



2025
Summary of Benefits
MIAMI-DADE COUNTY

DrMax
(HMO) H4140-001

DrSelect
(HMO) H4140-012

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

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.

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

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/2025Plans/ 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, 2026.
- ☐ **DrPlus (HMO D-SNP) H4140-002 & DrFlex (HMO D-SNP) H4140-013:** These plans are dual eligible special needs plans (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 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.
- ☐ **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.

2025 Summary of Benefits

DrMax (HMO) H4140-001

DrSelect (HMO) H4140-012

This is a summary of drug and health services covered by Doctors HealthCare Plans, Inc., beginning January 1, 2025, through December 31, 2025. 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)*, or you can view on our website at www.doctorshcp.com/2025Plans/.

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 & DrSelect 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 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/2025druglist/, 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/2025Providers/ 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. Depending on your plan, you may need a referral to visit a specialist. Except for emergency, urgent, and preventive services, certain services require prior authorization and/or referral.

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

DO YOU HAVE MEDICARE AND MEDICAID?

If you are cost-share protected by the 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 payment you have the right to a refund. If you have any questions, call us at 1-833-342-7463, 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 may require a prior authorization are noted with a "1" and services that may require a referral are noted with a "2" in the benefit titles listed in this booklet. For more information, you may refer to your *Evidence of Coverage*.

To request a prior authorization and/or referral, please contact your physician.

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.

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



2025 Summary of Benefits

PREMIUMS AND BENEFITS	DrMax (HMO) H4140-001	DrSelect (HMO) H4140-012
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.
Deductible	This plan does not have a deductible for medical services.	This plan does not have a deductible for medical services.
Maximum Out-of-Pocket (MOOP)	\$3,000 per year: This amount is the most you will pay during the plan year for in-network 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.	\$3,000 per year: This amount is the most you will pay during the plan year for in-network 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) H4140-001	DrSelect (HMO) H4140-012
Inpatient Hospital Care ¹	\$0 per admission: Our plan covers an unlimited number of days for an inpatient hospital stay.	\$0 per admission: Our plan covers an unlimited number of days for an inpatient hospital stay.
Outpatient Hospital Care	\$0 copay for: <ul style="list-style-type: none"> • Lab services • Mental health care group and individual therapy visits¹ • Physical therapy, occupational therapy, speech and language therapy^{1,2} • Cardiac and pulmonary rehabilitation services¹ • Diagnostic procedures and test • Basic radiology (x-ray) services^{1,2} \$50 copay for surgery at a hospital or facility. ¹ \$50 copay for observation services. ¹	\$0 copay for: <ul style="list-style-type: none"> • Lab services² • Mental health care group and individual therapy visits^{1,2} • Physical therapy, occupational therapy, speech and language therapy^{1,2} • Cardiac and pulmonary rehabilitation services^{1,2} • Diagnostic procedures and test² • Basic radiology (x-ray) services^{1,2} \$75 copay for surgery at a hospital or facility. ^{1,2} \$75 copay for observation services. ¹
Outpatient Surgery — Ambulatory Surgical Center (ASC)	\$25 copay ¹	\$25 copay ^{1,2}
Primary Care Physician (PCP)	\$0 copay for primary care physician visits. You must select a PCP from the network.	\$0 copay for primary care physician visits. You must select a PCP from the network.
Specialist	\$0 copay for specialist visits. ¹ A referral is NOT required for specialist visits.	\$0 copay for specialist visits. ^{1,2} A referral is required for specialist visits.

Services with a “1” may need prior authorization from the plan. Services with a “2” may need a referral from your primary care physician (PCP).

