Medicare Summary of BROWARD COUNTY



AVMED MEDICARE CHOICE a Medicare Advantage Health Maintenance Organization (HMO) by AvMed, Inc. with a Medicare contract January 1, 2015 – December 31, 2015 **BROWARD COUNTY**

Thank you for your interest in AvMed Medicare Choice.

This booklet gives you a summary of what we cover and what you pay. It doesn't 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 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 Choice).

TIPS FOR COMPARING YOUR MEDICARE **CHOICES**

This Summary of Benefits booklet gives you a summary of what AvMed Medicare Choice 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 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 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 Choice
- 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/TDD - 711 or 1-800-955-8771).

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 1-800-782-8633 (TTY/TDD - 711 o 1-800-955-8771). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

THINGS TO KNOW ABOUT AVMED MEDICARE CHOICE

Hours of Operation:

Customer Service Hours for October 1 – February 14: Sunday, Monday, Tuesday, Wednesday,

Thursday, Friday, Saturday, 8:00 a.m. – 8:00 p.m. Eastern Standard Time (EST).

Customer Service Hours for February 15 – September 30: Monday, Tuesday, Wednesday,

Thursday, Friday, 8:00 a.m. – 8:00 p.m.; Saturday 9:00 a.m.-1:00 p.m. EST.

Phone Numbers and Website:

- If you are a member of this plan, call toll-free
 1-800-782-8633 (or locally at 305-671-5437
 x22147). (TTY/TDD 711 or 1-800-955-8771).
- If you are not a member of this plan, call toll-free 1-800-535-9355 (or locally at 305-671-5437 x21003). (TTY/TDD 711 or 1-800-955-8771).
- Our website: www.avmed.org.

Who can join?

To join AvMed Medicare Choice, you must be entitled to Medicare Part A, and/or be enrolled in Medicare Part B, and live in our service area. Our service area includes Broward County, Florida.

Which doctors, hospitals, and pharmacies can I use?

AvMed Medicare Choice 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 (**www.avmed.org**).

Or, call us and we will send you a copy of the provider and pharmacy directory.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers - and more.

 Our plan members get all of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.

For others, you may pay less.

 Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs such as 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, 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.

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

AvMed Medicare Choice is an HMO plan with a Medicare contract. Enrollment in AvMed Medicare Choice depends on contract renewal.

How much is the monthly premium?	\$0 per month. In addition, you must keep paying
now much is the monthly premium:	your Medicare Part B premium.
	your Medicare Part & premium.
How much is the deductible?	This plan does not have a deductible.
Is there any limit on how much I will pay	Yes. Like all Medicare health plans, our plan
for my covered services?	protects you by having yearly limits on your out-
	of-pocket costs for medical and hospital care.
	Your yearly limit(s) in this plan:
	• \$5,000 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.
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Is there a limit on how much the plan	Our plan has a coverage limit every year for
will pay?	certain in-network benefits. Contact us for the
	services that apply.

COVERED MEDICAL AND HOSPITAL BENEFITS

Note: • Services with a ¹ may require prior authorization.

• Services with a ² may require a referral from your doctor.

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OOT ATTENT CARE AND SERVICES				
Acupuncture and Other Alternative Therapies	Not covered			
Ambulance ¹	\$100 copay Copay per one way transport.			
Chiropractic Care ¹	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): \$5 copay			
Dental Services	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): \$0-125 copay, depending on the service			
	Preventive dental services:			
	 Cleaning (for up to 1 every six months): \$0-45 copay, depending on the service 			
	 Dental x-ray(s) (for up to 1): \$0-28 copay, depending on the service 			
	Fluoride treatment: \$20 copay			
	 Oral exam (for up to 1 every six months): \$0-10 copay, depending on the service 			
	Bitewing X-rays (2-4 films) are limited to one set in any 12 consecutive month period.			
Diabetes Supplies and Services ²	Diabetes monitoring supplies: 20% of the cost			
	Diabetes self-management training: You pay nothing			
	Therapeutic shoes or inserts: 20% of the cost			

