DOCTORS
HEALTHCARE PLANS, INC.

# 2027

# SUMMARY OF BENEFITS



## DrMax-Dade (HMO) H4140-022

SOUTH FLORIDA

## DrSelect-SFL (HMO) H4140-023

H4140_SB2027DRMAXDADE022DRSELECTSFL023_M

**Pre-Enrollment Checklist**

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Member Services representative at (786) 460-3427 or toll-free (833) 342-7463 (TTY: 711), 7 days a week, 8AM to 8PM.

**Understanding the Benefits**

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit www.doctorshcp.com/2027plans/ or call (786) 460-3427 or toll-free (833) 342-7463 (TTY: 711) to view a copy of the EOC.
- ☐ Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the Provider Directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary or "Drug List" to make sure your drugs are covered.

**Understanding Important Rules**

- ☐ **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2028.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

# 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, www.doctorshcp.com/2027plans/.

## You have choices about how to get your Medicare benefits

- For coverage and cost of original Medicare, look in your current **"Medicare & You"** handbook. You can order a handbook, find, and compare health plans online at www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Hours of operation: 24 hours a day, 7 days a week.

## Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **DrMax-Dade (HMO)** and **DrSelect-SFL (HMO)** cover 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.

## Information covered in this booklet

- Things to Know About **DrMax-Dade (HMO)** and **DrSelect-SFL (HMO)**.
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services.
- Covered Medical and Hospital Benefits.
- Prescription Drug Benefits.

## Things to Know About DrMax-Dade (HMO) and DrSelect-SFL (HMO)

### Hours of Operation & Contact Information

- 7 days a week, 8AM to 8PM.
- If you are a member of this plan, call us toll-free at (833) 342-7463, TTY: 711.
- If you are not a member of this plan, call us toll-free at (833) 639-3427, TTY: 711.
- Our website: www.doctorshcp.com/2027plans/.

## Who can join?

To join **DrMax-Dade (HMO)** and **DrSelect-SFL (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

The service area for DrMax-Dade is Miami-Dade county. The service area for DrSelect-SFL is Broward and Miami-Dade counties.

## Which doctors, hospitals and pharmacies can you use?

**Doctors HealthCare Plans, Inc.**, has a network of doctors, hospitals, pharmacies, and other providers. Depending on your plan, you may need a referral to visit a specialist. Except for emergency, urgent, and preventive services, certain services require prior authorizations and/or referrals.

To get detailed information about your covered services, please see the Evidence of Coverage (EOC).

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.doctorshcp.com/2027providers/).

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

## Do you have Medicare and Medicaid?

If you are cost-share protected by Florida Medicaid, our providers aren't allowed to collect or bill you for services and items covered under Medicare Part A and Part B, including deductibles, coinsurance, and copayments. If a provider asks you to pay, that's against the law. You may however be responsible for a small Medicaid copayment. If you are cost-share protected and you are billed or asked to pay the provider for deductibles, coinsurance, or copayments on covered Medicare Part A and Part B services tell your provider you are cost-share protected and can't be charged. If you have already made a payment you have the right to a refund. If you have any questions, call us toll-free at (833) 342-7463, TTY- 711. We are open 7 days a week, 8AM to 8PM.

## Are prior authorizations or referrals required?

For certain procedures, services and drugs, you may need advanced approval. Please note that services that require a prior authorization and/or a referral are noted in the benefit descriptions listed in this booklet. For more information, you may refer to your *Evidence of Coverage*.

Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." Certain procedures, services and drugs may need advance approval from this plan. This is called "prior authorization." To learn more about services that require a referral or prior authorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) or call us.

## 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, www.doctorshcp.com/2027druglist/.
- Or, call us and we will send you a copy of the formulary.

## How will I determine my drug costs?

**With just a few easy steps, you can find out what your covered drugs will cost.** Our plan groups medications into 6 tiers. The amount you pay for the drug will depend on what tier your drug is in. You will need to use your formulary to determine the tier. Then, go to the Summary of Benefits Prescription Drug section and match your drug to the tier to determine the cost.

Generally speaking, members must use a pharmacy in our network. You may get your covered drugs from pharmacies not in our plan only when you are unable to get your prescription drugs from a pharmacy that is in our plan.

To find a pharmacy in our plan, see our online Provider Directory on our website at www.doctorshcp.com/2027providers/ or call us to obtain a copy.

