AvMed Embrace better health® **Individual AvMed Entrust Gold Standard (2023)** **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 1-800-477-8768 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:** $2,000 Individual / $4,000 Family<br>**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:** $8,700 Individual / $17,400 Family<br>**Out of Network:** Not Applicable<br>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. |


(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 |
|---|---|---|---|---|
| | | 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 | $30 copay/ visit | Not Covered | Additional charges may apply for non-preventive services performed in the Physician's office. |
| | Specialist visit | $60 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: 25% coinsurance after deductible; Hospital-affiliated facility: 25% 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) | Independent facility: 25% coinsurance after deductible; Hospital-affiliated facility: 25% coinsurance 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: $15 copay/ prescription; 90-day supply: $37.50 copay/ prescription<br><br>Generic drugs 30-day supply: $15 copay/ prescription 90-day supply: $37.50 copay/ prescription | Not Covered | Certain limits may apply, including, for example: prior authorization, step therapy, quantity limits.<br>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.<br>Drugs in Tier 5 & 6 are available up to a 30-day supply, at retail pharmacies only.<br>Brand additional charges may apply. |
| | Preferred brand drugs (Tier 3) | 30-day supply: $30 copay/ prescription; 90-day supply: $75 copay/ prescription | Not Covered | |

| 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: $60 copay/ prescription; 90-day supply: $150 copay/ prescription | Not Covered | Coupons or any other third-party prescription drug cost-sharing assistance will not apply toward any calendar year deductible or out-of-pocket limit. |
| | Specialty drugs (Tier 5 & Tier 6) | Preferred Specialty Drugs: $250 copay/ prescription (Retail only); Non-Preferred Specialty Drug: $250 copay/ prescription (Retail only) | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Independent facility: 25% coinsurance after deductible; Hospital-affiliated facility: 25% coinsurance after deductible | Not Covered | Prior authorization required. |
| | Physician/surgeon fees | 25% coinsurance after deductible | Not Covered | Prior authorization required. |
| **If you need immediate medical attention** | Emergency room care | 25% coinsurance after deductible | 25% coinsurance 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: $45 copay/ visit; Hospital-affiliated urgent care facility: $45 copay/ visit; Retail clinic: $40 copay/ visit | Independent urgent care facility: $45 copay/ visit; Hospital-affiliated urgent care facility: $45 copay/ visit; Retail clinic: Not Covered | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 25% coinsurance after deductible | Not Covered | Prior authorization required. |

| 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) | |
| | Physician/surgeon fees | 25% coinsurance after deductible | Not Covered | Prior authorization required. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $30 copay/ visit | Not Covered | Prior authorization may be required. |
| | Inpatient services | 25% coinsurance after deductible | Not Covered | Prior authorization may be required. |
| **If you are pregnant** | Office visits | Routine OB or midwife:<br>Visit 1 - 1: $30 copay/ visit;<br>Visit 2 and after: No Charge | Not Covered | None |
| | Childbirth/delivery professional services | 25% coinsurance after deductible | Not Covered | Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound). |
| | Childbirth/delivery facility services | Hospital:<br>25% coinsurance after deductible;<br>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 | $60 copay/ visit after deductible | Not Covered | Limited to 20 skilled visits per calendar year. Approved treatment plan required. |
| | Rehabilitation services | Independent facility:<br>$30 copay/ visit;<br>Hospital-affiliated facility:<br>$30 copay/ visit;<br>Chiropractic services:<br>$30 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:<br>$60 copay/ visit;<br>Hospital-affiliated facility:<br>$60 copay/ visit after deductible | Not Covered | Limited to 35 visits per calendar year for outpatient habilitative PT, OT and ST combined. |
| | Skilled nursing care | 25% coinsurance after deductible | 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. |
| | 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. |

| 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) | |
| | 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.)**

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-term Care
- Non-Emergency Care When Traveling Outside the U.S.
- 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.floir.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.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 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 | $2,000 |
| Specialist copayment | $60 |
| Hospital (facility) coinsurance | 25% |
| Other copayment | $30 |

**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 | $2,000 |
| Copayments | $40 |
| Coinsurance | $2,000 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,100** |

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

| | |
|---|---|
| The plan's overall deductible | $2,000 |
| Specialist copayment | $60 |
| Hospital (facility) coinsurance | 25% |
| Other copayment | $30 |

**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 | $100 |
| Copayments | $1,200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,320** |

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

| | |
|---|---|
| The plan's overall deductible | $2,000 |
| Specialist copayment | $60 |
| Hospital (facility) coinsurance | 25% |
| Other copayment | $30 |

**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 | $1,100 |
| Copayments | $600 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,700** |

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