



For Employees, Retirees, (and/or Dependents) of The State of Florida

2013 Health Plan Enrollment Information

AvMED
SELF-FUNDED OPTIONS

Table of Contents

AvMed Overview	2
Benefit Summary <i>State of Florida HMO Health Plan</i>	7
Benefit Summary <i>State of Florida Health Investor Health Plan</i>	17
Services and Programs	27
Privacy Notice	36

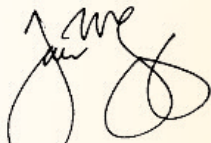
Special Member Services Team For State Employees

If you have any questions about your plan, from benefits, to co-payments, to provider lists, you can call our special State of Florida Member Services team. These specialists are just a phone call away 24-hours a day, 7 days a week. You can reach them at **1-888-762-8633** or via email at stateofflorida.members@avmed.org.

On Your Side, Right From The Start.

AvMed is proud to be serving you and The State of Florida. Whether you're a new or long-time member, we know that when it comes to health care coverage, easy is better. That's why AvMed has created health plans that make it easy for you and your family to access the prevention and treatment services you need. We call this the AvMed Advantage, and it starts the very first day you enroll. From plenty of choices of where to go for your health care – including one of the largest network of doctors and hospitals in Florida – to wellness programs to keep you feeling healthy, to 24-hour access to a real live person to answer questions you have about your benefits, AvMed is on your side.

We want to help you take advantage of the AvMed Advantage, so let us know how we can serve you.



James M. Repp

Senior Vice President, Sales & Marketing



The AvMed Advantage Get To Know Yellow.

For almost 40 years, we've designed our health plans with our members' input to develop benefits, special programs, and services that address the most common requests. As a result, all our plans include what members want most, including:

- **No referrals** to see any in-network physician
- **Access to an expanded network of doctors and hospitals** that includes an extensive selection of primary care physicians (PCPs), specialists, top-ranked hospitals, and outpatient facilities throughout the state of Florida
- **Retail clinic care** that allows you to pay your Urgent Care Clinic co-payment at participating clinics across the state
- **Member services all day, every day** by phone, email, or online to answer questions about your plan – from benefits, to providers, to payment balances
- **Wellness services** to keep you healthier and reduce your overall health care costs
- **Emergency coverage** when you travel outside of AvMed's network area
- **24/7 nurse on call service** that connects you to a registered nurse who can answer your important health care questions quickly and confidentially

Focused On Member Satisfaction

AvMed is a not-for-profit health plan, so we're focused on our members' health care rather than shareholders and stock dividends. It's part of the reason AvMed is consistently rated higher than our competitors for overall member satisfaction, according to the National Committee for Quality Assurance (NCQA) in the annual Consumer Assessment of Healthcare Providers and Systems survey (CAHPS). And it's why AvMed constantly seeks our members' feedback to make sure we're doing the best job possible. You can participate in the process by completing the survey you receive after enrolling.

Get Your Ounce Of Prevention For Free

One of the best defenses against illness – and high health care costs – is prevention. That's why AvMed's benefits include preventative care services at no charge. These include but are not limited to well-woman exams, annual physicals, well-child care, immunizations, colonoscopies, mammograms, obesity screenings, diabetes and cholesterol testing, tests for STDs, and smoking cessation counseling. If you want to know what screenings you're due to receive, visit www.avmed.org/go/state and log in to the "Member" section. Then, go to "Health and Wellness", click on "Prevention and Education", and look for the "Screening" link.



Start With Healthy Living.

Everyone enrolled in an AvMed health plan can take advantage of our Healthy Living Programs. These wellness tools and services help you make healthier lifestyle choices – choices that can keep you feeling good and reduce your overall health care costs. The Healthy Living Programs include:

- **Personal Health Assessment**, an interactive, confidential survey that identifies potential health risks and sets improvement goals based on your personal needs; you can access it by visiting www.avmed.org/go/state, select Health and Wellness, then click on "Take Your Assessment"
- **Discounts** on services like fitness center memberships as well as reduced rates from participating massage therapists, acupuncturists, and other alternative medicine providers
- **Reimbursements** when participating in the Weight Watchers® program
- **Educational materials** including a subscription to our award-winning publication, *AvMed Magazine*
- **Age and gender-based reminders for preventative screenings** such as mammograms and colonoscopies



Answers To Common Questions.

AvMed recognizes that our members have a lot of questions, but there are some that come up more often than others. We've answered three of the most common questions here to help you get the most out of your health plan from day one.

When Do I Need To Go To The ER?

When you're experiencing symptoms like pain, nausea, or faintness, it's hard to figure out how serious the problem is. Going to the nearest emergency room may seem like the right choice, but more than half of all ER visits are for minor problems that aren't life threatening. What's more, getting treatment in an ER is four times more expensive than getting similar treatment at an urgent care center. The table below lists some signs you should look for when figuring out where to go when you experience a medical emergency. Remember, these are just guidelines. If you're ever in doubt, err on the side of caution and call 9-1-1.

Urgent Care Center <i>Know where they are</i>	Emergency Room <i>Know how to get there fast</i>	Ambulance <i>Call 9-1-1</i>
<ul style="list-style-type: none">• Ear infections• Bronchitis• Fever	<ul style="list-style-type: none">• Sudden, sharp abdominal pain• Uncontrolled bleeding	<ul style="list-style-type: none">• Chest pain• Difficulty breathing• Unconsciousness

How Do I Find The Doctors I Want?

Whether you're looking for your family doctor or a highly recommended specialist, you can find out if they're part of AvMed's network by searching for their name, specialty, or location. What's more, AvMed offers access to our partner network for members within the AvMed service area. To find the physicians you're looking for, go to www.avmed.org/go/state or call 1-888-762-8633.

How Do I Handle My Transition of Care?

If you are new to AvMed and undergoing long-term care for a specific condition, like self-injectables or complex regular treatments, we want to make sure the transition does not interrupt your care. Fill out a Transition of Care form, and AvMed nurses will work with you to ensure continuity of care. To request a form, go to www.avmed.org/go/state and click "Forms", or call 1-888-762-8633.

