Summary of Benefits

Plan Year 2021

- SSM Health Plan Unity (HMO)
- SSM Health Plan Companion (HMO)
- SSM Health Plan Integrity (HMO-POS)
- SSM Health Plan Harmony (HMO-POS MA-Only)

H8019_WF2021SB_M

January 1, 2021 – December 31, 2021

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/medicare. 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.

WellFirst Health 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 **WellFirst Health** 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), St. Claire County (IL), Madison County (IL)**

Which doctors, hospitals and pharmacies can I use?

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

- You can see our plan's provider directory at our website, wellfirsthealth.com/doctors.
- You can see our plan's pharmacy directory at our website wellfirsthealth.com/medicare.

Monthly Premium, Deductibles, and Limits on

How Much You Pay for Covered Services

	SSM Unity (HMO)	SSM Companion (HMO)	SSM Integrity (HMO-POS)		SSM Harmony (HMO-POS) MA – Only	
	In Network	In Network	In Network	Out-of-Network	In Network	Out-of-Network
Monthly Premium You must continue to pay your Medicare Part B premium	**$0**	**$0**	**$0**		**$0**	
Part B Buy Back WellFirst Health provides a credit that will automatically be applied towards your Medicare Part B premium	$35	Not Applicable	Not Applicable		$50	
Medical Deductible	Not Applicable	Not Applicable	Not Applicable		Not Applicable	
Maximum Out-of-Pocket Responsibility 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. (Does not include prescription drugs)	$2,500 for in-network services	$2,500 for in-network services	$2,500 for in-network services $5,000 for in-network and out-of-network services combined		$2,500 for in-network services $5,000 for in-network and out-of-network services combined	

Covered Medical and Hospital Benefits

*Benefit may require prior authorization

Medical Benefit	SSM Unity (HMO)	SSM Companion (HMO)	SSM Integrity (HMO-POS)		SSM Harmony (HMO-POS) MA – Only	
	In Network	In 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 $0 each day for days 8 to discharge	$325 copay each day for days 1 - 7 $0 each day for days 8 to discharge	$325 copay each day for days 1 - 7 $0 each day for days 8 to discharge	$500 copay each day for days 1 - 7 $0 each day for days 8 to discharge	$300 copay each day for days 1 - 7 $0 each day for days 8 to discharge	$500 copay each day for days 1 - 7 $0 each day for days 8 to discharge
Outpatient Hospital Coverage*						
Outpatient Hospital:	$275 copay	$275 copay	$275 copay	20% coinsurance	$250 copay	20% coinsurance
Ambulatory Surgery Center:	$175 copay	$175 copay	$175 copay	20% coinsurance	$150 copay	20% coinsurance
Procedure performed during office visit:	$0 - $35 copay	$0 - $35 copay	$0 - $35 copay	$30 - $60 copay	$0 - $35 copay	$30 - $60 copay
Doctor Visits						
Primary Care Providers:	$0 copay	$0 copay	$0 copay	$30 copay	$0 copay	$30 copay
Specialists:	$35 copay	$35 copay	$35 copay	$60 copay	$35 copay	$60 copay
Preventive Care	$0 copay	$0 copay	$0 copay	$30 copay	$0 copay	$30 copay
Emergency Care In the U.S. (Waived if admitted)	$120 copay	$120 copay	$120 copay	$120 copay	$120 copay	$120 copay
Urgently Needed Services In the U.S.	$35 copay Your cost may be reduced based on level of treating provider	$35 copay Your cost may be reduced based on level of treating provider	$35 copay Your cost may be reduced based on level of treating provider	$35 copay	$35 copay Your cost may be reduced based on level of treating provider	$35 copay
Diagnostic Services / Labs / Imaging*						
Outpatient X-ray:	$10 copay	$10 copay	$10 copay	20% coinsurance	$10 copay	20% coinsurance
Laboratory Tests:	$0 copay	$0 copay	$0 copay	20% coinsurance	$0 copay	20% coinsurance
Radiation Therapy:	$35 copay	$35 copay	$35 copay	20% coinsurance	$35 copay	20% coinsurance
Diagnostic Procedures/Tests:	$0 copay	$0 copay	$0 copay	20% coinsurance	$0 copay	20% coinsurance
Diagnostic Mammograms:	$0 copay	$0 copay	$0 copay	20% coinsurance	$0 copay	20% coinsurance
Diagnostic Radiology:	$100 copay	$100 copay	$100 copay	20% coinsurance	$100 copay	20% coinsurance
Hearing Services						
Medicare-covered- exam to diagnose and treat hearing and balance issues:	$0 copay	$0 copay	$0 copay	$60 copay	$0 copay	$60 copay

