Advantage MD

SUMMARY OF **BENEFITS**

2025 Advantage MD Health Plans

Johns Hopkins Advantage MD (HMO)
Johns Hopkins Advantage MD Tribute (HMO)
Johns Hopkins Advantage MD (PPO)
Johns Hopkins Advantage MD Plus (PPO)
Johns Hopkins Advantage MD Primary (PPO)

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JOHNS HOPKINS
HEALTH PLANS

Section I: Introduction to Summary of Benefits

January 1, 2025 – December 31, 2025

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 or go online to view 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 Tribute (HMO), Johns Hopkins Advantage MD Primary (PPO), Johns Hopkins Advantage MD (HMO), Johns Hopkins Advantage MD (PPO) Johns Hopkins Advantage MD Plus (PPO).

Tips for comparing your Medicare choices:

If you want to compare our plans with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on 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 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 Our Plans
- 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, audio, data CD and large print. For additional information, call us at 1-888-403-7662 (TTY: 711).

Things to Know About Our Plans:

Hours of Operation

From October 1 to March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time.

From April 1 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 Primary (PPO), Johns Hopkins Advantage MD (PPO), and Johns Hopkins Advantage MD Plus (PPO), Phone Numbers:

If you are a member of these plans, call toll-free 1-877-293-5325 (TTY: 711). If you are not a member of these plans, call toll-free 1-888-403-7662 (TTY: 711).

Johns Hopkins Advantage MD Tribute (HMO) and Johns Hopkins Advantage MD (HMO) Phone Numbers:

If you are a member of this plan, call toll-free 1-877-293-4998 (TTY: 711). If you are not a member of this plan, call toll-free 1-888-403-7662 (TTY: 711).

Our plan website: www.hopkinsmedicare.com

Who can join?

To join, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in the plan's service area.

The Johns Hopkins Advantage MD Tribute (HMO) service area includes the following counties in Maryland: Anne Arundel, Baltimore, Frederick, Howard, and Montgomery.

The Johns Hopkins Advantage MD Primary (PPO) service area includes the following counties in Maryland: Anne Arundel, Baltimore, Frederick, Howard, and Montgomery.

The Johns Hopkins Advantage MD (HMO) service area includes the following counties in Maryland: Anne Arundel, Baltimore, Carroll, Frederick, Howard, Montgomery, Somerset, Washington, Wicomico, and Worcester.

The Johns Hopkins Advantage MD (PPO) and Johns Hopkins Advantage MD Plus (PPO) service area includes the following counties in Maryland: Anne Arundel, Baltimore, Carroll, Frederick, Howard, Montgomery, Somerset, Washington, Wicomico, and Worcester.

All PPO members:

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.

All HMO members:

If you use providers that are not in our network, the plan may not pay for these services. Referrals are required for specialty care only.

All members:

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. Our plans may offer supplemental benefits in addition to Part C benefits and Part D benefits. 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/radiation 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, 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, and Catastrophic Coverage.

Section II: Summary of Benefits

HMO Plans

Benefits & Coverage	Johns Hopkins Advantage MD Tribute (HMO) *Review service area*	Johns Hopkins Advantage MD (HMO) *Review service area*
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES		
Monthly plan premium (Part C and D premium, combined)	**$0** per month. In addition, you must keep paying your Medicare Part B premium.	**$20** per month. In addition, you must keep paying your Medicare Part B premium.
Part B premium buy-down, if applicable	Johns Hopkins Advantage MD will reduce your Medicare Part B Premium by $40 per month.	Not Applicable
Deductibles, including plan level and category level deductible	This plan does not have any medical deductibles.	This plan does not have any medical deductibles.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	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: **$6,800** for services you receive from in-network providers.	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: **$7,550** for services you receive from in-network providers.
	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. (Johns Hopkins Advantage MD Tribute (HMO) does not offer any Part D benefits.) Our plan has a coverage limit every year for certain benefits from any provider.	

Benefits & Coverage	Johns Hopkins Advantage MD Tribute (HMO) *Review service area*	Johns Hopkins Advantage MD (HMO) *Review service area*
Inpatient Hospital Coverage (Services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	Our plan covers 90 days for each Medicare-covered inpatient hospital stay. (Our plan also covers 60 lifetime reserve days.) $350 copay per day for days 1-5; $0 copay per day for days 6-90 for Medicare-covered inpatient hospital stay.	Our plan covers 90 days for each Medicare-covered inpatient hospital stay. (Our plan also covers 60 lifetime reserve days.) $350 copay per day for days 1-5; $0 copay per day for days 6-90 for Medicare-covered inpatient hospital stay.
Outpatient Hospital Coverage (Services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	$350 copay	$320 copay
Ambulatory Surgical Center (ASC) Services (Services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	$250 copay	$225 copay
Doctor Visits • Primary Care Providers • Specialists	 $0 copay $50 copay	 $0 copay $45 copay

Benefits & Coverage	Johns Hopkins Advantage MD Tribute (HMO) *Review service area*	Johns Hopkins Advantage MD (HMO) *Review service area*
Preventive Care (e.g. flu vaccine, diabetic screenings)	$0 copay	$0 copay
	Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Annual routine physical exam • Annual wellness visit • Barium enemas • Bone mass measurement (bone density) • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, FOBT and FIT kit) • Depression screening • Diabetes screenings • Diabetes self-management training, diabetic services, and supplies • Digital rectal exams • EKG following a Welcome Visit • Health and wellness education programs • HIV screening • Immunizations • Medical nutrition therapy services • Medicare diabetes prevention program (MDPP) • Obesity screening and therapy to promote sustained weight loss • Prostate cancer screening exams • Screening and counseling to reduce alcohol misuse • Screening for lung cancer with low dose computed tomography (LDCT) • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Smoking and tobacco use cessation (Counseling to stop smoking or tobacco use) • Vision care • “Welcome to Medicare” preventive visit (one-time) Any additional preventive services approved by Medicare during the contract year will be covered.	

Benefits & Coverage	Johns Hopkins Advantage MD Tribute (HMO) *Review service area*	Johns Hopkins Advantage MD (HMO) *Review service area*
Emergency Care	$110 copay The copay is waived if you are admitted to the hospital within 24 hours for the same condition. Emergency care is covered in the United States only.	$110 copay The copay is waived if you are admitted to the hospital within 24 hours for the same condition. Emergency care is covered in the United States only.
Urgently Needed Services	$40 copay The copay is not waived if you are admitted to the hospital. Urgently needed services are covered in the United States only.	$45 copay The copay is not waived if you are admitted to the hospital. Urgently needed services are covered in the United States only.
Diagnostic Services/ Labs/Imaging (Services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	**Lab services** *(e.g., Blood count, stool tests, creatinine, blood glucose)***:** $0 copay **Diagnostic tests and procedures** *(e.g., Biopsies, Endoscopies, cat scans)***:** 20% coinsurance **Diagnostic X-rays** *(such as mammography and ultrasound)***:** $50 copay **Diagnostic radiology services** *(such as MRIs and CT scans)***:** $250 copay **Therapeutic radiology services** *(such as radiation treatment for cancer)***:** 20% coinsurance	**Lab services** *(e.g., Blood count, stool tests, creatinine, blood glucose)***:** $0 copay **Diagnostic tests and procedures** *(e.g., Biopsies, Endoscopies, cat scans)***:** 20% coinsurance **Diagnostic X-rays** *(such as mammography and ultrasound)***:** $20 copay **Diagnostic radiology services** *(such as MRIs and CT scans)***:** $175 copay **Therapeutic radiology services** *(such as radiation treatment for cancer)***:** 20% coinsurance

