

2026

SUMMARY OF BENEFITS

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, 2026 – December 31, 2026

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 Primary (PPO), 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).

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

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 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.

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO)	Johns Hopkins Advantage MD (PPO)	Johns Hopkins Advantage MD Plus (PPO)
Monthly plan premium (Part C and D premium, combined)	\$5 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.	\$155 per month. In addition, you must keep paying your Medicare Part B premium.
Part B premium buy down, if applicable	Not available	Not available	Not available
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. See prescription drug coverage for Part D deductible.	This plan does not have any medical deductibles. See prescription drug coverage for Part D deductible.
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: From network providers: \$7,550 From network and out-of-network providers combined: \$11,300	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: From network providers: \$7,550 From network and out-of-network providers combined: \$11,300	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: From network providers: \$7,550 From network and out-of-network providers combined: \$11,300

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO)	Johns Hopkins Advantage MD (PPO)	Johns Hopkins Advantage MD Plus (PPO)
Inpatient Hospital Coverage (Services may require that your provider get prior authorization (extra approval in advance). Please see the <i>Evidence of Coverage</i> booklet for more information.)	In-Network \$350 copay per day for days 1 to 5 and \$0 copay per day for days 6 to 90 for Medicare-covered inpatient hospital care. \$0 copay for an additional 60 lifetime reserve days. <i>Prior Authorization may be required.</i> Out-of-Network 30% coinsurance for each Medicare-covered inpatient hospital stay.	In-Network \$330 copay per day for days 1 to 6 and \$0 copay per day for days 7 to 90 for Medicare-covered inpatient hospital care. \$0 copay for an additional 60 lifetime reserve days. <i>Prior Authorization may be required.</i> Out-of-Network 30% coinsurance for each Medicare-covered inpatient hospital stay.	In-Network \$330 copay per day for days 1 to 6 and \$0 copay per day for days 7 to 90 for Medicare-covered inpatient hospital care. \$0 copay for an additional 60 lifetime reserve days. <i>Prior Authorization may be required.</i> Out-of-Network 30% coinsurance for each Medicare-covered inpatient hospital stay.
Outpatient Hospital Coverage (Services may require that your provider get prior authorization (extra approval in advance). Please see the <i>Evidence of Coverage</i> booklet for more information.) Outpatient hospital services	In-Network \$320 copay <i>Prior Authorization may be required.</i>	In-Network \$320 copay <i>Prior Authorization may be required.</i>	In-Network \$320 copay <i>Prior Authorization may be required.</i>

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO)	Johns Hopkins Advantage MD (PPO)	Johns Hopkins Advantage MD Plus (PPO)
Outpatient hospital observation services	Out-of-Network 50% coinsurance In-Network \$320 copay per stay Out-of-Network 50% coinsurance	Out-of-Network 50% coinsurance In-Network \$320 copay per stay Out-of-Network 50% coinsurance	Out-of-Network 30% coinsurance In-Network \$320 copay per stay Out-of-Network 30% coinsurance
Ambulatory Surgical Center (ASC) Services (Services may require that your provider get prior authorization (extra approval in advance). Please see the <i>Evidence of Coverage</i> booklet for more information.)	In-Network \$250 copay <i>Prior Authorization may be required.</i> Out-of-Network 50% coinsurance	In-Network \$250 copay <i>Prior Authorization may be required.</i> Out-of-Network 50% coinsurance	In-Network \$250 copay <i>Prior Authorization may be required.</i> Out-of-Network 30% coinsurance
Doctor Visits Primary Care Providers Specialists	In-Network \$10 copay Out-of-Network 50% coinsurance In-Network \$45 copay Out-of-Network 50% coinsurance	In-Network \$5 copay Out-of-Network 40% coinsurance In-Network \$45 copay Out-of-Network 40% coinsurance	In-Network \$0 copay Out-of-Network 30% 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

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO)	Johns Hopkins Advantage MD (PPO)	Johns Hopkins Advantage MD Plus (PPO)
Emergency care	\$115 copay The copay is waived if you are admitted to the hospital within 24 hours for the same condition.	\$115 copay The copay is waived if you are admitted to the hospital within 24 hours for the same condition.	\$110 copay The copay is waived if you are admitted to the hospital within 24 hours for the same condition.
Urgently needed services	\$40 copay The copay is not waived if you are admitted to the hospital. Cost-sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.	\$40 copay The copay is not waived if you are admitted to the hospital. Cost-sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.	\$40 copay The copay is not waived if you are admitted to the hospital. Cost-sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.
Diagnostic Services/Labs/Imaging (Services may require that your provider get prior authorization (extra approval in advance). Please see the <i>Evidence of Coverage</i> booklet for more information.) Diagnostic tests and procedures	In-Network 20% coinsurance <i>Prior Authorization may be required.</i>	In-Network 20% coinsurance <i>Prior Authorization may be required.</i>	In-Network 20% coinsurance <i>Prior Authorization may be required.</i>

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO)	Johns Hopkins Advantage MD (PPO)	Johns Hopkins Advantage MD Plus (PPO)
Lab services	Out-of-Network 50% coinsurance In-Network \$0 copay <i>Prior Authorization may be required.</i>	Out-of-Network 50% coinsurance In-Network \$0 copay <i>Prior Authorization may be required.</i>	Out-of-Network 30% coinsurance In-Network \$0 copay <i>Prior Authorization may be required.</i>
Diagnostic radiology services (e.g. MRI, CAT Scan)	Out-of-Network 50% coinsurance In-Network \$175 copay <i>Prior Authorization may be required.</i>	Out-of-Network 50% coinsurance In-Network \$250 copay <i>Prior Authorization may be required.</i>	Out-of-Network 30% coinsurance In-Network \$250 copay <i>Prior Authorization may be required.</i>
Outpatient X-rays	Out-of-Network 50% coinsurance In-Network \$20 copay <i>Prior Authorization may be required.</i>	Out-of-Network 50% coinsurance In-Network \$30 copay <i>Prior Authorization may be required.</i>	Out-of-Network 30% coinsurance In-Network \$30 copay <i>Prior Authorization may be required.</i>
Therapeutic Radiology	Out-of-Network 50% coinsurance In-Network 20% coinsurance <i>Prior Authorization may be required.</i>	Out-of-Network 40% coinsurance In-Network 20% coinsurance <i>Prior Authorization may be required.</i>	Out-of-Network 30% coinsurance In-Network 20% coinsurance <i>Prior Authorization may be required.</i>
	Out-of-Network 50% coinsurance	Out-of-Network 50% coinsurance	Out-of-Network 30% coinsurance
Hearing services Exam to diagnose and treat hearing and balance issues:	In-Network \$50 copay	In-Network \$50 copay	In-Network \$40 copay

