turjumaan, keliya nagasoo wac 1-877-317-2410 (TTY: 711), Qof ku hadla luuqada af-Soomaaliga ayaa ku caawin kara. Kani waa adeeg bilaash ah.

**Tagalog-** Mayroon kaming mga libreng serbisyo ng interpreter para sagutin ang anumang tanong na maaaring mayroon ka tungkol sa aming plano sa kalusugan o gamot. Para makakuha ng interpreter, tumawag lamang sa amin sa 1-877-317-2410 (TTY: 711). Matutulungan ka ng isang taong nagsasalita ng Tagalog. Isa itong libreng serbisyo.

**Gujarati-** અમારી સ્વાસ્થ્ય કે દવા યોજના વિશે જો આપને કોઈ પ્રશ્ન હોય તો તેનો જવાબ આપવા અમારી પાસે મફત દુભાષિયા સેવા ઉપલબ્ધ છે. ગુજરાતી બોલીને આપને મદદ કરી શકે એવો દુભાષિયો મેળવવા માટે, માત્ર અમને 1-877-317-2410 (TTY: 711) પર કોલ કરો. આ મફત સેવા છે.

**Hindi-** हमारे पास हमारे स्वास्थ्य या औषधि योजना से संबंधित आपके किसी भी प्रश्न का उत्तर देने के लिए नि:शुल्क दुभाषिया सेवाएं हैं। दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-317-2410 (TTY: 711)

पर कॉल करें, कोई व्यक्ति जो हिंदी बोलता है, आपकी मदद कर सकता है। यह एक निःशुल्क सेवा है।

**Hmong-** Peb muaj cov kws txhais lus dawb los teb txhua nqi lus nug uas koj muaj hais txog peb li phiaj xwm kho mob los sis tshuaj muaj yees. Txhawm rau muaj tus kws pab txhais lus, thov hu rau peb tus xov tooj 1-877-317-2410 (TTY: 711), Yuav muaj tus hais ua lus Hmoob pab koj. No yog kev pab dawb.

**Polish-** Oferujemy bezpłatne usługi tłumacza, aby móc odpowiedzieć na wszelkie pytania dotyczące naszego planu opieki zdrowotnej lub planu lekowego. Aby skorzystać z pomocy tłumacza, wystarczy zadzwonić pod numer 1-877-317-2410 (TTY: 711). Osoba, która mówi po polsku, udzieli Państwu pomocy. Usługa jest bezpłatna.

**Korean-** 저희의 무료 통역 서비스를 통해 당사의 의료 보험 또는 의약품 보험에 대해 알고 싶으신 점을 질문하시고 답변을 받으십시오. 통역사가 필요하실 때는 1-877-317-2410 (TTY: 711)으로 전화 주십시오. 한국어가 가능한 직원이 도움을 드릴 것입니다. 무료로 이용하실 수 있습니다.

**Russian-** Мы предоставляем бесплатные услуги устного перевода, чтобы ответить на любые вопросы о нашем плане медицинского страхования или плане страхования стоимости лекарств. Чтобы получить помощь русского переводчика, просто позвоните по номеру 1-877-317-2410 (TTY: 711). Эта услуга является бесплатной.

**French-** Nous proposons des services d'interprétation gratuits pour répondre à toutes vos questions à propos de notre régime d'assurance maladie ou d'assurance médicaments. Pour bénéficier d'un(e) interprète, appelez simplement le 1 877 317 2410 (TTY: 711). Une personne parlant français pourra vous aider. Ce service est gratuit.

**Italian-** Offriamo servizi gratuiti di interpretazione per rispondere a eventuali domande in merito alla nostra assicurazione sanitaria o al nostro piano farmacologico. Per avvalersi dell'aiuto di un interprete in lingua italiana, chiamare il numero 1-877-317-2410 (TTY: 711). Il servizio è gratuito.

**Chinese-** 我们提供免费的口译服务，可回答您关于我们健康或药物计划的任何疑问。如需安排口译员，请致电 1-877-317-2410 (TTY: 711) 与我们联系，申请安排说中文的人员为您提供协助。此为免费服务。

**Vietnamese-** Chúng tôi có dịch vụ thông dịch viên miễn phí để trả lời các câu hỏi của quý vị về chương trình bảo hiểm sức khỏe hoặc thuốc. Nếu quý vị cần thông dịch viên, chỉ cần gọi cho chúng tôi theo số 1-877-317-2410 (TTY: 711), sẽ có nhân viên nói tiếng Việt có thể hỗ trợ quý vị. Đây là dịch vụ miễn phí.

**Arabic-**

لدينا خدمات مترجم فوري للإجابة ىع أي أسئلة قد تكون لديك حول خطتنا الدوائية أو الصحية. للحصول على مترجم فوري، فقط اتصل بنا على الرقم 1-877-317-2410، وستجد امصّخش يتحدث اللغة العربية يمكن أن يساعدك. هذه هي خدمة مجانية.

**German-** Wir bieten einen kostenlosen Dolmetscher-Service für Sie an, damit wir Ihre Fragen bezüglich unseres Gesundheits- oder Medikationsplans beantworten können. Rufen Sie uns einfach unter der Nummer 1 877 317 2410 (TTY: 711) an, um einen Dolmetscher anzufordern. Ihnen wird dann auf Deutsch weitergeholfen. Dies ist ein kostenloser Service.

**Urdu-**

ہمارے ہیلتھ یا ڈرگ پلان کے بارے میں آپ کے کسی بھی سوال کا جواب دینے کے لیے ہمارے پاس مفت مترجم کی خدمات دستیاب ہیں۔ مترجم حاصل کرنے کے لیے، ہمیں صرف 1-877-317-2410 (TTY: 711) پر کال کریں، اردو بولنے والا کوئی شخص آپ کی مدد کر سکتا ہے۔ یہ ایک مفت سروس ہے۔