Medical Benefit	SSM Unity (HMO)	SSM Companion (HMO)	SSM Integrity (HMO-POS)		SSM Harmony (HMO-POS) MA – Only	
	In Network	In Network	In Network	Out-of-Network	In Network	Out-of-Network
Routine hearing exam:	$0 copay per exam for 1 exam every calendar year	$0 copay per exam for 1 exam every calendar year	$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	$0 copay per fitting for 1 fitting every calendar year	$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 Our plan pays up to $750 both ears combined every calendar year for hearing aids You are responsible for costs beyond the plan limit	$0 copay Our plan pays up to $750 both ears combined every calendar year for hearing aids You are responsible for costs beyond the plan limit	$0 copay Our plan pays up to $750 both ears combined every calendar year for hearing aids You are responsible for costs beyond the plan limit	Not Covered	$0 copay Our plan pays up to $750 both ears combined every calendar year for hearing aids You are responsible for costs beyond the plan limit	Not Covered
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	Not Covered	$0 copay per visit for 2 visits every calendar year	Not Covered
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	Not Covered	$0 copay per visit for 2 visits every calendar year	Not Covered
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	Not Covered	$0 copay per visit for 1 visit every calendar year	Not Covered
Comprehensive Dental						
Diagnostic services:	$0 copay	$0 copay	$0 copay	Not Covered	$0 copay	Not Covered
Gum disease maintenance and bridge/implants/dentures repairs:	$45 copay	$45 copay	$45 copay	Not Covered	$45 copay	Not Covered
Fillings, gum disease treatment, and extractions:	$95 copay	$95 copay	$95 copay	Not Covered	$95 copay	Not Covered
Root canals, bridges, implants, dentures, and crowns:	$595 copay	$595 copay	$595 copay	Not Covered	$595 copay	Not Covered

Medical Benefit	SSM Unity (HMO)	SSM Companion (HMO)	SSM Integrity (HMO-POS)		SSM Harmony (HMO-POS) MA – Only	
	In Network	In Network	In Network	Out-of-Network	In Network	Out-of-Network
Dental Maximum Annual limit that WellFirst Health will pay for preventive and comprehensive dental services You are responsible for costs beyond the plan limit	$1,500 every calendar year for dental services	$1,500 every calendar year for dental services	$1,500 every calendar year for dental services	Not Covered	$1,500 every calendar year for dental services	Not Covered
Vision Services Medicare-covered exam to treat to diagnose and treat diseases and conditions of the eye:	$0 copay	$0 copay	$0 copay	$30 copay	$0 copay	$30 copay
Medicare-covered eyewear after cataract surgery:	$0 copay	$0 copay	$0 copay	Not Covered	$0 copay	Not Covered
Routine eye exam:	$0 copay per exam for 1 exam every calendar year	$0 copay per exam for 1 exam every calendar year	$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)	Our plan pays up to a total of $200 every calendar year You are responsible for costs beyond the plan limit	Our plan pays up to a total of $200 every calendar year You are responsible for costs beyond the plan limit	Our plan pays up to a total of $200 every calendar year You are responsible for costs beyond the plan limit	Not Covered	Our plan pays up to a total of $200 every calendar year You are responsible for costs beyond the plan limit	Not Covered
Mental Health Services: Hospital Care* For Medicare-covered stays	$325 copay each day for days 1 - 7 $0 each day for days 8 - 90	$325 copay each day for days 1 - 7 $0 each day for days 8 - 90	$325 copay each day for days 1 - 7 $0 each day for days 8 - 90	$500 copay each day for days 1 - 7 $0 each day for days 8 - 90	$300 copay each day for days 1 - 7 $0 each day for days 8 - 90	$500 copay each day for days 1 - 7 $0 each day for days 8 - 90
Mental Health Services: Outpatient Care* Outpatient Individual Therapy:	$0 copay	$0 copay	$0 copay	$30 copay	$0 copay	$30 copay
Outpatient Group Therapy:	$0 copay	$0 copay	$0 copay	$30 copay	$0 copay	$30 copay

