

2018 Summary of Benefits

Gateway Health Medicare Assured Diamond (HMO SNP)

Gateway Health Medicare Assured Ruby (HMO SNP)

Gateway Health Medicare Assured Prime (HMO MA-PD)

Gateway Health Medicare Assured Select (HMO MA-PD)

**This is a summary of drug and health benefits for
January 1, 2018 – December 31, 2018**

The benefit information provided is a summary of what we cover and what you pay. It does not list every benefit that we cover or list every limit or exclusion. To get a complete list of benefits we cover, please request the “Evidence of Coverage” by calling 1-877-Gateway (TTY users call 711). From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time. From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time. You can also view or download the Evidence of Coverage at www.MedicareAssured.com

North Carolina County Service Area

| | | |
|------------|-------------|--------------|
| Alexander | Greene | Pamlico |
| Alleghany | Halifax | Pender |
| Avery | Hertford | Pitt |
| Beaufort | Hyde | Polk |
| Bertie | Jackson | Sampson |
| Bladen | Johnston | Swain |
| Caswell | Jones | Transylvania |
| Catawba | Lincoln | Vance |
| Chatham | Madison | Wake |
| Chowan | Martin | Warren |
| Cumberland | McDowell | Wayne |
| Davie | Mitchell | Wilkes |
| Duplin | Northampton | Yancey |
| Durham | Orange | |

Gateway Health Medicare Assured Diamond and Ruby plans are Medicare Advantage HMO Special Needs Plans with a Medicare contract. These plans are designed specifically for people who have Medicare and who are also entitled to assistance from Medicaid.

Gateway Health Medicare Assured Prime and Select plans are Medicare Advantage HMO plans with a Medicare contract.



Summary of Benefits continued...



How to Find a Provider or Pharmacy

www.MedicareAssured.com



How to Contact Gateway Health

1-877-GATEWAY (428-3929)
(TTY 711)



Hours of Operation

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

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



More About Original Medicare

If you want to know more about the cost and coverage of Original Medicare, look in your current "**Medicare & You**" handbook.

View it online at <http://www.medicare.gov> or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Have Questions? 1-877-Gateway (428-3929) (TTY 711) 8 a.m. – 8 p.m. 7 days a week



Dual Eligible (D-SNP) Plans Highlights

Medicare Assured **DiamondSM (HMO SNP)[†]**

Monthly Plan Premium
\$0*

Primary Care Visits
as low as \$0

Deductible
\$0

Preventive Care

Urgent & Emergency Care
In and out-of-network

**Diagnostic Services/
Labs/Imaging**

Generic prescriptions
as low as \$0

Medicare Assured **RubySM (HMO SNP)^{††}**

Monthly Plan Premium
\$30.10*

Primary Care Visits
\$0

Deductible
\$0

Preventive Care

Urgent & Emergency Care
In and out-of-network

**Diagnostic Services/
Labs/Imaging**

Generic prescriptions
as low as \$0

[†]To be eligible for the Diamond plan, you must have Medicare Parts A and B and Medical Assistance (Full or QMB). Also, you must live in our service area and—with limited exceptions—you must not have End-Stage Renal Disease.

^{††}To be eligible for the Ruby plan, you must have Medicare Parts A and B and Medical Assistance (SLMB, QI or QDWI). Also, you must live in our service area and—with limited exceptions—you must not have End-Stage Renal Disease.

