



# QualityHealthPlans

of New York

"Where Quality Healthcare Begins"

## Summary of Benefits

### Advantage Silver Queens

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## ADVANTAGE SILVER - QUEENS (HMO)

(a Medicare Advantage Health Maintenance Organization (HMO) offered by QUALITY HEALTH PLANS OF NEW YORK, INC. with a Medicare contract)

### Summary of Benefits

January 1, 2015 - December 31, 2015

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

#### You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **ADVANTAGE SILVER - QUEENS (HMO)**).

#### Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **ADVANTAGE SILVER - QUEENS (HMO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on <http://www.medicare.gov>.
- If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at <http://www.medicare.gov> or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

#### Sections in this booklet

- Things to Know About **ADVANTAGE SILVER - QUEENS (HMO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print. This document may be available in a non-English language. For additional information, call us at 1-877-233-7058.

Este documento está disponible en otros formatos como Braille y en letra grande. Este documento puede estar disponible en un idioma que no sea Inglés. Para obtener información adicional, llámenos al 1-877-233-7058.

#### Things to Know About **ADVANTAGE SILVER - QUEENS (HMO)**

#### 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.

### ADVANTAGE SILVER - QUEENS (HMO) Phone Numbers and Website

- If you are a member of this plan, call toll-free 1-877-233-7058.
- If you are not a member of this plan, call toll-free 1-877-233-7058.
- Our website: <http://www.qualityhealthplansny.com>

### Who can join?

To join **Advantage Silver - Queens (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following county in New York: Queens.

### Which doctors, hospitals, and pharmacies can I use?

**ADVANTAGE SILVER - QUEENS (HMO)** has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

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 (<http://www.qualityhealthplansny.com>).

Or, call us and we will send you a copy of the provider and pharmacy directories.

### What do we cover?

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

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

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, <http://www.qualityhealthplansny.com>.
- Or, call us and we will send you a copy of the formulary.

### How will I determine my drug costs?

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

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**Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services**

<b>How much is the monthly premium?</b>	\$0 per month. In addition, you must keep paying your Medicare Part B premium.
<b>How much is the deductible?</b>	This plan does not have a deductible.
<b>Is there any limit on how much I will pay for my covered services?</b>	<p>Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. In this plan, you will pay nothing for Medicare-covered services from in-network providers.</p> <p>Your yearly limit(s) in this plan: \$3,400 for services you receive from in-network providers.</p> <p>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.</p> <p>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p>
<b>Is there a limit on how much the plan will pay?</b>	No. There are no limits on how much our plan will pay.

**Covered Medical and Hospital Benefits**

- Note:**
- Services with a<sup>1</sup> may require prior authorization.
  - Services with a<sup>2</sup> may require a referral from your doctor.

**Outpatient Care and Services**

Acupuncture and Other Alternative Therapies <sup>1,2</sup>	For up to 4 visit(s) every year: You pay nothing
Ambulance	\$125 copay
Chiropractic Care <sup>1,2</sup>	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): \$15 copay
Dental Services <sup>1,2</sup>	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): You pay nothing

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	<p>Preventive dental services:</p> <ul style="list-style-type: none"> <li>• Cleaning (for up to 1 every six months): You pay nothing</li> <li>• Dental x-ray(s): You pay nothing</li> <li>• Oral exam (for up to 1 every year): You pay nothing</li> </ul>
Diabetes Supplies and Services <sup>1,2</sup>	<p>Diabetes monitoring supplies: 0-20% of the cost, depending on the supply</p> <p>Diabetes self-management training: 0-20% of the cost, depending on the service</p> <p>Therapeutic shoes or inserts: 20% of the cost</p>
Diagnostic Tests, Lab and Radiology Services, and XRays <sup>1,2</sup>	<p>Diagnostic radiology services (such as MRIs, CT scans): \$0-250 copay, depending on the service</p> <p>Diagnostic tests and procedures: \$0-250 copay, depending on the service</p> <p>Lab services: \$0-100 copay, depending on the service</p> <p>Outpatient x-rays: \$5 copay</p> <p>Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost</p>
Doctor's Office Visits <sup>2</sup>	<p>Primary care physician visit: You pay nothing</p> <p>Specialist visit: \$12 copay</p>
Durable Medical Equipment ( <i>wheelchairs, oxygen, etc.</i> ) <sup>1</sup>	<p>0-20% of the cost, depending on the equipment</p> <p>If you go to a preferred vendor, your cost may be less. Contact us for a list of preferred vendors.</p>
Emergency Care	<p>\$65 copay</p> <p>If you are admitted to the hospital within 23 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.</p>
Foot Care ( <i>podiatry services</i> )	<p>Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: \$15 copay</p>
Hearing Services <sup>1,2</sup>	<p>Exam to diagnose and treat hearing and balance issues:</p>

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	<p>\$15 copay</p> <p>Routine hearing exam (for up to 1 every year): You pay nothing</p> <p>Hearing aid fitting/evaluation (for up to 1 every two years): \$15 copay</p> <p>Hearing aid: You pay nothing</p> <p>Our plan pays up to \$1,000 every two years for hearing aids</p>
Home Health Care <sup>1,2</sup>	You pay nothing
Mental Health Care <sup>1,2</sup>	<p><b>Inpatient visit:</b></p> <p>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <ul style="list-style-type: none"> <li>• \$150 copay per day for days 1 through 7</li> <li>• You pay nothing per day for days 8 through 90</li> </ul> <p>Outpatient group therapy visit: \$30 copay</p> <p>Outpatient individual therapy visit: \$30 copay</p>
Outpatient Rehabilitation <sup>1,2</sup>	<p>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): \$30 copay</p> <p>Occupational therapy visit: \$30 copay</p> <p>Physical therapy and speech and language therapy visit: \$30 copay</p>
Outpatient Substance Abuse <sup>1,2</sup>	Group therapy visit: \$30 copay

