MDwise
MEDICARE

2024

Summary Of Benefits

Jan. 1, 2024 —— Dec. 31, 2024

MDwise Medicare Inspire (HMO) – H7746-001

MDwise Medicare Inspire Plus (HMO) – H7746-002

MDwise Medicare Inspire Flex (HMO-POS) – H7746-003

SUMMARY OF BENEFITS

MDwise Medicare Inspire (HMO) H7746-001
MDwise Medicare Inspire Plus (HMO) H7746-002
MDwise Medicare Inspire Flex (HMO-POS) H7746-003

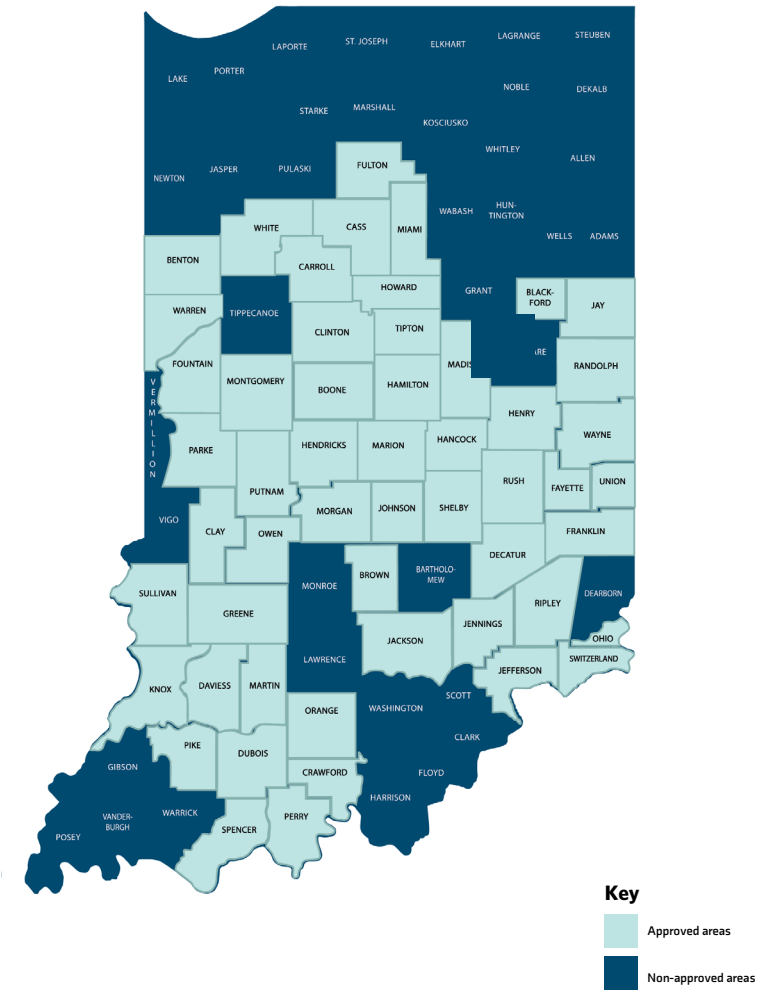
This is a summary of drug and health services covered by MDwise Medicare for **Jan. 1, 2024-Dec. 31, 2024**

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 see a complete list of services we cover, please review the Evidence of Coverage on **www.mdwise.org/mdwisemedicare.**

To join MDwise Medicare you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following Indiana counties: Benton, Blackford, Boone, Brown, Carroll, Cass, Clay, Clinton, Crawford, Daviess, Decatur, Dubois, Fayette, Fountain, Franklin, Fulton, Greene, Hamilton, Hancock, Hendricks, Henry, Howard, Jackson, Jay, Jefferson, Jennings, Johnson, Knox, Madison, Martin, Marion, Miami, Montgomery, Morgan, Ohio, Orange, Owen, Parke, Perry, Pike, Putnam, Randolph, Ripley, Rush, Shelby, Spencer, Sullivan, Switzerland, Tipton, Union, Warren, Wayne, and White.

MDwise Medicare has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

Out-of-network/non-contracted providers are under no obligation to treat members, except in emergency situations. Please call our member service number or review the Evidence of Coverage. For more information, including the cost-sharing that applies to out-of-network services.



