

**AvMed Health Plans**  
**2012 Medicare Choice Benefit Summary**  
**Miami-Dade County and Broward County – Provider Copy**  
(not for distribution to members)

**Effective January 1, 2012:**

<b>Benefit</b>	<b>AvMed Medicare Choice HMO</b> (Co-payments unless otherwise stated)
<i>Out of Pocket Maximum</i>	<ul style="list-style-type: none"> <li>• \$3400 – Once member reaches \$3400 out of pocket for Medicare Part A and Part B covered services, member pays \$0 for the remainder of the year.</li> </ul>
<i>Doctor Visits and Other Services</i>	<ul style="list-style-type: none"> <li>• \$0 per office visit for Primary Care doctor visit for Medicare-covered benefits.</li> <li>• *\$0-\$25 per visit for all Specialists with the following exceptions:</li> <li>• Cataract Surgery (Facility co-pay applies).</li> </ul> <p>* A Member’s co-payment is zero (\$0) if you have been awarded AvMed Health Plan’s “High Performance Network Designation”. High Performance providers are communicated to our members in the online directory and other member materials by way of this symbol (▲). Please access the online provider directory to view your unique network designation.</p>
<i>Chiropractic Services</i>	<ul style="list-style-type: none"> <li>• \$5 per visit for Medicare-covered benefits (Manual manipulation of the spine to correct a displacement or misalignment of a joint or body part).</li> </ul>
<i>Preventive Services and Wellness/Education Programs</i>	<ul style="list-style-type: none"> <li>• \$0 co-pay for all preventive services covered under Original Medicare at zero cost sharing: <ul style="list-style-type: none"> <li>• Abdominal Aortic Aneurysm Screening</li> <li>• Bone Mass Measurement</li> <li>• Cardiovascular Screening</li> <li>• Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam)</li> <li>• Colorectal Cancer Screening</li> <li>• Diabetes Screening</li> <li>• Influenza Vaccine</li> <li>• Hepatitis B Vaccine</li> <li>• HIV Screening</li> <li>• Breast Cancer Screening (Mammogram)</li> <li>• Medical Nutrition Therapy Services</li> <li>• Personalized Prevention Plan Services (Annual Wellness Visits)</li> <li>• Pneumococcal Vaccine</li> <li>• Prostate Cancer Screening (Prostate-Specific Antigen (PSA) test only)</li> <li>• Smoking Cessation (Counseling to Stop Smoking)</li> <li>• Welcome to Medicare Physical Exam (Initial Preventive Physical Exam)</li> </ul> </li> </ul>
<i>Cardiac and Pulmonary Rehabilitation Services</i>	<ul style="list-style-type: none"> <li>• \$5 for each Medicare-covered cardiac, intensive and pulmonary rehabilitation services.</li> </ul>
<i>Kidney Disease and Conditions</i>	<ul style="list-style-type: none"> <li>• 20% of the cost for renal dialysis.</li> <li>• \$0 co-pay for kidney disease education services.</li> </ul>
<i>Ambulance Services</i>	<ul style="list-style-type: none"> <li>• \$100 co-pay applies per each one way trip.</li> </ul>

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<p><i>Diabetes Self-Monitoring Training /Supplies</i>  (includes coverage for glucose monitors, test strips, lancets, screening tests, self-management training, retinal exam/glaucoma test, and foot exam/therapeutic soft shoes)</p>	<ul style="list-style-type: none"> <li>• \$0 for a Primary Care physician office visit for diabetes self-monitoring training.</li> <li>• 20% of the cost for therapeutic shoes or inserts.</li> <li>• 20% of the cost for Diabetes supplies.</li> <li>• Separate office visit cost sharing of \$0 to \$25 may apply.</li> </ul>
<p><i>Vision Services</i></p>	<ul style="list-style-type: none"> <li>• \$10 for Medicare-covered eyewear (one pair of eyeglasses or contact lenses after each cataract surgery).</li> <li>• \$5 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye).</li> <li>• \$5 for each Routine eye exam.</li> <li>• In addition to regular Medicare-covered eyewear, one (1) pair of glasses each year for a \$10 co-payment on selected eyewear.</li> </ul>
<p><i>Hearing Services</i></p>	<ul style="list-style-type: none"> <li>• \$5 for each Medicare-covered hearing exam (diagnostic hearing exam).</li> </ul>
<p><i>Podiatry Services</i></p>	<ul style="list-style-type: none"> <li>• \$5 for each Medicare-covered (medically necessary foot care) visit.</li> <li>• \$5 per visit for routine foot care, up to 1 visit(s).</li> </ul>
<p><i>Dental Services</i></p>	<ul style="list-style-type: none"> <li>• \$5 co-pay for Medicare covered dental benefits.</li> <li>• \$0 to \$20 for oral exams for oral exams.</li> <li>• \$0 to \$45 co-pay for cleanings</li> <li>• \$0 to \$35 co-pay for up to 1 dental x-ray(s)</li> <li>• Plan offers additional comprehensive dental benefits.</li> </ul>

