



2424 Niagara Falls Blvd.
Niagara Falls, NY 14304
1-800-399-1954 (TTY 711)
www.kaloshealth.org

SUMMARY OF BENEFITS

Kalos Health Gold Plus HMO-SNP H3227-001

This is a summary of drug and health services covered by Kalos Health Gold Plus HMO-SNP January 1, 2018 – December 31, 2018.

Kalos Health Gold Plus is a Health Maintenance Organization (HMO) Special Needs Plan (SNP) with a Medicare Contract and a coordination of benefits agreement with the New York State Department of Health. Enrollment in the Plan depends on contract renewal.

Kalos Health Gold Plus HMO-SNP is a Medicare Advantage Plan designed specifically for those who have Medicare and full New York State Medicaid benefits.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. Depending on your level of Medicaid eligibility, you may not have any cost-sharing responsibility for Medicare-covered services. Individuals with full Medicaid benefits will have the lower 0% coinsurance. You may also have additional benefits through the New York State Medicaid program. To get a complete list of services we cover, please request the "Evidence of Coverage."

To join Kalos Health Gold Plus, you must be age 21 or older, have Medicare Parts A and B, full New York State Medicaid benefits and live in our service area. Our service area includes the following counties in New York: Cattaraugus, Erie, Niagara and Orleans.

If you use the providers that are not in our network, we may not pay for these services. You can see our plan's provider directory, pharmacy directory, and the complete plan formulary (list of Part D prescription drugs) at our website at www.kaloshealth.org. The formulary, pharmacy network may change at any time. You will receive notice when necessary.

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

For more information, please call us at 1-800-399-1954 (TTY users should call 711), or visit us at www.kaloshealth.org.

PREMIUMS & BENEFITS	KALOS HEALTH GOLD PLUS
Monthly Plan Premium	<p>You pay \$0</p> <p>You must continue to pay your Medicare Part B premium.</p>
Deductible	No deductible
Maximum Out-of-Pocket Responsibility (<i>does not include prescription drugs</i>)	<p>You pay no more than \$6,700 annually</p> <p>Includes copays and other costs for medical services for the year.</p>
Inpatient Hospital Coverage **	<p>(Days 1-60) \$1,316 deductible</p> <p>(Days 61-90) \$329 copay per day</p> <p>(Days 91+) \$658 per lifetime reserve day</p>
Outpatient Hospital	You pay 20% of the cost of Medicare-covered services
Doctor Visits	You pay 20% per visit for both primary care and specialists
Preventive Care	<p>You pay \$0</p> <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>
Emergency Care	<p>You pay 20% of the cost of the visit up to \$80</p> <p>Coinsurance is waived upon hospital admission.</p>
Urgently Needed Services	<p>You pay 20% of the cost of the visit up to \$65</p> <p>Urgent care is covered within the United States and not worldwide.</p>
Diagnostic Services/Labs/Imaging **	<p>You pay 20% of the cost of Medicare-covered services</p> <p>Prior authorization is required for some services by your doctor or other network provider. Please contact the plan for more information.</p>
Hearing Services	You pay 20% of the cost of Medicare-covered services
Dental Services	You pay 20% of the cost of Medicare-covered services
Vision Services	You pay 20% of the cost of Medicare-covered services

PREMIUMS & BENEFITS	KALOS HEALTH GOLD PLUS
Mental Health Services Inpatient Visit Outpatient Individual/Group Therapy	(Days 1-60) \$1,316 deductible (Days 61-90) \$329 copay per day (Days 91+) \$658 per lifetime reserve day You pay 20% of the cost of outpatient group or individual therapy visits
Skilled Nursing Facility **	You pay \$0
Physical Therapy/Speech Language Pathology	You pay 20% of the cost of Medicare-covered services
Rehabilitation Services	You pay 20% of the cost of Medicare-covered services
Ambulance	You pay 20% of the cost of Medicare-covered services
Transportation	Non-emergency transportation is not covered by Medicare
Medicare Part B Drugs **	You pay 20% of the cost of Medicare-covered services

** Authorization may be required. Call Kalos Health Gold Plus for more information.

You may not have any copayment/coinsurance responsibility for Medicare covered services, depending on your level of Medicaid eligibility. Additional benefits may be available to you through the New York State Medicaid program.

