MEMORIAL HERMANN Health Plan

MEMORIAL HERMANN *ADVANTAGE* HMO

2022 PLUS HMO SUMMARY OF BENEFITS

Memorial Hermann *Advantage* Plus HMO

H7115, Plan 003

January 1, 2022 - December 31, 2022.

This Summary of Benefits documents provides an outline of health and drug services covered by **Memorial Hermann *Advantage* Plus HMO** January 1, 2022 to December 31, 2022.

Memorial Hermann *Advantage* Plus HMO is provided by Memorial Hermann Health Plan, Inc., a Medicare Advantage organization with a Medicare contract. Enrollment in this plan depends on contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call us and request the "Evidence of Coverage."

To join **Memorial Hermann *Advantage* Plus HMO**, 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 counties in Texas: Fort Bend, Harris, Montgomery, Liberty, and Galveston.

Except in emergency situations, if you use the providers that are not in our network, we may not pay for these services.

For coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227).TTY users should call 1-877-486-2048.

This document is available in other formats such as Braille, large print, audio, or non-English language.

This information is not a complete description of benefits. Call (855) 645-8448 (TTY users should call 711), for more information or visit us at http://healthplan.memorialhermann.org/medicare/. Hours of operation between October 1st and March 31st are 8 a.m. to 8 p.m., 7 days a week. Hours of operation between April 1st and September 30th are 8 a.m. to 8 p.m., Monday through Friday.

Premiums and Benefits	Memorial Hermann *Advantage* Plus HMO
Monthly Plan Premium	You pay $50. You must continue to pay your Medicare Part B premium.
Deductible	No deductible for medical.
Part D Deductible	$300 per year for Tier 4 and Tier 5 Part D prescription drugs.
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	You pay no more than $3,900 annually. Includes copays and other costs for medical services for the year.
Inpatient Hospital	You pay $350 per stay **Prior authorization rules may apply.**
Outpatient Hospital	You pay $175 for each Medicare-covered ambulatory surgical service. You pay $300 for each Medicare-covered outpatient hospital service. **Prior authorization rules may apply.**
Doctor Visits ○ Primary ○ Specialists	You pay nothing for each primary care visit. You pay $20 for each specialist visit. No referral for specialist is needed.
Preventive Care (e.g., flu vaccine, diabetic screenings)	You pay nothing. Other preventive services are available. There are some covered services that have a cost.
Emergency Care	You pay $90 per visit. If you are admitted to the hospital within 48 hours, then you do not have to pay $90.
Urgently Needed Services	You pay $35 per visit.
Diagnostic Services/Labs/Imaging ○ Diagnostic tests and procedures ○ Lab services ○ MRI, CAT Scan ○ X-Rays	 You pay $75 per test You pay nothing for Lab services You pay $250 per test You pay $10 per X-ray **Prior authorization is required for some services.**

Premiums and Benefits	Memorial Hermann *Advantage* Plus HMO
Hearing Services ○ Medicare-covered hearing exam ○ Routine hearing exam ○ Hearing aid	You pay $50 for annual Medicare-covered hearing exam. You pay $0 for basic hearing and balance exam performed by PCP. You pay $10 for exam to diagnose and treat hearing and balance Issued by an audiologist. $400 annual total allowance for sharing aid(s), both ears combined.
Dental Services ○ Oral exam, Cleaning & X-Rays (Preventive) ○ Comprehensive Services ○ Medicare-covered dental services (Comprehensive)	$2,500 annual maximum plan benefit. You pay nothing for preventive services. <u>Comprehensive services</u>: ○ You pay $50 for each Medicare-covered Comprehensive service. ○ You pay 0% of the cost for Diagnostic services. ○ You pay 20% coinsurance for Restorative services. ○ You pay 20% coinsurance for Periodontal services. ○ You pay 20% coinsurance for Endodontic services. ○ You pay 20% coinsurance for Extractions. ○ You pay 50% coinsurance for Prosthodontics, Other Oral/Maxillofacial Surgery, Other services. ○ $0 copay for Non-routine services.
Vision Services ○ Medicare-covered eye exams ○ Eyewear (contact, glasses)	You pay $50. $200 annual total allowance for surgical and non-surgical need for eyewear or contact lenses.
Mental Health Services ○ Outpatient group therapy/ individual therapy visit ○ Inpatient mental health care	You pay nothing for group or individual sessions for Mental Health Specialty services. You pay $20 per group or individual Psychiatric visit. You pay $350 per stay. **Prior authorization rules may apply.**
Skilled Nursing Facility	You pay nothing for days 1 through 20. You pay $150 per day for days 21 through 100. **Prior authorization rules may apply.**
Physical Therapy	You pay $25 per visit
Ambulance	You pay $250 per one-way trip.
Transportation	Not covered.
Medicare Part B Drugs	20% of the cost for chemotherapy drugs. 20% of the cost for other Part B drugs. **Prior authorization is required for drugs over $1,000.**