Benefits & Coverage	Johns Hopkins Advantage MD Tribute (HMO) *Review service area*	Johns Hopkins Advantage MD (HMO) *Review service area*
Hearing Services • Routine hearing exam • Hearing aids	**Medicare-covered exam to diagnose and treat hearing and balance issues:** $10 copay **Routine hearing exam:** $0 copay *(one routine hearing exam per year from a TruHearing provider)* **Hearing aids:** You pay a $399 copay per aid for Advanced hearing aids or $699 copay per aid for Premium hearing aids for up to two TruHearing-branded hearing aids every year (one per ear per year)	**Medicare-covered exam to diagnose and treat hearing and balance issues:** $0 copay **Routine hearing exam:** $0 copay *(one routine hearing exam per year from a TruHearing provider)* **Hearing aids:** You pay a $699 copay per aid for Advanced hearing aids or $999 copay per aid for Premium hearing aids for up to two TruHearing-branded hearing aids every year (one per ear per year)
Dental Services • Oral exam & cleaning • Optional supplemental benefits (available only with Advantage MD HMO) (Non-Medicare covered comprehensive services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	**Medicare-covered dental services:** $0 copay **Preventive dental services:** **Cleaning(s)** (*2 cleanings every year*): $0 copay **Fluoride treatments:** $0 copay **Dental X-ray(s)** *(Frequency determined by type of X-ray)*: $0 copay **Oral exam(s)** *(Frequency determined by type of oral exam)*: $0 copay **Comprehensive dental services:** *(Frequency dependent on procedure.)*	**Medicare-covered dental services:** 20% coinsurance **Preventive dental services:** **Cleaning(s)** (*1 cleaning every year*): $20 copay **Fluoride treatments:** Not covered **Dental X-ray(s)** *(Frequency determined by type of X-ray)*: $20 copay **Oral exam(s)** *(Frequency determined by type of oral exam)*: $20 copay **Comprehensive dental services:** Not covered.

Benefits & Coverage	Johns Hopkins Advantage MD Tribute (HMO) *Review service area*	Johns Hopkins Advantage MD (HMO) *Review service area*
Dental Services (continued)		**Optional Supplemental Benefit:** For an extra $25 per month, members can purchase a supplemental benefit that includes comprehensive dental.
	$2,000 maximum plan coverage amount every year for non-Medicare-covered comprehensive dental services. Members are responsible for the difference between the allowed amount and the billed amount for any out-of-network services.	The comprehensive dental benefit has a max coverage amount of $1,000 per year. Members are responsible for the difference between the allowed amount and the billed amount for any out-of-network services. The following comprehensive dental services are covered as part of the Optional Supplemental Benefits package **(available with additional premium)**:
	Restorative services *(such as inlays, onlays, crowns, resin restoration, etc.)* Frequency dependent on procedure. *In-network:* $0 copay	**Restorative services** *(such as inlays, onlays, crowns, resin restoration, etc.)* Frequency dependent on procedure. *In-network & Out-of-network:* $50 copay
	Endodontics *(such as root canals, retreatment, apicoectomy, etc.)* Frequency dependent on procedure. *In-network:* $0 copay	**Endodontics** *(such as root canals, retreatment, apicoectomy, etc.)* Frequency dependent on procedure. *In-network & Out-of-network:* $100 copay
	Periodontics *(such as periodontal maintenance, periodontal scaling, root planning, etc.)* Frequency dependent on procedure. *In-network:* $0 copay	**Periodontics** *(such as periodontal maintenance, periodontal scaling, root planning, etc.)* Frequency dependent on procedure. *In-network & Out-of-network:* $50 copay

Benefits & Coverage	Johns Hopkins Advantage MD Tribute (HMO) *Review service area*	Johns Hopkins Advantage MD (HMO) *Review service area*
Dental Services (continued)	**Extractions** *(such as extractions, coronectomy, etc.)* Frequency dependent on procedure. *In-network:* $0 copay **Prosthodontics/Other oral/maxillofacial surgery/Other services** *(such as removable complete and partial dentures, repair or replace teeth in dentures, removal of exostosis, anesthesia, etc.)* Frequency dependent on procedure. *In-network:* $0 copay	**Extractions** *(such as extractions, coronectomy, surgical access of an unerupted tooth, etc.)* Frequency dependent on procedure. *In-network & Out-of-network:* $100 copay **Prosthodontics/Other oral/maxillofacial surgery/Other services** *(such as removable complete and partial dentures, repair or replace teeth in dentures, removal of exostosis, anesthesia, etc.)* Frequency dependent on procedure. *In-network & Out-of-Network:* $50-$100 copay depending on the service
Vision Services	**Medicare-covered exam to diagnose and treat diseases and conditions of the eye:** $50 copay **Yearly Glaucoma Screening:** $0 copay **Routine eye exam** *(1 every year):* $0 copay **Eyeglasses or contact lenses after cataract surgery:** $0 copay **Routine eyewear:** Our plan pays up to $300 every two years for supplemental eyewear (retail or online) from any in-network Superior Vision provider.	**Medicare-covered exam to diagnose and treat diseases and conditions of the eye:** $50 copay **Yearly Glaucoma Screening:** $0 copay **Routine eye exam** *(1 every year):* $0 copay **Eyeglasses or contact lenses after cataract surgery:** $0 copay **Routine eyewear:** Our plan pays up to $250 every year for supplemental eyewear (retail or online) from any in-network Superior Vision provider.

Benefits & Coverage	Johns Hopkins Advantage MD Tribute (HMO) *Review service area*	Johns Hopkins Advantage MD (HMO) *Review service area*
Mental Health Services (Inpatient visit may require a prior authorization and/or referral. Please see the *Evidence of Coverage* booklet for more information.)	**Inpatient visit:** Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. $350 copay per day for days 1-5; $0 copay per day for days 6-90 for Medicare-covered inpatient hospital stay. **Outpatient mental health visits:** Individual or Group therapy visit: $25 copay **Outpatient substance abuse therapy visit:** Individual or Group therapy visit: $40 copay	**Inpatient visit:** Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. $350 copay per day for days 1-5; $0 copay per day for days 6-90 for Medicare-covered inpatient hospital stay. **Outpatient mental health visits:** Individual or Group therapy visit: $20 copay **Outpatient substance abuse therapy visit:** Individual or Group therapy visit: $20 copay
Skilled Nursing Facility (SNF) (Services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	Our plan covers up to 100 days in an SNF. $0 copay per day for days 1-20; $196 copay per day for days 21-100.	Our plan covers up to 100 days in an SNF. $0 copay per day for days 1-20; $203 copay per day for days 21-100.
Physical Therapy (Services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	$10 copay	$30 copay

Benefits & Coverage	Johns Hopkins Advantage MD Tribute (HMO) *Review service area*	Johns Hopkins Advantage MD (HMO) *Review service area*
Ambulance (Services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	$290 copay (ground) 20% coinsurance (air) 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 some cases, Medicare may pay for limited non-emergency ambulance transportation if a beneficiary has orders from the doctor saying that ambulance transportation is medically necessary.	$240 copay (ground) $240 copay (air) 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 some cases, Medicare may pay for limited non-emergency ambulance transportation if a beneficiary has orders from the doctor saying that ambulance transportation is medically necessary.
Transportation	$0 copay for up to 24 one-way non-emergent trips within the plan service area to any health-related location. Please contact Customer Service to arrange a ride. Arrangements should be made at least 48 hours in advance.	$0 copay for up to 12 one-way non-emergent trips within the plan service area to any health-related location. Please contact Customer Service to arrange a ride. Arrangements should be made at least 48 hours in advance.
Medicare Part B Drugs (Services may require that your provider get prior authorization (extra approval in advance). Please see the *Evidence of Coverage* booklet for more information.) Medicare-covered Part B Drugs may be subject to step therapy requirements.	For Part B drugs such as chemotherapy/radiation drugs: 0% to 20% coinsurance Other Part B drugs: 0% to 20% coinsurance Medicare Part B Insulin: Member pays lesser of 20% coinsurance or $35 copay for Part B insulin.	For Part B drugs such as chemotherapy/radiation drugs: 0% to 20% coinsurance Other Part B drugs: 0% to 20% coinsurance Medicare Part B Insulin: Member pays lesser of 20% coinsurance or $35 copay for Part B insulin.

