



**FRESENIUS
HEALTH PLANS**

Summary of Benefits

FRESENIUS TOTAL HEALTH (HMO SNP)

(a Medicare Advantage Health Maintenance Organization (HMO) offered by
FRESENIUS HEALTH PLANS OF NORTH CAROLINA, INC. with a Medicare contract)

Available in

Durham, Orange and Wake Counties, North Carolina

January 1, 2016 - December 31, 2016

Summary of Benefits

January 1, 2016 - December 31, 2016

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 **Fresenius Total Health (HMO SNP)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Fresenius Total Health (HMO SNP)** 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 **Fresenius Total Health (HMO SNP)**
- 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 1-855-598-6774/TTY (844) 209-9094.

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 más información, llámenos al 1-855-598-6774 / TTY (844) 209-9094.

Fresenius Total Health is an HMO SNP offered by Fresenius Health Plans of North Carolina, Inc. Fresenius Health Plans of North Carolina, Inc. is an HMO with a Medicare contract. Enrollment in Fresenius Health Plans of North Carolina, Inc. depends on contract renewal.

Things to Know About Fresenius Total Health (HMO SNP)

Hours of Operation

You can call us 7 days a week from 8:00 a.m. to 11:00 p.m. Eastern time.

Fresenius Total Health (HMO SNP) Phone Numbers and Website

- If you are a member of this plan, call toll-free 1-855-598-6774/TTY (844) 209-9094.
- If you are not a member of this plan, call toll-free 1-855-598-6774/TTY (844) 209-9094.
- Our website: <http://www.esrdplan.com>

Who can join?

To join **Fresenius Total Health (HMO SNP)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, be diagnosed with End-stage renal disease requiring dialysis (any mode of dialysis), and live in our service area. Our service area includes the following counties in North Carolina: Durham, Orange, and Wake.

Which doctors, hospitals, and pharmacies can I use?

Fresenius Total Health (HMO SNP) 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.esrdplan.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.esrdplan.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 after you meet your deductible: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

Summary of Benefits

for Contract H6320, Plan 001

FRESENIUS TOTAL HEALTH (HMO SNP)

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

How much is the monthly premium?	\$29.90 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan has deductibles for some hospital and medical services, and Part D prescription drugs. \$166 per year for in-network services. \$360 per year for Part D prescription drugs except for drugs listed on Tier 1 which are excluded from the deductible.
Is there any limit on how much I will pay for my covered services?	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. Your yearly limit(s) in this plan: <ul style="list-style-type: none"> \$6,700 for 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.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

Covered Medical and Hospital Benefits

NOTE:

- Services with a ¹ may require prior authorization.
- Services with a ² may require a referral from your doctor.

Outpatient Care and Services

Acupuncture	Not covered
Ambulance ¹	20% of the cost
Chiropractic Care ^{1,2}	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): 20% of the cost
Dental Services	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): \$5 copay Preventive dental services: <ul style="list-style-type: none"> Cleaning (for up to 1 every six months): \$0 copay Dental x-ray(s) (for up to 1 every six months): \$0 copay Fluoride treatment (for up to 1 every year): \$0 copay Oral exam (for up to 2 every year): \$0 copay Our plan pays up to \$1,500 every year for most dental services.
Diabetes Supplies and Services ^{1,2}	Diabetes monitoring supplies: You pay nothing Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: You pay nothing
Diagnostic Tests, Lab and Radiology Services, and X-Rays (Costs for these services may vary based on place of service) ^{1,2}	Diagnostic radiology services (such as MRIs, CT scans): 20% of the cost Diagnostic tests and procedures: 20% of the cost Lab services: 20% of the cost Outpatient x-rays: 20% of the cost Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost
Doctor's Office Visits ²	Primary care physician visit: You pay nothing Specialist visit: 0-20% of the cost, depending on the service \$0 coinsurance for nephrology office visits and 20% coinsurance for all other specialist services.
Durable Medical Equipment (wheelchairs, oxygen, etc.) ¹	20% of the cost
Emergency Care	20% of the cost (up to \$75) If you are admitted to the hospital within 24 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.
Foot Care (podiatry services)	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: 20% of the cost
Hearing Services	Exam to diagnose and treat hearing and balance issues: 20% of the cost