Monthly Premium, Deductibles and Coverage Limits

	MDwise Inspire (HMO) H7746-001	MDwise Inspire Plus (HMO) H7746-002	MDwise Inspire Flex (HMO-POS) H7746-003
Your Monthly Plan Premium (You must continue to pay your Medicare Part B premium.)	$0	$25	$49
Deductible	**Medical Services** $0 **Prescription Drugs** All Tiers $0	**Medical Services** $0 **Prescription Drugs** All Tiers $0	**Medical Services** $0 **Prescription Drugs** All Tiers $0
Maximum Out-of-Pocket Responsibility The most you pay for copays, coinsurance and other costs for medical services for the year. Once you reach the maximum out of pocket, our plan pays 100% of covered medical services. Your premium and prescription drugs don t count toward the maximum out of pocket.	$3,900 for in-network Medicare-covered benefits	$4,300 for in-network Medicare-covered benefits	$4,300 for in-network Medicare-covered benefits $10,000 for in-network and out-of-network Medicare-covered benefits combined

Covered Medical Benefits

	MDwise Inspire (HMO) H7746-001	MDwise Inspire Plus (HMO) H7746-002	MDwise Inspire Flex (HMO-POS) H7746-003
Inpatient Hospital Coverage We cover an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.	$295 copay per day for days 1 through 7 You pay nothing per day for days 8 through 90 You pay nothing per day for days 91 and beyond	$290 copay per day for days 1 through 7 You pay nothing per day for days 8 through 90 You pay nothing per day for days 91 and beyond	**In-network** $310 copay per day for days 1 through 7 You pay nothing per day for days 8 through 90 You pay nothing per day for days 91 and beyond **Point-of-service** 30% of the cost/stay

Covered Medical Benefits

	MDwise Inspire (HMO) H7746-001	MDwise Inspire Plus (HMO) H7746-002	MDwise Inspire Flex (HMO-POS) H7746-003
Outpatient Hospital Coverage Prior authorization may be required.	**Outpatient Hospital:** $275 copay for each visit **Ambulatory Surgical Center:** $250 copay for each visit **Observation:** $275 copay for each visit	**Outpatient Hospital:** $275 copay for each visit **Ambulatory Surgical Center:** $250 copay for each visit **Observation:** $275 copay for each visit	**In-network** **Outpatient Hospital:** $275 copay for each visit **Ambulatory Surgical Center:** $250 copay for each visit **Observation:** $275 copay for each visit **Point-of-service** 30% of the cost
Doctor Visits No referral is required for in network specialist visits.	**Primary Care:** $0 copay per visit **Specialist:** $40 copay per visit	**Primary Care:** $0 copay per visit **Specialist:** $40 copay per visit	**In-network** **Primary Care:** $0 copay per visit **Specialist:** $40 copay per visit **Point-of-service** 30% of the cost
Preventive Care	$0 copay	$0 copay	**In-network** $0 copay **Point-of-service** 30% of the cost
Emergency Care Your copay will be waived if you are admitted directly into the hospital.	You pay a $100 copay per visit in or out of network	You pay a $100 copay per visit in or out of network	You pay a $100 copay per visit in or out of network
Urgently Needed Services	You pay a $50 copay per visit in or out of network	You pay a $50 copay per visit in or out of network	You pay a $50 copay per visit in or out of network

