Memorial Hermann *Advantage* Golden Triangle HMO

H7115, Plan 004

January 1, 2024 – December 31, 2024

This Summary of Benefits documents provides an outline of health and drug services covered by **Memorial Hermann *Advantage* Golden Triangle HMO** January 1, 2024 to December 31, 2024.

Memorial Hermann *Advantage* Golden Triangle 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* Golden Triangle 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: Hardin and Jefferson

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 Customer Service at (855) 645-8448 (TTY users should call 711), for more information or visit us at: https://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.

Memorial Hermann *Advantage* Golden Triangle HMO

Summary of Benefits	What You Will Pay
Monthly Plan Premium	**$0** per month You must continue to pay your Medicare Part B premium.
Deductible	**$0** deductible for medical
Part D Deductible	**$0** deductible for Part D prescription drugs
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	You pay no more than **$3,200** annually. Includes copays and other costs for medical services for the year.
Inpatient Hospital	
Inpatient Hospital stay **Prior authorization rules may apply.**	**$350** copay
Outpatient Hospital Services	
Ambulatory Surgical Center (ASC)	**$125** copay
Outpatient Surgery	**$125** copay
Outpatient Hospital Observation services **Prior authorization rules may apply.**	**$125** copay
Doctor Visits	
Primary Care Provider (PCP)	**$0** copay
Specialists (No referral is needed.)	**$20** copay
Telehealth Provider visit with PCP or Specialists	You pay the same copay for Telehealth visits as you do for in-person office visits.
Memorial Hermann Virtual Office Visit https://www.memorialhermann.org/services/specialties/virtual-care/virtual-office-visit	**$0** copay
Virtual visits exclusively through **Teladoc**	**$0** copay

Summary of Benefits	What You Will Pay
Preventive Care	
○ Abdominal aortic aneurysm screening ○ Annual wellness visit ○ Bone mass measurement ○ Breast cancer screening ○ Cardiovascular disease testing every 5 years ○ Cervical and vaginal cancer screening ○ Colorectal cancer screening ○ Depression screening ○ Diabetes screening ○ Hepatitis C screening ○ HIV screening ○ Lung cancer screening ○ Medical nutrition therapy ○ Medicare Diabetes Prevention Program (MDPP) ○ Obesity screening and therapy ○ Prostate cancer screening ○ Screening and counseling to reduce alcohol misuse ○ Screening for sexually transmitted infections (STIs) ○ Tobacco use cessation counseling ○ Vaccines for flu, Hepatitis B, COVID-19, and pneumonia ○ "Welcome to Medicare" preventive visit	**$0** copay Please see your Evidence of Coverage for more information about these Medicare-covered preventive services.
Emergency and Urgently Needed Services	
Emergency care	**$125** per visit This copay is waived if admitted within 48 hours.
Worldwide Emergency care	**$125** USD per visit This copay is waived if admitted within 48 hours.
Worldwide Emergency Transportation	**20%** coinsurance
Urgently Needed services	**$25** per visit
Worldwide Urgently Needed services	**$25** USD per visit
$50,000 USD maximum benefit for worldwide emergency.	

Summary of Benefits	What You Will Pay
Diagnostic Services/ Labs/ Imaging	
Medicare-covered Therapeutic Radiology visit	**$25** copay per diagnostic test or procedure
Lab services	**$0** copay for lab services
X-rays	**$0** copay for x-rays
Complex Diagnostic Imaging services (MRI, CT, PET) **Prior authorization is required for some services.**	**$150** copay per test/service
Hearing Services	
Medicare-covered Annual Hearing Exam	**$20** copay
Routine Hearing Exam performed by PCP	**$0** copay for basic hearing and balance exam
Hearing Exam performed by Audiologist	**$0** copay for exam to diagnose and treat hearing and balance
Hearing Aid(s) *(Benefit amount combined with Vision)	**$900*** annual total allowance for hearing aid(s) for both ears combined
Dental Services	
$2,500 annual maximum plan benefit	
Preventive Services o Oral Exam (2 per plan year) o Prophylaxis (Cleanings) (2 per plan year) o X-rays (2 per plan year) o Fluoride Treatments (2 per plan year)	**$0** copay for Preventive services from a network provider **20%** coinsurance for Preventive services from a non-network provider
Comprehensive Services o Diagnostic o Restorative (fillings, bridges) o Periodontics (scaling, root planning) o Endodontics (root canal) o Extractions o Prosthodontics (dental appliances, dentures) o Other Oral/Maxillofacial Surgery o Other services o Non-routine services	**$20** copay per visit for each Medicare-covered Comprehensive service **$0** copay for in-network Diagnostic services, or **20%** coinsurance of the cost for out-of-network Diagnostic services **$8 - $200** copay for in-network Restorative services, or **50%** coinsurance for out-of-network services **$5 - $183** copay for in-network Periodontic services, or **50%** coinsurance for out-of-network services

