



## **Summary of Benefits**

**AvMed Premier Care  
January 1, 2010 - December 31, 2010  
Miami-Dade County**

*AvMed is a Medicare Advantage organization with a Medicare contract*

**Introduction to the Summary of Benefits**  
**For AVMED PREMIER CARE (HMO)**  
**January 1, 2010 – December 31, 2010**  
**MIAMI-DADE COUNTY**

---

Thank you for your interest in AvMed Premier Care (HMO). Our plan is offered by AVMED, INC/AvMed Medicare Preferred, a Medicare Advantage Health Maintenance Organization (HMO). This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call AvMed Premier Care (HMO) and ask for the "Evidence of Coverage".

### [YOU HAVE CHOICES IN YOUR HEALTH CARE](#)

---

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like AvMed Premier Care (HMO). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call AvMed Premier Care (HMO) at the telephone number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

### [HOW CAN I COMPARE MY OPTIONS?](#)

---

You can compare AvMed Premier Care (HMO) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

### [WHERE IS AVMED PREMIER CARE \(HMO\) AVAILABLE?](#)

---

The service area for this plan includes: Miami-Dade County, FL. You must live in this area to join the plan.

### [WHO IS ELIGIBLE TO JOIN AVMED PREMIER CARE \(HMO\)?](#)

---

You can join AvMed Premier Care (HMO) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease are generally not eligible to enroll in AvMed Premier Care (HMO) unless they are members of our organization and have been since their dialysis began.

### [CAN I CHOOSE MY DOCTORS?](#)

---

AvMed Premier Care (HMO) has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory or for an up-to-date list visit us at [www.avmed.org](http://www.avmed.org). Our customer service number is listed at the end of this introduction.

### [WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?](#)

---

If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither AvMed Premier Care (HMO) nor the Original Medicare Plan will pay for these services.

**Introduction to the Summary of Benefits  
For AVMED PREMIER CARE (HMO)  
January 1, 2010 – December 31, 2010  
MIAMI-DADE COUNTY**

---

**DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?**

---

AvMed Premier Care (HMO) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

**WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?**

---

AvMed Premier Care (HMO) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at <http://www.avmed.org/medicare/drug-list.asp>. Our customer service number is listed at the end of this introduction.

**WHAT IS A PRESCRIPTION DRUG FORMULARY?**

---

AvMed Premier Care (HMO) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at <http://www.avmed.org/medicare/drug-list.asp>.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

**HOW CAN I GET EXTRA HELP WITH MY PRESCRIPTION DRUG PLAN COSTS?**

---

You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week;
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or
- Your State Medicaid Office.

**WHAT ARE MY PROTECTIONS IN THIS PLAN?**

---

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 60 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of AvMed Premier Care (HMO), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you

**Introduction to the Summary of Benefits  
For AVMED PREMIER CARE (HMO)  
January 1, 2010 – December 31, 2010  
MIAMI-DADE COUNTY**

---

have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Florida Medical Quality Assurance, Inc. (FMQAI) at 1-800-844-0795.

As a member of AvMed Premier Care (HMO), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Florida Medical Quality Assurance, Inc. (FMQAI) at 1-800-844-0795.

#### **WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?**

---

A Medication Therapy Management (MTM) Program is a free service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact AvMed Premier Care (HMO) for more details.

#### **WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?**

---

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact AvMed Premier Care (HMO) for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin Alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia. --Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.

**Introduction to the Summary of Benefits**  
**For AVMED PREMIER CARE (HMO)**  
**January 1, 2010 – December 31, 2010**  
**MIAMI-DADE COUNTY**

---

- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and Infusion Drugs provided through DME.

**PLAN RATINGS**

---

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on [www.medicare.gov](http://www.medicare.gov) and select “Compare Medicare Prescription Drug Plans” or “Compare Health Plans and Medigap Policies in Your Area” to compare the plan ratings for Medicare plans in your area. You can also call us directly at (800)-782-8633 to obtain a copy of the plan ratings for this plan. TTY users call (877)-442-8633).

Please call AvMed Medicare Preferred for more information about AvMed Premier Care (HMO).

