ADVANTAGE MD
Johns Hopkins Medicine Medicare Plan

SUMMARY OF BENEFITS

2017 HEALTH PLANS

EFFECTIVE JANUARY 1, 2017 THROUGH DECEMBER 31, 2017

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H3890_002

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January 1, 2017 – December 31, 2017

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

You have choices about how to get your Medicare benefits

One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.

Another choice is to get your Medicare benefits by joining a Medicare health plan (such as Johns Hopkins Advantage MD (PPO) or Johns Hopkins Advantage MD Plus (PPO).

Tips for comparing your Medicare choices:

This Summary of Benefits booklet gives you a summary of what Johns Hopkins Advantage MD and Johns Hopkins Advantage MD Plus cover and what you pay.

If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About Johns Hopkins Advantage MD and Johns Hopkins Advantage MD Plus:
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats, such as Braille and large print

This document may be available in a non-English language. For additional information, call us at 1-888-403-7682 (TTY: 711).

Things to Know About Johns Hopkins Advantage MD and Johns Hopkins Advantage MD Plus:

Hours of Operation

From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time.

From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time.

Johns Hopkins Advantage MD and Johns Hopkins Advantage MD Plus Phone Numbers and Website

If you are a member of this plan, call toll-free 1-877-293-5325 (TTY: 711)

If you are not a member of this plan, call toll-free 1-888-403-7682 (TTY: 711)

Our website: http://www.HopkinsMedicare.com

Who can join?

To join Johns Hopkins Advantage MD or Johns Hopkins Advantage MD Plus, 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 Maryland: Anne Arundel, Baltimore, Baltimore City, Calvert, Carroll, Howard, Montgomery, Somerset, Washington, Wicomico, and Worcester.

Which doctors, hospitals, and pharmacies can I use?

Johns Hopkins Advantage MD and Johns Hopkins Advantage MD Plus have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directory at our website (www.HopkinsMedicare.com). Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers and more.

Our plan members get all of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less. Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this booklet.

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, http://www.HopkinsMedicare.com.

Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

QUESTIONS	ADVANTAGE MD	ADVANTAGE MD PLUS
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES		
How much is the monthly premium?	$44 per month. In addition, you must keep paying your Medicare Part B premium.	$78 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan does not have a deductible.	This plan does not have a deductible.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: $6,700 for services you receive from in-network providers. $10,000 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: $6,700 for services you receive from in-network providers. $10,000 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for optional supplemental benefits only.	Our plan has a coverage limit every year for certain benefits from any provider. Contact us for services that apply.

COVERED MEDICAL AND HOSPITAL BENEFITS		
Note: Services with a 1 may require prior authorization. Services with a 2 may require a referral from your doctor. Note in the Summary of Benefits in reference to referral or authorization.		
BENEFITS	**ADVANTAGE MD**	**ADVANTAGE MD PLUS**
Outpatient Care and Services		
Acupuncture	Not covered	Our plan will pay up to $200 a year for acupuncture services provided either in-network or out-of-network.
Ambulance[1] Prior authorization required for non-emergent services	In-network: $300 copay Out-of-network: $300 copay Copay includes one-way trip for emergency ambulance services and non-emergency ambulance services. The ambulance copay is not waived if you are admitted to the hospital.	In-network: $300 copay Out-of-network: $300 copay Copay includes one-way trip for emergency ambulance services and non-emergency ambulance services. The ambulance copay is not waived if you are admitted to the hospital.
Chiropractic Care[1]	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): In-network: $20 copay Out-of-network: 50% coinsurance	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): In-network: $20 copay Out-of-network: 30% coinsurance
Dental Services	Limited diagnostic dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): In-network: $30-$55 copay, depending on the service Preventive dental services: Cleaning (for up to 1 every year): In-network: $15 copay Dental X-ray(s) (for up to 1 every year): In-network: $25 copay Out-of-network: 50% allowed amount (Members are responsible for the difference between the allowed amount and the billed amount.)	Limited diagnostic dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): In-network: $20-$40 copay, depending on the service Preventive dental services: Cleaning (for up to 2 every year): In-network: $10 copay Dental X-ray(s) (for up to 2 every year): In-network: $20 copay Out-of-network: 45% allowed amount (Members are responsible for the difference between the allowed amount and the billed amount.)