Benefits & Coverage	Johns Hopkins Advantage MD Tribute (HMO) *Review service area*	Johns Hopkins Advantage MD (HMO) *Review service area*
Outpatient Prescription Drugs (Medicare Part D Drugs)		
Pharmacy (Part D) Deductible	Part D benefits are not offered with this plan.	You pay $590 except for covered insulin products and most adult Part D vaccines. The deductible does not apply to Tier 1: Preferred Generic and Tier 2: Generic drugs.
Initial Coverage	Part D benefits are not offered with this plan.	You pay the following until your out-of-pocket Part D drug costs reach $2,000. You may get your drugs at network retail pharmacies and mail order pharmacies. Cost-sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please call us or access our Evidence of Coverage booklet. For excluded drugs covered under our enhanced benefit, you pay up to a Tier 2 copay. Covered excluded drugs include select prescription vitamins, cough and cold medications, and erectile dysfunction medicine. These drugs and their quantity limits are listed in the Drug List booklet in the section titled “Coverage of additional drugs”.
• Standard Retail Cost-Sharing *(Insulin drug cost-share listed below)*	Part D benefits are not offered with this plan.	**Tier 1 *(Preferred Generic)*** $0 copay for a one-month supply $0 copay for a three-month supply

Benefits & Coverage	Johns Hopkins Advantage MD Tribute (HMO) *Review service area*	Johns Hopkins Advantage MD (HMO) *Review service area*
Initial Coverage (continued)	Part D benefits are not offered with this plan.	**Tier 2 *(Generic)*** $10 copay for a one-month supply $20 copay for a three-month supply **Tier 3 *(Preferred Brand)*** 25% coinsurance for a one-month supply 25% coinsurance for a three-month supply **Tier 4 *(Non-Preferred Drug)*** 25% coinsurance for a one-month supply 25% coinsurance for a three-month supply **Tier 5 *(Specialty Tier)*** 25% coinsurance of a one-month supply (long-term supply is not available)
• Standard Mail Order Cost-Sharing *(Insulin drug cost-share listed below)*	Part D benefits are not offered with this plan.	**Tier 1 *(Preferred Generic)*** $0 copay for a one-month supply $0 copay for a three-month supply **Tier 2 *(Generic)*** $10 copay for a one-month supply $20 copay for a three-month supply **Tier 3 *(Preferred Brand)*** 25% coinsurance for a one-month supply 25% coinsurance for a three-month supply **Tier 4 *(Non-Preferred Drug)*** 25% coinsurance for a one-month supply 25% coinsurance for a three-month supply

Benefits & Coverage	Johns Hopkins Advantage MD Tribute (HMO) *Review service area*	Johns Hopkins Advantage MD (HMO) *Review service area*
Initial Coverage (continued) • Standard Mail Order Cost-Sharing *(Insulin drug cost-share listed below) (continued)*		**Tier 5 *(Specialty Tier)*** 25% coinsurance of a one-month supply (long-term supply is not available) If you reside in a long-term care facility, you pay the same as at a retail pharmacy.
• Insulin Retail Cost-Sharing	Part D benefits are not offered with this plan.	**Tier 1 *(Preferred Generic)*** $0 copay for a one-month supply $0 copay for a three-month supply **Tier 2 *(Generic)*** $10 copay for a one-month supply $20 copay for a three-month supply **Tier 3 *(Preferred Brand)*** $35 copay for a one-month supply $105 copay for a three-month supply **Tier 4 *(Non-Preferred Drug)*** $35 copay for a one-month supply $105 copay for a three-month supply **Tier 5 *(Specialty Tier)*** $35 copay of a one-month supply (long-term supply is not available)

Benefits & Coverage	Johns Hopkins Advantage MD Tribute (HMO) *Review service area*	Johns Hopkins Advantage MD (HMO) *Review service area*
Initial Coverage (continued) • Insulin Mail Order Cost-Sharing	Part D benefits are not offered with this plan.	**Tier 1 *(Preferred Generic)*** $0 copay for a one-month supply $0 copay for a three-month supply **Tier 2 *(Generic)*** $10 copay for a one-month supply $20 copay for a three-month supply **Tier 3 *(Preferred Brand)*** $35 copay for a one-month supply $70 copay for a three-month supply **Tier 4 *(Non-Preferred Drug)*** $35 copay for a one-month supply $70 copay for a three-month supply **Tier 5 *(Specialty Tier)*** $35 copay of a one-month supply (long-term supply is not available) If you reside in a long-term care facility, you pay the same as at a retail pharmacy.
Catastrophic Coverage	Part D benefits are not offered with this plan.	After your yearly out-of-pocket drug costs *(including drugs purchased through your retail pharmacy and through mail order)* reach $2,000, you will stay in this payment stage until the end of the calendar year. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. For excluded drugs covered under our enhanced benefit, you pay nothing.

Benefits & Coverage	Johns Hopkins Advantage MD Tribute (HMO) *Review service area*	Johns Hopkins Advantage MD (HMO) *Review service area*
Additional Covered Medical and Hospital Benefits		
Acupuncture	**Medicare-covered acupuncture:** 20% coinsurance **Non-Medicare covered acupuncture:** Not covered	**Medicare-covered acupuncture:** 20% coinsurance **Non-Medicare covered acupuncture:** Not covered
Chiropractic Care (Services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	**Medicare-covered chiropractic care:** $10 copay **Non-Medicare covered chiropractic care:** Not covered	**Medicare-covered chiropractic care:** $15 copay **Non-Medicare covered chiropractic care:** Not covered
Silver&Fit® Healthy Aging and Exercise Program	$0 copay at participating fitness centers.	$0 copay at participating fitness centers.
Home Health Care (Services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	$0 copay	$0 copay
Over-the Counter Items	$0 copay $35 maximum plan coverage amount every 3 months for OTC items. Any unused amount does not carry over to the next period.	$0 copay $60 maximum plan coverage amount every 3 months for OTC items. Any unused amount does not carry over to the next period.

Benefits & Coverage	Johns Hopkins Advantage MD Tribute (HMO) *Review service area*	Johns Hopkins Advantage MD (HMO) *Review service area*
Rehabilitation Services Occupational therapy visits may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	**Cardiac (heart) rehab services** *(for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks)*: $0 copay **Occupational therapy visit:** $10 copay **Physical/speech therapy visit:** $10 copay	**Cardiac (heart) rehab services** *(for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks)*: $0 copay **Occupational therapy visit:** $30 copay **Physical/speech therapy visit:** $30 copay
Renal Dialysis	20% coinsurance	20% coinsurance
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.	
Post Discharge Meals	Not covered	After your inpatient stay *(in either a hospital or skilled nursing facility)* you are eligible to receive three (3) meals a day for five (5) days. Our Care Management team will work with eligible members to coordinate the delivery of meals provided by our vendor. Meal program is limited to four times per calendar year. $0 copay for post discharge meals.
Telehealth	$0 copay	$0 copay
Worldwide Emergency Care	Not covered	Not covered
Worldwide Urgent Care	Not covered	Not covered

PPO Plans

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO) *Review service area*	Johns Hopkins Advantage MD (PPO) *Review service area.*	Johns Hopkins Advantage MD Plus (PPO) *Review service area.*
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES			
Monthly plan premium (Part C and D premium, combined)	**$0** per month. In addition, you must keep paying your Medicare Part B premium.	**$95** per month. In addition, you must keep paying your Medicare Part B premium.	**$135** per month. In addition, you must keep paying your Medicare Part B premium.
Part B premium buy-down, if applicable	Not Applicable	Not Applicable	Not Applicable
Deductibles, including plan level and category level deductible	$950 medical deductible. The deductible is in and out of network combined.	This plan does not have any medical deductibles.	This plan does not have any medical deductibles.