Covered Medical Benefits

Outpatient Diagnostic Services/Labs/ Imaging Prior authorization is required for genetic testing, molecular pathology, Proton beam therapy and high intensity focused ultrasound.	**Diagnostic radiology service (CT/MRI):** $200 copay **Lab services:** $0 copay **Diagnostic tests and procedures:** $50 copay **Outpatient X-rays:** $25 copay	**Diagnostic radiology service (CT/MRI):** $150 copay **Lab services:** $0 copay **Diagnostic tests and procedures:** $30 copay **Outpatient X-rays:** $25 copay	**In-network** **Diagnostic radiology service (CT/MRI):** $150 copay **Lab services:** $0 copay **Diagnostic tests and procedures:** $30 copay **Outpatient X-rays:** $25 copay **Point-of-service** 30% of the cost
Hearing Services You must use TruHearing providers for all routine hearing exams and hearing aid services.	**Hearing exams:** You pay a $35 copay for a Medicare-covered hearing exam You pay a $0 copay for non-Medicare covered routine hearing exams **Hearing aids:** $699/$999 copay per hearing aid - one per ear every two years	**Hearing exams:** You pay a $35 copay for a Medicare-covered hearing exam You pay a $0 copay for non-Medicare covered routine hearing exams **Hearing aids:** $699/$999 copay per hearing aid - one per ear every two years	**In-network** **Hearing exams:** You pay a $35 copay for a Medicare-covered hearing exam **Point-of-service** 30% of the cost You pay a $0 copay for non-Medicare covered routine hearing exams **Hearing aids:** $699/$999 copay per hearing aid - one per ear every two years
Dental Services In network preventive dental services are provided by Delta Dental s Medicare Advantage network dentists.	**Oral exam and cleaning:** $0 copay for two exams and two cleanings (regular or periodontal) each year **Filings and crown repair:** 50% coinsurance **Bitewing X-rays:** $0 copay for one set each year **Full-mouth X-rays:** $0 copay once every five years **Simple extractions:** 50% coinsurance **You have a $1,500 limit on covered dental services.**		

Optional Supplemental Dental Benefits

(can be purchased separately)

	Delta Dental Option 1	Delta Dental Option 2
Premium These optional dental plans can be purchased for an additional monthly premium. For Delta Dental Option 1 and Delta Dental Option 2, services must be provided by Delta Dental s Medicare Advantage network dentists.	$23.50	$35.50
Deductible	$0	$0
Services	**Major restorative services, bridges, dentures and implant services:** 75% coinsurance **Endodontics, periodontics (surgical), bridge and denture repair, oral surgery and films, anesthesia & tests:** 50% coinsurance	**Major restorative services, bridges, dentures and implant services:** 50% coinsurance **Endodontics, periodontics (surgical), bridge and denture repair, oral surgery and films, anesthesia & tests:** 20% coinsurance
Maximum Benefit Limit	You will be covered for $1,000 of dental services per year. Once you reach this limit, you will have to pay all costs for optional supplemental dental services.	You will be covered for $1,500 of dental services per year. Once you reach this limit, you will have to pay all costs for optional supplemental dental services.

Covered Medical Benefits

	MDwise Inspire (HMO) H7746-001	MDwise Inspire Plus (HMO) H7746-002	MDwise Inspire Flex (HMO-POS) H7746-003
Vision Services	**Medicare-covered services:** $35 copay for each visit $0 copay for eyeglasses or contact lenses after cataract surgery $0 copay for glaucoma screening **Routine vision services:** $0 copay for a routine eye exam $0 copay for non-Medicare-covered routine corrective eyeglasses (lenses or frames) or contact lenses up to $200	**Medicare-covered services:** $35 copay for each visit $0 copay for eyeglasses or contact lenses after cataract surgery $0 copay for glaucoma screening **Routine vision services:** $0 copay for a routine eye exam $0 copay for non-Medicare-covered routine corrective eyeglasses (lenses or frames) or contact lenses up to $300	**In-network** **Medicare-covered services:** $35 copay for each visit $0 copay for eyeglasses or contact lenses after cataract surgery $0 copay for glaucoma screening **Routine vision services:** $0 copay for a routine eye exam $0 copay for non-Medicare-covered routine corrective eyeglasses (lenses or frames) or contact lenses up to $300 **Point-of-service** 30% of the cost
Mental Health Services Our plan covers up to 190 days in a lifetime for inpatient care in a psychiatric hospital. Our plan covers 90 days for an inpatient hospital stay. Prior authorization may be required for inpatient mental health services.	**Inpatient:** $265 copay per day for days 1 through 7 You pay nothing per day for days 8 through 90 **Outpatient therapy (group or individual):** $30 copay per session	**Inpatient:** $265 copay per day for days 1 through 7 You pay nothing per day for days 8 through 90 **Outpatient therapy (group or individual):** $25 copay per session	**In-network** **Inpatient:** $265 copay per day for days 1 through 7 You pay nothing per day for days 8 through 90 **Outpatient therapy (group or individual):** $25 copay per session **Point-of-service** 30% of the cost

