Plan Benefit	Memorial Hermann *Advantage* HMO	Memorial Hermann *Advantage* Plus HMO	Memorial Hermann *Advantage* Jefferson HMO
Monthly Plan Premium* *(*You must continue to pay your Part B Premium.)*	$0 a month	$50 a month	$0 a month
Deductible	No deductible	No deductible	No deductible
Maximum Out-of-Pocket Responsibility *(does not include Part D prescription drugs)*	You pay no more than $3,900 annually.	You pay no more than $3,900 annually.	You pay no more than $3,400 annually.
Inpatient Hospital Coverage	You pay $350 per stay.	You pay $350 per stay.	You pay $350 per stay.
Outpatient Hospital Coverage	You pay $300 for each Medicare-covered outpatient hospital facility visit.	You pay $300 for each Medicare-covered outpatient hospital facility visit.	You pay $125 for each Medicare-covered outpatient hospital facility visit.
Doctor Visits	Primary Care Physician (PCP) Visit: You pay $0 per visit. Specialist Visit: You pay $25 per visit. Preventive Care You pay nothing. Emergency Care You pay $90 per visit.	Primary Care Physician (PCP) Visit: You pay $0 per visit. Specialist Visit: You pay $20 per visit. Preventive Care You pay nothing. Emergency Care You pay $90 per visit.	Primary Care Physician (PCP) Visit: You pay $0 per visit. Specialist Visit: You pay $25 per visit. Preventive Care You pay nothing. Emergency Care You pay $120 per visit.
Urgently Needed Services	You pay $35 per visit.	You pay $35 per visit.	You pay $25 per visit.
Diagnostic Services/Labs/Imaging	You pay nothing for Blood Services (Transfusions). You pay $75 per test for Non-Radiologic Diagnostic You pay $250 per test for Diagnostic Radiology Services (MRI, CT, PET). Prior authorization required. You pay $0 per Lab Service. You pay $25 per session for Therapeutic Radiology Services (Radiation). You pay $10 per x-ray for Outpatient X-rays.	You pay nothing for Blood Services (Transfusions). You pay $75 per test for Non-Radiologic Diagnostic You pay $250 per test for Diagnostic Radiology Services (MRI, CT, PET). Prior authorization required. You pay $0 per Lab Service. You pay $25 per session for Therapeutic Radiology Services (Radiation). You pay $10 per x-ray for Outpatient X-rays.	You pay nothing for Blood Services (Transfusions). You pay $75 per test for Non-Radiologic Diagnostic You pay $175 per test for Diagnostic Radiology Services (MRI, CT, PET). Prior authorization required. You pay $0 per Lab Service. You pay $25 per session for Therapeutic Radiology Services (Radiation). You pay $0 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.	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.	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. No annual maximum plan benefit and no deductible. You pay $50 for Medicare-covered comprehensive (periodontal) dental services. 0% for diagnostic services. 20% for periodontics. 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.	Preventative dental services (such as routine dental care, oral exams, cleaning, x-rays) are covered at no cost to you. Annual maximum plan benefit of $2,500 and $0 deductible. You pay $50 for Medicare-covered comprehensive dental services. 0% for diagnostic services. 20% for restorative, endodontics, periodontics and extractions. 50% for Prosthodontics, oral/maxillofacial surgery and other services. You pay $0 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.	Preventative dental services (such as routine dental care, oral exams, cleaning, x-rays) are covered at no cost to you. Annual maximum plan benefit of $1,500 and $0 deductible. You pay $50 for Medicare-covered comprehensive dental services. 0% for diagnostic services. 20% for restorative, endodontics, periodontics and extractions. 50% for Prosthodontics, oral/maxillofacial surgery and other services. You pay $0 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 $0. Routine Eye Exam Performed by Optician/Optometrist/Ophthalmologist: You pay $50. Eyewear per year like Contact Lenses, Eyeglasses (frames and lenses): $200 annual benefit to go towards the purchase of eye-wear and contacts.	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): You pay $0. Routine Eye Exam Performed by Optician/Optometrist/Ophthalmologist: You pay $50. Eyewear per year like Contact Lenses, Eyeglasses (frames and lenses): $200 annual benefit to go towards the purchase of eye-wear and contacts.	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): You pay $0. Routine Eye Exam Performed by Optician/Optometrist/Ophthalmologist: You pay $50. 