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A Family of Medicare Advantage Brands

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PROMINENCE Health

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StableView Health Plan

Lexington, KY

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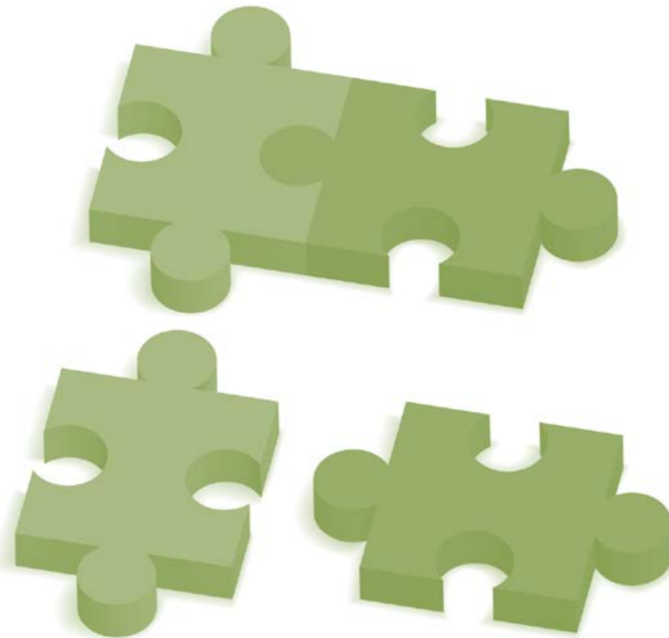

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StableView Service Area

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Kentucky Counties Include:

- Bourbon
- Fayette
- Jessamine
- Scott
- Woodford

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StableView Health Medicare Advantage Plan

Plan with Rx Coverage	Premium
Classic Plus Rx (HMO-POS) Bourbon, Fayette, Jessamine, Scott, and Woodford	**$0**

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StableView Major Networks & Hospitals

- KentuckyOne Medical Group
- Premier Heart and Vascular Centers
- Saint Joseph Cardiology Associates
- Saint Joseph Hospital
- Saint Joseph East
- Saint Joseph Internal Medicine
- Saint Joseph Primary Care Associates
- Seaton Family Health Center
- Wheelwright Family Health

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A full provider directory is available on our website in the Member Center.
Providers and facilities are subject to change.

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Classic Plus Rx (HMO-POS)

WITH PRESCRIPTION DRUG COVERAGE

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PENDING CMS APPROVAL

CLASSIC Plus Rx
Benefit Changes and Cost Sharing

PENDING CMS APPROVAL

Benefit	2015 (HMO)	2016 (HMO-POS)	
		In-Network	*Out-of-Network*
Monthly Premium	**$0**	**$0**	
Out of Pocket Maximum	$5,900 out-of-pocket limit every year for all Member cost sharing excluding Part D pharmacy.	$4,900 out-of-pocket limit every year for all Member cost sharing excluding Part D pharmacy*	No limit on the out-of-pocket Member cost sharing.
Inpatient Hospital Care (Includes Substance Abuse & Rehabilitation Services)	$250 copay per day 1-7 $0 copay per day 8-90 $0 copay for additional days	$250 copay per day 1-7 $0 copay per day 8-90 $0 copay for additional days	40% coinsurance

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* Non-Medicare covered preventive dental, eyewear, eye exam, fitness and hearing aid cost sharing does not count towards the MOOP.

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CLASSIC Plus Rx
Benefit Changes and Cost Sharing, cont…

Benefit	2015 (HMO)	2016 (HMO-POS)	
		In-Network	*Out-of-Network*
Inpatient Hospital Mental Health (190 days lifetime limit)	$250 copay per day 1-6 $0 copay per day 7-90 60 lifetime reserve days; copays for lifetime reserve days: $250 copay per day 1-6 $0 copay per day 7-60	250 copay per day 1-6 $0 copay per day 7-90 60 lifetime reserve days; copays for lifetime reserve days: $250 copay per day 1-6 $0 copay per day 7-60	40% coinsurance
Skilled Nursing Facility (In a Medicare-certified skilled nursing facility)	$0 copay per day 1-20 $155 copay per day 21-100 100 days per benefit period; no prior hospital stay is required	$0 copay per day 1-20 $160 copay per day 21-51 $0 copay per day 52-100 100 days per benefit period; no prior hospital stay is required	Not covered

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CLASSIC Plus Rx
Benefit Changes and Cost Sharing, cont…

Benefit	2015 (HMO)	2016 (HMO-POS)	
		In-Network	*Out-of-Network*
Urgently Needed Services (This is NOT emergency care)	$35 copay (not waived if admitted)	$50 copay (not waived if admitted)	$50 copay (not waived if admitted)
Home Health Care (Includes medically necessary intermittent skilled nursing care, home health aide services and rehabilitation services, etc.)	$0 copay	$0 copay	Not covered
Primary Care Physician Services	$5 copay	$5 copay	$10 copay
Chiropractic Services (Medicare Covered Services)	$20 copay	$20 copay	$50 copay
Physician Specialist Services	$35 copay	$35 copay	$50 copay

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CLASSIC Plus Rx
Benefit Changes and Cost Sharing, cont…

Benefit	2015 (HMO)	2016 (HMO-POS)	
		In-Network	*Out-of-Network*
Mental Health Specialty Services - Non-physician - Individual & Group	$40 copay	$40 copay	Not covered
Podiatry Services	$15 copay for diabetic foot care; $35 copay for other Medicare-covered services	$35 copay	$50 copay
Routine Podiatry Services (Up to six routine visits per year)	Not covered	$35	$50 copay
Psychiatric Services - Individual or Group	$40 copay	$40 copay	Not covered

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CLASSIC Plus Rx
Benefit Changes and Cost Sharing, cont…

