

Embrace  
better health™

Individual Engage LS550-IN27

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

| Important Questions                                                             | Answers                                                                                                                                                                                                                                | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | <a href="#">In-Network</a> : \$6,500 Individual / \$13,000 Family<br><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, <a href="#">urgent care</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. \$60 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 <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> : \$9,000 Individual / \$18,000 Family<br><a href="#">Out-of-Network</a> : Not Applicable<br>Pediatric Dental is limited to \$450 per child or \$900 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 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 1-800-477-8768 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> ?    | 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                                                                                                                                                                      |
|------------------------------------------------------------------------|---------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                        |                                                         | In-Network<br>(You will pay the least)                                                                                                                                                                                      | Out-of-Network<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        | Visit 1 - 1: No Charge, <a href="#">deductible</a> does not apply;<br>Visit 2 and after: \$55 <a href="#">copay</a> / visit, <a href="#">deductible</a> does not apply                                                      | Not Covered                               | Additional charges may apply for non-preventive services performed in the Physician's office.                                                                                                                               |
|                                                                        | <a href="#">Specialist</a> visit                        | \$110 <a href="#">copay</a> / visit, <a href="#">deductible</a> does not apply                                                                                                                                              | 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, <a href="#">deductible</a> does not apply                                                                                                                                                                        | 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. |
| If you have a test                                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)     | Independent facility:<br>\$125 <a href="#">copay</a> / visit, <a href="#">deductible</a> does not apply;<br>Hospital-affiliated facility:<br>\$250 <a href="#">copay</a> / visit, <a href="#">deductible</a> does not apply | 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:<br>\$325 <a href="#">copay</a> / visit, <a href="#">deductible</a> does not apply;<br>Hospital-affiliated facility:<br>\$650 <a href="#">copay</a> / visit, <a href="#">deductible</a> does not apply | 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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                      |                                          | In-Network<br>(You will pay the least)                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Out-of-Network<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> | Generic drugs<br>(Tier 1 & Tier 2)       | Preferred generic drugs<br>30-day supply:<br>\$25 <a href="#">copay</a> / prescription, <a href="#">deductible</a> does not apply;<br>90-day supply:<br>\$62.50 <a href="#">copay</a> / prescription, <a href="#">deductible</a> does not apply<br><br>Generic drugs<br>30-day supply:<br>\$45 <a href="#">copay</a> / prescription, <a href="#">deductible</a> does not apply<br>90-day supply:<br>\$112.50 <a href="#">copay</a> / prescription, <a href="#">deductible</a> does not apply | Not Covered                               | Certain <a href="#">preventive</a> medications (including certain contraceptives) are covered at No Charge.<br><br>Certain limits may apply, including, for example: <a href="#">Prior authorization</a> , step therapy, quantity limits.<br><br>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.<br><br>Drugs in Tier 5 are available up to a 30-day supply, at retail pharmacies only.<br><br>Brand additional charges may apply.<br><br>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> . |
|                                                                                                                                                                                                                      | Preferred brand drugs<br>(Tier 3)        | 30-day supply:<br>\$65 <a href="#">copay</a> / prescription, <a href="#">deductible</a> does not apply;<br>90-day supply:<br>\$162.50 <a href="#">copay</a> / prescription, <a href="#">deductible</a> does not apply                                                                                                                                                                                                                                                                        | Not Covered                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                                      | Non-Preferred brand drugs<br>(Tier 4)    | 30-day supply:<br>\$105 <a href="#">copay</a> / prescription, <a href="#">deductible</a> does not apply;<br>90-day supply:<br>\$262.50 <a href="#">copay</a> / prescription, <a href="#">deductible</a> does not apply                                                                                                                                                                                                                                                                       | Not Covered                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                                      | <a href="#">Specialty drugs</a> (Tier 5) | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a><br>(Retail only)                                                                                                                                                                                                                                                                                                                                                                                                            | Not Covered                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