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 $350 per stay. Our plan covers an unlimited number of days for an inpatient hospital stay. Outpatient Services Outpatient group therapy visit: You pay $0. Outpatient individual therapy visit: You pay $0. Outpatient individual therapy visit corresponds to total cost for each Medicare-covered individual therapy visit provided by a non-physician.	Inpatient Services: You pay $350 per stay. Our plan covers an unlimited number of days for an inpatient hospital stay. Outpatient Services Outpatient group therapy visit: You pay $0. Outpatient individual therapy visit: You pay $0. Outpatient individual therapy visit corresponds to total cost for each Medicare-covered individual therapy visit provided by a non-physician.	Inpatient Services: You pay $350 per stay.. Our plan covers an unlimited number of days for an inpatient hospital stay. Outpatient Services Outpatient group therapy visit: You pay $0. Outpatient individual therapy visit: You pay $0. 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 $0 for days 1 through 20. You pay $150 per day for days 21 through 100. Our plan covers up to 100 days in a skilled nursing facility per 60 day benefit period. Prior Authorization required.	You pay $0 for days 1 through 20. You pay $150 per day for days 21 through 100. Our plan covers up to 100 days in a skilled nursing facility per 60 day benefit period. Prior Authorization required.	You pay $0 for days 1 through 20. You pay $150 per day for days 21 through 100. 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 $25 per visit. Pulmonary Services: You pay $25 per visit. Occupational Therapy Visit: You pay $25 per visit. Physical Therapy and Speech and Language Therapy Visit: You pay $25 per visit.	Cardiac (heart) Rehab Services: You pay $25 per visit. Pulmonary Services: You pay $25 per visit. Occupational Therapy Visit: You pay $25 per visit. Physical Therapy and Speech and Language Therapy Visit: You pay $25 per visit.	Cardiac (heart) Rehab Services: You pay $0 per visit. Pulmonary Services: You pay $0 per visit. Occupational Therapy Visit: You pay $35 per visit. Physical Therapy and Speech and Language Therapy Visit: You pay $35 per visit.
Ambulance	You pay $250 per one-way trip.	You pay $250 per one-way trip.	You pay $250 per one-way trip.
Transportation	Memorial Hermann *Advantage* HMO does not offer transportation services.	Memorial Hermann *Advantage* HMO does not offer transportation services.	Up to 10 Plan-approved one-way trips per year.
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.	For Part B drugs such as chemotherapy drugs: You pay 20% coinsurance. Other Part B Drugs: You pay 20% coinsurance.	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	Foot exams and treatment: You pay $25. Routine Foot Care	Foot exams and treatment: You pay $25. Routine Foot Care
Over the Counter Benefit		$30 Over the counter benefit allowance per quarter, these dollars will not "roll-over" if not used within the quarter.	$25 Over the counter beneift allowance per quarter, these dollars will not "roll-over" if not used within the quarter.
Durable Medicare Equipment/Supplies	You pay 20% coinsurance. Prior Authorization required for items over $500.	You pay 20% coinsurance. Prior Authorization required for items over $500.	You pay 20% coinsurance. Prior Authorization required for items over $500.
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.	**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.	**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**	**Memorial Hermann *Advantage* Plus HMO**	**Memorial Hermann *Advantage* Plus HMO**
Deductible	$300 Deductible applies to Tiers 4-5	$300 Deductible applies to Tiers 4-5	$300 Deductible applies to Tiers 4-5
Initial Coverage Limit	$4,430	$4,430	$4,430
Tier 1: Preferred Generic	$0.00 for One-Month Supply // $0.00 for Two-Month Supply // $0.00 for Three-Month Supply	$0.00 for One-Month Supply // $0.00 for Two-Month Supply // $0.00 for Three-Month Supply	$0.00 for One-Month Supply // $0.00 for Two-Month Supply // $0.00 for Three-Month Supply
Tier 2: Generic	$5.00 for One-Month Supply // $10.00 for Two-Month Supply // $10.00 for Three-Month Supply	$5.00 for One-Month Supply // $10.00 for Two-Month Supply // $10.00 for Three-Month Supply	$5.00 for One-Month Supply // $10.00 for Two-Month Supply // $10.00 for Three-Month Supply
Tier 3: Preferred Brand	$39.00 for One-Month Supply // $78.00 for Two-Month Supply // $78.00 for Three-Month Supply	$39.00 for One-Month Supply // $78.00 for Two-Month Supply // $78.00 for Three-Month Supply	$39.00 for One-Month Supply // $78.00 for Two-Month Supply // $78.00 for Three-Month Supply
