AvMed Embrace better health® **JHS Select Network HMO**

**Coverage for:** Individual or Individual + Family| **Plan Type: HMO**

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-844-439-5378 or visit www.avmed.org/jhs. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-844-439-5378 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network: **$0** individual/ **$0** family | See the Common Medical Event chart below for your costs for services this **plan** covers. |
| **Are there services covered before you meet your deductible?** | This plan has no deductible In-Network. | This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost-sharing** and before you meet your **deductible**. See a list of covered **preventive services** at **https://www.healthcare.gov/coverage/preventive-care-benefits/**. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductibles** for specific services. |
| **What is the out-of-pocket limit for this plan?** | In-Network: **$1,500** individual/ **$3,000** dependent coverage (does not include prescription cost-sharing);<br>In-Network Prescription Drugs: **$1,500** individual/ **$3,000** dependent coverage (does not include medical cost-sharing) | The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, prescription drug brand additional charges, and services this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Will you pay less if you use a network provider?** | Yes. See **www.avmed.org/jhs or call 1-844-439-5378** for a list of participating providers. Participants must use **JHS Select Network Providers** and must reside in Miami-Dade, Broward, or Palm Beach County. | This **plan** uses a **provider** network. You will pay less if you use a **provider** in the plan's **network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the provider's charge and what your **plan** pays **(balance billing)**. Be aware, your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the **specialist** you choose without a **referral**. |



(DT - OMB control number: 1545-0047/Expiration DATE: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration DATE: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration DATE: 10/31/2022)

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | a JHS Select Network Provider (You will pay the least) | an Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $5 copay/ visit for PCP at JHS employed provider; $15 copay/ visit at all other;<br><br>$5 copay/ visit for allergy injections at JHS employed provider; $15 copay/ visit at all other;<br><br>$5 copay/ visit for chiropractic services at JHS employed provider; $15 copay/ visit at all other;<br><br>$5 copay/ visit for podiatry services at JHS employed provider; $15 copay/ visit at all other | Not Covered | Additional charges may apply for non-preventive services performed in the Physician's office. |
| | Specialist visit | $15 copay/ visit for specialist at JHS employed provider; $30 copay/ visit at all other;<br><br>$15 copay/ visit for allergy skin testing at JHS employed provider; $30 copay/ visit at all other;<br><br>$15 copay/ visit for infertility treatment at JHS employed provider; $30 copay/ visit at all other | Not Covered | Additional charges may apply for non-preventive services performed in the Physician's office.<br><br>Infertility treatment is limited to one sequence per member lifetime for the following: sperm count, endometrial biopsy, hysterosalpingography (HSG), and diagnostic laparoscopy. Artificial insemination, In-vitro fertilizations, GIFT, ZIFT, and other infertility treatments are not covered. |
| | Preventive care/screening/ immunization | No Charge | Not Covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | a JHS Select Network Provider (You will pay the least) | an Out-of-Network Provider (You will pay the most) | |
| | | | | your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No Charge | Not Covered | Charges for office visits may apply if services are performed in a Physician's office. |
| | Imaging (CT/PET scans, MRIs) | No Charge | Not Covered | Charges for office visits or Physician/professional services may also apply depending where services are received. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.avmed.org/jhs | Generic drugs (Tier 1) | $15 copay/ prescription (retail); $30 copay/ prescription (mail order) | Not Covered | This Plan uses the Preferred Pharmacy Network.<br><br>Retail charge applies per 30-day supply.<br><br>Generic & brand drugs: covers up to a 90-day supply at retail pharmacies; and 60-90 day supply via mail order.<br><br>Certain drugs in all tiers require prior authorization.<br><br>Brand additional charges may apply.<br><br>Specialty and cost-sharing drugs available in 30-day supply only; not available via mail order. |
| | Preferred brand drugs (Tier 2) | $25 copay/ prescription (retail); $50 copay/ prescription (mail order) | Not Covered | |
| | Non-preferred brand drugs (Tier 3) | $40 copay/ prescription (retail); $80 copay/ prescription (mail order) | Not Covered | |
| | Specialty Drugs (Tier 4) | $50 copay/ prescription (retail only) | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $200 copay/ visit; No charge at JHS | Not Covered | Prior authorization required. |
| | Physician/surgeon fees | No Charge | Not Covered | Prior authorization required. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | a JHS Select Network Provider (You will pay the least) | an Out-of-Network Provider (You will pay the most) | |
| **If you need immediate medical attention** | Emergency room care | $100 copay/ visit; $50 copay/ visit for age 17 and under (waived if admitted) | $100 copay/ visit; $50 copay/ visit for age 17 and under (waived if admitted) | AvMed must be notified within 24-hours of inpatient admission following emergency services, or as soon as reasonably possible. |
| | Emergency medical transportation | No Charge | No Charge | When pre-authorized or in the case of emergency. |
| | Urgent care | $5 copay/ visit at UHealth/ Jackson Urgent Care Centers; $50 copay/ visit at other in-network urgent care facilities; $15 copay/ visit at retail clinics | $100 copay/ visit at urgent care facilities or retail clinics | ----------None---------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $100 copay/ admission; No charge at JHS | Not Covered | Prior authorization required. |
| | Physician/surgeon fees | No Charge | Not Covered | Prior authorization required. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $5 copay/ visit at JHS employed provider; $15 copay/ visit at all other | Not Covered | ----------None---------- |
| | Inpatient services | Hospital stay: $100 copay/ admission; No charge at JHS Residential stay: No Charge | Not Covered | Prior authorization required. Residential stay is limited to 60 days per calendar year. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | a JHS Select Network Provider (You will pay the least) | an Out-of-Network Provider (You will pay the most) | |
| **If you are pregnant** | Office visits | Routine OB: $15 copay/ visit at JHS employed provider; $30 copay/ 1st visit only; subsequent visits at no charge | Not Covered | ----------None---------- |
| | Childbirth/delivery professional services | Routine OB & Midwife services: $15 copay/ visit at JHS employed provider; $30 copay/ 1st visit only; subsequent visits at no charge | Not Covered | Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound). |
| | Childbirth/delivery facility services | Hospital stay: $100 copay/ admissions; No charge at JHS<br>Birthing center: Same as routine OB | Not Covered | Prior authorization required. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | a JHS Select Network Provider (You will pay the least) | an Out-of-Network Provider (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Home health care | No Charge | Not Covered | Approved treatment plan required. |
| | Rehabilitation services | $30 copay/ visit | Not Covered | Limited to 60 visits per calendar year for rehabilitative physical, occupational, speech & respiratory therapies combined; 36 visits per calendar year for cardiac rehabilitation. Cardiac rehabilitation requires prior authorization. |
| | Habilitation services | $15 copay/ visit | Not Covered | Habilitative physical, occupational & speech therapies, when provided for the treatment of autism spectrum disorder and Down syndrome, are limited to a combined maximum of 100 visits per calendar year. |
| | Skilled nursing care | No Charge | Not Covered | Limited to 60 days post-hospitalization care per calendar year. Prior authorization required. |
| | Durable medical equipment | $50 copay/ episode of illness for DME or orthotic appliances; No charge/ device for prosthetic devices | Not Covered | Some limitations apply. Please see your Summary Plan Description for details. |
| | Hospice services | No Charge | Not Covered | Limited to 360 days per member lifetime maximum. Physician certification required. |
| **If your child needs dental or eye care** | Children's eye exam | $15 copay/ exam | Not Covered | Limited to one eye exam per calendar year to determine the need for sight correction. |
| | Children's glasses | Not Covered | Not Covered | ----------None---------- |
| | Children's dental check-up | Not Covered | Not Covered | ----------None---------- |