Summary of Benefits	What You Will Pay
Dental Services (continued) Dental benefits are provided by Liberty Dental. To search for a provider, visit their website at: https://client.libertydentalplan.com/MemorialHermannMedicare/FindADentist **Note: Copay amounts for in-network Comprehensive services vary depending on the type and intensity of the procedure or service. Please review the detailed dental fee schedule in the Liberty Dental Addendum to see the exact copay amount for each procedure type.**	**$9 - $331** copay for in-network Endodontic services, or **50%** coinsurance for out-of-network services **$22 - $94** copay for in-network Extraction services, or **50%** coinsurance for out-of-network services **$4 - $1,027** copay for in-network Prosthodontics, Other Oral/Maxillofacial Surgery, Other services, or **50%** coinsurance for out-of-network services Copays for in-network Non-routine services depend on type of service. **50%** coinsurance for out-of-network services.
Vision Services	
Medicare-covered Eye Exams	**$20** copay
Routine Vision Exams	**$0** copay
Glaucoma Screenings	**$0** copay for one annual screening
Diabetic Retinopathy Screenings for Diabetics	**$0** copay for one annual screening
Eyewear (contacts, lenses, frames) *(Benefit amount combined with Hearing)	**$900*** annual total benefit for eyewear or contact lenses
Mental Health / Substance Abuse Services	
Inpatient Mental Health care	**$350** copay per stay
Outpatient individual therapy or group therapy session with a non-physician provider	**$0** copay
Outpatient individual therapy or group therapy session with a Psychiatrist	**$20** copay
Outpatient Opioid Treatment Program	**$20** copay
Inpatient Opioid Treatment Program	**$350** copay per stay
Outpatient Substance Abuse visit	**$25** copay
Prior authorization rules may apply.	

Summary of Benefits	What You Will Pay
Skilled Nursing Facility	
Days 1 - 20	**$0** copay per day
Days 21 – 100	**$125** copay per day
Prior authorization rules may apply.	
Rehabilitation Services	
Physical Therapy, Occupational Therapy, and Speech and Language Therapy	**$35** copay
Cardiac Rehab services	**$0** copay
Pulmonary Rehab services	**$0** copay
Chiropractic care Manual manipulation of the spine to correct subluxation	**$20** copay
Acupuncture For the treatment of chronic lower back pain	**$35** copay
Ambulance	
Ground Ambulance (one-way)	**$250** copay
Air Ambulance (one-way)	**20%** coinsurance
Prior authorization is required for non-emergency Medicare services.	
Transportation	
Includes taxi, rideshare services, bus, subway, van, and medical transport.	Up to **20** plan-approved one-way transports to health-related locations per year
Medicare Part B Drugs	
Chemotherapy / Radiation drugs	**20%** of the cost
Other Part B drugs	**20%** of the cost
Prior authorization may be required for Part B drugs.	**20%** of the cost up to a **$35** maximum for a one-month supply of insulin furnished through a DME supplier.

Summary of Benefits	What You Will Pay
Home Infusion Therapy	
Medicare-covered home infusion therapy, including chemotherapy, anti-infectives, and other specialty medications to treat various conditions **Prior authorization may be required for Medicare Part B drugs.**	**20%** coinsurance
Home Health Care	
Medicare-covered Home Health visit	**$0** copay
Home-based Palliative care **Prior authorization rules may apply.**	**$0** copay
Diabetic Services and Supplies	
Medicare-covered Diabetic Supplies	**20%** coinsurance
Diabetes self-management training	**0%** coinsurance
Preferred exclusive brands of glucometers and test strips (One Touch by Life Scan and Accu-Chek by Roche)	**0%** coinsurance
Medicare-covered therapeutic custom-molded shoes or inserts	**20%** coinsurance
Continuous Glucose Monitors (CGM) are limited to our preferred manufacturers, DexCom G6/G7 and Freestyle Libre/Libre 2/Libre 14. We may only cover other brands and manufacturers if your doctor or other provider tells us that the preferred brand is not appropriate for your medical needs.	**20%** coinsurance for the preferred CGM brands at a network pharmacy (retail) **All other brands are excluded.**
Durable Medical Equipment (DME)	
Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.	**20%** coinsurance
Wigs for chemotherapy patients **Prior authorization rules may apply.**	**$0** copay

Summary of Benefits	What You Will Pay
Hospice	
Covered services include drugs for symptom control and pain relief, short-term respite care, and home care. **Prior authorization rules may apply.**	Covered
Telephone/Virtual Services	
Virtual visits through Primary Care Physicians	**$0** copay
Specialist Virtual visits	**$20** copay
Urgently Needed services	**$25** copay
Individual and Group sessions for: • Mental Health Specialty services • Psychiatric services • Outpatient Substance Abuse	 **$0** copay **$20** copay **$25** copay
Memorial Hermann Virtual Office Visit https://www.memorialhermann.org/services/specialties/virtual-care/virtual-office-visit	**$0** copay
24/7 Telephonic visit available through **Teladoc**. You may register or log in to Teladoc at https://www.teladoc.com/.	**$0** copay
Healthy Advantage Wellness Rewards Program	
Complete the following activities to earn rewards: • Annual Health Risk Assessment • Annual Wellness Visit • Breast Cancer Screening • Colon Cancer Screening • Retinal Eye Exam	Earn up to **$180** in gift card rewards for CMS-approved goods and services.

