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

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.

Y0097_1056 Accepted

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.**

Dual Eligible (D-SNP) Plans Highlights

Medicare Assured **Diamond℠** (HMO SNP)†	Medicare Assured **Ruby℠** (HMO SNP)††
Monthly Plan Premium **$0***	Monthly Plan Premium **$30.10***
Primary Care Visits **as low as $0**	Primary Care Visits **$0**
Deductible **$0**	Deductible **$0**
Preventive Care	**Preventive Care**
Urgent & Emergency Care In and out-of-network	**Urgent & Emergency Care** In and out-of-network
Diagnostic Services/ Labs/Imaging	**Diagnostic Services/ Labs/Imaging**
Generic prescriptions **as low as $0**	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**℠ (HMO SNP)	Gateway Health Medicare Assured **Ruby**℠ (HMO SNP)
Monthly Plan Premium	$0 Monthly Plan Premium*	$30.10 Monthly Plan Premium*
Deductible	$0 Deductible	$0 Deductible
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	$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^ (e.g., CT scan/MRI)	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 (every six months)	$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 (Davis Vision Network)	$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^ (podiatry services)	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^ (Amounts also apply to 60 and 90-day supplies)	**Part D Deductible:** $0 to $405* **Initial Coverage Limit:** $3,750 **Out-of-Pocket:** $5,000# **30-Day Supply** **Tier 1 Generic Drugs** *(including brand drugs treated as generic)* $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** *(including brand drugs treated as generic)* $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 **Prime℠** (HMO MA-PD)†††	Medicare Assured **Select℠** (HMO MA-PD)†††
Monthly Plan Premium **$107**	Monthly Plan Premium **$0**
Primary Care Visits **$0**	Primary Care Visits **$10**
Deductible **$0**	Deductible **$0**
Preventive Care	**Preventive Care**
Urgent & Emergency Care In and out-of-network	**Urgent & Emergency Care** In and out-of-network
Diagnostic Services/ Labs/Imaging	**Diagnostic Services/ Labs/Imaging**
Generic prescriptions **as low as $0**	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**℠ (HMO MA-PD)	Gateway Health Medicare Assured **Select**℠ (HMO MA-PD)
Monthly Plan Premium	$107 Monthly Plan Premium	$0 Monthly Plan Premium
Deductible	$0 Deductible	$0 Deductible
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	$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^ (e.g., CT scan/MRI)	$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 (every six months)	$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 (Davis Vision Network)	$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^ (podiatry services)	$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 (60 and 90-day retail and mail-order supplies also available)	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 (60 and 90-day retail and mail-order supplies also available)

***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