COVERED MEDICAL AND HOSPITAL BENEFITS (CONTINUED)

OUTPATIENT CARE AND SERVICES (CONTINUED	0)
Diagnostic Tests, Lab and Radiology Services, and X-Rays ^{1,2}	Diagnostic radiology services (such as MRIs, CT scans): \$75-175 copay or 20% of the cost, depending on the service
	Diagnostic tests and procedures: \$0-25 copay, depending on the service
	Lab services: You pay nothing
	Outpatient x-rays: \$25 copay
	Therapeutic radiology services (such as radiation treatment for cancer): \$35-60 copay, depending on the service
	Lower copay will apply for procedures performed in non-hospital affiliated facilities.
Doctor's Office Visits ²	Primary care physician visit: You pay nothing
	Specialist visit: \$10-30 copay, depending on the service
	Lower copay will apply when utilizing AvMed High Performance Network (HPN) providers.
	Additional information can be found in the AvMed 2015 Provider and Pharmacy Directory or in the 2015 Evidence of Coverage.
Durable Medical Equipment	20% of the cost
(wheelchairs, oxygen, etc.) ¹	

COVERED MEDICAL AND HOSPITAL BENEFITS (CONTINUED)				
OUTPATIENT CARE AND SERVICES (CONTINUED	0)			
Emergency Care \$65 copay				
	If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.			
	See the "Inpatient Hospital Care" section of this booklet for other costs.			
Foot Care (podiatry services)	Foot exams and treatment if you have diabetes- related nerve damage and/or meet certain conditions: \$5 copay			
	Routine foot care (for up to 1 visit(s)): \$5 copay			
	One visit every 60 days for routine foot care in addition to Original Medicare benefits.			
Hearing Services ²	Exam to diagnose and treat hearing and balance issues: \$5 copay			
Home Health Care ^{1,2}	You pay nothing			
Mental Health Care ^{1,2}	Inpatient visit:			
	Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit applies to inpatient mental services provided in a general hospital.			
	Our plan covers 90 days for an inpatient hospital stay.			
	Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. • \$150 copay per day for days 1 through 9 • You pay nothing per day for days 10 through 90 Outpatient group therapy visit: \$15 copay Outpatient individual therapy visit: \$15 copay			

COVERED MEDICAL AND HOSPITAL BENEFITS (CONTINUED)				
OUTPATIENT CARE AND SERVICES (CONTINUED)				
Outpatient Rehabilitation ^{1,2}	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): \$10 copay Occupational therapy visit: \$10 copay Physical therapy and speech and language therapy visit: \$10 copay			
Outpatient Substance Abuse ^{1,2}	Group therapy visit: \$15 copay Individual therapy visit: \$15 copay			
Outpatient Surgery ^{1,2}	Ambulatory surgical center: \$75-150 copay, depending on the service			
	Outpatient hospital: \$75-150 copay, depending on the service			
Over-the-Counter Items	Not covered			
Prosthetic Devices (braces, artificial limbs, etc.)	Prosthetic devices: You pay nothing Related medical supplies: You pay nothing			
Renal Dialysis ^{1,2}	20% of the cost			
Transportation	Not covered			
Urgent Care	\$25 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgent care. See the "Inpatient Hospital Care" section of this booklet for other costs.			
Vision Services ^{1,2}	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$5 copay Routine eye exam (for up to 1 every year): \$5 copay Contact lenses (for up to 1 every year): You pay nothing Eyeglasses (frames and lenses) (for up to 1 every year): You pay nothing.			

COVERED MEDICAL AND HOSPITAL BENEFITS (CONTINUED)

Vision Services^{1,2} (continued)

Eyeglasses or contact lenses after cataract surgery: You pay nothing

Our plan pays up to \$100 every year for contact lenses and eyeglasses (frames and lenses).

AvMed Medicare Choice provides a \$100 annual allowance toward one pair of eyeglasses with standard frames or contact lenses, in addition to Original Medicare coverage.