2 Convenient Ways To Become A Member.

In this kit, you will find the Benefit Guides for the two AvMed Health Plans – the HMO Health Plan and Investor Health Plan available to all state of Florida employees and retirees. You can enroll in either plan in one of two easy ways:

Online

Click on “peoplefirst.myflorida.com”. Type in your user ID and password. Click on “Process Elections” and follow the prompts.

By Phone

Call the People First Service Center at 1-866-663-4735 to speak with a specialist. They’re available Monday - Friday, 8:00 a.m. to 6:00 p.m.

For Families With Multiple Insurance Carriers

If your family has more than one health insurance carrier, you need to complete a Coordination of Benefits (COB) survey to make sure all claims are handled correctly. You can request a hardcopy COB survey from your benefits administrator, from AvMed Member Services, or fill out an online form at www.avmed.org/go/state.

After You Enroll

After you enroll, you will receive a welcome packet including a provider list, summary of benefits, privacy notification, and your yellow AvMed ID card. Remember you’ll need your ID card to access the majority of your benefits.

Replacing A Lost AvMed ID Card

If you lose your AvMed ID Card, just contact AvMed Member Services, and we’ll send you a new one. Until your replacement arrives, you can print out a temporary ID card by logging in to your account at www.avmed.org/go/state.

Benefit Summary

State of Florida
HMO Health Plan

JANUARY 2013

Member Services: 1-888-762-8633

For more information about AvMed Health Plans, call Member Services at the number listed on your AvMed ID card.

AvMED
SELF-FUNDED OPTIONS



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.avmed.org/go/state or by calling **1-888-762-8633**

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$0	See the chart starting on page 2 for other costs for services this plan covers.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$1,500 individual/ \$3,000 family	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premium, prescription copayments, deductible, and services this plan doesn't cover	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. For a list of participating providers, see www.avmed.org/go/state or call 1-888-762-8633.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <u>excluded services</u> .

Questions: Call 1-888-762-8633 or visit us at www.avmed.org/go/state

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.ccio.cms.gov or call 1-888-762-8633 to request a copy.

SF-State of Florida-HMO-13

SF-3505 (01/13)



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use AvMed network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use an		Limitations & Exceptions
		AvMed network Provider	Out-of-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copay/ visit	Not Covered	Additional charges will apply for non-preventive services performed in the Physician's office.
	Specialist visit	\$40 copay/ visit	Not Covered	Limited to 60 visits per injury.
	Other practitioner office visit	\$40 copay/ visit for chiropractic services	Not Covered	None
If you have a test	Preventive care/screening/immunization	No Charge	Not Covered	Certain services require prior authorization. Charges for office visits will also apply if services are performed in a Physician's office.
	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Prescription drug coverage is provided through Medco. For a list of participating pharmacies, please call Medco at 1-877-531-4793 or visit www.medco.com .
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Covers up to a 30-day supply for retail prescriptions; 31-90 day supply for mail order prescriptions. Certain drugs
If you need drugs to treat your illness or condition	Generic drugs	\$7 copay/ prescription (retail); \$14 copay/ prescription (mail order)	Not Covered	
	Preferred brand drugs	\$30 copay/ prescription (retail); \$60 copay/ prescription (mail order)	Not Covered	
	Non-preferred brand drugs	\$50 copay/ prescription (retail); \$100 copay/ prescription (mail order)	Not Covered	
More information about prescription drug coverage is				

Common Medical Event	Services You May Need	Your Cost If You Use an		Out-of-network Provider	Limitations & Exceptions
		AvMed network Provider	Out-of-network Provider		
available at www.medco.com .	Specialty drugs	Preferred brand Specialty drugs: \$30 copay/prescription (retail); \$60 copay/prescription (mail order)/ Non-preferred brand Specialty drugs: \$50 copay/prescription (retail); \$100 copay/prescription (mail order)	Not Covered		require prior authorization and/or are subject to quantity limits. Brand additional charge may apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered		Certain services require prior authorization. Charges for office visits will also apply if services are performed in any Physician's office
	Physician/surgeon fees	No Charge	Not Covered		
If you need immediate medical attention	Emergency room services	\$100 copay/visit	Same as AvMed network		AvMed must be notified within 24 hours of emergency admission or as soon as reasonably possible. When pre-authorized, or in the case of emergency.
	Emergency medical transportation	No Charge	Same as AvMed network		
	Urgent care	\$25 copay/visit	Same as AvMed network		
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 copay/visit	Not Covered		Prior authorization required.
	Physician/surgeon fee	No additional charge	Not Covered		



SELF-FUNDED OPTIONS : State of Florida Standard HMO Plan

Coverage Period: 01/01/2013 – 12/31/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: All Coverage Tiers | Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		AvMed network Provider	Out-of-network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$20 copay/ visit	Not Covered	None
	Mental/Behavioral health inpatient services	\$250 copay/ visit	Not Covered	Prior authorization required.
	Substance use disorder outpatient services	\$20 copay/ visit	Not Covered	None
	Substance use disorder inpatient services	\$250 copay/ visit	Not Covered	Prior authorization required.
If you are pregnant	Prenatal and postnatal care	\$40 copay/ 1 st visit only	Not Covered	Subsequent visits at no charge.
	Delivery and all inpatient services	\$250 copay/ visit	Not Covered	Prior authorization required.
If you need help recovering or have other special health needs	Home health care	No Charge/ visit	Not Covered	Approved treatment plan required.
	Rehabilitation services	\$40 copay/ visit for physical, occupational & speech therapies; \$40 copay/ visit applied behavior analysis services to treat Autism Spectrum Disorder; \$40 copay/ visit for physical, occupational & speech therapies to treat Autism Spectrum Disorder	Not Covered	Physical, speech & occupational therapies limited to 60 visits per injury. Coverage for all services related to treatment of Autism Spectrum Disorder is limited to \$36,000 annually & \$200,000 lifetime.
		Habilitation services	Not Covered	Not Covered
	Skilled nursing care	No Charge/ visit	Not Covered	Limited to 60 days per calendar year. Prior authorization required.
	Durable medical equipment	No Charge/ device	Not Covered	None
	Hospice service	No Charge/ visit	Not Covered	Physician certification required. Limited to 210 calendar days per lifetime.
If your child needs dental or	Eye exam	\$20 copay/ visit at primary; \$40 copay/ visit at specialist	Not Covered	Limited to one exam per year

Common Medical Event	Your Cost if You Use an		Limitations & Exceptions	
	Services You May Need	AvMed network Provider		Out-of-network Provider
eye care	Glasses	Not Covered	Not Covered	None
	Dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-762-8633. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cchio.cms.gov.

