Mutual of Omaha CareAdvantage (HMO)

2019
Summary of Benefits

Serving Bexar County, Texas

Mutual of Omaha Medicare Advantage

Summary of Benefits
January 1, 2019 – December 31, 2019

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" or you can view it on MutualofOmahaCareAdvantage.com.

This Summary of Benefits booklet gives you a summary of what **Mutual of Omaha CareAdvantage Complete (HMO)** covers and what you pay.

- 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 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 **Mutual of Omaha CareAdvantage Complete (HMO)**
- Table of Contents
- Monthly Premium, Deductibles and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits
- Other Covered 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 customer service at 1-866-488-0249 (TTY: 711).

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Things to Know About Mutual of Omaha CareAdvantage Complete

Hours of Operation

- From October 1 to March 31, you can call us seven days a week from 8:00 a.m. to 8:00 p.m.
- From April 1 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m.

Mutual of Omaha CareAdvantage Complete Phone Numbers and Website

- If you have questions, call toll-free 1-877-603-0787 (TTY: 711).
- Our website: MutualofOmahaCareAdvantage.com

Who can join?

To join **Mutual of Omaha CareAdvantage Complete**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, be a United States citizen or are lawfully present in the United States, live in our service area and cannot have End-Stage Renal Disease (ESRD). Our service area includes the following county in Texas: Bexar.

Which doctors, hospitals and pharmacies can I use?

Mutual of Omaha CareAdvantage Complete 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. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies. You can see our plan's provider directory at our website MutualofOmahaCareAdvantage.com. Or, call us and we will send you a copy of the provider directory.

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.

What drugs do we cover?

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, MutualofOmahaCareAdvantage.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. If you have questions about the different benefit stages, please contact the plan for more information or access the Evidence of Coverage on our website.

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

	Mutual of Omaha CareAdvantage Complete (HMO)
Monthly Plan Premium	$0 per month. You must continue to pay your Medicare Part B premium.
Deductibles	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	The maximum out-of-pocket amount is the most that you pay out-of-pocket during the calendar year for in-network covered hospital and medical services. Your yearly limit(s) in this plan: • $3,400 for covered hospital and medical services you receive from in-network providers. 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. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

Covered Medical and Hospital Benefits

	Mutual of Omaha CareAdvantage Complete (HMO)
Inpatient Hospital Coverage	Our plan covers an unlimited number of days for an inpatient hospital stay. • $125 copay per day, per stay: Days 1–7 • $0 copay per day, per stay: Days 8 and beyond Prior authorization is required.
Outpatient Hospital Coverage	Ambulatory surgical center: $95 copay Outpatient hospital: $95 copay Prior Authorization is required. A referral is required for outpatient hospital services.
Doctor Visits (Primary Care Providers and Specialists)	Primary care physician (PCP) visit: $0 copay Specialist visit: $35 copay A referral is required for specialist visits.

	Mutual of Omaha CareAdvantage Complete (HMO)
Preventive Care	You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screening • Diabetes self-management training, diabetic services and supplies • Health and wellness education programs • HIV screening • Immunizations (pneumonia, hepatitis B and influenza) • Medical nutrition therapy • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and therapy to promote sustained weight loss • Prostate cancer screening exams • Screening and counseling to reduce alcohol misuse • Screening for lung cancer with low dose computed tomography (LDCT) • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • Vision care • "Welcome to Medicare" preventive visit (one-time) Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	$120 copay If you are admitted to the same hospital within 24-hours for the same condition, you pay $0 for the emergency room visit. See the "Inpatient Hospital Care" section of this booklet for other costs. This coverage is worldwide.
Urgently Needed Services	$35 copay within the United States $120 copay outside of the United States This coverage is worldwide.

	Mutual of Omaha CareAdvantage Complete (HMO)
Diagnostic Services/Labs/ Imaging *(Costs for these services may vary based on place of service)*	Lab services: $0 copay Diagnostic procedures and tests: 20% coinsurance X-rays: $0 copay Diagnostic radiology services (such as MRI, CT and PET scans): 20% coinsurance Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance Prior authorization and a referral are required. There is no copay for abdominal aortic aneurysm, diabetes screening or prostate cancer screening when they are ordered as a preventive service.
Hearing Services	Exam to diagnose and treat hearing and balance issues: $0 copay Routine hearing exam: $0 copay Hearing aids are not covered.
Dental Services	Preventive dental services: $0 copay Preventive services include: • Periodic oral evaluation (two every calendar year) • Routine cleaning (two every calendar year) • Fluoride treatment (one every calendar year) • Horizontal bitewing x-ray(s) (once every calendar year) $35 copayment for Medicare-covered dental services. A referral is required for Medicare covered dental services. Services such as fillings, extractions, crowns and dentures are not covered under this routine preventive benefit.
Vision Services	Each visit to a specialist, such as an Ophthalmologist or Optometrist, for Medicare-covered benefits: $35 copay One pair of Medicare-covered eyeglasses or contact lenses after cataract surgery: $0 copay Our plan pays up to $200 every two calendar years for eyeglass frames or contact lenses after cataract surgery. A referral is required for Medicare-covered vision care. One routine eye exam every calendar year: $0 copay One pair of eyeglass lenses (standard plastic single, bifocal, trifocal, or lenticular lenses) per calendar year: $0 copay One pair of eyeglass frames or one pair of contact lenses (or two six packs) every two years. Our plan pays up to $200 every two calendar years for eyeglass frames or contact lenses: $0 copay Upgrades may come at an additional cost.

