



2025  
**Summary of Benefits**  
MIAMI-DADE COUNTY

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**DrPlus**

(HMO D-SNP) H4140-002

**DrFlex**

(HMO D-SNP) H4140-013

Doctors HealthCare Plans, Inc. is an HMO plan with a Medicare contract and a contract with the State of Florida Agency for Health Care Administration. Enrollment in Doctors Health Care Plans, Inc. depends on contract renewal.

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/2025Plans/](http://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

## DrPlus (HMO D-SNP) H4140-002

## DrFlex (HMO D-SNP) H4140-013

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/](http://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, live in our service area and be eligible for one of these Medicaid categories:

- » Qualified Medicare Beneficiary (QMB/QMB+)
- » Specified Low-Income Medicare Beneficiary (SLMB/SLMB+)
- » Qualified Individual (QI)
- » Qualified Disabled and Working Individual (QDWI)
- » Full Benefit Dual Eligible (FBDE)

The service area for DrPlus & DrFlex is Miami-Dade County. If you have any questions about your Medicaid eligibility or level of assistance, please contact us or your Florida Medicaid office.

### 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/2025druglist/](http://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/](http://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](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



## 2025 Summary of Benefits

Depending on your category of Medicaid eligibility, you may pay less than the cost-sharing amounts listed in this document. If your category of Medicaid eligibility changes or if you experience a change in the “Extra Help” you receive, your cost share may increase or decrease. Please refer to the *Evidence of Coverage* for additional benefit details.

PREMIUMS AND BENEFITS	DrPlus (HMO D-SNP) H4140-002	DrFlex (HMO D-SNP) H4140-013
Monthly Plan Premium	<b>\$0-\$20.30:</b> You must continue to pay your Medicare Part B premium. The Part B premium may be covered through your State Medicaid Program.	<b>\$0-\$20.30:</b> You must continue to pay your Medicare Part B premium. The Part B premium may be covered through your State Medicaid Program.
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)	<b>\$3,400 per year:</b> 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 <b>100%</b> 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.	<b>\$3,400 per year:</b> 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 <b>100%</b> 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	DrPlus (HMO D-SNP) H4140-002	DrFlex (HMO D-SNP) H4140-013
Inpatient Hospital Care <sup>1</sup>	<b>\$0 per admission:</b> Our plan covers an unlimited number of days for an inpatient hospital stay.	<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<sup>1</sup></li> <li>• Physical therapy, occupational therapy, speech and language therapy<sup>1,2</sup></li> <li>• Cardiac and pulmonary rehabilitation services<sup>1</sup></li> <li>• Diagnostic procedures and test</li> <li>• Basic radiology (x-ray) services<sup>1,2</sup></li> <li>• Diagnostic radiology services (including advanced imaging services such as MRI, MRA and CT scans)<sup>1,2</sup></li> <li>• Surgery at a hospital facility<sup>1</sup></li> </ul> <b>\$0 copay</b> for observation services. <sup>1</sup>	<b>\$0 copay</b> for: <ul style="list-style-type: none"> <li>• Lab services<sup>2</sup></li> <li>• Mental health care group and individual therapy visits<sup>1,2</sup></li> <li>• Physical therapy, occupational therapy, speech and language therapy<sup>1,2</sup></li> <li>• Cardiac and pulmonary rehabilitation services<sup>1,2</sup></li> <li>• Diagnostic procedures and test<sup>2</sup></li> <li>• Basic radiology (x-ray) services<sup>1,2</sup></li> <li>• Diagnostic radiology services (including advanced imaging services such as MRI, MRA and CT scans)<sup>1,2</sup></li> <li>• Surgery at a hospital facility<sup>1,2</sup></li> </ul> <b>\$0 copay</b> for observation services. <sup>1</sup>

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	DrPlus (HMO D-SNP) H4140-002	DrFlex (HMO D-SNP) H4140-013
Outpatient Surgery — Ambulatory Surgical Center (ASC)	<b>\$0 copay</b> <sup>1</sup>	<b>\$0 copay</b> <sup>1,2</sup>
Primary Care Physician (PCP)	<b>\$0 copay</b> for primary care physician visits. You must select a PCP from the network.	<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. <sup>1</sup> A referral is NOT required for specialist visits.	<b>\$0 copay</b> for specialist visits. <sup>1,2</sup> 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).

