

# Benefit Summary

## POINT-OF-SERVICE SCHEDULE OF BENEFITS



MIAMI-DADE COUNTY & JACKSON HEALTHSYSTEM		COST TO MEMBER	
	In Network	Out-of-Network***	
<b>LIFETIME MAXIMUM</b>	Unlimited	\$1,000,000* benefit maximum to the member	
<b>CO-INSURANCE LEVELS</b>	Plan pays 100%; Member Pays 0%	Plan pays 70% of U&C**; Member Pays 30% of the U&C charge, after Deductible	
<b>CASH DEDUCTIBLE</b> Individual (per contract year)  Family (per contract year) <i>Deductible does not apply toward the Out-of-Pocket Maximum</i>  <b>Individual Calculation:</b> Family members meet only their individual deductible and then their claims will be covered under the plan co-insurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan co-insurance.	Not Applicable  Not Applicable	\$200 per individual  \$500 per family	
<b>OUT-OF-POCKET MAXIMUM</b> Individual Maximum  Family Maximum  <b>Individual Calculation:</b> Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%.	Not Applicable  Not Applicable	\$1500 per individual  Not Applicable	
<b>PHYSICIAN SERVICES</b> Services at Physician's offices include, but are not limited to: Primary Care Physician's Office Visit  Surgery in Physician's Office  Specialty Care Physician's Office Visits Consultant and Referral Physician's Services  Second Opinion Consultations (provided on a voluntary basis)  Allergy Treatment  Allergy Injections  Allergy Serum (dispensed by the physician in the office)	\$10 per visit  \$10 per visit  \$10 per visit  \$10 per visit  \$10 per visit  No Charge  No Charge	30% of the U&C charge, after Deductible 30% of the U&C charge, after Deductible 30% of the U&C charge, after Deductible 30% of the U&C charge, after Deductible 30% of the U&C charge, after Deductible 30% of the U&C charge, after Deductible 30% of the U&C charge, after Deductible	
<b>PREVENTIVE CARE</b> Routine Preventive Care: Birth through age 15 (Well-Baby and Well-Child including immunizations)  Immunizations (birth through age 15)  Routine Preventive Care: Adult including immunizations  Immunizations (age 16 and above)	\$10 per visit  No Charge  \$10 per visit  No Charge	No Charge  No Charge  In-Network coverage only  In-Network coverage only	

\* The \$1,000,000 lifetime benefit is the maximum allowed for all Out-of-Network services.

\*\* Usual and Customary (U&C)

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## POINT-OF-SERVICE SCHEDULE OF BENEFITS, CONTINUED

MIAMI-DADE COUNTY & JACKSON HEALTHSYSTEM	COST TO MEMBER	
	In Network	Out-of-Network***
<p><b>MAMMOGRAM, PSA, PAP SMEAR</b> Preventive care related services (i.e. “routine” services)</p> <p>Diagnostic related services (i.e. “non-routine”)</p>	<p>No Charge</p> <p><b>Note:</b> The associated wellness exam is subject to the \$10 Specialist visit co-payment</p> <p>Subject to the plan’s x-ray and laboratory benefit, based on place of service</p>	<p>30% of the U&amp;C charge, after Deductible</p> <p><b>Note:</b> The associated wellness exam is not covered</p> <p>Subject to the plan’s x-ray and laboratory benefit, based on place of service</p>
<b>ACUPUNCTURE</b>	Out-of-network coverage only	30% of the U&C charge, after Deductible
<p><b>INPATIENT HOSPITAL SERVICES</b> Hospital inpatient care includes:</p> <p style="padding-left: 40px;">Room and board – unlimited days (semi-private)</p> <p style="padding-left: 40px;">Private Room</p> <p style="padding-left: 40px;">Special Care Units (ICU/CCU)</p>	<p>No Charge</p> <p>Limited to the semi-private room negotiated rate</p> <p>No Charge</p>	<p>30% of the U&amp;C charge, after Deductible</p> <p>Limited to the semi-private room rate</p> <p>30% of the U&amp;C charge, after Deductible</p>
<p><b>OUTPATIENT FACILITY SERVICES</b> Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room</p> <p>Diagnostic Testing</p>	<p>No Charge</p> <p>No Charge</p>	<p>30% of the U&amp;C charge, after Deductible</p> <p>30% of the U&amp;C charge, after Deductible</p>
<b>INPATIENT HOSPITAL PHYSICIAN’S VISITS/ CONSULTATIONS</b>	No Charge	30% of the U&C charge, after Deductible
<b>INPATIENT/OUTPATIENT HOSPITAL PROFESSIONAL SERVICES</b>	No Charge	30% of the U&C charge, after Deductible
<p><b>EMERGENCY AND URGENT CARE SERVICES</b> Physician’s Office</p> <p>Hospital Emergency Room</p> <p>Outpatient Professional Services (radiology, pathology, ER physician)</p> <p>Medical Services performed at a retail clinic</p> <p>Urgent Care Facility or Outpatient Facility</p> <p>X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)</p> <p>Independent X-ray and/or Lab Facility in conjunction with an ER visit</p> <p>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) The scan co-payment applies per type of scan per day</p> <p>Ambulance</p>	<p>\$10 per visit</p> <p>\$50 per visit (waived if admitted)</p> <p>No Charge</p> <p>\$10 per visit</p> <p>\$50 per visit (waived if admitted)</p> <p>No Charge</p> <p>No Charge</p> <p>No Charge</p> <p>No Charge</p> <p>No Charge</p>	<p>\$10 per visit</p> <p>\$50 per visit (waived if admitted)</p> <p>No Charge</p> <p>\$50 per visit</p> <p>\$50 per visit (waived if admitted)</p> <p>No Charge</p> <p>No Charge</p> <p>No Charge</p> <p>No Charge</p>