Visit us at [www.avmed.org](http://www.avmed.org) or, call us:

Customer Service Hours: Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday,  
Open 24 Hours Eastern

Current members should call toll-free (800)-782-8633 for questions related to the Medicare Advantage Program. (TTY/TDD (877)-442-8633 )

Prospective members should call toll-free (800)-535-9355 for questions related to the Medicare Advantage Program. (TTY/TDD (877)-442-8633 )

Current members should call locally (305)-671-5437 ext. 22147 for questions related to the Medicare Advantage Program. (TTY/TDD (877)-442-8633 )

Prospective members should call locally (305)-671-5437 ext. 21003 for questions related to the Medicare Advantage Program. (TTY/TDD (877)-442-8633 )

Current members should call toll-free (800)-782-8633 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (877)-442-8633 )

Prospective members should call toll-free (800)-535-9355 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (877)-442-8633 )

Current members should call locally (305)-671-5437 ext. 22147 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (877)-442-8633 )

Prospective members should call locally (305)-671-5437 ext. 21003 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (877)-442-8633 )

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227).

TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Or, visit [www.medicare.gov](http://www.medicare.gov) on the web.

**Summary of Benefits  
AvMed Premier Care (HMO) Miami-Dade County  
2010**

Benefit Category	Original Medicare	AvMed Premier Care (HMO)
------------------	-------------------	--------------------------

**IMPORTANT INFORMATION**

**1 - Premium and Other Important Information**

In 2009 the monthly Part B Premium was \$96.40 and will change for 2010 and the yearly Part B deductible amount was \$135 and will change for 2010.

If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.

Most people will pay the standard monthly Part B premium. However, starting January 1, 2010, some people will pay a higher premium because of their yearly income. (For 2009, this amount was \$85,000 for singles, \$170,000 for married couples. This amount may change for 2010.) For more information about Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

**General**

\$0 monthly plan premium in addition to your monthly Medicare Part B premium.

**In-Network**

\$3,400 out-of-pocket limit.

This limit includes only Medicare-covered services.

**2 - Doctor and Hospital Choice**

(For more information, see Emergency - #15 and Urgently Needed Care - #16.)

You may go to any doctor, specialist or hospital that accepts Medicare.

**In-Network**

You must go to network doctors, specialists, and hospitals.

Referral required for network hospitals and specialists (for certain benefits).

**SUMMARY OF BENEFITS**

**INPATIENT CARE**

**3 - Inpatient Hospital Care**

(includes Substance Abuse and Rehabilitation Services)

In 2009 the amounts for each benefit period were:

Days 1 - 60: \$1068 deductible

Days 61 - 90: \$267 per day

Days 91 - 150: \$534 per lifetime reserve day

These amounts will change for 2010.

**In-Network**

For Medicare-covered hospital stays:

Days 1 - 3: \$0 copay per day

Days 4 - 23: \$100 copay per day

Days 24 - 90: \$0 copay per day

\$0 copay for each additional hospital day.

**Summary of Benefits**  
**AvMed Premier Care (HMO) Miami-Dade County**  
**2010**

Benefit Category	Original Medicare	AvMed Premier Care (HMO)
<b>3 - Inpatient Hospital Care, continued</b>	<p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</p> <p>A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p>No limit to the number of days covered by the plan each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
<b>4 - Inpatient Mental Health Care</b>	<p>Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above).</p> <p>190 day lifetime limit in a Psychiatric Hospital.</p>	<p><b>In-Network</b></p> <p>For Medicare-covered hospital stays:  Days 1 - 10: \$100 copay per day  Days 11 - 90: \$0 copay per day</p> <p>Plan covers 60 lifetime reserve days.  Cost per lifetime reserve day:  Days 1 - 10: \$100 copay per day  Days 11 - 60: \$0 copay per day</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
<b>5 - Skilled Nursing Facility (SNF)</b> (in a Medicare-certified skilled nursing facility)	<p>In 2009 the amounts for each benefit period after at least a 3-day covered hospital stay were:  Days 1 - 20: \$0 per day  Days 21 - 100: \$133.50 per day  These amounts will change for 2010.  100 days for each benefit period.  A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care.</p>	<p><b>General</b></p> <p>Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>For SNF stays:  Days 1 - 20: \$0 copay per day  Days 21 - 100: \$133.50 copay per day</p> <p>Plan covers up to 100 days each benefit period</p> <p>No prior hospital stay is required.</p>