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO)	Johns Hopkins Advantage MD (PPO)	Johns Hopkins Advantage MD Plus (PPO)
Routine hearing exam	Out-of-Network 50% coinsurance In-Network <u>Not</u> covered Out-of-Network <u>Not</u> covered	Out-of-Network 50% coinsurance 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)	Out-of-Network 30% coinsurance 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)
Fitting-evaluation(s) for hearing aids	In-Network <u>Not</u> covered Out-of-Network <u>Not</u> covered	In-Network \$0 copay Unlimited visits every year Out-of-Network \$0 copay	In-Network \$0 copay Unlimited visits every year Out-of-Network \$0 copay
Hearing aids All types	In-Network <u>Not</u> covered Out-of-Network <u>Not</u> covered	In-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	In-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

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO)	Johns Hopkins Advantage MD (PPO)	Johns Hopkins Advantage MD Plus (PPO)
		hearing aids every year (one per ear per year). Benefit is limited to the TruHearing's Advanced and Premium hearing aids. 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). Benefit is limited to the TruHearing's Advanced and Premium hearing aids.	hearing aids every year (one per ear per year). Benefit is limited to the TruHearing's Advanced and Premium hearing aids. 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). Benefit is limited to the TruHearing's Advanced and Premium hearing aids.
Dental services	In-Network \$0 copay for each Medicare-covered service. Out-of-Network 50% coinsurance for each Medicare-covered service. <i>Referral may be required.</i>	In-Network \$0 copay for each Medicare-covered service. Out-of-Network 50% coinsurance for each Medicare-covered service.	In-Network \$0 copay for each Medicare-covered service. Out-of-Network 30% coinsurance for each Medicare-covered service.

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO)	Johns Hopkins Advantage MD (PPO)	Johns Hopkins Advantage MD Plus (PPO)
Preventive dental services ○ Oral Exams	In-Network \$0 copay Frequency dependent on procedure: • Periodic oral exams, Extensive oral exam – problem focused, Re-Evaluation – limited problem focused – two per calendar year • Limited Oral Exam – 3 per calendar Year • Comprehensive Oral Exam or Comprehensive Periodontal Exam – One per 3 years per provider or location Out-of-Network 50% coinsurance	In-Network \$0 copay Frequency dependent on procedure: • Periodic oral exams, Extensive oral exam – problem focused, Re-Evaluation – limited problem focused – two per calendar year • Limited Oral Exam – 3 per calendar Year • Comprehensive Oral Exam or Comprehensive Periodontal Exam – One per 3 years per provider or location Out-of-Network 50% coinsurance	In-Network \$0 copay Frequency dependent on procedure: • Periodic oral exams, Extensive oral exam – problem focused, Re-Evaluation – limited problem focused – two per calendar year • Limited Oral Exam – 3 per calendar Year • Comprehensive Oral Exam or Comprehensive Periodontal Exam – One per 3 years per provider or location Out-of-Network 30% coinsurance
○ Prophylaxis (Cleaning)	In-Network \$0 copay Limited to 2 cleaning(s) every year Out-of-Network 50% coinsurance	In-Network \$0 copay Limited to 2 cleaning(s) every year Out-of-Network 50% coinsurance	In-Network \$0 copay Limited to 2 cleaning(s) every year Out-of-Network 30% coinsurance

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO)	Johns Hopkins Advantage MD (PPO)	Johns Hopkins Advantage MD Plus (PPO)
○ Fluoride Treatment ○ Dental X-Rays	In-Network \$0 copay Limited to 2 fluoride treatment(s) every year Out-of-Network 50% coinsurance In-Network \$0 copay Frequency dependent on procedure: • Intraoral or Intraoral Tomosynthesis complete series of radiographic images, one set of vertical bitewing-7 to 8 films, panoramic radiographic image- one every 3 years • Intraoral-occlusal radiographic image-two every 2 years • Intraoral Tomosynthesis Periapical Radiographic Image – One per calendar year • Bitewings (1-4 images) or Intraoral	In-Network \$0 copay Limited to 2 fluoride treatment(s) every year Out-of-Network 50% coinsurance In-Network \$0 copay Frequency dependent on procedure: • Intraoral or Intraoral Tomosynthesis complete series of radiographic images, one set of vertical bitewing-7 to 8 films, panoramic radiographic image- one every 3 years • Intraoral-occlusal radiographic image-two every 2 years • Intraoral Tomosynthesis Periapical Radiographic Image – One per calendar year • Bitewings (1-4 images) or Intraoral	In-Network \$0 copay Limited to 2 fluoride treatment(s) every year Out-of-Network 30% coinsurance In-Network \$0 copay Frequency dependent on procedure: • Intraoral or Intraoral Tomosynthesis complete series of radiographic images, one set of vertical bitewing-7 to 8 films, panoramic radiographic image- one every 3 years • Intraoral-occlusal radiographic image-two every 2 years • Intraoral Tomosynthesis Periapical Radiographic Image – One per calendar year • Bitewings (1-4 images) or Intraoral

