

A photograph of two men, one Black and one white, both with beards and glasses, smiling and engaged in conversation. The Black man is on the left, wearing a green shirt. The white man is in the center, wearing a grey jacket over a blue shirt. A third person's face is partially visible on the right. The background is a warm, indoor setting with wooden beams.

MEMORIAL<sup>®</sup>  
HERMANN  
Health Plan

MEMORIAL HERMANN ADVANTAGE  
HMO

## **2022 DUAL ADVANTAGE HMO (D-SNP) SUMMARY OF BENEFITS**

# Memorial Hermann *Dual Advantage* HMO D-SNP

H7115, Plan 005

January 1, 2022 - December 31, 2022.

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

**Memorial Hermann *Dual Advantage* HMO D-SNP** 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."

This plan is a Dual Eligible Special Needs Plan (D-SNP) for people who have both Medicare and Medicaid. To join one of our plans, you must be entitled to Medicare Part A, receive medical assistance from Medicaid, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Texas: Fort Bend, Harris, and Montgomery.

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](http://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.

This plan is a **Dual Eligible Special Needs Plan (D-SNP)** for people who have both Medicare and Medicaid. You may enroll in the Memorial Hermann *Advantage* D-SNP HMO if you fall into one of the four (4) categories:

- **Qualified Medicare Beneficiary Plus (QMB+)**

You get Medicaid coverage of Medicare cost-share and are also eligible for full Medicaid benefits. Medicaid pays your Part A and Part B premiums, deductibles, coinsurance, and copayment amounts. You pay for Part D prescription drug copays.

- **Qualified Medicare Beneficiary (QMB)**

You get Medicaid coverage of Medicare cost-share but are not eligible for full Medicaid benefits. Medicaid pays your Part A and Part B premiums, deductibles, coinsurance, and copayment amounts only. You pay for Part D prescription drug copays.

- **Specified Low-Income Medicare Beneficiary (SLMB+)**

You are eligible for full Medicaid benefits. Medicaid pays your Part B premium and provides full Medicaid benefits. You may also be eligible for limited assistance from your state Medicaid agency in paying your Medicare cost share amounts. Generally, your cost share is 0% when the service is covered by both Medicare and Medicaid. There may be instances where you have to pay cost sharing when a service or benefit is not covered by Medicaid.

- **Full Benefits Dual Eligible (FBDE)**

You are eligible for full Medicaid benefits. Medicaid may provide limited assistance with Medicare cost-sharing. You may also be eligible for limited assistance from the State Medicaid Office in paying your Medicare cost share amounts. Generally, your cost share is 0% when the service is covered by both Medicare and Medicaid. There may be instances where you have to pay cost sharing when a service or benefit is not covered by Medicaid.

Medicare pays covered dually eligible beneficiaries' medical services first, because Medicaid is generally the payer of last resort. Medicaid may cover medical costs Medicare may not cover or partially covers. Coverage for dually eligible beneficiaries varies by State.

Below is a list of the types of services covered by our plan and by Medicaid:

	<b>Memorial Hermann Advantage D-SNP HMO</b>	<b>Medicaid</b>
Preventive Care	Covered	Covered
Doctor Office Visits	Covered	Covered
Inpatient Hospital Care	Covered	Covered
Outpatient Hospital Services	Covered	Covered
Diagnostic Lab and X-Ray	Covered	Covered
Radiology Services	Covered	Covered
Prescription Drug Benefits	Covered	Covered
Inpatient Mental Health Care	Covered	Covered
Outpatient Mental Health Services	Covered	Covered
Dental Services	Covered	Covered
Vision Services	Covered	Covered
Hearing Services	Covered	Covered
Chiropractic Care	Covered	Covered
Podiatry Services	Covered	Covered
Emergency Services	Covered	Covered
Urgently Needed Services	Covered	Covered
Ambulance	Covered	Covered
Transportation	Covered	Covered
Renal Dialysis	Covered	Covered
Home Health Care	Covered	Covered
Prosthetic Devices	Covered	Covered
Skilled Nursing Facility (SNF)	Covered	Not Covered
Hospice Care	Covered	Not Covered

Premiums and Benefits	Memorial Hermann <i>Dual Advantage</i> HMO D-SNP
Monthly Plan Premium	You pay \$25.10 (paid for by Medicaid). You must continue to pay your Medicare Part B premium.
Deductible	No deductible for medical.
Part D Deductible	\$480 per year for Tier 4 and Tier 5 Part D prescription drugs.
Maximum Out-of-Pocket Responsibility <i>(does not include prescription drugs)</i>	You pay no more than \$7,550 annually. Includes copays and other costs for medical services for the year.
Inpatient Hospital	You pay 20% for each Inpatient stay.  <b>Prior authorization rules may apply.</b>
Outpatient Hospital	You pay 20% for each Medicare-covered ambulatory surgical service. You pay 20% for each Medicare-covered outpatient hospital service.  <b>Prior authorization rules may apply.</b>
Doctor Visits <ul style="list-style-type: none"> <li>○ Primary</li> <li>○ Specialists</li> </ul>	You pay 20% 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 20% up to \$90 for each visit If you are admitted to the hospital within 48 hours, then you do not have to pay \$90.
Urgently Needed Services	You pay 20% up to \$65 for each visit
Diagnostic Services/Labs/Imaging <ul style="list-style-type: none"> <li>○ Diagnostic tests and procedures</li> <li>○ Lab services</li> <li>○ MRI, CAT Scan</li> <li>○ X-Rays</li> </ul>	You pay 20% per diagnostic test or procedure. You pay 20% for lab services. You pay 20% per test/service. You pay 20% per x-ray.  <b>Prior authorization is required for some services.</b>

