



 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:
<b>What is the overall <a href="#">deductible</a>?</b>	<b>In-Network:</b> \$1,850 Individual / \$3,700 Family <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> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No. There are no other specific deductibles.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<b>In-Network:</b> \$1,850 Individual / \$3,700 Family <b>Out of Network:</b> Not Applicable Pediatric Dental is limited to \$400 per child or \$800 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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<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> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	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 (You will pay the least)	Out of Network (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	\$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: \$100 <a href="#">copay</a> / visit; Hospital-affiliated facility: \$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: \$300 <a href="#">copay</a> / visit; Hospital-affiliated facility: \$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> 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 30-day supply: \$15 <a href="#">copay</a> / prescription; 90-day supply: \$37.50 <a href="#">copay</a> / 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 are available up to a 30-day supply, at retail pharmacies only.
	Preferred brand drugs (Tier 3)	Generic drugs 30-day supply: \$30 <a href="#">copay</a> / prescription 90-day supply: \$75 <a href="#">copay</a> / prescription	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.
	Non-Preferred brand drugs (Tier 4)	30-day supply: \$40 <a href="#">copay</a> / prescription; 90-day supply: \$100 <a href="#">copay</a> / prescription	Not Covered	
		30-day supply: \$80 <a href="#">copay</a> / prescription; 90-day supply: \$200 <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 (You will pay the least)	Out of Network (You will pay the most)	
	<a href="#">Specialty drugs</a> (Tier 5)	50% <a href="#">coinsurance</a> (Retail only)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Independent facility: No charge after <a href="#">deductible</a> ; Hospital-affiliated facility: No charge 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.
If you need immediate medical attention	<a href="#">Emergency room care</a>	No charge after <a href="#">deductible</a>	No charge 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: \$200 <a href="#">copay</a> / one way ground transport; Air/Water: 50% <a href="#">coinsurance</a>	Ground: \$200 <a href="#">copay</a> / one way ground transport; Air/Water: 50% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	Independent urgent care facility: \$125 <a href="#">copay</a> / visit; Hospital-affiliated urgent care facility: \$250 <a href="#">copay</a> / visit; Retail clinic: \$50 <a href="#">copay</a> / visit	Independent urgent care facility: \$125 <a href="#">copay</a> / visit; Hospital-affiliated urgent care facility: \$250 <a href="#">copay</a> / visit; Retail clinic: Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge 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.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 <a href="#">copay</a> / visit	Not Covered	Prior authorization may be required.
	Inpatient services	No charge after <a href="#">deductible</a>	Not Covered	Prior authorization may be required.
If you are pregnant	Office visits	Routine OB or midwife: Visit 1 - 1: \$40 <a href="#">copay</a> / visit; 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).

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 facility services	Hospital: No charge after <a href="#">deductible</a> ; 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>	No charge 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: \$80 <a href="#">copay</a> / visit; Hospital-affiliated facility: No charge after <a href="#">deductible</a> ; Chiropractic services: \$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: \$80 <a href="#">copay</a> / visit; Hospital-affiliated facility: No charge 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>	No charge after <a href="#">deductible</a>	Not Covered	Limited to 60 days post-hospitalization care per calendar year. Prior authorization required.
	<a href="#">Durable medical equipment</a>	No charge 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.
	<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	Not Covered
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
- Hearing Aids
- Infertility Treatment
- Long-term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- 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
- Dental Care (Adult)
- 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.flor.com/consumers](http://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](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.flor.com/consumers](http://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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,850	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,850	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,850
■ <a href="#">Specialist copayment</a>	\$80	■ <a href="#">Specialist copayment</a>	\$80	■ <a href="#">Specialist copayment</a>	\$80
■ Hospital (facility)	Not Applicable	■ Hospital (facility)	Not Applicable	■ Hospital (facility)	Not Applicable
■ Other <a href="#">copayment</a>	\$40	■ Other <a href="#">copayment</a>	\$40	■ Other <a href="#">copayment</a>	\$40
<b>This EXAMPLE event includes services like:</b> 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> )		<b>This EXAMPLE event includes services like:</b> 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> )		<b>This EXAMPLE event includes services like:</b> 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> )	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$1,500	Deductibles	\$0	Deductibles	\$1,000
Copayments	\$400	Copayments	\$1,600	Copayments	\$800
Coinsurance	\$0	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
<b>The total Peg would pay is</b>	<b>\$1,910</b>	<b>The total Joe would pay is</b>	<b>\$1,620</b>	<b>The total Mia would pay is</b>	<b>\$1,800</b>

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