Embrace better health®

2020 Summary of Benefits

AvMed Medicare Circle - Miami-Dade County

H1016, Plan 023 (HMO)

January 1, 2020 - December 31, 2020

This is a summary of health and drug services covered by AvMed Medicare Circle.

AvMed Medicare Circle 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* (EOC) or you may view the EOC online at http://www.avmed.org.

To join AvMed Medicare Circle, 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 county in Florida: Miami-Dade.

As a member you must select an in-network doctor to act as your Primary Care Provider (PCP). Except in emergency situations, if you use providers that are not in our network, we will not pay for these services. Also, if you use pharmacies that are not in our network to obtain prescription drugs, the plan may not pay for those drugs.

You may visit http://www.avmed.org to search for a network provider or pharmacy using the online directories. You can also view the Plan Drug List (Formulary) to see what drugs are covered, and if there are any restrictions.

For coverage and costs of Original Medicare, look in your current *Medicare & You* handbook. View it online at https://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 1-800-535-9355 (TTY users should call 711), or visit us at http://www.avmed.org. From October 1 to March 31, you can call us 7 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. and Saturdays 9:00 a.m. to 1:00 p.m.

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Premiums and Benefits	AvMed Medicare Circle	What You Should Know
Monthly Plan Premium	You pay nothing	You must continue to pay your Medicare Part B premium.
Deductible	You pay nothing	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$6,700 annually	Includes copays and other costs for medical services for the year.
Inpatient Coverage	You Pay $0 copay	Our plan covers an unlimited number of days for an inpatient hospital stay. Requires prior authorization.
Outpatient Hospital Coverage	You pay $175 copay for services at a hospital or hospital-owned facility You pay 20% coinsurance for radiation therapy You pay $15 for substance abuse visits	May require prior authorization.
Ambulatory Surgical Center	You Pay $50 at independent centers	May require prior authorization.
Doctor Visits • Primary • Specialists	You pay $0 copay per PCP visit You pay $0 copay per specialist visit	Referral from your PCP may be required for a specialist visit.
Preventive Care (includes flu and pneumonia vaccine, diabetic screenings, screening mammography)	You pay $0 copay	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care (worldwide)	You pay $90 copay per visit	If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.
Urgently Needed Services	You pay $10 copay per visit	
Diagnostic Services/Labs/ Imaging • Diagnostic radiology service (e.g. MRI) • Lab services • Diagnostic tests and procedures • Outpatient x-rays • PET scans	You pay 0% of the cost You pay $0 copay You pay $0 - $15 copay You pay $0 copay You pay 20% of the cost	Prior authorization is required for some services. Copay may vary based on where you have the test or service performed. Please contact the plan for more information.

Premiums and Benefits	AvMed Medicare Circle	What You Should Know
Hearing Services • Medicare-covered hearing services • Routine hearing exam • Hearing aids	You pay $0 for each Medicare-covered diagnostic hearing exam You pay $0 for a routine hearing exam $600 per ear allowance toward hearing aids each year	
Dental Services • Oral exam • X-rays • Cleaning	You pay $0 - $25 for oral exams You pay $0 - $35 for dental x-rays You pay $0 - $45 for cleanings	Please see Delta Dental information in the *Evidence of Coverage* for additional details. Must use Delta Dental network providers for services to be covered.
Vision Services • Medicare-covered vision services • Eyewear, post-cataract • Routine eye exam • Eyeglasses (frames and lenses) or contact lenses	You pay $0 for Medicare-covered office visits related to vision, including diabetic eye exams You pay $0 for one pair of eyeglasses, post-cataract surgery You pay $0 for routine eye exams/ refraction, one per year $350 eyewear allowance per year	
Mental Health Services • Inpatient • Outpatient group therapy visit • Outpatient individual therapy visit	You pay $150 per day for days 1 - 9 You pay $0 per day for days 10 - 90 You pay $15 outpatient group therapy visit You pay $15 outpatient individual therapy visit	This plan has a 190-day lifetime maximum for inpatient mental health services.
Skilled Nursing Facility (SNF)	You pay $0 per day for days 1- 20 You pay $160 copay per day for days 21-62 You pay $0 per day for days 63 - 100	This plan covers up to 100 days in a SNF per benefit period.
Physical Therapy • Occupational therapy visit • Physical therapy and speech and language therapy visit	You pay $0 copay You pay $0 copay	
Ambulance	You pay $145 copay per one-way trip	

