AvMed

AvMed Entrust Silver 550 - 73% AV

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 1-800-477-8768 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 1-800-477-8768 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$3,000** individual / **$6,000** 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, certain lab tests, certain prescription drugs, ambulance and urgent care, and certain recovery services, e.g., habilitation and rehabilitation services, 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?	No. There are no other specific **deductibles**.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services your plan covers.
What is the out-of-pocket limit for this plan?	**$5,500** individual / **$11,000** 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, prescription drug brand additional charges and 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 1-800-477-8768** 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**.

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 In-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	No charge for first non-preventive visit; $40 copay/ visit thereafter	Not Covered	Additional charges may apply for non-preventive services performed in the Physician's office.
	Specialist visit	$80 copay/ visit	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 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)	$100 copay/ visit at independent facilities; $200 copay/ visit at hospital-owned or affiliated facilities; $30 copay/ visit 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 at independent facilities; $600 copay/ visit at hospital-owned or affiliated facilities	Not Covered	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 In-Network Provider (You will pay the least)	an Out of Network Provider (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.avmed.org	Preferred generic drugs (Tier 1)	$25 copay/ prescription (retail); $50 copay/ prescription (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)	$45 copay/ prescription (retail); $112.50 copay/ prescription (mail order)	Not Covered	
	Preferred brand drugs (Tier 3)	$65 copay/ prescription (retail); $162.50 copay/ prescription (mail order)	Not Covered	
	Non-preferred brand drugs (Tier 4)	$105 copay/ prescription (retail); $262.50 copay/ prescription (mail order)	Not Covered	
	Specialty drugs (Tiers 5 & 6)	40% coinsurance after deductible for preferred (retail only); 60% coinsurance after deductible for non-preferred (retail only)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 copay/ visit 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	$500 copay/ visit after deductible	$500 copay/ visit after deductible	AvMed must be notified within 24-hours of inpatient admission following emergency services, or as soon as reasonably possible. Charges are waived if admitted.
	Emergency medical transportation	$200 copay/ one way ground transport	$200 copay/ one way ground transport	50% coinsurance after deductible for air and water transportation.
	Urgent care	$125 copay/ visit at independent urgent care facilities; $250 copay/ visit at hospital-owned or affiliated urgent care facilities; $50 copay/ visit at retail clinics	$125 copay/ visit at independent urgent care facilities; $250 copay/ visit at hospital-owned or affiliated urgent care facilities	Retail clinics are not covered out-of-network.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an AvMed In-Network Provider (You will pay the least)	an Out of Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/ admission 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	$40 copay/ visit	Not Covered	Prior authorization may be required.
	Inpatient services	$500 copay/ admission after deductible	Not Covered	Prior authorization may be required.
If you are pregnant	Office visits	Routine OB & midwife: $40 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: $500 copay/ admission 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
		an AvMed In-Network Provider (You will pay the least)	an Out of Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$80 copay/ visit after deductible	Not Covered	Limited to 20 skilled visits per calendar year. Approved treatment plan required.
	Rehabilitation services	$80 copay/ visit at independent facilities; $80 copay/ visit after deductible at hospital-owned or affiliated facilities; $40 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	$80 copay/ visit	Not Covered	Limited to 35 visits per calendar year for outpatient habilitative PT, OT and ST combined.
	Skilled nursing care	$250 copay/ admission after deductible	Not Covered	Limited to 60 days post-hospitalization care per calendar year. Prior authorization required.
	Durable medical equipment	$100 copay/ episode of illness 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	Not Covered	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
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult)
- 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

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 1-800-477-8768. You may also contact your state insurance department. 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? Not Applicable.
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 1-800-477-8768.

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	$3,000
Specialist copayment	$80
Hospital (facility) copayment	$500
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$4,260

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

The plan's overall deductible	$3,000
Specialist copayment	$80
Hospital (facility) copayment	$500
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$2,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,320

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

The plan's overall deductible	$3,000
Specialist copayment	$80
Hospital (facility) copayment	$500
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,000

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

AvMed complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AvMed does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

AvMed:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact AvMed Member Engagement, P.O. Box 749, Gainesville, FL 32627, by phone 1-800-882-8633 (TTY 711), by fax 1-352-337-8612, or by email to members@avmed.org.

If you believe that AvMed has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with AvMed's Regulatory Correspondence Coordinator, P.O. Box 749, Gainesville, FL 32627, by phone 1-800-346-0231 (TTY 711), by fax 1-352-337-8780, or by email to regulatory.correspondence@avmed.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Regulatory Correspondence Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html.*

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-882-8633 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-882-8633 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-882-8633 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-882-8633 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-882-8633（TTY：711）。

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-882-8633 (ATS : 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-882-8633 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-882-8633 (телетайп: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-882-8633 (رقم هاتف الصم والبكم:711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-882-8633 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-882-8633 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-882-8633 (TTY: 711)번으로 전화해 주십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-882-8633 (TTY: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-882-8633 (TTY: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-882-8633 (TTY: 711).