



2023 / MIAMI-DADE COUNTY  
**SUMMARY OF BENEFITS**

H4140\_SBDREMAX2023\_M

**DrMax**  
(HMO-POS) H4140-001



Doctors HealthCare Plans, Inc. is an HMO plan with a Medicare contract. Enrollment in Doctors HealthCare Plans, Inc., depends on contract renewal.

**ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (786) 460-3427 o (833) 342-7463 (TTY:711).

This information is not a complete description of benefits. Call (786) 460-3427 or (833) 342-7463 (TTY:711) from 8AM to 8PM, 7 days a week, for more information.

# PRE-ENROLLMENT CHECKLIST

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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 with 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/2023Plans/](http://www.doctorshcp.com/2023Plans/) or call (786) 460-3427 or toll-free (833) 342-7463 (TTY:711) to view or request 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 medicines 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 prescription medications are included.

## UNDERSTANDING IMPORTANT RULES

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month. If you have Medicaid, your Part B premium may be paid by the state.
- Benefits, premiums and/or copayments/co-insurance may change on January 1, 2024.
- Point-of-Service benefit (POS):** All plans have a Point-of-Service benefit. This benefit allows you to access out-of-network specialists in Miami-Dade and Broward Counties. The following specialties are excluded: Pain Management, Dermatology, Oncology, and Behavioral Health. This benefit allows you access up to your plan’s specific benefit amount for specialist office visits only, without a referral. These services require a prior authorization. Your specialist should call the plan for authorization. Prior authorization allows for coordinated, efficient use of providers for covered health care services and ensures that members receive the most appropriate level of care in the appropriate clinical setting. As a member of our plan, you can choose to receive care from out-of-network physicians, for office visits only. However, please note providers not contracted with the plan are under no obligation to treat you except in emergency or urgent situations. To get detailed information about your covered services please see your EOC.
- DrPlus (HMO-POS D-SNP) H4140-002:** This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.
- DrExtraCare (HMO-POS C-SNP) H4140-004:** This plan is a chronic condition special needs plan (C-SNP), for people living with Chronic Heart Failure and/or Diabetes Mellitus. Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.

# 2023 SUMMARY OF BENEFITS

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## DrMax (HMO-POS) H4140-001

This is a summary of drug and health services covered by Doctors HealthCare Plans, Inc., beginning January 1, 2023, through December 31, 2023. The Summary of Benefits does not list every service covered by the plan or list every limitation or exclusion. For a complete list of covered services, please call us and ask for the Evidence of Coverage (EOC) document, or you can view on our website at [www.doctorshcp.com/2023Plans/](http://www.doctorshcp.com/2023Plans/).

### WHO CAN JOIN

To join Doctors HealthCare Plans, Inc., 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 is Miami-Dade County.

### HOW YOU CAN COMPARE MEDICARE PLANS

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](http://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.

### WHAT WE COVER

Everything that Original Medicare covers and much more including Medicare Part D drugs, Part B drugs (such as chemotherapy and some drugs administered by your provider). For more information, please refer to the Evidence of Coverage (EOC).

### Important Message About What You Pay for

**Insulin:** You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

### 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.

For a complete plan formulary (list of Part D drugs) and information on any restrictions or limitations, visit our website at: [www.doctorshcp.com/2023druglist/](http://www.doctorshcp.com/2023druglist/), or call us to obtain a copy of the drug formulary.

### 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/2023Providers/](http://www.doctorshcp.com/2023Providers/) or call us to obtain a copy.



## WHICH DOCTORS, HOSPITALS AND PHARMACIES CAN YOU USE?

Doctors HealthCare Plans, Inc., has a network of doctors, hospital, pharmacies, and other providers. You do not need a referral to visit a specialist in or out-of-network. Except for emergency, urgent, and preventive services, certain services require prior authorization (see your EOC for a complete listing). All of our plans have a Point-of-Service benefit. This benefit allows you to access out-of-network specialists in Miami-Dade and Broward Counties. The following specialties are excluded: Pain Management, Dermatology, Oncology, and Behavioral Health. This benefit allows you access up to your plan's specific benefit amount for specialist office visits only, without a referral. These services require a prior authorization. However, please note providers not contracted with the plan are under no obligation to treat you except in emergency or urgent situations.

