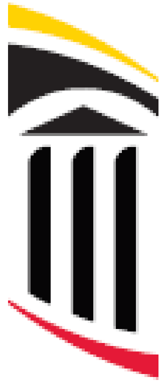

UNIVERSITY of MARYLAND HEALTH ADVANTAGE COMPLETE

2018 Summary of Benefits

University of Maryland Health Advantage COMPLETE Plan (HMO)

H8854 – 001

This is a summary of drug and health services covered by University of Maryland Health Advantage COMPLETE Plan (HMO) from January 1, 2018 – December 31, 2018.

University of Maryland Health Advantage Complete is a Medicare Advantage HMO plan with a Medicare contract and a State of Maryland Department of Health Medicaid program contract. Enrollment in our 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 request the "Evidence of Coverage".

To join **University of Maryland Health Advantage Complete (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 Maryland: Anne Arundel, Baltimore, Baltimore City, Caroline, Carroll, Cecil, Charles, Dorchester, Harford, Howard, Kent, Montgomery, Prince George's, Queen Anne's, and Talbot.

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 or large print.

For more information, please call us at 1-844-262-1122, TTY users should call 711. From October 1 to February 14, you can call us 7 days a week from 8 am to 8 pm ET. From February 15 to September 30, you can call us Monday through Friday from 8 am to 8 pm ET. Or visit us at www.UMMedicareAdvantage.org.

H8854_18_1099-03_001_OE CMS Accepted 8/27/2017

Premiums and Benefits	University of Maryland Health Advantage COMPLETE Plan (HMO)	What you should know
Monthly Plan Premium	You pay $41 per month ▪ $15 for your Part C benefits ▪ $26 for your Part D benefits	You must continue to pay your Medicare Part B premium.
Deductible	You pay nothing.	Our plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (MOOP) *(does not include prescription drugs)*	You pay up to $6,700 annually	This is the most you pay for copays, coinsurance, and other costs for medical services for the year. Please see the *Evidence of Coverage (EOC)*, Chapter 4, "Benefits Chart (what is covered and what you pay)" for a listing of services that do not apply to the Maximum Out-of-Pocket (MOOP).
Inpatient Hospital Coverage	▪ You pay a $275 copay per day for days 1 through 7 ▪ You pay nothing per day for days 8 through 90 ▪ You pay nothing per day for Lifetime Reserve Days 91 through 150	Prior authorization is required for inpatient hospital services. Our plan also covers an additional 60 "extra" days beyond day 90. These are called Lifetime Reserve Days. If your hospital stay is longer than 90 days, you can use these extra days. Once you use these extra 60 days, your inpatient hospital coverage will be limited to 90 days.
Outpatient Hospital Coverage	▪ For surgical procedures performed in an outpatient hospital facility, you pay a $250 copay per visit ▪ For surgical procedures performed in an ambulatory surgical center, you pay a $210 copay per visit	Except in an emergency, prior authorization is required for outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers.
Doctor Visits o Primary care provider o Specialist	▪ You pay $10 copay per visit ▪ You pay $45 copay per visit	Additional services provided in a doctor's office may have additional cost-shares. Please contact our plan for details.
Preventive Care	You pay nothing	For a complete list of all covered preventive services please refer to the *Evidence of Coverage* (EOC). Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	You pay $80 copay per visit	If you are admitted to the hospital within 24 hours, you do not have to pay the copayment for emergency care. Emergency care is only covered within the US and its Territories.