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO) *Review service area*	Johns Hopkins Advantage MD (PPO) *Review service area.*	Johns Hopkins Advantage MD Plus (PPO) *Review service area.*
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	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: **$7,550** for services you receive from in-network providers. **$11,300** for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit.	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: **$7,550** for services you receive from in-network providers. **$11,300** for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit.	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: **$7,550** for services you receive from in-network providers. **$11,300** 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. Our plan has a coverage limit every year for certain benefits from any provider.		

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO) *Review service area*	Johns Hopkins Advantage MD (PPO) *Review service area.*	Johns Hopkins Advantage MD Plus (PPO) *Review service area.*
Inpatient Hospital Coverage (Services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	Our plan covers 90 days for each Medicare-covered in-network or out-of-network inpatient hospital stay. (Our plan also covers 60 lifetime reserve days.) *In-network:* $350 copay per day for days 1-5; $0 copay per day for days 6-90 for Medicare-covered inpatient hospital stay. *Out-of-network:* 30% coinsurance per stay	Our plan covers 90 days for each Medicare-covered in-network or out-of-network inpatient hospital stay. (Our plan also covers 60 lifetime reserve days.) *In-network:* $330 copay per day for days 1-6; $0 copay per day for days 7-90 for Medicare-covered inpatient hospital stay. *Out-of-network:* 30% coinsurance per stay	Our plan covers 90 days for each Medicare-covered in-network or out-of-network inpatient hospital stay. (Our plan also covers 60 lifetime reserve days.) *In-network:* $330 copay per day for days 1-6; $0 copay per day for days 7-90 for Medicare-covered inpatient hospital stay. *Out-of-network:* 30% coinsurance per stay
Outpatient Hospital Coverage (Services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	*In-network:* $320 copay *Out-of-network:* 50% coinsurance	*In-network:* $320 copay *Out-of-network:* 50% coinsurance	*In-network:* $320 copay *Out-of-network:* 30% coinsurance

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO) *Review service area*	Johns Hopkins Advantage MD (PPO) *Review service area.*	Johns Hopkins Advantage MD Plus (PPO) *Review service area.*
Ambulatory Surgical Center (ASC) Services (Services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	*In-network:* $250 copay *Out-of-network:* 50% coinsurance	*In-network:* $250 copay *Out-of-network:* 50% coinsurance	*In-network:* $250 copay *Out-of-network:* 30% coinsurance
Doctor Visits • Primary Care Providers	*In-network:* $10 copay *Out-of-network:* 50% coinsurance	*In-network:* $5 copay *Out-of-network:* 40% coinsurance	*In-network:* $0 copay *Out-of-network:* 30% coinsurance
• Specialists	*In-network:* $45 copay *Out-of-network:* 50% coinsurance	*In-network:* $45 copay *Out-of-network:* 40% coinsurance	*In-network:* $40 copay *Out-of-network:* 30% coinsurance
Preventive Care (e.g. flu vaccine, diabetic screenings)	*In-network:* $0 copay *Out-of-network:* 50% coinsurance	*In-network:* $0 copay *Out-of-network:* 50% coinsurance	*In-network:* $0 copay *Out-of-network:* 30% coinsurance
	Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Annual routine physical exam • Annual wellness visit • Barium enemas • Bone mass measurement (bone density) • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening		

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO) *Review service area*	Johns Hopkins Advantage MD (PPO) *Review service area.*	Johns Hopkins Advantage MD Plus (PPO) *Review service area.*
Preventive Care (e.g. flu vaccine, diabetic screenings) (continued)	• Colorectal cancer screenings (colonoscopy, FOBT and FIT kit) • Depression screening • Diabetes screenings • Diabetes self-management training, diabetic services, and supplies • Digital rectal exams • EKG following a Welcome Visit • Health and wellness education programs • HIV screening • Immunizations • Medical nutrition therapy services • Medicare diabetes prevention program (MDPP) • Obesity screening and therapy to promote sustained weight loss • Prostate cancer screening exams • Screening and counseling to reduce alcohol misuse • Screening for lung cancer with low dose computed tomography (LDCT) • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Smoking and tobacco use cessation (Counseling to stop smoking or tobacco use) • Vision care • “Welcome to Medicare” preventive visit (one-time) Any additional preventive services approved by Medicare during the contract year will be covered.		

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO) *Review service area*	Johns Hopkins Advantage MD (PPO) *Review service area.*	Johns Hopkins Advantage MD Plus (PPO) *Review service area.*
Emergency Care	*In-network & Out-of-network:* $110 copay The copay is waived if you are admitted to the hospital within 24 hours for the same condition. Emergency care is covered worldwide.	*In-network & Out-of-network:* $110 copay The copay is waived if you are admitted to the hospital within 24 hours for the same condition. Emergency care is covered worldwide.	*In-network & Out-of-network:* $110 copay The copay is waived if you are admitted to the hospital within 24 hours for the same condition. Emergency care is covered worldwide.
Urgently Needed Services	*In-network & Out-of-network:* $45 copay The copay is not waived if you are admitted to the hospital. Urgently needed services are covered worldwide.	*In-network & Out-of-network:* $40 copay The copay is not waived if you are admitted to the hospital. Urgently needed services are covered worldwide.	*In-network & Out-of-network:* $40 copay The copay is not waived if you are admitted to the hospital. Urgently needed services are covered worldwide.
Diagnostic Services/Labs/ Imaging	**Lab services** *(e.g., Blood count, stool tests, creatinine, blood glucose)***:** *In-network:* $0 copay *Out-of-network:* 50% coinsurance	**Lab services** *(e.g., Blood count, stool tests, creatinine, blood glucose)***:** *In-network:* 0% coinsurance *Out-of-network:* 50% coinsurance	**Lab services** *(e.g., Blood count, stool tests, creatinine, blood glucose)***:** *In-network:* $0 copay *Out-of-network:* 30% coinsurance

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO) *Review service area*	Johns Hopkins Advantage MD (PPO) *Review service area.*	Johns Hopkins Advantage MD Plus (PPO) *Review service area.*
Diagnostic Services/Labs/ Imaging (continued) (Services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	**Diagnostic tests and procedures** *(e.g., Biopsies, Endoscopies, cat scans)***:** *In-network:* 20% coinsurance *Out-of-network:* 50% coinsurance **Diagnostic X-rays** *(such as mammography and ultrasound)***:** *In-network:* $20 copay *Out-of-network:* 50% coinsurance **Diagnostic radiology services** *(such as MRIs and CT scans)***:** *In-network:* $175 copay *Out-of-network:* 50% coinsurance **Therapeutic radiology services** *(such as radiation treatment for cancer)***:** *In-network:* 20% coinsurance *Out-of-network:* 50% coinsurance	**Diagnostic tests and procedures** *(e.g., Biopsies, Endoscopies, cat scans)***:** *In-network:* 20% coinsurance *Out-of-network:* 50% coinsurance **Diagnostic X-rays** *(such as mammography and ultrasound)***:** *In-network:* $30 copay *Out-of-network:* 40% coinsurance **Diagnostic radiology services** *(such as MRIs and CT scans)***:** *In-network:* $250 copay *Out-of-network:* 50% coinsurance **Therapeutic radiology services** *(such as radiation treatment for cancer)***:** *In-network:* 20% coinsurance *Out-of-network:* 50% coinsurance	**Diagnostic tests and procedures** *(e.g., Biopsies, Endoscopies, cat scans)***:** *In-network:* 20% coinsurance *Out-of-network:* 30% coinsurance **Diagnostic X-rays** *(such as mammography and ultrasound)***:** *In-network:* $30 copay *Out-of-network:* 30% coinsurance **Diagnostic radiology services** *(such as MRIs and CT scans)***:** *In-network:* $250 copay *Out-of-network:* 30% coinsurance **Therapeutic radiology services** *(such as radiation treatment for cancer)***:** *In-network:* 20% coinsurance *Out-of-network:* 30% coinsurance