Health & Wellness Benefits	KALOS HEALTH GOLD PLUS
Wellness Program - SilverSneakers® (fitness)	You pay \$0 Includes unlimited access to every participating gym and fitness center in the network. Please contact the plan for more information.
Over-The-Counter (OTC) Supplemental Benefit	\$25 available every month for the purchase of OTC items.
Hearing Aids	\$500 maximum benefit per year
Nurse Connect 24/7 access to registered nurses by phone or online	You pay \$0

OUTPATIENT PRESCRIPTION DRUGS

	PREFERRED RETAIL RX 30-DAY SUPPLY	NON-PREFERRED RETAIL RX 30-DAY SUPPLY	MAIL ORDER 90- DAY SUPPLY
Phase: Initial Coverage (After you pay you deductible, if applicable)			
Tier 1: ALL RX	25%	25%	25%

Cost sharing may change when entering another phase of the Part D benefit. Please call Kalos Health Gold Plus for more information at 1-800-399-1954 or access the Evidence of Coverage online at www.kaloshealth.org.

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.

Additional Benefit Information - Summary of Medicaid-Covered Benefits for Contract H3227, Plan 001

People who qualify for Medicare and Medicaid are known as dual eligibles. As a dual eligible, you are eligible for benefits under both the federal Medicare program and the state-operated Medicaid program.

The kind of Medicaid benefits you receive are determined by your state and may vary based upon your income and resources. With the assistance of Medicaid, some dual eligibles do not have to pay for certain Medicare costs.

The following table contains services that are available under Medicaid for people who qualify for full Medicaid benefits. The benefits described in the Premium and Benefits section of the Summary of Benefits are covered by Medicare. If our plan does not provide the benefit, members who qualify for full Medicaid benefits can obtain the service from Medicaid fee-for-service using their Medicaid Benefit Identification card. It is important to know that Medicaid benefits can vary based on your income level and other standards. Also, your Medicaid benefits can change throughout the year. For the most current and accurate information regarding your eligibility and benefits, contact your local Department of Social Services.

Benefit Category	New York State Medicaid Coverage
<p>Adult Day Health Care</p> <p>Medicaid covers Adult Day Health Care services provided in a residential health care facility or approved extension. Adult day health care includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities which are a planned program of diverse meaningful activities, dental, pharmaceutical, and other ancillary services.</p>	Covered
<p>AIDS Adult Day Health Care Medicaid covers AIDS Adult Day Health Care Programs (ADHCP), designed to assist individuals with HIV disease to live more independently in the community or eliminate the need for residential health care services.</p>	Covered
<p>Assisted Living Program</p> <p>Medicaid covers personal care, housekeeping, supervision, home health aides, personal emergency response services, nursing, physical therapy, occupational therapy, speech therapy, medical supplies and equipment, adult day health care, a range of home health services and the case management services of a registered professional nurse. Services are provided in an adult home or enriched housing setting.</p>	Covered
<p>Certain Mental Health Services Including:</p> <ul style="list-style-type: none"> • Intensive psychiatric rehabilitation treatment programs • Day treatment • Continuing day treatment • Case management for seriously and persistently mentally ill • Partial hospitalization • Assertive community treatment (ACT) • Personalized recovery oriented services (PROS) 	Covered
<p>Comprehensive Medicaid Case Management (CMCM)</p> <p>Provides “social work” case management referral services to a targeted population. A CMCM case manager will assist a client in accessing necessary services in accordance with goals outlined in a written case management plan.</p>	Covered