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

## DO YOU HAVE MEDICARE AND MEDICAID?

Certain levels of Medicaid (Qualified Medicare Beneficiary – QMB) are cost share protected and have a zero cost-sharing liability. Please make sure to discuss Medicaid status with your agent or call the plan for more details.

## WHEN ARE PRIOR AUTHORIZATIONS REQUIRED?

For certain procedures, services and drugs, you may need advanced approval. Please contact your physician to get prior authorization from Doctors HealthCare Plans for certain services. Services that may require a prior authorization are noted with a "\*" in the benefit titles listed in the Summary of Benefits or refer to the Evidence of Coverage for plan details.

### HOW TO REACH US

If you have any questions and would like to reach us, please call the phone numbers listed below or visit us at [www.doctorshcp.com](http://www.doctorshcp.com).

**If you are a member of this plan**, call Member Services at our local number (786) 460-3427 or toll-free at (833) 342-7463 (TTY:711).

Hours of operation: 7 days a week, 8AM to 8PM EST.

**If you are NOT a member of this plan**, you can call a licensed sales agent at our local number (786) 420-3427 or toll-free at (833) 639-3427 (TTY:711).

Hours of operation: 7 days a week, 8AM to 8PM EST.

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

 @DoctorsHealthCarePlans |  @DoctorsHCP

# 2023 SUMMARY OF BENEFITS *(continued)*

PREMIUMS AND BENEFITS	DrMax (HMO-POS) H4140-001
Monthly Plan Premium	<b>\$0:</b> You must continue to pay your Medicare Part B premium.
Deductible	This plan does not have a deductible for medical services.
Maximum Out-of-Pocket (MOOP)	<b>\$3,000 per year:</b> This amount is the most you will pay during the plan year for approved medical services under our plan. Once you have paid this amount, we pay 100% of your covered services for the rest of the year, excluding any prescription drug costs, health expenses incurred during foreign travel, or supplemental benefit costs.

COVERED MEDICAL AND HOSPITAL SERVICES	DrMax (HMO-POS) H4140-001
Inpatient Hospital Care*	<b>\$0 per admission:</b> Our plan covers an unlimited number of days for an inpatient hospital stay.
Outpatient Hospital Care*	<b>\$0 copay</b> for: <ul style="list-style-type: none"> <li>– Lab services</li> <li>– Mental health care group and individual therapy visits</li> <li>– Physical therapy, occupational therapy, speech and language therapy</li> <li>– Cardiac and pulmonary rehabilitation services</li> <li>– Diagnostic procedures and test</li> <li>– Basic radiology (x-ray) services</li> </ul> <b>\$50 copay</b> for surgery at a hospital or facility <b>20% coinsurance</b> for: <ul style="list-style-type: none"> <li>– Chemotherapy/radiation drugs</li> <li>– Renal dialysis</li> </ul>
Outpatient Surgery — Ambulatory Surgical Center (ASC)*	<b>\$25 copay</b>
Primary Care Physician (PCP)	<b>\$0 copay</b> for primary care physician visits. You must select a PCP from the network.
Specialist*	<b>\$0 copay</b> for specialist visits. You do not need a referral for Specialist office visits.