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## POINT-OF-SERVICE SCHEDULE OF BENEFITS, CONTINUED

MIAMI-DADE COUNTY & JACKSON HEALTHSYSTEM	COST TO MEMBER	
	In Network	Out-of-Network***
<p><b>INPATIENT SERVICES AT OTHER HEALTH CARE FACILITIES</b> Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute facilities</p> <p>Contract Year Maximum: 60 days combined</p> <p>No prior hospitalization required</p>	No Charge	30% of the U&C charge, after Deductible
<p><b>LABORATORY/ RADIOLOGY SERVICES</b> (includes pre-admission testing)</p> <p>Physician's office visit</p> <p>Outpatient hospital facility</p> <p>Independent x-ray and/or laboratory facility</p>	No Charge  No Charge  No Charge	30% of the U&C charge, after Deductible  30% of the U&C charge, after Deductible  30% of the U&C charge, after Deductible
<p><b>ADVANCED RADIOLOGICAL IMAGING</b> (i.e. MRI MRA, CAT scans and PET scans) The scan co-payment/deductible applies per type of scan per day</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Office</p>	No Charge  No Charge  No Charge	30% of the U&C charge, after Deductible  30% of the U&C charge, after Deductible  30% of the U&C charge, after Deductible
<p><b>OUTPATIENT SHORT-TERM REHABILITATIVE THERAPY AND CHIROPRACTIC SERVICES</b> Contract Year Maximum: 60 days for all therapy combined Includes:</p> <ul style="list-style-type: none"> <li>Physical Therapy</li> <li>Speech Therapy</li> <li>Occupational Therapy</li> <li>Pulmonary Rehabilitation</li> <li>Cognitive Therapy</li> <li>Chiropractic Therapy (includes Chiropractors)</li> <li>Respiratory Therapy</li> </ul>	\$10 per visit	30% of the U&C charge, after Deductible
<p><b>CARDIAC REHABILITATION</b> Contract Maximum: 36 visits</p> <p>Cardiac Rehabilitation is covered for the following conditions:</p> <ul style="list-style-type: none"> <li>Acute myocardial infarction</li> <li>Percutaneous transluminal coronary angioplasty (PTCA)</li> <li>Repair or replacement of heart valves</li> <li>Coronary artery bypass graft (CABG), or Heart Transplant</li> </ul>	\$10 per visit	30% of the U&C charge, after Deductible
<p><b>HOME HEALTH CARE</b> Contract Year Maximum:</p> <p>(including outpatient private nursing when approved as medically necessary)</p>	Unlimited Days  No Charge	60 visits  30% of the U&C charge, after Deductible