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO) *Review service area*	Johns Hopkins Advantage MD (PPO) *Review service area.*	Johns Hopkins Advantage MD Plus (PPO) *Review service area.*
Hearing Services • Routine hearing exam	**Medicare-covered exam to diagnose and treat hearing and balance issues:** *In-network:* $50 copay *Out-of-network:* 50% coinsurance **Routine hearing exam:** Not covered	**Medicare-covered exam to diagnose and treat hearing and balance issues:** *In-network:* $50 copay *Out-of-network:* 50% coinsurance **Routine hearing exam:** *In-network:* $0 copay *(one routine hearing exam per year from a TruHearing provider)* *Out-of-network:* $0 copay *(one routine hearing exam per year from a TruHearing provider)*	**Medicare-covered exam to diagnose and treat hearing and balance issues:** *In-network:* $40 copay *Out-of-network:* 30% coinsurance **Routine hearing exam:** *In-network:* $0 copay *(one routine hearing exam per year from a TruHearing provider)* *Out-of-network:* $0 copay *(one routine hearing exam per year from a TruHearing provider)*
• Hearing aids	**Hearing aids:** Not covered	**Hearing aids:** *In-network & Out-of-network:* You pay a $699 copay per aid for Advanced hearing aids or $999 copay per aid for Premium hearing aids for up to two TruHearing-branded hearing aids every year (one per ear per year)	**Hearing aids:** *In-network & Out-of-network:* You pay a $699 copay per aid for Advanced hearing aids or $999 copay per aid for Premium hearing aids for up to two TruHearing-branded hearing aids every year (one per ear per year)

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO) *Review service area*	Johns Hopkins Advantage MD (PPO) *Review service area.*	Johns Hopkins Advantage MD Plus (PPO) *Review service area.*
Dental Services • Oral exam & cleaning	**Medicare-covered dental services:** *In-network:* $0 copay *Out-of-network:* 50% coinsurance **Preventive dental services:** **Cleaning(s)** (*2 cleanings every year*): *In-network:* $0 copay *Out-of-network:* 50% coinsurance **Fluoride treatments:** *(2 fluoride treatments every year):* *In-network:* $0 copay *Out-of-network:* 50% coinsurance **Dental X-ray(s)** *(Frequency determined by type of X-ray)*: *In-network:* $0 copay *Out-of-network:* 50% coinsurance **Oral exam(s)** *(Frequency determined by type of oral exam)*: *In-network:* $0 copay *Out-of-network:* 50% coinsurance	**Medicare-covered dental services:** *In-network:* $0 copay *Out-of-network:* 50% coinsurance **Preventive dental services:** **Cleaning(s)** (*2 cleanings every year*): *In-network:* $0 copay *Out-of-network:* 50% coinsurance **Fluoride treatments:** *(2 fluoride treatments every year):* *In-network:* $0 copay *Out-of-network:* 50% coinsurance **Dental X-ray(s)** *(Frequency determined by type of X-ray)*: *In-network:* $0 copay *Out-of-network:* 50% coinsurance **Oral exam(s)** *(Frequency determined by type of oral exam)*: *In-network:* $0 copay *Out-of-network:* 50% coinsurance	**Medicare-covered dental services:** *In-network:* 20% coinsurance *Out-of-network:* $100 copay **Preventive dental services:** **Cleaning(s)** (*2 cleanings every year*): *In-network:* $0 copay *Out-of-network:* 30% coinsurance **Fluoride treatments:** Not covered **Dental X-ray(s)** *(Frequency determined by type of X-ray)*: *In-network:* $0 copay *Out-of-network:* 30% coinsurance **Oral exam(s)** *(Frequency determined by type of oral exam)*: *In-network:* $0 copay *Out-of-network:* 30% coinsurance

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO) *Review service area*	Johns Hopkins Advantage MD (PPO) *Review service area.*	Johns Hopkins Advantage MD Plus (PPO) *Review service area.*
Dental Services (continued) • Optional supplemental benefits (available only with Advantage MD Plus PPO) (Non-Medicare covered comprehensive services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	**Comprehensive dental services:** *(Frequency dependent on procedure.)* $2,000 maximum plan coverage amount every year for in- and out-of-network non-Medicare-covered comprehensive dental services. Members are responsible for the difference between the allowed amount and the billed amount for any out-of-network services.	**Comprehensive dental services:** *(Frequency dependent on procedure.)* $1,000 maximum plan coverage amount every year for in- and out-of-network non-Medicare-covered comprehensive dental services. Members are responsible for the difference between the allowed amount and the billed amount for any out-of-network services.	**Comprehensive dental services:** Not covered **Optional Supplemental Benefit:** For an extra $25 per month, members can purchase a supplemental benefit that includes comprehensive dental. The comprehensive dental benefit has a max coverage amount of $1,000 per year. Members are responsible for the difference between the allowed amount and the billed amount for any out-of-network services. The following comprehensive dental services are covered as part of the Optional Supplemental Benefits package **(available with additional premium)**:

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO) *Review service area*	Johns Hopkins Advantage MD (PPO) *Review service area.*	Johns Hopkins Advantage MD Plus (PPO) *Review service area.*
Dental Services (continued)	**Restorative services** *(such as inlays, onlays, crowns, resin restoration, etc.)* Frequency dependent on procedure. *In-network:* $0 copay *Out-of-network:* 50% coinsurance **Endodontics** *(such as root canals, retreatment, apicoectomy, etc.)* Frequency dependent on procedure. *In-network:* $0 copay *Out-of-network:* 50% coinsurance **Periodontics** *(such as periodontal maintenance, periodontal scaling, root planning, etc.)* Frequency dependent on procedure. *In-network:* $0 copay *Out-of-network:* 50% coinsurance	**Restorative services** *(such as inlays, onlays, crowns, resin restoration, etc.)* Frequency dependent on procedure. *In-network:* $0 copay *Out-of-network:* 50% coinsurance **Endodontics** *(such as root canals, retreatment, apicoectomy, etc.)* Frequency dependent on procedure. *In-network:* $0 copay *Out-of-network:* 50% coinsurance **Periodontics** *(such as periodontal maintenance, periodontal scaling, root planning, etc.)* Frequency dependent on procedure. *In-network:* $0 copay *Out-of-network:* 50% coinsurance	**Restorative services** *(such as inlays, onlays, crowns, resin restoration, etc.)* Frequency dependent on procedure. *In-network & Out-of-network:* $50 copay **Endodontics** *(such as root canals, retreatment, apicoectomy, etc.)* Frequency dependent on procedure. *In-network & Out-of-network:* $100 copay **Periodontics** *(such as periodontal maintenance, periodontal scaling, root planning, etc.)* Frequency dependent on procedure. *In-network & Out-of-network:* $50 copay

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO) *Review service area*	Johns Hopkins Advantage MD (PPO) *Review service area.*	Johns Hopkins Advantage MD Plus (PPO) *Review service area.*
Dental Services (continued)	**Extractions** *(such as extractions, coronectomy, surgical access of an unerupted tooth, etc.)* Frequency dependent on procedure. *In-network:* $0 copay *Out-of-network:* 50% coinsurance **Prosthodontics/ Other oral/maxillofacial surgery/Other services** *(such as removable complete and partial dentures, repair or replace teeth in dentures, removal of exostosis, anesthesia, etc.)* Frequency dependent on procedure. *In-network:* $0 copay *Out-of-network:* 50% coinsurance	**Extractions** *(such as extractions, coronectomy, surgical access of an unerupted tooth, etc.)* Frequency dependent on procedure. *In-network:* $0 copay *Out-of-network:* 50% coinsurance **Prosthodontics/ Other oral/maxillofacial surgery/Other services** *(such as removable complete and partial dentures, repair or replace teeth in dentures, removal of exostosis, anesthesia, etc.)* Frequency dependent on procedure. *In-network:* $0 copay *Out-of-network:* 50% coinsurance	**Extractions** *(such as extractions, coronectomy, surgical access of an unerupted tooth, etc.)* Frequency dependent on procedure. *In-network & Out-of-network:* $100 copay **Prosthodontics/ Other oral/maxillofacial surgery/Other services** *(such as removable complete and partial dentures, repair or replace teeth in dentures, removal of exostosis, anesthesia, etc.)* Frequency dependent on procedure. *In-network & Out-of-network:* $50-$100 copay depending on the service
Vision Services	**Medicare-covered exam to diagnose and treat diseases and conditions of the eye**: *In-network:* $50 copay *Out-of-network:* 50% coinsurance	**Medicare-covered exam to diagnose and treat diseases and conditions of the eye**: *In-network:* $50 copay *Out-of-network:* 50% coinsurance	**Medicare-covered exam to diagnose and treat diseases and conditions of the eye:** *In-network:* $40 copay *Out-of-network:* 30% coinsurance