COVERED MEDICAL AND HOSPITAL SERVICES	DrMax (HMO) H4140-001	DrSelect (HMO) H4140-012
Preventive Care Services	<p>\$0 copay for the following supplemental preventative services:</p> <ul style="list-style-type: none"> • Alcohol Misuse Screening & Counseling • Annual Wellness Visit • Bone Mass Measurement • Cardiovascular Disease Screening Test • Cervical Cancer Screening • Colorectal Cancer Screening • Counseling to Prevent Tobacco Use • COVID-19 Vaccine & Administration • Depression Screening • Diabetes Screening • Diabetes Self-Management Training • Flu Shot & Administration • Glaucoma Screening • Hepatitis B Screening • Hepatitis B Shot & Administration • Hepatitis C Screening • HIV Screening • IBT for Cardiovascular Disease • IBT for Obesity • Initial Preventive Physical Exam • Lung Cancer Screening • Mammography Screening • Medical Nutrition Therapy • Medicare Diabetes Prevention Program • Pneumococcal Shot & Administration • Prolonged Preventive Services • Prostate Cancer Screening • Screening Pap Test • Screening Pelvic Exam • STI Screening & HIBC to Prevent STIs • Ultrasound AAA Screening <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>	<p>\$0 copay for the following supplemental preventative services:</p> <ul style="list-style-type: none"> • Alcohol Misuse Screening & Counseling • Annual Wellness Visit • Bone Mass Measurement • Cardiovascular Disease Screening Test • Cervical Cancer Screening • Colorectal Cancer Screening • Counseling to Prevent Tobacco Use • COVID-19 Vaccine & Administration • Depression Screening • Diabetes Screening • Diabetes Self-Management Training • Flu Shot & Administration • Glaucoma Screening • Hepatitis B Screening • Hepatitis B Shot & Administration • Hepatitis C Screening • HIV Screening • IBT for Cardiovascular Disease • IBT for Obesity • Initial Preventive Physical Exam • Lung Cancer Screening • Mammography Screening • Medical Nutrition Therapy • Medicare Diabetes Prevention Program • Pneumococcal Shot & Administration • Prolonged Preventive Services • Prostate Cancer Screening • Screening Pap Test • Screening Pelvic Exam • STI Screening & HIBC to Prevent STIs • Ultrasound AAA Screening <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>

Services with a “1” may need prior authorization from the plan. Services with a “2” may need a referral from your primary care physician (PCP).

2025 Summary of Benefits *(continued)*

COVERED MEDICAL AND HOSPITAL SERVICES	DrMax (HMO) H4140-001	DrSelect (HMO) H4140-012
Emergency Care	\$75 copay , waived if admitted within 24 hours.	\$75 copay , waived if admitted within 24 hours.
Urgent Care	\$0 copay	\$0 copay
Worldwide Emergency and Urgent Care Services	<p>\$125 copay for emergency services obtained outside the U.S.</p> <p>\$25 copay for urgent care services obtained outside the U.S.</p> <p>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>	<p>\$125 copay for emergency services obtained outside the U.S.</p> <p>\$25 copay for urgent care services obtained outside the U.S.</p> <p>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>
Diagnostic Services	<p>Diagnostic procedures and tests:</p> <ul style="list-style-type: none"> • \$0 copay at your primary care physician's office • \$0 copay at a specialist's office • \$0 copay at a hospital facility as an outpatient <p>Basic radiology (X-ray) services:</p> <ul style="list-style-type: none"> • \$0 copay at your primary care physician's office • \$0 copay at a specialist's office^{1,2} • \$0 copay at a freestanding radiological facility^{1,2} • \$0 copay at a hospital facility as an outpatient^{1,2} <p>Diagnostic radiology services (includes advanced imaging services such as MRI, MRA and CT Scans):</p> <ul style="list-style-type: none"> • \$0 copay at your primary care physician's office • \$0 copay at a specialist's office^{1,2} • \$0 copay at a freestanding radiological facility^{1,2} • \$75 copay at a hospital facility as an outpatient^{1,2} <p>Therapeutic radiology (radiation therapy) services:^{1,2}</p> <ul style="list-style-type: none"> • \$75 copay <p>Lab services:</p> <ul style="list-style-type: none"> • \$0 copay 	<p>Diagnostic procedures and tests:</p> <ul style="list-style-type: none"> • \$0 copay at your primary care physician's office • \$0 copay at a specialist's office² • \$0 copay at a hospital facility as an outpatient² <p>Basic radiology (X-ray) services:</p> <ul style="list-style-type: none"> • \$0 copay at your primary care physician's office • \$0 copay at a specialist's office^{1,2} • \$0 copay at a freestanding radiological facility^{1,2} • \$0 copay at a hospital facility as an outpatient^{1,2} <p>Diagnostic radiology services (includes advanced imaging services such as MRI, MRA and CT Scans):</p> <ul style="list-style-type: none"> • \$0 copay at your primary care physician's office • \$0 copay at a specialist's office^{1,2} • \$0 copay at a freestanding radiological facility^{1,2} • \$75 copay at a hospital facility as an outpatient^{1,2} <p>Therapeutic radiology (radiation therapy) services:^{1,2}</p> <ul style="list-style-type: none"> • \$75 copay <p>Lab services:²</p> <ul style="list-style-type: none"> • \$0 copay

