Plan Benefit	Memorial Hermann *Dual Advantage* D-SNP HMO
Monthly Plan Premium* (**You must continue to pay your Part B Premium.*)	$25.10 a month (paid by Medicaid)
Deductible	No deductible
Maximum Out-of-Pocket Responsibility *(does not include Part D prescription drugs)*	You pay no more than $7,550 annually.
Inpatient Hospital Coverage	You pay 20% per stay.
Outpatient Hospital Coverage	You pay 20% for each Medicare-covered outpatient hospital facility visit.
Doctor Visits	Primary Care Physician (PCP) Visit: You pay 20% per visit. Specialist Visit: You pay 20% per visit. Preventive Care You pay nothing. Emergency Care You pay 20% per visit.
Urgently Needed Services	You pay 20% per visit.
Diagnostic Services/Labs/Imaging	You pay nothing for Blood Services (Transfusions). You pay 20% per test for Non-Radiologic Diagnostic You pay 20% per test for Diagnostic Radiology Services (MRI, CT, PET). Prior authorization required. You pay 20% per Lab Service. You pay 20% per session for Therapeutic Radiology Services (Radiation). You pay 20% per x-ray for Outpatient X-rays.
Hearing Services	Basic hearing and balance exam performed by a primary care doctor: You pay $0. Exam to diagnose and treat hearing and balance issues: You pay $10. Annual hearing exam: You pay $50. Hearing Aid(s) per year: $400 annual benefit to go towards the purchase of hearing aids.
Dental Services	Preventative dental services (such as routine dental care, oral exams, cleaning, x-rays) are covered at no cost to you.
	$1,500 annual maximum plan benefit and no deductible. You pay $50 for Medicare-covered comprehensive dental services.$0 copay for diagnostic services.$0 copay for periodontics. $0 copay for endodontics. $0 copay for extractions. $0 copay for prosthodontics, other oral/maxillofacial surgery, other services. $0 copay for non-routine services.
	Please review the Liberty Dental fee schedule [TBD] for a complete list of fees and services. (Please note that by clicking on this link, you will be leaving Memorial Hermann Advantage website).

	We cover: Medicare-covered dental services limited to surgery of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician. Prior Authorization required.
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): You pay 20%.
	Routine Eye Exam Performed by Optician/Optometrist/Ophthalmologist: You pay 20%.
	Eyewear per year like Contact Lenses, Eyeglasses (frames and lenses): $200 annual benefit to go towards the purchase of eye-wear and contacts.
Mental Health Services (including Inpatient)	Inpatient Services: You pay 20% per stay. Our plan covers an unlimited number of days for an inpatient hospital stay.
	Outpatient Services Outpatient group therapy visit: You pay 20%. Outpatient individual therapy visit: You pay 20%. Outpatient individual therapy visit corresponds to total cost for each Medicare-covered individual therapy visit provided by a non-physician.
Skilled Nursing Facility	You pay 20%. Our plan covers up to 100 days in a skilled nursing facility per 60 day benefit period. Prior Authorization required.
Rehabilitation Services	Cardiac (heart) Rehab Services: You pay 20% per visit. Pulmonary Services: You pay 20% per visit. Occupational Therapy Visit: You pay 20% per visit. Physical Therapy and Speech and Language Therapy Visit: You pay 20% per visit.
Ambulance	You pay 20% per one-way trip.
Transportation	Up to 60 one-way trips per year approved.
Medicare Part B & D Drugs	For Part B drugs such as chemotherapy drugs: You pay 20% coinsurance. Other Part B Drugs: You pay 20% coinsurance.
Foot Care (Podiatry Services)	Foot exams and treatment: You pay $25. Routine Foot Care
Over the Counter Benefit	Reimbursement up to $75.00 every three (3) month period.
Durable Medicare Equipment/Supplies	You pay 20% coinsurance. Prior Authorization required for items over $500.
Meal Benefit	10 meals covered post-surgery or following inpatient hospitalization.
Wellness Programs (e.g. Fitness)	**Silver&Fit® Program**: You pay nothing. Memorial Hermann *Advantage* MHO offers the Silver&Fit® program which includes Home Fitness kits, gym memberships to participating fitness facilities and more - at no extra cost.
	24 Hour Nurse Line: You pay nothing.

Initial Coverage – Preferred Retail Cost-Sharing *(After you pay your deductible, if applicable.)*	**Memorial Hermann *Advantage* HMO**
Deductible	$480 Deductible applies to Tiers 4-5

Initial Coverage Limit	$4,430
Tier 1: Preferred Generic	25% for One-Month Supply // 25% for Two-Month Supply // 25% for Three-Month Supply
Tier 2: Generic	25% for One-Month Supply // 25% for Two-Month Supply // 25% for Three-Month Supply
Tier 3: Preferred Brand	25% for One-Month Supply // 25% for Two-Month Supply // 25% for Three-Month Supply
Tier 4: Non-Preferred Brand	25% for One-Month Supply // 25% for Two-Month Supply // 25% for Three-Month Supply
Tier 5: Specialty Tier Drugs	25% for One-Month Supply
Tier 6: Select Care Drugs	25% for One-Month Supply // 25% for Two-Month Supply // 25% for Three-Month Supply
Initial Coverage – Standard Retail Cost-Sharing *(After you pay your deductible, if applicable.)*	**Memorial Hermann *Advantage* HMO**
Tier 1: Preferred Generic	25% for One-Month Supply // 25% for Two-Month Supply // 25% for Three-Month Supply
Tier 2: Generic	25% for One-Month Supply // 25% for Two-Month Supply // 25% for Three-Month Supply
Tier 3: Preferred Brand	25% for One-Month Supply // 25% for Two-Month Supply // 25% for Three-Month Supply
Tier 4: Non-Preferred Brand	25% for One-Month Supply // 25% for Two-Month Supply // 25% for Three-Month Supply
Tier 5: Specialty Tier Drugs	25% for One-Month Supply
Tier 6: Select Care Drugs	25% for One-Month Supply // 25% for Two-Month Supply // 25% for Three-Month Supply

Mail Order Availability	**Tier**	**One- Month Supply**
	Tier 1 (Preferred Generic)	25%
	Tier 2 (Generic)	25%
	Tier 3 (Preferred Brand)	25%
	Tier 4 (Non-Preferred Brand)	25%
	Tier 5 (Specialty Tier Drugs)	25%
	Tier 6 (Select Care Drugs)	25%
	Note - If you reside in a long-term care facility, you pay the same as at a retail pharmacy.	

Coverage Gap	Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,430. After you enter the coverage gap, 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. Not everyone will enter the coverage gap.
Catastrophic Coverage Rx	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,050, you pay the greater of: 5% of the cost, or $3.95 copay for a generic or preferred multi-source drug (including brand drugs treated as generic) and a $9.85 copay for all other drugs.