



## Small Group Engage LG300-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](http://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](http://www.cciio.cms.gov) or call 1-800-376-6651 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                                                                                                                                   | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$1,000 individual / \$2,000 family                                                                                                                                                                                                                                                                                                       | Generally, you must pay all 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, tests, certain <a href="#">prescription drugs</a> , outpatient surgery, <a href="#">urgent and emergent care</a> , inpatient services, and certain recovery services, e.g., <a href="#">habilitation and rehabilitation services</a> , are covered before you meet your deductible. | This <a href="#">plan</a> covers some items and services 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?              | Yes. \$65 per child for Pediatric Dental. Doesn't apply to the overall <a href="#">deductible</a> . There are no other specific <a href="#">deductibles</a> .                                                                                                                                                                             | You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$6,800 individual / \$13,600 family<br>Pediatric Dental is limited to \$350 per child or \$700 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 limits</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> , pediatric dental <a href="#">deductible</a> , <a href="#">prescription drug</a> brand additional charges or manufacturer assistance, and services 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 1-800-376-6651 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</a> network. 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                                                                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-----------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                         |                                                        | an AvMed Network Provider<br>(You will pay the least)                       | an Out of Network Provider<br>(You will pay the most) |                                                                                                                                                             |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                  | Primary care visit to treat an injury or illness       | No charge for first 2 non-preventive visits; \$25 copay/ visit thereafter   | Not Covered                                           | Additional charges may apply for non-preventive services performed in the Physician's office.                                                               |
|                                                                                                                                                                         | <a href="#">Specialist</a> visit                       | \$50 copay/ visit                                                           | Not Covered                                           | Additional charges may apply for non-preventive services performed in the Physician's office.                                                               |
|                                                                                                                                                                         | <a href="#">Preventive care/screening/immunization</a> | 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                                                                                                                                                      | <a href="#">Diagnostic test</a> (x-ray, blood work)    | \$75 copay/ visit; no charge 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)                           | \$300 copay/ visit                                                          | 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<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.avmed.org</a> | Value generic drugs (Tier 1)                           | \$15 copay/ prescription (retail); \$37.50 copay/ prescription (mail order) | Not Covered                                           | Retail charge applies per 30-day supply.                                                                                                                    |
|                                                                                                                                                                         | Generic drugs (Tier 2)                                 | \$25 copay/ prescription (retail); \$62.50 copay/ prescription (mail order) | Not Covered                                           | Generic & brand drugs: covers up to a 90-day supply at retail pharmacies and a 60-90 day supply via mail order.                                             |
|                                                                                                                                                                         | Preferred brand drugs (Tier 3)                         | \$40 copay/ prescription (retail); \$100 copay/ prescription (mail order)   | Not Covered                                           | Certain drugs in all tiers require prior authorization.                                                                                                     |
|                                                                                                                                                                         | Non-preferred brand drugs (Tier 4)                     | \$80 copay/ prescription (retail); \$200 copay/ prescription (mail order)   | Not Covered                                           | Brand additional charges may apply.                                                                                                                         |
|                                                                                                                                                                         | Specialty drugs (Tier 5)                               | 50% coinsurance after deductible (retail only)                              | Not Covered                                           | Specialty drugs available in 30-day supply only; not available via mail order.                                                                              |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                                                                       |                                                                                   | Limitations, Exceptions, & Other Important Information                                                                                                         |
|---------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | an AvMed Network Provider<br>(You will pay the least)                                                   | an Out of Network Provider<br>(You will pay the most)                             |                                                                                                                                                                |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | \$500 copay/ visit                                                                                      | Not Covered                                                                       | Prior authorization required.                                                                                                                                  |
|                                                                           | Physician/surgeon fees                           | No Charge                                                                                               | Not Covered                                                                       | Prior authorization required.                                                                                                                                  |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$500 copay/ visit                                                                                      | \$500 copay/ visit                                                                | 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> | \$150 copay/ one way ground transport                                                                   | \$150 copay/ one way ground transport                                             | 50% coinsurance after deductible for air and water transportation.                                                                                             |
|                                                                           | <a href="#">Urgent care</a>                      | \$125 copay/ visit at urgent care facilities; \$25 copay/ visit at retail clinics                       | \$125 copay/ visit at urgent care facilities; \$25 copay/ visit at retail clinics | -----None-----                                                                                                                                                 |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | \$600 copay/ day for the first 3 days per admission                                                     | Not Covered                                                                       | Prior authorization required.                                                                                                                                  |
|                                                                           | Physician/surgeon fees                           | No Charge                                                                                               | Not Covered                                                                       | Prior authorization required.                                                                                                                                  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | \$50 copay/ visit                                                                                       | Not Covered                                                                       | Prior authorization may be required.                                                                                                                           |
|                                                                           | Inpatient services                               | \$600 copay/ day for the first 3 days per admission                                                     | Not Covered                                                                       | Prior authorization may be required.                                                                                                                           |
| If you are pregnant                                                       | Office visits                                    | Routine OB & midwife: \$25 copay/ 1st visit only; subsequent visits at no charge                        | Not Covered                                                                       | -----None-----                                                                                                                                                 |
|                                                                           | Childbirth/delivery professional services        | No Charge                                                                                               | Not Covered                                                                       | Maternity care may include tests and services described elsewhere in this SBC (e.g., ultrasound).                                                              |
|                                                                           | Childbirth/delivery facility services            | Hospital stay: \$600 copay/ day for the first 3 days per admission; Birthing center: same as routine OB | Not Covered                                                                       | Prior authorization required.                                                                                                                                  |