Services with a "1" may need prior authorization from the plan. Services with a "2" may need a referral from your primary care physician (PCP).

COVERED MEDICAL AND HOSPITAL SERVICES	DrMax (HMO) H4140-001	DrSelect (HMO) H4140-012
Hearing Services	\$0 copay for routine hearing exam. \$0 copay for hearing aid fitting/evaluation every 2 calendar years. Up to \$1,350 allowance for hearing aids every 2 calendar years.	\$0 copay for routine hearing exam. \$0 copay for hearing aid fitting/evaluation every 2 calendar years. Up to \$1,350 allowance for hearing aids every 2 calendar years.
Dental Services — Preventive	\$0 copay for the following preventive dental services: <ul style="list-style-type: none"> • Oral exam, up to 2 per calendar year • Prophylaxis cleaning(s), up to 2 per calendar year • Fluoride, up to 2 per calendar year • Bitewing x-rays, up to 2 per calendar year • Panoramic x-ray, up to 1 per 3 calendar years 	\$0 copay for the following preventive dental services: <ul style="list-style-type: none"> • Oral exam, up to 2 per calendar year • Prophylaxis cleaning(s), up to 2 per calendar year • Fluoride, up to 2 per calendar year • Bitewing x-rays, up to 2 per calendar year • Panoramic x-ray, up to 1 per 3 calendar years
Dental Services — Comprehensive ¹	\$0 copay for the following supplemental dental services: <ul style="list-style-type: none"> • Fillings (amalgam or resin), up to 6 per calendar year • Extractions, up to 4 per calendar year • Root canal, up to 1 per calendar year • Crowns, up to 2 per calendar year • Implants, up to 2 per calendar year • Scaling and root planing (deep cleaning), up to 1 per quadrant per 2 years • Dentures, up to 1 full upper and 1 full lower denture per 5 years or 1 partial upper and 1 partial lower denture per 5 calendar years You must visit a participating dental network provider to receive dental benefits. Please refer to the plans website www.doctorshcp.com/2025Providers/ for participating dental providers.	\$0 copay for the following supplemental dental services: <ul style="list-style-type: none"> • Fillings (amalgam or resin), up to 2 per calendar year • Extractions, up to 4 per calendar year • Root canal, up to 1 per calendar year • Crown, up to 1 per calendar year • Implant, up to 1 per calendar year • Scaling and root planing (deep cleaning), up to 1 per quadrant per 2 years • Dentures, up to 1 full upper and 1 full lower denture per 5 years or 1 partial upper and 1 partial lower denture per 5 calendar years You must visit a participating dental network provider to receive dental benefits. Please refer to the plans website www.doctorshcp.com/2025Providers/ for participating dental providers.

Services with a “1” may need prior authorization from the plan. Services with a “2” may need a referral from your primary care physician (PCP).