| Common Medical Event                    | Services You May Need                            | What You Will Pay                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                       | Limitations, Exceptions, & Other Important Information                                                                                                                          |
|-----------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                         |                                                  | In-Network<br>(You will pay the least)                                                                                                                                                                                                                                                                                                                                                  | Out-of-Network<br>(You will pay the most)                                                                                                                                                                                                                                                                             |                                                                                                                                                                                 |
| If you have outpatient surgery          | Facility fee (e.g., ambulatory surgery center)   | Independent facility:<br>\$500 <a href="#">copay</a> / visit after <a href="#">deductible</a> ;<br>Hospital-affiliated facility:<br>\$500 <a href="#">copay</a> / visit after <a href="#">deductible</a>                                                                                                                                                                                | Not Covered                                                                                                                                                                                                                                                                                                           | <a href="#">Prior authorization</a> required.                                                                                                                                   |
|                                         | Physician/ surgeon fees                          | No charge after <a href="#">deductible</a>                                                                                                                                                                                                                                                                                                                                              | Not Covered                                                                                                                                                                                                                                                                                                           | <a href="#">Prior authorization</a> required.                                                                                                                                   |
| If you need immediate medical attention | <a href="#">Emergency room care</a>              | \$600 <a href="#">copay</a> / visit after <a href="#">deductible</a>                                                                                                                                                                                                                                                                                                                    | \$600 <a href="#">copay</a> / visit after <a href="#">In-Network deductible</a>                                                                                                                                                                                                                                       | 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. |
|                                         | <a href="#">Emergency medical transportation</a> | Ground:<br>\$200 <a href="#">copay</a> / one way ground transport, <a href="#">deductible</a> does not apply;<br>Air/Water:<br>50% <a href="#">coinsurance</a> after <a href="#">deductible</a>                                                                                                                                                                                         | Ground:<br>\$200 <a href="#">copay</a> / one way ground transport, <a href="#">deductible</a> does not apply;<br>Air/Water:<br>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:<br>\$125 <a href="#">copay</a> / visit, <a href="#">deductible</a> does not apply;<br>Hospital-affiliated <a href="#">urgent care</a> facility:<br>\$250 <a href="#">copay</a> / visit, <a href="#">deductible</a> does not apply;<br>Retail clinic:<br>\$65 <a href="#">copay</a> / visit, <a href="#">deductible</a> does not apply | Independent <a href="#">urgent care</a> facility:<br>\$125 <a href="#">copay</a> / visit, <a href="#">deductible</a> does not apply;<br>Hospital-affiliated <a href="#">urgent care</a> facility:<br>\$250 <a href="#">copay</a> / visit, <a href="#">deductible</a> does not apply;<br>Retail clinic:<br>Not Covered | None                                                                                                                                                                            |
| If you have a hospital stay             | Facility fee (e.g., hospital room)               | \$500 <a href="#">copay</a> / admission after <a href="#">deductible</a>                                                                                                                                                                                                                                                                                                                | Not Covered                                                                                                                                                                                                                                                                                                           | <a href="#">Prior authorization</a> required.                                                                                                                                   |
|                                         | Physician/ surgeon fees                          | No charge after <a href="#">deductible</a>                                                                                                                                                                                                                                                                                                                                              | Not Covered                                                                                                                                                                                                                                                                                                           | <a href="#">Prior authorization</a> required.                                                                                                                                   |

| Common Medical Event                                                             | Services You May Need                     | What You Will Pay                                                                                                                                                                                |                                           | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                        |
|----------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                           | In-Network<br>(You will pay the least)                                                                                                                                                           | Out-of-Network<br>(You will pay the most) |                                                                                                                                                                                                                                               |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$55 <a href="#">copay</a> / visit, <a href="#">deductible</a> does not apply                                                                                                                    | Not Covered                               | The cost sharing applies to outpatient office visits only. All other outpatient services [e.g, Detox, Neuropsychology, Psychological testing] may be subject to additional cost sharing. <a href="#">Prior authorization</a> may be required. |
|                                                                                  | Inpatient services                        | \$500 <a href="#">copay</a> / admission 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:<br>Visit 1 - 1: \$55 <a href="#">copay</a> / visit, <a href="#">deductible</a> does not apply;<br>Visit 2 and after: No Charge, <a href="#">deductible</a> does not apply | Not Covered                               | None                                                                                                                                                                                                                                          |
|                                                                                  | Childbirth/delivery professional services | No charge 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:<br>\$500 <a href="#">copay</a> / admission after <a href="#">deductible</a> ;<br>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>          | \$110 <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.                                                                                                                                             |