# 2 SECTION II - SUMMARY OF BENEFITS

| MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES | | |
|---|---|---|
| **Premiums and Benefits** | **DrMax-Dade (HMO)** | **DrSelect-SFL (HMO)** |
| **Monthly Plan Premium** | **$0:** you must continue to pay your Medicare Part B premium. | **$0:** you must continue to pay your Medicare Part B premium. |
| **Part B Premium Reduction** | Up to **$17 monthly**<br>We will reduce your monthly Part B premium by up to **$17 monthly**. Depending on how you pay your Medicare Part B premium, your reduction may be credited to your Social Security check or credited on your Medicare Part B premium statement. Sometimes reductions can take several months to be issued; however, you will receive a full credit. You must continue to pay your Medicare Part B premium until Social Security completes their processing. See your Evidence of Coverage (EOC) for more details. | Not covered |
| **Deductible** | Medical Deductible: Not Applicable.<br>Prescription Drug Deductible: Not Applicable. | Medical Deductible: Not Applicable.<br>Prescription Drug Deductible: Not Applicable. |

| MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES | | |
|---|---|---|
| **Maximum Out-of-Pocket Responsibility (does not include prescription drugs)** | Your yearly limit(s) in this plan:<br>• **$3,000** for services you receive from in-network providers.<br>This amount is the most you will pay during the plan year for in-network approved medical services under our plan.<br>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. | Your yearly limit(s) in this plan:<br>• **$3,000** for services you receive from in-network providers.<br>This amount is the most you will pay during the plan year for in-network approved medical services under our plan.<br>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. |

| COVERED MEDICAL AND HOSPITAL BENEFITS | | |
|---|---|---|
| **Benefits/Services** | **DrMax-Dade (HMO)** | **DrSelect-SFL (HMO)** |
| **Inpatient Hospital Coverage** | **$0 per admission**<br>Our plan covers an unlimited number of days for an inpatient hospital stay.<br>Requires a prior authorization (PA) from the plan | **$0 per admission**<br>Our plan covers an unlimited number of days for an inpatient hospital stay.<br>Requires a prior authorization (PA) from the plan |
| **Outpatient Hospital Coverage** | **In-Network:**<br>Outpatient hospital observation: **$0 copay**<br>Outpatient hospital surgery: **$50 copay**<br>Requires a prior authorization (PA) from the plan | **In-Network:**<br>Outpatient hospital observation: **$0 copay**<br>Outpatient hospital surgery: **$75 copay**<br>Requires a referral from your primary care physician (PCP) and a prior authorization (PA) from the plan |
| **Ambulatory Surgical Center (ASC) Services** | **In-Network:**<br>Ambulatory surgical center: **$50 copay**<br>Requires a prior authorization (PA) from the plan | **In-Network:**<br>Ambulatory surgical center: **$50 copay**<br>Requires a referral from your primary care physician (PCP) and a prior authorization (PA) from the plan |
| **Doctor Visits (Primary Care Providers and Specialists)** | **In-Network:**<br>Primary care physician visit: **$0 copay**<br>Specialist visit: **$0 copay**<br>For specialist visits, a prior authorization (PA) from the plan is required | **In-Network:**<br>Primary care physician visit: **$0 copay**<br>Specialist visit: **$0 copay**<br>For specialist visits, a referral from your primary care physician (PCP) and a prior authorization (PA) from the plan is required |
| **Preventive Care** | **In-Network:**<br>**$0 copay** for all preventive services covered under Original Medicare.<br>Some of these services include:<br>• Annual Wellness visits<br>• Bone mass measurements | **In-Network:**<br>**$0 copay** for all preventive services covered under Original Medicare.<br>Some of these services include:<br>• Annual Wellness visits<br>• Bone mass measurements |

| COVERED MEDICAL AND HOSPITAL BENEFITS | | |
|---|---|---|
| **Benefits/Services** | **DrMax-Dade (HMO)** | **DrSelect-SFL (HMO)** |
| | • Breast cancer screenings (mammograms)<br>• Cardiovascular screenings<br>• Cervical and vaginal cancer screenings<br>• Colorectal cancer screenings<br>• Diabetes screenings<br>• Prostate cancer screenings (PSA)<br>• Vaccines (including Flu shots, Hepatitis B shots, Pneumococcal shots, COVID shots)<br>For a complete list of covered preventive services, please refer to your Evidence of Coverage (EOC). Any additional preventive services approved by Medicare during the contract year will be covered. | • Breast cancer screenings (mammograms)<br>• Cardiovascular screenings<br>• Cervical and vaginal cancer screenings<br>• Colorectal cancer screenings<br>• Diabetes screenings<br>• Prostate cancer screenings (PSA)<br>• Vaccines (including Flu shots, Hepatitis B shots, Pneumococcal shots, COVID shots)<br>For a complete list of covered preventive services, please refer to your Evidence of Coverage (EOC). Any additional preventive services approved by Medicare during the contract year will be covered. |
| **Emergency Care** | Emergency care: **$100 copay** per visit.<br>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.<br>Worldwide emergency coverage: **$125 copay**<br>Benefits for emergency care and urgent care received outside the United States and its territories are limited to a combined **$50,000** maximum per calendar year. | Emergency care: **$100 copay** per visit.<br>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.<br>Worldwide emergency coverage: **$125 copay**<br>Benefits for emergency care and urgent care received outside the United States and its territories are limited to a combined **$50,000** maximum per calendar year. |
| **Urgently Needed Services** | Urgently needed services: **$0 copay** per visit. | Urgently needed services: **$0 copay** per visit. |