## 2025 Summary of Benefits *(continued)*

COVERED MEDICAL AND HOSPITAL SERVICES	DrPlus (HMO D-SNP) H4140-002	DrFlex (HMO D-SNP) H4140-013
Preventive Care Services	<p><b>\$0 copay</b> for the following supplemental preventative services:</p> <ul style="list-style-type: none"> <li>• Alcohol Misuse Screening &amp; Counseling</li> <li>• Annual Wellness Visit</li> <li>• Bone Mass Measurement</li> <li>• Cardiovascular Disease Screening Test</li> <li>• Cervical Cancer Screening</li> <li>• Colorectal Cancer Screening</li> <li>• Counseling to Prevent Tobacco Use</li> <li>• COVID-19 Vaccine &amp; Administration</li> <li>• Depression Screening</li> <li>• Diabetes Screening</li> <li>• Diabetes Self-Management Training</li> <li>• Flu Shot &amp; Administration</li> <li>• Glaucoma Screening</li> <li>• Hepatitis B Screening</li> <li>• Hepatitis B Shot &amp; Administration</li> <li>• Hepatitis C Screening</li> <li>• HIV Screening</li> <li>• IBT for Cardiovascular Disease</li> <li>• IBT for Obesity</li> <li>• Initial Preventive Physical Exam</li> <li>• Lung Cancer Screening</li> <li>• Mammography Screening</li> <li>• Medical Nutrition Therapy</li> <li>• Medicare Diabetes Prevention Program</li> <li>• Pneumococcal Shot &amp; Administration</li> <li>• Prolonged Preventive Services</li> <li>• Prostate Cancer Screening</li> <li>• Screening Pap Test</li> <li>• Screening Pelvic Exam</li> <li>• STI Screening &amp; HIBC to Prevent STIs</li> <li>• Ultrasound AAA Screening</li> </ul> <p>Any extra preventive services approved by Medicare during the contract year will be covered. When you use doctors in this plan, <b>100%</b> of the cost of preventive care screenings are covered.</p>	<p><b>\$0 copay</b> for the following supplemental preventative services:</p> <ul style="list-style-type: none"> <li>• Alcohol Misuse Screening &amp; Counseling</li> <li>• Annual Wellness Visit</li> <li>• Bone Mass Measurement</li> <li>• Cardiovascular Disease Screening Test</li> <li>• Cervical Cancer Screening</li> <li>• Colorectal Cancer Screening</li> <li>• Counseling to Prevent Tobacco Use</li> <li>• COVID-19 Vaccine &amp; Administration</li> <li>• Depression Screening</li> <li>• Diabetes Screening</li> <li>• Diabetes Self-Management Training</li> <li>• Flu Shot &amp; Administration</li> <li>• Glaucoma Screening</li> <li>• Hepatitis B Screening</li> <li>• Hepatitis B Shot &amp; Administration</li> <li>• Hepatitis C Screening</li> <li>• HIV Screening</li> <li>• IBT for Cardiovascular Disease</li> <li>• IBT for Obesity</li> <li>• Initial Preventive Physical Exam</li> <li>• Lung Cancer Screening</li> <li>• Mammography Screening</li> <li>• Medical Nutrition Therapy</li> <li>• Medicare Diabetes Prevention Program</li> <li>• Pneumococcal Shot &amp; Administration</li> <li>• Prolonged Preventive Services</li> <li>• Prostate Cancer Screening</li> <li>• Screening Pap Test</li> <li>• Screening Pelvic Exam</li> <li>• STI Screening &amp; HIBC to Prevent STIs</li> <li>• Ultrasound AAA Screening</li> </ul> <p>Any extra preventive services approved by Medicare during the contract year will be covered. When you use doctors in this plan, <b>100%</b> 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).



