AvMed Embrace better health® **State of Florida High Deductible Health Plan**

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 1-888-762-8633 or visit www.avmed.org/state. 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 1-888-762-8633 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Self-only: **$1,500** Family: **$3,000**	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**, the overall family **deductible** limit must be met.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This **plan** covers some items and services even 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?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	Self-only: **$3,000** Family: **$6,000**	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**, the overall family **out-of-pocket limit** must be met.
What is not included in the out-of-pocket limit?	Premiums 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/state or call 1-888-762-8633** for a list of participating providers. No coverage out-of-network.	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 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.

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(HHS - OMB control number: 0938-1146/Expiration DATE: 10/31/2022)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance after deductible; No charge after deductible/ visit for Telehealth via MDLive; No charge after deductible/ visit for Telehealth via an AvMed Provider	Not Covered	Additional charges may apply for non-preventive services performed in the Physician's office.
	Specialist visit	20% coinsurance after deductible	Not Covered	Additional charges may 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 you 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)	20% coinsurance after deductible	Not Covered	Charges for office visits may apply if services are performed in a Physician's office. Charges for certain other labs and Specialty labs will be higher.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	Not Covered	Charges for office visits of 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
		In-Network (You will pay the least)	Out-of-Network (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.caremark.com/sofrxplan	Generic drugs (Tier 1)	30% coinsurance after deductible/ prescription (participating retail pharmacy or mail-order)	Not Covered	Prescription drug coverage is provided through CVS/Caremark. For a list of participating pharmacies go to www.caremark.com/sofrxplan or call 1-888-766-5490. 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)	30% coinsurance after deductible/ prescription (participating retail pharmacy or mail-order)	Not Covered	
	Non-preferred brand drugs (Tier3)	50% coinsurance after deductible/ prescription (participating retail pharmacy or mail-order)	Not Covered	
	Specialty drugs (Tier 4)	Preferred brand Specialty drugs: 30% coinsurance after deductible/ prescription (participating retail pharmacy or mail order); Non-preferred brand Specialty drugs: 50% coinsurance after deductible/ prescription (participating retail pharmacy or mail order)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	Not Covered	Charges for office visits may also apply if services are performed in a Physician's office. Prior authorization required.
	Physician/surgeon fees	20% coinsurance after deductible	Not Covered	Charges for office visits may also apply if services are performed in a Physician's office. Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible	20% coinsurance after deductible	AvMed must be notified within 24-hours of inpatient admission following emergency services, or as soon as reasonably possible.
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	----------None----------
	Urgent care	20% coinsurance after deductible at urgent care facility or retail clinic	20% coinsurance after deductible at urgent care facility or retail clinic	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	Not Covered	Prior authorization required.
	Physician/surgeon fees	20% coinsurance after deductible	Not Covered	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	Not Covered	Prior authorization required.
	Inpatient services	Hospital stay: 20% coinsurance after deductible; Residential stay: 20% coinsurance after deductible	Not Covered	Prior authorization required.
If you are pregnant	Office visits	Routine OB & Midwife services: 20% coinsurance after deductible	Not Covered	----------None----------
	Childbirth/delivery professional services	20% coinsurance after deductible	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	Hospital stay: 20% coinsurance after deductible 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
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	Not Covered	Approved treatment plan required.
	Rehabilitation services	20% coinsurance after deductible; 20% coinsurance after deductible for chiropractic services	Not Covered	Rehabilitative physical, speech and occupational therapy to treat injuries is limited to 60 visits per injury. Chiropractic services is limited to 60 visits per injury.
	Habilitation services	20% coinsurance after deductible	Not Covered	Habilitative occupational therapy is limited to home health care, hospice care, treatment of Autism Spectrum disorder, treatment of Developmental Disabilities, and Down syndrome.
	Skilled nursing care	20% coinsurance after deductible	Not Covered	Limited to 60 days post-hospitalization care per calendar year. Prior authorization required.
	Durable medical equipment	20% coinsurance after deductible	Not Covered	Some limitation apply. Please see your Summary Plan Description for details.
	Hospice services	20% coinsurance after deductible	Not Covered	Limited to a lifetime max of 210 days. Physician certification required.
If your child needs dental or eye care	Children's eye exam	20% coinsurance after deductible	Not Covered	Limited to 1 eye exam per calendar year to determine the need for sight correction.
	Children's glasses	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.
	Children's dental check-up	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Dental Care (Child)
- Glasses
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care
- Routine Eye Care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Florida Office of Insurance Regulation at 1-877-693-5236 or www.floir.com/consumers, the U.S. Department of Labor, Employee Benefits Security Administration, at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or the U.S. Department of Health and Human Services at 1-877-267- 2323 x61565 or www.cciio.cms.gov. 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 on how 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 1-800-682-8633. 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.**
Minimum Essential Coverage generally includes plans, health insurance available through the **Marketplace** or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of **Minimum Essential Coverage**, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **Yes.**
If your **plan** doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** to help you pay for a **plan** through the **Marketplace**.

Language Access Services:
Para obtener asistencia en Español, llame al 1-888-762-8633.

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	**$1,500**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,060

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

The plan's overall deductible	**$1,500**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,260

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

The plan's overall deductible	**$1,500**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,800

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