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO)	Johns Hopkins Advantage MD (PPO)	Johns Hopkins Advantage MD Plus (PPO)
	Tomosynthesis bitewing image -one per calendar year Out-of-Network 50% coinsurance	Tomosynthesis bitewing image -one per calendar year Out-of-Network 50% coinsurance	Tomosynthesis bitewing image -one per calendar year Out-of-Network 30% coinsurance
Vision care Exam to diagnose and treat diseases and conditions of the eye For people with diabetes, screening for diabetic retinopathy is covered once per year. Eyewear after cataract surgery Glaucoma screening Routine eye exam	In-Network \$50 copay Out-of-Network 50% coinsurance 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 50% coinsurance In-Network \$0 copay Limited to 1 visit(s) every year	In-Network \$50 copay Out-of-Network 50% coinsurance In-Network \$0 copay Out-of-Network 50% coinsurance In-Network \$0 copay Out-of-Network 50% coinsurance In-Network \$0 copay Limited to 1 visit(s) every year	In-Network \$40 copay Out-of-Network 30% coinsurance In-Network \$0 copay Out-of-Network 30% coinsurance In-Network \$0 copay Out-of-Network 30% coinsurance In-Network \$0 copay Limited to 1 visit(s) every year

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO)	Johns Hopkins Advantage MD (PPO)	Johns Hopkins Advantage MD Plus (PPO)
Additional routine eyewear	Out-of-Network 50% coinsurance Our plan pays up to \$150 every year for supplemental eyewear (retail or online) from any in-network Superior Vision provider.	Out-of-Network 50% coinsurance Our plan pays up to \$200 every year for supplemental eyewear (retail or online) from any in-network Superior Vision provider.	Out-of-Network 45% coinsurance Our plan pays up to \$250 every year for supplemental eyewear (retail or online) from any in-network Superior Vision provider.
Mental Health Services (Services may require that your provider get prior authorization (extra approval in advance). Please see the <i>Evidence of Coverage</i> booklet for more information.) Inpatient visit	In-Network \$350 copay per day for days 1 to 5 and \$0 copay per day for days 6 to 90 for Medicare-covered inpatient hospital care. \$0 copay for an additional 60 lifetime reserve days. <i>Prior Authorization may be required.</i>	In-Network \$330 copay per day for days 1 to 6 and \$0 copay per day for days 7 to 90 for Medicare-covered inpatient hospital care. \$0 copay for an additional 60 lifetime reserve days. <i>Prior Authorization may be required.</i>	In-Network \$330 copay per day for days 1 to 6 and \$0 copay per day for days 7 to 90 for Medicare-covered inpatient hospital care. \$0 copay for an additional 60 lifetime reserve days. <i>Prior Authorization may be required.</i>

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO)	Johns Hopkins Advantage MD (PPO)	Johns Hopkins Advantage MD Plus (PPO)
Outpatient group therapy visit	Out-of-Network 30% coinsurance for each Medicare-covered inpatient hospital stay. In-Network \$40 copay <i>Prior Authorization may be required.</i>	Out-of-Network 30% coinsurance for each Medicare-covered inpatient hospital stay. In-Network \$40 copay <i>Prior Authorization may be required.</i>	Out-of-Network 30% coinsurance for each Medicare-covered inpatient hospital stay. In-Network \$40 copay <i>Prior Authorization may be required.</i>
Outpatient individual therapy visit	Out-of-Network 50% coinsurance In-Network \$40 copay <i>Prior Authorization may be required.</i> Out-of-Network 50% coinsurance	Out-of-Network 50% coinsurance In-Network \$40 copay <i>Prior Authorization may be required.</i> Out-of-Network 50% coinsurance	Out-of-Network 30% coinsurance In-Network \$40 copay <i>Prior Authorization may be required.</i> Out-of-Network 30% coinsurance
Skilled nursing facility (SNF) care (Services may require that your provider get prior authorization (extra approval in advance). Please see the <i>Evidence of Coverage</i> booklet for more information.)	In-Network \$0 copay per day for days 1 to 20 and \$218 copay per day for days 21 to 100 for Medicare-covered skilled nursing facility care. <i>Prior Authorization may be required.</i>	In-Network \$0 copay per day for days 1 to 20 and \$218 copay per day for days 21 to 100 for Medicare-covered skilled nursing facility care. <i>Prior Authorization may be required.</i>	In-Network \$0 copay per day for days 1 to 20 and \$150 copay per day for days 21 to 100 for Medicare-covered skilled nursing facility care. <i>Prior Authorization may be required.</i>

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO)	Johns Hopkins Advantage MD (PPO)	Johns Hopkins Advantage MD Plus (PPO)
	Out-of-Network 50% coinsurance for each Medicare-covered skilled nursing facility stay.	Out-of-Network 50% coinsurance for each Medicare-covered skilled nursing facility stay.	Out-of-Network 30% coinsurance for each Medicare-covered skilled nursing facility stay.
Physical Therapy (Services may require that your provider get prior authorization (extra approval in advance). Please see the <i>Evidence of Coverage</i> booklet for more information.)	In-Network \$40 copay <i>Prior Authorization may be required.</i> Out-of-Network 50% coinsurance	In-Network \$40 copay <i>Prior Authorization may be required.</i> Out-of-Network 50% coinsurance	In-Network \$30 copay <i>Prior Authorization may be required.</i> Out-of-Network 30% coinsurance
Ambulance services (Services may require that your provider get prior authorization (extra approval in advance). Please see the <i>Evidence of Coverage</i> booklet for more information.) Authorization required for non-emergency Medicare services.	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	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	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

