AvMed

Large Group Choice

Coverage for: Individual or Individual + Family| **Plan Type:** POS

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 1-800-88-AVMED (1-800-882-8633) or visit www.avmed.org. 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.cciio.cms.gov or call 1-800-88-AVMED (1-800-882-8633) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	AvMed Network: **$0** individual **/ $0** family PHCS Network (outside AvMed service area): **$250** individual **/ $750** family Out-of-Network: **$500** individual **/ $1,500** family Accumulates across all benefit levels.	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. All services from AvMed Network Providers except prescription drugs; preventive care, certain office visits, urgent and emergent care, and inpatient services from PHCS providers are covered before you meet your deductible.	This **plan** covers some items and services 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?	Yes. **$200** individual **/ $400** family for prescription drugs. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific **deductible** amount before this **plan** begins to pay for these services.
What is the out-of-pocket limit for this plan?	AvMed Network: **$2,500** individual / **$5,000** family PHCS Network (outside AvMed service area): **$3,750** individual / **$7,750** family Out-of-Network: **$5,500** individual / **$11,500** family Accumulates across all benefit levels.	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 limits** 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, balance billed charges, and services 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 1-800-88-AVMED (1-800-882-8633)** 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?	No.	You can see the **specialist** you choose without a **referral**.

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
		an AvMed Network Provider (You will pay the least)	a PHCS Network Provider (outside AvMed service area) (You will pay more than Tier A)	an Out of Network Provider (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	$20 copay/ visit	$25 copay/ visit	40% coinsurance after deductible	Additional charges may apply for non-preventive services performed in the Physician's office.
	Specialist visit	$40 copay/ visit	$50 copay/ visit	40% coinsurance after deductible	Additional charges may apply for non-preventive services performed in the Physician's office.
	Preventive care/screening/ immunization	No Charge	No Charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance; no charge for lab work at certain participating labs	20% coinsurance after deductible	40% coinsurance after deductible	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)	15% coinsurance	20% coinsurance after deductible	40% coinsurance after deductible	Charges for office visits or Physician/professional services may also apply depending where services are received.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		an AvMed Network Provider (You will pay the least)	a PHCS Network Provider (outside AvMed service area) (You will pay more than Tier A)	an Out of Network Provider (You will pay the most)	
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)	$20 copay/ prescription after deductible (retail); $40 copay/ prescription after deductible (mail order)	Not Covered	Not Covered	Retail charge applies per 30-day supply. Generic & brand drugs: covers up to a 90-day supply at retail pharmacies and a 60-90 day supply via mail order. Certain drugs in all tiers require prior authorization. Brand additional charges may apply. Specialty and cost-sharing drugs available in 30-day supply only; not available via mail order.
	Preferred brand drugs (Tier 2)	$40 copay/ prescription after deductible (retail); $80 copay/ prescription after deductible (mail order)	Not Covered	Not Covered	
	Non-preferred brand drugs (Tier 3)	$60 copay/ prescription after deductible (retail); $120 copay/ prescription after deductible (mail order)	Not Covered	Not Covered	
	Specialty drugs (Tier 4)	$75 copay/ prescription after deductible (retail)	Not Covered	Not Covered	
	Cost-sharing drugs (Tier 5)	50% coinsurance (retail)	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	20% coinsurance after deductible	40% coinsurance after deductible	Prior authorization required.
	Physician/surgeon fees	15% coinsurance	20% coinsurance after deductible	40% coinsurance after deductible	Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		an AvMed Network Provider (You will pay the least)	a PHCS Network Provider (outside AvMed service area) (You will pay more than Tier A)	an Out of Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$100 copay/ visit	Same as AvMed Network	Same as AvMed Network	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	15% coinsurance one way ground transport	15% coinsurance one way ground transport	15% coinsurance one way ground transport after deductible	50% coinsurance after deductible for air and water transportation.
	Urgent care	$40 copay/ visit at urgent care facilities; $20 copay/ visit at retail clinics	$60 copay/ visit at urgent care facilities; $25 copay/ visit at retail clinics	$60 copay/ visit at urgent care facilities or retail clinics	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/ admission	$750 copay/ admission	40% coinsurance after deductible	Prior authorization required.