| Plan Benefits | Gateway Health Medicare Assured Diamond SM (HMO SNP) | Gateway Health Medicare Assured Ruby SM (HMO SNP) |
|---|--|---|
| Monthly Plan Premium | \$0 Monthly Plan Premium* | \$30.10 Monthly Plan Premium* |
| Deductible | \$0 Deductible | \$0 Deductible |
| Maximum Out-of-Pocket Responsibility <i>(does not include prescription drugs)</i> | \$3,400 Out-of-Pocket Limit for In-Network Medicare-covered Services | \$6,700 Out-of-Pocket Limit for In-Network Medicare-covered Services |
| Inpatient Hospital Coverage [^] | \$0 Copay per day for days 1-90 | \$0 or \$275* Copay per day for days 1-5; \$0 Copay per day for days 6-90 |
| Outpatient Hospital Coverage [^] | 0% or 20%* of the cost for outpatient surgery and observation services | \$0 or \$200* Copay for outpatient surgery \$0 or \$275* Copay for observation services |
| Doctor Visits | 0% or 20%* of the cost | \$0 Copay PCP / \$0 or \$35* Copay Specialist |
| Preventive Care | \$0 Copay | \$0 Copay |
| Emergency Care | 0% or 20%* of the cost | \$0 or \$80* Copay |
| Urgently Needed Services | 0% or 20%* of the cost | \$0 or \$45* Copay |
| Lab Services & Diagnostic Tests [^] | 0% or 20%* of the cost | \$0 or \$35* Copay |
| X-rays / Complex Imaging [^] <i>(e.g., CT scan/MRI)</i> | 0% or 20%* of the cost for X-rays and Complex Imaging | \$0 or \$35* Copay / \$0 to \$175* Copay |
| Hearing Exam | 0% or 20%* of the cost | \$0 Copay |
| Hearing Aid | Up to \$750 every two years | Up to \$750 every two years |
| Preventive Dental Services <i>(every six months)</i> | \$0 Copay / One oral exam and cleaning One bitewing x-ray per side | \$0 Copay / One oral exam and cleaning One bitewing x-ray per side |
| Vision Services <i>(Davis Vision Network)</i> | \$0 Copay for Routine Eye Exam; One pair of standard contact lenses or one pair of standard eyeglasses (lenses and frames) covered in full per year / \$90 maximum benefit applies to non-standard eyeglasses and \$100 maximum benefit applies to specialty contacts | \$0 Copay for Routine Eye Exam; One pair of standard contact lenses or one pair of standard eyeglasses (lenses and frames) covered in full per year / \$90 maximum benefit applies to non-standard eyeglasses or \$100 maximum benefit applies to specialty contacts |
| Mental Health Services | 0% or 20%* of the cost | \$0 or \$35* Copay |
| Skilled Nursing Facility [^] | \$0 Copay per day for days 1-100 | \$0 Copay per day for days 1-20; \$0 or \$167.50* Copay per day for days 21-100 |
| Physical Therapy [^] | 0% or 20%* of the cost | \$0 or \$35* Copay |
| Ambulance [^] | 0% or 20%* of the cost | \$0 or \$200* Copay |
| Transportation [^] | \$0 Copay for 36 One-way trips to plan-approved locations every year | \$0 Copay for 24 One-way trips to plan-approved locations every year |
| Medicare Part B Drugs [^] | 0% or 20%* of the cost For covered chemotherapy and other drugs | 0% or 20%* of the cost For covered chemotherapy and other drugs |
| Foot Care [^] <i>(podiatry services)</i> | 0% or 20%* of the cost | \$0 or \$35* Copay |
| Medical Equipment/Supplies & Prosthetics [^] | 0% or 20%* of the cost | 0% or 20%* of the cost |
| Diabetic Testing Supplies | 0% or 20%* of the cost | 0% or 20%* of the cost |
| SilverSneakers Fitness Program | Covered | Covered |
| Part D Prescription Drugs Initial Coverage Period [^] <i>(Amounts also apply to 60 and 90-day supplies)</i> | Part D Deductible: \$0 to \$405* Initial Coverage Limit: \$3,750 Out-of-Pocket: \$5,000 [#] 30-Day Supply Tier 1 Generic Drugs <i>(including brand drugs treated as generic)</i> \$0.00, \$1.25 or \$3.35 Copay* Tier 1 All Other Drugs \$0.00, \$3.70 or \$8.35 Copay* | Part D Deductible: \$0 to \$405* Initial Coverage Limit: \$3,750 Out-of-Pocket: \$5,000 [#] 30-Day Supply Tier 1 Generic Drugs <i>(including brand drugs treated as generic)</i> \$0.00, \$1.25 or \$3.35 Copay; or 15% of the cost* Tier 1 All Other Drugs \$0.00, \$3.70 or \$8.35 Copay; or 15% of the cost* |

*Depending on your level of Medicaid eligibility and/or level of Extra Help #Once you pay \$5,000 out-of-pocket, the plan will pay all or most of the drug costs for the remainder of the calendar year. ^Prior authorization may be required



Medicare Advantage Prescription Drug Plan (MA-PD) Highlights

Medicare Assured **PrimeSM** (HMO MA-PD)^{†††}

Monthly Plan Premium
\$107

Primary Care Visits
\$0

Deductible
\$0

Preventive Care

Urgent & Emergency Care
In and out-of-network

Diagnostic Services/ Labs/Imaging

Generic prescriptions
as low as \$0

Medicare Assured **SelectSM** (HMO MA-PD)^{†††}

Monthly Plan Premium
\$0

Primary Care Visits
\$10

Deductible
\$0

Preventive Care

Urgent & Emergency Care
In and out-of-network

Diagnostic Services/ Labs/Imaging

Generic prescriptions
as low as \$1

^{†††}To be eligible to enroll in our MA-PD plans, you must have both Medicare Parts A and B, you must live in our service area and—with limited exceptions—you must not have End-Stage Renal Disease.