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO) *Review service area*	Johns Hopkins Advantage MD (PPO) *Review service area.*	Johns Hopkins Advantage MD Plus (PPO) *Review service area.*
Vision Services (continued)	**Yearly Glaucoma Screening:** *In-network:* $0 copay *Out-of-network:* 50% coinsurance **Routine eye exam** *(1 every year):* *In-network:* $0 copay *Out-of-network:* 50% coinsurance **Eyeglasses or contact lenses after cataract surgery:** *In-network:* $0 copay *Out-of-network:* 50% coinsurance **Routine eyewear:** Our plan pays up to $200 every year for supplemental eyewear (retail or online) from any in-network Superior Vision provider.	**Yearly Glaucoma Screening:** *In-network:* $0 copay *Out-of-network:* 50% coinsurance **Routine eye exam** *(1 every year):* *In-network:* $0 copay *Out-of-network:* 50% coinsurance **Eyeglasses or contact lenses after cataract surgery:** *In-network:* $0 copay *Out-of-network:* 50% coinsurance **Routine eyewear:** Our plan pays up to $300 every year for supplemental eyewear (retail or online) from any in-network Superior Vision provider.	**Yearly Glaucoma Screening:** *In-network:* $0 copay *Out-of-network:* 30% coinsurance **Routine eye exam** *(1 every year):* *In-network:* $0 copay *Out-of-network:* 45% coinsurance **Eyeglasses or contact lenses after cataract surgery:** *In-network:* $0 copay *Out-of-network:* 30% coinsurance **Routine eyewear:** Our plan pays up to $150 every year for supplemental eyewear (retail or online) from any in-network Superior Vision provider.

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO) *Review service area*	Johns Hopkins Advantage MD (PPO) *Review service area.*	Johns Hopkins Advantage MD Plus (PPO) *Review service area.*
Mental Health Services (Inpatient visit may require a prior authorization and/or referral. Please see the *Evidence of Coverage* booklet for more information.)	**Inpatient visit:** Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. *In-network:* $350 copay per day for days 1-5; $0 copay per day for days 6-90 for Medicare-covered inpatient hospital stay. *Out-of-network:* 30% coinsurance per stay for Medicare-covered inpatient hospital stay. **Outpatient mental health visits:** Individual or Group therapy visit: *In-network:* $40 copay *Out-of-network:* 50% coinsurance **Outpatient substance abuse therapy visit:** Individual or Group 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. *In-network:* $310 copay per day for days 1-6; $0 copay per day for days 7-90 for Medicare-covered inpatient hospital stay. *Out-of-network:* 30% coinsurance per stay for Medicare-covered inpatient hospital stay. **Outpatient mental health visits:** Individual or Group therapy visit: *In-network:* $40 copay *Out-of-network:* 50% coinsurance **Outpatient substance abuse therapy visit:** Individual or Group 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. *In-network:* $310 copay per day for days 1-6; $0 copay per day for days 7-90 for Medicare-covered inpatient hospital stay. *Out-of-network:* 30% coinsurance per stay for Medicare-covered inpatient hospital stay. **Outpatient mental health visits:** Individual or Group therapy visit: *In-network:* $40 copay *Out-of-network:* 30% coinsurance **Outpatient substance abuse therapy visit:** Individual or Group therapy visit: *In-network:* $40 copay *Out-of-network:* 30% coinsurance

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO) *Review service area*	Johns Hopkins Advantage MD (PPO) *Review service area.*	Johns Hopkins Advantage MD Plus (PPO) *Review service area.*
Skilled Nursing Facility (SNF) (Services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	Our plan covers up to 100 days in an SNF. *In-network:* $0 copay per day for days 1-20; $196 copay per day for days 21-100. *Out-of-network:* 30% coinsurance per stay	Our plan covers up to 100 days in an SNF. *In-network:* $0 copay per day for days 1-20; $160 copay per day for days 21-100. *Out-of-network:* 50% coinsurance per stay	Our plan covers up to 100 days in an SNF. *In-network:* $0 copay per day for days 1-20; $150 copay per day for days 21-100. *Out-of-network:* 30% coinsurance per stay
Physical Therapy (Services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	*In-network:* $40 copay *Out-of-network:* 50% coinsurance	*In-network:* $40 copay *Out-of-network:* 50% coinsurance	*In-network:* $30 copay *Out-of-network:* 30% coinsurance
Ambulance (Services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	*In-network & Out-of-network:* $275 copay (ground) 20% coinsurance (air) 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 & Out-of-network:* $210 copay (ground) $210 copay (air) 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 & Out-of-network:* $210 copay (ground) $210 copay (air) 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.

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO) *Review service area*	Johns Hopkins Advantage MD (PPO) *Review service area.*	Johns Hopkins Advantage MD Plus (PPO) *Review service area.*
Ambulance (continued)	(Prior authorization is required for non-emergent Ambulance Services.)	(Prior authorization is required for non-emergent Ambulance Services.)	Prior authorization is required for non-emergent ambulance services.
Transportation	Not covered	Not covered	Not covered
Medicare Part B Drugs (Services may require that your provider get prior authorization (extra approval in advance). Please see the *Evidence of Coverage* booklet for more information.) Medicare-covered Part B Drugs may be subject to step therapy requirements.	For Part B drugs such as chemotherapy/radiation drugs: *In-network:* 0% to 20% coinsurance *Out-of-network:* 50% coinsurance Other Part B drugs: *In-network:* 0% to 20% coinsurance *Out-of-network:* 50% coinsurance Medicare Part B Insulin: *In-network:* 20% coinsurance or $35 copay Member pays lesser of 20% coinsurance or $35 copay for Part B insulin. *Out-of-network:* 50% coinsurance	For Part B drugs such as chemotherapy/radiation drugs: *In-network:* 0% to 20% coinsurance *Out-of-network:* 45% coinsurance Other Part B drugs: *In-network:* 0% to 20% coinsurance *Out-of-network:* 45% coinsurance Medicare Part B Insulin: *In-network:* 20% coinsurance or $35 copay Member pays lesser of 20% coinsurance or $35 copay for Part B insulin. *Out-of-network:* 45% coinsurance	For Part B drugs such as chemotherapy/radiation drugs: *In-network:* 0% to 20% coinsurance *Out-of-network:* 30% coinsurance Other Part B drugs: *In-network:* 0% to 20% coinsurance *Out-of-network:* 30% coinsurance Medicare Part B Insulin: *In-network:* 20% coinsurance or $35 copay Member pays lesser of 20% coinsurance or $35 copay for Part B insulin. *Out-of-network:* 30% coinsurance