	Mutual of Omaha CareAdvantage Complete (HMO)
Mental Health Services	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. • $125 copay per day, per stay: Days 1–7 • $0 copay per day, per stay: Days 8 and beyond Outpatient individual therapy visit: $35 copay Outpatient group therapy visit: $30 copay Prior authorization may be required.
Skilled Nursing Facility	The plan covers up to 100 days each benefit period. No prior hospital stay is required. • $0 copay per day, per stay: Days 1–20 • $172 copay per day, per stay: Days 21–100 Prior authorization is required.
Physical Therapy	$35 copay A referral is required.
Ambulance	$250 copay This copay applies to each one-way trip. Prior authorization may be required for non-emergent transportation by ambulance.
Transportation	$0 copay Limited to 20 one-way trips to plan-approved locations every year.

Prescription Drug Benefits

	Mutual of Omaha CareAdvantage Complete (HMO)			
Medicare Part B Drugs	For Part B drugs such as chemotherapy drugs: 20% coinsurance Other Part B drugs: 20% coinsurance Prior authorization is required.			
Deductible	This plan does not have a deductible.			
Initial Coverage	You pay the following until your total yearly drug costs reach $3,820. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.			
	Preferred Retail Cost-Sharing			
	Tier	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**
	Tier 1 (Preferred Generic)	$2 copay	$4 copay	$6 copay
	Tier 2 (Generic)	$7 copay	$14 copay	$21 copay
	Tier 3 (Preferred Brand)	$42 copay	$84 copay	$126 copay
	Tier 4 (Non-Preferred Brand)	$87 copay	$174 copay	$261 copay
	Tier 5 (Specialty Drug)	33% coinsurance	Not Offered	Not Offered
	Standard Retail Cost-Sharing			
	Tier	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**
	Tier 1 (Preferred Generic)	$7 copay	$14 copay	$21 copay
	Tier 2 (Generic)	$14 copay	$28 copay	$42 copay
	Tier 3 (Preferred Brand)	$47 copay	$94 copay	$141 copay
	Tier 4 (Non-Preferred Brand)	$97 copay	$194 copay	$291 copay
	Tier 5 (Specialty Drug)	33% coinsurance	Not Offered	Not Offered

<table>
<tr><th></th><th colspan="4">Mutual of Omaha CareAdvantage Complete (HMO)</th></tr>
<tr><td>Initial Coverage Continued</td><td colspan="4">If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

You may get drugs from an out-of-network pharmacy at the same cost as a standard retail pharmacy. Coverage is limited to certain situations if you go out-of-network.</td></tr>
<tr><td></td><td colspan="4">Standard Mail Order Cost-Sharing</td></tr>
<tr><td></td><td>Tier</td><td>30-Day Supply</td><td>60-Day Supply</td><td>90-Day Supply</td></tr>
<tr><td></td><td>Tier 1 (Preferred Generic)</td><td>$7 copay</td><td>$14 copay</td><td>$0 copay</td></tr>
<tr><td></td><td>Tier 2 (Generic)</td><td>$14 copay</td><td>$28 copay</td><td>$0 copay</td></tr>
<tr><td></td><td>Tier 3 (Preferred Brand)</td><td>$47 copay</td><td>$94 copay</td><td>$115 copay</td></tr>
<tr><td></td><td>Tier 4 (Non-Preferred Brand)</td><td>$97 copay</td><td>$194 copay</td><td>$275 copay</td></tr>
<tr><td></td><td>Tier 5 (Specialty Drugs)</td><td>33% coinsurance</td><td>Not Offered</td><td>Not Offered</td></tr>
<tr><td>Coverage Gap</td><td colspan="4">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 $3,820.

