



 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 1-800-882-8633 or visit [www.avmed.org](http://www.avmed.org) and sign into the Member Portal. 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.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-800-882-8633 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<a href="#">In-Network</a> : \$4,000 Individual / \$8,000 Family <a href="#">Out-of-Network</a> : Not Applicable	Generally, you must pay all of the costs from <a href="#">providers</a> 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, certain diagnostic tests, certain imaging, certain <a href="#">prescription drugs</a> , <a href="#">urgent care</a> , <a href="#">emergency room</a> , outpatient <a href="#">rehabilitation</a> are covered before you meet your <a href="#">deductible</a> .	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> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. \$250 Individual / \$500 Family for <a href="#">prescription drugs</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 <a href="#">services</a> .
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<a href="#">In-Network</a> : \$5,500 Individual / \$11,000 Family <a href="#">Out-of-Network</a> : Not Applicable	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 limit</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> , <a href="#">prescription drug</a> brand additional charges and manufacturer assistance, and health care 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 1-800-882-8633 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 network</a> . 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 <a href="#">provider's</a> 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> ?	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
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary Care visit to treat an injury or illness	\$25 <a href="#">copay</a> / visit	Not Covered	Additional charges may apply for non-preventive services performed in the Physician's office.
	<a href="#">Specialist</a> visit	\$50 <a href="#">copay</a> / visit	Not Covered	Additional charges may apply for non-preventive services performed in the Physician's office.
	<a href="#">Preventive care/screening</a> /immunization	No Charge	Not Covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	Independent facility: \$100 <a href="#">copay</a> / visit; Hospital-affiliated facility: \$200 <a href="#">copay</a> / visit	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)	Independent facility: \$100 <a href="#">copay</a> / visit; Hospital-affiliated facility: \$200 <a href="#">copay</a> / visit	Not Covered	Charges for office visits or Physician/professional services may also apply depending on where services are received.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.avmed.org">www.avmed.org</a>	Value generic drugs (Tier 1)	30-day supply: \$5 <a href="#">copay</a> / prescription; 90-day supply: \$12.50 <a href="#">copay</a> / prescription	Not Covered	Certain <a href="#">preventive</a> medications (including certain contraceptives) are covered at No Charge.  Certain limits may apply, including, for example: <a href="#">Prior authorization</a> , step therapy, quantity limits.
	Generic drugs (Tier 2)	30-day supply: \$25 <a href="#">copay</a> / prescription; 90-day supply: \$62.50 <a href="#">copay</a> / prescription	Not Covered	Covered drugs in Tiers 1-4 are available up to a 90-day supply at retail pharmacies; and a 60-90-day supply via mail order.

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)	
	Preferred brand drugs (Tier 3)	30-day supply: 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> ; 90-day supply: 50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	Drugs in Tier 5 are available up to a 30-day supply, at retail pharmacies only. Brand additional charges may apply. Coupons or any other third-party <a href="#">prescription drug cost-sharing</a> assistance will not apply toward any calendar year <a href="#">deductible</a> or <a href="#">out-of-pocket limit</a> .
	Non-Preferred brand drugs (Tier 4)	30-day supply: 75% <a href="#">coinsurance</a> after <a href="#">deductible</a> ; 90-day supply: 75% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	
	<a href="#">Specialty drugs</a> (Tier 5)	75% <a href="#">coinsurance</a> after <a href="#">deductible</a> (Retail only)	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Independent facility: 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> ; Hospital-affiliated facility: 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	<a href="#">Prior authorization</a> required.
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	<a href="#">Prior authorization</a> required.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$200 <a href="#">copay</a> / visit	\$200 <a href="#">copay</a> / visit	AvMed must be notified within 24-hours of inpatient admission following <a href="#">emergency services</a> , or as soon as reasonably possible. Charges are waived if admitted.