2025 Summary of Benefits *(continued)*

COVERED MEDICAL AND HOSPITAL SERVICES	DrMax (HMO) H4140-001	DrSelect (HMO) H4140-012
Vision Services	<p>\$0 copay for eye exams.</p> <p>Up to \$400 allowance for eyeglasses and/or contact lenses per calendar year.</p> <p>or</p> <p>Up to 3 pairs of eyeglasses at no cost from the iCare Grand Lux Collection per calendar year.</p>	<p>\$0 copay for eye exams.</p> <p>Up to \$400 allowance for eyeglasses and/or contact lenses per calendar year.</p> <p>or</p> <p>Up to 3 pairs of eyeglasses at no cost from the iCare Grand Lux Collection per calendar year.</p>
Mental Health Care — InPatient ¹	<p>\$0 copay per stay: 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.</p>	<p>\$0 copay per stay: 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.</p>
Mental Health Care Services — Outpatient	<p>\$0 copay: Group¹</p> <p>\$0 copay: Individual¹</p> <p>Includes outpatient treatment for mental illness and/or substance abuse.</p>	<p>\$0 copay: Group^{1,2}</p> <p>\$0 copay: Individual^{1,2}</p> <p>Includes outpatient treatment for mental illness and/or substance abuse.</p>

Services with a “1” may need prior authorization from the plan. Services with a “2” may need a referral from your primary care physician (PCP).

PART D PRESCRIPTION DRUG BENEFITS FOR DrMax & DrSelect

Deductible	These plans have no deductible.	
Initial Coverage Phase	DrMax (HMO) & DrSelect (HMO): You pay the following until you reach your maximum annual out-of-pocket (OOP) threshold of \$2,000 for Part D drugs.	
TIERS	RETAIL COST-SHARING	MAIL-ORDER COST-SHARING
Tier 1: Preferred Generics	\$0 copay for 30-day supply \$0 copay for 90-day supply	\$0 copay for 30-day supply \$0 copay for 90-day supply
Tier 2: Generics	\$0 copay for 30-day supply \$0 copay for 90-day supply	\$0 copay for 30-day supply \$0 copay for 90-day supply
Tier 3: Preferred Brands	\$0 copay for 30-day supply \$0 copay for 90-day supply	\$0 copay for 30-day supply \$0 copay for 90-day supply
Tier 4: Non-Preferred Drugs	\$55 copay for 30-day supply \$165 copay for 90-day supply <i>(You pay no more than \$35 per month supply of each covered insulin product on this tier.)</i>	\$55 copay for 30-day supply \$165 copay for 90-day supply <i>(You pay no more than \$35 per month supply of each covered insulin product on this tier.)</i>
Tier 5: Specialty	33% coinsurance for 30-day supply <i>(You pay no more than \$35 per month supply of each covered insulin product on this tier.)</i>	33% coinsurance for 30-day supply <i>(You pay no more than \$35 per month supply of each covered insulin product on this tier.)</i>
Tier 6: Supplemental Drugs	\$0 copay for 30 day-supply \$0 copay for 90-day supply	\$0 copay for 30 day-supply \$0 copay for 90-day supply

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.

Tiers 1, 2 and 6 Drugs are covered at **\$0 copayment** throughout all your benefit stages.

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

Important Message About What You Pay for Insulin: You won’t pay more than **\$35** for a one-month supply (no more than \$70 for a two-month supply and \$105 for a three-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.

Services with a “1” may need prior authorization from the plan. Services with a “2” may need a referral from your primary care physician (PCP).

2025 Summary of Benefits *(continued)*

CATASTROPHIC COVERAGE FOR DrMax & DrSelect

Once your annual out-of-pocket (OOP) threshold of \$2,000 is reached, you enter the Catastrophic Phase. You will stay in this payment stage until the end of the calendar year. During this stage, the plan pays the full cost for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

You pay nothing.