**Summary of Benefits**  
**AvMed Premier Care (HMO) Miami-Dade County**  
**2010**

Benefit Category	Original Medicare	AvMed Premier Care (HMO)
<b>5 - Skilled Nursing Facility (SNF), continued</b>	If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	
<b>6 - Home Health Care</b> (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	\$0 copay.	<p><b>General</b></p> <p>Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>\$0 copay for Medicare-covered home health visits.</p>
<b>7 - Hospice</b>	<p>You pay part of the cost for outpatient drugs and inpatient respite care.</p> <p>You must get care from a Medicare-certified hospice.</p>	<p><b>General</b></p> <p>You must get care from a Medicare-certified hospice.</p>
<b>OUTPATIENT CARE</b>		
<b>8 - Doctor Office Visits</b>	20% coinsurance	<p><b>General</b></p> <p>See "Physical Exams," for more information.</p> <p><b>In-Network</b></p> <p>\$0 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$25 copay for each in-area, network urgent care Medicare-covered visit.</p> <p>\$5 copay for each specialist visit for Medicare-covered benefits.</p>
<b>9 - Chiropractic Services</b>	<p>Routine care not covered</p> <p>20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>	<p><b>In-Network</b></p> <p>\$5 copay for each Medicare-covered visit.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>

**Summary of Benefits**  
**AvMed Premier Care (HMO) Miami-Dade County**  
**2010**

Benefit Category	Original Medicare	AvMed Premier Care (HMO)
<b>10 - Podiatry Services</b>	Routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	<b>In-Network</b> \$5 copay for each Medicare-covered visit. \$5 copay for up to 1 routine visit(s) Medicare-covered podiatry benefits are for medically-necessary foot care.
<b>11 - Outpatient Mental Health Care</b>	45% coinsurance for most outpatient mental health services.	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$5 copay for each Medicare-covered individual or group therapy visit.
<b>12 - Outpatient Substance Abuse Care</b>	20% coinsurance	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$5 copay for Medicare-covered individual or group visit.
<b>13 - Outpatient Services/Surgery</b>	20% coinsurance for the doctor 20% of outpatient facility charges	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$0 copay for each Medicare-covered ambulatory surgical center visit. \$100 copay for each Medicare-covered outpatient hospital facility visit.
<b>14 - Ambulance Services</b> (medically necessary ambulance services)	20% coinsurance	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$75 copay for Medicare-covered ambulance benefits.

**Summary of Benefits**  
**AvMed Premier Care (HMO) Miami-Dade County**  
**2010**

Benefit Category	Original Medicare	AvMed Premier Care (HMO)
<p><b>15 - Emergency Care</b>            (You may go to any emergency room if you reasonably believe you need emergency care.)</p>	<p>20% coinsurance for the doctor</p> <p>20% of facility charge, or a set copay per emergency room visit</p> <p>You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p><b>General</b></p> <p>\$50 copay for Medicare-covered emergency room visits.</p> <p>Worldwide coverage.</p> <p>If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit</p>
<p><b>16 - Urgently Needed Care</b>            (This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>20% coinsurance, or a set copay</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p><b>General</b></p> <p>\$25 copay for Medicare-covered urgently needed care visits.</p> <p>If you are admitted to the hospital within 24-hour(s) for the same condition, \$0 for the urgent-care visit.</p>
<p><b>17 - Outpatient Rehabilitation Services</b>            (Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p>	<p>20% coinsurance</p>	<p><b>In-Network</b></p> <p>\$5 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$5 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.</p>
<p><b>OUTPATIENT MEDICAL SERVICES AND SUPPLIES</b></p>		
<p><b>18 - Durable Medical Equipment</b>            (includes wheelchairs, oxygen, etc.)</p>	<p>20% coinsurance</p>	<p><b>In-Network</b></p> <p>\$0 copay for Medicare-covered items.</p>
<p><b>19 - Prosthetic Devices</b>            (includes braces, artificial limbs and eyes, etc.)</p>	<p>20% coinsurance</p>	<p><b>In-Network</b></p> <p>\$0 copay for Medicare-covered items.</p>

