

Benefit highlights

Preferred Choice Dade (HMO)

This is a short description of your 2022 plan benefits. For complete information, please refer to your Summary of Benefits or Evidence of Coverage. Limitations, exclusions and restrictions may apply.

Plan Costs

Monthly plan premium	\$0
----------------------	-----

Medical Benefits

	Your Cost
Annual Medical Deductible	No deductible
Annual out-of-pocket maximum (The most you may pay in a year for covered medical care)	\$2,900
Doctor's office visit	Primary Care Provider: \$0 copay Specialist: \$0 copay (no referral needed) Virtual visits: \$0 copay; Speak to network telehealth providers using your computer or mobile device.
Preventive services	\$0 copay
Inpatient hospital care	\$0 copay per stay for unlimited days
Skilled nursing facility (SNF)	\$0 copay per day: days 1-20 \$25 copay per day: days 21-100
Outpatient hospital, including surgery (Cost sharing for additional plan services will apply)	\$75 copay
Mental health (outpatient and virtual)	Group therapy: \$0 copay Individual therapy: \$0 copay Virtual visits: \$0 copay; Speak to network telehealth providers using your computer or mobile device.
Diabetes monitoring supplies	\$0 copay for covered brands
Diagnostic radiology services (such as MRIs, CT scans)	\$0 copay
Diagnostic tests and procedures (non-radiological)	\$0 copay
Lab services	\$0 copay
Outpatient x-rays	\$0 copay
Ambulance	\$250 copay for ground or air
Emergency care	\$100 copay (\$0 copay for emergency care outside the United States) per visit
Urgently needed services	\$0 copay (worldwide)

Benefits and Services Beyond Original Medicare

	Your Cost
Routine physical	\$0 copay; 1 per year
Routine eye exams	\$0 copay; 1 each year
Routine eyewear	\$0 copay every year; up to \$200 for lenses/frames and contacts
Dental - preventive	\$0 copay for exams, cleanings, x-rays, and fluoride
Dental - comprehensive	Covered; for a complete list of services and copays, please contact the plan
Hearing - routine exam	\$0 copay; 1 per year
Hearing aids	\$600 allowance per ear, maximum benefit of \$1200 every 2 years; up to 2 hearing aids
Fitness program	Renew Active fitness membership, classes and online brain exercises at no cost to you.
Routine Transportation	\$0 copay for unlimited one-way trips to or from approved medically related appointments and pharmacies
Foot care - routine	\$0 copay; 6 visits per year
Over-the-Counter Benefit	\$50 credit per month to use from a plan approved listing of products.
NurseLine	Speak with a registered nurse (RN) 24 hours a day, 7 days a week.

Prescription Drugs

	Your Cost	
Annual prescription (Part D) deductible	\$0	
Initial coverage stage	Standard Retail (30-day)	Preferred Mail Order (100-day)
Tier 1: Preferred Generic	\$0 copay	\$0 copay
Tier 2: Generic ¹	\$0 copay	\$0 copay
Tier 3: Preferred Brand	\$0 copay	\$0 copay
Select Insulin Drugs ²	\$0 copay	\$0 copay
Tier 4: Non-Preferred Drug	\$40 copay	\$110 copay
Tier 5: Specialty Tier	33% coinsurance	N/A ³
Coverage gap stage	Tier 1 and Tier 2 drugs are covered in the gap. For covered drugs on other tiers, after your total drug costs reach \$5,000, you pay 25% coinsurance for generic drugs and 25% coinsurance for brand name drugs during the coverage gap	

Prescription Drugs

	Your Cost
Catastrophic coverage stage	After your total out-of-pocket costs reach \$7,050, you will pay the greater of \$3.95 copay for generic (Including brand drugs treated as generic), \$9.85 copay for all other drugs, or 5% coinsurance

¹ Tier includes enhanced drug coverage

² For 2022, this plan participates in the Part D Senior Savings Model which offers lower, stable, and predictable out of pocket costs for covered insulin through the different Part D benefit coverage stages. You will pay a maximum of \$0 for a 1-month supply of Part D select insulin drugs during the deductible, initial coverage and coverage gap or "donut hole" stages of your benefit. You will pay 5% of the cost of your insulin in the catastrophic stage. This cost-sharing only applies to members who do not qualify for a program that helps pay for your drugs ("Extra Help").

³ Limited to a 30-day supply



This information is not a complete description of benefits. Contact the plan for more information.

Y0066_MABH_2022_M H1045001000

PCFL22HM4999222_000