AvMed

Embrace better health®

2023 Summary of Benefits

Medicare Advantage Plans with Part D Prescription Drug Coverage

AvMed Medicare Circle (HMO) Broward County
H1016, Plan 024

January 1, 2023 – December 31, 2023

H1016_CE557-082022_M MEDPRF-1170(08/22)

1 SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

The benefit information provided is a summary of what we cover and what you pay. It does not 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 can also see the *Evidence of Coverage* on our website, http://www.avmed.org.

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 **AvMed Medicare Circle (HMO) Broward County**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **AvMed Medicare Circle (HMO) Broward County** 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 https://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 https://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 **AvMed Medicare Circle (HMO) Broward County.**
- 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 1-800-782-8633 TTY: 711.

Things to Know About AvMed Medicare Circle (HMO) Broward County

Hours of Operation & Contact Information

- From October 1 to March 31 we're open 8 a.m. – 8 p.m., 7 days a week.
- From April 1 to September 30, we're open 8 a.m. – 8 p.m., Monday through Friday.
- If you are a member of this plan, call us at 1-800-782-8633, TTY: 711.
- If you are not a member of this plan, call us at 1-800-535-9355, TTY: 711.
- Our website: http://www.avmed.org.

Who can join?

To join **AvMed Medicare Circle (HMO) Broward County**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. Our service area includes this county in Florida: Broward.

Which doctors, hospitals, and pharmacies can I use?

AvMed Medicare Circle (HMO) Broward County 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.avmed.org).

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*. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs including 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.avmed.org.
- 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 any questions about this plan's benefits or costs, please contact AvMed Medicare

2 SECTION II - SUMMARY OF BENEFITS

AvMed Medicare Circle (HMO) Broward County

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	You do not pay a separate monthly plan premium for AvMed Medicare Circle (HMO) Broward County. You must continue to pay your Medicare Part B premium.
Deductible	Medical Deductible: $0 Copay. Prescription Drug Deductible: $0 Copay.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $2,500 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.
COVERED MEDICAL AND HOSPITAL BENEFITS	
Inpatient Hospital	**In-Network:** $0 Copay per stay. May require prior authorization.
Outpatient Hospital	**In-Network:** Outpatient hospital: $100 Copay. Outpatient surgery: $100 Copay. May require prior authorization.
Ambulatory Surgical Center	**In-Network:** Ambulatory Surgical Center: $75 Copay. May require prior authorization.
Doctor's Office Visits	**In-Network:** Primary care physician visit: $0 Copay. Specialist visit: $0 Copay. May require a referral from your doctor to see a specialist.

Preventive Care ***(e.g., flu vaccine, diabetic screenings)***	**In-Network:** $0 Copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	**In-Network:** $75 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. Worldwide Emergency Coverage: $75 Copay.
Urgently Needed Services	**In-Network:** $10 Copay per visit. Worldwide Urgent Coverage: $10 Copay.
Diagnostic Services / Labs/ Imaging	**In-Network:** Diagnostic tests and procedures: $0 - $25 Copay. Lab services: $0 Copay. Diagnostic radiology services (such as MRI, CAT Scan): $25 - $50 Copay. X-rays: $0 - $25 Copay. Therapeutic radiology services (such as radiation treatment for cancer): $0 - $25 Copay. May require prior authorization.
Hearing Services	**In-Network:** Exam to diagnose and treat hearing: $0 Copay. Hearing aid (up to 2 hearing aids every two years): $0 Copay. Hearing aid allowance: $1,500 every two years.
Dental Services	**In-Network:** Preventive dental services: • Oral exam: $0 Copay. • Cleaning (up to 2 visit(s) every year): $0 Copay. • Dental X-rays (up to 1 visit(s) every two years): $0 Copay.

	Comprehensive dental services: • Diagnostic Services: $0 - $147 Copay. • Non-routine Services: $0 Copay. • Restorative Services (up to 2 visit(s) every year): $0 Copay. • Endodontics (up to 1 visit(s) every year): $0 Copay. • Periodontics (up to 1 visit(s) every year): $0 Copay. • Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: (up to 1 visit(s) other, describe): $0 Copay. • Extractions (up to 3 visit(s) every year): $0 Copay. Other Medicare-covered comprehensive services: $0-$100 Copay Please see Delta Dental information in the *Evidence of Coverage* for additional details. Must use Delta Dental network providers for services to be covered. May require prior authorization.
Vision Services	**<u>In-Network:</u>** Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0 Copay. Routine eye exam (up to 1 visit(s) every year): $0 Copay. Eyeglasses or contact lenses after cataract surgery: $0 Copay. Contact lenses: $0 Copay. Eyeglasses (frames and lenses): $0 Copay. Our plan pays up to $450 every year for eyewear. May require a referral from your doctor.

Mental Health Care	**In-Network:** Outpatient group therapy visit: $15 Copay. Individual therapy visit: $15 Copay. Inpatient Mental Health Care: Days 1-9: $150 Copay per day for each admission. Days 10-90: $0 Copay per day. May require prior authorization. May require a referral from your doctor.
Skilled Nursing Facility (SNF)	**In-Network:** Days 1-20: $0 Copay per day. Days 21-62: $135 Copay per day. Days 63-100: $0 Copay per day. May require prior authorization. May require a referral from your doctor.
Outpatient Rehabilitation	**In-Network:** Occupational therapy visit: $0 Copay. Physical therapy and speech and language therapy visit: $0 Copay. May require a referral from your doctor.
Ambulance	**In-Network:** Ground Ambulance: $180 Copay. Air Ambulance: 20% Coinsurance.
Transportation	**In-Network:** $0 Copay.
Medicare Part B Drugs	**In-Network:** For Part B drugs such as chemotherapy drugs: 10% - 20% Coinsurance. Other Part B drugs: 10% - 20% Coinsurance. May require prior authorization.
Foot Care (podiatry services), including foot exams and treatment	**In-Network:** You pay $5 Copay per visit. You pay $5 Copay for routine foot care, one visit every 60 days.