**Summary of Benefits**  
**AvMed Premier Care (HMO) Miami-Dade County**  
**2010**

Benefit Category	Original Medicare	AvMed Premier Care (HMO)
<p><b>20 - Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies</b>            (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)</p>	<p>20% coinsurance</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p><b>In-Network</b></p> <p>\$0 to \$5 copay for Diabetes self-monitoring training.</p> <p>\$0 to \$5 copay for Nutrition Therapy for Diabetes.</p> <p>\$0 to \$20 copay for Diabetes supplies.</p>
<p><b>21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services</b></p>	<p>20% coinsurance for diagnostic tests and x-rays</p> <p>\$0 copay for Medicare-covered lab services</p> <p>Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.</p>	<p><b>General</b></p> <p>Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>\$0 copay for Medicare-covered lab services.</p> <p>\$25 to \$100 copay [or 20% of the cost] for Medicare-covered diagnostic procedures and tests.</p> <p>\$25 copay for Medicare-covered X-rays.</p> <p>\$25 to \$100 copay [or 20% of the cost] for Medicare-covered diagnostic radiology services.</p> <p>\$25 to \$100 copay [or 20% of the cost] for Medicare-covered therapeutic radiology services.</p>
<p><b>PREVENTIVE SERVICES</b></p>		
<p><b>22 - Bone Mass Measurement</b>            (for people with Medicare who are at risk)</p>	<p>20% coinsurance</p> <p>Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.</p>	<p><b>In-Network</b></p> <p>\$0 copay for Medicare-covered bone mass measurement</p>
<p><b>23 - Colorectal Screening Exams</b>            (for people with Medicare age 50 and older)</p>	<p>20% coinsurance</p> <p>Covered when you are high risk or when you are age 50 and older.</p>	<p><b>In-Network</b></p> <p>\$0 copay for Medicare-covered colorectal screenings</p> <p>up to 1 additional screening (s) every year</p>

**Summary of Benefits**  
**AvMed Premier Care (HMO) Miami-Dade County**  
**2010**

Benefit Category	Original Medicare	AvMed Premier Care (HMO)
<p><b>24 - Immunizations</b>            (Flu vaccine, Hepatitis B vaccine -for people with Medicare who are at risk, Pneumonia vaccine)</p>	<p>\$0 copay for Flu and Pneumonia vaccines</p> <p>20% coinsurance for Hepatitis B vaccine</p> <p>You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.</p>	<p><b>In-Network</b></p> <p>\$0 copay for Flu and Pneumonia vaccines.</p> <p>\$0 copay for Hepatitis B vaccine.</p> <p>No referral needed for Flu and pneumonia vaccines.</p>
<p><b>25 - Mammograms (Annual Screening)</b>            (for women with Medicare age 40 and older)</p>	<p>20% coinsurance</p> <p>No referral needed.</p> <p>Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.</p>	<p><b>In-Network</b></p> <p>\$0 copay for Medicare-covered screening mammograms</p>
<p><b>25 - Mammograms (Annual Screening), continued</b></p>	<p>up to 1 additional screening mammogram(s) every year</p>	<p>up to 1 additional screening mammogram(s) every year</p>
<p><b>26 - Pap Smears and Pelvic Exams</b>            (for women with Medicare)</p>	<p>\$0 copay for Pap smears</p> <p>Covered once every 2 years. Covered once a year for women with Medicare at high risk.</p> <p>20% coinsurance for Pelvic Exams</p>	<p><b>In-Network</b></p> <p>\$0 copay for Medicare-covered pap smears and pelvic exams</p> <p>up to 1 additional pap smear(s) and pelvic exam(s) every year</p>
<p><b>27 - Prostate Cancer Screening Exams</b>            (for men with Medicare age 50 and older)</p>	<p>20% coinsurance for the digital rectal exam.</p> <p>\$0 for the PSA test; 20% coinsurance for other related services.</p> <p>Covered once a year for all men with Medicare over age 50.</p>	<p><b>In-Network</b></p> <p>\$0 copay for Medicare-covered prostate cancer screening</p>
<p><b>28 - End-Stage Renal Disease</b></p>	<p>20% coinsurance for renal dialysis</p> <p>20% coinsurance for Nutrition Therapy for End-Stage Renal Disease</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p><b>General</b></p> <p>Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>20% of the cost for renal dialysis</p> <p>\$0 to \$5 copay for Nutrition Therapy for End-Stage Renal Disease.</p>