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)	
	<a href="#">Emergency medical transportation</a>	Ground: \$150 <a href="#">copay</a> / one way ground transport after <a href="#">deductible</a> ; Air/Water: 50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Ground: \$150 <a href="#">copay</a> / one way ground transport after <a href="#">In-Network deductible</a> ; Air/Water: 50% <a href="#">coinsurance</a> after <a href="#">In-Network deductible</a>	None
	<a href="#">Urgent care</a>	Independent <a href="#">urgent care</a> facility: \$40 <a href="#">copay</a> / visit; Hospital-affiliated <a href="#">urgent care</a> facility: \$40 <a href="#">copay</a> / visit; Retail clinic: \$25 <a href="#">copay</a> / visit	Independent <a href="#">urgent care</a> facility: \$40 <a href="#">copay</a> / visit after <a href="#">deductible</a> ; Hospital-affiliated <a href="#">urgent care</a> facility: \$40 <a href="#">copay</a> / visit after <a href="#">deductible</a> ; Retail clinic: \$25 <a href="#">copay</a> / visit after <a href="#">deductible</a>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	<a href="#">Prior authorization</a> required.
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	<a href="#">Prior authorization</a> required.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25 <a href="#">copay</a> / visit	Not Covered	<a href="#">Prior authorization</a> may be required.
	Inpatient services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	<a href="#">Prior authorization</a> may be required.
<b>If you are pregnant</b>	Office visits	Routine OB or midwife: Visit 1 - 1: \$25 <a href="#">copay</a> / visit; Visit 2 and after: No Charge	Not Covered	None

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)	
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth/delivery facility services	Hospital: 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> ; Birthing center: Same as routine OB	Not Covered	<a href="#">Prior authorization</a> required.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$50 <a href="#">copay</a> / visit after <a href="#">deductible</a>	Not Covered	Limited to 20 skilled visits per calendar year. Approved treatment <a href="#">plan</a> required.
	<a href="#">Rehabilitation services</a>	Independent facility: \$50 <a href="#">copay</a> / visit; Hospital-affiliated facility: \$50 <a href="#">copay</a> / visit after <a href="#">deductible</a> ; Chiropractic services: \$25 <a href="#">copay</a> / visit	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 <a href="#">prior authorization</a> .
	<a href="#">Habilitation services</a>	Independent facility: \$50 <a href="#">copay</a> / visit; Hospital-affiliated facility: \$50 <a href="#">copay</a> / visit after <a href="#">deductible</a>	Not Covered	None
	<a href="#">Skilled nursing care</a>	Day 1 - 5: \$250 <a href="#">copay</a> / day per admission after <a href="#">deductible</a> ; Day 6 and after: No charge after <a href="#">deductible</a>	Not Covered	Limited to 60 days post-hospitalization care per calendar year. <a href="#">Prior authorization</a> required.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	Excludes vehicle modifications, home modifications, exercise equipment, and bathroom equipment.
	<a href="#">Hospice services</a>	No charge after <a href="#">deductible</a>	Not Covered	Physician certification 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 your child needs dental or eye care	Children’s eye exam	\$35 <a href="#">copay</a> / exam	Not Covered	Limited to one exam per calendar year to determine the need for sight correction.
	Children’s glasses	Not Covered	Not Covered	None
	Children’s dental check-up	Not Covered	Not Covered	None

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric Surgery</li> <li>Child Dental Check Up</li> <li>Child Glasses</li> <li>Cosmetic Surgery</li> </ul>	<ul style="list-style-type: none"> <li>Dental Care (Adult)</li> <li>Hearing Aids</li> <li>Infertility Treatment</li> <li>Long-term Care</li> <li>Non-Emergency Care When Traveling Outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private-Duty Nursing</li> <li>Routine Eye Care (Adult)</li> <li>Routine Foot Care</li> <li>Weight Loss Programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your <a href="#">plan</a> document.)
<ul style="list-style-type: none"> <li>Chiropractic Care</li> </ul>

**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/healthreform](http://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](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 1-800-882-8633. 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](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**

[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 the 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 1-800-882-8633.

*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](#) **\$4,000**
- [Specialist copayment](#) **\$50**
- Hospital (facility) [coinsurance](#) **20%**
- Other [copayment](#) **\$25**

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:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$4,000
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,160</b>

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

- The [plan's](#) overall [deductible](#) **\$4,000**
- [Specialist copayment](#) **\$50**
- Hospital (facility) [coinsurance](#) **20%**
- Other [copayment](#) **\$25**

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:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$900
<a href="#">Coinsurance</a>	\$1,400
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,620</b>

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

- The [plan's](#) overall [deductible](#) **\$4,000**
- [Specialist copayment](#) **\$50**
- Hospital (facility) [coinsurance](#) **20%**
- Other [copayment](#) **\$25**

This EXAMPLE event includes services like:  
[Emergency room care](#) (*including medical supplies*)  
[Diagnostic tests](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

**Total Example Cost** **\$2,800**

In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,200
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,800</b>

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