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO)	Johns Hopkins Advantage MD (PPO)	Johns Hopkins Advantage MD Plus (PPO)
Ground Ambulance Air Ambulance	orders from the doctor saying that ambulance transportation is medically necessary. In-Network \$270 copay <i>Prior Authorization may be required.</i> Out-of-Network \$270 copay In-Network 20% coinsurance <i>Prior Authorization may be required.</i> Out-of-Network 20% coinsurance	orders from the doctor saying that ambulance transportation is medically necessary. In-Network \$210 copay <i>Prior Authorization may be required.</i> Out-of-Network \$210 copay In-Network \$210 copay <i>Prior Authorization may be required.</i> Out-of-Network \$210 copay	orders from the doctor saying that ambulance transportation is medically necessary. In-Network \$210 copay <i>Prior Authorization may be required.</i> Out-of-Network \$210 copay In-Network \$210 copay <i>Prior Authorization may be required.</i> Out-of-Network \$210 copay
Transportation (additional routine) (Services may require that your provider get prior authorization (extra approval in advance). Please see the <i>Evidence of Coverage</i> booklet for more information.)	In-Network <u>Not</u> covered Out-of-Network <u>Not</u> covered	In-Network <u>Not</u> covered Out-of-Network <u>Not</u> covered	In-Network <u>Not</u> covered Out-of-Network <u>Not</u> covered
Medicare Part B Drugs (Services may require that your provider get prior authorization (extra approval in advance). Please see the <i>Evidence of</i>			

Benefits & Coverage	Johns Hopkins Advantage MD Primary (PPO)	Johns Hopkins Advantage MD (PPO)	Johns Hopkins Advantage MD Plus (PPO)
Coverage booklet for more information.)			
Chemotherapy/Radiation drugs	In-Network 0% - 20% coinsurance <i>Prior Authorization may be required.</i>	In-Network 0% - 20% coinsurance <i>Prior Authorization may be required.</i>	In-Network 0% - 20% coinsurance <i>Prior Authorization may be required.</i>
Other Part B drugs	Out-of-Network 50% coinsurance In-Network 0% - 20% coinsurance <i>Prior Authorization may be required.</i>	Out-of-Network 45% coinsurance In-Network 0% - 20% coinsurance <i>Prior Authorization may be required.</i>	Out-of-Network 30% coinsurance In-Network 0% - 20% coinsurance <i>Prior Authorization may be required.</i>
Insulin drugs	Out-of-Network 50% coinsurance In-Network Member pays lesser of 20% coinsurance or \$35 copay for Part B insulin. <i>Prior Authorization may be required.</i> Out-of-Network 50% coinsurance	Out-of-Network 45% coinsurance In-Network Member pays lesser of 20% coinsurance or \$35 copay for Part B insulin. <i>Prior Authorization may be required.</i> Out-of-Network 45% coinsurance	Out-of-Network 30% coinsurance In-Network Member pays lesser of 20% coinsurance or \$35 copay for Part B insulin. <i>Prior Authorization may be required.</i> Out-of-Network 30% coinsurance

Additional Benefits

	Johns Hopkins Advantage MD Primary (PPO)	Johns Hopkins Advantage MD (PPO)	Johns Hopkins Advantage MD Plus (PPO)
Acupuncture	In-Network <u>Not</u> covered Out-of-Network <u>Not</u> covered	In-Network <u>Not</u> covered Out-of-Network <u>Not</u> covered	In-Network Non-Medicare covered acupuncture: \$200 maximum plan coverage amount every year every year for routine acupuncture services. Out-of-Network Non-Medicare covered acupuncture: \$200 maximum plan coverage amount every year for routine acupuncture services.
Annual routine physical exam	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
Chiropractic services (Services may require that your provider get prior authorization (extra approval in advance). Please	In-Network \$15 copay <i>Prior Authorization may be required.</i>	In-Network \$15 copay <i>Prior Authorization may be required.</i>	In-Network \$15 copay <i>Prior Authorization may be required.</i>

	Johns Hopkins Advantage MD Primary (PPO)	Johns Hopkins Advantage MD (PPO)	Johns Hopkins Advantage MD Plus (PPO)
see the <i>Evidence of Coverage</i> booklet for more information.) Routine chiropractic care	Out-of-Network 50% coinsurance In-Network <u>Not</u> covered Out-of-Network <u>Not</u> covered	Out-of-Network 50% coinsurance In-Network <u>Not</u> covered Out-of-Network <u>Not</u> covered	Out-of-Network 30% coinsurance In-Network \$20 copay Limited to 12 visit(s) every year <i>Prior Authorization</i> <i>may be required.</i> Out-of-Network 30% coinsurance
Diabetic monitoring supplies (Services may require that your provider get prior authorization (extra approval in advance). Please see the <i>Evidence of Coverage</i> booklet for more information.)	In-Network \$0 copay <i>Prior Authorization</i> <i>may be required.</i> Out-of-Network 50% coinsurance	In-Network \$0 copay <i>Prior Authorization</i> <i>may be required.</i> Out-of-Network 50% coinsurance	In-Network \$0 copay <i>Prior Authorization</i> <i>may be required.</i> Out-of-Network 30% coinsurance
Diabetic therapeutic shoes or inserts (Services may require that your provider get prior authorization (extra approval in advance). Please see the <i>Evidence of Coverage</i> booklet for more information.)	In-Network 20% coinsurance <i>Prior Authorization</i> <i>may be required.</i> Out-of-Network 50% coinsurance	In-Network 20% coinsurance <i>Prior Authorization</i> <i>may be required.</i> Out-of-Network 50% coinsurance	In-Network 20% coinsurance <i>Prior Authorization</i> <i>may be required.</i> Out-of-Network 30% coinsurance
Durable medical equipment (DME) and related supplies (Services may require that your provider get prior authorization (extra approval in advance). Please see the <i>Evidence of Coverage</i> booklet for more information.)	In-Network 20% coinsurance <i>Prior Authorization</i> <i>may be required.</i> Out-of-Network 45% coinsurance	In-Network 20% coinsurance <i>Prior Authorization</i> <i>may be required.</i> Out-of-Network 40% coinsurance	In-Network 20% coinsurance <i>Prior Authorization</i> <i>may be required.</i> Out-of-Network 30% coinsurance