| COVERED MEDICAL AND HOSPITAL BENEFITS | | |
|---|---|---|
| **Benefits/Services** | **DrMax-Dade (HMO)** | **DrSelect-SFL (HMO)** |
| | Worldwide urgent coverage: **$25 copay**<br><br>Benefits for emergency care and urgent care received outside the United States and its territories are limited to a combined **$50,000** maximum per calendar year. | Worldwide urgent coverage: **$25 copay**<br><br>Benefits for emergency care and urgent care received outside the United States and its territories are limited to a combined **$50,000** maximum per calendar year. |
| **Diagnostic Services/Labs/Imaging** | **In-Network:**<br><br>Diagnostic tests and procedures: **$0 copay**<br><br>Lab services: **$0 copay**<br><br>Diagnostic radiology services (such as MRI, CAT Scan): **$0 copay** at physician office or freestanding facility - **$75 copay** at outpatient hospital facility.<br><br>X-rays: **$0 copay**<br><br>Therapeutic radiology services (such as radiation treatment for cancer): **20% coinsurance**<br><br>Diagnostic radiology services, X-rays, and therapeutic radiology services require a referral from your primary care physician (PCP) and a prior authorization (PA). | **In-Network:**<br><br>Diagnostic tests and procedures: **$0 copay**<br><br>Lab services: **$0 copay**<br><br>Diagnostic radiology services (such as MRI, CAT Scan): **$0 copay** at physician office or freestanding facility - **$75 copay** at outpatient hospital facility.<br><br>X-rays: **$0 copay**<br><br>Therapeutic radiology services (such as radiation treatment for cancer): **20% coinsurance**<br><br>Diagnostic tests and procedures and lab services require a referral from your primary care physician (PCP) and do not require a prior authorization (PA).<br><br>Diagnostic radiology services, X-rays, and therapeutic radiology services require a referral from your primary care physician (PCP) and a prior authorization (PA). |
| **Hearing Services** | **In-Network:**<br><br>**$0 copay** for routine hearing exam.<br><br>**$0 copay** for hearing aid fitting/ evaluation every 2 calendar years. | **In-Network:**<br><br>**$0 copay** for routine hearing exam.<br><br>**$0 copay** for hearing aid fitting/ evaluation every 2 calendar years. |

| COVERED MEDICAL AND HOSPITAL BENEFITS | | |
|---|---|---|
| **Benefits/Services** | **DrMax-Dade (HMO)** | **DrSelect-SFL (HMO)** |
| | Up to **$1,350** allowance for hearing aids every 2 calendar years. | Up to **$1,350** allowance for hearing aids every 2 calendar years. |
| **Dental Services** | **In-Network:**<br>**$0 copay** for the following preventive dental services:<br>• Oral exam, up to **2** per calendar year.<br>• Prophylaxis (cleanings), up to **2** per calendar year.<br>• Fluoride, up to **2** per calendar year.<br>• Bitewing x-rays, up to **2** per calendar year.<br>• Panoramic x-ray, up to 1 per **3** calendar years.<br>**$0 copay** for the following supplemental dental services:<br>• Fillings (amalgam or resin), up to **6** per calendar year.<br>• Crowns, up to **2** per calendar year.<br>• Extractions, up to **4** per calendar year.<br>• Root canal, up to **1** per calendar year.<br>• Implants, up to **2** per calendar year.<br>• Scaling and root planing (deep cleaning), up to **1** per quadrant per 2 calendar years.<br>• Dentures, up to **1** full upper and **1** full lower denture per 5 years or **1** partial upper and **1** partial | **In-Network:**<br>**$0 copay** for the following preventive dental services:<br>• Oral exam, up to **2** per calendar year.<br>• Prophylaxis (cleanings), up to **2** per calendar year.<br>• Fluoride, up to **2** per calendar year.<br>• Bitewing x-rays, up to **2** per calendar year.<br>• Panoramic x-ray, up to 1 per **3** calendar years.<br>**$0 copay** for the following supplemental dental services:<br>• Fillings (amalgam or resin), up to **2** per calendar year.<br>• Crowns, up to **1** per calendar year.<br>• Extractions, up to **4** per calendar year.<br>• Root canal, up to **1** per calendar year.<br>• Implants, up to **1** per calendar year.<br>• Scaling and root planing (deep cleaning), up to **1** per quadrant per 2 calendar years.<br>• Dentures, up to **1** full upper and **1** full lower denture per 5 years or **1** partial upper and **1** partial |