Eye exams performed by optometrists do not require a referral. However, referrals are required for eye exams performed by an ophthalmologist.

PREVENTIVE CARE

You pay nothing.

Our plan covers many preventive services, including:

- Abdominal aortic aneurysm screening
- Alcohol misuse counseling
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular screenings
- Cervical and vaginal cancer screening
- Colonoscopy
- Colorectal cancer screenings
- Depression screening
- Diabetes screenings
- Fecal occult blood test
- Flexible sigmoidoscopy
- HIV screening
- Medical nutrition therapy services
- Obesity screening and counseling

COVERED MEDICAL AND HOSPITAL BENEFITS (CONTINUED)

PREVENTIVE CARE (CONTINUED)				
	Prostate cancer screenings (PSA)			
	 Sexually transmitted infections screening and counseling 			
	 Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) 			
	 Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots 			
	"Welcome to Medicare" preventive visit (one-time)			
	Yearly "Wellness" visit			
	Any additional preventive services approved by Medicare during the contract year will be			

HOSPICE

You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.

covered.

Inpatient Care				
Inpatient Hospital Care ¹	Our plan covers an unlimited number of days for an inpatient hospital stay. • You pay nothing per day for days 1 through 5 • \$80 copay per day for days 6 through 20 • You pay nothing per day for days 21 through 90 • You pay nothing per day for days 91 and beyond			
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.			
Skilled Nursing Facility (SNF) ^{1,2}	 Our plan covers up to 100 days in a SNF. You pay nothing per day for days 1 through 20 \$135 copay per day for days 21 through 100 			

PRESCRIPTION DRUG BENEFITS						
How much do I pay?		For Part B drugs such as c 10-20% of the cost depe				
		Other Part B drugs ¹ : 10-20				
		depending on the drug				
Initial Coverage		You pay the following until your total yearly drug costs reach \$3,000. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.				
Standard Retail Cost-Sharing						
TIER	One-Month Supply	Two-Month Supply	Three-Month Supply			
Tier 1 (Preferred Generic)	\$0	\$0	\$0			
Tier 2 (Non-Preferred Generic)	\$7	\$14	\$21			
Tier 3 (Preferred Brand)	\$35 copay	\$70 copay	\$105 copay			
Tier 4 (Non-Preferred Brand)	\$70 copay	\$140 copay	\$210 copay			
Tier 5 (Specialty Tier)	33% of the co	st Not offered	Not offered			
Standard Mail Order Cost-Shari	ing					
TIER	Three-Month Տսլ	pply				
Tier 1 (Preferred Generic)	\$0					
Tier 2 (Non-Preferred Generic)	\$21		_			
Tier 3 (Preferred Brand)	\$105 copay					
Tier 4 (Non-Preferred Brand)	\$210 copay					

PRESCRIPTION	DRUG E	BENEFITS ((CONTINUE	D)
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Initial Coverage (continued)

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

COVERAGE GAP

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$3,000.

After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 65% of the plan's cost for covered generic drugs until your costs total \$4,700, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.

Standard Retail Cost-Sharing						
TIER	Drugs Covered	One-Month Supply	Two-Month Supply	Three-Month Supply		
Tier 1 (Preferred Generic	All :)	\$0	\$0	\$0		
Tier 2 (Non-Preferred Generic)	All	\$7 co-pay	\$14 co-pay	\$21 co-pay		
Standard Mail Order Cost-Sharing						
TIER		Drugs Covered	Three-Month Supply			
Tier 1 (Preferred Generic)		All	\$0			
Tier 2 (Non-Preferred Generic)		All	\$21 co-pay			

PRESCRIPTION DRUG BENEFITS (CONTINUED)

CATASTROPHIC COVERAGE

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,700, you pay the greater of:

- 5% of the cost, or
- \$2.65 copay for generic (including brand drugs treated as generic) and a \$6.60 copayment for all other drugs.



