



 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 1-800-477-8768 or visit www.avmed.org and sign into the Member Portal. 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.healthcare.gov/sbc-glossary or call 1-800-477-8768 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall deductible? | In-Network: \$6,500 Individual / \$13,000 Family Out of Network: Not Applicable | 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 , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible . |
| Are there services covered before you meet your deductible? | Yes. Preventive care , office visits, certain prescription drugs , urgent care , outpatient rehabilitation are covered before you meet your deductible . | 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. There are no other specific deductibles. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | In-Network: \$7,900 Individual / \$15,800 Family Out of Network: Not Applicable Pediatric Dental is limited to \$375 per child or \$750 for 2 or more children. | 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 limit 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 manufacturer assistance, and health care 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 or call 1-800-477-8768 for a list of network providers . | 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? | Yes. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist . |

 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 |
|---|---|--|---|---|
| | | In-Network (You will pay the least) | Out of Network (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 | \$70 copay / visit | Not Covered | Additional charges may apply for non-preventive services performed in the Physician's office. |
| | Specialist visit | \$140 copay / visit | 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 your provider if the services needed are preventive . Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | Independent facility: \$75 copay / visit after deductible ; Hospital-affiliated facility: \$150 copay / visit 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) | Independent facility: \$250 copay / visit after deductible ; Hospital-affiliated facility: \$500 copay / visit after deductible | Not Covered | Charges for office visits or Physician/professional services may also apply depending on 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 | Generic drugs (Tier 1 & Tier 2) | Value generic drugs 30-day supply: \$25 copay / prescription; 90-day supply: \$62.50 copay / prescription Generic drugs 30-day supply: \$45 copay / prescription 90-day supply: \$112.50 copay / prescription | Not Covered | Certain limits may apply, including, for example: prior authorization, step therapy, quantity limits. Covered drugs in Tiers 1-4 are available up to a 90-day supply at retail pharmacies; and a 60-90-day supply via mail order. Drugs in Tier 5 & 6 are available up to a 30-day supply, at retail pharmacies only. |
| | Preferred brand drugs (Tier 3) | 30-day supply: \$85 copay / prescription after deductible ; 90-day supply: \$212.50 copay / prescription after deductible | Not Covered | Brand additional charges may apply. Coupons or any other third-party prescription drug cost-sharing assistance will not apply toward any calendar year deductible or out-of-pocket limit. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|--|---|--|
| | | In-Network (You will pay the least) | Out of Network (You will pay the most) | |
| | Non-Preferred brand drugs (Tier 4) | 30-day supply: 50% coinsurance after deductible ; 90-day supply: 50% coinsurance after deductible | Not Covered | |
| | Specialty drugs (Tier 5 & Tier 6) | Preferred Specialty Drugs: 40% coinsurance after deductible (Retail only); Non-Preferred Specialty Drug: 60% coinsurance after deductible (Retail only) | Not Covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | Independent facility: 30% coinsurance after deductible ; Hospital-affiliated facility: 30% coinsurance after deductible | Not Covered | Prior authorization required. |
| | Physician/surgeon fees | 30% coinsurance after deductible | Not Covered | Prior authorization required. |
| If you need immediate medical attention | Emergency room care | \$500 copay / visit after deductible | \$500 copay / visit after In-Network deductible | AvMed must be notified within 24-hours of inpatient admission following emergency services, or as soon as reasonably possible. Charges are waived if admitted. |
| | Emergency medical transportation | Ground: \$200 copay / one way ground transport; Air/Water: 50% coinsurance after deductible | Ground: \$200 copay / one way ground transport; Air/Water: 50% coinsurance after In-Network deductible | None |
| | Urgent care | Independent urgent care facility: \$125 copay / visit; Hospital-affiliated urgent care facility: \$250 copay / visit; Retail clinic: \$80 copay / visit | Independent urgent care facility: \$125 copay / visit; Hospital-affiliated urgent care facility: \$250 copay / visit; Retail clinic: Not Covered | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|---|---|
| | | In-Network (You will pay the least) | Out of Network (You will pay the most) | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$500 copay / admission after deductible | Not Covered | Prior authorization required. |
| | Physician/surgeon fees | No charge after deductible | Not Covered | Prior authorization required. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$70 copay / visit | Not Covered | Prior authorization may be required. |
| | Inpatient services | \$500 copay / admission after deductible | Not Covered | Prior authorization may be required. |
| If you are pregnant | Office visits | Routine OB or midwife: Visit 1 - 1: \$70 copay / visit; Visit 2 and after: No Charge | Not Covered | None |
| | Childbirth/delivery professional services | No charge after deductible | Not Covered | Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound). |
| | Childbirth/delivery facility services | Hospital: \$500 copay / admission after deductible ; Birthing center: Same as routine OB | Not Covered | Prior authorization required. |
| If you need help recovering or have other special health needs | Home health care | \$140 copay / visit after deductible | Not Covered | Limited to 20 skilled visits per calendar year. Approved treatment plan required. |
| | Rehabilitation services | Independent facility: \$140 copay / visit; Hospital-affiliated facility: \$140 copay / visit after deductible ; Chiropractic services: \$70 copay / visit | Not Covered | Limited to 35 visits per calendar year for outpatient rehabilitative PT, OT, ST, cardiac rehab, pulmonary rehab, and chiropractic services combined. Cardiac and pulmonary rehab require prior authorization. |
| | Habilitation services | Independent facility: \$140 copay / visit; Hospital-affiliated facility: \$140 copay / visit after deductible | Not Covered | Limited to 35 visits per calendar year for outpatient habilitative PT, OT and ST combined. |
| | Skilled nursing care | Day 1 - 2: \$250 copay / day per admission after deductible ; Day 3 and after: No Charge | Not Covered | Limited to 60 days post-hospitalization care per calendar year. Prior authorization required. |
| | Durable medical equipment | \$100 copay / episode of illness after deductible | Not Covered | Excludes vehicle modifications, home modifications, exercise equipment, and bathroom equipment. |
| | | | | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|----------------------------------|---|--|---|
| | | In-Network (You will pay the least) | Out of Network (You will pay the most) | |
| | Hospice services | No charge after deductible | Not Covered | Physician certification required. |
| If your child needs dental or eye care | Children's eye exam | No Charge | Not Covered | Limited to one exam per calendar year to determine the need for sight correction. |
| | Children's glasses | No Charge | Not Covered | Limited to one pair per calendar year from a pre-selected group of frames. |
| | Children's dental check-up | No charge for preventive care at Delta Dental Network providers | Not Covered | Limited to one exam every 6 months. See the dental portion of your AvMed Contract for coverage details. |