| COVERED MEDICAL AND HOSPITAL BENEFITS | | |
|---|---|---|
| **Benefits/Services** | **DrMax-Dade (HMO)** | **DrSelect-SFL (HMO)** |
| | lower denture per 5 calendar years.<br>Requires a prior authorization (PA) from the plan | lower denture per 5 calendar years.<br>Requires a prior authorization (PA) from the plan |
| **Vision Services** | **In-Network:**<br>**$0 copay** for eye exams.<br>Up to **$400** allowance for eyeglasses and/or contact lenses per calendar year or up to **3** pairs of eyeglasses at no cost from a select eyewear collection per calendar year. | **In-Network:**<br>**$0 copay** for eye exams.<br>Up to **$400** allowance for eyeglasses and/or contact lenses per calendar year or up to **3** pairs of eyeglasses at no cost from a select eyewear collection per calendar year. |
| **Mental Health Services** | **In-Network:**<br>Outpatient group therapy visit: **$0 copay**<br>Individual therapy visit: **$0 copay**<br>Inpatient mental health care:<br>**$0 copay per stay**<br>Requires a prior authorization (PA) from the plan | **In-Network:**<br>Outpatient group therapy visit: **$0 copay**<br>Individual therapy visit: **$0 copay**<br>Inpatient mental health care:<br>**$0 copay per stay**<br>Requires a prior authorization (PA) from the plan |

| PRESCRIPTION DRUG BENEFITS | | |
|---|---|---|
| **Benefits/Services** | **DrMax-Dade (HMO)** | **DrSelect-SFL (HMO)** |
| **Deductible** | Prescription Drug Deductible: Not Applicable. | Prescription Drug Deductible: Not Applicable. |
| **Initial Coverage**<br>You stay in the Initial Coverage Stage until your total out-of-pocket costs reach **$2,400**. You then move on to the Catastrophic Coverage Stage. | | |
| | **Retail Cost-Sharing** | **Retail Cost-Sharing** |
| **Tier** | **One-month supply** | **One-month supply** |
| Tier 1: Preferred Generics | **$0 copay** | **$0 copay** |
| Tier 2: Generics | **$0 copay** | **$0 copay** |
| Tier 3: Preferred Brands | **$0 copay** | **$0 copay** |
| Tier 4: Non-Preferred Drugs | **$55 copay*** | **$55 copay*** |
| Tier 5: Specialty | **33% coinsurance*** | **33% coinsurance*** |
| Tier 6: Supplemental Drugs | **$0 copay** | **$0 copay** |
| | | |
| **Tier** | **Two-month supply** | **Two-month supply** |
| Tier 1: Preferred Generics | **$0 copay** | **$0 copay** |
| Tier 2: Generics | **$0 copay** | **$0 copay** |
| Tier 3: Preferred Brands | **$0 copay** | **$0 copay** |
| Tier 4: Non-Preferred Drugs | **$110 copay*** | **$110 copay*** |
| Tier 5: Specialty | **Not Applicable** | **Not Applicable** |
| Tier 6: Supplemental Drugs | **$0 copay** | **$0 copay** |
| | | |
| **Tier** | **Three-month supply** | **Three-month supply** |
| Tier 1: Preferred Generics | **$0 copay** | **$0 copay** |
| Tier 2: Generics | **$0 copay** | **$0 copay** |
| Tier 3: Preferred Brands | **$0 copay** | **$0 copay** |

| | | |
|---|---|---|
| Tier 4: Non-Preferred Drugs | **$165 copay*** | **$165 copay*** |
| Tier 5: Specialty | **Not Applicable** | **Not Applicable** |
| Tier 6: Supplemental Drugs | **$0 copay** | **$0 copay** |

| | **Mail Order Cost-Sharing** | **Mail Order Cost-Sharing** |
|---|---|---|
| **Tier** | **One-month supply** | **One-month supply** |
| Tier 1: Preferred Generics | **Not Applicable** | **Not Applicable** |
| Tier 2: Generics | **Not Applicable** | **Not Applicable** |
| Tier 3: Preferred Brands | **Not Applicable** | **Not Applicable** |
| Tier 4: Non-Preferred Drugs | **Not Applicable** | **Not Applicable** |
| Tier 5: Specialty | **33% coinsurance*** | **33% coinsurance*** |
| Tier 6: Supplemental Drugs | **Not Applicable** | **Not Applicable** |

| | **Mail Order Cost-Sharing** | **Mail Order Cost-Sharing** |
|---|---|---|
| **Tier** | **Two-month supply** | **Two-month supply** |
| Tier 1: Preferred Generics | **Not Applicable** | **Not Applicable** |
| Tier 2: Generics | **Not Applicable** | **Not Applicable** |
| Tier 3: Preferred Brands | **Not Applicable** | **Not Applicable** |
| Tier 4: Non-Preferred Drugs | **Not Applicable** | **Not Applicable** |
| Tier 5: Specialty | **Not Applicable** | **Not Applicable** |
| Tier 6: Supplemental Drugs | **Not Applicable** | **Not Applicable** |

| | **Mail Order Cost-Sharing** | **Mail Order Cost-Sharing** |
|---|---|---|
| **Tier** | **Three-month supply** | **Three-month supply** |
| Tier 1: Preferred Generics | **$0 copay** | **$0 copay** |
| Tier 2: Generics | **$0 copay** | **$0 copay** |
| Tier 3: Preferred Brands | **$0 copay** | **$0 copay** |

| | | |
|---|---|---|
| Tier 4: Non-Preferred Drugs | **$165 copay*** | **$165 copay*** |
| Tier 5: Specialty | **Not Applicable** | **Not Applicable** |
| Tier 6: Supplemental Drugs | **$0 copay** | **$0 copay** |

A long-term supply (also called an "extended supply") is available for all drugs in Tiers 6 and certain drugs in Tiers 1-4. Drugs in Tiers 1-4 that are not available for long-term supply are indicated with "NDS" in the formulary. A long-term supply is not available for any drugs in Tier 5 - Specialty Tier.