Your Grievance and Appeals Rights:



If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact AvMed’s Member Services Department at 1-888-762-8633.

For plans subject to ERISA, you may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cms.gov.

Language Access Services:

Para obtener asistencia en Español, llame al 1-888-762-8633.

_____ *To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,120
- Patient pays \$420

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

deductibles	\$0
Copays	\$300
Coinsurance	\$0
Limits or exclusions	\$120
Total	\$420

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,200
- Patient pays \$1,200

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

deductibles	\$0
Copays	\$1,100
Coinsurance	\$0
Limits or exclusions	\$100
Total	\$1,200

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the 'Patient Pays' box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-888-762-8633 or visit us at www.avmed.org/go/state

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SF-State of Florida-HMO-13

Benefit Summary

State of Florida Health
Investor Health Plan

JANUARY 2013

Member Services: 1-888-762-8633

For more information about AvMed Health Plans, call Member Services at the number listed on your AvMed ID card.

AvMED
SELF-FUNDED OPTIONS




This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.avmed.org/go/state or by calling 1-888-762-8633

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$1,250 individual/ \$2,500 family Doesn't apply to preventive care.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$3,000 individual/ \$6,000 family	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premium, prescription drug brand additional charges, and services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. For a list of participating providers, see www.avmed.org/go/state or call 1-888-762-8633.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers in their network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without permission from this plan.

Questions: Call 1-888-762-8633 or visit us at www.avmed.org/go/state
 If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.ccio.cms.gov or call 1-888-762-8633 to request a copy.
 SF-State of Florida-HIHP-13
 SF-3496 (01/13)

Are there services this plan doesn't cover?	Yes.
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Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

-  **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use AvMed network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		AvMed network Provider	Out-of-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance after deductible	Not Covered	Additional charges will apply for non-preventive services performed in the Physician's office.
	Specialist visit	20% coinsurance after deductible	Not Covered	Limited to 60 visits per injury.
	Other practitioner office visit	20% coinsurance after deductible/ chiropractic services	Not Covered	None
	Preventive care/screening/immunization	No Charge	Not Covered	Certain services require prior authorization. Charges for office visits will also apply if services are performed in a Physician's office.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	Not Covered	
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	Not Covered	

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		AvMed network Provider	Out-of-network Provider	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.medco.com .	Generic drugs	30% coinsurance after deductible/prescription (retail or mail order)	Not Covered	Prescription drug coverage is provided through Medco. For a list of participating pharmacies, please call Medco at 1-877-531-4793 or visit www.medco.com . Covers up to a 30-day supply for retail prescriptions; 31-90 day supply for mail order prescriptions. Certain drugs require prior authorization and/or are subject to quantity limits. Brand additional charge may apply.
	Preferred brand drugs	30% coinsurance after deductible/prescription (retail or mail order)	Not Covered	
	Non-preferred brand drugs	50% coinsurance after deductible/prescription (retail or mail order)	Not Covered	
	Specialty drugs	Preferred brand Specialty drugs: 30% coinsurance after deductible/prescription (retail or mail order)/ Non-preferred brand Specialty drugs: 50% coinsurance after deductible/prescription (retail or mail order)	Not Covered	
	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees	20% coinsurance after deductible	Not Covered	
If you need immediate medical attention	Emergency room services	20% coinsurance after deductible	Same as AvMed network	Certain services require prior authorization. Charges for office visits will also apply if services are performed in any Physician's office AvMed must be notified within 24 hours of emergency admission or as soon as reasonably possible. When pre-authorized, or in the case of emergency.
	Emergency medical transportation	20% coinsurance after deductible	Same as AvMed network	
	Urgent care	20% coinsurance after deductible	Same as AvMed network	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	Not Covered	Prior authorization required.
	Physician/surgeon fee	20% coinsurance after deductible	Not Covered	



SELF-FUNDED OPTIONS : State of Florida Health Investor Health Plan Coverage Period: 01/01/2013 – 12/31/2013
Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individual + Family | Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost If You Use an			Limitations & Exceptions
		AVMed network Provider	Out-of-network Provider		
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance after deductible	Not Covered	None	
	Mental/Behavioral health inpatient services	20% coinsurance after deductible	Not Covered	Prior authorization required.	
	Substance use disorder outpatient services	20% coinsurance after deductible	Not Covered	None	
	Substance use disorder inpatient services	20% coinsurance after deductible	Not Covered	Prior authorization required.	
If you are pregnant	Prenatal and postnatal care	20% coinsurance after deductible	Not Covered	None	
	Delivery and all inpatient services	20% coinsurance after deductible	Not Covered	Prior authorization required.	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	Not Covered	Approved treatment plan required. Physical, speech & occupational therapies limited to 60 visits per injury.	
	Rehabilitation services	20% coinsurance after deductible	Not Covered	Coverage for all services related to treatment of Autism Spectrum Disorder is limited to \$36,000 annually & \$200,000 lifetime.	
	Habilitation services	Not Covered	Not Covered	None	
	Skilled nursing care	20% coinsurance after deductible	Not Covered	Limited to 60 days per calendar year. Prior authorization required.	
	Durable medical equipment	20% coinsurance after deductible	Not Covered	None	
	Hospice service	20% coinsurance after deductible	Not Covered	Physician certification required. Limited to 210 calendar days per lifetime.	
If your child needs dental or eye care	Eye exam	20% coinsurance after deductible	Not Covered	Limited to one exam per year	
	Glasses	Not Covered	Not Covered	None	
	Dental check-up	Not Covered	Not Covered	None	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-762-8633. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact AvMed's Member Services Department at 1-888-762-8633.

For plans subject to ERISA, you may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Language Access Services:

Para obtener asistencia en Español, llame al 1-888-762-8633.