Premiums and Benefits	Memorial Hermann <i>Dual Advantage</i> HMO D-SNP
<b>Hearing Services</b> <ul style="list-style-type: none"> <li>○ Medicare-covered hearing exam</li> <li>○ Routine hearing exam</li> <li>○ Hearing aid</li> </ul>	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 hearing aid(s), both ears combined.
<b>Dental Services</b> <ul style="list-style-type: none"> <li>○ Oral exam, Cleaning &amp; X-rays (Preventive)</li> <li>○ Comprehensive Services</li> <li>○ Medicare-covered dental services (Comprehensive)</li> </ul>	\$1,500 Annual maximum plan benefit You pay nothing for Preventive services. Comprehensive services: <ul style="list-style-type: none"> <li>○ You pay \$50 for each Medicare-covered comprehensive service.</li> <li>○ You pay \$0 copay for Diagnostic services.</li> <li>○ You pay \$0 for Restorative services.</li> <li>○ You pay \$0 for Periodontal services.</li> <li>○ You pay \$0 for Endodontic services.</li> <li>○ You pay \$0 for Extractions.</li> <li>○ You pay \$0 for Prosthodontics, Other Oral/Maxillofacial surgery, Other services.</li> <li>○ You pay \$0 copay for Non-routine services.</li> </ul>
<b>Vision Services</b> <ul style="list-style-type: none"> <li>○ Medicare-covered eye exams</li> <li>○ Eyewear (contact, glasses)</li> </ul>	You pay 20% \$200 annual total allowance for surgical and non-surgical need for eyewear or contact lenses.
<b>Mental Health Services</b> <ul style="list-style-type: none"> <li>○ Outpatient group therapy/ individual therapy visit</li> <li>○ Inpatient mental health care</li> </ul>	You pay 20% for group or individual sessions for Mental Health Specialty services. You pay 20% per group or individual Psychiatric visit. You pay 20% for each Inpatient stay.  <b>Prior authorization rules may apply.</b>
<b>Skilled Nursing Facility</b>	You pay 20%.  <b>Prior authorization rules may apply.</b>
<b>Physical Therapy</b>	You pay 20% for each visit.
<b>Ambulance</b>	You pay 20% per one-way trip.
<b>Transportation</b>	Up to 60 one-way trips approved.
<b>Medicare Part B Drugs</b>	20% of the cost for chemotherapy drugs. 20% of the cost for other Part B drugs.  <b>Prior authorization is required for drugs over \$1,000.</b>



Premiums and Benefits		Memorial Hermann <i>Dual Advantage</i> HMO D-SNP	
Telephone/Virtual Services	You pay 20% for all Telehealth Services/Virtual Visits.  You pay nothing for 24/7 Telephonic visit available through Teladoc.		
PRESCRIPTION DRUG BENEFITS (PART D)			
Deductible Phase	During this stage, you pay <b>the full cost</b> of your Tier 4 and Tier 5 drugs. You stay in this stage until you have paid \$480 for your Tier 4 and Tier 5 drugs.		
<b>Initial Coverage Phase –</b> During this stage, the plan pays its share of the cost of your Tier 1, Tier 2, Tier 3 and Tier 6 drugs and <b>you pay your share of the cost.</b> After you (or others on your behalf) have met your Tier 4 and Tier 5 deductible, the plan pays its share of the of your Tier 4 and Tier 5 drugs and you pay your share. You stay in this Initial Coverage Stage until your <b>total drug costs</b> (total of all payments made for your covered Part D drugs) for the year reach <b>\$4,430</b> .			
	<b>Retail Cost-sharing</b> (In-Network) (30-day supply)	<b>Retail Cost-sharing</b> (In-Network) (90-day supply)	<b>Mail Order Cost-sharing</b> (90-day supply)
Initial Coverage			
Tier 1: Preferred Generic	You pay 25%	You pay 25%	You pay 25%
Tier 2: Generic	You pay 25%	You pay 25%	You pay 25%
Tier 3: Preferred Brand	You pay 25%	You pay 25%	You pay 25%
Tier 4: Non-Preferred Drug	You pay 25%	You pay 25%	You pay 25%
Tier 5: Specialty	You pay 25%	You pay 25%	You pay 25%
Tier 6: Select Care	You pay 25%	You pay 25%	You pay 25%
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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