	Johns Hopkins Advantage MD Primary (PPO)	Johns Hopkins Advantage MD (PPO)	Johns Hopkins Advantage MD Plus (PPO)
Silver&Fit Healthy Aging and Exercise Program	In-Network \$0 copay at participating fitness centers. Out-of-Network \$0 copay at participating fitness centers.	In-Network \$0 copay at participating fitness centers. Out-of-Network \$0 copay at participating fitness centers.	In-Network \$0 copay at participating fitness centers. Out-of-Network \$0 copay at participating fitness centers.
Home Health Care (Services may require that your provider get prior authorization (extra approval in advance). Please see the <i>Evidence of Coverage</i> booklet for more information.)	In-Network \$0 copay <i>Prior Authorization may be required.</i> Out-of-Network 50% coinsurance	In-Network \$0 copay <i>Prior Authorization may be required.</i> Out-of-Network 40% coinsurance	In-Network \$0 copay <i>Prior Authorization may be required.</i> 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.	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.
Nursing hotline	In-Network \$0 copay Out-of-Network \$0 copay	In-Network \$0 copay Out-of-Network \$0 copay	In-Network \$0 copay Out-of-Network \$0 copay

	Johns Hopkins Advantage MD Primary (PPO)	Johns Hopkins Advantage MD (PPO)	Johns Hopkins Advantage MD Plus (PPO)
Opioid treatment program services	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
Outpatient diagnostic tests and therapeutic services and supplies (Services may require that your provider get prior authorization (extra approval in advance). Please see the <i>Evidence of Coverage</i> booklet for more information.)	In-Network 20% coinsurance <i>Prior Authorization may be required.</i> Out-of-Network 50% coinsurance	In-Network 20% coinsurance <i>Prior Authorization may be required.</i> Out-of-Network 50% coinsurance	In-Network 20% coinsurance <i>Prior Authorization may be required.</i> Out-of-Network 30% coinsurance
Outpatient rehabilitation services Services provided by an occupational therapist (Services may require that your provider get prior authorization (extra approval in advance). Please see the <i>Evidence of Coverage</i> booklet for more information.)	In-Network \$35 copay <i>Prior Authorization may be required.</i> Out-of-Network 50% coinsurance	In-Network \$35 copay <i>Prior Authorization may be required.</i> Out-of-Network 50% coinsurance	In-Network \$30 copay <i>Prior Authorization may be required.</i> Out-of-Network 30% coinsurance
Outpatient substance use disorder services	In-Network \$40 copay for each Medicare-covered Individual Session. \$40 copay for each Medicare-covered Group Session. Out-of-Network 50% coinsurance for each Medicare-covered Individual Session.	In-Network \$40 copay for each Medicare-covered Individual Session. \$40 copay for each Medicare-covered Group Session. Out-of-Network 50% coinsurance for each Medicare-covered Individual Session.	In-Network \$40 copay for each Medicare-covered Individual Session. \$40 copay for each Medicare-covered Group Session. Out-of-Network 30% coinsurance for each Medicare-covered Individual Session.

	Johns Hopkins Advantage MD Primary (PPO)	Johns Hopkins Advantage MD (PPO)	Johns Hopkins Advantage MD Plus (PPO)
	50% coinsurance for each Medicare-covered Group Session.	50% coinsurance for each Medicare-covered Group Session.	30% coinsurance for each Medicare-covered Group Session.
Partial hospitalization services and Intensive outpatient services (Services may require that your provider get prior authorization (extra approval in advance). Please see the <i>Evidence of Coverage</i> booklet for more information.)	In-Network \$60 copay per day <i>Prior Authorization may be required.</i> Out-of-Network 50% coinsurance per day	In-Network \$50 copay per day <i>Prior Authorization may be required.</i> Out-of-Network 40% coinsurance per day	In-Network \$50 copay per day <i>Prior Authorization may be required.</i> Out-of-Network 20% coinsurance per day
Podiatry services Additional routine foot care	In-Network \$45 copay Out-of-Network 50% coinsurance In-Network <u>Not covered</u> Out-of-Network <u>Not covered</u>	In-Network \$45 copay Out-of-Network 50% coinsurance In-Network <u>Not covered</u> Out-of-Network <u>Not covered</u>	In-Network \$40 copay Out-of-Network 30% coinsurance In-Network 20% coinsurance Limited to 6 visit(s) every year Out-of-Network 30% coinsurance
Prosthetic and orthotic devices and related supplies (Services may require that your provider get prior authorization (extra approval in advance). Please see the <i>Evidence of Coverage</i> booklet for more information.)	In-Network 20% coinsurance <i>Prior Authorization may be required.</i> Out-of-Network 45% coinsurance	In-Network 20% coinsurance <i>Prior Authorization may be required.</i> Out-of-Network 40% coinsurance	In-Network 20% coinsurance <i>Prior Authorization may be required.</i> Out-of-Network 30% coinsurance

	Johns Hopkins Advantage MD Primary (PPO)	Johns Hopkins Advantage MD (PPO)	Johns Hopkins Advantage MD Plus (PPO)
Services to treat kidney disease 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
Telehealth	In-Network \$0 copay Out-of-Network \$0 copay	In-Network \$0 copay Out-of-Network \$0 copay	In-Network \$0 copay Out-of-Network \$0 copay
Welcome to Medicare preventive visit	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
Worldwide Emergency Care	\$115 copay \$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	\$115 copay \$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	\$110 copay \$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

	Johns Hopkins Advantage MD Primary (PPO)	Johns Hopkins Advantage MD (PPO)	Johns Hopkins Advantage MD Plus (PPO)
	services rendered upfront and must submit your claim(s) and proof of payment for reimbursement consideration.	services rendered upfront and must submit your claim(s) and proof of payment for reimbursement consideration.	services rendered upfront and must submit your claim(s) and proof of payment for reimbursement consideration.
Worldwide Urgent Care	\$40 copay \$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 \$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 \$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.

