AvMed

# State of Florida High Deductible Health Plan

**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 1-888-762-8633 or visit www.avmed.org/go/state. 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 1-888-762-8633 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | Self-only: **$1,400**<br>Family: **$2,800** | Generally, you must pay all of the costs from providers up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, the overall family **deductible** limit must be met. |
| Are there services covered before you meet your deductible? | Yes. Preventive care is covered before you meet your deductible. | This **plan** covers some items and services 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? | Self-only: **$3,000**<br>Family: **$6,000** | 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**, the overall family **out-of-pocket limit** must be met. |
| What is not included in the out-of-pocket limit? | Premiums 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/go/state or call 1-888-762-8633** for a list of participating providers.<br>No coverage out-of-network. | If you use an in-network doctor or other health care **provider**, 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 **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| Do you need a referral to see a specialist? | No. | You can see the **specialist** you choose without a **referral**. |

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 |
|---|---|---|---|---|
| | | an AvMed 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 | 20% coinsurance after deductible | Not Covered | Additional charges may apply for non-preventive services performed in the Physician's office. |
| | Specialist visit | 20% coinsurance after deductible | Not Covered | Additional charges may apply for non-preventive services performed in the Physician's office. |
| | Preventive care/screening/ immunization | No Charge | Not Covered | You may have to pay for services that aren't preventive. Ask you provider if the services you need are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% coinsurance after deductible | Not Covered | Charges for office visits may apply if services are performed in a Physician's office. Charges for certain other labs and Specialty labs will be higher. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance after deductible | Not Covered | Charges for office visits of Physician/professional services may also apply depending where services are received. |

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| | | an AvMed Network Provider (You will pay the least) | an Out of Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition** More information about prescription drug coverage is available at www.caremark.com/sofrxplan | Generic drugs (Tier 1) | 30% coinsurance after deductible/ prescription (participating retail pharmacy or mail-order) | Not Covered | Prescription drug coverage is provided through CVS/Caremark. For a list of participating pharmacies go to www.caremark.com/sofrxplan or call 1-888-766-5490.<br><br>Generic & Brand drugs: covers up to a 90-day supply at retail pharmacies and a 60-90 day supply via mail order.<br><br>Certain drugs in all tiers require prior authorization. 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) | 30% coinsurance after deductible/ prescription (participating retail pharmacy or mail-order) | Not Covered | |
| | Non-preferred brand drugs (Tier3) | 50% coinsurance after deductible/ prescription (participating retail pharmacy or mail-order) | Not Covered | |
| | Specialty drugs (Tier 4) | Preferred brand Specialty drugs: 30% coinsurance after deductible/ prescription (participating retail pharmacy or mail order); Non-preferred brand Specialty drugs: 50% coinsurance after deductible/ prescription (participating retail pharmacy or mail order) | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance after deductible | Not Covered | Charges for office visits may also apply if services are performed in a Physician's office. Prior authorization required. |
| | Physician/surgeon fees | 20% coinsurance after deductible | Not Covered | Charges for office visits may also apply if services are performed in a Physician's office. Prior authorization required. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | an AvMed 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 | 20% coinsurance after deductible | 20% coinsurance after deductible | AvMed must be notified within 24-hours of inpatient admission following emergency services, or as soon as reasonably possible. |
| | Emergency medical transportation | 20% coinsurance after deductible | 20% coinsurance after deductible | ----------None---------- |
| | Urgent care | 20% coinsurance after deductible at urgent care facility or retail clinic | Not Covered | ----------None---------- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance after deductible | Not Covered | Prior authorization required. |
| | Physician/surgeon fees | 20% coinsurance after deductible | Not Covered | Prior authorization required. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 20% coinsurance after deductible | Not Covered | Prior authorization required. |
| | Inpatient services | Hospital stay: 20% coinsurance after deductible; Residential stay: 20% coinsurance after deductible | Not Covered | Prior authorization required. |
| If you are pregnant | Office visits | Routine OB & Midwife services: 20% coinsurance after deductible | Not Covered | ----------None---------- |
| | Childbirth/delivery professional services | 20% coinsurance after deductible | Not Covered | Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth/delivery facility services | Hospital stay: 20% coinsurance after deductible 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 |
|---|---|---|---|---|
| | | an AvMed 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 | 20% coinsurance after deductible | Not Covered | Approved treatment plan required. |
| | Rehabilitation services | 20% coinsurance after deductible; 20% coinsurance after deductible for chiropractic services | Not Covered | Rehabilitative physical, speech and occupational therapy to treat injuries is limited to 60 visits per injury. Chiropractic services is limited to 60 visits per injury. |
| | Habilitation services | 20% coinsurance after deductible | Not Covered | Habilitative occupational therapy is limited to home health care, hospice care, treatment of Autism Spectrum disorder, treatment of Developmental Disabilities, and Down syndrome. |
| | Skilled nursing care | 20% coinsurance after deductible | Not Covered | Limited to 60 days post-hospitalization care per calendar year. Prior authorization required. |
| | Durable medical equipment | 20% coinsurance after deductible | Not Covered | Some limitation apply. Please see your Summary Plan Description for details. |
| | Hospice services | 20% coinsurance after deductible | Not Covered | Limited to a lifetime max of 210 days. Physician certification required. |
| If your child needs dental or eye care | Children's eye exam | 20% coinsurance after deductible | Not Covered | Limited to 1 eye exam per calendar year to determine the need for sight correction. |
| | Children's glasses | Not Covered | Not Covered | Not covered under this medical and pharmacy benefits plan. |
| | Children's dental check-up | Not Covered | Not Covered | Not covered under this medical and pharmacy benefits plan. |

## 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 | • Glasses | • Non-Emergency Care When Traveling Outside the U.S. |
| • Bariatric Surgery | • Hearing Aids | • Private-Duty Nursing |
| • Cosmetic Surgery | • Infertility Treatment | • Routine Foot Care |
| • Dental Care (Adult) | • Long-Term Care | • Weight Loss Programs |
| • Dental Care (Child) | | |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | |
|---|---|
| • Chiropractic Care | • Routine Eye Care (Adult) |

**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 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 1-888-762-8633.

**Does this plan provide Minimum Essential Coverage?** Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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 1-888-762-8633.

*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 | $1,400 |
| Specialist coinsurance | 20% |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**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 | $12,800 |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,208 |
| Copayments | $0 |
| Coinsurance | $1,792 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | $3,060 |

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

| | |
|---|---|
| The plan's overall deductible | $1,400 |
| Specialist coinsurance | 20% |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**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 | $7,400 |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,400 |
| Copayments | $0 |
| Coinsurance | $1,490 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | $2,945 |

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

| | |
|---|---|
| The plan's overall deductible | $1,400 |
| Specialist coinsurance | 20% |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**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 | $1,900 |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $407 |
| Copayments | $0 |
| Coinsurance | $102 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | $509 |

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