Tier 4: Non-Preferred Brand	$92.00 for One-Month Supply // $184.00 for Two-Month Supply // $184.00 for Three-Month Supply	$92.00 for One-Month Supply // $184.00 for Two-Month Supply // $184.00 for Three-Month Supply	$92.00 for One-Month Supply // $184.00 for Two-Month Supply // $184.00 for Three-Month Supply
Tier 5: Specialty Tier Drugs	28% for One-Month Supply // Not available for Two-Month Supply // Not available for Three-Month Supply	28% for One-Month Supply // Not available for Two-Month Supply // Not available for Three-Month Supply	28% for One-Month Supply // Not available for Two-Month Supply // Not available for Three-Month Supply
Tier 6: Select Care Drugs	$0.00 for One-Month Supply // $0.00 for Two-Month Supply // $0.00 for Three-Month Supply	$0.00 for One-Month Supply // $0.00 for Two-Month Supply // $0.00 for Three-Month Supply	$0.00 for One-Month Supply // $0.00 for Two-Month Supply // $0.00 for Three-Month Supply

Initial Coverage – Standard Retail Cost-Sharing *(After you pay your deductible, if applicable.)*	**Memorial Hermann *Advantage* HMO**	**Memorial Hermann *Advantage* Plus HMO**	**Memorial Hermann *Advantage* Plus HMO**
Tier 1: Preferred Generic	$10.00 for One-Month Supply // $20.00 for Two-Month Supply // $20.00 for Three-Month Supply	$10.00 for One-Month Supply // $20.00 for Two-Month Supply // $20.00 for Three-Month Supply	$10.00 for One-Month Supply // $20.00 for Two-Month Supply // $20.00 for Three-Month Supply
Tier 2: Generic	$18.00 for One-Month Supply // $36.00 for Two-Month Supply // $36.00 for Three-Month Supply	$18.00 for One-Month Supply // $36.00 for Two-Month Supply // $36.00 for Three-Month Supply	$18.00 for One-Month Supply // $36.00 for Two-Month Supply // $36.00 for Three-Month Supply
Tier 3: Preferred Brand	$47.00 for One-Month Supply // $94.00 for Two-Month Supply // $94.00 for Three-Month Supply	$47.00 for One-Month Supply // $94.00 for Two-Month Supply // $94.00 for Three-Month Supply	$47.00 for One-Month Supply // $94.00 for Two-Month Supply // $94.00 for Three-Month Supply
Tier 4: Non-Preferred Brand	$100.00 for One-Month Supply // $200.00 for Two-Month Supply // $200.00 for Three-Month Supply	$100.00 for One-Month Supply // $200.00 for Two-Month Supply // $200.00 for Three-Month Supply	$100.00 for One-Month Supply // $200.00 for Two-Month Supply // $200.00 for Three-Month Supply
Tier 5: Specialty Tier Drugs	28% for One-Month Supply // Not available for Two-Month Supply // Not available for Three-Month Supply	28% for One-Month Supply // Not available for Two-Month Supply // Not available for Three-Month Supply	28% for One-Month Supply // Not available for Two-Month Supply // Not available for Three-Month Supply
Tier 6: Select Care Drugs	$8.00 for One-Month Supply // $16.00 for Two-Month Supply // $16.00 for Three-Month Supply	$8.00 for One-Month Supply // $16.00 for Two-Month Supply // $16.00 for Three-Month Supply	$8.00 for One-Month Supply // $16.00 for Two-Month Supply // $16.00 for Three-Month Supply

Mail Order Availability

Tier	One- Month Supply	Two- Month Supply	Three- Month Supply	Tier	One- Month Supply	Two- Month Supply	Three- Month Supply	Tier	One- Month Supply	Two- Month Supply	Three- Month Supply
Tier 1 (Preferred Generic)	$0	$0	$0	Tier 1 (Preferred Generic)	$0	$0	$0	Tier 1 (Preferred Generic)	$0	$0	$0
Tier 2 (Generic)	$5.00	$10.00	$10.00	Tier 2 (Generic)	$5.00	$10.00	$10.00	Tier 2 (Generic)	$5.00	$10.00	$10.00
Tier 3 (Preferred Brand)	$39.00	$78.00	$78.00	Tier 3 (Preferred Brand)	$39.00	$78.00	$78.00	Tier 3 (Preferred Brand)	$39.00	$78.00	$78.00
Tier 4 (Non-Preferred Brand)	$92.00	$184.00	$184.00	Tier 4 (Non-Preferred Brand)	$92.00	$184.00	$184.00	Tier 4 (Non-Preferred Brand)	$92.00	$184.00	$184.00
Tier 5 (Specialty Tier Drugs)	28%	Not available	Not available	Tier 5 (Specialty Tier Drugs)	28%	Not available	Not available	Tier 5 (Specialty Tier Drugs)	28%	Not available	Not available
Tier 6 (Select Care Drugs)	$0	$0	$0	Tier 6 (Select Care Drugs)	$0	$0	$0	Tier 6 (Select Care Drugs)	$0	$0	$0
Note - If you reside in a long-term care facility, you pay the same as at a retail pharmacy.				Note - If you reside in a long-term care facility, you pay the same as at a retail pharmacy.				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.	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.	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.	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.	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.