| Common Medical Event                   | Services You May Need                     | What You Will Pay                                                                                                                                                                                                                                                                                                              |                                                                                                        | Limitations, Exceptions, & Other Important Information                                                                                                                                                                         |
|----------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                        |                                           | In-Network<br>(You will pay the least)                                                                                                                                                                                                                                                                                         | Out-of-Network<br>(You will pay the most)                                                              |                                                                                                                                                                                                                                |
|                                        | <a href="#">Rehabilitation services</a>   | Independent facility:<br>\$110 <a href="#">copay</a> / visit, <a href="#">deductible</a> does not apply;<br>Hospital-affiliated facility:<br>\$110 <a href="#">copay</a> / visit after <a href="#">deductible</a> ;<br>Chiropractic services:<br>\$55 <a href="#">copay</a> / visit, <a href="#">deductible</a> does not apply | 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:<br>\$110 <a href="#">copay</a> / visit, <a href="#">deductible</a> does not apply;<br>Hospital-affiliated facility:<br>\$110 <a href="#">copay</a> / visit after <a href="#">deductible</a>                                                                                                              | Not Covered                                                                                            | Limited to 35 visits per calendar year for outpatient habilitative PT, OT and ST combined.                                                                                                                                     |
|                                        | <a href="#">Skilled nursing care</a>      | Day 1 - 2: \$250 <a href="#">copay</a> / day per admission after <a href="#">deductible</a> ;<br>Day 3 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> | 50% <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.                                                                                                                                                                                              |
| If your child needs dental or eye care | Children's eye exam                       | No Charge, <a href="#">deductible</a> does not apply                                                                                                                                                                                                                                                                           | Not Covered                                                                                            | Limited to one exam per calendar year to determine the need for sight correction.                                                                                                                                              |
|                                        | Children's glasses                        | No Charge, <a href="#">deductible</a> does not apply                                                                                                                                                                                                                                                                           | Not Covered                                                                                            | Limited to one pair per calendar year from a pre-selected group of frames.                                                                                                                                                     |
|                                        | Children's dental check-up                | No charge for <a href="#">preventive care</a> at Delta Dental <a href="#">Network providers</a> , <a href="#">deductible</a> does not apply                                                                                                                                                                                    | <a href="#">Preventive care</a> may be subject to cost sharing if billed charges exceed allowed amount | Limited to one 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.)

- |                         |                 |                     |
|-------------------------|-----------------|---------------------|
| • Child Dental Check Up | • Child Glasses | • 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.flor.com/consumers](http://www.flor.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 1-800-477-8768. 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.flor.com/consumers](http://www.flor.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 1-800-477-8768.

*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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$6,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$110   |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$500   |
| ■ Other <a href="#">copayment</a>                               | \$55    |

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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$6,500 |
| <a href="#">Copayments</a>  | \$1,000 |
| <a href="#">Coinsurance</a> | \$0     |

| What isn't covered   |      |
|----------------------|------|
| Limits or exclusions | \$60 |

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Peg would pay is</b> | <b>\$7,560</b> |
|-----------------------------------|----------------|

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$6,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$110   |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$500   |
| ■ Other <a href="#">copayment</a>                               | \$55    |

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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$0     |
| <a href="#">Copayments</a>  | \$1,800 |
| <a href="#">Coinsurance</a> | \$0     |

| What isn't covered   |      |
|----------------------|------|
| Limits or exclusions | \$20 |

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Joe would pay is</b> | <b>\$1,820</b> |
|-----------------------------------|----------------|

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$6,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$110   |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$500   |
| ■ Other <a href="#">copayment</a>                               | \$55    |

This EXAMPLE event includes services like:

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

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$1,000 |
| <a href="#">Copayments</a>  | \$1,000 |
| <a href="#">Coinsurance</a> | \$0     |

| What isn't covered   |     |
|----------------------|-----|
| Limits or exclusions | \$0 |

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Mia would pay is</b> | <b>\$2,000</b> |
|-----------------------------------|----------------|

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