COVERED MEDICAL AND HOSPITAL SERVICES	DrPlus (HMO D-SNP) H4140-002	DrFlex (HMO D-SNP) H4140-013
Emergency Care	<b>\$0 copay</b>	<b>\$0 copay</b> for QMB, QMB+, SLMB+ and FBDE members. <b>\$75 copay</b> for all other members, waived if admitted within 24 hours.
Urgent Care	<b>\$0 copay</b>	<b>\$0 copay</b>
Worldwide Emergency and Urgent Care Services	<b>\$0 copay</b> for emergency and urgent care services obtained outside the U.S. This plan may cover emergency care, urgent care and transportation up to a <b>\$50,000 limit</b> . 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	<b>\$0 copay</b> for emergency and urgent care services obtained outside the U.S. This plan may cover emergency care, urgent care and transportation up to a <b>\$50,000 limit</b> . 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
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 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<sup>1,2</sup></li> <li>• <b>\$0 copay</b> at a freestanding radiological facility<sup>1,2</sup></li> <li>• <b>\$0 copay</b> at a hospital facility as an outpatient<sup>1,2</sup></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<sup>1,2</sup></li> <li>• <b>\$0 copay</b> at a freestanding radiological facility<sup>1,2</sup></li> <li>• <b>\$0 copay</b> at a hospital facility as an outpatient<sup>1,2</sup></li> </ul> <p>Therapeutic radiology (radiation therapy) services:<sup>1,2</sup></p> <ul style="list-style-type: none"> <li>• <b>\$0 copay</b></li> </ul> <p>Lab services:</p> <ul style="list-style-type: none"> <li>• <b>\$0 copay</b></li> </ul>	<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<sup>2</sup></li> <li>• <b>\$0 copay</b> at a hospital facility as an outpatient<sup>2</sup></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<sup>1,2</sup></li> <li>• <b>\$0 copay</b> at a freestanding radiological facility<sup>1,2</sup></li> <li>• <b>\$0 copay</b> at a hospital facility as an outpatient<sup>1,2</sup></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<sup>1,2</sup></li> <li>• <b>\$0 copay</b> at a freestanding radiological facility<sup>1,2</sup></li> <li>• <b>\$0 copay</b> at a hospital facility as an outpatient<sup>1,2</sup></li> </ul> <p>Therapeutic radiology (radiation therapy) services:<sup>1,2</sup></p> <ul style="list-style-type: none"> <li>• <b>\$0 copay</b></li> </ul> <p>Lab services:<sup>2</sup></p> <ul style="list-style-type: none"> <li>• <b>\$0 copay</b></li> </ul>

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	DrPlus (HMO D-SNP) H4140-002	DrFlex (HMO D-SNP) H4140-013
Hearing Services	<b>\$0 copay</b> for routine hearing exam. <b>\$0 copay</b> for hearing aid fitting/evaluation every 2 calendar years. Up to <b>\$1,300 allowance</b> for hearing aids every 2 calendar years.	<b>\$0 copay</b> for routine hearing exam. <b>\$0 copay</b> for hearing aid fitting/evaluation every 2 calendar years. Up to <b>\$1,500 allowance</b> for hearing aids every 2 calendar years.
Dental Services — Preventive	<b>\$0 copay</b> for the following preventive dental services: <ul style="list-style-type: none"> <li>• Oral exam, up to <b>2</b> per calendar year</li> <li>• Prophylaxis cleaning(s), up to <b>2</b> per calendar year</li> <li>• Fluoride, up to <b>2</b> per calendar year</li> <li>• Bitewing x-rays, up to <b>2</b> per calendar year</li> <li>• Panoramic x-ray, up to <b>1</b> per 3 calendar years</li> </ul>	<b>\$0 copay</b> for the following preventive dental services: <ul style="list-style-type: none"> <li>• Oral exam, up to <b>2</b> per calendar year</li> <li>• Prophylaxis cleaning(s), up to <b>2</b> per calendar year</li> <li>• Fluoride, up to <b>2</b> per calendar year</li> <li>• Bitewing x-rays, up to <b>2</b> per calendar year</li> <li>• Panoramic x-ray, up to <b>1</b> per 3 calendar years</li> </ul>
Dental Services — Comprehensive <sup>1</sup>	<b>\$0 copay</b> for the following comprehensive dental services: <ul style="list-style-type: none"> <li>• Fillings (amalgam or resin), up to <b>4</b> per calendar year</li> <li>• Extractions, up to <b>4</b> per calendar year</li> <li>• Root canal, up to <b>1</b> per calendar year</li> <li>• Crowns, up to <b>3</b> per calendar year</li> <li>• Implant, up to <b>1</b> per calendar year</li> <li>• Scaling and root planing (deep cleaning), up to <b>1</b> per quadrant per 2 years</li> <li>• Dentures, up to <b>1</b> full upper and <b>1</b> full lower denture per 5 years or 1 partial upper and 1 partial lower denture per 5 calendar years</li> </ul> You must visit a participating dental network provider to receive dental benefits. Please refer to the plans website <a href="http://www.doctorshcp.com/2025Providers/">www.doctorshcp.com/2025Providers/</a> for participating dental providers.	<b>\$0 copay</b> for the following comprehensive dental services: <ul style="list-style-type: none"> <li>• Fillings (amalgam or resin), up to <b>4</b> per calendar year</li> <li>• Extractions, up to <b>4</b> per calendar year</li> <li>• Root canal, up to <b>1</b> per calendar year</li> <li>• Crowns, up to <b>3</b> per calendar year</li> <li>• Implant, up to <b>1</b> per calendar year</li> <li>• Scaling and root planing (deep cleaning), up to <b>1</b> per quadrant per 2 years</li> <li>• Dentures, up to <b>1</b> full upper and <b>1</b> full lower denture per 5 years or 1 partial upper and 1 partial lower denture per 5 calendar years</li> </ul> You must visit a participating dental network provider to receive dental benefits. Please refer to the plans website <a href="http://www.doctorshcp.com/2025Providers/">www.doctorshcp.com/2025Providers/</a> for participating dental providers.
Vision Services	<b>\$0 copay</b> for eye exams. Up to <b>\$400 allowance</b> for eyeglasses and/or contact lenses per calendar year.	<b>\$0 copay</b> for eye exams. Up to <b>\$400 allowance</b> for eyeglasses and/or contact lenses per calendar year.