Prescription Drug Coverage	Johns Hopkins Advantage MD Primary (PPO)	Johns Hopkins Advantage MD (PPO)	Johns Hopkins Advantage MD Plus (PPO)
Stage 1: Annual Prescription Deductible			
Pharmacy (Part D) Deductible	\$590 for Tier 3, Tier 4, and Tier 5 Part D prescription drugs. For all other formulary drugs, you will not have to pay any deductible and will start receiving coverage immediately.	\$615 for Tier 3, Tier 4, Tier 5 Part D prescription drugs. For all other formulary drugs, you will not have to pay any deductible and will start receiving coverage immediately.	\$615 for Tier 3, Tier 4, Tier 5 Part D prescription drugs. For all other formulary drugs, you will not have to pay any deductible and will start receiving coverage immediately.
Stage 2: Initial Coverage (after you pay your deductible, if applicable)			
Standard Retail cost-sharing (30-day/up to a 100-day supply for Tier 1 and up to a 90-day supply for Tier 2 - Tier 4)			
Tier 1 (Preferred Generic)	\$0/\$0 copay	\$0/\$0 copay	\$0/\$0 copay
Tier 2 (Generic)	\$6/\$12 copay	\$15/\$30 copay	\$15/\$30 copay
Tier 3 (Preferred Brand)	\$45/\$135 copay	25%/25% coinsurance	25%/25% coinsurance
Tier 4 (Non-Preferred Drug)	25%/25% coinsurance	25%/25% coinsurance	25%/25% coinsurance
Tier 5 (Specialty Tier)	26% coinsurance/Not Available	25% coinsurance/Not Available	25% coinsurance/Not Available
Mail-order cost sharing (up to a 100-day supply for Tier 1 and up to a 90-day supply for Tier 2 - Tier 4)			
Tier 1 (Preferred Generic)	\$0 copay	\$0 copay	\$0 copay
Tier 2 (Generic)	\$12 copay	\$30 copay	\$30 copay

Prescription Drug Coverage	Johns Hopkins Advantage MD Primary (PPO)	Johns Hopkins Advantage MD (PPO)	Johns Hopkins Advantage MD Plus (PPO)
Tier 3 (Preferred Brand)	\$135 copay	25% coinsurance	25% coinsurance
Tier 4 (Non-Preferred Drug)	25% coinsurance	25% coinsurance	25% coinsurance
Tier 5 (Specialty Tier)	Not Available	Not Available	Not Available
Stage 3: Catastrophic Coverage			
Cost-Sharing for Covered Drugs	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$2,100, 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 also pay nothing.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$2,100, 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 also pay nothing.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$2,100, 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 also pay nothing.

PPO Primary: You won't pay more than \$0 for tier 1, \$6 for tier 2, \$35 for tier 3, \$35 for tier 4, and \$35 for tier 5 for a one-month supply, \$0 for tier 1, \$9 for tier 2, \$70 for tier 3, and \$70 for tier 4 for a two-month supply, and \$0 for tier 1, \$12 for tier 2, \$105 for tier 3, and \$105 for tier 4 for a three-month supply of each covered insulin product regardless of the cost-sharing tier, even if you haven't paid your deductible.

PPO & PPO Plus: You won't pay more than \$0 for tier 1, \$15 for tier 2, \$35 for tier 3, \$35 for tier 4, and \$35 for tier 5 for a one-month supply, \$0 for tier 1, \$22.50 for tier 2, \$70 for tier 3, and \$70 for tier 4 for a two-month supply, and \$0 for tier 1, \$30 for tier 2, \$105 for tier 3, and \$105 for tier 4 for a three-month supply of each covered insulin product regardless of the cost-sharing tier, even if you haven't paid your deductible.

Optional Supplemental Benefits

	Johns Hopkins Advantage MD Primary (PPO)	Johns Hopkins Advantage MD (PPO)	Johns Hopkins Advantage MD Plus (PPO)
Optional Supplemental Benefits available with a separate premium	Comprehensive Dental	Comprehensive Dental	Comprehensive Dental
Monthly Premium	\$23 premium	\$23 premium	\$23 premium
Dental Services			
Comprehensive Dental			
Endodontics	\$100 copay Frequency dependent on procedure: Frequency of services: • Root canals and retreatment, apicoectomy, clinical crown lengthening-once per tooth per lifetime <i>Prior Authorization may be required.</i>	\$100 copay Frequency dependent on procedure: Frequency of services: • Root canals and retreatment, apicoectomy, clinical crown lengthening-once per tooth per lifetime <i>Prior Authorization may be required.</i>	\$100 copay Frequency dependent on procedure: Frequency of services: • Root canals and retreatment, apicoectomy, clinical crown lengthening-once per tooth per lifetime <i>Prior Authorization may be required.</i>
Extractions	\$50 - \$100 copay Frequency dependent on procedure: Frequency of services: • Alveoloplasty - 1 per quadrant per lifetime • Vestibuloplasty, frenulectomy,	\$50 - \$100 copay Frequency dependent on procedure: Frequency of services: • Alveoloplasty - 1 per quadrant per lifetime • Vestibuloplasty, frenulectomy,	\$50 - \$100 copay Frequency dependent on procedure: Frequency of services: • Alveoloplasty - 1 per quadrant per lifetime • Vestibuloplasty, frenulectomy,

