



UNIVERSITY *of* MARYLAND HEALTH ADVANTAGE DUAL

2018 Summary of Benefits

University of Maryland Health Advantage DUAL Plan (HMO-SNP)

H8854 – 002

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

University of Maryland Health Advantage Dual is a Medicare Advantage HMO-SNP 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 Dual (HMO-SNP)** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, have Medical Assistance from the State of Maryland, 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.

Premiums and Benefits	Medicaid State Plan	University of Maryland Health Advantage DUAL Plan (HMO-SNP)	What you should know
Monthly Plan Premium	\$0 copay for Medicaid covered services	You pay \$30.70 per month <ul style="list-style-type: none"> \$0 for your Part C benefits \$30.70 for your Part D benefits 	You must continue to pay your Medicare Part B premium. Full-Dual enrollees of University of Maryland Health Advantage will have their Medicare Part B premium paid for by the State of Maryland.
Deductible	\$0 copay for Medicaid covered services	You pay \$0 - \$183 per year for in-network services, depending on your level of Medicaid eligibility	Our plan has deductibles for some hospital and medical services.
Maximum Out-of-Pocket Responsibility (MOOP) <i>(does not include prescription drugs)</i>	There is no maximum out-of-pocket.	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 <i>Evidence of Coverage (EOC)</i> , 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	\$0 copay for Medicaid covered services	<ul style="list-style-type: none"> You pay \$1,340 deductible for days 1 through 60 You pay a \$335 copay per day for days 61 through 90 You pay a \$670 copay per day for Lifetime Reserve Days 91 through 150 <p>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0</p>	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	\$0 copay for Medicaid covered services	You pay 20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0	Except in an emergency, prior authorization is required for outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers.
Doctor Visits <ul style="list-style-type: none"> Primary care provider Specialists 	\$0 copay for Medicaid covered services	<ul style="list-style-type: none"> You pay 20% of the cost You pay 20% of the cost <p>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0</p>	Additional services provided in a doctor's office may have additional cost-shares. Please contact our plan for details.

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Preventive Care	\$0 copay for Medicaid covered services Medicaid covered services include: early and periodic screenings, diagnosis and treatment services (for beneficiary under 21 years of age).	You pay nothing	For a complete list of all covered preventive services please refer to the <i>Evidence of Coverage</i> (EOC). Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	\$0 copay for Medicaid covered services	You pay 20% of cost per visit If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0	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.
Urgently Needed Services	\$0 copay for Medicaid covered services	You pay 20% of cost per visit. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0	Urgently needed services are only covered within the US and its Territories.
Diagnostic Services/ Labs/Imaging <ul style="list-style-type: none"> ○ Diagnostic radiology service (e.g., MRI) ○ Lab services ○ Diagnostic tests and procedures ○ Outpatient x-rays 	\$0 copay for Medicaid covered services	<ul style="list-style-type: none"> ▪ You pay 20% of the cost ▪ You pay 20% of the cost ▪ You pay 20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0	Prior authorization is required for some services by your doctor and other network providers. Please contact our plan for details.
Hearing Services <ul style="list-style-type: none"> ○ Hearing exam ○ Hearing aid 	\$0 copay for Medicaid covered services Medicaid covered services include: hearing aids for beneficiaries under 21 years of age.	<ul style="list-style-type: none"> ▪ You pay nothing for routine hearing exam and hearing aid fitting evaluations ▪ You pay nothing per hearing aid 	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 Preventive	\$0 copay for Medicaid covered services Medicaid covered services include: dental services and dentures for beneficiaries under 21 years of age.	You pay nothing per visit	Preventive Coverage is limited to: <ul style="list-style-type: none"> ▪ 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