Some drugs can be filled for up to 100 days' supply. These will be noted in the formulary with a "100 DS" symbol.

Non-Formulary drugs approved via the Formulary Exception process will be subject to the Tier 5-Specialty Tier coinsurance.

**VACCINES**

Important Message About What You Pay for Vaccines: Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

***INSULIN**

You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

Please call us or see the plan's **"Evidence of Coverage"** on our website (www.doctorshcp.com/2027plans/) for complete information about your costs for covered drugs.

**Catastrophic Coverage**

After your yearly out-of-pocket drug costs reach **$2,400**, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

| Additional Benefits/Services | DrMax-Dade (HMO) | DrSelect-SFL (HMO) |
|---|---|---|
| **Part B Drugs** | **0% coinsurance** for select Nebulized Medications. These include: Albuterol Sulfate, Budesonide, Cromolyn Sodium, Ipratropium Bromide, Ipratropium-Albuterol and Levalbuterol HCL<br>**0% - 20% coinsurance** for:<br>• Chemotherapy/radiation drugs<br>• Other Part B Drugs<br>• Part B Insulins (not to exceed **$35** monthly)<br>**$0 copay** for administration of Part B Drugs.<br>Requires a prior authorization (PA) from the plan | **0% coinsurance** for select Nebulized Medications. These include: Albuterol Sulfate, Budesonide, Cromolyn Sodium, Ipratropium Bromide, Ipratropium-Albuterol and Levalbuterol HCL<br>**0% - 20% coinsurance** for:<br>• Chemotherapy/radiation drugs<br>• Other Part B Drugs<br>• Part B Insulins (not to exceed **$35** monthly)<br>**$0 copay** for administration of Part B Drugs.<br>Requires a prior authorization (PA) from the plan |
| **Skilled Nursing Facility (SNF)** | **$0 copay** per day for days 1 through 20.<br>**$75 copay** per day for days 21 through 100.<br>Our plan covers up to 100 days in a SNF per benefit period. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient hospital care or skilled care in a SNF for 60 days in a row. If you go into a hospital or SNF after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods.<br>Requires a prior authorization (PA) from the plan | **$0 copay** per day for days 1 through 20.<br>**$60 copay** per day for days 21 through 100.<br>Our plan covers up to 100 days in a SNF per benefit period. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient hospital care or skilled care in a SNF for 60 days in a row. If you go into a hospital or SNF after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods.<br>Requires a prior authorization (PA) from the plan |
| **Physical Therapy and other Rehabilitation Services** | **$0 copay** per visit for the following services:<br>• Cardiac rehabilitation services<br>• Occupational therapy services | **$0 copay** per visit for the following services:<br>• Cardiac rehabilitation services<br>• Occupational therapy services |

| Additional Benefits/Services | DrMax-Dade (HMO) | DrSelect-SFL (HMO) |
|---|---|---|
| | • Physical therapy services<br>• Pulmonary rehabilitation services<br>• Speech therapy services<br>• Supervised Exercise Therapy (SET) services<br>Requires a referral from your primary care physician (PCP) and a prior authorization (PA) from the plan | • Physical therapy services<br>• Pulmonary rehabilitation services<br>• Speech therapy services<br>• Supervised Exercise Therapy (SET) services<br>Requires a referral from your primary care physician (PCP) and a prior authorization (PA) from the plan |
| **Ambulance** | Emergency Ground Ambulance: **$125 copay**<br>Emergency Air Ambulance: **20% coinsurance** | Emergency Ground Ambulance: **$125 copay**<br>Emergency Air Ambulance: **20% coinsurance** |
| **Transportation** | **$0 copay** for **unlimited** trips to plan-approved locations per calendar year.<br>You must call our contracted transportation vendor to schedule an appointment. | **$0 copay** for **unlimited** trips to plan-approved locations per calendar year.<br>You must call our contracted transportation vendor to schedule an appointment. |
| **Podiatry Services** | **$0 copay** Medicare-covered foot care.<br>**$0 copay** routine foot care, up to **6** visits per year. | **$0 copay** Medicare-covered foot care.<br>**$0 copay** routine foot care, up to **6** visits per year. |
| **Renal Dialysis** | **20% coinsurance**<br>Requires a referral from your primary care physician (PCP) and a prior authorization (PA) from the plan | **20% coinsurance**<br>Requires a referral from your primary care physician (PCP) and a prior authorization (PA) from the plan |
| **Telehealth Services** | **$0 copay** per telehealth visit for:<br>• Primary Care Physician Services<br>• Occupational Therapy Services<br>• Physician Specialists Services<br>• Individual Sessions for Mental Health Specialty<br>• Group Sessions for Mental Health Specialty<br>• Podiatry Services | **$0 copay** per telehealth visit for:<br>• Primary Care Physician Services<br>• Occupational Therapy Services<br>• Physician Specialists Services<br>• Individual Sessions for Mental Health Specialty<br>• Group Sessions for Mental Health Specialty<br>• Podiatry Services |