Premiums and Benefits	Memorial Hermann *Advantage* Plus HMO
Telephone/Virtual Services	You pay nothing for Virtual Visits available through some Primary Care Physicians. You pay a $35.00 Copay for Urgently Needed Services. You pay a $20.00 Copay for Specialist Virtual Visits. You pay nothing for Individual Sessions for Mental Health Specialty Services. You pay a $20.00 Copay for Individual Psychiatric Sessions. You pay a $20.00 Copay for Individual Sessions for Outpatient Substance Abuse. You pay nothing for 24/7 Telephonic visit available through Teladoc.
PRESCRIPTION DRUG BENEFITS (PART D)	
Deductible Phase	During this stage, you pay **the full cost** of your Tier 4 and Tier 5 drugs. You stay in this stage until you have paid $300 for your Tier 4 and Tier 5 drugs.

Initial Coverage Phase –

During this stage, the plan pays its share of the cost of your Tier 1, Tier 2, Tier 3 and Tier 6 drugs and **you pay your share of the cost.**

After you (or others on your behalf) have met your Tier 4 and Tier 5 deductible, the plan pays its share of the costs of your Tier 4 and Tier 5 drugs and you pay your share.

You stay in this Initial Coverage Stage until your **total drug costs** (total of all payments made for your covered Part D drugs) for the year reach **$4,430**.

	Retail Cost-sharing (In-Network) (30-day supply)	**Retail Cost-sharing** (In-Network) (90-day supply)	**Mail Order Cost-sharing** (90-day supply)
Initial Coverage	Preferred Pharmacy	Preferred Pharmacy	
Tier 1: Preferred Generic	You pay $0	You pay $0	You pay $0
Tier 2: Generic	You pay $5	You pay $10	You pay $10
Tier 3: Preferred Brand	You pay $39	You pay $78	You pay $78
Tier 4: Non-Preferred Drug	You pay $92	You pay $184	You pay $184
Tier 5: Specialty	You pay 28%	Not offered	Not offered
Tier 6: Select Care	You pay $0	You pay $0	You pay $0

Cost-Sharing may change depending on the pharmacy you choose and when you enter a new phase of the Part D benefit.

PRESCRIPTION DRUG BENEFITS (PART D)

Coverage Gap -

During this stage, you pay 25% of the price for brand name drugs (plus a portion of the dispensing fee) and 25% of the price for generic drugs.

You stay in this stage until your year-to-date **"out-of-pocket costs"** (total of all payments made for your covered Part D drugs) reach a total of **$7,050**. This amount and rules for counting costs toward this amount have been set by Medicare. Not everyone will enter the Coverage Gap.

Catastrophic Coverage -

You qualify for the Catastrophic Coverage Stage when your out-of-pocket drug costs have reached the **$7,050** limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs.

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the *larger* amount:
    - – *either* – coinsurance of 5% of the cost of the drug
    - –*Or* – $3.95 for a generic drug or a drug that is treated like a generic and $9.85 for all other drugs.
- **Our plan pays the rest** of the cost.

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H7115_PDSBCAHMO00322_M CMS Accepted 9/4/2021