BENEFITS	ADVANTAGE MD	ADVANTAGE MD PLUS
Dental Services (Continued)	Oral exam (for up to 1 every year): In-network: $15 copay Out-of-network: 50% coinsurance	Oral exam (for up to 2 every year): In-network: $10 copay Out-of-network: 45% coinsurance
Medicare-covered dental services	In-network: $75 copay for Medicare-covered services performed by a PCP/Specialist $75 copay for services performed in an Emergency setting Out-of-network: 50% coinsurance, once per year.	In-network: $75 copay for Medicare-covered Services performed by a PCP/Specialist $75 copay for services performed in an Emergency setting Out-of-network: 45% coinsurance, once per year.
Diabetes Supplies and Services[1] and diabetic therapeutic shoes and inserts:	In-network: You pay 0-20% of the total cost. Out-of-network: 40% coinsurance Prior authorization is required for Diabetic Supplies and Services exceeding $1,000. Diabetic Supplies covered at 0-20% coinsurance, depending on the supply. 0% coinsurance applies when supplies are received from Johns Hopkins Home Care Group. 20% coinsurance applies when supplies are received from all other diabetic supply providers.	In-network: You pay 0-20% of the total cost. Out-of-network: 30% coinsurance Prior authorization is required for Diabetic Supplies and Services exceeding $1,000. Diabetic Supplies covered at 0-20% coinsurance, depending on the supply. 0% coinsurance applies when supplies are received from Johns Hopkins Home Care Group. 20% coinsurance applies when supplies are received from all other diabetic supply providers.

BENEFITS	ADVANTAGE MD	ADVANTAGE MD PLUS
Diagnostic Tests, Lab and Radiology Services, and X-Rays (*Costs for these services may vary based on place of service*)[1]	Diagnostic radiology services (such as MRIs, CT scans): In-network: $250 copay Out-of-network: 50% coinsurance Diagnostic tests and procedures: In-network: 20% coinsurance Out-of-network: 50% coinsurance Lab services: In-network: 0% coinsurance Out-of-network: 50% coinsurance Outpatient X-rays: In-network: 20% coinsurance Out-of-network: 30% coinsurance Therapeutic radiology services (such as radiation treatment for cancer): In-network: 20% coinsurance Out-of-network: 50% coinsurance	Diagnostic radiology services (such as MRIs, CT scans): In-network: $250 copay Out-of-network: 45% coinsurance Diagnostic tests and procedures: In-network: 20% coinsurance Out-of-network: 45% coinsurance Lab services: In-network: 0% coinsurance Out-of-network: 45% coinsurance Outpatient X-rays: In-network: $20 copay Out-of-network: 20% coinsurance Therapeutic radiology services (such as radiation treatment for cancer): In-network: 20% coinsurance Out-of-network: 45% coinsurance
Doctor's Office Visits	Primary Care Provider visits: In-network: $10 copay Out-of-network: 30% coinsurance Specialist visit: In-network: $50 copay Out-of-network: 30% coinsurance	Primary Care Provider visits: In-network: $5 copay Out-of-network: 30% coinsurance Specialist visit: In-network: $40 copay Out-of-network: 30% coinsurance

BENEFITS	ADVANTAGE MD	ADVANTAGE MD PLUS
Durable Medical Equipment (*wheelchairs, oxygen, etc.*)[1]	In-network: 20% coinsurance Out-of-network: 50% coinsurance	In-network: 20% coinsurance Out-of-network: 45% coinsurance
Emergency Care[1]	In-network: $75 copay Out-of-network: $75 copay	In-network: $75 copay Out-of-network: $75 copay
Foot Care (*podiatry services*)	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: In-network: $50 copay Out-of-network: 40% coinsurance	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: In-network: $40 copay Out-of-network: 30% coinsurance
Hearing Services	Exam to diagnose and treat hearing and balance issues: In-network: $50 copay Out-of-network: 50% coinsurance	Exam to diagnose and treat hearing and balance issues: In-network: $40 copay Out-of-network: 45% coinsurance Routine hearing exam: In-network: $40 copay Out-of-network: 45% coinsurance Hearing aid: You pay $699 or $999 per hearing aid for up to two TruHearing Flyte hearing aids every year (one per ear per year). Benefit is limited to the TruHearing Flyte 700 and Flyte 900 hearing aid. You must see a TruHearing provider to use this benefit. Benefit does not include or cover any of the following: • Ear molds • Hearing aid accessories • Additional provider visits • Extra batteries • Hearing aids that are not the TruHearing Flyte 700 or Flyte 900 • Hearing aid return fees • Loss & damage warranty claims. Routine hearing exam and hearing aid copayments are not subject to the maximum out-of-pocket.