After you enter the coverage gap, you pay 25% of the plan’s cost for covered brand name drugs and 37% of the plan’s cost for covered generic drugs until your out-of-pocket costs total $5,100, which is the end of the coverage gap. Not everyone will enter the coverage gap.</td></tr>
<tr><td>Catastrophic Coverage</td><td colspan="4">After your yearly out-of-pocket drug costs reach $5,100, you pay the greater of:
• 5% coinsurance, or
• $3.40 copay for generic (including brand drugs treated as generic) and a $8.50 copay for all other drugs.</td></tr>
</table>

Other Covered Benefits

	Mutual of Omaha CareAdvantage Complete (HMO)
Chiropractic Care	Manual manipulation of the spine to correct subluxation: $10 copay A referral is required.
Diabetes Supplies and Services	Diabetes self-management training: $0 copay Diabetes monitoring supplies (including blood glucose monitors, lancets, and test strips*): 20% coinsurance Diabetic therapeutic custom-molded shoes or inserts: 20% coinsurance Prior authorization is required for diabetic therapeutic custom-molded shoes and inserts only. *See Evidence of Coverage for a complete listing.
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*	20% coinsurance Prior authorization may be required.
Foot Care *(podiatry services)*	$35 copay A referral is required.
Home Health Care	$0 copay A referral is required.
Hospice	You pay nothing for hospice care from any Medicare-certified hospice program. Please contact us for more details.
Outpatient Substance Abuse	Individual therapy visit: $35 copay Group therapy visit: $30 copay Prior authorization is required.
Over-the-Counter Coverage (OTC)	$45 credit per quarter to use on approved health products that can be ordered online, by phone or by mail. Up to 2 orders per quarter is allowed and left over allowance does not roll over from quarter to quarter.

	Mutual of Omaha CareAdvantage Complete (HMO)
Prosthetic Devices	Prosthetic devices: 20% coinsurance Related medical supplies: 20% coinsurance Prior authorization may be required.
Rehabilitation Services	Cardiac rehabilitation services: $30 copay per day Occupational, speech and language therapy visits: $35 copay A separate copayment for Occupational Therapy will apply if other outpatient therapy services are rendered on the same day. A referral is required.
Wellness Programs	Health Club Membership/Fitness classes through SilverSneakers®: $0 copay

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Notice of Non-Discriminatory Practices

Mutual of Omaha Medicare Advantage Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Mutual of Omaha Medicare Advantage Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Mutual of Omaha Medicare Advantage Company:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified interpreter services
- Written information in other formats

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreter services
- Information written in other languages

If you need these services, contact Customer Service at 1-866-488-0249 (TTY: 711).

If you believe that Mutual of Omaha Medicare Advantage Company 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:

Section 1557 Compliance Coordinator
ATTN: Discrimination Grievance
Compliance Coordinator
3300 Mutual of Omaha Plaza
Omaha, NE 68175
1-866-896-2898
Email: MedAdvantage.Compliance.Officer@mutualofomaha.com

You must file a grievance using the prescribed form in writing by mail, fax, or email. You may request a form and instruction on how to file a grievance from the Coordinator at the contact information above.

If you need help filing a grievance, the Compliance Coordinator 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/portal/lobby.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, 1–800–868–1019, 800–537–7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Mutual of Omaha Medicare Advantage Company is an HMO plan with a Medicare contract. Enrollment in Mutual of Omaha Medicare Advantage Company depends on contract renewal.

ENGLISH: ATTENTION: If you speak another language other than English, language assistance services, free of charge, are available to you. Call 1-866-488-0249 (TTY: 711).

SPANISH: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-488-0249 (TTY: 711).

VIETAMESE: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-488-0249 (TTY: 711).

CHINESE: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-488-0249 (TTY: 711)。

KOREAN: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-488-0249 번 (TTY: 711 번)으로 전화하십시오.

ARABIC: ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل على الرقم 1-866-488-0249 (711 :هاتف الصم والبكم)

URDU: خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کری 1-866-488-0249 (TTY: 711).کریں

TAGALOG: PAUNAWA: Kung nagsasalita ka ng Tagalog, may mga libreng serbisyo para sa tulong sa wika na maaari mong gamitin. Tumawag sa 1-866-488-0249 (TTY: 711).

FRENCH: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-488-0249 (ATS : 711).

HINDI: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-488-0249 (TTY: 711) पर कॉल करें।

PERSIAN (FARSI): توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-866-488-0249 (TTY: 711) تماس بگیرید.

GERMAN: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie uns an unter 1-866-488-0249 (TTY: 711).

GUJARATI: સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-488-0249 (TTY: 711).

RUSSIAN: ВНИМАНИЕ! Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните по номеру 1-866-488-0249 (телетайп: 711).

JAPANESE: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-488-0249（TTY:711）まで、お電話にてご連絡ください。

LAOTIAN: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-866-488-0249 (TTY: 711).

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 customer service representative at 1-866-488-0249 (TTY: 711).

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit MutualofOmahaCareAdvantage.com or call 1-866-488-0249 (TTY: 711) to view a copy of the EOC.

- ☐ Review the provider/pharmacy 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 provider/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.

Understanding Important Rules

- ☐ 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.

- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2020.

- ☐ 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).

Why Mutual of Omaha

For more than a century, Mutual of Omaha has been committed to listening to our customers and helping them through life's transitions by providing an array of insurance, financial and banking products.

MutualofOmahaCareAdvantage.com

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This information is not a complete description of benefits. Call 1-866-488-0249 (TTY: 711) for more information.

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