Covered Medical Benefits

	MDwise Inspire (HMO) H7746-001	MDwise Inspire Plus (HMO) H7746-002	MDwise Inspire Flex (HMO-POS) H7746-003
Skilled Nursing Facility (SNF) Our plan covers up to 100 days each benefit period in a SNF. A benefit period starts the day you go into a SNF and ends when you go 60 days in a row without SNF care. No prior hospital stay is required. Prior authorization may be required.	You pay nothing per day for days 1 through 20 $203 copay per day for days 21 through 100	You pay nothing per day for days 1 through 20 $203 copay per day for days 21 through 100	**In-network** You pay nothing per day for days 1 through 20 $203 copay per day for days 21 through 100 **Point-of-service** 30% of the cost
Physical Therapy	$40 copay per visit	$40 copay per visit	**In-network** $40 copay per visit **Point-of-service** 30% of the cost
Ambulance Prior authorization is required for Medicare covered non emergency transport.	$220 copay per one-way transport	$220 copay per one-way transport	$220 copay per one-way transport
Transportation Limited to 50 miles per one way trip.	You pay nothing for 30 one-way, non-emergency trips per year to plan approved health-related locations.	You pay nothing for 30 one-way, non-emergency trips per year to plan approved health-related locations.	You pay nothing for 30 one-way, non-emergency trips per year to plan approved health-related locations.
Medicare Part B Drugs Prior authorization may be required.	**Chemotherapy and Other Part B Drugs:** 20% of the cost **Home Infusion Drugs:** $0 copay	**Chemotherapy and Other Part B Drugs:** 20% of the cost **Home Infusion Drugs:** $0 copay	**In-network** **Chemotherapy and Other Part B Drugs:** 20% of the cost **Home Infusion Drugs:** $0 copay **Point-of-service** 30% of the cost

Prescription Drug Benefits

	MDwise Inspire (HMO) H7746-001	MDwise Inspire Plus (HMO) H7746-002	MDwise Inspire Flex (HMO-POS) H7746-003
Stage 1: Deductible Because you have no deductible, you will start in the Initial Coverage Stage when you fill your first prescription of the year.			
Stage 2: Initial Coverage Stage You will pay the copays/coinsurance until you total drug cost reaches $5,030.			
	Retail pharmacy (30-day supply)		Mail-Order pharmacy (90-day supply)
Tier 1: Preferred Generic	$0		$0
Tier 2: Generic	$12 Insulins: $10		$27 Insulins: $23
Tier 3: Preferred Brand	$47 Insulins: $35		$105.75 Insulins: $79
Tier 4: Non-Preferred Brand	$100		$225
Tier 5: Specialty	33%		N/A
Tier 6: Select Care Drugs	$0		$0
Stage 3: Coverage Gap Stage During this stage, you will continue to have plan coverage for your drugs in Tier 1 and Tier 6. Your out of pocket costs for covered insulin product will be $10 $35. For all other generic drugs, you will pay 25% of the price. For brand name drugs, you pay 25% of the price (plus a portion of the dispensing fee). You will remain in this stage until the out of pocket costs reach $8,000.			
Stage 4: Catastrophic Coverage Stage In this stage, our plan pays the full cost for your covered Part D drugs.			

Additional Covered Medical Benefits

	MDwise Inspire (HMO) H7746-001	MDwise Inspire Plus (HMO) H7746-002	MDwise Inspire Flex (HMO-POS) H7746-003
Acupuncture Medicare covered acupuncture for chronic lower back pain.	You pay a $25 copay per visit	You pay a $25 copay per visit	**In-network** You pay a $25 copay per visit **Point-of-service** Not covered out-of-network
Annual Physical Exam Comprehensive preventive medical evaluation.	$0 copay	$0 copay	**In-network** $0 copay **Point-of-service** 30% of the cost
Chiropractic Care	$20 copay per visit	$20 copay per visit	**In-network** $20 copay per visit **Point-of-service** 30% of the cost
Durable Medical Equipment Prior authorization is required for items that cost more than $1,000, insulin pumps, bone stimulators and neurostimulators.	You pay a 20% coinsurance	You pay a 20% coinsurance	**In-network** You pay a 20% coinsurance **Point-of-service** 30% of the cost
Enhanced Disease Management	If you have chronic conditions, you may qualify for one of our enhanced disease management programs. These special education programs promote a deep understanding of the disease process and provide individual teaching and coaching to help you achieve a healthier lifestyle. A care manager is available to those who qualify for these customized programs. You pay nothing for enhanced disease management.		
Fitness Membership	Up to a maximum allowance of $100 annually for your fitness membership.	Up to a maximum allowance of $200 annually for your fitness membership.	Up to a maximum allowance of $200 annually for your fitness membership.

