





Small Group Elite S100-SG21

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

 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a **summary**. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-376-6651 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:  |
|---|---|--|
| <p>What is the overall <a href="#">deductible</a>?</p>                                | <p>AvMed Network: <b>\$4,750</b> individual / <b>\$9,500</b> family<br/>                     Out-of-Network: <b>\$14,250</b> individual / <b>\$28,500</b> family</p>  | <p>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>.</p>   |
| <p>Are there services covered before you meet your <a href="#">deductible</a>?</p>    | <p>Yes. <a href="#">Preventive care</a>, <a href="#">emergency room care</a>, office visits, and outpatient habilitation therapies are covered before you meet your <a href="#">deductible</a>. Also covered before you meet your <a href="#">deductible</a> are certain tests and outpatient surgeries at independent facilities, and most <a href="#">prescription drugs</a>.</p> | <p>This <a href="#">plan</a> covers some items and services even 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>.</p>   |
| <p>Are there other <a href="#">deductibles</a> for specific services?</p>             | <p>Yes. <b>\$65</b> per child for Pediatric Dental. Doesn't apply to the overall <a href="#">deductible</a>. There are no other specific <a href="#">deductibles</a>.</p>   | <p>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.</p>  |
| <p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p> | <p>AvMed Network: <b>\$8,100</b> individual / <b>\$16,200</b> family<br/>                     Out-of-Network: <b>\$24,300</b> individual / <b>\$48,600</b> family<br/>                     Pediatric Dental is limited to <b>\$350</b> per child or <b>\$700</b> for 2 or more children.</p>  | <p>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.</p>  |
| <p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>               | <p><a href="#">Premiums</a>, pediatric dental <a href="#">deductible</a>, <a href="#">prescription drug</a> brand additional charges or manufacturer assistance, <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.</p>  | <p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>  |
| <p>Will you pay less if you use a <a href="#">network provider</a>?</p>               | <p>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>.</p>  | <p>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.</p> |

| Important Questions  | Answers | Why This Matters:  |
|--|---------|--|
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | No.     | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</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       | \$40 copay/ visit   | 50% coinsurance after deductible                      | Additional charges may apply for non-preventive services performed in the Physician's office.   |
|  | <a href="#">Specialist</a> visit                       | \$80 copay/ visit   | 50% coinsurance after deductible                      | Additional charges may apply for non-preventive services performed in the Physician's office.   |
|  | <a href="#">Preventive care/screening/immunization</a> | No Charge   | 50% coinsurance after deductible                      | 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)    | \$125 copay/ visit at independent facilities; 30% coinsurance after deductible at hospital-owned or affiliated facilities; \$40 copay/ visit for lab work at participating labs | 50% coinsurance after deductible                      | 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)                           | \$350 copay/ visit at independent facilities; 30% coinsurance after deductible at hospital-owned or affiliated facilities   | 50% coinsurance after deductible                      | Charges for office visits or Physician/professional services may also apply depending on where services are received.                                       |

| 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)  |  |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="http://www.avmed.org">prescription drug coverage</a> is available at <a href="http://www.avmed.org">www.avmed.org</a> | Value generic drugs (Tier 1)                     | \$25 copay/ prescription (retail); \$62.50 copay/ prescription (mail order)  | Not Covered  | Retail charge applies per 30-day supply.   |
|  | Generic drugs (Tier 2)                           | \$45 copay/ prescription (retail); \$112.50 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)                   | \$100 copay/ prescription (retail); \$250 copay/ prescription (mail order)   | Not Covered  | Certain drugs in all tiers require prior authorization.  |
|  | Non-preferred brand drugs (Tier 4)               | 50% coinsurance after deductible (retail & 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.   |
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center)   | \$750 copay/ visit at independent facilities; 30% coinsurance after deductible at hospital-owned or affiliated facilities  | 50% coinsurance after deductible   | Prior authorization required.  |
|  | Physician/surgeon fees                           | No Charge  | 50% coinsurance after deductible   | Prior authorization required.  |
| <b>If you need immediate medical attention</b>   | <a href="#">Emergency room care</a>              | \$700 copay/ visit   | \$700 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 after deductible   | \$150 copay/ one way ground transport after In-Network deductible  | 50% coinsurance after In-Network deductible for air and water transportation.  |
|  | <a href="#">Urgent care</a>                      | \$125 copay/ visit at independent urgent care facilities; 30% coinsurance after deductible at hospital-owned or affiliated urgent care facilities; \$50 copay/ visit at retail clinics | \$125 copay/ visit after deductible at independent urgent care facilities; 50% coinsurance after deductible at hospital-owned or affiliated urgent care facilities; \$50 copay/ visit after deductible at retail clinics | -----None-----   |