	Johns Hopkins Advantage MD Primary (PPO)	Johns Hopkins Advantage MD (PPO)	Johns Hopkins Advantage MD Plus (PPO)
	frenuloplasty - 1 per arch per lifetime • Removal of exostosis, torus palatinus and mandibularis, surgical reduction of osseous tuberosity - 2 per lifetime • Oralantral fistula closure, primary closure of a sinus perforation - 2 per arch per lifetime • Extractions, coronectomy, surgical access of an unerupted tooth-once per tooth • Other Surgical Services covered with a \$50 copayment • Alveoloplasty • Vestibuloplasty, frenulectomy, frenuloplasty • Removal of exostosis, torus palatinus and mandibularis, excision of hyperplastic tissue per arch, excision of pericoronal gingiva • Excision of lesions and	frenuloplasty - 1 per arch per lifetime • Removal of exostosis, torus palatinus and mandibularis, surgical reduction of osseous tuberosity - 2 per lifetime • Oralantral fistula closure, primary closure of a sinus perforation - 2 per arch per lifetime • Extractions, coronectomy, surgical access of an unerupted tooth-once per tooth • Other Surgical Services covered with a \$50 copayment • Alveoloplasty • Vestibuloplasty, frenulectomy, frenuloplasty • Removal of exostosis, torus palatinus and mandibularis, excision of hyperplastic tissue per arch, excision of pericoronal gingiva • Excision of lesions and	frenuloplasty - 1 per arch per lifetime • Removal of exostosis, torus palatinus and mandibularis, surgical reduction of osseous tuberosity - 2 per lifetime • Oralantral fistula closure, primary closure of a sinus perforation - 2 per arch per lifetime • Extractions, coronectomy, surgical access of an unerupted tooth-once per tooth • Other Surgical Services covered with a \$50 copayment • Alveoloplasty • Vestibuloplasty, frenulectomy, frenuloplasty • Removal of exostosis, torus palatinus and mandibularis, excision of hyperplastic tissue per arch, excision of pericoronal gingiva • Excision of lesions and

	Johns Hopkins Advantage MD Primary (PPO)	Johns Hopkins Advantage MD (PPO)	Johns Hopkins Advantage MD Plus (PPO)
Periodontics	other surgical incisions • Other Services including biopsy of oral tissue and oroantral fistula closure Services covered with a \$100 copayment • Extractions, coronectomy, surgical access of an unerupted tooth - once per tooth <i>Prior Authorization may be required.</i> \$50 copay Frequency dependent on procedure: • Gingivectomy, gingivoplasty, gingival flap procedure, osseous surgery, periodontal scaling and root planning - once per quadrant per 3 years • Full mouth debridement - once per 3 years • Clinical crown lengthening-hard tissue - 1 per	other surgical incisions • Other Services including biopsy of oral tissue and oroantral fistula closure Services covered with a \$100 copayment • Extractions, coronectomy, surgical access of an unerupted tooth - once per tooth <i>Prior Authorization may be required.</i> \$50 copay Frequency dependent on procedure: • Gingivectomy, gingivoplasty, gingival flap procedure, osseous surgery, periodontal scaling and root planning - once per quadrant per 3 years • Full mouth debridement - once per 3 years • Clinical crown lengthening-hard tissue - 1 per	other surgical incisions • Other Services including biopsy of oral tissue and oroantral fistula closure Services covered with a \$100 copayment • Extractions, coronectomy, surgical access of an unerupted tooth - once per tooth <i>Prior Authorization may be required.</i> \$50 copay Frequency dependent on procedure: • Gingivectomy, gingivoplasty, gingival flap procedure, osseous surgery, periodontal scaling and root planning - once per quadrant per 3 years • Full mouth debridement - once per 3 years • Clinical crown lengthening-hard tissue - 1 per

	Johns Hopkins Advantage MD Primary (PPO)	Johns Hopkins Advantage MD (PPO)	Johns Hopkins Advantage MD Plus (PPO)
Prosthodontics, Oral Maxifacial Surgery and other services	permanent tooth per lifetime <i>Prior Authorization may be required.</i> \$50 - \$100 copay Frequency dependent on procedure: Services covered with a \$50 copayment • Recement or rebond fixed partial dentures Services covered with a \$100 copayment • Removable partial and full dentures, fixed partial dentures including associated retainers• Partial denture - one every 5 years • Re-cement or re-bond fixed partial denture repair, partial fixed dentures - once every 2 years after 6 months of initial placement <i>Prior Authorization may be required.</i>	permanent tooth per lifetime <i>Prior Authorization may be required.</i> \$50 - \$100 copay Frequency dependent on procedure: Services covered with a \$50 copayment • Recement or rebond fixed partial dentures Services covered with a \$100 copayment • Removable partial and full dentures, fixed partial dentures including associated retainers• Partial denture - one every 5 years • Re-cement or re-bond fixed partial denture repair, partial fixed dentures - once every 2 years after 6 months of initial placement <i>Prior Authorization may be required.</i>	permanent tooth per lifetime <i>Prior Authorization may be required.</i> \$50 - \$100 copay Frequency dependent on procedure: Services covered with a \$50 copayment • Recement or rebond fixed partial dentures Services covered with a \$100 copayment • Removable partial and full dentures, fixed partial dentures including associated retainers• Partial denture - one every 5 years • Re-cement or re-bond fixed partial denture repair, partial fixed dentures - once every 2 years after 6 months of initial placement <i>Prior Authorization may be required.</i>
Restorative services	\$50 copay	\$50 copay	\$50 copay

	Johns Hopkins Advantage MD Primary (PPO)	Johns Hopkins Advantage MD (PPO)	Johns Hopkins Advantage MD Plus (PPO)
	Frequency dependent on procedure: Frequency of services: • Inlays, onlays – 1 every 5 years • Crowns - 1 every 5 years • Re-cement or re-bond inlay, onlay, crowns – once every 2 years after 6 months of initial placement • Core buildup, pins and pin retention, cast post and core - once per tooth every 5 years • Amalgam and resin restorations - 1 every 2 years • Protective restoration – once per tooth <i>Prior Authorization may be required.</i>	Frequency dependent on procedure: Frequency of services: • Inlays, onlays – 1 every 5 years • Crowns - 1 every 5 years • Re-cement or re-bond inlay, onlay, crowns – once every 2 years after 6 months of initial placement • Core buildup, pins and pin retention, cast post and core - once per tooth every 5 years • Amalgam and resin restorations - 1 every 2 years • Protective restoration – once per tooth <i>Prior Authorization may be required.</i>	Frequency dependent on procedure: Frequency of services: • Inlays, onlays – 1 every 5 years • Crowns - 1 every 5 years • Re-cement or re-bond inlay, onlay, crowns – once every 2 years after 6 months of initial placement • Core buildup, pins and pin retention, cast post and core - once per tooth every 5 years • Amalgam and resin restorations - 1 every 2 years • Protective restoration – once per tooth <i>Prior Authorization may be required.</i>

Notice of Nondiscrimination



Johns Hopkins Advantage MD (HMO) and Johns Hopkins Advantage MD (PPO) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, (including limited English proficiency and primary language) age, disability, or sex (consistent with the scope of sex discrimination described in the Code of Federal Regulations Title 45 §92.101(a)(2)). Johns Hopkins Advantage MD does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Johns Hopkins Advantage MD:

- Provides reasonable modifications for individuals with disabilities, and appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, such as braille or large print, free of charge and in a timely manner, when such modifications, aids, and services are necessary to ensure accessibility and an equal opportunity to participate to individuals with disabilities.
- Provides language assistance services, including electronic and written translated documents and oral interpretation, free of charge and in a timely manner, when such services are a reasonable step to provide meaningful access to an individual with limited English proficiency.