Premiums and Benefits	University of Maryland Health Advantage COMPLETE Plan (HMO)	What you should know
Urgently Needed Services	You pay $50 copay per visit	Urgently needed services is only covered within the US and its Territories.
Diagnostic Services/ Labs/Imaging o Diagnostic radiology service *(e.g., MRI)* o Lab services o Diagnostic tests and procedures o Outpatient x-rays	▪ You pay 20% of the cost ▪ You pay nothing ▪ You pay 20% of the cost ▪ You pay $25 per x-ray	Prior authorization is required for some services by your doctor and other network providers. Please contact our plan for details.
Hearing Services o Hearing exam o Hearing aid	▪ You pay nothing for routine hearing exam and hearing aid fitting evaluations ▪ $750 allowance towards hearing aids	Diagnostic hearing and balance evaluations, to determine if medical treatment is needed, are covered as outpatient care when conducted by a physician, audiologist, or other qualified provider.
Dental Services o Preventive o Comprehensive	▪ You pay $45 per visit ▪ You pay $50 per visit	**Preventive Coverage** is limited to: One (1) oral exam every six (6) months One (1) cleaning every six (6) months One (1) fluoride treatment every six (6) months One (1) set of dental x-rays every 12 months **Comprehensive Coverage** is limited to: One (1) comprehensive oral evaluation every three (3) years Bitewing x-rays; two (2) or four (4) films every one (1) year Four (4) restorative services; not to exceed six (6) surfaces every one (1) year Endodontics; once per lifetime, per tooth Periodontics; two (2) quadrants of scaling per one (1) year Extractions; no limit This plan does not cover dentures.

Premiums and Benefits	University of Maryland Health Advantage COMPLETE Plan (HMO)	What you should know
Vision Services o Diagnosis and treatment of diseases and injuries of the eye, including glaucoma screening and eyeglasses following cataract surgery o Routine eye exam o Eyeglasses, frames and contact lenses	▪ You pay 20% of the cost ▪ You pay nothing ▪ Our plan provides a $150 allowance towards the purchase of contact lenses, eyeglass lenses, and eyeglass frames every two (2) years	The routine vision care benefit is limited to one (1) routine eye examination every two (2) years.
Mental Health Services o Inpatient services o Outpatient Services Individual therapy Group therapy	▪ You pay a $230 copay per day for days 1 through 7 ▪ You pay nothing per day for days 8 through 90 ▪ You pay nothing per day for Lifetime Reserve Days 91 through 190 ▪ You pay $40 copay per visit ▪ You pay $40 copay per visit	Prior authorization is required for inpatient hospital services. Our plan also covers additional "extra" days beyond day 90. These are called Lifetime Reserve Days. If your hospital stay is longer than 90 days, you can use these extra days. Once you used these extra days, your inpatient mental health coverage will be limited to 90 days.
Skilled Nursing Facility (SNF)	▪ You pay nothing per day for days 1 through 20 ▪ You pay a $150 copay per day for days 21 through 100	Prior authorization is required for skilled nursing facility services. Our plan covers up to 100 days in a skilled nursing facility.
Physical Therapy	You pay a $40 copay per visit	Prior authorization is required physical therapy services.
Ambulance	You pay a $275 copayment per one-way trip.	Prior authorization is required for non-emergency ambulance services. Our plan covers non-emergency ambulance transportation when the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.
Transportation	Not covered	
Medicare Part B Drugs	You pay 20% of the cost	Prior authorization is required for chemotherapy and other Medicare Part B covered drugs.

Premiums and Benefits	University of Maryland Health Advantage COMPLETE Plan (HMO)	What you should know
Foot Care *(podiatry services)* o Diagnosis and medical/surgical treatment of injuries and diseases of the foot o Routine foot care	▪ You pay a $50 copay per visit ▪ You pay 20% of the cost	Our plan covers foot care for members with certain medical conditions affecting the lower limbs. In addition, our plan also covers specific routine foot care for all members up to 12 visits per calendar year. Please contact our plan for details.
Chiropractic Care	You pay a $20 copay per visit	Services include manual manipulation of the spine to correct subluxation. Routine chiropractic services are not covered.
Home Health Care	You pay nothing	Prior authorization is required for select home health care services. Please contact the plan for details about what serviced need prior authorization.
Meals	Not covered	
Medical Equipment/Supplies o Durable medical equipment (e.g., wheelchairs, oxygen) o Prosthetics (e.g., braces, artificial limbs) o Diabetic shoes and inserts o Diabetes supplies	▪ You pay 20% of the cost ▪ You pay 20% of the cost ▪ You pay 20% of the cost ▪ You pay nothing	Prior authorization is required for all durable medical equipment and prosthetics over $500 and rentals. Diabetic test strips are limited to 100 strips per month.
Nursing Hotline	You pay nothing	Our plan offers 24/7 nursing hotline.
Occupational Therapy	You pay a $40 copay per visit.	Prior authorization is required for occupational therapy services.
Outpatient Substance Abuse o Individual Therapy o Group Therapy	▪ You pay a $40 copay per visit ▪ You pay a $40 copay per visit	Prior authorization is required for outpatient substance abuse services.
Over-the-Counter Drugs/Products	Not covered	
Speech and Language Therapy	You pay a $40 copay per visit	Prior authorization is required for speech and language therapy services.