Premiums and Benefits	AvMed Medicare Circle	What You Should Know
Transportation	You pay $0 copay for transportation Up to 20 one-way trips per year	Transportation provided by contracted vendor to plan-approved locations.
Medicare Part B Drugs	You pay 10% - 20% of the cost for chemotherapy drugs You pay 10% - 20% of the cost for other Part B drugs	10% in-office or non-hospital affiliated facility 20% at a hospital or hospital-affiliated facility
Foot Care (podiatry services), including foot exams and treatment Routine foot care	You pay $5 copay You pay $5 copay for routine foot care, one visit every 60 days	
Medical Equipment/Supplies • Durable Medical Equipment (e.g., wheelchairs, oxygen) • Diabetes supplies • Prosthetics (e.g., braces, artificial limbs)	You pay 10% of the cost You pay $0 copay for diabetic supplies You pay $0 copay for prosthetics 20% coinsurance for diabetic shoes/inserts	
Telemedicine / Virtual Visits	You pay $0 for each virtual visit	Please see the *Evidence of Coverage* for additional detail.
Over-the-Counter (OTC) Items	$50 monthly allowance toward the purchase of select OTC items.	Visit our plan website to see our list of covered OTC items.
Wellness Programs • Fitness • Health education • Nursing Hotline	You pay $0 copay	For more information on Wellness Programs, please call us or access our *Evidence of Coverage* online.

Outpatient Prescription Drugs				
This plan does not have a Part D deductible. You pay the following until your total yearly drug costs reach $4,500. Total yearly drug costs are the total drug costs paid by both you and our Part plan.				
Preferred Cost Sharing	**Retail Pharmacy**		**Mail Order**	
	30-day Supply	**90-day Supply**	**30-day Supply**	**90-day Supply**
Tier 1 - Preferred Generic	$0 copay	$0 copay	$0 copay	$0 copay
Tier 2 - Non-Preferred	$0 copay	$0 copay	$0 copay	$0 copay
Tier 3 - Preferred Brand	$15 copay	$37.50 copay	$15 copay	$37.50 copay
Tier 4 - Non-Preferred Brand	$65 copay	$162.50 copay	$65 copay	$162.50 copay
Tier 5 - Specialty Tier	33%	Not offered	Not offered	Not offered

Standard Cost Sharing	**Retail Pharmacy**		**Mail Order**	
	30-day Supply	**90-day Supply**	**30-day Supply**	**90-day Supply**
Tier 1 - Preferred Generic	$0 copay	$0 copay	$0 copay	$0 copay
Tier 2 - Non-Preferred	$10 copay	$25 copay	$10 copay	$30 copay
Tier 3 - Preferred Brand	$25 copay	$62.50 copay	$25 copay	$75 copay
Tier 4 - Non-Preferred Brand	$85 copay	$212.50 copay	$85 copay	$255 copay
Tier 5 - Specialty Tier	33%	Not offered	Not offered	Not offered

Cost-Sharing may change depending on the pharmacy you choose. Amounts shown reflect benefit up until Initial Coverage Limit. For more information on pharmacy specific cost-sharing and the phases of the Part D benefit, please call us or access our *Evidence of Coverage* online at http://www.avmed.org.

Important note: If you are a dual-eligible beneficiary enrolled in both Medicare and Medicaid or are a Qualified Medicare Beneficiary, you may not have to pay the medical costs displayed in this booklet, and your prescription drug costs may also be reduced. Always show your Medicaid ID card in addition to your AvMed ID card to make your provider aware that you may have additional coverage.