BENEFITS	ADVANTAGE MD	ADVANTAGE MD PLUS
Home Health Care[1]	In-network: You pay nothing Out-of-network: 30% coinsurance	In-network: You pay nothing Out-of-network: 30% coinsurance
Mental Health Care[1]	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay per year. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. In-network: $250 copay per day for days 1 through 6. You pay nothing per day for days 7 through 90. You pay nothing per day for days 91 and beyond. Out-of-network: 30% coinsurance per stay Outpatient group therapy visit: In-network: $40 copay Out-of-network: 50% coinsurance Outpatient individual therapy visit: In-network: $40 copay Out-of-network: 50% coinsurance	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay per year. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. In-network: $200 copay per day for days 1 through 6 You pay nothing per day for days 7 through 90. You pay nothing per day for days 91 and beyond. Out-of-network: 30% coinsurance per stay Outpatient group therapy visit: In-network: $40 copay Out-of-network: 45% coinsurance Outpatient individual therapy visit: In-network: $40 copay Out-of-network: 45% coinsurance

BENEFITS	ADVANTAGE MD	ADVANTAGE MD PLUS
Outpatient Rehabilitation[1]	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): In-network: $15 copay Out-of-network: 40% coinsurance Occupational therapy visit: In-network: $40 copay Out-of-network: 40% coinsurance Physical therapy and speech and language therapy visit: In-network: $40 copay Out-of-network: 40% coinsurance	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): In-network: You pay nothing Out-of-network: 30% coinsurance Occupational therapy visit: In-network: $30 copay Out-of-network: 30% coinsurance Physical therapy and speech and language therapy visit: In-network: $30 copay Out-of-network: 30% coinsurance
Outpatient Substance Abuse[1]	Group therapy visit: In-network: 20% coinsurance Out-of-network: 50% coinsurance Individual therapy visit: In-network: 20% coinsurance Out-of-network: 50% coinsurance	Group therapy visit: In-network: $40 copay Out-of-network: 45% coinsurance Individual therapy visit: In-network: $40 copay Out-of-network: 45% coinsurance
Outpatient Surgery[1]	Ambulatory surgical center: In-network: $275 copay Out-of-network: 50% coinsurance Outpatient hospital: In-network: $400 copay Out-of-network: 50% coinsurance	Ambulatory surgical center: In-network: $200 copay Out-of-network: 45% coinsurance Outpatient hospital: In-network: $250 copay Out-of-network: 45% coinsurance
Over-the-Counter Items	Not Covered	Not Covered
Prosthetic Devices[1] (*braces, artificial limbs, etc.*)[1]	Prosthetic devices: In-network: 20% coinsurance Out-of-network: 50% coinsurance Related medical supplies: In-network: 20% coinsurance Out-of-network: 50% coinsurance	Prosthetic devices: In-network: 20% coinsurance Out-of-network: 45% coinsurance Related medical supplies: In-network: 20% coinsurance Out-of-network: 45% coinsurance

BENEFITS	ADVANTAGE MD	ADVANTAGE MD PLUS
Renal Dialysis	In-network: 20% coinsurance Out-of-network: 50% coinsurance	In-network: 20% coinsurance Out-of-network: 45% coinsurance
Transportation	Not covered	Not covered
Urgently Needed Services	$50 copay	$40 copay
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): In-network: $10 copay Out-of-network: 50% coinsurance Routine eye exam (for up to 1 every year): In-network: $10 copay Out-of-network: 50% coinsurance Eyeglasses or contact lenses after cataract surgery: In-network: $0 copay Out-of-network: 50% coinsurance	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): In-network: $0 copay Out-of-network: 45% coinsurance Routine eye exam (for up to 1 every year): In-network: $0 copay Out-of-network: 45% coinsurance You have an eyeware allowance of $150, every 2 years. This allowance may be used on eyeware, including lenses, frames and contact lenses from any provider. Eyeglasses or contact lenses after cataract surgery: In-network: $0 copay Out-of-network: 45% coinsurance
Preventive Care	In-network: You pay nothing Out-of-network: 50% coinsurance Our plan covers many preventive services, including: Abdominal aortic aneurysm screening Alcohol misuse counseling	In-network: You pay nothing Out-of-network: 45% coinsurance Our plan covers many preventive services, including: Abdominal aortic aneurysm screening Alcohol misuse counseling

