

AvMed Health Plans
2010 Premier Care HMO Benefit Summary - Miami-Dade County
Provider Copy - Not for distribution to members

Benefit Category	AvMed Premier Care (HMO)
Out of Pocket Maximum	<p>In-Network</p> <p>\$3,400 out-of-pocket limit.</p> <p>This limit includes only Medicare-covered services.</p>
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INPATIENT CARE	
<p>Inpatient Hospital Care <i>(includes Substance Abuse and Rehabilitation Services)</i> <i>Except in an emergency, referral required for network hospitals (for certain benefits).</i></p>	<p>In-Network</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 - 3: \$0 copay per day Days 4 - 23: \$100 copay per day Days 24 - 90: \$0 copay per day \$0 copay for each additional hospital day.</p> <p><i>No limit to the number of days covered by the plan each benefit period.</i></p> <p><i>Except in an emergency, doctors must tell AvMed that a member is going to be admitted to the hospital.</i></p> <p><i>Requires prior authorization to be covered</i></p>
<p>Inpatient Mental Health Care</p>	<p>In-Network</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 - 10: \$100 copay per day Days 11 - 90: \$0 copay per day</p> <p>Plan covers 60 lifetime reserve days. Cost per lifetime reserve day:</p> <p>Days 1 - 10: \$100 copay per day Days 11 - 60: \$0 copay per day</p> <p><i>Member has a 190-day lifetime benefit maximum in a Psychiatric Hospital.</i></p> <p><i>Except in an emergency, doctors must tell AvMed that a member is going to be admitted to the hospital.</i></p> <p><i>Requires prior authorization to be covered</i></p>
<p>Skilled Nursing Facility (SNF) <i>(in a Medicare-certified skilled nursing facility)</i></p>	<p>In-Network</p> <p>For SNF stays:</p> <p>Days 1 - 20: \$0 copay per day Days 21 - 100: \$133.50 copay per day</p> <p><i>Plan covers up to 100 days each benefit period</i></p> <p><i>No prior hospital stay is required.</i></p> <p><i>Requires prior authorization to be covered</i></p>
<p>Home Health Care <i>(includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</i></p>	<p>In-Network</p> <p>\$0 copay for Medicare-covered home health visits.</p> <p><i>Requires prior authorization to be covered</i></p>

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Hospice	General Member must get care from a Medicare-certified hospice.
OUTPATIENT CARE	
Doctor Office Visits <i>Members must go to network doctors, specialists, and hospitals.</i> <i>Referral required for network hospitals and specialists (for certain benefits).</i>	In-Network \$0 copay for each primary care doctor visit for Medicare-covered benefits. \$5 copay for each specialist visit for Medicare-covered benefits. \$0 copay per allergy injection by allergy physician \$0 copay for each allergy skin testing
Chiropractic Services	In-Network \$5 copay for each Medicare-covered visit. <i>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation if received from a chiropractor or other qualified provider.</i>
Podiatry Services <i>One routine visit is allowed every 60 days without authorization.</i>	In-Network \$5 copay for each Medicare-covered visit. \$5 copay for up to 1 routine visit <i>Medicare-covered podiatry benefits are for medically-necessary foot care.</i>
Outpatient Mental Health Care	In-Network \$5 copay for each Medicare-covered individual or group therapy visit.
Outpatient Substance Abuse Care	In-Network \$5 copay for Medicare-covered individual or group visit.
Outpatient Services/Surgery	In-Network \$0 copay for each Medicare-covered ambulatory surgical center visit. \$100 copay for each Medicare-covered outpatient hospital facility visit.
Ambulance Services <i>(medically necessary ambulance services)</i>	General \$75 copay for Medicare-covered ambulance benefits. Copay applies for each one-way trip.
Emergency Care	General \$50 copay for Medicare-covered emergency room visits. <i>Worldwide coverage.</i> <i>If admitted to the hospital within 24-hours for the same condition, member pays \$0 for the emergency room visit</i>