_____ *To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,710
- Patient pays \$1,830

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

deductibles	\$1,250
Copays	\$0
Coinsurance	\$430
Limits or exclusions	\$150
Total	\$1,830

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,300
- Patient pays \$2,100

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

deductibles	\$1,250
Copays	\$0
Coinsurance	\$770
Limits or exclusions	\$80
Total	\$2,100

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Questions: Call 1-888-762-8633 or visit us at www.avmed.org/go/state

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.ccio.cms.gov or call 1-888-762-8633 to request a copy.

SF-State of Florida-HIHP-13

The following information is intended to provide a summary of services and programs offered by AvMed Health Plans. This Benefit Guide is not a contract. For specific information on benefits, exclusions and limitations, please consult your AvMed Group Medical and Hospital Service Contract or Summary Plan Description.

Behavioral Health Services

AvMed provides its members with a high quality mental health program. Depending on your plan, you may have direct access to mental health providers throughout the state without having to contact your PCP. Mental health diagnosis and treatment services are covered on an outpatient basis. Additional mental health services or substance abuse services may be available. For more detailed information about your coverage, please refer to your Benefit Summary and Amendment. Members must use AvMed's participating providers for all inpatient and outpatient services. Choice and POS members may utilize out-of-network benefits. Please refer to your Certificate of Coverage or Summary Plan Description for specific plan information.

Emergency, Urgent Care and Retail Clinic Options

Talk to your doctor about what to do if you need immediate medical care. Be sure to discuss after-hours care and weekend accessibility, and if there is another number you can call. If your doctor isn't available or if an accident or injury calls for immediate attention, you should know your options. Knowing the difference can save you time, money and stress.

- **When is it an emergency?**

If you have an emergency (your condition is life-threatening; loss of consciousness; sudden, sharp abdominal pain; uncontrolled bleeding; complicated fractures) you should go to the nearest hospital or call 911 for emergency medical assistance. You may be responsible for a portion of the cost and non-covered supplies or services (refer to your Benefit Summary for more information). For a detailed definition of an emergency, please refer to your Group Medical and Hospital Service Contract (Certificate of Coverage) or Summary Plan Description.

Urgent Care Center Know where they are	Emergency Room Know how to get there fast	Ambulance Call 911	Retail Clinic Basic medical care
<ul style="list-style-type: none">• Ear Infections• Minor cuts• Fever	<ul style="list-style-type: none">• Sudden, sharp, abdominal pain• Uncontrolled bleeding	<ul style="list-style-type: none">• Chest Pain• Difficulty breathing• Loss of consciousness	<ul style="list-style-type: none">• After hours and weekends, when the doctor can't fit you in.

- **Urgent Care Center**

If you encounter a minor medical emergency (sprained ankle, minor cuts or high fever), an urgent care center (UCC) may be a more convenient, and often a more cost-effective, alternative to the emergency room. The facilities handle non-emergency visits during and after regular physician office hours. Most are open seven days a week, with extended hours and do not require an appointment. They are staffed with qualified physicians and offer a wide array of health care services, including radiology, laboratory, pharmacy and procedure rooms for lacerations and fracture care. AvMed Health Plans currently contracts with a number of UCCs throughout the state. For a complete list of urgent care centers in your area, you can refer to the Provider Directory or visit our Web site at www.avmed.org/go/state.

- **Retail Clinic Care**

Another option is retail clinic care, staffed by board-certified practitioners (nurse practitioners and/or physician assistants); a clinic can be a convenient and affordable choice. Clinics offer quality, basic medical care after hours, on weekends and when your doctor's office can't get you in.

- No appointment needed
- Open seven days a week
- Pay your applicable Urgent Care Clinic co-payment at participating clinics across the state

To find a participating clinic near you, access AvMed's Web site at www.avmed.org/go/state. Follow the instructions under *Find a Doctor* on the home page. AvMed's Member Services is always available to help you. Call them at the toll-free number listed on the back of your AvMed ID card or e-mail us at stateoffloridamembers@avmed.org. *You must choose a retail clinic that is an AvMed-participating clinic in Florida. Otherwise, you will pay your urgent care co-payment, co-insurance or deductible.

Terms You Should Know

Co-payment

A fixed fee paid by the member to the provider for covered medical services.

Co-insurance

A percentage a member must pay toward the cost of covered services once the deductible has been met. The co-insurance amount will vary depending on the network selected.

Deductible

An annual dollar amount that you must pay for covered services before AvMed begins paying for eligible expenses. Your plan may or may not have a deductible. Please refer to your Summary of Benefits for more details.

Out-of-Pocket Maximum

The maximum dollar amount of co-payments and co-insurance the member will have to pay in a calendar year, not including the deductible. Once the out-of-pocket maximum has been met, AvMed pays 100 percent of covered expenses for the remainder of that calendar year.

Services and Programs

AvMed adds value to your membership by providing the following services.

Member Services – 24 Hours a Day, 7 Days a Week

AvMed's Member Services representatives are available to you to answer questions regarding benefits, claims, changing physicians or anything involving your AvMed membership. AvMed takes pride in providing excellent customer service.

You can call the Member Services Department toll-free from anywhere, any time. TTY users should call 1-877-442-8633 for assistance, Monday through Friday, 24 hours a day. You may also visit our Web site at www.avmed.org/go/state or e-mail Member Services at stateofflorida.members@avmed.org.

With Language Line Services, we have the ability to speak 140 languages. If you need to speak with a Member Services representative in another language, AvMed accesses Language Line Services and connects you with a translator who relays your questions or concerns back to AvMed. There is no charge to you.

Medical Technology

AvMed's Medical Technology Assessment program is designed to evaluate and assess new and existing technologies for the purpose of safe and effective health care. If you have questions regarding medical technologies, including procedures, medications, or devices, please contact your primary care physician or call AvMed's **Nurse On Call** at 1-888-866-5432, 24 hours a day, seven days a week.

Our medical directors work with practicing physician-consultants to continuously review and evaluate published medical scientific studies and information from the U.S. Food and Drug Administration and other federal agencies to ensure safe and effective treatment. By carefully assessing new approaches in medicine, we live up to our commitment of improving our members' health.

AvMed's Nurse On Call – 24 Hours a Day, 7 Days a Week

By calling AvMed's Nurse On Call, you can speak confidentially with an AvMed registered nurse about health concerns any time you need to. Our nurses can help you make an informed decision about an appropriate course of action related to an illness or injury, including when to call your physician.

