



 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](http://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](http://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 <a href="#">deductible</a> ?                                | <b>In-Network:</b> \$3,000 Individual / \$6,000 Family<br><b>Out of Network:</b> Not Applicable   | Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> , office visits, certain diagnostic tests, certain imaging, certain <a href="#">prescription drugs</a> , <a href="#">urgent care</a> , outpatient <a href="#">rehabilitation</a> are covered before you meet your <a href="#">deductible</a> . | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .   |
| Are there other <a href="#">deductibles</a> for specific services?              | No. There are no other specific deductibles.  | You don't have to meet <a href="#">deductibles</a> for specific services.   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | <b>In-Network:</b> \$7,650 Individual / \$15,300 Family<br><b>Out of Network:</b> Not Applicable<br>Pediatric Dental is limited to \$375 per child or \$750 for 2 or more children.   | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limit</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.  |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">prescription drug</a> brand additional charges and manufacturer assistance, and health care this <a href="#">plan</a> doesn't cover.   | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.avmed.org">www.avmed.org</a> or call 1-800-477-8768 for a list of <a href="#">network providers</a> .  | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | Yes.  | This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .  |



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<br>(You will pay the least)   | Out of Network<br>(You will pay the most) |   |
| <b>If you visit a health care provider's office or clinic</b>   | Primary Care visit to treat an injury or illness        | Visit 1 - 1: No Charge;<br>Visit 2 and after: \$40 <a href="#">copay</a> / visit   | Not Covered                               | Additional charges may apply for non-preventive services performed in the Physician's office.   |
|   | <a href="#">Specialist</a> visit                        | \$80 <a href="#">copay</a> / visit   | Not Covered                               | Additional charges may apply for non-preventive services performed in the Physician's office.   |
|   | <a href="#">Preventive care/screening</a> /immunization | No Charge  | Not Covered                               | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.   |
| <b>If you have a test</b>   | <a href="#">Diagnostic test</a> (x-ray, blood work)     | Independent facility:<br>\$100 <a href="#">copay</a> / visit;<br>Hospital-affiliated facility:<br>\$200 <a href="#">copay</a> / visit              | 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:<br>\$300 <a href="#">copay</a> / visit;<br>Hospital-affiliated facility:<br>\$600 <a href="#">copay</a> / visit              | Not Covered                               | Charges for office visits or Physician/professional services may also apply depending on where services are received.   |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.avmed.org">www.avmed.org</a> | Generic drugs (Tier 1 & Tier 2)                         | Value generic drugs<br>30-day supply:<br>\$20 <a href="#">copay</a> / prescription;<br>90-day supply:<br>\$50 <a href="#">copay</a> / prescription | Not Covered                               | Certain limits may apply, including, for example: prior authorization, step therapy, quantity limits.<br><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><br>Drugs in Tier 5 & 6 are available up to a 30-day supply, at retail pharmacies only.<br><br>Brand additional charges may apply.<br><br>Coupons or any other third-party prescription drug cost-sharing assistance will not apply toward any calendar year deductible or out-of-pocket limit. |
|   |   | Generic drugs<br>30-day supply:<br>\$40 <a href="#">copay</a> / prescription<br>90-day supply:<br>\$100 <a href="#">copay</a> / prescription       |   |   |
|   | Preferred brand drugs (Tier 3)                          | 30-day supply:<br>\$80 <a href="#">copay</a> / prescription;<br>90-day supply:<br>\$200 <a href="#">copay</a> / prescription                       | Not Covered                               |   |
|   | Non-Preferred brand drugs (Tier 4)                      | 30-day supply:<br>\$100 <a href="#">copay</a> / prescription;<br>90-day supply:<br>\$250 <a href="#">copay</a> / prescription                      | Not Covered                               |   |

| Common Medical Event                           | Services You May Need                                | What You Will Pay  |   | Limitations, Exceptions, & Other Important Information   |
|--|--|--|---|--|
|  |  | In-Network<br>(You will pay the least)   | Out of Network<br>(You will pay the most)   |  |
|  | <a href="#">Specialty drugs</a><br>(Tier 5 & Tier 6) | Preferred Specialty Drugs:<br>40% <a href="#">coinsurance</a> after <a href="#">deductible</a> (Retail only);<br>Non-Preferred Specialty Drug:<br>60% <a href="#">coinsurance</a> after <a href="#">deductible</a> (Retail only) | Not Covered   |  |
| <b>If you have outpatient surgery</b>          | Facility fee (e.g., ambulatory surgery center)       | Independent facility:<br>\$725 <a href="#">copay</a> / visit after <a href="#">deductible</a> ;<br>Hospital-affiliated facility:<br>\$725 <a href="#">copay</a> / visit after <a href="#">deductible</a>                         | Not Covered   | Prior authorization required.  |
|  | Physician/surgeon fees                               | No charge after <a href="#">deductible</a>   | Not Covered   | Prior authorization required.  |
| <b>If you need immediate medical attention</b> | <a href="#">Emergency room care</a>                  | \$500 <a href="#">copay</a> / visit after <a href="#">deductible</a>   | \$500 <a href="#">copay</a> / visit after In-Network <a href="#">deductible</a>   | AvMed must be notified within 24-hours of inpatient admission following emergency services, or as soon as reasonably possible. Charges are waived if admitted. |
|  | <a href="#">Emergency medical transportation</a>     | Ground:<br>\$200 <a href="#">copay</a> / one way ground transport;<br>Air/Water:<br>50% <a href="#">coinsurance</a> after <a href="#">deductible</a>   | Ground:<br>\$200 <a href="#">copay</a> / one way ground transport;<br>Air/Water:<br>50% <a href="#">coinsurance</a> after In-Network <a href="#">deductible</a>                                 | None   |
|  | <a href="#">Urgent care</a>                          | Independent urgent care facility:<br>\$125 <a href="#">copay</a> / visit;<br>Hospital-affiliated urgent care facility:<br>\$250 <a href="#">copay</a> / visit;<br>Retail clinic:<br>\$50 <a href="#">copay</a> / visit           | Independent urgent care facility:<br>\$125 <a href="#">copay</a> / visit;<br>Hospital-affiliated urgent care facility:<br>\$250 <a href="#">copay</a> / visit;<br>Retail clinic:<br>Not Covered | None   |
| <b>If you have a hospital stay</b>             | Facility fee (e.g., hospital room)                   | Day 1 - 2: \$900 <a href="#">copay</a> / day per admission after <a href="#">deductible</a> ;<br>Day 3 and after: No Charge  | Not Covered   | Prior authorization required.  |
|  | Physician/surgeon fees                               | No charge after <a href="#">deductible</a>   | Not Covered   | Prior authorization required.  |
|  | Outpatient services                                  | \$40 <a href="#">copay</a> / visit   | Not Covered   | Prior authorization may be required.   |