**Summary of Benefits  
AvMed Premier Care (HMO) Miami-Dade County  
2010**

<b>Benefit Category</b>	<b>Original Medicare</b>	<b>AvMed Premier Care (HMO)</b>
<b>29 - Prescription Drugs</b>	<p>Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p>	<p><b>Drugs covered under Medicare Part B</b></p> <p><b>General</b></p> <p>20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs</p> <p><b>Drugs Covered under Medicare Part D</b></p> <p><b>General</b></p> <p>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at <a href="http://www.avmed.org/medicare/drug-list.asp">http://www.avmed.org/medicare/drug-list.asp</a> on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> <li>-have limited incomes,</li> <li>-live in long term care facilities, or</li> <li>-have access to Indian/Tribal/Urban (Indian Health Service).</li> </ul> <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from AvMed Premier Care (HMO) for certain drugs.</p>

**Summary of Benefits  
AvMed Premier Care (HMO) Miami-Dade County  
2010**

Benefit Category	Original Medicare	AvMed Premier Care (HMO)
<b>29 - Prescription Drugs, continued</b>		<p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>If you request a tier exception in this plan, you will pay Tier 3 cost sharing.</p> <p><b>In-Network</b></p> <p>\$0 deductible.</p> <p>Some covered drugs don't count toward your out-of-pocket drug costs.</p> <p><b>Initial Coverage</b></p> <p>You pay the following until total yearly drug costs reach \$4,000:</p> <p><b>Retail Pharmacy</b></p> <p><i>Tier 1</i></p> <p>-\$0 copay for a one-month (30-day) supply of drugs in this tier</p> <p>-\$0 copay for a three-month (90-day) supply of drugs in this tier</p> <p><i>Tier 2</i></p> <p>-\$20 copay for a one-month (30-day) supply of drugs in this tier</p> <p>-\$60 copay for a three-month (90-day) supply of drugs in this tier</p> <p><i>Tier 3</i></p> <p>-\$50 copay for a one-month (30-day) supply of drugs in this tier</p>

**Summary of Benefits  
AvMed Premier Care (HMO) Miami-Dade County  
2010**

Benefit Category	Original Medicare	AvMed Premier Care (HMO)
<b>29 - Prescription Drugs, continued</b>		<p>-\$150 copay for a three-month (90-day) supply of drugs in this tier</p> <p><i>Tier 4</i></p> <p>-25% coinsurance for a one-month (30-day) supply of drugs in this tier</p> <p><b>Long Term Care Pharmacy</b></p> <p><i>Tier 1</i></p> <p>-\$0 copay for a one-month (31-day) supply of drugs in this tier</p> <p><i>Tier 2</i></p> <p>-\$20 copay for a one-month (31-day) supply of drugs in this tier</p> <p><i>Tier 3</i></p> <p>-\$50 copay for a one-month (31-day) supply of drugs in this tier</p> <p><i>Tier 4</i></p> <p>-25% coinsurance for a one-month (31-day) supply of drugs in this tier</p> <p><b>Mail Order</b></p> <p><i>Tier 1</i></p> <p>-\$0 copay for a three-month (90-day) supply of drugs in this tier</p> <p><i>Tier 2</i></p> <p>-\$60 copay for a three-month (90-day) supply of drugs in this tier</p> <p><i>Tier 3</i></p> <p>-\$150 copay for a three-month (90-day) supply of drugs in this tier</p> <p><b>Coverage Gap</b></p> <p>The plan covers all generics (100% of formulary generic drugs) through the coverage gap.</p> <p>You pay the following:</p> <p><b>Retail Pharmacy</b></p> <p><i>Tier 1</i></p> <p>-\$0 copay for a one-month (30-day) supply of all drugs covered in this tier</p>

**Summary of Benefits  
AvMed Premier Care (HMO) Miami-Dade County  
2010**

Benefit Category	Original Medicare	AvMed Premier Care (HMO)
<b>29 - Prescription Drugs, continued</b>		<p>-\$0 copay for a three-month (90-day) supply of all drugs covered in this tier</p> <p><b>Long Term Care Pharmacy</b></p> <p><i>Tier 1</i></p> <p>-\$0 copay for a one-month (31-day) supply of all drugs covered in this tier</p> <p><b>Mail Order</b></p> <p><i>Tier 1</i></p> <p>-\$0 copay for a three-month (90-day) supply of all drugs covered in this tier</p> <p>For all other covered drugs, after your total yearly drug costs reach \$4,000, you pay 100% until your yearly out-of-pocket drug costs reach \$4,550.</p> <p><b>Catastrophic Coverage</b></p> <p>After your yearly out-of-pocket drug costs reach \$ 4,550, you pay the greater of:</p> <ul style="list-style-type: none"> <li>-A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or</li> <li>-5% coinsurance.</li> </ul> <p><b>Out-of-Network</b></p> <p>Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from AvMed Premier Care (HMO).</p>