Medical Benefit	SSM Unity (HMO)	SSM Companion (HMO)	SSM Integrity (HMO-POS)		SSM Harmony (HMO-POS) MA – Only	
	In Network	In Network	In Network	Out-of-Network	In Network	Out-of-Network
Skilled Nursing Facility* Our plan covers up to 100 day per benefit period in a SNF: 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 $184 each day for days 21 - 100	$0 each day for days 1 - 20 $184 each day for days 21 - 100	$0 each day for days 1 - 20 $184 each day for days 21 - 100	$150 each day for days 1 - 100	$0 each day for days 1 - 20 $184 each day for days 21 - 100	$150 each day for days 1 - 100
Therapy* Outpatient physical therapy, speech language pathology, and occupational therapy:	$35 copay per visit	$35 copay per visit	$35 copay per visit	$60 copay per visit	$35 copay per visit	$60 copay per visit
Ambulance For each one-way Medicare-covered trip	$250 copay	$250 copay	$250 copay	40% coinsurance	$250 copay	40% coinsurance
Transportation For rides to medical appointments	$0 copay per ride for 24 one-way rides every calendar year	$0 copay per ride for 24 one-way rides every calendar year	$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
Medicare Part B Drugs*	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance

Medicare Part D Prescription Drug Coverage

Plan Name	SSM Unity (HMO)	SSM Companion (HMO)	SSM Integrity (HMO-POS)	SSM Harmony (HMO-POS) MA - Only
Part D Deductible	$0	$0	$0	Not Covered
PREFERRED RETAIL 30 day supply				
Tier 1 Preferred Generic	$0 copay	$0 copay	$0 copay	Not Covered
Tier 2 Generic	$5 copay	$5 copay	$5 copay	Not Covered
Tier 3 Preferred Brand	$40 copay	$40 copay	$40 copay	Not Covered
Tier 4 Non-Preferred Drugs	$90 copay	$90 copay	$90 copay	Not Covered
Tier 5 Specialty Drugs	33% coinsurance	33% coinsurance	33% coinsurance	Not Covered
Tier 6 Part D Vaccines (Tdap, Shingrix, and Zostavax)	$0 copay	$0 copay	$0 copay	Not Covered
STANDARD RETAIL 30 day supply				
Tier 1 Preferred Generic	$7 copay	$7 copay	$7 copay	Not Covered
Tier 2 Generic	$12 copay	$12 copay	$12 copay	Not Covered
Tier 3 Preferred Brand	$47 copay	$47 copay	$47 copay	Not Covered
Tier 4 Non-Preferred Drugs	$100 copay	$100 copay	$100 copay	Not Covered
Tier 5 Specialty Drugs	33% coinsurance	33% coinsurance	33% coinsurance	Not Covered
Tier 6 Part D Vaccines (Tdap, Shingrix, and Zostavax)	$0 copay	$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 90 day supply				
Tier 1 Preferred Generic	$0 copay	$0 copay	$0 copay	Not Covered
Tier 2 Generic	$10 copay	$10 copay	$10 copay	Not Covered
Tier 3 Preferred Brand	$100 copay	$100 copay	$100 copay	Not Covered
Tier 4 Non-Preferred Drugs	$270 copay	$270 copay	$270 copay	Not Covered
Tier 5 Specialty Drugs	Not Applicable	Not Applicable	Not Applicable	Not Covered
Tier 6 Part D Vaccines (Tdap, Shingrix, and Zostavax)	Not Applicable	Not Applicable	Not Applicable	Not Covered
STANDARD RETAIL 90 day supply				