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<p>Dental Services (continued)</p> <p>Comprehensive</p>	<p>\$0 copay for Medicaid covered services</p> <p>Medicaid covered services include: dental services and dentures for beneficiaries under 21 years of age.</p>	<p>You pay nothing per visit</p>	<p>Comprehensive Coverage is limited to:</p> <ul style="list-style-type: none"> ▪ One (1) comprehensive oral evaluation every three (3) months ▪ Bitewing x-rays; two (2) or four (4) films every one (1) year ▪ Endodontics; once per lifetime, per tooth ▪ Extractions; no limit <p>Our plan provides an annual allowance of \$1,000 per calendar year for the following services:</p> <ul style="list-style-type: none"> ▪ Four (4) restorative services; not to exceed six (6) surfaces every one (1) year ▪ Periodontics; two (2) quadrants of scaling per one (1) year ▪ Dental plates, either upper or lower or partial, or any combination thereof, once every three (3) years ▪ Dentures; two (2) of any four (4) adjustments every one (1) year
<p>Vision Services</p> <ul style="list-style-type: none"> ○ Diagnosis and treatment of diseases and injuries of the eye, including glaucoma screening and eyeglasses following cataract surgery ○ Routine eye exam ○ Eyeglasses, frames, and contact lenses 	<p>\$0 copay for Medicaid covered services</p> <p>Medicaid covered services include: eyeglasses for beneficiaries under 21 years of age, and an eye exam every two (2) years.</p>	<ul style="list-style-type: none"> ▪ You pay 20% of the cost <p>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0</p> <ul style="list-style-type: none"> ▪ You pay nothing ▪ Our plan provides a \$100 towards the purchase of contact lenses, eyeglass frames, and eyeglass frames every one (1) year 	<p>The routine vision care benefit is limited to one (1) routine eye examination every two (2) years.</p>

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Mental Health Services Inpatient services Outpatient services <ul style="list-style-type: none"> ○ Individual therapy ○ Group therapy 	\$0 copay for Medicaid covered services	<ul style="list-style-type: none"> ▪ You pay a \$1,340 deductible for days 1 through 60 ▪ You pay a \$335 copay per day for days 61 through 90 ▪ You pay a \$670 copay per Lifetime Reserve Day for days 91 through 150 ▪ You pay 20% of the cost ▪ You pay 20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.	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 use these extra days, your inpatient mental health coverage will be limited to 90 days.
Skilled Nursing Facility (SNF)	\$0 copay for Medicaid covered services	<ul style="list-style-type: none"> ▪ You pay nothing per day for days 1 through 20 ▪ You pay \$167.50 copay per day for days 21 through 100. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.	Prior authorization is required for skilled nursing facility services. Our plan covers up to 100 days in a skilled nursing facility.
Physical Therapy	\$0 copay for Medicaid covered services	You pay 20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.	Prior authorization is required for physical therapy services.
Ambulance	\$0 copay for Medicaid covered services	You pay 20% of cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.	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	\$0 copay for Medicaid covered services	You pay nothing	Our plan offers 24 one-way trips per year to plan approved locations. Prior authorization is required. Please contact our plan for details.

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Medicare Part B Drugs	\$0 copay for Medicaid covered services	You pay 20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.	Prior authorization is required for chemotherapy and other Medicare Part B covered drugs.
Foot Care (<i>podiatry services</i>) <ul style="list-style-type: none"> ○ Diagnosis and medical/surgical treatment of injuries and diseases of the foot ○ Routine foot care 	\$0 copay for Medicaid covered services	<ul style="list-style-type: none"> ▪ You pay 20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0. <ul style="list-style-type: none"> ▪ You pay nothing 	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	\$0 copay for Medicaid covered services	You pay 20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.	Services include manual manipulation of the spine to correct subluxation. Routine chiropractic services are not covered.
Home Health Care	\$0 copay for Medicaid covered services	You pay nothing	Prior authorization is required for select home health care services. Please contact our plan for details about what services need prior authorization.
Meals	\$0 copay for Medicaid covered services	You pay nothing	Our plan offers up to 42 meals to eligible members recovering from an inpatient stay in a hospital or skilled nursing facility (SNF) who have no support at home upon discharge. Prior authorization is required for meals post-discharge.
Medical Equipment/Supplies <ul style="list-style-type: none"> ○ Durable medical equipment (e.g., wheelchairs, oxygen) ○ Prosthetics (e.g., braces, artificial limbs) ○ Diabetic shoes and inserts ○ Diabetes supplies 	\$0 copay for Medicaid covered services	<ul style="list-style-type: none"> ▪ You pay 20% of the cost ▪ You pay 20% of the cost ▪ You pay 20% of the cost ▪ You pay 20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.	Prior authorization is required for all durable medical equipment and prosthetics over \$500 and rentals. Diabetic test strips are limited to 100strips per month.