SUPPLEMENTAL DRUG COVERAGE AND VITAMINS FOR DrMax & DrSelect

Our plan offers additional coverage of some prescription drugs not normally covered in a Medicare prescription drug plan under our enhanced benefit (Tier 6 – Supplemental Drugs). 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 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.

Your Plan's Formulary includes additional information about all drugs covered under this benefit.

ADDITIONAL PRESCRIPTION DRUG INFORMATION FOR DrMax & DrSelect

If you receive "Extra Help", you pay whichever is less: your plan cost-share or the Low Income Subsidy (LIS) cost-share. *Please refer to your LIS Rider for the specific amount you pay.*

CONTINUATION OF BENEFITS	DrMax (HMO) H4140-001	DrSelect (HMO) H4140-012
Part B Drugs ¹	<p>0% coinsurance for select Nebulized Medications.</p> <p>These include: Albuterol Sulfate, Budesonide, Cromolyn Sodium, Ipratropium Bromide, Ipratropium-Albuterol and Levalbuterol HCL</p> <p>0%-20% coinsurance for:</p> <ul style="list-style-type: none"> • Chemotherapy/radiation drugs • Other Part B Drugs • Part B Insulins (not to exceed \$35 monthly) <p>\$0 copay for administration of Part B Drugs.</p>	<p>0% coinsurance for select Nebulized Medications.</p> <p>These include: Albuterol Sulfate, Budesonide, Cromolyn Sodium, Ipratropium Bromide, Ipratropium-Albuterol and Levalbuterol HCL</p> <p>0%-20% coinsurance for:</p> <ul style="list-style-type: none"> • Chemotherapy/radiation drugs • Other Part B Drugs • Part B Insulins (not to exceed \$35 monthly) <p>\$0 copay for administration of Part B Drugs.</p>
Skilled Nursing Facility (SNF) ¹	<p>\$0 copay per day for days 1 through 20.</p> <p>\$60 copay per day for days 21 through 100.</p> <p>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.</p>	<p>\$0 copay per day for days 1 through 20.</p> <p>\$60 copay per day for days 21 through 100.</p> <p>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.</p>
Physical Therapy ^{1,2}	\$0 copay	\$0 copay
Ambulance	<p>\$125 copay per trip for emergency ground ambulance services.</p> <p>20% coinsurance per trip for emergency air ambulance services.</p>	<p>\$125 copay per trip for emergency ground ambulance services.</p> <p>20% coinsurance per trip for emergency air ambulance services.</p>
Transportation	<p>\$0 copay for unlimited trips to plan-approved locations per calendar year. You must call our contracted transportation vendor to schedule an appointment.</p>	<p>\$0 copay for unlimited trips to plan-approved locations per calendar year. You must call our contracted transportation vendor to schedule an appointment.</p>
Outpatient Rehabilitation	<p>\$0 copay per visit for:</p> <ul style="list-style-type: none"> • Cardiac rehabilitation services¹ • Pulmonary rehabilitation services¹ • Occupational therapy services^{1,2} • Supervised Exercise Therapy (SET) services¹ 	<p>\$0 copay per visit for:</p> <ul style="list-style-type: none"> • Cardiac rehabilitation services^{1,2} • Pulmonary rehabilitation services^{1,2} • Occupational therapy services^{1,2} • Supervised Exercise Therapy (SET) services^{1,2}

Services with a "1" may need prior authorization from the plan. Services with a "2" may need a referral from your primary care physician (PCP).