Additional Covered Medical Benefits

	MDwise Inspire (HMO) H7746-001	MDwise Inspire Plus (HMO) H7746-002	MDwise Inspire Flex (HMO-POS) H7746-003
Meals After Discharge	$0 for two meals per day for 14 days (28 meals), delivered directly to your home after each discharge from an inpatient acute care or skilled nursing facility stay. Annual limit of five discharges for a total of 140 meals per year.		
Nutritional/Dietary Benefit	We cover six counseling session through a registered dietitian or other nutrition professional. We want to help you improve your health and lifestyle by providing tools so you make healthy choices. Talk to our physician to see if you would benefit from nutritional counseling. You pay nothing for these sessions.		
Over-the-Counter Items	You are eligible to receive a $225 quarterly benefit to be used toward the purchase of over-the-counter (OTC) health and wellness products that do not need a prescription. No rollover.		
Personal Emergency Response System (PERS)	Not covered	Not covered	You are eligible to receive a Mobile Plus personal emergency response system (PERS) device equipped with two-way voice communication, GPS location technology, and the option of auto fall detection with 24/7 monitoring. You pay nothing for this benefit.
Prosthetic Devices and Related Medical Supplies Prior authorization is required for items that cost more than $1,000.	You pay a 20% coinsurance	You pay a 20% coinsurance	**In-network** You pay a 20% coinsurance **Point-of-service** 30% of the cost

Additional Covered Medical Benefits

	MDwise Inspire (HMO) H7746-001	MDwise Inspire Plus (HMO) H7746-002	MDwise Inspire Flex (HMO-POS) H7746-003
Special Supplemental Benefits for the Chronically Ill (SSBCI) Healthy Groceries/ Utilities This benefit is part of a special supplemental program for the chronically ill. Not all members qualify.	Not covered	To be eligible, you must have one or more qualifying comorbid and medically complex chronic conditions, be at high risk for hospitalization or other adverse health outcomes and require intensive care coordination. If you qualify, you will receive a Mastercard® Prepaid Card with a $100 monthly healthy grocery/utilities allowance to be used to purchase qualifying healthy foods and produce at participating retail locations or online through NationsBenefits with free home delivery and/or to use to help cover the cost of utilities for your home. The monthly allowance does not rollover from month to month. For a complete list of qualifying conditions, please call Member Services.	
Worldwide Emergency	Not covered	You may receive covered emergency and urgent care services anywhere in the world. If you are outside of the United States or its territories, your worldwide emergency and urgent care is limited to $50,000 per year. All costs over $50,000 for emergency and urgent care services are your responsibility. You pay a $100 copay per visit.	
Worldwide Urgently Needed Care	Not covered	You may receive covered emergency and urgent care services anywhere in the world. If you are outside of the United States or its territories, your worldwide emergency and urgent care is limited to $50,000 per year. All costs over $50,000 for emergency and urgent care services are your responsibility. You pay a $50 copay per visit.	

If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. This document is available in other formats such as Braille, large print or audio.

For more information, please call us at the phone number below or visit us at www.mdwise.org/mdwisemedicare.

Toll-free: 1-833-358-2140; TTY users should call 711.
Oct. 1-March 31: Seven days a week, 8 a.m. to 8 p,m. ET (except Thanksgiving and Christmas days)
April 1-Sept. 30: Monday-Friday, 8 a.m. to 8 p.m. ET

You can see our plan's provider/pharmacy directory at www.mdwise.org/mdwisemedicare.

MDwise Medicare is an HMO/HMO-POS plan with a Medicare contract. Enrollment in MDwise Medicare depends on contract renewal.

H7746_SB2024_M

Notes:


MDwise
MEDICARE