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	DrPlus (HMO D-SNP) H4140-002	DrFlex (HMO D-SNP) H4140-013
Mental Health Care — InPatient <sup>1</sup>	<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.	<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 <sup>1</sup> <b>\$0 copay:</b> Individual <sup>1</sup> Includes outpatient treatment for mental illness and/or substance abuse.	<b>\$0 copay:</b> Group <sup>1,2</sup> <b>\$0 copay:</b> Individual <sup>1,2</sup> Includes outpatient treatment for mental illness and/or substance abuse.

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)*

PART D PRESCRIPTION DRUG BENEFITS FOR DrPlus & DrFlex		
Deductible	These plans have no deductible.	
Initial Coverage Phase	\$0 copay for all covered 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*	\$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 5: Specialty*	\$0 copay for 30-day supply	\$0 copay for 30-day supply
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.

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

### 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 \$0 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. **You pay nothing (\$0) for your covered Part D drugs.**

\*Medicare approved Doctors HealthCare Plans, Inc. to provide these benefits and lower co- payments as part of the Value-Based Insurance Design program. This program lets Medicare try new ways to improve Medicare Advantage plans.

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).

### **CATASTROPHIC COVERAGE FOR DrPlus & DrFlex**

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 DrPlus & DrFlex**

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 DrPlus & DrFlex**

Because you receive "Extra Help," **you pay nothing (\$0) for your covered Part D drugs** for the entire year.

## 2025 Summary of Benefits *(continued)*

CONTINUATION OF BENEFITS	DrPlus (HMO D-SNP) H4140-002	DrFlex (HMO D-SNP) H4140-013
Part B Drugs <sup>1</sup>	<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>0%-20% coinsurance</b> for:</p> <ul style="list-style-type: none"> <li>• Chemotherapy/radiation drugs</li> <li>• Other Part B Drugs</li> <li>• Part B Insulins (not to exceed \$35 monthly)</li> </ul> <p><b>\$0 copay</b> for administration of Part B Drugs.</p>	<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>0%-20% coinsurance</b> for:</p> <ul style="list-style-type: none"> <li>• Chemotherapy/radiation drugs</li> <li>• Other Part B Drugs</li> <li>• Part B Insulins (not to exceed \$35 monthly)</li> </ul> <p><b>\$0 copay</b> for administration of Part B Drugs.</p>
Skilled Nursing Facility (SNF) <sup>1</sup>	<p><b>\$0 copay</b> per day for days 1 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.</p>	<p><b>\$0 copay</b> per day for days 1 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.</p>
Physical Therapy <sup>1,2</sup>	<b>\$0 copay</b>	<b>\$0 copay</b>
Ambulance	<p>QMB, QMB+, SLMB+ and FBDE members:</p> <ul style="list-style-type: none"> <li>• <b>\$0 copay</b> per trip for emergency ground and air ambulance services</li> </ul> <p>All other members:</p> <ul style="list-style-type: none"> <li>• <b>\$0 copay</b> per trip for emergency ground ambulance services</li> <li>• <b>20% coinsurance</b> per trip for emergency air ambulance services</li> </ul>	<p>QMB, QMB+, SLMB+ and FBDE members:</p> <ul style="list-style-type: none"> <li>• <b>\$0 copay</b> per trip for emergency ground and air ambulance services</li> </ul> <p>All other members:</p> <ul style="list-style-type: none"> <li>• <b>\$50 copay</b> per trip for emergency ground ambulance services</li> <li>• <b>20% coinsurance</b> per trip for emergency air ambulance services</li> </ul>
Transportation	<p><b>\$0 copay</b> for <b>unlimited</b> trips to plan-approved locations per calendar year. You must call our contracted transportation vendor to schedule an appointment.</p>	<p><b>\$0 copay</b> for <b>unlimited</b> trips to plan-approved locations per calendar year. You must call our contracted transportation vendor to schedule an appointment.</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).