You also have the option to listen to pre-recorded health information from AvMed's Audio Health Library on more than 500 health topics. Each topic includes information on symptoms, self-care, home treatment and prevention. You can find this health information on AvMed's Web site at www.avmed.org/go/state.

Utilization Management

The goal of AvMed's Utilization Management (UM) program is to validate the medical appropriateness and to coordinate covered services for our members. Utilization Management has several comprehensive components which include, but are not limited to:

- Prior-authorization requests from providers prior to providing covered services.
- Concurrent review of all patients hospitalized in acute-care, psychiatric, rehabilitation, and skilled nursing facilities, including on-site review when appropriate.
- Case management and discharge planning for all inpatients and those requiring continued care in an alternative setting (such as home care or a skilled care facility) and for outpatients when deemed appropriate; and
- The Benefit Coordination Program which is designed to conduct prospective reviews for select medical services to ensure that these are covered and medically necessary. The Benefit Coordination Program may also advocate alternative cost-effective settings for the delivery of prescribed care and may identify other options for non-covered health care needs.

AvMed's Health Report Card

AvMed's Health Report Card is a user-friendly, interactive and confidential personal health assessment which will help you to identify health risks and set goals based on your health needs. Log on to AvMed's Web site at www.avmed.org/go/state.

Once logged in, click on:

- 'My Account', then 'My Health Tools.'
- Scroll down to find the *Health Report Card* link.

Healthy Living Programs

At AvMed, we're constantly exploring ways to help you maintain good health. To that end, we offer a variety of wellness strategies and programs that can enhance both your well-being and your quality of life, putting you on the road to better health and keeping you there.

If you want to maintain your good health we give you many options to help you become more proactive and prevent illness. Plus, plenty of support and motivation with programs such as:

- Weight Watchers™ Reimbursement program
- Discounts on fitness centers
- Nutrition counseling
- Yoga and other alternative health services

To find a practitioner in your area, go to AvMed's Web site at www.avmed.org/go/state. Log in to click on "Health and Wellness" from the list at the left of the screen. When you enter through our Web site, the information you receive is customized for AvMed members. If you don't have Internet access, call AvMed Member Services for assistance.

AvMed's Healthy Living and Case Management Programs

When you are facing chronic illness, our disease management philosophy is to provide you access to high-tech, high-touch, personalized service that is coordinated to ease your concerns. AvMed's highly trained care team works closely with your doctor and family to answer health-related questions consider treatment options and assist in coordinating your care. You will receive periodic calls to help you manage your condition

AvMed's Healthy Living offers you support to deal with the following conditions:

- Asthma
- CAD – coronary artery disease
- COPD – chronic obstructive pulmonary disease
- Congestive heart failure
- Diabetes

An acute condition is an injury or illness that requires short-term, sometimes intensive, therapy. AvMed's Case Management Program can work closely with you, your doctor and family to address these complex health issues:

- Organ transplant
- High-risk maternity care
- Cancer
- Kidney disease
- Wound care

For more information, call AvMed Member Services at the number listed on your AvMed ID card.

Discounts on Eye Exams, Glasses, Lenses and Contacts

Discounts on eye exams, glasses, lenses and contacts are available through some of AvMed's vision partners. For more information, call AvMed Member Services at the number listed on your AvMed ID card.

AvMed's Web Site

Your Best Source for Fast Information on Your Health Plan

Visit our Web site at www.avmed.org/go/state to access a vast amount of information and a great number of resources that are available to you as an AvMed member. Some areas are immediately accessible, such as Online Consumer Tools, AvMed's Provider Directory and AvMed's Preferred Medication List. You can view and do so much more, however, by registering for full access to the Web site. With your user ID and password, you're able to obtain your personal health information and interact with AvMed in the following areas:

- Benefits
- Request an AvMed ID card or a temporary ID card
- Eligibility
- Information on co-payment, deductible and/or co-insurance accumulations
- Status changes
- Change PCP, address, phone
- Authorization inquiries
- Medical and pharmacy claims inquiries

You can also submit Coordination of Benefits (COB) information and any personal information changes. Our Web site's extensive provider directory offers the names of participating PCPs, hospitals and ancillary facilities, as well as every type of specialist physician. Updated weekly, the online directory contains information on our contracted doctors' backgrounds, office hours, office locations, languages spoken and more. The AvMed Web site also includes health information and current press releases on company developments and achievements.

Online Consumer Tools

Research shows that health plan members who are engaged in choosing and using their health benefits become informed, cost-conscious consumers. AvMed's Online Consumer Tools are available at www.avmed.org/go/state to help you make effective decisions about your health care. These resources can assist you in choosing and determining what prescription drugs, physicians and hospitals best meet your needs. Stay connected to stay healthy!

Learn About Your Health.

AvMed's online medical encyclopedia is a valuable reference tool containing comprehensive medical information designed to keep you informed and proactive in your health decisions. Find out how common your condition is among people your age group. Learn about treatment options and find out how quickly you can expect to recover.

Find a High-Quality Physician.

Search for physicians by name, location and specialty. Physician profiles include such useful details as education, board certification, sanctions and malpractice issues. You also can learn about estimated treatment costs and view affiliated hospitals and patient satisfaction survey results. With this information, you'll be able to compare doctors and find the one who's right for you.

Find a High-Quality Hospital.

Search hospitals by name, location, procedure/condition or overall quality. Ratings and cost estimates are easy to understand, with side-by-side comparisons and detailed profiles. This tool can help you manage your health care costs and avoid complications associated with poor care.

Estimate Health Care Costs.

Research and approximate the total cost of the most common inpatient, outpatient and diagnostic testing procedures. The treatment cost calculator helps you understand and manage costs as well as plan for future healthcare expenses. Compare costs through searching by gender, region and age. When finished, you'll receive a summary of anticipated costs.