<b>COVERED MEDICAL AND HOSPITAL SERVICES</b>	<b>DrMax (HMO-POS) H4140-001</b>
Preventive Care Services	<p><b>\$0 copay</b> for the following supplemental preventative services:</p> <ul style="list-style-type: none"> <li>– Abdominal aortic aneurysm screening</li> <li>– Alcohol misuse screening and counseling</li> <li>– Annual “wellness” visit</li> <li>– Bone mass measurement</li> <li>– Breast cancer screening (mammogram)</li> <li>– Cardiovascular disease risk reduction (therapy for cardiovascular disease)</li> <li>– Cardiovascular disease testing (screening)</li> <li>– Cervical and vaginal cancer screening</li> <li>– Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)</li> <li>– Depression screening</li> <li>– Diabetes screenings and monitoring</li> <li>– Diabetes self-management training, diabetic services and supplies</li> <li>– Health and wellness education programs</li> <li>– HIV screening</li> <li>– Lung cancer screenings</li> <li>– Medical nutrition therapy services</li> <li>– Obesity screenings and therapy</li> <li>– Prostate cancer screenings (PSA)</li> <li>– Sexually transmitted infections screenings and counseling</li> <li>– Smoking and tobacco use cessation counseling</li> <li>– Vaccines, including vaccines for the flu, hepatitis B, COVID-19 and pneumococcal</li> <li>– Vision care: Glaucoma screening</li> <li>– “Welcome to Medicare” preventive visit (one-time)</li> </ul> <p>Any extra preventive services approved by Medicare during the contract year will be covered. When you use doctors in this plan, 100% of the cost of preventive care screenings are covered.</p>
Emergency Care	<b>\$75 copay</b> , waived if admitted within 24 hours.
Urgent Care	<b>\$0 copay</b>
Worldwide Emergency and Urgent Care Services	<p><b>\$125 copay</b> for emergency services obtained outside the U.S.  <b>\$25 copay</b> for urgent care services obtained outside the U.S. This plan may cover emergency care, urgent care and transportation up to a \$50,000 limit. The plan will reimburse you for our share of the cost up to the Medicare allowable charge. If the cost of the service is more than \$50,000 you will have to pay the difference.</p>



# 2023 SUMMARY OF BENEFITS *(continued)*

COVERED MEDICAL AND HOSPITAL SERVICES	DrMax (HMO-POS) H4140-001
Diagnostic Services*	<p>Diagnostic procedures and tests:</p> <ul style="list-style-type: none"> <li>– <b>\$0 copay</b> at your primary care physician’s office</li> <li>– <b>\$0 copay</b> at a specialist’s office</li> <li>– <b>\$0 copay</b> at an urgent care center</li> <li>– <b>\$0 copay</b> at a hospital facility as an outpatient</li> </ul> <p>Basic radiology (X-ray) services:</p> <ul style="list-style-type: none"> <li>– <b>\$0 copay</b> at your primary care physician’s office</li> <li>– <b>\$0 copay</b> at a specialist’s office</li> <li>– <b>\$0 copay</b> at an urgent care center</li> <li>– <b>\$0 copay</b> at a freestanding radiological facility</li> <li>– <b>\$0 copay</b> at a hospital facility as an outpatient</li> </ul> <p>Diagnostic radiology services (includes advanced imaging services such as MRI, MRA and CT Scans):</p> <ul style="list-style-type: none"> <li>– <b>\$0 copay</b> at your primary care physician’s office</li> <li>– <b>\$0 copay</b> at a specialist’s office</li> <li>– <b>\$0 copay</b> at a freestanding radiological facility</li> <li>– <b>\$50 copay</b> at a hospital facility as an outpatient</li> </ul> <p>Therapeutic radiology (radiation therapy) services:</p> <ul style="list-style-type: none"> <li>– <b>\$50 copay</b></li> </ul> <p>Lab services:</p> <ul style="list-style-type: none"> <li>– <b>\$0 copay</b></li> </ul>
Hearing Exams	<b>\$0 copay</b> for routine hearing exam.
Hearing Aid Limit	<b>\$0 copay</b> for hearing aid fitting/evaluation every 2 calendar years. Our plan covers up to \$1,200 maximum plan benefit for hearing aids every 2 calendar years.
Dental Services*	<p><b>\$0 copay</b> for limited Medicare-covered dental services.</p> <p><b>\$0 copay</b> for the following supplemental dental services:</p> <ul style="list-style-type: none"> <li>– Periodic oral evaluation(s), up to 2 per calendar year</li> <li>– Comprehensive oral evaluation, up to 2 per calendar year</li> <li>– Prophylaxis cleaning(s), up to 2 per calendar year</li> <li>– Fluoride, up to 2 per calendar year</li> <li>– Bitewing x-rays, up to 2 per calendar year</li> <li>– Panoramic x-ray, up to 1 per 3 calendar years</li> <li>– Amalgam or resin filling(s), up to 2 per calendar year</li> <li>– Extractions, up to 4 per calendar year</li> <li>– Root canals, up to 1 per calendar year</li> <li>– Crowns, up to 1 per calendar year</li> <li>– Scaling and root planing (deep cleaning), up to 1 per quadrant per 2 years</li> <li>– Complete or partial dentures (upper and/or lower), up to 1 set every 5 calendar years</li> </ul> <p>You must visit a participating dental network provider to receive dental benefits. Please refer to the plans website <a href="http://www.doctorshcp.com/2023Providers/">www.doctorshcp.com/2023Providers/</a> for participating dental providers.</p>