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO) *Review service area*	Johns Hopkins Advantage MD (PPO) *Review service area.*	Johns Hopkins Advantage MD Plus (PPO) *Review service area.*
Pharmacy (Part D) Deductible	You pay $590 except for covered insulin products and most adult Part D vaccines. The deductible does not apply to Tier 1: Preferred Generic and Tier 2: Generic drugs.	You pay $590 except for covered insulin products and most adult Part D vaccines. The deductible does not apply to Tier 1: Preferred Generic and Tier 2: Generic drugs.	You pay $590 except for covered insulin products and most adult Part D vaccines. The deductible does not apply to Tier 1: Preferred Generic and Tier 2: Generic drugs.
Initial Coverage • Standard Retail Cost-Sharing *(Insulin drug cost-share listed below)*	You pay the following until your out-of-pocket Part D drug costs reach $2,000. You may get your drugs at network retail pharmacies and mail order pharmacies. Cost-sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please call us or access our Evidence of Coverage booklet. For excluded drugs covered under our enhanced benefit, you pay up to a Tier 2 copay. Covered excluded drugs include select prescription vitamins, cough and cold medications, and erectile dysfunction medicine. These drugs and their quantity limits are listed in the Drug List booklet in the section titled “Coverage of additional drugs”.		
	Tier 1 *(Preferred Generic)* $0 copay for a one-month supply $0 copay for a three-month supply **Tier 2 *(Generic)*** $20 copay for a one-month supply $40 copay for a three-month supply	**Tier 1 *(Preferred Generic)*** $0 copay for a one-month supply $0 copay for a three-month supply **Tier 2 *(Generic)*** $15 copay for a one-month supply $30 copay for a three-month supply	**Tier 1 *(Preferred Generic)*** $0 copay for a one-month supply $0 copay for a three-month supply **Tier 2 *(Generic)*** $15 copay for a one-month supply $30 copay for a three-month supply

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO) *Review service area*	Johns Hopkins Advantage MD (PPO) *Review service area.*	Johns Hopkins Advantage MD Plus (PPO) *Review service area.*
Initial Coverage (continued) • Standard Retail Cost-Sharing (continued)	**Tier 3 *(Preferred Brand)*** 25% coinsurance for a one-month supply 25% coinsurance for a three-month supply **Tier 4 *(Non-Preferred Drug)*** 25% coinsurance for a one-month supply 25% coinsurance for a three-month supply **Tier 5 *(Specialty Tier)*** 25% coinsurance of a one-month supply (long-term supply is not available)	**Tier 3 *(Preferred Brand)*** 25% coinsurance for a one-month supply 25% coinsurance for a three-month supply **Tier 4 *(Non-Preferred Drug)*** 25% coinsurance for a one-month supply 25% coinsurance for a three-month supply **Tier 5 *(Specialty Tier)*** 25% coinsurance of a one-month supply (long-term supply is not available)	**Tier 3 *(Preferred Brand)*** 25% coinsurance for a one-month supply 25% coinsurance for a three-month supply **Tier 4 *(Non-Preferred Drug)*** 25% coinsurance for a one-month supply 25% coinsurance for a three-month supply **Tier 5 *(Specialty Tier)*** 25% coinsurance of a one-month supply (long-term supply is not available)
• Standard Mail Order Cost-Sharing *(Insulin drug cost-share listed below)*	**Tier 1 *(Preferred Generic)*** $0 copay for a one-month supply $0 copay for a three-month supply **Tier 2 *(Generic)*** $20 copay for a one-month supply $40 copay for a three-month supply **Tier 3 *(Preferred Brand)*** 25% coinsurance for a one-month supply 25% coinsurance for a three-month supply	**Tier 1 *(Preferred Generic)*** $0 copay for a one-month supply $0 copay for a three-month supply **Tier 2 *(Generic*** $15 copay for a one-month supply $30 copay for a three-month supply **Tier 3 *(Preferred Brand)*** 25% coinsurance for a one-month supply 25% coinsurance for a three-month supply	**Tier 1 *(Preferred Generic)*** $0 copay for a one-month supply $0 copay for a three-month supply **Tier 2 *(Generic)*** $15 copay for a one-month supply $30 copay for a three-month supply **Tier 3 *(Preferred Brand)*** 25% coinsurance for a one-month supply 25% coinsurance for a three-month supply

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO) *Review service area*	Johns Hopkins Advantage MD (PPO) *Review service area.*	Johns Hopkins Advantage MD Plus (PPO) *Review service area.*
Initial Coverage (continued) • Standard Mail Order Cost-Sharing (continued)	**Tier 4 *(Non-Preferred Drug)*** 25% coinsurance for a one-month supply 25% coinsurance for a three-month supply **Tier 5 *(Specialty Tier)*** 25% coinsurance of a one-month supply (long-term supply is not available) If you reside in a long-term care facility, you pay the same as at a retail pharmacy.	**Tier 4 *(Non-Preferred Drug)*** 25% coinsurance for a one-month supply 25% coinsurance for a three-month supply **Tier 5 *(Specialty Tier)*** 25% coinsurance of a one-month supply (long-term supply is not available) If you reside in a long-term care facility, you pay the same as at a retail pharmacy.	**Tier 4 *(Non-Preferred Drug)*** 25% coinsurance for a one-month supply 25% coinsurance for a three-month supply **Tier 5 *(Specialty Tier)*** 25% coinsurance of a one-month supply (long-term supply is not available) If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO) *Review service area*	Johns Hopkins Advantage MD (PPO) *Review service area.*	Johns Hopkins Advantage MD Plus (PPO) *Review service area.*
Initial Coverage (continued) • Insulin Retail Cost-Sharing	**Tier 1 *(Preferred Generic)*** $0 copay for a one-month supply $0 copay for a three-month supply **Tier 2 *(Generic)*** $20 copay for a one-month supply $40 copay for a three-month supply **Tier 3 *(Preferred Brand)*** $35 copay for a one-month supply $105 copay for a three-month supply **Tier 4 *(Non-Preferred Drug)*** $35 copay for a one-month supply $105 copay for a three-month supply **Tier 5 *(Specialty Tier)*** $35 copay of a one-month supply (long-term supply is not available)	**Tier 1 *(Preferred Generic)*** $0 copay for a one-month supply $0 copay for a three-month supply **Tier 2 *(Generic)*** $15 copay for a one-month supply $30 copay for a three-month supply **Tier 3 *(Preferred Brand)*** $35 copay for a one-month supply $105 copay for a three-month supply **Tier 4 *(Non-Preferred Drug)*** $35 copay for a one-month supply $105 copay for a three-month supply **Tier 5 *(Specialty Tier)*** $35 copay of a one-month supply (long-term supply is not available)	**Tier 1 *(Preferred Generic)*** $0 copay for a one-month supply $0 copay for a three-month supply **Tier 2 *(Generic)*** $15 copay for a one-month supply $30 copay for a three-month supply **Tier 3 *(Preferred Brand)*** $35 copay for a one-month supply $105 copay for a three-month supply **Tier 4 *(Non-Preferred Drug)*** $35 copay for a one-month supply $105 copay for a three-month supply **Tier 5 *(Specialty Tier)*** $35 copay of a one-month supply (long-term supply is not available)

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO) *Review service area*	Johns Hopkins Advantage MD (PPO) *Review service area.*	Johns Hopkins Advantage MD Plus (PPO) *Review service area.*
Initial Coverage (continued) • Insulin Mail Order Cost-Sharing	**Tier 1 *(Preferred Generic)*** $0 copay for a one-month supply $0 copay for a three-month supply **Tier 2 *(Generic)*** $20 copay for a one-month supply $40 copay for a three-month supply **Tier 3 *(Preferred Brand)*** $35 copay for a one-month supply $70 copay for a three-month supply **Tier 4 *(Non-Preferred Drug)*** $35 copay for a one-month supply $70 copay for a three-month supply **Tier 5 *(Specialty Tier)*** $35 copay of a one-month supply (long-term supply is not available) If you reside in a long-term care facility, you pay the same as at a retail pharmacy	**Tier 1 *(Preferred Generic)*** $0 copay for a one-month supply $0 copay for a three-month supply **Tier 2 *(Generic)*** $15 copay for a one-month supply $30 copay for a three-month supply **Tier 3 *(Preferred Brand)*** $35 copay for a one-month supply $70 copay for a three-month supply **Tier 4 *(Non-Preferred Drug)*** $35 copay for a one-month supply $70 copay for a three-month supply **Tier 5 *(Specialty Tier)*** $35 copay of a one-month supply (long-term supply is not available) If you reside in a long-term care facility, you pay the same as at a retail pharmacy	**Tier 1 *(Preferred Generic)*** $0 copay for a one-month supply $0 copay for a three-month supply **Tier 2 *(Generic)*** $15 copay for a one-month supply $30 copay for a three-month supply **Tier 3 *(Preferred Brand)*** $35 copay for a one-month supply $70 copay for a three-month supply **Tier 4 *(Non-Preferred Drug)*** $35 copay for a one-month supply $70 copay for a three-month supply **Tier 5 *(Specialty Tier)*** $35 copay of a one-month supply (long-term supply is not available) If you reside in a long-term care facility, you pay the same as at a retail pharmacy

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO) *Review service area*	Johns Hopkins Advantage MD (PPO) *Review service area.*	Johns Hopkins Advantage MD Plus (PPO) *Review service area.*
Catastrophic Coverage	After your yearly out-of-pocket drug costs *(including drugs purchased through your retail pharmacy and through mail order)* reach $2,000, you will stay in this payment stage until the end of the calendar year. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. For excluded drugs covered under our enhanced benefit, you pay nothing.		