**Summary of Benefits  
AvMed Premier Care (HMO) Miami-Dade County  
2010**

Benefit Category	Original Medicare	AvMed Premier Care (HMO)
<b>29 - Prescription Drugs, continued</b>		<p><b>Out-of-Network Initial Coverage</b></p> <p>You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$4,000:</p> <p><i>Tier 1</i> -\$0 copay for a one-month (30-day) supply of drugs in this tier</p> <p><i>Tier 2</i> -\$20 copay for a one-month (30-day) supply of drugs in this tier</p> <p><i>Tier 3</i> -\$50 copay for a one-month (30-day) supply of drugs in this tier</p> <p><i>Tier 4</i> -25% coinsurance for a one-month (30-day) supply of drugs in this tier</p> <p><b>Out-of-Network Coverage Gap</b></p> <p>You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following:</p> <p><i>Tier 1</i> -\$0 copay for a one-month (30-day) supply of all drugs covered in this tier</p> <p><i>Tier 2</i> -After your total yearly drug costs reach \$4,000, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by AvMed Premier Care (HMO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to AvMed Premier Care (HMO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p>

**Summary of Benefits**  
**AvMed Premier Care (HMO) Miami-Dade County**  
**2010**

Benefit Category	Original Medicare	AvMed Premier Care (HMO)
------------------	-------------------	--------------------------

**29 - Prescription Drugs,  
continued**

*Tier 3*

-After your total yearly drug costs reach \$4,000, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by AvMed Premier Care (HMO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to AvMed Premier Care (HMO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.

*Tier 4*

-After your total yearly drug costs reach \$4,000, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by AvMed Premier Care (HMO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to AvMed Premier Care (HMO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.

**Out-of-Network Catastrophic Coverage**

After your yearly out-of-pocket drug costs reach \$ 4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following:  
 -A \$ 2.50 copay for generic (including brand drugs treated as generic) and a \$ 6.30 copay for all other drugs, or  
 -5% coinsurance.

**Summary of Benefits**  
**AvMed Premier Care (HMO) Miami-Dade County**  
**2010**

Benefit Category	Original Medicare	AvMed Premier Care (HMO)
<b>30 - Dental Services</b>	Preventive dental services (such as cleaning) not covered.	<p><b>In-Network</b></p> <p>In general, preventive dental benefits (such as cleaning) not covered.</p> <p>-\$5 copay for Medicare-covered dental benefits.</p>
<b>31 - Hearing Services</b>	<p>Routine hearing exams and hearing aids not covered.</p> <p>20% coinsurance for diagnostic hearing exams.</p>	<p><b>In-Network</b></p> <p>In general, routine hearing exams and hearing aids not covered.</p> <p>-\$5 copay for Medicare-covered diagnostic hearing exams.</p>
<b>32 - Vision Services</b>	<p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.</p> <p>Routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>	<p><b>In-Network</b></p> <p>-\$10 copay for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>-\$5 copay for exams to diagnose and treat diseases and conditions of the eye.</p> <p>-\$5 copay for routine eye exams</p> <p>-\$10 copay for up to 1 pair(s) of glasses every year.</p>
<b>33 - Physical Exams</b>	<p>20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage</p> <p>When you get Medicare Part B, you can get a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.</p>	<p><b>In-Network</b></p> <p>-\$0 copay for routine exams.</p> <p>No limit on the number of covered exams.</p>
<b>34 - Health/Wellness Education</b>	<p>Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.</p>	<p><b>In-Network</b></p> <p>The plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> <li>-Written health education materials, including Newsletters</li> <li>-Health Club Membership/Fitness Classes</li> <li>-Nursing Hotline</li> </ul> <p>-\$0 copay for each Medicare-covered smoking cessation counseling session.</p>

**Summary of Benefits**  
**AvMed Premier Care (HMO) Miami-Dade County**  
**2010**

<b>Benefit Category</b>	<b>Original Medicare</b>	<b>AvMed Premier Care (HMO)</b>
<b>Transportation</b> (Routine)	Not covered.	<b>In-Network</b> This plan does not cover routine transportation.
<b>Acupuncture</b>	Not covered.	<b>In-Network</b> This plan does not cover Acupuncture.