| 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 a hospital stay   | Facility fee (e.g., hospital room)        | \$750 copay/ day for the first 3 days per admission after deductible   | 50% coinsurance after deductible                      | Prior authorization required.   |
|   | Physician/surgeon fees                    | No charge after deductible   | 50% coinsurance after deductible                      | Prior authorization required.   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$40 copay/ visit  | 50% coinsurance after deductible                      | Prior authorization may be required.  |
|   | Inpatient services                        | \$750 copay/ day for the first 3 days per admission after deductible   | 50% coinsurance after deductible                      | Prior authorization may be required.  |
| If you are pregnant   | Office visits                             | Routine OB & midwife: \$40 copay/ 1st visit only; subsequent visits at no charge   | 50% coinsurance after deductible                      | -----None-----  |
|   | Childbirth/delivery professional services | No charge after deductible   | 50% coinsurance after deductible                      | Maternity care may include tests and services described elsewhere in this SBC (e.g., ultrasound). |
|   | Childbirth/delivery facility services     | Hospital stay: \$750 copay/ day for the first 3 days per admission after deductible; Birthing center: same as routine OB | 50% coinsurance after deductible                      | Prior authorization required.   |

| Common Medical Event   | Services You May Need                     | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information   |
|--|---|---|--|--|
|  |   | an AvMed Network Provider<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>          | \$80 copay/ visit after deductible  | 50% coinsurance after deductible   | Limited to 20 skilled visits per calendar year. Approved treatment plan required.  |
|  | <a href="#">Rehabilitation services</a>   | \$80 copay/ visit at independent facilities; \$80 copay/ visit after deductible at hospital-owned or affiliated facilities; \$40 copay/ visit for chiropractic services | 50% coinsurance after deductible   | 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>     | \$80 copay/ visit   | 50% coinsurance after deductible   | 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 after deductible  | 50% coinsurance after deductible   | 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  | 50% coinsurance after deductible   | Excludes vehicle modifications, home modifications, exercise equipment, and bathroom equipment.  |
|  | <a href="#">Hospice services</a>          | No charge after deductible  | 50% coinsurance after deductible   | Physician certification required.  |
| If your child needs dental or eye care                         | Children's eye exam                       | No Charge   | 50% coinsurance after deductible   | Limited to 1 eye exam per calendar year to determine the need for sight correction.  |
|  | Children's glasses                        | No Charge   | 50% coinsurance after deductible   | 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.flair.com/consumers](http://www.flair.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.flair.com/consumers](http://www.flair.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 1-800-376-6651.

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   | \$4,750         | ■ The plan's overall deductible   | \$4,750        | ■ The plan's overall deductible   | \$4,750        |
| ■ Specialist copayment  | \$80            | ■ Specialist copayment  | \$80           | ■ Specialist copayment  | \$80           |
| ■ Hospital (facility) copayment   | \$750           | ■ Hospital (facility) copayment   | \$750          | ■ Hospital (facility) copayment   | \$750          |
| ■ Other coinsurance   | N/A             | ■ Other coinsurance   | N/A            | ■ Other coinsurance   | N/A            |
| <p><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>)</p> |                 | <p><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>)</p> |                | <p><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>)</p> |                |
| <b>Total Example Cost</b>   | <b>\$12,700</b> | <b>Total Example Cost</b>   | <b>\$5,600</b> | <b>Total Example Cost</b>   | <b>\$2,800</b> |
| <b>In this example, Peg would pay:</b>  |                 | <b>In this example, Joe would pay:</b>  |                | <b>In this example, Mia would pay:</b>  |                |
| <i>Cost Sharing</i>   |                 | <i>Cost Sharing</i>   |                | <i>Cost Sharing</i>   |                |
| Deductibles   | \$4,750         | Deductibles   | \$0            | Deductibles   | \$1,200        |
| Copayments  | \$1,500         | Copayments  | \$2,600        | Copayments  | \$1,100        |
| 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  | \$20           | Limits or exclusions  | \$0            |
| <b>The total Peg would pay is</b>   | <b>\$6,310</b>  | <b>The total Joe would pay is</b>   | <b>\$2,620</b> | <b>The total Mia would pay is</b>   | <b>\$2,300</b> |

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