Outpatient Prescription Drugs

Phase 1: Initial Coverage

You begin in this stage when you fill your first prescription of the year. During this stage, our plan pays its share of the cost of your drugs and **you pay your share of the cost.** You stay in this stage until your year-to-date **"total drug costs"** (your payments plus any Part D plan's payments) total $3,750.

	Retail Cost-Sharing	Mail Order Cost- Sharing	Long-Term Care (LTC) Cost- Sharing	Out-of-Network Cost-Sharing *(Coverage is limited to certain situations. Please contact our plan for details.)*
Tier 1: Preferred Generic drugs	You pay a $4 copay per prescription up to a 30-day supply You pay a $12 copay per prescription up to a 90-day supply	You pay a $4 copay per prescription up to a 30-day supply You pay a $12 copay per prescription up to a 90-day supply	You pay a $4 copay per prescription up to a 31-day supply	You pay a $4 copay per prescription up to a 10-day supply
Tier 2: Generic drugs	You pay a $15 copay per prescription up to a 30-day supply You pay a $45 copay per prescription up to a 90-day supply	You pay a $15 copay per prescription up to a 30-day supply You pay a $45 copay per prescription up to a 90-day supply	You pay a $15 copay per prescription up to a 31-day supply	You pay a $15 copay per prescription up to a 10-day supply
Tier 3: Preferred Brand drugs	You pay a $47 copay per prescription up to a 30-day supply You pay a $141 copay per prescription up to a 90-day supply	You pay a $47 copay per prescription up to a 30-day supply You pay a $141 copay per prescription up to a 90-day supply	You pay a $47 copay per prescription up to a 31-day supply	You pay a $47 copay per prescription up to a 10-day supply
Tier 4: Non-Preferred Brand drugs	You pay a $100 copay per prescription up to a 30-day supply You pay a $300 copay per prescription up to a 90-day supply	You pay a $100 copay per prescription up to a 30-day supply You pay a $300 copay per prescription up to a 90-day supply	You pay a $100 copay per prescription up to a 31-day supply	You pay a $100 copay per prescription up to a 10-day supply
Tier 5: Specialty drugs	You pay 33% of the cost of the drug up to a 30-day or 90-day supply	Not covered	You pay 33% of the cost of the drug up to a 31-day supply	You pay 33% of the cost of the drug up to a 10-day supply

Phase 2: Coverage Gap

- During this stage, you pay 35% of the price for brand name drugs (plus a portion of the dispensing fee) and 44% of the price for generic drugs.

You stay in this stage until your year-to-date "**out-of-pocket costs**" (your payments) reach a total of $5,000. This amount and rules for counting costs toward this amount have been set by Medicare.

Phase 3: Catastrophic Coverage

- 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* – $3.35 for a generic drug or a drug that is treated like a generic and $8.35 for all other drugs.

During this stage, **our plan will pay most of the cost** of your drugs for the rest of the calendar year (through December 31, 2018).

For more information, please visit us at www.UMMedicareAdvantage.org or call us toll-free: 1-844-262-1122, TTY users should call 711. From October 1 to February 14, you can call us 7 days a week from 8 am to 8 pm ET. From February 15 to September 30, you can call us Monday through Friday from 8 am to 8 pm ET.

You can access the *Evidence of Coverage* (EOC), which provides a full listing of the Plan's benefits and services, on our website at www.UMMedicareAdvantage.org, or by calling the telephone number listed above. You may view our plan's provider directory on our website at www.UMMedicareAdvantage.org/Find-a-Doctor. You can see our plan's pharmacy directory at our website at www.UMMedicareAdvantage.org/Find-a-Medication-Pharmacy. We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at www.UMMedicareAdvantage.org/Find-a-Medication-Pharmacy.

This information is not a complete description of benefits. Contact the plan for more information, Limitations, copayments and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium. This document is available in other formats such as Braille and large print.