Home Health Care^{1,2}	You pay nothing
Mental Health Care^{1,2}	<p>Inpatient visit:</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>The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.</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> <p>In 2016 the amounts for each benefit period are:</p> <ul style="list-style-type: none"> • \$1,288 deductible for days 1 through 60 • \$322 copay per day for days 61 through 90 • \$644 copay per day for 60 lifetime reserve days <p>Outpatient group therapy visit: 20% of the cost</p> <p>Outpatient individual therapy visit: 20% of the cost</p>
Outpatient Rehabilitation^{1,2}	<p>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): 20% of the cost</p> <p>Occupational therapy visit: 20% of the cost</p> <p>Physical therapy and speech and language therapy visit: 20% of the cost</p>
Outpatient Substance Abuse^{1,2}	<p>Group therapy visit: 20% of the cost</p> <p>Individual therapy visit: 20% of the cost</p>
Outpatient Surgery^{1,2}	<p>Ambulatory surgical center: 20% of the cost</p> <p>Outpatient hospital: 20% of the cost</p>
Over-the-Counter Items	<p>Please visit our website to see our list of covered over-the-counter items.</p> <p>Plan covers \$20.00 every month</p>
Prosthetic Devices (braces, artificial limbs, etc.)¹	<p>Prosthetic devices: 20% of the cost</p> <p>Related medical supplies: 20% of the cost</p>
Renal Dialysis	20% of the cost
Transportation^{1,2}	<p>You pay nothing</p> <p>(30 one-way trips/year)</p>
Urgently Needed Services	20% of the cost (up to \$65)

Vision Services	<p>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$0 copay</p> <p>Routine eye exam (for up to 1 every year): \$0 copay</p> <p>Contact lenses: \$0 copay</p> <p>Our plan pays up to \$175 every year for contact lenses.</p> <p>Eyeglass frames (for up to 1 every year): \$0 copay</p> <p>Our plan pays up to \$175 every year for eyeglass frames.</p> <p>Eyeglass lenses (for up to 1 every year): \$0 copay</p> <p>Eyeglasses or contact lenses after cataract surgery: \$0 copay</p>
Preventative Care	<p>You pay nothing</p> <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>
Hospice	<p>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. Hospice is covered outside of our plan. Please contact us for more details.</p>

Inpatient Care

<p>Inpatient Hospital Care^{1,2}</p>	<p>The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.</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> <p>In 2016 the amounts for each benefit period are:</p> <ul style="list-style-type: none"> • \$1,288 deductible for days 1 through 60 • \$322 copay per day for days 61 through 90 • \$644 copay per day for 60 lifetime reserve days
<p>Inpatient Mental Health Care</p>	<p>For inpatient mental health care, see the "Mental Health Care" section of this booklet.</p>
<p>Skilled Nursing Facility (SNF)^{1,2}</p>	<p>Our plan covers up to 100 days in a SNF.</p> <p>In 2016 the amounts for each benefit period are:</p> <ul style="list-style-type: none"> • You pay nothing for days 1 through 20 • \$161 copay per day for days 21 through 100 <p>A benefit period begins the day you're admitted as an inpatient in a SNF. The benefit period ends when you haven't received any skilled care in a SNF for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period begins.</p>

Prescription Drug Benefits

<p>How much do I pay?</p>	<p>For Part B drugs such as chemotherapy drugs: 20% of the cost</p> <p>Other Part B drugs: 20% of the cost</p>																				
<p>Initial Coverage</p>	<p>After you pay your yearly deductible, you pay the following until your total yearly drug costs reach \$3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.</p> <p>You may get your drugs at network retail pharmacies and mail order pharmacies.</p>																				
<p>Standard Retail Cost-Sharing</p>	<table border="1"> <thead> <tr> <th>Tier</th> <th>One-month supply</th> <th>Three-month supply</th> </tr> </thead> <tbody> <tr> <td>Tier 1 (<i>Preferred Generic</i>)</td> <td>\$0</td> <td>\$0</td> </tr> <tr> <td>Tier 2 (<i>Generic</i>)</td> <td>25% of the cost</td> <td>25% of the cost</td> </tr> <tr> <td>Tier 3 (<i>Preferred Brand</i>)</td> <td>25% of the cost</td> <td>25% of the cost</td> </tr> <tr> <td>Tier 4 (<i>Non-Preferred Brand</i>)</td> <td>25% of the cost</td> <td>25% of the cost</td> </tr> <tr> <td>Tier 5 (<i>Specialty Tier</i>)</td> <td>25% of the cost</td> <td>Not Offered</td> </tr> </tbody> </table>	Tier	One-month supply	Three-month supply	Tier 1 (<i>Preferred Generic</i>)	\$0	\$0	Tier 2 (<i>Generic</i>)	25% of the cost	25% of the cost	Tier 3 (<i>Preferred Brand</i>)	25% of the cost	25% of the cost	Tier 4 (<i>Non-Preferred Brand</i>)	25% of the cost	25% of the cost	Tier 5 (<i>Specialty Tier</i>)	25% of the cost	Not Offered		
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	<p>If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy and pay the same as an in-network pharmacy, but you will get less of the drug.</p>																				
<p>Coverage Gap</p>	<p>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 \$3,310.</p> <p>After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 58% of the plan's cost for covered generic drugs until your costs total \$4,850, which is the end of the coverage gap. Not everyone will enter the coverage gap.</p>																				
<p>Catastrophic Coverage</p>	<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,850, you pay the greater of:</p> <ul style="list-style-type: none"> • 5% of the cost, or • \$2.95 copay for generic (including brand drugs treated as generic) and a \$7.40 copayment for all other drugs. 																				



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