| Additional Benefits/Services | DrMax-Dade (HMO) | DrSelect-SFL (HMO) |
|---|---|---|
| | • Other Health Care Professional Services<br>• Individual Sessions for Psychiatric Services<br>• Group Sessions for Psychiatric Services<br>• Physical Therapy and Speech-Language Pathology Services<br>• Opioid Treatment Program Services<br>• Individual Sessions for Outpatient Substance Abuse<br>• Group Sessions for Outpatient Substance Abuse<br>• Kidney Disease Educational Services<br>• Diabetes Self-Management Training<br>Requires a prior authorization (PA) from the plan | • Other Health Care Professional Services<br>• Individual Sessions for Psychiatric Services<br>• Group Sessions for Psychiatric Services<br>• Physical Therapy and Speech-Language Pathology Services<br>• Opioid Treatment Program Services<br>• Individual Sessions for Outpatient Substance Abuse<br>• Group Sessions for Outpatient Substance Abuse<br>• Kidney Disease Educational Services<br>• Diabetes Self-Management Training<br>Requires a referral from your primary care physician (PCP) and a prior authorization (PA) from the plan |
| **Durable Medical Equipment (DME)** | **0% coinsurance** for covered items, including but not limited to:<br>• CPAP machines<br>• And all other medical equipment<br>**20% coinsurance** for covered items, including but not limited to:<br>• Powered wheelchairs<br>• Powered mattress systems<br>• And other electric devices<br>The list of preferred vendors and manufacturers for durable medical equipment (DME) can be found in your EOC and online at www.doctorshcp.com/2027plans/.<br>Requires a prior authorization (PA) from the plan | **0% coinsurance** for covered items, including but not limited to:<br>• CPAP machines<br>• And all other medical equipment<br>**20% coinsurance** for covered items, including but not limited to:<br>• Powered wheelchairs<br>• Powered mattress systems<br>• And other electric devices<br>The list of preferred vendors and manufacturers for durable medical equipment (DME) can be found in your EOC and online at www.doctorshcp.com/2027plans/.<br>Requires a prior authorization (PA) from the plan |

| Additional Benefits/Services | DrMax-Dade (HMO) | DrSelect-SFL (HMO) |
|---|---|---|
| **Prosthetic Devices** | **0% coinsurance** for all other prosthetic devices.<br>**20% coinsurance** for braces/ artificial limbs.<br>Requires a prior authorization (PA) from the plan | **0% coinsurance** for all other prosthetic devices.<br>**20% coinsurance** for braces/ artificial limbs.<br>Requires a prior authorization (PA) from the plan |
| **Diabetic Supplies** | **0% coinsurance** for preferred diabetic supplies (test strips, lancets, lancet devices and control solutions).<br>Preferred Diabetic Supplies include: Abbott Diabetes Care products: **Freestyle Insulinx, Freestyle Lite, FreeStyle Precision Neo, Freestyle, Precision XTRA and Trividia Health Products: ReliOn True Metrix, True Metrix.**<br>**20% coinsurance** for non-preferred diabetic supplies (test strips, lancets, lancet devices and control solutions).<br>Non-preferred diabetic supplies (test strips) will require a prior authorization (PA).<br>Non-preferred diabetic supplies (lancets, lancet devices and control solutions) will not require prior authorization (PA). | **0% coinsurance** for preferred diabetic supplies (test strips, lancets, lancet devices and control solutions).<br>Preferred Diabetic Supplies include: Abbott Diabetes Care products: **Freestyle Insulinx, Freestyle Lite, FreeStyle Precision Neo, Freestyle, Precision XTRA and Trividia Health Products: ReliOn True Metrix, True Metrix.**<br>**20% coinsurance** for non-preferred diabetic supplies (test strips, lancets, lancet devices and control solutions).<br>Non-preferred diabetic supplies (test strips) will require a prior authorization (PA).<br>Non-preferred diabetic supplies (lancets, lancet devices and control solutions) will not require prior authorization (PA). |
| **Therapeutic Shoes or Inserts** | **$0 copay** Medicare-covered therapeutic shoes or inserts.<br>Requires a prior authorization (PA) from the plan | **$0 copay** Medicare-covered therapeutic shoes or inserts.<br>Requires a prior authorization (PA) from the plan |