Benefit Category	New York State Medicaid Coverage
<p>Dental Services</p> <p>Necessary preventive, prophylactic and other routine dental care, services and supplies and dental prosthetics to alleviate a serious health condition. Ambulatory or inpatient surgical dental services subject to prior authorization.</p>	Covered
<p>Directly Observed Therapy for Tuberculosis (TB) Disease Medicaid covers Tuberculosis Directly Observed Therapy (TB/DOT), which is the direct observation of oral ingestion of TB medications to assure patient compliance with the physician's prescribed medication regimen.</p>	Covered
<p>Hearing Services</p> <p>Services and products when medically necessary to alleviate disability caused by the loss or impairment of hearing: e.g., hearing aid selecting, fitting and dispensing; hearing aid checks following dispensing; conformity evaluations and hearing aid repairs.</p>	Covered
<p>Home and Community Based Waiver Program Services</p> <p>Medicaid covers personal care services to a participant who requires assistance with personal care services tasks and whose health and welfare in the community is at risk because oversight and supervision of the participant is required when no personal care task is being performed. These services are provided under the direction and supervision of a Registered Professional Nurse.</p>	Covered
<p>Medical Social Services</p>	Covered
<p>Home and Community Based Waiver Program Services</p>	Covered
<p>Hospice</p>	Covered
<p>Medical and Surgical Supplies</p>	Covered
<p>Methadone Maintenance Treatment Programs</p>	Covered
<p>Non-Emergency Transportation</p> <p>Expenses are covered when transportation is essential in order for a member to obtain necessary medical care and services which are covered under the Medicaid program. For members with disabilities, the method of transportation must reasonably accommodate their needs, taking into account the severity and nature of the disability.</p>	Covered

Benefit Category	New York State Medicaid Coverage
<p>Non-Medicare Covered Durable Medical Equipment</p> <p>Including devices and equipment other than medical/surgical supplies, enteral formula, and prosthetic or orthotic appliances having the following characteristics: can withstand repeated use for a protracted period of time; are primarily and customarily used for medical purposes; are generally not useful to a person in the absence of illness or injury; and are usually fitted, designed or fashioned for a particular individual's use. Must be ordered by a qualified practitioner. No homebound prerequisite. Also includes non-Medicare DME covered by Medicaid (e.g., tub stool, grab bars).</p>	Covered
<p>Office for People With Developmental Disabilities (OPWDD) Services</p>	Covered
<p>Personal Care Services</p> <p>Personal care services (PCS), which involve the provision of some or total assistance with personal hygiene, dressing and feeding and nutritional and environmental support (meal preparation and housekeeping). Personal care services must be medically necessary, ordered by a physician, and provided by a qualified person in accordance with a plan of care</p>	Covered
<p>Personal Emergency Response Services (PERS)</p> <p>An electronic device which enables certain high-risk patients to secure help in the event of a physical, emotional or environmental emergency.</p>	Covered
<p>Vision Services</p> <p>Services of optometrists, ophthalmologists and ophthalmic dispensers including eyeglasses, medically necessary contact lenses and polycarbonate lenses, artificial eyes, low vision aids and low-vision services. Also includes the repairs or replacement of parts. Also includes examinations for diagnosis and treatment for visual defects and/or eye disease. Examinations for refraction are limited to every two years unless otherwise medically justified.</p>	Covered

Discrimination is Against the Law

Kalos Health Gold Plus complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kalos Health Gold Plus does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Kalos Health Gold Plus:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Kalos Health Gold Plus Member Services Department at 1-800-399-1954 (TTY 711). If you believe that Kalos Health Gold Plus 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:

Kalos Health Gold Plus
Member Services Department – Nondiscrimination
2424 Niagara Falls Blvd.
Niagara Falls, NY 14304
1-800-399-1954, (TTY-711),
Fax: 716-731-2013
Email: info@kaloshealth.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Kalos Health Gold Plus Member Services at 1-800-399-1954 (TTY 711) 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

MULTI-LANGUAGE INTERPRETIVE SERVICE

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-399-1954 (TTY:711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-399-1954 (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Call 1-800-399-1954 (TTY:711)。

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-399-1954. (телетайп: 711).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-399-1954 (TTY-711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-399-1954 (TTY:711) 번으로 전화해 주십시오.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-399-1954 (TTY:711) .

Yiddish: אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. 1-800-399-1954 (TTY:711) רופ

Bengali: লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নি:খরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-800-399-1954 (TTY:711)।

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-399-1954 (TTY:711).

Arabic: (رقم 1-800-399-1954 ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-399-1954 (TTY:711). هاتف الصم والبكم:-)

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-399-1954 (TTY:711).

Urdu: 1-800-399-1954 خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں (TTY:711)۔

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-399-1954 (TTY:711).

Greek: ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-399-1954 (TTY:711).

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-399-1954 (TTY: 711).