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	Individual therapy visit: \$30 copay
Outpatient Surgery <sup>1,2</sup>	Ambulatory surgical center: \$75 copay  Outpatient hospital: \$175-200 copay, depending on the service
Over-the-Counter Items	Please visit our website to see our list of covered over-the-counter items. You have a \$77 allowance every 3 months
Prosthetic Devices ( <i>braces, artificial limbs, etc.</i> ) <sup>1</sup>	Prosthetic devices: 20% of the cost  Related medical supplies: 20% of the cost, depending on the supply
Renal Dialysis <sup>1,2</sup>	20% of the cost
Transportation <sup>1,2</sup>	There is a limit to how much our plan will pay: You pay nothing. 17 one-way trips to plan approved location, \$10/trip reimbursement for an annual max of \$170
Urgent Care	\$15 copay
Vision Services <sup>1,2</sup>	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$15 copay  Routine eye exam (for up to 1 every year): \$30 copay  Contact lenses (for up to 1 every year): \$30 copay  Eyeglasses (frames and lenses) (for up to 1 every year): \$30 copay  Eyeglasses or contact lenses after cataract surgery: \$30 copay  Our plan pays up to \$100 every year for contact lenses and eyeglasses (frames and lenses).
Preventive Care <sup>1,2</sup>	You pay nothing Our plan covers many preventive services, including: <ul style="list-style-type: none"> <li>• Abdominal aortic aneurysm screening</li> <li>• Alcohol misuse counseling</li> <li>• Bone mass measurement</li> <li>• Breast cancer screening (mammogram)</li> <li>• Cardiovascular disease (behavioral therapy)</li> <li>• Cardiovascular screenings</li> </ul>

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	<ul style="list-style-type: none"> <li>• Cervical and vaginal cancer screening</li> <li>• Colonoscopy</li> <li>• Colorectal cancer screenings</li> <li>• Depression screening</li> <li>• Diabetes screenings</li> <li>• Fecal occult blood test</li> <li>• Flexible sigmoidoscopy</li> <li>• HIV screening</li> <li>• Medical nutrition therapy services</li> <li>• Obesity screening and counseling</li> <li>• Prostate cancer screenings (PSA)</li> <li>• Sexually transmitted infections screening and counseling</li> <li>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li> <li>• Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots</li> <li>• "Welcome to Medicare" preventive visit (one-time)</li> <li>• Yearly "Wellness" visit</li> </ul> <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>
<b>Hospice</b>	You pay nothing for hospice care from a Medicare-certified Hospice. You may have to pay part of the cost for drugs and respite care.
<b>Inpatient Care</b>	
Inpatient Hospital Care <sup>1,2</sup>	<p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <ul style="list-style-type: none"> <li>• \$95 copay per day for days 1 through 7</li> <li>• You pay nothing per day for days 8 through 90</li> </ul>
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Skilled Nursing Facility (SNF) <sup>1,2</sup>	<p>Our plan covers up to 100 days in a SNF.</p> <ul style="list-style-type: none"> <li>• You pay nothing per day for days 1 through 20</li> <li>• \$125 copay per day for days 21 through 100</li> </ul>



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**Prescription Drug Benefits**

**How much do I pay?**

For Part B drugs such as chemotherapy drugs<sup>1</sup>: 20% of the cost  
  
 Other Part B drugs<sup>1</sup>: 20% of the cost

**Initial Coverage**

You pay the following until your total yearly drug costs reach \$2,960. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

You may get your drugs at network retail pharmacies and mail order pharmacies.

**Standard Retail Cost Sharing**

<b>Tier</b>	<b>One-month Supply</b>	<b>Three-month supply</b>
Tier 1 (Preferred Generic)	\$0	\$0
Tier 2 (Non-Preferred Generic)	\$10 copay	\$30 copay
Tier 3 (Preferred Brand)	\$30 copay	\$90 copay
Tier 4 (Non-Preferred Brand)	\$75 copay	\$225 copay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered

**Standard Mail Order Cost Sharing**

<b>Tier</b>	<b>One-month Supply</b>	<b>Three-month supply</b>
Tier 1 (Preferred Generic)	\$0	\$0
Tier 2 (Non-Preferred Generic)	\$10 copay	\$20 copay
Tier 3 (Preferred Brand)	\$30 copay	\$90 copay
Tier 4 (Non-Preferred Brand)	\$75 copay	\$225 copay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered

If you reside in a long-term care facility, you pay the same as at a

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retail pharmacy.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

**Coverage Gap**

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$2,960.

After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 65% of the plan's cost for covered generic drugs until your costs total \$4,700, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.

**Standard Retail Cost Sharing**

<b>Tier</b>	<b>Drugs Covered</b>	<b>One-month Supply</b>	<b>Three-month supply</b>
Tier 1 (Preferred Generic)	All	\$4 copay	\$12 copay

**Standard Mail Order Cost Sharing**

<b>Tier</b>	<b>Drugs Covered</b>	<b>One-month Supply</b>	<b>Three-month supply</b>
Tier 1 (Preferred Generic)	All	\$4 copay	\$8 copay

**Catastrophic Coverage**

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order)

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reach \$4,700, you pay the greater of:

- 5% of the cost, or
- \$2.65 copay for generic (including brand drugs treated as generic) and a \$6.60 copayment for all other drugs.