2025 Summary of Benefits *(continued)*

CONTINUATION OF BENEFITS	DrMax (HMO) H4140-001	DrSelect (HMO) H4140-012
Podiatry Services	\$0 copay Medicare-covered foot care. \$0 copay routine foot care, up to 6 visits per year.	\$0 copay Medicare-covered foot care. \$0 copay routine foot care, up to 6 visits per year.
Renal Dialysis ^{1,2}	20% coinsurance	20% coinsurance
Telehealth Services	\$0 copay per telehealth visit for: ¹ <ul style="list-style-type: none"> • Primary Care Physician Services • Occupational Therapy Services • Physician Specialists Services • Individual Sessions for Mental Health Specialty • Group Sessions for Mental Health Specialty • Podiatry Services • Other Health Care Professional Services • Individual Sessions for Psychiatric Services • Group Sessions for Psychiatric Services • Physical Therapy and Speech-Language Pathology Services • Opioid Treatment Program Services • Individual Sessions for Outpatient Substance Abuse • Group Sessions for Outpatient Substance Abuse • Kidney Disease Educational Services • Diabetes Self-Management Training 	\$0 copay per telehealth visit for: ^{1,2} <ul style="list-style-type: none"> • Primary Care Physician Services • Occupational Therapy Services • Physician Specialists Services • Individual Sessions for Mental Health Specialty • Group Sessions for Mental Health Specialty • Podiatry Services • Other Health Care Professional Services • Individual Sessions for Psychiatric Services • Group Sessions for Psychiatric Services • Physical Therapy and Speech-Language Pathology Services • Opioid Treatment Program Services • Individual Sessions for Outpatient Substance Abuse • Group Sessions for Outpatient Substance Abuse • Kidney Disease Educational Services • Diabetes Self-Management Training

Services with a “1” may need prior authorization from the plan. Services with a “2” may need a referral from your primary care physician (PCP).

MEDICAL EQUIPMENT AND SUPPLIES	DrMax (HMO) H4140-001	DrSelect (HMO) H4140-012
Durable Medical Equipment (DME) ¹	<p>20% coinsurance for covered items, including but not limited to:</p> <ul style="list-style-type: none"> • Powered wheelchairs • Powered mattress systems • Non-preferred continuous blood glucose monitors (CBGMs) • And other electric devices <p>0% coinsurance for:</p> <ul style="list-style-type: none"> • CPAP machines • Preferred continuous blood glucose monitors (CBGM's). <p>The Plan's preferred continuous blood glucose monitors (CBGM's) include: Freestyle®Libre, Dexcom G6 and Dexcom G7.</p> <ul style="list-style-type: none"> • And all other medical equipment <p>A Prior Authorization is required for non-preferred CBGM's.</p> <p>The list of preferred vendors and manufacturers for durable medical equipment (DME) can be found in your EOC and online at www.doctorshcp.com/2025Plans/.</p>	<p>20% coinsurance for covered items, including but not limited to:</p> <ul style="list-style-type: none"> • Powered wheelchairs • Powered mattress systems • Non-preferred continuous blood glucose monitors (CBGMs) • And other electric devices <p>0% coinsurance for:</p> <ul style="list-style-type: none"> • CPAP machines • Preferred continuous blood glucose monitors (CBGM's). <p>The Plan's preferred continuous blood glucose monitors (CBGM's) include: Freestyle®Libre, Dexcom G6 and Dexcom G7.</p> <ul style="list-style-type: none"> • And all other medical equipment <p>A Prior Authorization is required for non-preferred CBGM's.</p> <p>The list of preferred vendors and manufacturers for durable medical equipment (DME) can be found in your EOC and online at www.doctorshcp.com/2025Plans/.</p>
Prosthetic Devices ¹	<p>20% coinsurance for braces/artificial limbs.</p> <p>0% coinsurance for all other prosthetic devices.</p>	<p>20% coinsurance for braces/artificial limbs.</p> <p>0% coinsurance for all other prosthetic devices.</p>
Diabetic Supplies ¹	<p>0% coinsurance for preferred glucometers, test strips, lancets, lancet devices and control solutions.</p> <p>The Plan's Preferred Diabetic Supplies include Abbott products: FreeStyle® Lite, FreeStyle® Freedom Lite, Precision Xtra and Trividia products: True Metrix.</p> <p>20% coinsurance for non-preferred glucometers, test strips, lancets, lancet devices and control solutions. A Prior Authorization is only required for non-preferred glucometers and test strips.</p>	<p>0% coinsurance for preferred glucometers, test strips, lancets, lancet devices and control solutions.</p> <p>The Plan's Preferred Diabetic Supplies include Abbott products: FreeStyle® Lite, FreeStyle® Freedom Lite, Precision Xtra and Trividia products: True Metrix.</p> <p>20% coinsurance for non-preferred glucometers, test strips, lancets, lancet devices and control solutions. A Prior Authorization is only required for non-preferred glucometers and test strips.</p>
Therapeutic Shoes or Inserts; Medicare-covered ¹	0% coinsurance	0% coinsurance

