Small Group Focus B200-SG20

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

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 1-800-376-6651 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 1-800-376-6651 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$7,550** individual / **$15,100** family	Generally, you must pay all 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, and outpatient rehabilitation/habilitation therapies 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. **$65** per child for Pediatric Dental. Doesn't apply to the overall deductible. 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?	**$7,550** individual / **$15,100** family Pediatric Dental is limited to **$350** per child or **$700** 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 limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	Premiums, pediatric dental deductible, prescription drug brand additional charges or manufacturer assistance, 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 1-800-376-6651** 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**.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 6, 2016

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)	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	$50 copay/ visit	Not Covered	Additional charges will apply for non-preventive services performed in the Physician's office.
	Specialist visit	$100 copay/ visit	Not Covered	Additional charges will 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 you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge after deductible; $50 copay/ visit for lab work at participating labs	Not Covered	Charges for office visits may apply if services are performed in a Physician's office. Charges for specialty labs will be higher.
	Imaging (CT/PET scans, MRIs)	No charge 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	Value generic drugs (Tier 1)	No charge after deductible (retail & mail order)	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 drugs available in 30-day supply only; not available via mail order.
	Generic drugs (Tier 2)	No charge after deductible (retail & mail order)	Not Covered	
	Preferred brand drugs (Tier 3)	No charge after deductible (retail & mail order)	Not Covered	
	Non-preferred brand drugs (Tier 4)	No charge after deductible (retail & mail order)	Not Covered	
	Specialty drugs (Tier 5)	No charge after deductible (retail only)	Not Covered	

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)	an Out of Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	Not Covered	Prior authorization required.
	Physician/surgeon fees	No charge after deductible	Not Covered	Prior authorization required.
If you need immediate medical attention	Emergency room care	No charge after deductible	No charge after deductible	AvMed must be notified within 24-hours of inpatient admission following emergency services, or as soon as reasonably possible.
	Emergency medical transportation	No charge after deductible/ one way ground transport	No charge after deductible/ one way ground transport	No charge after deductible for air and water transportation.
	Urgent care	$125 copay/ visit at independent urgent care facilities; no charge after deductible at hospital-owned or affiliated urgent care facilities; $60 copay/ visit at retail clinics	$125 copay/ visit at independent urgent care facilities; no charge after deductible at hospital-owned or affiliated urgent care facilities	Retail clinics are not covered out-of-network.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	Not Covered	Prior authorization required.
	Physician/surgeon fees	No charge after deductible	Not Covered	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$100 copay/ visit	Not Covered	Prior authorization may be required.
	Inpatient services	No charge after deductible	Not Covered	Prior authorization may be required.
If you are pregnant	Office visits	Routine OB & midwife: $50 copay/ 1st visit only; subsequent visits at no charge	Not Covered	---------------------None---------------------
	Childbirth/delivery professional services	No charge after deductible	Not Covered	Maternity care may include tests and services described elsewhere in this SBC (e.g., ultrasound).
	Childbirth/delivery facility services	Hospital stay: no charge after deductible; Birthing center: same as routine OB	Not Covered	Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay: an AvMed Network Provider (You will pay the least)	What You Will Pay: an Out of Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	No charge after deductible	Not Covered	Limited to 20 skilled visits per calendar year. Approved treatment plan required.
	Rehabilitation services	$100 copay/ visit; $50 copay/ visit for chiropractic services	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	$100 copay/ visit	Not Covered	Limited to 35 visits per calendar year for outpatient habilitative PT, OT and ST combined.
	Skilled nursing care	No charge after deductible	Not Covered	Limited to 60 days post-hospitalization care per calendar year. Prior authorization required.
	Durable medical equipment	No charge 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 1 eye exam per calendar year to determine the need for sight correction.
	Children's glasses	No Charge	Not Covered	Limited to 1 pair of glasses 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	Preventive care may be subject to cost sharing if billed charges exceed allowed amount	Limited to 1 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.)
• 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 1-800-376-6651. 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 1-800-376-6651.

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	**$7,550**
Specialist copayment	**$100**
Hospital (facility) copayment	**N/A**
Other coinsurance	**N/A**

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	$6,000
Copayments	$1,550
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$7,610

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

The plan's overall deductible	**$7,550**
Specialist copayment	**$100**
Hospital (facility) copayment	**N/A**
Other coinsurance	**N/A**

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	$5,945
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$7,400

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

The plan's overall deductible	**$7,550**
Specialist copayment	**$100**
Hospital (facility) copayment	**N/A**
Other coinsurance	**N/A**

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	$1,416
Copayments	$484
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,900

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