| Plan Benefits | Gateway Health Medicare Assured Prime SM (HMO MA-PD) | Gateway Health Medicare Assured Select SM (HMO MA-PD) |
|--|--|--|
| Monthly Plan Premium | \$107 Monthly Plan Premium | \$0 Monthly Plan Premium |
| Deductible | \$0 Deductible | \$0 Deductible |
| Maximum Out-of-Pocket Responsibility <i>(does not include prescription drugs)</i> | \$6,700 Out-of-Pocket Limit for In-Network Medicare-covered Services | \$6,700 Out-of-Pocket Limit for In-Network Medicare-covered Services |
| Inpatient Hospital Coverage [^] | \$200 Copay per day for days 1-5; \$0 Copay per day for days 6-90 | \$350 Copay per day for days 1-5; \$0 Copay per day for days 6-90 |
| Outpatient Hospital Coverage [^] | \$150 Copay for outpatient surgery \$200 Copay for observation services | \$200 Copay for outpatient surgery \$350 Copay for observation services |
| Doctor Visits | \$0 Copay PCP / \$25 Copay Specialist | \$10 Copay PCP / \$45 Copay Specialist |
| Preventive Care | \$0 Copay | \$0 Copay |
| Emergency Care | \$80 Copay | \$80 Copay |
| Urgently Needed Services | \$25 Copay | \$45 Copay |
| Lab Services & Diagnostic Tests [^] | \$0 Copay | \$0 Copay |
| X-rays / Complex Imaging [^] <i>(e.g., CT scan/MRI)</i> | \$25 Copay/\$25 to \$150 Copay | \$75 Copay/0% to 20% of the cost |
| Hearing Exam | \$25 Copay | \$50 Copay |
| Hearing Aid | Up to \$1,000 every two years | Up to \$1,000 every two years |
| Preventive Dental Services <i>(every six months)</i> | \$0 Copay / One oral exam and cleaning One bitewing x-ray per side | \$0 Copay / One oral exam and cleaning One bitewing x-ray per side |
| Vision Services <i>(Davis Vision Network)</i> | \$0 Copay for Routine Eye Exam; One pair of standard contact lenses or one pair of standard eyeglasses (lenses and frames) covered in full per year / \$90 maximum benefit applies to non-standard eyeglasses and \$150 maximum benefit applies to specialty contacts | \$0 Copay for Routine Eye Exam; One pair of standard contact lenses or one pair of standard eyeglasses (lenses and frames) covered in full per year / \$90 maximum benefit applies to non-standard eyeglasses and \$225 maximum benefit applies to specialty contacts |
| Mental Health Services | \$25 Copay | \$40 Copay |
| Skilled Nursing Facility [^] | \$0 Copay per day for days 1-20; \$167.50 Copay per day for days 21-100 | \$0 Copay per day for days 1-20; \$167.50 Copay per day for days 21-100 |
| Physical Therapy [^] | \$25 Copay | \$40 Copay |
| Ambulance [^] | \$150 Copay | \$200 Copay |
| Transportation | Not Covered | Not Covered |
| Medicare Part B Drugs [^] | 20% of the cost For covered chemotherapy and other drugs | 20% of the cost For covered chemotherapy and other drugs |
| Foot Care [^] <i>(podiatry services)</i> | \$25 Copay | \$50 Copay |
| Medical Equipment/Supplies & Prosthetics [^] | 20% of the cost | 15% of the cost |
| Diabetic Testing Supplies | 20% of the cost | 20% of the cost |
| SilverSneakers Fitness Program | Covered | Covered |
| Part D Prescription Drugs Initial Coverage Period ^{#^} | Part D Deductible: \$250* Initial Coverage Limit: \$3,750 Out-of-Pocket: \$5,000 30-Day Supply Tier 1 Preferred Generic: \$0 Copay Tier 2 Non-Preferred Generic: \$20 Copay Tier 3 Preferred Brand: \$45 Copay Tier 4 Non-Preferred Brand: \$95 Copay Tier 5 Specialty: 28% of the cost <i>(60 and 90-day retail and mail-order supplies also available)</i> | Part D Deductible: \$200* Initial Coverage Limit: \$3,750 Out-of-Pocket: \$5,000 30-Day Supply Tier 1 Preferred Generic: \$1 Copay Tier 2 Non-Preferred Generic: \$16 Copay Tier 3 Preferred Brand: \$45 Copay Tier 4 Non-Preferred Brand: \$95 Copay Tier 5 Specialty: 29% of the cost <i>(60 and 90-day retail and mail-order supplies also available)</i> |

*Excludes tiers 1 and 2 #Your cost-sharing may change depending on the day supply, the stage of the Part D benefit and if you receive Extra Help paying for your drug costs. Refer to the Evidence of Coverage for details.

[^]Prior authorization may be required

Gateway HealthSM offers HMO plans with a Medicare Contract. Some Gateway Health plans have a contract with Medicaid in the states where they are offered. Enrollment in these plans depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium – The State pays the Part B premium for full dual members.

Premium, co-pays, co-insurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details.

If you use providers that are not in our network, we may not pay for these services.

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