BENEFITS	ADVANTAGE MD	ADVANTAGE MD PLUS
Preventive Care (Continued)	Bone mass measurement	Bone mass measurement
	Breast cancer screening (mammogram)	Breast cancer screening (mammogram)
	Cardiovascular disease (behavioral therapy)	Cardiovascular disease (behavioral therapy)
	Cardiovascular screenings	Cardiovascular screenings
	Cervical and vaginal cancer screening	Cervical and vaginal cancer screening
	Colorectal cancer screenings (Colonoscopy, Flexible sigmoidoscopy)	Colorectal cancer screenings (Colonoscopy, Flexible sigmoidoscopy)
	Depression screening	Depression screening
	Diabetes screenings	Diabetes screenings
	HIV screening	HIV screening
	Screening for lung cancer with low dose computed tomography (LDCT)	Screening for lung cancer with low dose computed tomography (LDCT)
	Medical nutrition therapy services	Medical nutrition therapy services
	Obesity screening and counseling	Obesity screening and counseling
	Prostate cancer screenings (PSA)	Prostate cancer screenings (PSA)
	Sexually transmitted infections screening and counseling	Sexually transmitted infections screening and counseling
	Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)	Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)
	Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots	Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots
	"Welcome to Medicare" preventive visit (one-time)	"Welcome to Medicare" preventive visit (one-time)
	Yearly "Wellness" visit	Yearly "Wellness" visit
	Any additional preventive services approved by Medicare during the contract year will be covered.	Any additional preventive services approved by Medicare during the contract year will be covered.
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part coinsurance for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part coinsurance for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.

BENEFITS	ADVANTAGE MD	ADVANTAGE MD PLUS
Inpatient Care		
Inpatient Hospital Care[1]	Our plan covers days 1 through 90 of inpatient hospital care annually. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. In-network: $275 copay per day for days 1 through 7. You pay nothing per day for days 8 through 90. You pay nothing for any lifetime reserve days used (up to 60 lifetime reserve days) Out-of-network: 30% coinsurance per stay	Our plan covers an unlimited number of days for an inpatient hospital stay. In-network: $250 copay per day for days 1 through 7 You pay nothing per day for days 8 through 90 You pay nothing per day for days 91 and beyond Out-of-network: 30% coinsurance per stay
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Skilled Nursing Facility (SNF)[1]	Our plan covers up to 100 days in a SNF. In-network: You pay nothing per day for days 1 through 20 $160 copay per day for days 21 through 100 Out-of-network: 30% coinsurance per stay	Our plan covers up to 100 days in a SNF. In-network: You pay nothing per day for days 1 through 20 $150 copay per day for days 21 through 100 Out-of-network: 30% coinsurance per stay
Prescription Drug		
How much do I pay?	For Part B drugs such as chemotherapy drugs: In-network: 20% coinsurance Out-of-network: 40% coinsurance Other Part B drugs: In-network: 20% coinsurance Out-of-network: 40% coinsurance	For Part B drugs such as chemotherapy drugs: In-network: 20% coinsurance Out-of-network: 30% coinsurance Other Part B drugs: In-network: 20% coinsurance Out-of-network: 30% coinsurance
Initial Coverage	You pay the following until your total yearly drug costs reach $3,700. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.	You pay the following until your total yearly drug costs reach $3,700. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

BENEFITS	ADVANTAGE MD	ADVANTAGE MD PLUS
Initial Coverage (Continued)	You may get your drugs at network retail pharmacies and mail order pharmacies.	You may get your drugs at network retail pharmacies and mail order pharmacies.
	Standard Retail Cost-Sharing Tier 1 (Preferred Generic) $7 copay for a one-month supply $14 copay for a two-month supply $21 copay for a three-month supply Tier 2 (Generic) $15 copay for a one-month supply $30 copay for a two-month supply $45 copay for a three-month supply Tier 3 (Preferred Brand) $45 copay for a one-month supply $90 copay for a two-month supply $135 copay for a three-month supply Tier 4 (Non-Preferred Brand) $95 copay for a one-month supply $190 copay for a two-month supply $285 copay for a three-month supply Tier 5 (Specialty Tier) 33% coinsurance of a one-month supply	**Standard Retail Cost-Sharing** Tier 1 (Preferred Generic) $4 copay for a one-month supply $8 copay for a two-month supply $12 copay for a three-month supply Tier 2 (Generic) $12 copay for a one-month supply $24 copay for a two-month supply $36 copay for a three-month supply Tier 3 (Preferred Brand) $42 copay for a one-month supply $84 copay for a two-month supply $126 copay for a three-month supply Tier 4 (Non-Preferred Brand) $92 copay for a one-month supply $184 copay for a two-month supply $276 copay for a three-month supply Tier 5 (Specialty Tier) 33% coinsurance of a one-month supply
	Standard Mail Order Cost-Sharing Tier 1 (Preferred Generic) $7 copay for a one-month supply $14 copay for a two-month supply $17.50 copay for a three-month supply Tier 2 (Generic) $15 copay for a one-month supply $30 copay for a two-month supply $37.50 copay for a three-month supply	**Standard Mail Order Cost-Sharing** Tier 1 (Preferred Generic) $4 copay for a one-month supply $8 copay for a two-month supply $10 copay for a three-month supply Tier 2 (Generic) $12 copay for a one-month supply $24 copay for a two-month supply $30 copay for a three-month supply

