



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.avmed.org or by calling 1-800-286-3326

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$200 individual/ \$400 family. One individual in a family must meet the individual deductible. Remaining family members contribute to the other \$200.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$2,000 individual/ \$4,000 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, prescription drug brand additional charges, and services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See www.avmed.org or call 1-800-286-3326 for a list of participating providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services .

Questions: Call 1-800-286-3326 or visit us at www.avmed.org. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-286-3326 to request a copy.



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Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use AvMed network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use an AvMed Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copay/ visit after deductible	Not Covered	Additional charges may apply for non-preventive services performed in the physician's office. Office visit copay (but not deductible) waived when care is received from a Baptist Health Medical Group or Baptist Health Quality Network physician.
	Specialist visit	\$40 copay/ visit after deductible	Not Covered	Additional charges may apply for non-preventive services performed in the physician's office.
	Other practitioner office visit	\$40 copay/ visit for chiropractic services; \$20 copay/ visit after deductible for allergy injections; \$50 copay/ per course of testing, after deductible, for allergy skin testing	Not Covered	-----None-----
	Preventive care/ screening/ immunization	No Charge	Not Covered	-----None-----
If you have a test	Diagnostic test (x-ray, blood work)	\$25 copay/ visit after deductible for diagnostic imaging; No charge for lab services at BHSF facility or participating independent labs	Not Covered	Charges for office visits may also apply if services are performed in a physician's office. Certain services require prior authorization.
	Imaging (CT/PET scans, MRIs)	\$150 copay/ visit after deductible, for Nuclear Medicine and PET scans at a BHSF facility, or an In-Network provider in Broward or Palm Beach County only	Not Covered	Certain services require prior authorization.
		\$150 copay/ visit after deductible, for CT, MRI, MRA, and sleep study at a BHSF facility, or an In-Network provider in Palm Beach County only	Not Covered	Certain services require prior authorization.



Baptist-AvMed Health Plan

Coverage Period: 01/01/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: All Coverage Tiers | Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost if You Use an AvMed Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.avmed.org	Generic drugs	\$15 copay/ prescription (retail); \$45 copay/ prescription (mail order)	Not Covered	Retail copay applies per 30-day supply. 60-90 day supply via mail order. Certain drugs require prior authorization.
	Preferred brand drugs	\$30 copay/ prescription (retail); \$90 copay/ prescription (mail order)	Not Covered	Brand additional charges may apply. Certain drugs may require prior authorization.
	Non-preferred brand drugs	\$50 copay/ prescription (retail); \$150 copay/ prescription (mail order)	Not Covered	Brand additional charges may apply. Certain drugs may require prior authorization.
	Specialty drugs	\$75 copay/ prescription (retail)	Not Covered	These medications may be limited in distribution to participating specialty pharmacies and Prior Authorization is often required. Not available via mail order. Brand additional charges may apply.
	Cost-sharing Medications	50% coinsurance	Not Covered	Not available via mail order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 copay/ visit after deductible, at BHSF facilities or In-Network Broward or Palm Beach County facilities; No charge for colonoscopies at BHSF facilities or In-Network Broward or Palm Beach County facilities	Not Covered	Charges for office visits may also apply if services are performed in a physician's office. Prior authorization required. Non-emergency OP surgeries & colonoscopies are covered at BHSF facilities or In-Network Broward or Palm Beach providers only. Outside Broward and Palm Beach Counties, elective OP surgery available at BHSF facilities only.
	Physician/ surgeon fees	No charge after deductible; No charge for colonoscopies at BHSF facilities or In-Network Broward or Palm Beach County facilities	Not Covered	Charges for office visits may also apply if services are performed in a physician's office. Prior authorization required.
If you need immediate medical attention	Emergency room services	\$200 copay/ visit after deductible	Same as AvMed Network	AvMed must be notified within 24 hours of emergency admission or as soon as reasonably possible.
	Emergency medical transportation	\$100 copay/ one way after deductible	Same as AvMed Network	When pre-authorized or in the case of emergency.
	Urgent care	\$75 copay/ visit after deductible at urgent care; \$20 copay/ visit after deductible at retail clinic	\$75 copay/ visit after deductible at urgent care facility or retail clinic	-----None-----



Baptist-AvMed Health Plan

Coverage Period: 01/01/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: All Coverage Tiers | Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost if You Use an AvMed Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	\$150 copay/ day, first 5 days per admission, after deductible	Not Covered	Prior authorization required.
	Physician/surgeon fee	No charge after deductible	Not Covered	Prior authorization required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$20 copay/ visit	Not Covered	Includes Applied Behavior Analysis for treatment of Autism Spectrum Disorder and Down syndrome.
	Mental/Behavioral health inpatient services	\$150 copay/ day, first 5 days per admission, after deductible	Not Covered	Prior authorization required.
	Substance use disorder outpatient services	\$20 copay/ visit	Not Covered	-----None-----
	Substance use disorder inpatient services	\$150 copay/ day, first 5 days per admission, after deductible	Not Covered	Prior authorization required.
If you are pregnant	Prenatal and postnatal care	\$20 copay/ 1 st visit only	Not Covered	Subsequent visits at no charge.
	Delivery and all inpatient services	\$150 copay/ day, first 5 days per admission, after deductible	Not Covered	Prior authorization required.
If you need help recovering or have other special health needs	Home health care	No charge/ visit	Not Covered	Limited to 60 skilled visits per calendar year. Approved treatment plan required. Excludes rehabilitative and habilitative therapies.
	Rehabilitation services	\$20 copay/ visit after deductible for physical, occupational & speech therapy and cardiac rehabilitation	Not Covered	Limited to 30 visits per calendar year for physical, occupational & speech therapy combined; 18 visits per calendar year for cardiac rehab. Cardiac rehabilitation requires prior authorization.
	Habilitation services	\$20 copay/ visit after deductible for physical, occupational & speech therapies to treat Autism Spectrum Disorder and Down syndrome	Not Covered	Habilitative physical, occupational, & speech therapy services, when provided for the treatment of Autism Spectrum Disorder and Down syndrome, are covered to a combined maximum of 100 visits per calendar year.
	Skilled nursing care	\$50 copay/ day after deductible	Not Covered	Limited to 20 days per calendar year. Prior authorization required.



Common Medical Event	Services You May Need	Your Cost if You Use an AvMed Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Durable medical equipment	\$50 copay per episode of illness for DME and orthotic appliances; No charge after deductible for prosthetic devices	Not Covered	Some limitations apply. Please see your contract for details.
	Hospice service	No charge/ visit	Not Covered	Physician certification required.
If your child needs dental or eye care	Eye exam	\$20 copay/ visit after deductible	Not Covered	Eye exams to determine the need for sight correction. Limited to one exam per year.
	Glasses	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.
	Dental check-up	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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|---|---|---|
| <ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care | <ul style="list-style-type: none"> • Hearing aids • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Private duty nursing • Routine eye care (Adult) • Routine foot care • Weight loss programs |
|---|---|---|

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-286-3326. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact AvMed's Member Services Department at 1-800-286-3326.

For plans subject to ERISA, you may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.



Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en Español, llame al 1-800-286-3326.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,140
- Patient pays \$400

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

deductibles	\$180
Copays	\$190
Coinsurance	\$0
Limits or exclusions	\$30
Total	\$400

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,860
- Patient pays \$1,540

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

deductibles	\$200
Copays	\$1,300
Coinsurance	\$0
Limits or exclusions	\$40
Total	\$1,540

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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