<b>COVERED MEDICAL AND HOSPITAL SERVICES</b>	<b>DrMax (HMO-POS) H4140-001</b>
Vision Exams	<b>\$0 copay</b> for eye exams.
Vision Services	Our plan covers up to <b>\$200 allowance</b> for eyeglasses and/or contact lenses every year.
Mental Health Care — InPatient*	<b>\$0 copay per stay:</b> Our plan has a lifetime limit of 190 days for inpatient mental health care in a psychiatric hospital. This limit does not apply to inpatient mental health services provided in a general hospital. Our plan also covers 60 “lifetime reserve days.” These are “extra” days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.
Mental Health Care Services — Outpatient*	<b>\$0 copay:</b> Group <b>\$0 copay:</b> Individual Includes outpatient treatment for mental illness and/or substance abuse.
Skilled Nursing Facility (SNF)*	<b>\$0 copay</b> per day for days 1 through 20. <b>\$50 copay</b> per day for days 21 through 100. 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.
Physical Therapy*	<b>\$0 copay</b>
Ambulance	<b>\$100 copay</b> per trip for emergency ambulance services.
Transportation	<b>\$0 copay</b> for unlimited trips per calendar year. Routine transportation coverage to and from your medical appointments to plan-approved locations. You must call our contracted transportation vendor to schedule an appointment.

<b>MEDICARE PART B DRUGS</b>	
Part B Drugs*	<p><b>0% coinsurance</b> for select Nebulized Medications. These include: Albuterol Sulfate, Budesonide, Cromolyn Sodium, Ipratropium Bromide, Ipratropium-Albuterol and Levalbuterol HCL</p> <p><b>20% coinsurance</b> for chemotherapy/radiation drugs.</p> <p><b>20% coinsurance</b> for other Part B Drugs.</p> <p><b>\$0 copay</b> for administration of Part B Drugs.</p> <p>Beginning April 1, 2023, The Centers for Medicare &amp; Medicaid Services (CMS) will specify the adjusted coinsurance amount for each “<b>Part B Rebatable Drug</b>” in the quarterly pricing files. Your coinsurance will be adjusted based on this quarterly report from Medicare. <b>You will not pay more than 20%.</b></p> <p><b>Part B Insulins:</b> Beginning July 1, 2023, <b>you will not pay more than \$35 for a one-month supply</b> of insulin covered under Part B.</p> <p>The Plan utilizes Step Therapy for the following Part B Drugs: Viscosupplements, Eylea, and Lucentis.</p>