BENEFITS	ADVANTAGE MD	ADVANTAGE MD PLUS
Initial Coverage (Continued)	Tier 3 (Preferred Brand) $45 copay for a one-month supply $90 copay for a two-month supply $112.50 copay for a three-month supply Tier 4 (Non-Preferred Brand) $95 copay for a one-month supply $190 copay for a two-month supply $237.50 copay for a three-month supply Tier 5 (Specialty Tier) 33% coinsurance of a one-month supply If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.	Tier 3 (Preferred Brand) $42 copay for a one-month supply $84 copay for a two-month supply $105 copay for a three-month supply Tier 4 (Non-Preferred Brand) $92 copay for a one-month supply $184 copay for a two-month supply $230 copay for a three-month supply Tier 5 (Specialty Tier) 33% coinsurance of a one-month supply If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network 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 $3,700. After you enter the coverage gap, you pay 40% of the plan's cost for covered brand name drugs and 51% of the plan's cost for covered generic drugs until your costs total $4,950, which is the end of 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 $3,700. After you enter the coverage gap, you pay 40% of the plan's cost for covered brand name drugs and 51% of the plan's cost for covered generic drugs until your costs total $4,950, which is the end of the coverage gap.
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,950, you pay the greater of: 5% coinsurance, or $3.30 copay for generic (including brand drugs treated as generic) and a $8.25 copayment for all other drugs.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,950, you pay the greater of: 5% coinsurance, or $3.30 copay for generic (including brand drugs treated as generic) and a $8.25 copayment for all other drugs.

OPTIONAL SUPPLEMENTAL DENTAL PACKAGE *(for an extra premium each month)*

For an additional **$28** per month, you can purchase an optional supplemental dental package. You must keep paying your Medicare Part B premium and either your **$44** for your **Johns Hopkins Advantage MD (PPO)** plan or **$78** for your **Johns Hopkins Advantage MD Plus (PPO)** plan.

The supplemental dental package pays up to **$1,200** per year.

This package covers comprehensive dental services such as:

BASIC RESTORATIVE (In-Network) **Out-of-network cost may be higher*

- Endodontics: $200 copay
- General anesthesia when medically necessary and administered in connection with oral or dental surgery: $50 copay
- Oral Surgery: $50 copay
- Oral Pathology Biopsy: $50 copay
- Periodontics: $50 copay
- Restorative Fillings: $50 copay

MAJOR RESTORATIVE (In-Network) **Out-of-network cost may be higher*

- Bridges installation or addition due to the covered extraction of one or more natural teeth: $400 copay
- Bridges adjustment or repair more than six months after installation: $50 copay
- Bridges replacement due to structural change in the mouth: $400 copay
- Crowns, inlays, and onlays installation: $400 copay
- Crowns, inlays, and onlays adjustment or repair more than six months after installation: $50 copay
- Crowns, inlays, and onlays replacement: $400 copay
- Dentures (full or partial); installation or addition due to the covered extraction of one or more natural teeth: $400 copay
- Dentures (full or partial); adjustment or repair more than six months after installation: $50 copay
- Dentures (full or partial); replacement of full denture due to structural change in the mouth: $400 copay

Members are responsible for the difference between the allowed amount and the billed amount. For more information, please review the Evidence of Coverage.

Prior authorizations are required for the following: endodontics, general anesthesia when medically necessary and administered in connection with oral or dental surgery, oral surgery, periodontics, bridges, crowns, inlays, onlays, and dentures (full or partial).

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ADVANTAGE MD
Johns Hopkins Medicine Medicare Plan

6704 Curtis Court
Glen Burnie, MD 21060
HopkinsMedicare.com

For updated information regarding plan providers, please visit our website at HopkinsMedicare.com, or call Advantage MD Member Service at:

1-888-403-7662 (TTY: 711)

NOT YET A MEMBER? HAVE QUESTIONS?

Please call us at: 1-888-403-7662 (TTY: 711)
8 a.m. – 8 p.m., 7 days a week
8 a.m. to 8 p.m., Monday – Friday between February 15 and September 30

You must continue to pay your Medicare Part B premium.

Johns Hopkins Advantage MD is a PPO plan with a Medicare contract. Enrollment in Johns Hopkins Advantage MD depends on contract renewal.

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 copayments/coinsurance may change on January 1 of each year. The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat Johns Hopkins Advantage MD members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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