| Additional Benefits/Services | DrMax-Dade (HMO) | DrSelect-SFL (HMO) |
|---|---|---|
| **Diabetic Monitors: Glucometers and Continuous Blood Glucose Monitors (CBGM)** | **0% coinsurance** for preferred glucometers.<br><br>Preferred diabetic glucometers include Abbott Diabetes Care Products: **Freestyle Lite, Freestyle Freedom Lite and Trividia Health Products: ReliOn True Metrix Air, True Metrix, True Metrix Air.**<br><br>**20% coinsurance** for non-preferred glucometers.<br><br>Non-preferred glucometers will require a prior authorization (PA).<br><br>**0% coinsurance** for preferred CBGMs (Continuous Blood Glucose Monitors).<br><br>A preferred CBGM will automatically process if you have a qualifying paid claim for Insulin within a 120-day lookback. If there is no qualifying paid claim for Insulin within a 120-day lookback, the preferred CBGM will reject and will require a PA to confirm insulin use.<br><br>Preferred CBGMs include **Abbott Diabetes Care Products: Freestyle Libre 2, Freestyle Libre 2 Plus, Freestyle Libre 3, Freestyle Libre 3 Plus, Freestyle Libre 14 Day. Dexcom Products: Dexcom G6, Dexcom G7 and Dexcom G7 15 Day.**<br><br>Non-preferred CBGMs require PA and trial of a preferred CBGM. If approved, you pay **20% coinsurance** for a non-preferred CBGM. | **0% coinsurance** for preferred glucometers.<br><br>Preferred diabetic glucometers include Abbott Diabetes Care Products: **Freestyle Lite, Freestyle Freedom Lite and Trividia Health Products: ReliOn True Metrix Air, True Metrix, True Metrix Air.**<br><br>**20% coinsurance** for non-preferred glucometers.<br><br>Non-preferred glucometers will require a prior authorization (PA).<br><br>**0% coinsurance** for preferred CBGMs (Continuous Blood Glucose Monitors).<br><br>A preferred CBGM will automatically process if you have a qualifying paid claim for Insulin within a 120-day lookback. If there is no qualifying paid claim for Insulin within a 120-day lookback, the preferred CBGM will reject and will require a PA to confirm insulin use.<br><br>Preferred CBGMs include **Abbott Diabetes Care Products: Freestyle Libre 2, Freestyle Libre 2 Plus, Freestyle Libre 3, Freestyle Libre 3 Plus, Freestyle Libre 14 Day. Dexcom Products: Dexcom G6, Dexcom G7 and Dexcom G7 15 Day.**<br><br>Non-preferred CBGMs require PA and trial of a preferred CBGM. If approved, you pay **20% coinsurance** for a non-preferred CBGM. |

| Additional Benefits/Services | DrMax-Dade (HMO) | DrSelect-SFL (HMO) |
|---|---|---|
| **Prepaid Card*** *Special Supplemental Benefits for the Chronically Ill (SSBCI): The benefits mentioned are part of a special supplemental program for chronically ill members with one of the following conditions: Diabetes mellitus, Cardiovascular disorders, Chronic and disabling mental health conditions, Chronic heart failure, Chronic lung disorder. This is not a complete list of qualifying conditions. Having a qualifying condition alone does not mean you will receive the benefits. Other requirements apply. | Not covered | **$143 monthly** on a prepaid card to be used at approved locations. This card helps you cover out-of-pocket expenses for the following:<br>• Healthy foods<br>• Meals<br>• OTC<br>• Personal care items<br>• Pet supplies<br>• Utilities<br>• Gas at the pump<br>Amounts do not roll over from month to month. Funds will be available at the beginning of the month. |
| **Health Education** | Interactive sessions with a certified health educator for members who qualify. | Interactive sessions with a certified health educator for members who qualify. |
| **Fitness Benefit** | **$0 copay** Membership and access to fitness facilities, healthy aging coaching, home fitness kits and fitness education materials. | **$0 copay** Membership and access to fitness facilities, healthy aging coaching, home fitness kits and fitness education materials. |

| Additional Benefits/Services | DrMax-Dade (HMO) | DrSelect-SFL (HMO) |
|---|---|---|
| **Meals Benefit** | **$0 copay** for up to **16** meals per calendar year following discharge from hospital.<br>Requires a referral from your primary care physician (PCP) and a prior authorization (PA) from the plan | **$0 copay** for up to **16** meals per calendar year following discharge from hospital.<br>Requires a referral from your primary care physician (PCP) and a prior authorization (PA) from the plan |
| **Over-the-Counter (OTC) Benefit** | **$80** monthly<br>Unused OTC amounts do not roll over from month to month. Please visit www.cvs.com/otchs/doctorshcp to see a list of covered over-the-counter items. | *Please refer to your benefit labeled "Prepaid Card."* |
| **Chiropractor Care** | **$0 copay** Medicare-covered chiropractic services.<br>**$0 copay** routine chiropractic care, up to **12** visits per year. | **$0 copay** Medicare-covered chiropractic services.<br>**$0 copay** routine chiropractic care, up to **12** visits per year. |
| **Acupuncture** | **$0 copay** Medicare-covered acupuncture treatments.<br>**$0 copay** supplemental acupuncture treatments, up to **20** visits per year.<br>Requires a prior authorization (PA) from the plan | **$0 copay** Medicare-covered acupuncture treatments.<br>**$0 copay** supplemental acupuncture treatments, up to **20** visits per year.<br>Requires a referral from your primary care physician (PCP) and a prior authorization (PA) from the plan |
| **Home Health Services** | **$0 copay** for limited skilled nursing care and certain other health services you get in your home for the treatment of an illness or injury.<br>Number of covered visits is based on medical need as determined by your physician and authorized by the plan.<br>Requires a prior authorization (PA) from the plan | **$0 copay** for limited skilled nursing care and certain other health services you get in your home for the treatment of an illness or injury.<br>Number of covered visits is based on medical need as determined by your physician and authorized by the plan.<br>Requires a referral from your primary care physician (PCP) and a prior authorization (PA) from the plan |