# 2023 SUMMARY OF BENEFITS *(continued)*

PART D PRESCRIPTION DRUG BENEFITS		
<b>Deductible</b>	This plan does not have a deductible.	
<b>Initial Coverage Limit</b>	You pay the following until your yearly drug costs reach <b>\$7,000</b> .	
<b>TIERS</b>	<b>RETAIL COST-SHARING</b>	<b>MAIL-ORDER COST-SHARING</b>
Tier 1: Preferred Generics	<b>\$0 copay</b> for 30-day supply <b>\$0 copay</b> for 90-day supply <sup>†</sup>	<b>\$0 copay</b> for 30-day supply <b>\$0 copay</b> for 90-day supply <sup>†</sup>
Tier 2: Generics	<b>\$0 copay</b> for 30-day supply <b>\$0 copay</b> for 90-day supply <sup>†</sup>	<b>\$0 copay</b> for 30-day supply <b>\$0 copay</b> for 90-day supply <sup>†</sup>
Tier 3: Preferred Brands	<b>\$0 copay</b> for 30-day supply <b>\$0 copay</b> for 90-day supply <sup>†</sup> Insulin Savings Program: You pay \$0 for Select Insulins. (See 2023 Drug List for Select Insulin drugs). <sup>‡</sup>	<b>\$0 copay</b> for 30-day supply <b>\$0 copay</b> for 90-day supply <sup>†</sup> Insulin Savings Program: You pay \$0 for Select Insulins. (See 2023 Drug List for Select Insulin drugs). <sup>‡</sup>
Tier 4: Non-Preferred Drugs	<b>\$45 copay</b> for 30-day supply <b>\$135 copay</b> for 90-day supply <sup>†</sup>	<b>\$45 copay</b> for 30-day supply <b>\$135 copay</b> for 90-day supply <sup>†</sup>
Tier 5: Specialty	<b>33% coinsurance</b> for 30-day supply	<b>33% coinsurance</b> for 30-day supply
	A long-term supply is not available for drugs in the Specialty Tier.	
Tier 6: Supplemental Drugs	<b>\$0 copay</b> for 30 day-supply <b>\$0 copay</b> for 90-day supply <sup>†</sup>	<b>\$0 copay</b> for 30 day-supply <b>\$0 copay</b> for 90-day supply <sup>†</sup>

<sup>†</sup> Any medication being filled for the FIRST TIME is subject to a 30-day supply limit.

If the plan approves a drug that is not available on the formulary, it will be subject to a Tier 4 copay.

*The amount you pay is determined by the covered Part D prescription and your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for the specific amount you pay.*

<sup>‡</sup> This plan participates in the Insulin Savings Program which offers lower out-of-pocket costs for select, covered insulins. You will pay a \$0 copayment for a one-month supply of covered insulins during the Initial Coverage and Coverage Gap stages of your benefit. Note: Beneficiaries who receive “Extra Help” from Medicare do not qualify for the Insulin Savings Program during the Initial Coverage and Coverage Gap Stages.

During the Catastrophic Stage, you will pay a maximum \$35 copayment for a one-month supply of your covered insulins. Your cost may be less if you receive “Extra Help” from Medicare. To find out which drugs are Select Insulins, review the most recent Drug List we provided electronically. You can identify Select Insulins by the “SI” symbol. If you have questions about the Drug List, you can also call Member Services.

**Important Message About What You Pay for Insulin:** You won’t pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it’s on and this is applicable throughout all coverage stages.

**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.

## COVERAGE GAP

After your total yearly drug costs (what you and the plan pay) reach **\$7,000**, you enter the Coverage Gap.

- » You pay \$0 copay for all drugs in Tiers 1, 2 and 6 through the Coverage Gap.
- » You pay only 25% of the cost and portion of the dispensing fee for Brand Name drugs in Tiers 3, 4 and 5.
- » You pay no more than 25% of the cost of Generic drugs in Tiers 3, 4 and 5. The plan pays the rest.
- » When you reach an out-of-pocket limit of **\$7,400**, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

DrMax (HMO-POS) offers additional gap coverage for Select Insulins. During the Coverage Gap Stage, your out-of-pocket costs for Select Insulins will be \$0 for a 1-month supply.

Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

## CATASTROPHIC COVERAGE

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **\$7,400**, you pay the greater of:

- » 5% of the cost, or
- » **\$4.15** copay for generic (including brand drugs treated as generic) and a **\$10.35** copay for all other drugs.
- » You pay a \$0 copay for Tier 6 drugs in the Catastrophic Coverage Stage.
- » Your yearly out-of-pocket drug costs is the total of any Part D-covered drug payments made during the calendar year by you, on your behalf, or under another Medicare prescription drug plan before you joined our plan, and determines when you enter the Catastrophic Coverage Stage.

During the Catastrophic Stage, you will pay a maximum \$35 copayment for a one-month supply of your covered insulins. Your cost may be less if you receive "Extra Help" from Medicare.

Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

## SUPPLEMENTAL DRUG COVERAGE

Our plan offers additional coverage of some prescription drugs not normally covered in a Medicare prescription drug plan. Covered drugs include:

- » Some drugs used for the relief of cough and cold symptoms, such as benzonatate.
- » Some prescription vitamins, such as ergocalciferol (Vitamin D2) oral with a limit of four (4) capsules per 28 days and cyanocobalamin (Vitamin B12) injectable with a limit of 10mLs per month.
- » Some erectile dysfunction drugs, such as sildenafil (generic for Viagra®) and tadalafil (generic for Cialis®), with a limit of four (4) tablets per month.

Please refer to your Evidence of Coverage (EOC) document to determine how much you will pay. Your Plan's Formulary includes additional information about all drugs covered under this benefit.

## ADDITIONAL PRESCRIPTION DRUG INFORMATION

If you receive "Extra Help" from Medicare, your costs for prescription drugs may be lower than the cost-shares in this booklet. You pay whichever is less.

# 2023 SUMMARY OF BENEFITS *(continued)*

ADDITIONAL BENEFITS	DrMax (HMO-POS) H4140-001
Outpatient Rehabilitation*	<p><b>\$0 copay:</b> Cardiac rehabilitation</p> <p><b>\$0 copay:</b> Pulmonary rehabilitation</p> <p><b>\$0 copay:</b> Occupational therapy visit</p>
Podiatry Services	<p><b>\$0 copay</b> Medicare-covered foot care.</p> <p><b>\$0 copay</b> routine foot care, up to 6 visits per year.</p>
Point-of-Service (POS)*	<p><b>\$10,000:</b> This benefit allows you to access out-of-network specialists in Miami-Dade and Broward Counties. The following specialties are excluded: Pain Management, Dermatology, Oncology, and Behavioral Health. This benefit allows you access up to your plan’s specific benefit amount, without a referral. These services require a prior authorization. Your specialist should call the plan for authorization.</p>
Additional Telehealth Benefit for Part B Services*	<p><b>\$0 copay</b> per telehealth visit for:</p> <ul style="list-style-type: none"> <li>– Primary Care Physician Services</li> <li>– Occupational Therapy Services</li> <li>– Physician Specialists Services</li> <li>– Individual Sessions for Mental Health Specialty</li> <li>– Group Sessions for Mental Health Specialty</li> <li>– Podiatry Services</li> <li>– Other Health Care Professional Services</li> <li>– Individual Sessions for Psychiatric Services</li> <li>– Group Sessions for Psychiatric Services</li> <li>– Physical Therapy and Speech-Language Pathology Services</li> <li>– Opioid Treatment Program Services</li> <li>– Individual Sessions for Outpatient Substance Abuse</li> <li>– Group Sessions for Outpatient Substance Abuse</li> <li>– Kidney Disease Educational Services</li> <li>– Diabetes Self-Management Training</li> </ul>