Services with a "1" may need prior authorization from the plan. Services with a "2" may need a referral from your primary care physician (PCP).

2025 Summary of Benefits *(continued)*

WELLNESS PROGRAMS	DrMax (HMO) H4140-001	DrSelect (HMO) H4140-012
Prepaid Card*	Not covered	<p>\$122 monthly on a prepaid card to be used at approved locations to purchase groceries and over-the-counter (OTC) products. Amounts do not roll over from month to month. Funds will be available at the beginning of the month.</p> <p>The prepaid card is only available to members with certain chronic health conditions. Refer to your Evidence of Coverage (EOC) for details.</p> <p>*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.</p>
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.
Meals Benefit ^{1,2}	\$0 copay for up to 16 meals per calendar year following discharge from hospital.	\$0 copay for up to 16 meals per calendar year following discharge from hospital.
Over-the-Counter (OTC) Benefit	<p>\$75 monthly</p> <p>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.</p>	<i>Please refer to your benefit labeled "Prepaid Card"</i>
Chiropractor Care	<p>\$0 copay Medicare-covered chiropractic services.</p> <p>\$0 copay routine chiropractic care, up to 12 visits per year.</p>	<p>\$0 copay Medicare-covered chiropractic services.</p> <p>\$0 copay routine chiropractic care, up to 12 visits per year.</p>

Services with a "1" may need prior authorization from the plan. Services with a "2" may need a referral from your primary care physician (PCP).

WELLNESS PROGRAMS	DrMax (HMO) H4140-001	DrSelect (HMO) H4140-012
Acupuncture	<p>\$0 copay Medicare-covered acupuncture treatments.</p> <p>\$0 copay supplemental acupuncture treatments, up to 20 visits per year.¹</p>	<p>\$0 copay Medicare-covered acupuncture treatments.</p> <p>\$0 copay supplemental acupuncture treatments, up to 20 visits per year.^{1,2}</p>
Home Health Services	<p>\$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.¹</p> <p>Number of covered visits is based on medical need as determined by your physician and authorized by the plan.</p>	<p>\$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.^{1,2}</p> <p>Number of covered visits is based on medical need as determined by your physician and authorized by the plan.</p>

Services with a “1” may need prior authorization from the plan. Services with a “2” may need a referral from your primary care physician (PCP).

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements

Doctors HealthCare Plans, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). Doctors HealthCare Plans, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, 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 on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with:

Doctors HealthCare Plans, Inc.

Attn: Member Services/Civil Rights
2020 Ponce De Leon Blvd, PHI
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>.

MULTI-LANGUAGE INTERPRETER SERVICES

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 pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-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 Arzneimittelpplan. 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 도와드릴 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 ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके ककसी भी प्रश्न के जवाब देने के कएि हमारे पास मुफ्त दुभाकिया सेवाएँ उपब्धि हैं। एक दुभाकिया प्रारप्त करने के कएि, बस हमें 833-342-7463 (TTY:711) पर फोन करें। कोई व्यक्ति कहन्दी बोता है आपको मदद कर सकता है। यह एक मुफ्त सेवा है।

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.

Portuguese: 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 o 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.

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。日本語を話す人が支援いたします。これは無料のサービスです。