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Nursing Hotline	\$0 copay for Medicaid covered services	You pay nothing	Our plan offers 24/7 nursing support.
Occupational Therapy	\$0 copay for Medicaid covered services	You pay 20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.	Prior authorization is required for occupational therapy services.
Outpatient Substance Abuse o Individual therapy o Group therapy	\$0 copay for Medicaid covered services	<ul style="list-style-type: none"> ▪ You pay 20% of the cost ▪ You pay 20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0	Prior authorization is required for outpatient substance abuse services.
Over-the-Counter Drugs/Products	\$0 copay for Medicaid covered services	Our plan pays a maximum quarterly benefit amount of \$60 per quarter per calendar year. You pay the balance.	Any unused benefit expires at the end of each quarter and cannot be carried over to the next quarter.
Speech and Language Therapy	\$0 copay for Medicaid covered services	You pay 20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.	Prior authorization is required for speech and language therapy services.

Outpatient Prescription Drugs

Medicaid Covered Prescription Drugs:

You pay up to a \$1 copayment for generic drugs.
You pay up to a \$3 copayment for brand-name drugs.

University of Maryland Health Advantage DUAL Plan (HMO-SNP)

Phase 1: Deductible Stage

Because you are eligible for Medicaid, you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. Your deductible amount will be either \$0 or \$82, depending on the level of “Extra Help” you receive.

- *If your deductible is \$0:* This payment stage does not apply to you.
- *If your deductible is \$82:* You pay the full cost of your drugs until you have paid \$82.

Phase 2: Initial Coverage Stage

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 “**out-of-pocket costs**” total \$5,000. You then move on to the Catastrophic Coverage Stage.

	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.)
All covered drugs (Depending on your income and institutional status)	For generic drugs (including brand drugs treated as generic), you pay either: \$0, \$1.25, or \$3.35 copay. For all other drugs, you pay either: \$0, \$3.35, or \$8.35 copay.	For generic drugs (including brand drugs treated as generic), you pay either: \$0, \$1.25, or \$3.35 copay. For all other drugs, you pay either: \$0, \$3.35, or \$8.35 copay.	For generic drugs (including brand drugs treated as generic), you pay either: \$0, \$1.25, or \$3.35 copay. For all other drugs, you pay either: \$0, \$3.35, or \$8.35 copay.	For generic drugs (including brand drugs treated as generic), you pay either: \$0, \$1.25, or \$3.35 copay. For all other drugs, you pay either: \$0, \$3.35, or \$8.35 copay.

Phase 3: Catastrophic Coverage

- You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the \$5,000 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.
 - **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the larger amount:
 - o – *either* – Coinsurance of 5% of the cost of the drug
 - o – *or* – \$3.35 for a generic drug or a drug that is treated like a generic and \$8.35 for all other drugs.
 - **Our plan pays the rest** of the cost.

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 our 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 at 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. Premium co-pays, co-insurance and deductibles may vary based on the level of extra Help you receive. Please contact the plan for further details. The University of Maryland Health Advantage Dual Plan is available to anyone who has both Medical Assistance from the State and Medicare. You must continue to pay your Medicare Part B Premium. The state will pay for the Part B premium if you are a Full-Dual enrollee. This document is available in other formats such as Braille and large print.