	Physician/surgeon fees	No Charge	No Charge	40% coinsurance after deductible	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/ visit	$25 copay/ visit	40% coinsurance after deductible	Prior notification required.
	Inpatient services	Hospital stay: $500 copay/ admission; Residential stay: 15% coinsurance	Hospital stay: $750 copay/ admission; Residential stay: 20% coinsurance after deductible	40% coinsurance after deductible	Prior authorization required. Residential stay is limited to 20 days per calendar year.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		an AvMed Network Provider (You will pay the least)	a PHCS Network Provider (outside AvMed service area) (You will pay more than Tier A)	an Out of Network Provider (You will pay the most)	
If you are pregnant	Office visits	Routine OB: $40 copay/ 1st visit only; subsequent visits at no charge	Routine OB: $50 copay/ 1st visit only; subsequent visits at no charge	40% coinsurance after deductible	----------None----------
	Childbirth/delivery professional services	Routine OB & Midwife services: $40 copay/ 1st visit only; subsequent visits at no charge	Routine OB & Midwife services: $50 copay/ 1st visit only; subsequent visits at no charge	40% coinsurance after deductible	Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth/delivery facility services	Hospital stay: $500 copay/ admission Birthing center: same as routine OB	Hospital stay: $750 copay/ admission; Birthing center: same as routine OB	40% coinsurance after deductible	Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		an AvMed Network Provider (You will pay the least)	a PHCS Network Provider (outside AvMed service area) (You will pay more than Tier A)	an Out of Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	15% coinsurance	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 60 skilled visits per calendar year. Approved treatment plan required.
	Rehabilitation services	15% coinsurance; $20 copay/ visit for chiropractic services	20% coinsurance after deductible; $25 copay/ visit for chiropractic services	40% coinsurance after deductible	Limited to 30 visits per calendar year for rehabilitative outpatient PT & OT combined; 24 visits per calendar year for speech therapy; 18 visits per calendar year for cardiac rehabilitation. Cardiac rehabilitation requires prior authorization. Chiropractic services are limited to 26 visits per calendar year.
	Habilitation services	15% coinsurance	20% coinsurance after deductible	40% coinsurance after deductible	Habilitative PT, OT, and ST, when provided for the treatment of autism spectrum disorder and Down syndrome, are limited to a combined maximum of 100 visits per calendar year.
	Skilled nursing care	15% coinsurance	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 20 days post-hospitalization care per calendar year. Prior authorization required.
	Durable medical equipment	15% coinsurance	20% coinsurance after deductible	40% coinsurance after deductible	Excludes vehicle modifications, home modifications, exercise equipment, and bathroom equipment.
	Hospice services	15% coinsurance	20% coinsurance after deductible	40% coinsurance after deductible	Physician certification required.
If your child needs dental or eye care	Children's eye exam	$20 copay/ exam	$25 copay/ exam	40% coinsurance after deductible	Limited to 1 refractive exam per calendar year to determine the need for sight correction.
	Children's glasses	Not Covered	Not Covered	Not Covered	----------None----------
	Children's dental check-up	Not Covered	Not Covered	Not Covered	----------None----------

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
- Child Dental Check Up
- Child Glasses
- 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.)

- 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/contactEBSA/consumerassistance.html, 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 1-800-882-8633. For plans subject to ERISA, you may also contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. 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.**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet 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 pay for a plan through the Marketplace.

Language Access Services:
Para obtener asistencia en Español, llame al 1-800-882-8633.

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	$0
Specialist copayment	$40
Hospital (facility) copayment	$500
Other coinsurance	15%

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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$1,300
Coinsurance	$30
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,390

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

The plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility) copayment	$500
Other coinsurance	15%

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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,380
Coinsurance	$250
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,690

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

The plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility) copayment	$500
Other coinsurance	15%

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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$420
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$470

This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above."

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