CONTINUATION OF BENEFITS	DrPlus (HMO D-SNP) H4140-002	DrFlex (HMO D-SNP) H4140-013
Outpatient Rehabilitation	<b>\$0 copay</b> per visit for: <ul style="list-style-type: none"> <li>• Cardiac rehabilitation services<sup>1</sup></li> <li>• Pulmonary rehabilitation services<sup>1</sup></li> <li>• Occupational therapy services<sup>1,2</sup></li> <li>• Supervised Exercise Therapy (SET) services<sup>1</sup></li> </ul>	<b>\$0 copay</b> per visit for: <ul style="list-style-type: none"> <li>• Cardiac rehabilitation services<sup>1,2</sup></li> <li>• Pulmonary rehabilitation services<sup>1,2</sup></li> <li>• Occupational therapy services<sup>1,2</sup></li> <li>• Supervised Exercise Therapy (SET) services<sup>1,2</sup></li> </ul>
Podiatry Services	<b>\$0 copay</b> Medicare-covered foot care. <b>\$0 copay</b> routine foot care, up to 6 visits per year.	<b>\$0 copay</b> Medicare-covered foot care. <b>\$0 copay</b> routine foot care, up to 6 visits per year.
Renal Dialysis <sup>1,2</sup>	<b>20% coinsurance</b>	<b>20% coinsurance</b>
Telehealth Services	<b>\$0 copay</b> per telehealth visit for: <sup>1</sup> <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>\$0 copay</b> per telehealth visit for: <sup>1,2</sup> <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>
Personal/Respite Care	<b>\$0 copay</b> per visit for <b>1 hour a day, 5 days a week</b> , up to 60 hours per year. Supplemental home health services that include Personal/Assistive care for members to compensate for physical functional impairment that impact the member's ability to complete activities of daily living.	<b>\$0 copay</b> per visit for <b>1 hour a day, 5 days a week</b> , up to 60 hours per year. Supplemental home health services that include Personal/Assistive care for members to compensate for physical functional impairment that impact the member's ability to complete activities of daily living.