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Urgently Needed Care	General
	\$25 copay for Medicare-covered urgently needed care visits. <i>If admitted to the hospital within 24-hours for the same condition, the member pays \$0 for the urgent-care visit.</i>
Outpatient Rehabilitation Services <i>(Occupational Therapy, Physical Therapy, Speech and Language Therapy)</i>	In-Network
	\$5 copay for Medicare-covered Occupational Therapy visits. \$5 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.
Durable Medical Equipment <i>(includes wheelchairs, oxygen, etc.)</i>	In-Network
	\$0 copay for Medicare-covered items.
Prosthetic Devices <i>(includes braces, artificial limbs and eyes, etc.)</i>	In-Network
	\$0 copay for Medicare-covered items.
Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies <i>(includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)</i>	In-Network
	\$0 to \$5 copay for Diabetes self-monitoring training. \$0 to \$5 copay for Nutrition Therapy for Diabetes. \$0 to \$20 copay for Diabetes supplies.
Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	In-Network
	\$0 copay for Medicare-covered lab services. \$25 copay for Medicare-covered X-rays and simple radiology procedures, such as ultrasound. \$100 copay for Medicare-covered complex diagnostic radiology services, including CT scans, MRA, MRI, and nuclear medicine. 20% coinsurance for PET scans <i>Complex radiology services require prior authorization to be covered</i>
PREVENTIVE SERVICES	
Bone Mass Measurement <i>(for people with Medicare who are at risk)</i>	In-Network
	\$0 copay for Medicare-covered bone mass measurement
Colorectal Screening Exams <i>(for people with Medicare age 50 and older)</i>	In-Network
	\$0 copay for Medicare-covered colorectal screenings; up to 1 additional screening every year
Immunizations <i>(Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at moderate or high risk, Pneumonia vaccine)</i>	In-Network
	\$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. <i>No referral needed for Flu and pneumonia vaccines.</i>
Mammogram (Annual Screening) <i>(for women with Medicare age 40 and older)</i>	In-Network
	\$0 copay for Medicare-covered screening mammograms; up to 1 additional screening mammogram every year

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Pap Smears and Pelvic Exams <i>(for women with Medicare)</i>	In-Network \$0 copay for Medicare-covered pap smears and pelvic exams; up to 1 additional pap smear and pelvic exam every year
Prostate Cancer Screening Exams <i>(for men with Medicare age 50 and older)</i>	In-Network \$0 copay for Medicare-covered prostate cancer screening
End-Stage Renal Disease	In-Network 20% of the cost for renal dialysis \$0 to \$5 copay for Nutrition Therapy for End-Stage Renal Disease. <i>Requires prior authorization to be covered</i>
Prescription Drugs <i>If a tier exception is requested, member will pay Tier 3 cost sharing.</i>	Drugs covered under Medicare Part B General 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs
	Drugs Covered under Medicare Part D In-Network \$0 deductible. <i>Some covered drugs don't count toward the member's out-of-pocket drug costs.</i> Initial Coverage Member pays the following until total yearly drug costs reach \$4,000: Retail Pharmacy <i>Tier 1</i> \$0 copay for a one-month (30-day) supply of drugs in this tier \$0 copay for a three-month (90-day) supply of drugs in this tier <i>Tier 2</i> \$20 copay for a one-month (30-day) supply of drugs in this tier \$60 copay for a three-month (90-day) supply of drugs in this tier <i>Tier 3</i> \$50 copay for a one-month (30-day) supply of drugs in this tier \$150 copay for a three-month (90-day) supply of drugs in this tier <i>Tier 4</i> 25% coinsurance for a one-month (30-day) supply of drugs in this tier. <i>Drugs in this tier are available in a one-month (30-day) supply only.</i> Coverage Gap AvMed covers all generics (100% of formulary generic drugs) through the coverage gap.

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Prescription Drugs, continued	<p>Catastrophic Coverage</p> <p>After yearly out-of-pocket drug costs reach \$ 4,550, the member pays the greater of:</p> <p>\$2.50 copay for generic (including brand drugs treated as generic), \$6.30 copay for all other drugs, or 5% coinsurance.</p>
Dental Services	<p>In-Network</p> <p>In general, preventive dental benefits (such as cleaning) not covered. \$5 copay for Medicare-covered dental benefits.</p>
Hearing Services	<p>In-Network</p> <p>In general, routine hearing exams and hearing aids not covered. \$5 copay for Medicare-covered diagnostic hearing exams.</p>
Vision Services	<p>In-Network</p> <p>\$10 copay for one pair of eyeglasses or contact lenses after cataract surgery. \$5 copay for exams to diagnose and treat diseases and conditions of the eye. \$5 copay for routine eye exams \$10 copay for up to 1 pair of glasses every year in addition to the Medicare-covered eyewear after cataract surgery.</p>
Physical Exams	<p>In-Network</p> <p>\$0 copay for routine exams. <i>No limit on the number of covered exams.</i></p>
Health/Wellness Education	<p>In-Network</p> <p>AvMed covers the following health/wellness education benefits at no cost to members:</p> <ul style="list-style-type: none"> • Written health education materials, including Newsletters • Silver Sneakers[®] Fitness Program (Health Club Membership/Fitness Classes) • 24-Hour Nursing Hotline • \$0 copay for each Medicare-covered smoking cessation counseling session.
Transportation (Routine)	<p>In-Network</p> <p>AvMed does not cover routine transportation.</p>
Acupuncture	<p>In-Network</p> <p>AvMed does not cover Acupuncture.</p>