Benefit	2015 (HMO)	2016 (HMO-POS)	
		In-Network	*Out-of-Network*
Physical, Speech & Language Therapy	$35 copay	$35 copay	$50 copay
Lab Services (Per day, per visit limits)	$0 pt/inr (coumadin) $15 diabetes panel (diabetes) $30 all others per day *tiered, these are per visit limits*	$15 copay	$15 copay
Diagnostic Procedures & Tests (Per day)	20% coinsurance	20% coinsurance	40% coinsurance
X-Rays (Per day)	20% coinsurance	$20 copay	$25 copay
Diagnostic Radiology Services (not including X-rays)	20% coinsurance	20% coinsurance	40% coinsurance

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CLASSIC Plus Rx
Benefit Changes and Cost Sharing, cont…

Benefit	2015 (HMO)	2016 (HMO-POS)	
		In-Network	*Out-of-Network*
Outpatient Hospital Services	$200 copay facility $35 copay for O/P clinic	$200 copay facility $35 copay for O/P clinic	40% coinsurance
Ambulatory Surgery Center Services	$175 copay	$175 copay	40% coinsurance
Outpatient Substance Abuse Services - Individual or Group	$40 copay	$40 copay	$50 copay
Ambulance Services (Medically necessary)	$200 copay; waived if admitted	$240 copay; **not** waived if admitted	$240 copay; **not** waived if admitted
Durable Medical Equipment (Includes wheelchairs, oxygen, etc.)	0 - 20% coinsurance	20% coinsurance	Not covered

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CLASSIC Plus Rx
Benefit Changes and Cost Sharing, cont…

Benefit	2015 (HMO)	2016 (HMO-POS)	
		In-Network	*Out-of-Network*
Prosthetic Devices (Includes braces, artificial limbs, etc.)	20% coinsurance	20% coinsurance	40% coinsurance
Medical Supplies	0 - 20% coinsurance	20% coinsurance	40% coinsurance
Diabetes Monitoring Supplies & Therapeutic Shoes or Inserts	$0 supplies/ 20% coinsurance shoes and inserts	$0 supplies/ 20% coinsurance shoes and inserts*	40% coinsurance
Chemotherapy Drugs & Other Part B Covered Drugs	20% coinsurance	20% coinsurance	40% coinsurance
Dental – Preventive	$10 copay	$10 copay	Not covered

* Coverage for Medicare-covered diabetic supplies processed at pharmacy locations is limited to the Abbott manufactured products of FreeStyle and Precision.

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CLASSIC Plus Rx
Benefit Changes and Cost Sharing, cont…

Benefit	2015 (HMO)	2016 (HMO-POS)	
		In-Network	*Out-of-Network*
Dental Services (Medicare covered dental benefits)	$40 copay	$35 copay	Not covered
Eye Exams (Medicare-covered eye exam)	$0 copay glaucoma test; $35 copay other	$0 copay glaucoma test; $35 copay other	$50 copay
Eye Exams Supplemental (One routine eye exam every year; $0 copay with VSP Vision Solutions)	$0 copay	$0 copay	$50 copay
Eyewear (One pair of eyeglasses or contact lenses after cataract surgery)	$0 copay	$0 copay	40% coinsurance
Eyewear Supplemental (One pair of glasses, contacts, or lenses, per 24 months)	$25 copay $120 per 24 months allowable	$25 copay $120 per 24 months allowable	Not covered

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CLASSIC Plus Rx
Benefit Changes and Cost Sharing, cont…

Benefit	2015 (HMO)	2016 (HMO-POS)	
		In-Network	*Out-of-Network*
Hearing Exams (Medicare-covered diagnostic exam; $0 copay Hearing Care Solutions)	\$0 - \$35 copay	\$0 - \$35 copay	\$50 copay
Hearing Exams Supplemental (One supplemental routine hearing exam every year: $0 copay Hearing Care Solutions)	\$0 - \$35 copay	\$0 - \$35 copay	\$50 copay
Hearing Aids ($1,000 annual benefit limit per ear towards the purchase of hearing aids through Hearing Care Solutions)	Not covered	\$0 copay	Not covered

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CLASSIC Plus Rx
Benefit Changes and Cost Sharing, cont…

Benefit	2015 (HMO)	2016 (HMO-POS)	
		In-Network	*Out-of-Network*
Health Club Membership & Fitness Benefit	$0 copay; American Specialty Health Silver & Fit program includes FREE membership to local gyms, exercise classes, and online support to achieve fitness goals.	$0 copay; American Specialty Health Silver & Fit program includes FREE membership to local gyms, exercise classes, and online support to achieve fitness goals.	Not covered

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CLASSIC Plus Rx - PART D BENEFITS

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Deductible Period:

$0 Annual Deductible

Initial Coverage Period:

	Retail Pharmacy			***Mail-Order Pharmacy***		
Drug Tiers	**31 day**	**62 day**	**93 day**	**31 day**	**62 day**	**93 day**
Tier 1 - Preferred Generics	$2	$4	$5	$2	$4	$6
Tier 2 - Non-Preferred Generics	$10	$20	$25	$10	$20	$30
Tier 3 - Preferred Brand	$38	$76	$95	$38	$76	$114
Tier 4 - Non-Preferred Brand	35%	35%	35%	35%	35%	35%
Tier 5 - Specialty	33%	33%	33%	33%	33%	33%

Coverage Gap:

After your yearly drug costs reach $3,310 you receive a discount on drugs and pay no more than 45% of the plan's costs for all brand name drugs and 58% of the plan's cost for generic drugs until your yearly out-of-pocket drug costs reach $4,850.

Catastrophic Coverage:

Generics - Greater of $2.95 or	All other drugs – Greater of $7.40 or
5% coinsurance	

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