| Common Medical Event   | Services You May Need                     | What You Will Pay  |   | Limitations, Exceptions, & Other Important Information  |
|--|---|--|---|---|
|  |   | In-Network<br>(You will pay the least)   | Out of Network<br>(You will pay the most) |   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Inpatient services                        | Day 1 - 2: \$900 <a href="#">copay</a> / day per admission after <a href="#">deductible</a> ;<br>Day 3 and after: No Charge  | Not Covered                               | Prior authorization may be required.  |
| <b>If you are pregnant</b>   | Office visits                             | Routine OB or midwife:<br>Visit 1 - 1: \$40 <a href="#">copay</a> / visit;<br>Visit 2 and after: No Charge   | Not Covered                               | None  |
|  | Childbirth/delivery professional services | No charge after <a href="#">deductible</a>   | Not Covered                               | Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).  |
|  | Childbirth/delivery facility services     | Hospital:<br>Day 1 - 2: \$900 <a href="#">copay</a> / day per admission after <a href="#">deductible</a> ;<br>Day 3 and after: No Charge;<br>Birthing center: Same as routine OB   | Not Covered                               | Prior authorization required.   |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>          | \$80 <a href="#">copay</a> / visit after <a href="#">deductible</a>  | Not Covered                               | Limited to 20 skilled visits per calendar year. Approved treatment plan required.   |
|  | <a href="#">Rehabilitation services</a>   | Independent facility:<br>\$80 <a href="#">copay</a> / visit;<br>Hospital-affiliated facility:<br>\$80 <a href="#">copay</a> / visit after <a href="#">deductible</a> ;<br>Chiropractic services:<br>\$40 <a href="#">copay</a> / 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. |
|  | <a href="#">Habilitation services</a>     | Independent facility:<br>\$80 <a href="#">copay</a> / visit;<br>Hospital-affiliated facility:<br>\$80 <a href="#">copay</a> / visit after <a href="#">deductible</a>   | Not Covered                               | Limited to 35 visits per calendar year for outpatient habilitative PT, OT and ST combined.  |
|  | <a href="#">Skilled nursing care</a>      | Day 1 - 5: \$250 <a href="#">copay</a> / day per admission after <a href="#">deductible</a> ;<br>Day 6 and after: No Charge  | Not Covered                               | Limited to 60 days post-hospitalization care per calendar year. Prior authorization required.   |
|  | <a href="#">Durable medical equipment</a> | \$100 <a href="#">copay</a> / episode of illness after <a href="#">deductible</a>  | Not Covered                               | Excludes vehicle modifications, home modifications, exercise equipment, and bathroom equipment.   |
|  | <a href="#">Hospice services</a>          | No charge after <a href="#">deductible</a>   | Not Covered                               | Physician certification 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) |   |
| 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"> <li>• Acupuncture</li> <li>• Bariatric Surgery</li> <li>• Cosmetic Surgery</li> <li>• Dental Care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing Aids</li> <li>• Infertility Treatment</li> <li>• Long-term Care</li> <li>• Non-Emergency Care When Traveling Outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private-Duty Nursing</li> <li>• Routine Eye Care (Adult)</li> <li>• Routine Foot Care</li> <li>• Weight Loss Programs</li> </ul> |
|---|---|---|

**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](http://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](http://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](http://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](http://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](http://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](#) **\$3,000**
- [Specialist copayment](#) **\$80**
- [Hospital \(facility\) copayment](#) **\$900**
- [Other copayment](#) **\$40**

**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                       | \$3,000        |
| Copayments                        | \$1,300        |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$4,360</b> |

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

- The [plan's](#) overall [deductible](#) **\$3,000**
- [Specialist copayment](#) **\$80**
- [Hospital \(facility\) copayment](#) **\$900**
- [Other copayment](#) **\$40**

**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                       | \$0            |
| Copayments                        | \$1,900        |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,920</b> |

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

- The [plan's](#) overall [deductible](#) **\$3,000**
- [Specialist copayment](#) **\$80**
- [Hospital \(facility\) copayment](#) **\$900**
- [Other copayment](#) **\$40**

**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                       | \$1,000        |
| Copayments                        | \$900          |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,900</b> |

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