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)*

MEDICAL EQUIPMENT AND SUPPLIES	DrPlus (HMO D-SNP) H4140-002	DrFlex (HMO D-SNP) H4140-013
Durable Medical Equipment (DME) <sup>1</sup>	<p><b>20% coinsurance</b> for covered items, including but not limited to:</p> <ul style="list-style-type: none"> <li>• Powered wheelchairs</li> <li>• Powered mattress systems</li> <li>• Non-preferred continuous blood glucose monitors (CBGMs)</li> <li>• And other electric devices.</li> </ul> <p><b>0% coinsurance</b> for:</p> <ul style="list-style-type: none"> <li>• CPAP machines</li> <li>• Preferred continuous blood glucose monitors (CBGM's). The Plan's preferred continuous blood glucose monitors (CBGM's) include: Freestyle®Libre, Dexcom G6 and Dexcom G7.</li> <li>• And all other medical equipment</li> </ul> <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 <a href="http://www.doctorshcp.com/2025Plans/">www.doctorshcp.com/2025Plans/</a>.</p>	<p><b>20% coinsurance</b> for covered items, including but not limited to:</p> <ul style="list-style-type: none"> <li>• Powered wheelchairs</li> <li>• Powered mattress systems</li> <li>• Non-preferred continuous blood glucose monitors (CBGMs)</li> <li>• And other electric devices.</li> </ul> <p><b>0% coinsurance</b> for:</p> <ul style="list-style-type: none"> <li>• CPAP machines</li> <li>• Preferred continuous blood glucose monitors (CBGM's). The Plan's preferred continuous blood glucose monitors (CBGM's) include: Freestyle®Libre, Dexcom G6 and Dexcom G7.</li> <li>• And all other medical equipment</li> </ul> <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 <a href="http://www.doctorshcp.com/2025Plans/">www.doctorshcp.com/2025Plans/</a>.</p>
Prosthetic Devices <sup>1</sup>	<p><b>20% coinsurance</b> for braces/artificial limbs.</p> <p><b>0% coinsurance</b> for all other prosthetic devices.</p>	<p><b>20% coinsurance</b> for braces/artificial limbs.</p> <p><b>0% coinsurance</b> for all other prosthetic devices.</p>
Diabetic Supplies <sup>1</sup>	<p><b>0% coinsurance</b> for preferred glucometers, test strips, lancets, lancet devices and control solutions. The Plan's Preferred Diabetic Supplies include <b>Abbott products: FreeStyle® Lite, FreeStyle® Freedom Lite, Precision Xtra and Trividia products: True Metrix.</b></p> <p><b>20% coinsurance</b> 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><b>0% coinsurance</b> for preferred glucometers, test strips, lancets, lancet devices and control solutions. The Plan's Preferred Diabetic Supplies include <b>Abbott products: FreeStyle® Lite, FreeStyle® Freedom Lite, Precision Xtra and Trividia products: True Metrix.</b></p> <p><b>20% coinsurance</b> 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 <sup>1</sup>	<b>0% coinsurance</b>	<b>0% coinsurance</b>

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	DrPlus (HMO D-SNP) H4140-002	DrFlex (HMO D-SNP) H4140-013
Prepaid Card*	<p><b>\$50 monthly</b> on a prepaid card to be used at approved locations. This card helps you cover out-of-pocket expenses for the following:</p> <ul style="list-style-type: none"> <li>• Groceries (nutritional food)</li> <li>• Utilities (electricity, gas, telephone, water &amp; sewage)</li> <li>• Prepared meals</li> </ul> <p>Amounts do not rollover from month to month. Funds will be available at the beginning of the month.</p> <p>*Medicare approved Doctors HealthCare Plans, Inc. to provide these benefits and lower co- payments as part of the Value-Based Insurance Design program. This program lets Medicare try new ways to improve Medicare Advantage plans.</p>	<p><b>\$275 monthly</b> on a prepaid card to be used at approved locations. This card helps you cover out-of-pocket expenses for the following:</p> <ul style="list-style-type: none"> <li>• Groceries (nutritional food)</li> <li>• Over-the-counter products</li> <li>• Utilities (electricity, gas, telephone, water &amp; sewage)</li> <li>• Prepared meals</li> </ul> <p>Amounts do not rollover from month to month. Funds will be available at the beginning of the month.</p> <p>*Medicare approved Doctors HealthCare Plans, Inc. to provide these benefits and lower co- payments as part of the Value-Based Insurance Design program. This program lets Medicare try new ways to improve Medicare Advantage plans.</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	<b>\$0 copay:</b> Membership and access to fitness facilities, healthy aging coaching, home fitness kits and fitness education materials.	<b>\$0 copay:</b> Membership and access to fitness facilities, healthy aging coaching, home fitness kits and fitness education materials.
Meals Benefit <sup>1,2</sup>	<b>\$0 copay</b> for up to <b>16</b> meals per calendar year following discharge from hospital.	<b>\$0 copay</b> for up to <b>16</b> meals per calendar year following discharge from hospital.
Over-the-Counter (OTC) Benefit	<p><b>\$105 monthly</b></p> <p>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.</p>	<i>Please refer to your benefit labeled "Prepaid Card"</i>
Chiropractor Care	<p><b>\$0 copay</b> Medicare-covered chiropractic services.</p> <p><b>\$0 copay</b> routine chiropractic care, up to <b>12</b> visits per year.</p>	<p><b>\$0 copay</b> Medicare-covered chiropractic services.</p> <p><b>\$0 copay</b> routine chiropractic care, up to <b>12</b> 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).

