

# 2023

## Summary of Benefits

**Dignity Health Plan (HMO I-SNP)**

**January 1, 2023 – December 31, 2023**



**Member Services: 1-866-266-6010**

**8:00 a.m. to 8:00 p.m., 7 days a week**

# Dignity Health Plan (HMO I-SNP)

H8492, Plan 001

January 1, 2023 – December 31, 2023

**Dignity Health Plan (HMO I-SNP)** is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the “Evidence of Coverage” by calling member services at 1-866-266-6010. Hours are seven (7) days a week from 8:00 am to 8:00 pm. TTY users call 1-833-312-0046 or visit our website at

[DignityHealthPlan.com](http://DignityHealthPlan.com).

To join **Dignity Health Plan (HMO I-SNP)**, 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 parishes in Louisiana: Acadia, Ascension, Assumption, Avoyelles, Beauregard, Bienville, Bossier, Caddo, Catahoula, Claiborne, Concordia, De Soto, East Baton Rouge, East Feliciana, Grant, Iberville, Jefferson, Jefferson Davis, LaSalle, Lafayette, Lafourche, Livingston, Morehouse, Natchitoches, Orleans, Ouachita, Plaquemines, Pointe Coupee, Rapides, Red River, Richland, Sabine, St. Bernard, St. Charles, St. Helena, St. James, St. John the Baptist, St. Landry, St. Martin, St. Tammany, Tangipahoa, Terrebonne, Union, Vermillion, Vernon, Washington, Webster, West Baton Rouge, West Feliciana, and Winn.

Except in emergency situations, if you use the providers that are not in our network, we may not pay for these services.

For coverage and costs of Original Medicare, look in your current “Medicare & You” handbook. View it online at [www.medicare.gov](http://www.medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

This document is available in other formats such as Braille, large print or audio.

For more information, please call us at 1-866-266-6010 (TTY users should call 1-833-312-0046), or visit us at [DignityHealthPlan.com](http://DignityHealthPlan.com)

*Revised 04192023*

<b>Premiums and Benefits</b>	<b>Dignity Health Plan (HMO I-SNP)</b>
Monthly Plan Premium	You pay \$38.00  You must continue to pay your Medicare Part B premium
Medical Part B Deductible	\$226
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	You pay no more than \$8,300 annually  Includes copays and other costs for medical services for the year.
Inpatient Hospital	You pay \$1,600 deductible for days 1-60  You pay \$400 copay per day for days 61-90  You pay \$800 per lifetime reserve day  Cost shares are applied starting on the first day of admission and do not include the date of discharge.  If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.  Prior authorization required.
Outpatient Hospital	A 20% of the cost for Medicare covered services  Prior authorization required
Ambulatory Surgery Center	20% of the cost for Medicare covered services  Prior authorization required if over \$500
Doctor Visits <ul style="list-style-type: none"> <li>• Primary</li> <li>• Specialists</li> </ul>	You pay 20% per visit You pay 20% per visit
Preventative Care  (e.g., flu vaccine, diabetic screenings)	You pay nothing  Other preventative services are available. There are some covered services that have a cost.
Emergency Care	20% of the cost of Medicare covered services (Up to \$90 per visit)  If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered.