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](#).)

- | | | |
|---|---|---|
| <ul style="list-style-type: none"> • Acupuncture • Bariatric Surgery • Cosmetic Surgery • Dental Care (Adult) | <ul style="list-style-type: none"> • Hearing Aids • Infertility Treatment • Long-term Care • Non-Emergency Care When Traveling Outside the U.S. | <ul style="list-style-type: none"> • Private-Duty Nursing • Routine Eye Care (Adult) • Routine Foot Care • Weight Loss Programs |
|---|---|---|

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- | | | |
|-------------------------|-----------------|---------------------|
| • Child Dental Check Up | • Child Glasses | • Chiropractic Care |
|-------------------------|-----------------|---------------------|

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.flor.com/consumers, the U.S. Department of Labor, Employee Benefits Security Administration, at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, 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 1-800-477-8768. You may also contact your state insurance department. 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.flor.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 the 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 you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Para obtener asistencia en Español, llame al 1-800-477-8768.

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 | \$6,500 |
| ■ Specialist copayment | \$140 |
| ■ Hospital (facility) copayment | \$500 |
| ■ Other copayment | \$70 |

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$6,500 |
| Copayments | \$700 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$7,260 |

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$6,500 |
| ■ Specialist copayment | \$140 |
| ■ Hospital (facility) copayment | \$500 |
| ■ Other copayment | \$70 |

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$3,100 |
| Copayments | \$1,400 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$4,520 |

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$6,500 |
| ■ Specialist copayment | \$140 |
| ■ Hospital (facility) copayment | \$500 |
| ■ Other copayment | \$70 |

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,100 |
| Copayments | \$900 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,000 |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.