Things You Should Know

Members' Rights and Responsibilities**Members have a right to:**

- Considerate, courteous, and dignified treatment by all participating providers without regard to race, religion, gender, national origin, or disability and a reasonable response to a request for services, evaluation and/or referral for specialty care.
- Receive information about AvMed Health Plans, our products and services, our contracted practitioners and providers, and members' rights and responsibilities.
- Be informed of the health services covered and available to them or excluded from coverage, including a clear explanation of how to obtain services and applicable charges.
- Access quality care, receive preventative health services and know the identity and professional status of individuals providing services to them.
- The confidentiality of information about their medical health condition being maintained by the Plan and the right to approve or refuse the release of member specific information including medical records, by AvMed, except when the release is required by law.
- Participate in decisions involving their health care and to give informed consent for any procedure after receiving information about risk, length of inactivity, and choices of alternative treatment plans available regardless of cost or benefit coverage.
- To refuse medical treatment, including treatment considered experimental, and to be informed of the medical consequences of this decision.
- Have available and reasonable access to service during regular hours and to after-hours and emergency coverage, including how to obtain out-of-area coverage.
- A second opinion from another participating physician or non-participating consultant in the AvMed Health Plans' service area.*
- Know about any transfer to another hospital, including information about why the transfer is necessary and any alternatives available.
- Be fully informed of the complaint, and grievance processes and use them without fear of interruption of health services.
- To make recommendations regarding the Plan's members' rights and responsibilities policies.
- Written notice of any termination or change in benefits, services or the member's providers.

** A portion of the cost of a non-participating consultant will be the responsibility of the member. This benefit includes consultation only and does not guarantee continued care with consulting provider.*

Members have the responsibility to:

- Choose an AvMed participating Primary Care Physician and establish themselves with this physician.**
- Become knowledgeable about their health plan coverage including covered benefits, limitations and exclusions, procedures regarding use of participating providers and referrals.
- Take part in improving their health by maximizing healthy habits.
- Provide accurate and complete information about their health.
- Ask any questions and seek any clarification necessary to adequately understand their illness and/or treatment. Follow the recommended and mutually agreed upon treatment plan.
- Keep appointments reliably, and promptly notify the provider when unable to so.
- Fulfill financial obligations for receiving care, as required by their health plan agreement, in a timely manner.
- Show consideration and respect to providers and provider staff.

***Certain AvMed Plans do not require that you choose a Primary Care Physician. However, AvMed encourages all members to establish a relationship with a Primary Care Physician, to help coordinate your care.*

Member Inquiries and Concerns

We want to ensure that your concerns are addressed promptly. If at any time you have complaints, you may call AvMed Member Services at the number listed on your AvMed ID card. Representatives are available to assist you 24 hours a day, 7 days a week. You may also contact Member Services by writing us at stateofflorida.members@avmed.org. If you have a concern regarding the quality of medical care or service you are receiving, we encourage you to first discuss it directly with your provider.

For complete information regarding AvMed's grievance procedure, please refer to your Group Medical and Hospital Service Contract (Certificate of Coverage) or Summary Plan Description.

Claims

In most cases, providers will file claims directly with AvMed Health Plans. However, if you feel that you have incurred charges that should be considered for payment or reimbursement, you will need to submit an itemized statement of charges, date(s) of service, including diagnostic and procedure codes, together with proof of payment to the AvMed Claims Center at:

P.O. Box 569000
Miami, Florida 33256-9000

Please note: For specific claim filing requirements, please refer to your Group Medical and Hospital Service Contract (Certificate of Coverage) or Summary Plan Description.

Advance Directives

Your Rights

AvMed wishes to inform you of Florida law regarding Living Wills and Advance Directives. Under Florida law, every adult has the right to make certain decisions concerning his or her medical treatment. The law also allows for your rights and personal wishes to be respected even if you are too sick to make decisions yourself.

You have the right, under certain conditions, to decide whether to accept or reject medical treatment, including whether to continue medical treatment and other procedures that would prolong your life artificially.

You may also designate another person, or surrogate, who may make decisions for you if you become mentally or physically unable to do so. This surrogate may function on your behalf for a brief time longer, for a life-threatening or a non-life-threatening illness. Any limits to the power of the surrogate in making decisions for you should be clearly expressed.

Your health care provider will furnish you written information about its policy regarding Advance Directives.

The legal basis for these rights can be found in the Florida Statutes: Health Care Advance Directives, Chapter 765; Durable Power of Attorney Section 709.08; and guardianship, Chapter 744; and in the Florida Supreme Court decision on the constitutional right of privacy, *Guardianship of Estelle Browning, 1990*.

What is an Advance Directive?

An Advance Directive is a “written instruction, such as a Living Will or Durable Power of Attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the state) and relating to the provision of such care when the individual is incapacitated.”

The law of Florida provides three ways to express your *written desires*, in advance, so your doctor and family will know how you want to be treated in the event you become unable to tell them.

Living Will

A Living Will is a written personal statement made by you that lets others know your wishes for medical care at the end of life. You must be 18 years of age and of sound mind to write a Living Will. Most Living Wills direct physicians to limit or forego certain treatments, for example, connecting a person to a respirator/breathing machine. The Living Will is used only in situations where you are both terminally ill and unable to take part in mental decisions. A Living Will does not cover all situations that may present themselves, so you may want to have other documents prepared.

Health Care Surrogate

A Health Care Surrogate is a person you choose to make health care decisions for you when you are no longer able to do so. Your surrogate should be someone who knows your wishes and will make decisions based on what he/she believes you would want. A Health Care Surrogate is usually a family member or close friend who can be readily available to your physician. You are encouraged to appoint a Health Care Surrogate even if you have made other written expressions of your wishes, since it is difficult to address every possible situation in a Living Will.

Durable Power of Attorney

A Power of Attorney is a document by which you give another person – your “agent” – the authority to make decisions about the financial aspects of your life. In Florida, you can also give your agent the authority to make decisions about your medical treatment. A Durable Power of Attorney remains in effect even if you become incapacitated. For example, you can authorize your agent to consent to medical and surgical procedures for you under certain circumstances (*usually* when you are unable to make these decisions). You must be 18 years old and you can revoke or change your power of attorney at any time before you become incompetent.

Common Questions:

Q. Are Living Wills, HealthCare Surrogates and Durable Powers of Attorney just for senior citizens?

A. No. A severe illness or serious accident can happen to any person at any age. If you have strong feelings about what choices you would want in such a situation, regardless of your age, you are encouraged to consider an Advance Directive. However, parents of minors under the age of 18 will be responsible for the health care decisions of their children (unless special facts apply).