<b>Premiums and Benefits</b>	<b>Dignity Health Plan (HMO I-SNP)</b>
Urgently Needed Services	20% of the cost for Medicare covered services (up to \$60 per visit) and up to 3 days
Diagnostic Services/Labs/Imaging <ul style="list-style-type: none"> <li>• Diagnostic tests and procedures</li> <li>• Lab services</li> <li>• MRI, CAT Scan</li> <li>• X-Rays</li> </ul>	20% of the cost for Medicare covered services  A separate facility charge could apply for the facility in which the services are received.  You pay \$0 copay for lab services  Prior Authorization is required for some services  In addition, DME, Part B drugs, physicians' services and doctor's office visit cost share may also apply  Authorization required for high tech radiological services such as CT, CAA, MRI, MRA, and PET scans  No authorization is required for X-Ray services
Hearing Services <ul style="list-style-type: none"> <li>• Routine hearing exam</li> <li>• Hearing aid</li> </ul>	Number for Routine Hearing Exams: 1 every year. You pay a \$0 copay. Number for Fitting/Evaluation for Hearing Aid: 2 every year. You pay a \$0 copay.  Maximum Plan Benefit Coverage amount: \$1,000 every year  20% of the cost of Medicare covered services
Dental Services	20% of the cost for Medicare covered services
Vision Services	Routine eye exam: You pay a \$0 copay for an annual routine eye exam.  You may get glasses and frames.  Maximum Plan Benefit Coverage amount for routine eye exam and glasses and lenses: \$300 every year  20% of the cost for Medicare covered services
Mental Health Services <ul style="list-style-type: none"> <li>• Outpatient group therapy/ individual therapy visit</li> </ul>	20% of the cost for Medicare covered services

Mental Health Services <ul style="list-style-type: none"> <li>Inpatient</li> </ul>	You pay \$1,600 deductible for days 1-60. You pay \$400 copay per day for days 61-90. You pay \$800 per lifetime reserve day. Prior authorization is required. Cost shares are applied starting on the first day of admission. and do not include the date of discharge.
Skilled Nursing Facility	You pay nothing for the first 20 days of each benefit period. You pay \$200 per day for days 21-100 You pay all costs for each day after day 100 These are 2022 cost sharing amounts. 3-day inpatient hospital stay prior to SNF admission is not required.
Physical Therapy	20% of the cost for Medicare covered services Prior authorization required
Ambulance	20% of the cost for Medicare covered services
Transportation	Not covered
Medicare Part B Rx Drugs and Home Infusion Drugs	20% of the cost of Medicare covered services Authorization are required if over \$500.
Over-the-Counter Products (OTC)	\$155 per calendar quarter for covered OTC items

<b>Outpatient Prescription Drugs</b>			
<b>Stage 1</b> <i>Yearly Deductible Stage</i>	<b>Stage 2</b> <i>Initial Coverage Stage</i>	<b>Stage 3</b> <i>Coverage Gap Stage</i>	<b>Stage 4</b> <i>Catastrophic Coverage Stage</i>
<p>You begin in this payment stage when you fill your first prescription of the year. During this stage, <b>you pay the full cost</b> of your brand name drugs.</p> <p>You stay in this stage until you have paid <b>\$505</b> for your brand name drugs (<b>\$505</b> is the amount of your brand name deductible).</p>	<p>During this stage, the plan pays its share of the cost of your generic drugs and <b>you pay your 25% share of the cost.</b></p> <p>After you (or others on your behalf) have met your brand name deductible, the plan pays its share of the costs of your brand name drugs and you pay your share.</p> <p>You stay in this stage until your year-to-date <b>“total drug costs”</b> (your payments plus any Part D plan’s payments) total <b>\$4660.</b></p>	<p>During this stage, you pay 25% of the price for brand name drugs (plus a portion of the dispensing fee) and 25% of the price for generic drugs.</p> <p>You stay in this stage until your year-to-date <b>“out-of-pocket costs”</b> (your payments) reach a total of <b>\$7400.</b> This amount and rules for counting costs toward this amount have been set by Medicare.</p>	<p>During this stage, <b>the plan will pay most of the cost</b> of your drugs for the rest of the calendar year (through December 31, 2023).</p>

Note: Costs may differ based on pharmacy type or status (e.g., preferred /non-preferred, mail order, long-term care (LTC) or home infusion, and 30 or 90 day supply).

**Important Message About What You Pay for Vaccines** - Our plan covers most Part D vaccines at no cost to you, even if you haven’t paid your deductible. Call Member Services for more information.

**Important Message About What You Pay for Insulin** - You won’t pay more than \$35 for a onemonth supply of each insulin product covered by our plan, no matter what cost-sharing tier it’s on, even if you haven’t paid your deductible

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