## Excluded Services & Other Covered Services:

| Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.) | | |
|---|---|---|
| • Acupuncture | • Long-Term Care | • Routine Eye Care (Adult) |
| • Cosmetic Surgery | • Non-Emergency Care When Traveling Outside the U.S. | • Routine Foot Care |
| • Dental Care (Adult) | • Private-Duty Nursing | • Weight Loss Programs |
| • Hearing Aids | | |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Bariatric Surgery (limited to JHS Facilities) | • Chiropractic Care | • Infertility Treatment (1 sequence per lifetime) |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Florida Office of Insurance Regulation at 1-877-693-5236 or www.floir.com/consumers, the U.S. Department of Labor, Employee Benefits Security Administration, at 1-866-444-3272 or www.dol.gov/ebsa/contactEBSA/consumerassistance.html, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance **Marketplace**. For more information about the **Marketplace**, visit **www.HealthCare.gov** or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your **plan** for a denial of a **claim**. This complaint is called a **grievance** or **appeal**. For more information about your rights, look at the explanation of benefits you will receive for that medical **claim**. Your **plan** documents also provide complete information on how to submit a **claim**, **appeal**, or a **grievance** for any reason to your **plan**. For more information about your rights, this notice, or assistance, contact AvMed's Member Engagement Center at 1-844-439-5378. For plans subject to ERISA, you may also contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your **appeal**. Contact the Florida Department of Financial Services, Division of Consumer Services, at 1-877-693-5236 or www.floir.com/consumers.

**Does this plan provide Minimum Essential Coverage?** **Yes.**
**Minimum Essential Coverage** generally includes plans, health insurance available through the **Marketplace** or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of **Minimum Essential Coverage**, you may not be eligible for the premium tax credit.

**Does this plan meet Minimum Value Standards?** **YES.**
If your **plan** doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** to help pay for a **plan** through the **Marketplace**.

**Language Access Services:**
Para obtener asistencia en Español, llame al 1-844-439-5378.

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

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| **The plan's overall deductible** | **$0** |
| **Specialist copayment** | **$15** |
| **Hospital (facility) copayment** | **$100** |
| **Other payment** | **$0** |

**This EXAMPLE event includes services like:**
Specialist office visits (*prenatal care*)
Childbirth/delivery professional services
Childbirth/delivery facility services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $100 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | $160 |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| **The plan's overall deductible** | **$0** |
| **Specialist copayment** | **$15** |
| **Hospital (facility) copayment** | **$100** |
| **Other payment** | **$0** |

**This EXAMPLE event includes services like:**
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $1,200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | $1,220 |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| **The plan's overall deductible** | **$0** |
| **Specialist copayment** | **$15** |
| **Hospital (facility) copayment** | **$100** |
| **Other copayment** | **$0** |

**This EXAMPLE event includes services like:**
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | $400 |

The **plan** would be responsible for the other costs of these EXAMPLE covered services.