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO) *Review service area*	Johns Hopkins Advantage MD (PPO) *Review service area.*	Johns Hopkins Advantage MD Plus (PPO) *Review service area.*
Additional Covered Medical and Hospital Benefits			
Acupuncture	**Medicare-covered acupuncture:** *In-network:* 20% coinsurance *Out-of-network:* 50% coinsurance **Non-Medicare covered acupuncture:** Not covered	**Medicare-covered acupuncture:** *In-network:* 20% coinsurance *Out-of-network:* 30% coinsurance **Non-Medicare covered acupuncture:** Not covered	**Medicare-covered acupuncture:** *In-network:* 20% coinsurance *Out-of-network:* 30% coinsurance **Non-Medicare covered acupuncture:** *In-network & Out-of-network:* $200 maximum plan coverage amount every year for routine acupuncture services.
Chiropractic Care (Services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	**Medicare-covered chiropractic care:** *In-network:* $15 copay *Out-of-network:* 50% coinsurance **Non-Medicare covered chiropractic care:** Not covered	**Medicare-covered chiropractic care:** *In-network:* $15 copay *Out-of-network:* 50% coinsurance **Non-Medicare covered chiropractic care:** Not covered	**Medicare-covered chiropractic care:** *In-network:* $15 copay *Out-of-network:* 30% coinsurance **Non-Medicare covered chiropractic care:** *(12 visits every year)* *In-network:* $20 copay *Out-of-network:* 30% coinsurance

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO) *Review service area*	Johns Hopkins Advantage MD (PPO) *Review service area.*	Johns Hopkins Advantage MD Plus (PPO) *Review service area.*
Silver&Fit® Healthy Aging and Exercise Program	$0 copay at participating fitness centers.	$0 copay at participating fitness centers.	$0 copay at participating fitness centers.
Home Health Care (Services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	*In-network:* $0 copay *Out-of-network:* 50% coinsurance	*In-network:* $0 copay *Out-of-network:* 40% coinsurance	*In-network:* $0 copay *Out-of-network:* 30% coinsurance
Over-the -Counter Items	$0 copay $50 maximum plan coverage amount every 3 months for OTC items. Any unused amount does not carry over to the next period.	Not covered	Not covered
Rehabilitation Services Occupational therapy visits may require that your provider get prior authorization (approval in advance).	**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:* $0 copay *Out-of-network:* 50% 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:* $0 copay *Out-of-network:* 50% 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:* $0 copay *Out-of-network:* 30% coinsurance

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO) *Review service area*	Johns Hopkins Advantage MD (PPO) *Review service area.*	Johns Hopkins Advantage MD Plus (PPO) *Review service area.*
Rehabilitation Services (continued) Please see the *Evidence of Coverage* booklet for more information.	**Occupational therapy visit:** *In-network:* $35 copay *Out-of-network:* 50% coinsurance **Physical/speech therapy visit:** *In-network:* $40 copay *Out-of-network:* 50% coinsurance	**Occupational therapy visit:** *In-network:* $35 copay *Out-of-network:* 50% coinsurance **Physical/speech therapy visit:** *In-network:* $40 copay *Out-of-network:* 50% coinsurance	**Occupational therapy visit:** *In-network:* $30 copay *Out-of-network:* 30% coinsurance **Physical/speech therapy visit:** *In-network:* $30 copay *Out-of-network:* 30% coinsurance
Renal Dialysis	*In-network:* 20% coinsurance *Out-of-network:* 50% coinsurance	*In-network:* 20% coinsurance *Out-of-network:* 50% coinsurance	*In-network:* 20% coinsurance *Out-of-network:* 30% coinsurance
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.		
Post Discharge Meals	Not covered	Not covered	Not covered
Telehealth	$0 copay	$0 copay	$0 copay

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO) *Review service area*	Johns Hopkins Advantage MD (PPO) *Review service area.*	Johns Hopkins Advantage MD Plus (PPO) *Review service area.*
Worldwide Emergency Care	$110 copay for emergency care services $50,000 maximum plan benefit coverage amount every year for the worldwide benefit. (USD) combined limit per year for urgently needed or emergency care services provided outside the U.S. and its territories. You are responsible for services rendered upfront and must submit your claim(s) and proof of payment for reimbursement consideration.	$110 copay for emergency care services $50,000 maximum plan benefit coverage amount every year for the worldwide benefit. (USD) combined limit per year for urgently needed or emergency care services provided outside the U.S. and its territories. You are responsible for services rendered upfront and must submit your claim(s) and proof of payment for reimbursement consideration.	$110 copay for emergency care services $50,000 maximum plan benefit coverage amount every year for the worldwide benefit. (USD) combined limit per year for urgently needed or emergency care services provided outside the U.S. and its territories. You are responsible for services rendered upfront and must submit your claim(s) and proof of payment for reimbursement consideration.

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO) *Review service area*	Johns Hopkins Advantage MD (PPO) *Review service area.*	Johns Hopkins Advantage MD Plus (PPO) *Review service area.*
Worldwide Urgent Care	$45 copay for urgent care services $50,000 maximum plan benefit coverage amount every year for the worldwide benefit. (USD) combined limit per year for urgently needed or emergency care services provided outside the U.S. and its territories. You are responsible for services rendered upfront and must submit your claim(s) and proof of payment for reimbursement consideration.	$40 copay for urgent care services $50,000 maximum plan benefit coverage amount every year for the worldwide benefit. (USD) combined limit per year for urgently needed or emergency care services provided outside the U.S. and its territories. You are responsible for services rendered upfront and must submit your claim(s) and proof of payment for reimbursement consideration.	$40 copay for urgent care services $50,000 maximum plan benefit coverage amount every year for the worldwide benefit. (USD) combined limit per year for urgently needed or emergency care services provided outside the U.S. and its territories. You are responsible for services rendered upfront and must submit your claim(s) and proof of payment for reimbursement consideration.

SUPPLEMENTAL BENEFIT PURCHASE OPTIONS

ADVANTAGE MD (HMO)	*ADVANTAGE MD PLUS (PPO)*
For an extra **$25** per month (**$45** per month total), members can purchase the supplemental comprehensive dental benefit.	For an extra **$25** per month (**$160** per month total), members can purchase the supplemental comprehensive dental benefit.

- **Please see the dental section in this booklet for information about comprehensive dental services coverage. Additional information can be found in the Evidence of Coverage for your plan.**

JOHNS HOPKINS
HEALTH PLANS

7231 Parkway Dr. Suite 100
Hanover, MD 21076
HopkinsMedicare.com

Questions?

For updated information about plan providers or a list of covered prescription drugs, please visit our website at HopkinsMedicare.com, or call Advantage MD Member Services at:

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

8 a.m. to 8 p.m., 7 days a week
8 a.m. to 8 p.m., Monday – Friday between April 1 and September 30

Johns Hopkins Advantage MD is a Medicare Advantage Plan with a Medicare contract offering HMO and PPO products. Enrollment in Johns Hopkins Advantage MD HMO, or PPO depends on contract renewal.

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.