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                                                 |                                                                                        | Limitations, Exceptions, & Other Important Information                                                                                                                                                        |
|----------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------|----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | an AvMed Network Provider<br>(You will pay the least)             | an Out of Network Provider<br>(You will pay the most)                                  |                                                                                                                                                                                                               |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | \$50 copay/ visit after deductible                                | Not Covered                                                                            | Limited to 20 skilled visits per calendar year. Approved treatment plan required.                                                                                                                             |
|                                                                | <a href="#">Rehabilitation services</a>   | \$50 copay/ visit;<br>\$25 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. |
|                                                                | <a href="#">Habilitation services</a>     | \$50 copay/ visit                                                 | Not Covered                                                                            | Limited to 35 visits per calendar year for outpatient habilitative PT, OT and ST combined.                                                                                                                    |
|                                                                | <a href="#">Skilled nursing care</a>      | \$250 copay/ day for the first 5 days per admission               | Not Covered                                                                            | Limited to 60 days post-hospitalization care per calendar year. Prior authorization required.                                                                                                                 |
|                                                                | <a href="#">Durable medical equipment</a> | \$100 copay/ episode of illness after deductible                  | Not Covered                                                                            | Excludes vehicle modifications, home modifications, exercise equipment, and bathroom equipment.                                                                                                               |
|                                                                | <a href="#">Hospice services</a>          | No Charge                                                         | 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](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/contactEBSA/consumerassistance.html](http://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](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 1-800-376-6651. 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](http://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](http://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<br>(9 months of in-network pre-natal care and a hospital delivery)                                                                                                                                                                                                          |                 | Managing Joe's type 2 Diabetes<br>(a year of routine in-network care of a well-controlled condition)                                                                                                                                                   |                | Mia's Simple Fracture<br>(in-network emergency room visit and follow up care)                                                                                                                                                                              |                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| ■ The plan's overall deductible                                                                                                                                                                                                                                                                  | \$1,000         | ■ The plan's overall deductible                                                                                                                                                                                                                        | \$1,000        | ■ The plan's overall deductible                                                                                                                                                                                                                            | \$1,000        |
| ■ Specialist copayment                                                                                                                                                                                                                                                                           | \$50            | ■ Specialist copayment                                                                                                                                                                                                                                 | \$50           | ■ Specialist copayment                                                                                                                                                                                                                                     | \$50           |
| ■ Hospital (facility) copayment                                                                                                                                                                                                                                                                  | \$600           | ■ Hospital (facility) copayment                                                                                                                                                                                                                        | \$600          | ■ Hospital (facility) copayment                                                                                                                                                                                                                            | \$600          |
| ■ Other coinsurance                                                                                                                                                                                                                                                                              | N/A             | ■ Other coinsurance                                                                                                                                                                                                                                    | N/A            | ■ Other coinsurance                                                                                                                                                                                                                                        | N/A            |
| <b>This EXAMPLE event includes services like:</b><br>Specialist office visits ( <i>prenatal care</i> )<br>Childbirth/delivery professional services<br>Childbirth/delivery facility services<br>Diagnostic tests ( <i>ultrasounds and blood work</i> )<br>Specialist visit ( <i>anesthesia</i> ) |                 | <b>This EXAMPLE event includes services like:</b><br>Primary care physician office visits ( <i>including disease education</i> )<br>Diagnostic tests ( <i>blood work</i> )<br>Prescription drugs<br>Durable medical equipment ( <i>glucose meter</i> ) |                | <b>This EXAMPLE event includes services like:</b><br>Emergency room care ( <i>including medical supplies</i> )<br>Diagnostic test ( <i>x-ray</i> )<br>Durable medical equipment ( <i>crutches</i> )<br>Rehabilitation services ( <i>physical therapy</i> ) |                |
| <b>Total Example Cost</b>                                                                                                                                                                                                                                                                        | <b>\$12,800</b> | <b>Total Example Cost</b>                                                                                                                                                                                                                              | <b>\$7,400</b> | <b>Total Example Cost</b>                                                                                                                                                                                                                                  | <b>\$1,900</b> |
| In this example, Peg would pay:                                                                                                                                                                                                                                                                  |                 | In this example, Joe would pay:                                                                                                                                                                                                                        |                | In this example, Mia would pay:                                                                                                                                                                                                                            |                |
| <i>Cost Sharing</i>                                                                                                                                                                                                                                                                              |                 | <i>Cost Sharing</i>                                                                                                                                                                                                                                    |                | <i>Cost Sharing</i>                                                                                                                                                                                                                                        |                |
| Deductibles                                                                                                                                                                                                                                                                                      | \$0             | Deductibles                                                                                                                                                                                                                                            | \$0            | Deductibles                                                                                                                                                                                                                                                | \$0            |
| Copayments                                                                                                                                                                                                                                                                                       | \$1,250         | Copayments                                                                                                                                                                                                                                             | \$2,445        | Copayments                                                                                                                                                                                                                                                 | \$1,475        |
| 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                                                                                                                                                                                                                                   | \$55           | Limits or exclusions                                                                                                                                                                                                                                       | \$0            |
| <b>The total Peg would pay is</b>                                                                                                                                                                                                                                                                | <b>\$1,310</b>  | <b>The total Joe would pay is</b>                                                                                                                                                                                                                      | <b>\$2,500</b> | <b>The total Mia would pay is</b>                                                                                                                                                                                                                          | <b>\$1,475</b> |

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