



 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: \$1,500 Individual / \$3,000 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, 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 Out of Network: Not Applicable Pediatric Dental is limited to \$400 per child or \$800 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	\$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)	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.
	Preferred brand drugs (Tier 2)	30-day supply: \$30 copay / prescription; 90-day supply: \$75 copay / prescription	Not Covered	Covered drugs in Tiers 1-3 are available up to a 90-day supply at retail pharmacies; and a 60-90-day supply via mail order.
	Non-Preferred brand drugs (Tier 3)	30-day supply: \$60 copay / prescription; 90-day supply: \$150 copay / prescription	Not Covered	Drugs in Tier 4 are available up to a 30-day supply, at retail pharmacies only.
	Specialty drugs (Tier 4)	\$250 copay / prescription (Retail only)	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)	
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.
	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: Visit 1 - 1: \$30 copay / visit; Visit 2 and after: No Charge	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)	
	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: 25% coinsurance 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	\$60 copay / visit after deductible	Not Covered	Limited to 20 skilled visits per calendar year. Approved treatment plan required.
	Rehabilitation services	Independent facility: \$30 copay / visit; Hospital-affiliated facility: \$30 copay / visit; Chiropractic services: \$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: \$60 copay / visit; Hospital-affiliated facility: \$60 copay / visit	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.
	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 | • Hearing Aids | • Private-Duty Nursing |
| • Bariatric Surgery | • Infertility Treatment | • Routine Eye Care (Adult) |
| • Cosmetic Surgery | • Long-term Care | • Routine Foot Care |
| • Dental Care (Adult) | • Non-Emergency Care When Traveling Outside the U.S. | • Weight Loss Programs |

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

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|-------------------------|-----------------|---------------------|
| • 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.ccio.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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$1,500	■ The plan's overall deductible	\$1,500	■ The plan's overall deductible	\$1,500
■ Specialist copayment	\$60	■ Specialist copayment	\$60	■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	25%	■ Hospital (facility) coinsurance	25%	■ Hospital (facility) coinsurance	25%
■ Other copayment	\$30	■ Other copayment	\$30	■ Other copayment	\$30
This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)		This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$1,500	Deductibles	\$100	Deductibles	\$1,100
Copayments	\$40	Copayments	\$1,200	Copayments	\$600
Coinsurance	\$2,100	Coinsurance	\$0	Coinsurance	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
The total Peg would pay is	\$3,700	The total Joe would pay is	\$1,320	The total Mia would pay is	\$1,700

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