Benefit Summary

AvMed
Self-Funded Options

HIGH OPTION HMO

MIAMI-DADE COUNTY & JACKSON HEALTH SYSTEM	SCHEDULE OF BENEFITS	COST TO MEMBER
CALENDAR YEAR DEDUCTIBLE	INDIVIDUAL / FAMILY	N/A
OUT-OF-POCKET MAXIMUM Per Calendar Year	INDIVIDUAL / FAMILY	$1500/$3000
LIFETIME MAXIMUM		UNLIMITED
PRIMARY CARE PHYSICIAN	Services at participating doctors' offices include, but are not limited to: ▪ Routine office visits / annual gyn examination when performed by primary care physician ▪ Pediatric care and well-baby care ▪ Periodic health evaluation and immunizations ▪ Diagnostic imaging, laboratory or other diagnostic services ▪ Minor surgical procedures ▪ Vision and hearing examinations for children under 18	$10 per visit
SPECIALIST'S SERVICES	▪ Office visits ▪ Annual gyn examination when performed by participating specialist	$10 per visit
MATERNITY CARE	▪ Initial visit ▪ Subsequent visits	$10 per visit No charge
ALLERGY TREATMENTS	▪ Visits and/or injections ▪ Skin testing (per course of treatment)	$10 per visit
CHIROPRACTIC	▪ Chiropractic	$10 per visit
PODIATRY	▪ Podiatry	$10 per visit
HOSPITAL	Inpatient care at participating hospitals includes: ▪ Room and board - unlimited days (semi-private) ▪ Physicians', specialists' and surgeons' services ▪ Anesthesia, use of operating and recovery rooms, oxygen, drugs and medication ▪ Intensive care unit and other special units, general and special duty nursing ▪ Laboratory and diagnostic imaging ▪ Required special diets ▪ Radiation and inhalation therapies	No charge
OUTPATIENT SERVICES	▪ Outpatient surgeries, including cardiac catheterizations and angioplasty	No charge

Benefit Summary, continued

OUTPATIENT DIAGNOSTIC TESTS	▪ Complex radiological imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging)	No charge
	▪ Other diagnostic imaging tests and laboratory	No charge
	▪ Mammogram	No charge
EMERGENCY SERVICES	An emergency is the sudden and unexpected onset of a condition requiring immediate medical or surgical care.	
	▪ Emergency services at participating hospitals	$25 Co-payment (waived if admitted)
	▪ Emergency services - non-participating hospitals, facilities and/or physicians	$50 Co-payment (waived if admitted)
	AvMed must be notified within 24 hours of inpatient admission following emergency services or as soon as reasonably possible.	
URGENT/IMMEDIATE CARE	▪ Medical services at a participating Urgent/Immediate Care facility or services rendered after hours in your Primary Care Physician's office	$25 Co-payment
	▪ Medical Services at a participating retail clinic	$10 Co-payment
	▪ Medical Services at a non-participating Urgent/Immediate Care facility or non-participating retail clinic	$50 Co-payment
HOME HEALTH CARE	▪ Per occurrence	No charge
DRUG AND ALCOHOL REHABILITATION PROGRAMS	▪ Inpatient	No charge
	▪ Outpatient	$10 per visit
MENTAL / NERVOUS DISORDERS	▪ Inpatient	No charge
	▪ Outpatient	$10 per visit
FAMILY PLANNING	▪ Voluntary family planning services	$10 per visit
	▪ Sterilization	$100 Co-payment
AMBULANCE	▪ When pre-authorized or in the case of emergency	No charge
PHYSICAL, SPEECH, RESPIRATORY AND OCCUPATIONAL THERAPIES	▪ Short-term physical, speech, respiratory and occupational therapy for acute conditions	$10 per visit
	Coverage is limited to 60 visits combined per calendar year	
SKILLED NURSING FACILITIES AND REHABILITATION CENTERS	▪ Up to 60 days post-hospitalization care per calendar year when prescribed by physician and authorized by AvMed	No charge
CARDIAC REHABILITATION	Cardiac rehabilitation is covered for the following conditions:	$10 per visit

Benefit Summary, continued

	▪ Acute myocardial infarction ▪ Percutaneous transluminal coronary angioplasty (PTCA) ▪ Repair or replacement of heart valves ▪ Coronary artery bypass graft (CABG), or ▪ Heart transplant Coverage is limited to 36 visits per calendar year	
INFERTILITY TREATMENT	▪ Infertility treatment (limited to diagnostic testing and procedures)	$10 per visit
DURABLE MEDICAL EQUIPMENT AND ORTHOTIC APPLIANCES	Equipment includes but not limited to: ▪ Hospital beds ▪ Walkers ▪ Crutches ▪ Wheelchairs Orthotic appliances are limited to: ▪ Leg, arm, back and neck custom-made braces	$50 per episode of illness **Benefits limited to $2000 per calendar year**
PROSTHETIC DEVICES	Prosthetic devices are limited to: ▪ Artificial limbs ▪ Artificial joints ▪ Ocular prostheses	No charge
HOSPICE CARE	▪ Hospice Care (360 day lifetime limit)	No charge
AUTISM SERVICES*	▪ Physical, speech, occupational therapy ▪ Applied Behavioral Analysis * Calendar year maximum $36,000 * Lifetime maximum $200,000	$10 per visit $10 per visit
	PRESCRIPTION DRUG BENEFIT (INCLUDES INJECTABLES) **Prescription Drug Co-payments do not count toward annual out-of-pocket maximum**	
PRESCRIPTION DRUGS-RETAIL (INCLUDES CONTRACEPTIVES) (30 DAY SUPPLY)		$10 Co-payment Generic $20 Co-payment Preferred Brand $30 Co-payment Non-Preferred Brand
PRESCRIPTION DRUGS-MAIL ORDER (INCLUDES CONTRACEPTIVES) (90 DAY SUPPLY)		$20 Co-payment Generic $40 Co-payment Preferred Brand $60 Co-payment Non-Preferred Brand

"Brand Additional Charge" means the additional charge that must be paid if you choose a Brand medication when a Generic equivalent is available. The charge is the difference between the cost of the Brand medication and the Generic medication. This charge must be paid in addition to the applicable Non-Preferred Brand Co-payment.

Benefit Summary, continued

PRIOR AUTHORIZATION IS REQUIRED FOR SPECIFIC COVERED SERVICES INCLUDING, BUT NOT LIMITED TO:

- All inpatient services
- Observation services
- Residential treatment
- Outpatient surgery
- Intensive outpatient programs
- Complex radiological imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging)
- Non emergency ambulance
- Dialysis services
- Transplant services
- Use of Non-Participating Providers
- Select medications including injectables

FOR ADDITIONAL INFORMATION, PLEASE CALL 1-800-68-AVMED (1-800-682-8633)

THIS SCHEDULE OF CO-PAYMENTS IS NOT A CONTRACT.
FOR SPECIFIC INFORMATION ON BENEFITS, EXCLUSIONS AND LIMITATIONS PLEASE SEE YOUR SUMMARY PLAN DESCRIPTION.