Plan Name	SSM Unity (HMO)	SSM Companion (HMO)	SSM Integrity (HMO-POS)	SSM Harmony (HMO-POS) MA - Only
Tier 1 Preferred Generic	$7 copay	$7 copay	$7 copay	Not Covered
Tier 2 Generic	$24 copay	$24 copay	$24 copay	Not Covered
Tier 3 Preferred Brand	$117.50 copay	$117.50 copay	$117.50 copay	Not Covered
Tier 4 Non-Preferred Drugs	$300 copay	$300 copay	$300 copay	Not Covered
Tier 5 Specialty Drugs	Not Applicable	Not Applicable	Not Applicable	Not Covered
Tier 6 Part D Vaccines (Tdap, Shingrix, and Zostavax)	Not Applicable	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.	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 **$4,130**	You pay copays or coinsurance, and we pay the remainder until together our spending reaches **$4,130**	You pay copays or coinsurance, and we pay the remainder until together our spending reaches **$4,130**	Not Covered
Stage 3 Coverage Gap	Above **$4,130** , you pay 25% of the cost for generics and brand drugs until your expenses reach **$6,550**	Above **$4,130** , you pay 25% of the cost for generics and brand drugs until your expenses reach **$6,550**	Above **$4,130** , you pay 25% of the cost for generics and brand drugs until your expenses reach **$6,550**	Not Covered
Stage 4 Catastrophic	Above **$6,550** you pay the greater of **5%** or **$3.70** for generics and **$9.20** for all other drugs and we pay the remainder	Above **$6,550** you pay the greater of **5%** or **$3.70** for generics and **$9.20** for all other drugs and we pay the remainder	Above **$6,550** you pay the greater of **5%** or **$3.70** for generics and **$9.20** for all other drugs and we pay the remainder	Not Covered

Additional Benefits

Plan Name	SSM Unity (HMO)	SSM Companion (HMO)	SSM Integrity (HMO-POS)		SSM Harmony (HMO-POS) MA - Only	
	In Network	In Network	In Network	Out-of-Network	In Network	Out-of-Network
In Home Support and Companionship Papa Pals provide companionship, technology lessons, house chore support and other assistance both in home or virtually.	Not Covered	$0 copay per visit for 10 visits every month	Not Covered	Not Covered	$0 copay per visit for 10 visits every month	Not Covered
Over the Counter Allowance More than 150 covered items including: non-prescription medicine (pain relief, cough, allergies), toothpaste, first aid items, and vitamins. Members can order online, over the phone, or visit a designated store location.	$60 quarterly allowance	$60 quarterly allowance	$60 quarterly allowance	Not Covered	$60 quarterly allowance	Not Covered
Post Discharge Meals Ready to eat meals delivered directly to your home if you are discharged from a hospital or skilled nursing facility	Two meals per day for 7 days after an inpatient stay at no cost to you	Two meals per day for 7 days after an inpatient stay at no cost to you	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
Virtual Visits See conditions treated and complete an online health interview at wellfirsthealth.com/virtualvisit	$0 copay	$0 copay	$0 copay	Not Covered	$0 copay	Not Covered
Nurse Line 24/7 access to a medical professional who can help answer your questions	$0 copay	$0 copay	$0 copay	Not Covered	$0 copay	Not Covered
Worldwide Emergency and Urgent Care Outside the US	$120 copay No Limit	$120 copay No Limit	$120 copay No Limit	$120 copay No Limit	$120 copay No Limit	$120 copay No Limit
Fitness Benefit Silver&Fit	$0 copay	$0 copay	$0 copay	Not Covered	$0 copay	Not Covered
Routine Chiropractic	$10 copay for an additional 12 routine chiropractic visits every calendar year	$10 copay for an additional 12 routine chiropractic visits every calendar year	$10 copay for an additional 12 routine chiropractic visits every calendar year	$30 copay for an additional combined 12 routine chiropractic visits every calendar year	$10 copay for an additional 12 routine chiropractic visits every calendar year	$30 copay for an additional combined 12 routine chiropractic visits every calendar year