## DISCLAIMERS

Doctors Healthcare Plans, Inc. is an HMO plan with a Medicare contract. Enrollment in Doctors HealthCare Plans, Inc. depends on contract renewal.
Limitations, copayments, coinsurance, and restrictions may apply. Benefits, preferred drug list, pharmacy network, premium and/or copayments/co-insurance may change.

The benefit information provided is a brief summary, not a complete description of benefits. For more information call (786) 460-3427 or toll-free at (833) 342-7463 (TTY: 711) from 8AM to 8PM, 7 days a week.

# Notice of Non-Discrimination

Doctors HealthCare Plans, Inc. complies with applicable Federal civil rights laws and does not discriminate or exclude people on the basis of race, color, creed, religion, national origin, age, disability, political affiliations or beliefs, or sex (including pregnancy, sexual orientation, and gender identity).

Doctors HealthCare Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages
- If you need these services, contact Member Services/Civil Rights.

If you believe that Doctors HealthCare Plans has failed to provide these services or discriminated in another way, you can file a grievance with:

**Doctors HealthCare Plans, Inc.**
Attn: Member Services/Civil Rights
2020 Ponce De Leon Blvd., PH1
Coral Gables, FL 33134
Telephone: 833-342-7463 (TTY: 711)
Fax: 786-578-0293
Email: civilrights@doctorshcp.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Member Services/Civil Rights, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

**U.S. Department of Health and Human Services**
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html.

## NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE, AUXILIARY AIDS AND SERVICES

**English:** ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 833-342-7463 (TTY:711) or speak to your provider.

**Spanish:** ATENCIÓN: Si habla español, están disponibles servicios de asistencia lingüística gratuita para usted. También están disponibles sin carga adecuada apoyos y servicios para proporcionar información en formatos accesibles. Llame al 833-342-7463 (TTY:711) o hable con su proveedor.

**Haitian Creole:** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 833-342-7463 (TTY:711) oswa pale avèk founisè w la.

**Arabic:** تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم - (1-833-342-7463) (TTY: 711) أو تحدث إلى مقدم الخدمة".

**Chinese Traditional:** 注意：如果您說[台語]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 833-342-7463(TTY:711) 或與您的提供者討論。」

**Chinese Simplified:** 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 833-342-7463 (文本电话： (TTY:711) 或咨询您的服务提供商。

**French:** ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 833-342-7463 (TTY: 711) ou parlez à votre fournisseur.

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachhilfe- Dienste zur Verfügung. Angemessene Hilfsmittel und Dienste zur Bereitstellung von Informationen in zugänglichen Formaten sind ebenfalls kostenlos verfügbar. Rufen Sie 833-342-7463 (TTY: 711) an oder sprechen Sie mit Ihrem Anbieter.

**Gujarati:** ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઓક્ઝિલરી સહાય અને એક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 833-342-7463 (TTY:711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

**Italian:** ATTENZIONE: Se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti per te. Sono disponibili anche ausili e servizi appropriati per fornire informazioni in formati accessibili, anch'essi gratuiti. Chiama il 833-342-7463 (TTY:711) o parla con il tuo fornitore.

**Korean:** 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 833-342-7463 (TTY:711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

**Polish:** UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 833-342-7463 (TTY:711) lub porozmawiaj ze swoim dostawcą".

**Portuguese:** ATENÇÃO: Se você fala Português, serviços de assistência linguística gratuitos estão disponíveis para você. Ajudas e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 833-342-7463 (TTY:711) ou converse com seu prestador de serviços.

**Russian:** ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 833-342-7463 (TTY:711) или обратитесь к своему поставщику услуг.

**Taglog:** PPAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 833-342-7463 (TTY:711) o makipag-usap sa iyong provider."

**Thai:** หมายเหตุ: หากคุณใช้ภาษา ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-833-342-7463 (TTY: 711) หรือปรึกษาผู้ให้บริการของคุณ"

**Vietnamese:** LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số Người khuyết tật: 833-342-7463 (TTY:711) hoặc trao đổi với người cung cấp dịch vụ của bạn."

# Notes

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