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<b><i>Outpatient Prescription Drugs</i></b>	<p>Drugs covered under Medicare Part B (General)</p> <ul style="list-style-type: none"> <li>• 20% of the cost for Part B covered chemotherapy drugs and other Part B covered drugs</li> </ul> <p>Drugs covered under Medicare Part D</p> <ul style="list-style-type: none"> <li>• \$0 co-payment for a one-month (30 day) supply of Generic drugs at an in-network pharmacy.</li> <li>• \$20 co-payment for a one-month (30 day) supply of Preferred Brand drugs at an in-network pharmacy.</li> <li>• \$50 co-payment for a one-month (30 day) supply of Non-Preferred Brand drugs at an in-network pharmacy.</li> <li>• 33% co-insurance for a one-month (30 day) supply of Specialty drugs at an in-network pharmacy.</li> <li>• Specialty drugs are not available via mail order.</li> <li>• \$0 co-payment for a three-month (90 day) supply or mail order supply at an in-network pharmacy of Generic drugs.</li> <li>• \$60 co-payment for a three-month (90 day) supply or mail order supply at an in-network pharmacy of Preferred Brand drugs.</li> <li>• \$150 co-payment for a three-month (90 day) supply or mail order supply at an in-network pharmacy of Non-Preferred Brand drugs.</li> <li>• After the total yearly drug costs (paid by both member and plan) reach \$4,000, member pays \$0 co-payment for Generic drugs and 50% of the cost for most Brands.</li> <li>• After yearly out-of-pocket drug costs reach \$4,700 member pays the greater of:  -\$2.50 for Generic drug or a drug that is treated like a generic and \$6.30 for all other drugs, or  -5% coinsurance.</li> <li>• Certain prescription drugs will have maximum quantity limits.</li> <li>• Prior authorization from AvMed may be required for certain prescription drugs.</li> </ul>

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<b>Facility Benefits</b>	
<b><i>Inpatient Hospital Care</i></b> <i>(Includes substance abuse and rehabilitation services)</i>	<ul style="list-style-type: none"> <li>• \$0 per day, Days 1 - 5.</li> <li>• \$100 per day, Days 6 – 23</li> <li>• \$0 per day, Days 24 – 90</li> <li>• \$0 co-pay for each additional hospital day.</li> </ul>
<b><i>Inpatient Mental Health Care</i></b>	<ul style="list-style-type: none"> <li>• \$150 per day, Days 1 – 10</li> <li>• \$0 per day, Days 11 - 90</li> <li>• There is a lifetime limit of 190 days in a psychiatric hospital.</li> </ul>
<b><i>Outpatient Mental Health Care</i></b>	<ul style="list-style-type: none"> <li>• \$15 co-pay for Medicare-covered Mental Health visit(s).</li> <li>•</li> </ul>
<b><i>Outpatient Substance Abuse</i></b>	<ul style="list-style-type: none"> <li>• \$15 co-pay for Medicare-covered Substance Abuse visit(s).</li> </ul>
<b><i>Skilled Nursing Facility</i></b>	<ul style="list-style-type: none"> <li>• \$0 per day for days 1 through 20,</li> <li>• \$135 per day for days 21 through 100.</li> <li>• There is a limit of 100 days for each benefit period.</li> </ul>
<b><i>Home Health Care</i></b>	<ul style="list-style-type: none"> <li>• \$0 for Medicare-covered home health visits.</li> </ul>
<b><i>Emergency</i></b>	<ul style="list-style-type: none"> <li>• \$65 for each emergency room visit; member does not pay this amount if admitted to the hospital within 24 hours for the same condition. Worldwide coverage.</li> </ul>
<b><i>Urgent Care Center</i></b>	<ul style="list-style-type: none"> <li>• \$25 for each urgently needed care visit at an Urgent Care Center; member does not pay this amount if admitted to the hospital within 24 hours for the same condition.</li> </ul>
<b><i>Outpatient Services/Surgery</i></b>	<ul style="list-style-type: none"> <li>• \$25 co-pay for each Medicare covered service in a non-hospital affiliated ambulatory surgical center.</li> <li>• \$100 co-pay for each Medicare covered service hospital affiliated ambulatory surgery center and outpatient hospital visit.</li> </ul>
<b><i>Diagnostic Tests, X-Rays, and Lab Services</i></b>	<ul style="list-style-type: none"> <li>• Member is responsible for the office visit co-payment when services are performed in an office setting. No additional co-payment applies when services are performed in the doctor’s office. The following co-payment applies for diagnostic services performed in a facility setting: <ul style="list-style-type: none"> <li>• \$100 for “each” complex outpatient diagnostic test for CT, MRI, MRA and Nuclear Cardiac Imaging studies. (requires prior authorization)</li> <li>• \$25 for Medicare covered simple outpatient diagnostic test.</li> <li>• \$50 for each course of Medicare covered radiation therapy (requires prior authorization)</li> <li>• 20% of the cost for PET scans (requires prior authorization).</li> <li>• \$0 for Medicare covered preventive diagnostic tests</li> <li>• \$0 for Medicare covered lab services.</li> </ul> </li> </ul>
<b><i>DME</i></b>	<ul style="list-style-type: none"> <li>• 20% of the cost for Medicare covered items.</li> </ul>
<b><i>Prosthetic Devices</i></b>	<ul style="list-style-type: none"> <li>• \$0 for Medicare-covered items.</li> </ul>
<b><i>Outpatient Rehabilitation Services</i></b>	<ul style="list-style-type: none"> <li>• \$5 for Medicare-covered Occupational, Physical and/or Speech/Language Therapy visits.</li> </ul>
<b><i>Hospice</i></b>	<ul style="list-style-type: none"> <li>• Hospice covered by Medicare.</li> </ul>

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