Routine foot care	
Medical Equipment/Supplies • **Durable Medical Equipment (e.g., wheelchairs, oxygen)** • **Prosthetics (e.g., braces, artificial limbs)** • **Diabetes supplies**	**In-Network:** You pay 10% Coinsurance. You pay $0 Copay for prosthetics. You pay 0% Coinsurance for diabetic supplies; 20% Coinsurance for diabetic shoes/ inserts. May require prior authorization.
Telemedicine/Virtual Visits	**In-Network:** You pay $0 Copay for each virtual visit. Please see the *Evidence of Coverage* for additional details. May require prior authorization.
Over-the-Counter (OTC) Items	**In-Network:** $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** • **SilverSneakers®**	**In-Network:** You pay $0 Copay. For more information on Wellness Programs, please call us or access our *Evidence of Coverage* online. May require prior authorization.
Meal Benefit	**In-Network:** You pay $0 Copay. Benefit provides for 10 meals over 5 days post-hospitalization once per year.
Chiropractic Care	**In-Network:** You pay $5 Copay.

<table>
<tr><td>Manual manipulation of the spine to correct subluxation</td><td></td></tr>
<tr><td>Flex Card Benefit - Vision, Dental, Hearing, OTC</td><td>You receive a $75 monthly allowance. Any unused dollars roll over each month and must be used by 12/31/2023.</td></tr>
<tr><td colspan="2">PRESCRIPTION DRUG BENEFITS</td></tr>
<tr><td>Deductible</td><td>Prescription Drug Deductible: $0 Copay.</td></tr>
<tr><td>Initial Coverage</td><td>You pay the following until your total yearly drug costs reach $6,000. Total yearly drug costs are the drug costs paid by both you and our Part D plan.
<table>
<tr><th colspan="3">Standard Retail Cost-Sharing</th></tr>
<tr><th>Tier</th><th>30-day supply</th><th>100-day supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 Copay</td><td>$0 Copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$10 copay</td><td>$25 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$30 copay</td><td>$75 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$100 copay</td><td>$250 copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>33% coinsurance</td><td>Not Applicable</td></tr>
<tr><th colspan="3">Preferred Retail Cost-Sharing</th></tr>
<tr><th>Tier</th><th>30-day supply</th><th>100-day supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 Copay</td><td>$0 Copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$0 Copay</td><td>$0 Copay</td></tr>
</table></td></tr>
</table>

Tier 3 (Preferred Brand)	$10 copay	$25 copay
Tier 4 (Non-Preferred Drug)	$65 copay	$162.50 copay
Tier 5 (Specialty Tier)	33% coinsurance	Not Applicable

Standard Mail Order

Tier	30-day supply	100-day supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$10 copay	$30 copay
Tier 3 (Preferred Brand)	$30 copay	$90 copay
Tier 4 (Non-Preferred Drug)	$100 copay	$300 copay
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable

Preferred Mail Order

Tier	30-day supply	100-day supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$0 Copay	$0 Copay
Tier 3 (Preferred Brand)	$10 copay	$25 copay

<table>
<tr><td></td><td>
<table>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$65 copay</td><td>$162.50 copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>Not Applicable</td><td>Not Applicable</td></tr>
</table>
Your cost-sharing may be different if you use a Long Term Care pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 100 days) of a drug.

Please call us or see the plan's "Evidence of Coverage" on our website (http://www.avmed.org) for complete information about your costs for covered drugs.
</td></tr>
<tr><td>Coverage Gap</td><td>
The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $6,000.

After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $7,400, which is the end of the coverage gap.

Our plan covers Tier 1 Preferred Generics and Tier 2 Generics in the coverage gap.
<table>
<tr><th colspan="2">Standard Retail Cost-Sharing</th></tr>
<tr><th>Tier</th><th>30-day supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 Copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$10 copay</td></tr>
</table>
</td></tr>
<tr><td>Catastrophic Amount</td><td>
After your yearly out-of-pocket drug costs reach $7,400, you pay the greater of:

$4.15 copay for generic (including brand drugs treated as generic) and a $10.35 copayment for all other drugs, or
5% of the cost.

</td></tr>
</table>

DISCLAIMERS

This document is available in other alternate formats.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-800-782-8633 TTY: 711.

ATENCIÓN: Si habla español, hay servicios de traducción, libre de cargos, disponibles para usted. Llame al 1-800-535-9355 TTY: 711.

AvMed Medicare Circle Broward County is a HMO plan with a Medicare contract. Enrollment in **AvMed Medicare Circle Broward County** depends on contract renewal.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat AvMed Medicare members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Member Services number or see your "*Evidence of Coverage*" for more information, including the cost-sharing that applies to out-of-network services.

Cost-Sharing may change depending on the pharmacy you choose. Amounts shown reflect the benefit up until the Initial Coverage Limit. For full information on pharmacy specific cost-sharing (including Long Term Care and home infusion) and the phases of the Part D benefit, please call us or access our *Evidence of Coverage* online at 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.

Health coverage is offered by AvMed, Inc.

THANK YOU

Connect with us

Contact Information : 1-800-782-8633, TTY: 711

Organization Name: AvMed, Inc.

Organization website: www.avmed.org

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-882-8633. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-882-8633. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-882-8633。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-882-8633。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-882-8633. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-882-8633. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-882-8633 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-882-8633. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-882-8633 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-882-8633. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-822-8633. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-882-8633 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-882-8633. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-882-8633. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-882-8633. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-882-8633. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-882-8633 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。