## 2025 Summary of Benefits *(continued)*

WELLNESS PROGRAMS	DrPlus (HMO D-SNP) H4140-002	DrFlex (HMO D-SNP) H4140-013
Acupuncture	<b>\$0 copay</b> Medicare-covered acupuncture treatments. <b>\$0 copay</b> supplemental acupuncture treatments, up to <b>20</b> visits per year. <sup>1</sup>	<b>\$0 copay</b> Medicare-covered acupuncture treatments. <b>\$0 copay</b> supplemental acupuncture treatments, up to <b>20</b> visits per year. <sup>1,2</sup>
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. <sup>1</sup> Number of covered visits is based on medical need as determined by your physician and authorized by the plan.	<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. <sup>1,2</sup> Number of covered visits is based on medical need as determined by your physician and authorized by the plan.
Nurse Line	<b>\$0 copay:</b> Speak with a registered nurse 24 hours a day, 7 days a week	<b>\$0 copay:</b> Speak with a registered nurse 24 hours a day, 7 days a week

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).

# Statement of Medicaid Benefits and Cost-Sharing Protections

The benefits listed below are covered by Medicaid based on your level of Medicaid eligibility. The Plan shall provide covered services contained within the following Medicaid rules and associated fee schedules found in the next section. Medicaid Services will be provided by the plan when the Medicaid limit is greater than the Medicare limit. In those instances where the Medicare limit has been exhausted, the Plan will cover the difference for members eligible for Full Medicaid. When the below list of services is covered only by Medicaid, the Plan will cover these services for full dual Medicaid members.

BENEFIT	FLORIDA MEDICAID	DrPlus (HMO D-SNP) & DrFlex (HMO D-SNP)
Allergy Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Ambulatory Surgical Center Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Anesthesia Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Assistive Care Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Behavioral Health Overlay Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Behavioral Health Assessment Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Behavioral Health Community Support Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Behavioral Health Intervention Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Behavioral Health Medication Management Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Behavioral Health Therapy Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Cardiovascular Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Child Health Services Targeted Case Management	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Chiropractic Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
County Health Department Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Dental Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Dialysis Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.

## Statement of Medicaid Benefits and Cost-Sharing Protections *(continued)*

BENEFIT	FLORIDA MEDICAID	DrPlus (HMO D-SNP) & DrFlex (HMO D-SNP)
Durable Medical Equipment and Medical Supplies	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Early Intervention Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Emergency Transportation Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Evaluation and Management Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Federally Qualified Health Center Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Gastrointestinal Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Genitourinary Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Hearing Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Home Health Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Inpatient Hospital Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Integumentary Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Laboratory Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Medical Foster Care Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Medical Massage Therapy (AIDS)	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Mental Health Targeted Case Management	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Neurology Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Non-Emergency Transportation Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Nursing Facility Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Occupational Therapy Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Oral and Maxillofacial Surgery Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.

<b>BENEFIT</b>	<b>FLORIDA MEDICAID</b>	<b>DrPlus (HMO D-SNP) &amp; DrFlex (HMO D-SNP)</b>
Orthopedic Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Outpatient Hospital Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Pain Management Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Personal Care Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Physical Therapy Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Podiatry Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Prescribed Drug Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Private Duty Nursing Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Radiology and Nuclear Medicine Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Regional Perinatal Intensive Care Center Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Reproductive Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Respiratory System and Therapy Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Rural Health Clinic Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Specialized Therapeutic Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Speech-Language Pathology Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Statewide Inpatient Psychiatric Program	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Transplant Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Visual Aid Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.
Visual Care Services	Covered by Medicaid based on your eligibility level.	Covered by DrPlus & DrFlex. See your <i>Evidence of Coverage</i> for further details.

# Notice Informing Individuals About Nondiscrimination and Accessibility Requirements

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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, PH1  
Coral Gables, FL 33134  
Telephone: 833-342-7463 (TTY: 711)  
Fax: 786-578-0293,  
Email: [civilrights@doctorshcp.com](mailto: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 Arzneimittelpfen. 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 किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाकिया सेवाएँ उपब्ध हैं। एक दुभाकिया प्रार्थ करने के लिए, बस हमें 833-342-7463 (TTY:711) पर फोन करें। कोई व्यक्ति जो कहने दी 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 Italiani 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。