If you need these services, please contact our Customer Service Department at 1-877-293-5325 (TTY: 711) or visit www.HopkinsMedicare.com.

If you believe Johns Hopkins Advantage MD has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Johns Hopkins Attn: Compliance at 7231 Parkway Dr., Suite 100, Hanover, MD 21076, phone: 1-844-422-6957 (TTY: 711) Monday – Friday 8 a.m. to 5 p.m. or 1-844-SPEAK2US (1-844-773-2528, available 24/7), fax: 1-410-762-1527 or by email: compliance@jhhp.org.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Johns Hopkins Advantage MD Compliance team member is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at <https://www.hhs.gov/ocr/complaints/index.html>.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-877-293-5325 (TTY: 711) or speak to your provider.

Spanish (Español)

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-877-293-5325 (TTY 711) o hable con su proveedor.

Portuguese (Português do Brasil)

ATENÇÃO: Se você fala Português, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-877-293-5325 (TTY 711) ou fale com seu provedor.

German (Deutsch)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-877-293-5325 (TTY 711) an oder sprechen Sie mit Ihrem Provider.

French (Français)

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-877-293-5325 (TTY : 711) ou parlez à votre fournisseur.

French/Haitian Creole (Kreyòl Ayisyen)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòm aksesib yo disponib gratis tou. Rele nan 1-877-293-5325 (TTY : 711) oswa pale avèk founisè w la.

Farsi

فارسي

توجه: اگر [وارد کردن زبان] صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 1-877-293-5325 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.

Simplified Chinese 中文

注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-877-293-5325（文本电话：711）或咨询您的服务提供商。

Traditional Chinese 台語

注意：如果您說[台語]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-877-293-5325（TTY：711）或與您的提供者討論。」

Korean 한국어

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-877-293-5325 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Vietnamese Việt

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-877-293-5325 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

Tagalog

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-877-293-5325 (TTY: 711) o makipag-usap sa iyong provider.

Russian РУССКИЙ

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-877-293-5325 (TTY: 711) или обратитесь к своему поставщику услуг.

Gujarati ગુજરાતી

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઓફિસલરી સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-877-293-5325 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

Arabic

العربية

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-877-293-5325 (711) أو تحدث إلى مقدم الخدمة".

Hindi हिंदी

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-877-293-5325 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Japanese 日本語

注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-877-293-5325（TTY：711）までお電話ください。または、ご利用の事業者にご相談ください。

Urdu

اردو

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ -1-
” (800-293-5325 (TTY: 711 پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔“

Thai ไทย

หมายเหตุ: หากคุณใช้ภาษา ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-877-293-5325 (TTY:711) หรือปรึกษาผู้ให้บริการของคุณ

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a member service representative at 1-888-403-7662 (TTY: 711). 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 Standard Time. From April 1 through September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern Standard Time. On weekends and holidays you will need to leave a message.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit HopkinsMedicare.com or call 1-888-403-7662 (TTY: 711) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts.
- ☐ If you have TRICARE, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact TRICARE for more information.
- ☐ If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2027.

- ☐ **Advantage MD (HMO), Advantage MD (PPO), Advantage MD Plus (PPO), Advantage MD Primary (PPO):** In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ **Advantage MD Tribute (HMO), Advantage MD D-SNP (HMO D-SNP) and Advantage MD Select (HMO):** You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ **Advantage MD Tribute (HMO):** You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month. Johns Hopkins Advantage MD will reduce your Medicare Part B premium by \$40 per month.
- ☐ **Advantage MD D-SNP (HMO D-SNP), Advantage MD Tribute (HMO), Advantage MD Select (HMO) and Advantage MD (HMO):** Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ **Advantage MD (PPO), Advantage MD Plus (PPO), Advantage MD Primary (PPO):** Our plan allows you to see providers outside of our network (non-contracted providers). However, we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher copayment for services received by non-contracted providers.
- ☐ **Advantage MD D-SNP (HMO D-SNP):** This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.

You can enroll in this plan if you have both Medicare and Medicaid and do not pay anything for covered medical services. How much Medicaid covers depends on your income, resources and other factors. Some people get full Medicaid benefits.

Your eligibility to enroll in this plan depends on your type of Medicaid. If your category of Medicaid eligibility changes, your cost share may also increase or decrease. You must recertify your Medicaid enrollment to continue to receive your Medicare coverage.

Johns Hopkins Advantage MD is a Medicare Advantage Plan with a Medicare contract offering HMO and PPO products. Johns Hopkins Advantage MD D-SNP is an HMO D-SNP plan with a Medicare contract and a State of Maryland Medicaid contract. Enrollment in Johns Hopkins Advantage MD, HMO, PPO or D-SNP (HMO D-SNP) depends on contract renewal.



JOHNS HOPKINS

HEALTH PLANS

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

Questions?

For enrollment information, please visit our website at HopkinsMedicare.com, or call Johns Hopkins Advantage MD at:

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

Oct. 1 through March 31: Monday through Sunday, 8 a.m. to 8 p.m.

April 1 through Sept. 30: Monday through Friday, 8 a.m. to 8 p.m.

On weekends and holidays, you may need to leave a message.

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.