2022 Summary of Benefits

AvMed Medicare Choice - Broward County

H1016, Plan 021 (HMO)

January 1, 2022 - December 31, 2022

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

AvMed Medicare Choice 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 https://www.avmed.org.

To join AvMed Medicare Choice, 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: Broward.

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 https://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), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

This document is available in other formats such as braille, large print and audio.

For more information, please call us at 1-800-535-9355 (TTY users should call 711), or visit us at https://www.avmed.org. From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. and Saturdays 8 a.m. to 12 p.m.

Premiums and Benefits	AvMed Medicare Choice	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)	$3,400 annually	Includes copays and other costs for medical services for the year.
Inpatient Coverage	You pay $0 copay per day for days 1-5 You pay $40 copay per day for days 6-20 You pay $0 copay per day for days 21-90 and beyond	Our plan covers an unlimited number of days for an inpatient hospital stay. Requires prior authorization.
Outpatient Hospital Coverage	You pay $200 copay per visit for services at a hospital or hospital-owned facility	May require prior authorization.
Ambulatory Surgical Center	You pay $75 copay	May require prior authorization.
Doctor Visits • Primary • Specialists	You pay $0 copay per PCP visit You pay $10 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/Urgent Care	You pay $100 copay per visit for emergency care You pay $10 copay per visit for urgent care	If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.
Diagnostic Services/Labs/ Imaging • Diagnostic tests and procedures • Lab services • Diagnostic radiology service (e.g. MRI) • Outpatient x-rays	You pay $5-$25 copay You pay $0 copay You pay $75-$100 copay You pay $5-$25 copay	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 Choice	What You Should Know
Hearing Services • Hearing exam (Medicare-covered hearing services) • Fitting/Evaluation • Hearing aids	You pay $5 copay for each Medicare-covered diagnostic hearing exam You pay $0 copay for fitting/evaluation $1200 allowance per ear toward hearing aids every 2 years	Please see the *Evidence of Coverage* for additional details.
Preventive Dental • Oral exam • Cleaning • X-rays	You pay $0 for oral exams You pay $0 for cleanings You pay $0 for dental x-rays	Please see Delta Dental information in the *Evidence of Coverage* for additional details. Must use Delta Dental network providers for services to be covered.
Comprehensive Dental • Non-routine services • Diagnostic services • Restorative services • Endodontics • Periodontics • Extractions • Prosthodontics, other oral/maxillofacial surgery, other services Other Medicare-covered comprehensive services	You pay $0-$165 for non-routine services You pay $0-$8 for diagnostic services You pay $0-$425 for restorative services; $0 for crowns You pay $22-$535 for endodontics You pay $0-$435 for periodontics You pay $45-$175 for extractions You pay $0-$700 for prosthodontics You pay $10-$200	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 • Routine eye exam • Eyeglasses (frames and lenses) or contact lenses • Eyewear, post-cataract surgery	You pay $0 for Medicare-covered office visits related to vision, including diabetic eye exams You pay $0 for routine eye exams/refraction, one per year $200 eyewear allowance per year You pay $0 for one pair of eyeglasses, post-cataract surgery	
Mental Health Services • Inpatient • Outpatient group therapy visit • Outpatient individual therapy visit	You pay $150 copay per day for days 1 - 9 You pay $0 copay per day for days 10-90 You pay $15 copay per outpatient group therapy visit You pay $15 copay per outpatient individual therapy visit	This plan has a 190-day lifetime maximum for inpatient mental health services.

Premiums and Benefits	AvMed Medicare Choice	What You Should Know
Skilled Nursing Facility (SNF)	You pay $0 copay per day for days 1-20 You pay $135 copay per day for days 21-100	This plan covers up to 100 days in a SNF per benefit period.
Rehabilitation services • Occupational therapy visit • Physical therapy and speech and language therapy visit	You pay $15 copay per visit You pay $20 copay per visit	
Ambulance	You pay $180 copay per one-way trip via ground ambulance	
Transportation	You pay $0 copay for transportation up to 8 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 per visit You pay $5 copay for routine foot care, one visit every 60 days	
Medical Equipment/Supplies • Durable Medical Equipment (e.g., wheelchairs, oxygen) • Prosthetics (e.g., braces, artificial limbs) • Diabetes supplies	You pay 20% of the cost You pay $0 copay for prosthetics You pay $0 copay for diabetic supplies; 20% coinsurance for diabetic shoes/inserts	
Telemedicine/Virtual Visits	You pay $0 copay for each virtual visit	Please see the *Evidence of Coverage* for additional details.
Over-the-Counter (OTC) Items	$25 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®	You pay $0 copay	For more information on Wellness Programs, please call us or access our *Evidence of Coverage* online.
Meal Benefit	You pay $0 copay	Benefit provides for 10 meals over 5 days post-hospitalization once per year.

Outpatient Prescription Drugs

Initial Coverage Phase This plan does not have a Part D deductible. You pay the following until your total yearly drug cost reach $4,500. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.				
Preferred Cost Sharing	**Retail Pharmacy**		**Mail Order**	
	30-day supply	**100-day supply**	**30-day supply**	**100-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	$30 copay	$75 copay	$30 copay	$75 copay
Tier 4 - Non-Preferred Brand	$75 copay	$187.50 copay	$75 copay	$187.50 copay
Tier 5 - Specialty Tier	33%	Not offered	Not offered	Not offered

Standard Cost Sharing	Retail Pharmacy		Mail Order	
	30-day supply	**100-day supply**	**30-day supply**	**100-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	$40 copay	$100 copay	$40 copay	$120 copay
Tier 4 - Non-Preferred Brand	$100 copay	$250 copay	$100 copay	$300 copay
Tier 5 - Specialty Tier	33%	Not offered	Not offered	Not offered

Gap Coverage Phase (After the total drug costs paid by you and the plan reach $4,500, up to the out-of-pocket threshold of $7,050)				
Preferred Cost Sharing	**Retail Pharmacy**		**Mail Order**	
	30-day supply	**100-day supply**	**30-day supply**	**100-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
Standard Cost Sharing	**Retail Pharmacy**		**Mail Order**	
	30-day supply	**100-day supply**	**30-day supply**	**100-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
For all other generic and brand-name drugs, you pay 25%.				

Catastrophic Coverage Phase (When your annual out-of-pocket costs exceed $7,050)	
Generic drugs	$3.95 copay or 5% (whichever costs more)
Brand-name drugs	$9.85 copay or 5% (whichever costs more)

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 https://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.