Q. May I change my Living Will, name a different Health Care Surrogate or Durable Power of Attorney?

A. Yes, you may make changes at any time. If you do make changes to your Living Will, name a new Health Care Surrogate or Durable Power of Attorney be sure to destroy all of the outdated copies and provide copies of the updated information to your physician, family members and others whom you think need to know your wishes.

Q. May I request that I not be given food or water artificially (tube feedings, IVs)?

A. Yes. Florida law gives you the right to refuse food and water. A Living Will usually allows you to do this when you medical condition is terminal and such efforts only serve to prolong the process of dying. A Health Care Surrogate or Durable Power of Attorney, appointed independent of your Living Will, is able to direct that IVs and tube feedings be discontinued in situations where no recovery is deemed possible.

Q. Are there any limitations on carrying out my instructions?

A. No. The document need only be signed in the presence of two witnesses. One of the witnesses must be someone who is not your spouse, blood relative, heir or person responsible for paying your medical bills.

Q. What do I do after I complete a Living Will, appoint a Health Care Surrogate and/or Durable Power of Attorney?

A. Once you have completed a Living Will, appointed a Health Care Surrogate and/or Durable Power of Attorney, you should give a copy to your physician, minister, family members, close friends and your Health Care Surrogate or Durable Power of Attorney. Discuss with them the details of your Advance Directive and ask that they keep a copy to make available if and when needed.

Q. Is it necessary to state my wishes in writing?

A. It is probably best to put your wishes in writing. There is authority for oral declarations but if you have stated your desires in writing, misunderstandings can be avoided.

Remember...

- It may be best to sign multiple documents because the appointment of a Health Care Surrogate and Durable Power of Attorney are more flexible and apply to more than just end of life situations.
- An Advance Directive that is valid in another state may not be valid in Florida.
- If you have a health care Power of Attorney that you signed in another state you should probably have a local attorney review it to assure its validity.
- Update your document regularly.

AvMed Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices is directed to all members of AvMed's health plans. It describes how we may collect, use, and disclose your protected health information, and your rights concerning your protected health information. "Protected health information" is information about you, including demographic information collected from you, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health condition, the provision of health care to you or the payment for that care.

We are required to maintain the privacy of your protected health information and to provide you this notice about our legal duties and privacy practices. We must follow the privacy practices described in this notice while it is in effect. This notice first took effect April 14, 2003, and will remain in effect until we replace or modify it.

Protection of Oral, Written and Electronic Information

AvMed is committed to safeguarding your protected health information in all forms or formats. This includes protected health information that we may have in oral, written and electronic format.

Uses and Disclosures for Payment, Health Care Operations, and Treatment

We use and disclose protected health information in a number of different ways in connection with the payment for your health care, our health care operations, and your treatment. The following are only a few examples of the types of uses and disclosures of your protected health information that we are permitted to make without your authorization.

Payment: We will use and disclose your protected health information to administer your health benefits policy or contract, which may involve the determination of eligibility; claims payment; utilization review and management; medical necessity review; coordination of care, benefits and other services; and responding to complaints, appeals and external review requests. For some plans, we may also use and disclose protected health information for purposes of obtaining premiums, underwriting, ratemaking, and determining cost sharing amounts.

Health Care Operations: We will use and disclose your protected health information to support other business activities, including the following:

- Quality assessment and improvement activities, such as peer review, credentialing of providers, and accreditation by independent organizations such as the National Committee for Quality Assurance (NCQA).
- Performance measurement and outcomes assessment, health claims analysis and health services research.
- Operation of preventive health, early detection and disease and case management and coordination of care programs in plans that offer these programs, including information about treatment alternatives, therapies, health care providers, settings of care or other health-related benefits and services.
- Underwriting and ratemaking (i.e., determining premiums) and administration of reinsurance, stop loss and excess of loss policies.
- Risk management, auditing and detection and investigation of fraud and other unlawful conduct.
- Transfer of policies or contracts from and to other insurers (e.g., successor carriers), HMOs or third party administrators; and facilitation of any potential sale, transfer, merger, or consolidation of all or part of "Covered Entity" with another covered entity and due diligence related to that activity.
- Other general administrative activities, including data and information systems management and customer service.

Treatment: We may disclose your protected health information to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers) who request it in connection with your treatment. In plans that offer these programs, we may also disclose your protected health information to health care providers in connection with preventive health, early detection, and disease and case management programs.

In connection with the foregoing activities, we may collect the following types of information about you:

- Information we receive directly or indirectly from you or your employer or benefits plan sponsor or one of their business associates through applications, surveys, or other forms (e.g., name, address, social security number, date of birth, marital status, dependent information, employment information and medical history).
- Information about your relationships and transactions with us and others (e.g., health care claims and encounters, medical history, eligibility information, payment information and appeal and complaint information).

We may share your protected health information with affiliates and third party "business associates" that perform various activities for us or on our behalf. Whenever such an arrangement involves the use or disclosure of your protected health information, we will have a written contract that contains terms designed to protect the privacy of your protected health information. We may also contact you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may, in the case of some group health plans, disclose protected health information to the plan sponsor (e.g., your employer) to permit the plan sponsor to perform plan administration functions. Please see your plan documents, where applicable, for a full explanation of the limited uses and disclosures that the plan sponsor may make of your protected health information in providing plan administration functions for your group health plan.

If we obtain protected health information for underwriting purposes and the policy or contract of health insurance or health benefits is not written with us, we will not use or disclose that protected health information for any other purpose, except as required by law.

We do not destroy protected health information when individuals terminate their coverage with us. The information is necessary and used for many of the purposes described above, even after an individual leaves a plan, and in many cases is subject to legal retention requirements.

However, the policies and procedures that protect that information against inappropriate use and disclosure apply regardless of the status of any individual member.