<b>MEDICAL EQUIPMENT AND SUPPLIES</b>	<b>DrMax (HMO-POS) H4140-001</b>
Durable Medical Equipment (DME)*	<p><b>20% coinsurance</b> for covered items, including but not limited to powered wheelchairs, powered mattress systems, continuous glucose monitors (CGMs), and other electric devices.</p> <p><b>0% coinsurance</b> for the total cost of CPAP machines.</p> <p><b>0% coinsurance</b> for all other medical equipment.</p> <p>The list of preferred vendors and manufacturers for durable medical equipment (DME) can be found in your EOC and online at <a href="http://www.doctorshcp.com/2023Plans/">www.doctorshcp.com/2023Plans/</a>.</p>
Prosthetic Devices*	<p><b>20% coinsurance</b> for braces/artificial limbs.</p> <p><b>0% coinsurance</b> for all other prosthetic devices.</p>
Diabetic Supplies*	<p><b>0% coinsurance</b> for preferred glucometers, test strips, lancets, lancet devices and control solutions.</p> <p>The Plan's Preferred Diabetic Supplies include <b>Abbott: Freestyle® products (not including Freestyle Libre®), Abbott: Precision Xtra® products and LifeScan: OneTouch® products.</b></p> <p><b>20% coinsurance</b> for non-preferred glucometers, lancets, test strips and other diabetic supplies. A Prior Authorization is required for non-preferred glucometers and test strips.</p>
Therapeutic Shoes or Inserts; Medicare-covered*	<p><b>0% coinsurance</b></p>
<b>WELLNESS PROGRAMS</b>	<b>DrMax (HMO-POS) H4140-001</b>
Health Education	Interactive sessions with a certified health educator for members who qualify.
Fitness Benefit	<b>\$0 copay:</b> Membership and access to fitness facilities, healthy aging coaching, home fitness kits and fitness education materials.
Meals Benefit*	<b>\$0 copay</b> for up to 16 meals per calendar year following discharge from hospital.
Over-the-Counter (OTC) Benefit	<b>\$55 limit per month:</b> This plan covers certain approved, non-prescription, over-the-counter drugs and health-related items, up to \$55 every month. Unused OTC amounts do not roll over from month to month. Please visit <a href="http://www.cvs.com/otchs/doctorshcp">www.cvs.com/otchs/doctorshcp</a> to see a list of covered over-the-counter items.
Chiropractor Care	<p><b>\$0 copay</b> Medicare-covered chiropractic services.</p> <p><b>\$0 copay</b> routine chiropractic care, up to 12 visits per year.</p>
Acupuncture	<p><b>\$0 copay</b> Medicare-covered acupuncture treatments.</p> <p><b>\$0 copay</b> supplemental acupuncture treatments, up to 20 visits per year.</p>
Home Health Services*	<b>\$0 copay</b> for limited skilled nursing care and certain other health services you get in your home for the treatment of an illness or injury. Number of covered visits is based on medical need as determined by your physician and authorized by the plan.

## DISCRIMINATION IS AGAINST THE LAW

Doctors HealthCare Plans, Inc. complies with applicable civil rights laws and does not discriminate or exclude individuals on the basis of race, color, national origin, age disability, sex, sexual orientation, pregnancy, gender, gender identity, or religion.

Doctors HealthCare Plans, Inc. provides: (1) free aids and services to people with disabilities to communicate effectively with us, such as, qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats); and, (2) free language services to individuals whose primary language is not English, such as, qualified interpreters and information written in other languages.

If you need these services, contact the number on the back of your ID Card. If you believe that Doctors HealthCare Plans, Inc., has failed to provide these services or discriminated in any way, you can file a grievance with: **Doctors HealthCare Plans, Inc.**, Attention: Member Services Department, 2020 Ponce de Leon Blvd., PH 1, Coral Gables, FL 33134 or call (786) 460-3427 or (833) 342-7463, TTY:711; 7 days a week; 8AM to 8PM EST.

You can file a grievance by calling, in person or by mail. If you need help filing a grievance, our Member Services Representatives are available to help you at the number listed above. You can also file a civil rights complaint electronically through the U.S. Department of Health and Human Services, 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 or call (800) 368-1019, (800) 537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## MULTI-LANGUAGE INTERPRETER SERVICE

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at (833) 342-7463 (TTY:711). Someone who speaks English/Language can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al (833) 342-7463 (TTY:711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务,帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务,请致电 (833) 342-7463 (TTY:711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問,為此我們提供免費的翻譯服務。如需翻譯服務,請致電 (833) 342-7463 (TTY:711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasalang-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasalang-wika, tawagan lamang kami sa (833) 342-7463 (TTY:711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au (833) 342-7463 (TTY:711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.



**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi (833) 342-7463 (TTY:711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter (833) 342-7463 (TTY:711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 (833) 342-7463 (TTY:711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону (833) 342-7463 (TTY:711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:**

إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (833) 342-7463 (TTY:711). سيقوم شخص بمساعدتك. هذه خدمة مجانية ما يتحدث العربية.

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero (833) 342-7463 (TTY:711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portugués:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número (833) 342-7463 (TTY:711). Irá encontrar alguém que fale idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan (833) 342-7463 (TTY:711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer (833) 342-7463 (TTY:711). Ta usługa jest bezpłatna.

**Hindi:** हमारे सवा य या दवा की योजना के बारे में आपके किसी भी परन के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया परापत करने के लिए, बस हमों (833) 342-7463 (TTY:711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

**Japanese:** 当社の健康健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、(833) 342-7463 (TTY:711) にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。