Summary of Benefits	What You Will Pay
Meals	
Meals provided immediately following inpatient hospitalization discharge.	Up to **10** meals delivered per hospital discharge
Over-the-counter (OTC) Items	
The Plan provides a benefit for certain CMS-approved OTC items every three (3) months. Unused funds at the end of the quarter do not roll over to the next quarter.	**$40** maximum allowance per quarter
Food and Produce (Groceries)	
The Plan provides an annual benefit for approved food and produce (groceries) for member upon successful completion of a Case Management Program.	**$500** per plan year
Flexible Spending Debit Card (Mastercard)	
The Flex Card includes three (3) spending categories:	
Hearing and Vision Hearing and Vision have a combined annual allowance to spend as needed for eyewear and/or hearing aids.	**$900** annual combined allowance
Over-the-Counter (OTC) items OTC benefit is every three (3) months for CMS-approved items. Unused funds at the end of the quarter do not roll over to the next quarter.	**$40** quarterly allowance
Grocery Benefit Grocery benefit may be added to the Flex Card upon successful completion of a Case Management Program. Acceptable groceries follow the USDA SNAP guidelines.	**$500** annual allowance

Case Management

A Case Manager is a Registered Nurse (RN) who provides one-on-one care to the member, with a focus on maintaining wellness and independence. Examples include:

- helping to understand a new diagnosis and how to manage it;
- finding a new in-network provider; and
- helping a member find community resources if they're struggling to pay bills or having trouble moving safely around their home

Summary of Benefits	What You Will Pay
Additional Health & Wellness Benefits	
Fitness Center Membership With new and fun ways to get fit and stay healthy, the Silver & Fit program includes: ○ Being a member at a Silver & Fit fitness center or fitness studio that participates in Memorial Hermann Prime Value MA Only HMO basic program is at no cost to you. You may choose to purchase additional buy-up services. Contact your fitness center. ○ Silver & Fit Home Fitness kits, if you cannot get to a fitness center or prefer to work out at home. ○ Workout plans to help you start or continue an exercise routine. ○ On-demand workout videos for all fitness levels on the Silver&Fit website. ○ The Well-Being Club for live virtual classes and events and exclusive resources. ○ The Silver Slate® newsletter 4 times per year. ○ The Silver&Fit website. A toll-free telephone hotline to answer questions about the program. ○ Available contracted fitness club location must be utilized throughout the service area. Specific class offerings will vary by location. The Silver&Fit program is provided by American Specialty Health Fitness, Inc. (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit is a federally registered trademark of ASH and used with permission herin. Kits are subject to change. Fitness center participation may vary by location and is subject to change.	**$0** copay for Fitness Program via home exercise kit program

PRESCRIPTION DRUG BENEFITS (PART D)	
Deductible Phase	**$0** deductible for Part D drugs

Initial Coverage Phase

During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.**

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 **$5,030**.

Initial Coverage	**Retail Cost- sharing** (In-Network) (30-day supply)	**Retail Cost- sharing** (In-Network) (90-day supply)	**Mail Order Cost-sharing** (90-day supply) through **Costco**
Tier 1: Preferred Generic	**$0** copay	**$0** copay	**$0** copay
Tier 2: Generic	**$0** copay	**$0** copay	**$0** copay
Tier 3: Preferred Brand	**$47** copay	**$141** copay	**$141** copay
Tier 4: Non-Preferred Drug	**$100** copay	**$300** copay	**$300** copay
Tier 5: Specialty	**33%** coinsurance	Not offered	Not offered
Tier 6: Select Care	**$0** copay	**$0** copay	**$0** copay

Cost-Sharing may change when you enter a new phase of the Part D benefit.

You won't pay more than $35.00 per month supply of each covered insulin product, regardless of the cost-sharing tier.

Select Care Drugs (Tier 6) have no copayment for this tier and are limited to select generic medications commonly prescribed to treat ongoing health conditions like high blood pressure, cholesterol, and diabetes.

Important Message About What You Pay for Vaccines – Our Plan covers most Part D vaccines at no cost to you. Call Customer Service for more information.

PRESCRIPTION DRUG BENEFITS (PART D) (continued)

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 **$8,000**. This amount and rules for counting costs toward this amount have been set by Medicare.

Select Care Drugs (Tier 6) are available at **$0** copayment during the Coverage Gap stage.

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 **$8,000** 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 pays the full cost for your covered Part D drugs. You pay nothing.

Mail Order Pharmacy

Receive up to a 90-day supply of your drug through Costco. You do not need to be a Costco member to use their mail order pharmacy service.

Pharmacy Network

To find out more about the pharmacy network, please visit our site at:
https://healthplan.memorialhermann.org/medicare-advantage/pharmacy-benefits/pharmacy-directory .