Some of the uses and disclosures described in this notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

Other Uses and Disclosures

We may also use or disclose your protected health information in the following situations without your consent or authorization.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, the protected health information directly relevant to that person's involvement in your health care or payment for health care. If you are present for such a disclosure (whether in person or on a telephone call), we will either seek your verbal agreement to the disclosure or provide you an opportunity to object to it. We may also make such disclosures to the persons described above in situations where you are not present or you are unable to agree or object to the disclosure, if we determine that the disclosure is in your best interest. For example, if a family member or a caregiver calls our customer service line with basic information about you (address, date of birth, etc.) and with prior knowledge of a claim, we will confirm whether or not the claim has been received and paid, unless you have previously informed us in writing that you do not want us to make any such disclosures to that party. We may also disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Unless we are given an alternative address, we will mail explanation of benefits forms and other mailings containing protected health information to the address we have on record for the subscriber of the health benefits plan. We will not make separate mailings for enrolled dependents of the subscriber, unless it is requested in writing.

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye, or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. Seq.

Uses and Disclosures Based Upon Your Written Authorization

We require a special written authorization before making any disclosure of personal information for purposes not listed above (e.g., marketing/promotional activities and research projects conducted by third parties, etc.). In the event that you are unable to give the required consent (for example, if you are or become legally incompetent), we accept consent from any person legally authorized to give consent on your behalf.

A special authorization may be revoked except to the extent that we have taken action upon it. To revoke a special authorization that you previously gave, you may send us a letter stating that you would like to revoke your special authorization. Please provide your name, address, member identification number, the date the special authorization was given, and a telephone number where you may be reached.

Your Rights Regarding Medical and Health Information About You

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to AvMed. In your request, you must tell us (a) what information you want to limit; (b) whether you want to limit our use, disclosure or both; and (c) to whom you want the limits to apply.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location, if you advise us that communicating with you in the usual manner could endanger you. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to AvMed, stating that communicating with you in the usual manner could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Inspect and Copy: You have the right to inspect and receive copies of medical information that may be used to make decisions about your care. Usually, this includes enrollment, payment, claims adjudication, and case or medical management record systems maintained by AvMed. If you want to access the claims or other related information we maintain concerning you and your dependents, or the identity, if recorded, of those persons to whom personal information has been disclosed, you must submit your request in writing to AvMed Health Plan. Records will be available for transactions that occur after April 14, 2003. We may charge a fee for the costs of copying, mailing, or other administrative expenses associated with your request.

If you want to access medical record information about yourself, or if you have a question regarding your care, you should go to the provider (e.g. doctor, pharmacy, hospital or other caregiver) that generated the original records. We do not have custody of these medical records. If you believe the information in your medical records is wrong or incomplete, contact the provider who was responsible for the service or treatment in question. If we are the source of a confirmed error in our records concerning you, we will correct or amend the records we maintain. We are not able to correct the records created or maintained by your provider or other third parties.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for AvMed. To request an amendment, your request must be made in writing and submitted to AvMed Health Plan. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- ◆ was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- ◆ is not part of the medical information kept by or for AvMed;

- ♦ is not part of the information which you would be permitted to inspect and copy; or
- ♦ is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. This does **not include** uses of information for treatment, payment, or operations; disclosures to you or disclosures made at your request or the request of anyone you appoint as your representative; disclosures to correctional institutions; disclosures for law enforcement, national security, or intelligence purposes if the requesting officer asks for non-disclosure for a specified period of time. To request this list or accounting of disclosures, you must submit your request in writing to AvMed Health Plan. Your request must state a time-period, which may not be longer than six years prior to the date of your request. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Receive a Paper Copy: You have the right to receive a paper copy of this notice, upon request, even if you have previously agreed to receive the notice electronically.

Our Privacy Obligations

Federal law requires that we maintain the privacy of Protected Health Information and provide you with this Notice of our legal duties and privacy practices with respect to Protected Health Information. We are required to abide by the terms of this Notice (or other notice in effect at a given time). If we make changes to this Notice we must follow the requirements established by the Privacy Standards. Federal law also requires that we provide an internal **complaint process for privacy issues**.

Distribution and Duration of This Notice: We send this Notice to our subscribers or employers who sponsor our plans, as permitted, upon enrollment in any of our health benefits plans, when our privacy practices are materially changed, and annually upon renewal of the member's health plan.

We reserve the right to change the terms of this notice and to make the provisions of the new notice effective for all nonpublic personal health information we maintain at that time. Updates of this Notice are distributed to our subscribers or employers who sponsor our plans, can be requested by contacting our Member Services Department at the phone number on the back of your identification card, and are also available by request on our website, at www.avmed.org.

Violation of Privacy Rights: If you believe your privacy rights have been violated, you may file a complaint with AvMed Health Plan. You also have the right to complain to the Secretary of the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint.

How to Contact AvMed if You Feel That Your Information has Been Used Inappropriately

You may file a complaint with AvMed by following the grievance procedures described in your Member Handbook or Explanation of Coverage (EOC). If you wish to remain anonymous or believe an AvMed employee has violated your privacy rights, you may call AvMed's Compliance Hotline at 1-877-286-3889 or write to:

AvMed Health Plan, Inc.
HIPAA Privacy Officer
P.O. Box 749
Gainesville, FL 32602-0749

If you have questions about this privacy notice, please call our Member Services Department at the telephone numbers listed below. We are available 24 hours a day, 7 days a week.

Medicare Members: 1-800-782-8633

Commercial Members: 1-800-882-8633

Our TDD/TTY lines are available 24 hours a day, 7 days a week. In Miami, call 305-671-4948. In all other areas, call 1-877-442-8633.

Alternatively, you may write to us:

In South Florida:

AvMed Health Plan
P.O. Box 569000
Miami, FL 33256-9000

All Other Areas:

AvMed Health Plan
P.O. Box 823
Gainesville, FL 32606-0823

Need More Information? Get It Online

Whether you need to know the difference between a co-payment and co-insurance, need to find a doctor, or want more information about your benefits, call visit www.avmed.org/go/state, or call **1-888-762-8633**.

AvMED
SELF-FUNDED OPTIONS

2013 Health Plan Enrollment Information

*Highest overall rating of statewide plans reporting Health Maintenance Organization (HMO) and Point of Service (POS) product data to the National Committee for Quality Assurance (NCQA) for the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). CAHPS® is a registered trademark of the Agency of Healthcare Research and Quality (AHRQ).