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## POINT-OF-SERVICE SCHEDULE OF BENEFITS, CONTINUED

MIAMI-DADE COUNTY & JACKSON HEALTHSYSTEM	COST TO MEMBER	
	In Network	Out-of-Network***
<b>HOSPICE</b>		
Inpatient/Outpatient Services  Limited to 360 day lifetime limit	No Charge	30% of the U&C charge, after Deductible
<b>BEREAVEMENT COUNSELING</b>		
Services provided as part of Hospice Care		
Inpatient	No Charge	In-Network coverage only
Outpatient	No Charge	In-Network coverage only
Services provided by Mental Health Professionals	Covered under Mental Health benefit	In-Network coverage only
<b>MATERNITY CARE SERVICES</b>		
Initial visit to confirm pregnancy	\$10 per visit	30% of the U&C charge, after Deductible
All subsequent prenatal visits, postnatal visits and Physician's delivery charges (i.e. global maternity fee)	No Charge	30% of the U&C charge, after Deductible
Delivery facility (in-patient hospital, birthing center)	No Charge	30% of the U&C charge, after Deductible
<b>ABORTION</b>		
Includes non-elective procedures only		
Physician's Office Visit	\$10 per visit	30% of the U&C charge, after Deductible
Inpatient Facility	No Charge	30% of the U&C charge, after Deductible
Outpatient Facility	No Charge	30% of the U&C charge, after Deductible
Physician's Services	No Charge	30% of the U&C charge, after Deductible
<b>FAMILY PLANNING SERVICES</b>		
Physician's Office Visit (testing and counseling)	\$10 per visit	30% of the U&C charge, after Deductible
Surgical Sterilization Procedures for Vasectomy/Tubal Ligation (excludes reversals) Inpatient Facility, Outpatient Facility, and Physician's Services	No Charge	30% of the U&C charge, after Deductible
<b>INFERTILITY TREATMENT</b>		
Coverage will be provided for the following services: Testing and treatment for services performed in conjunction with an underlying medical condition. Testing performed exclusively to determine the cause of infertility. Treatment and/or procedures performed exclusively to restore fertility (e.g. procedures to correct infertility condition). Services Not Covered: Artificial Insemination, In-vitro, GIFT, ZIFT, etc.		
Physician's Office Visit (Lab and Radiology tests, counseling)	\$10 per visit	30% of the U&C charge, after Deductible
Surgical Procedure Co-payment	\$200 Surgical Co-payment	30% of the U&C charge, after Deductible
Inpatient Facility, Outpatient Facility and Physician Services	No Charge	30% of the U&C charge, after Deductible

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SF-AV-MDC-POS-10

SF-3476(01/10)

# Benefit Summary

## POINT-OF-SERVICE SCHEDULE OF BENEFITS, CONTINUED

MIAMI-DADE COUNTY & JACKSON HEALTHSYSTEM	COST TO MEMBER	
	In Network	Out-of-Network***
<b>ORGAN TRANSPLANTS</b> Includes all medically appropriate, non-experimental transplants		
Physician's Office Visit	\$10 per visit	30% of the U&C charge, after Deductible
Inpatient Facility	No Charge	30% of the U&C charge, after Deductible
Inpatient Physician Services	No Charge	30% of the U&C charge, after Deductible
Lifetime Travel Maximum: \$10,000 per transplant	No Charge	In-Network coverage only
<b>DURABLE MEDICAL EQUIPMENT</b> Contract Year Maximum: Unlimited	No Charge	30% of the U&C charge, after Deductible
<b>EXTERNAL PROSTHETIC APPLIANCES (EPA)</b> Contract Year Maximum: Unlimited	No Charge after \$200 EPA deductible; per Contract Year	In-Network coverage only
<b>NUTRITIONAL EVALUATION</b> Contract Year Maximum: 3 visits per person		
Physician's Office Visit	\$10 per visit	30% of the U&C charge, after Deductible
Inpatient Facility	No Charge	30% of the U&C charge, after Deductible
Outpatient Facility	No Charge	30% of the U&C charge, after Deductible
Physician Services	No Charge	30% of the U&C charge, after Deductible
<b>DENTAL CARE</b> Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.		
Physician's Office Visit	\$10 per visit	30% of the U&C charge, after Deductible
Inpatient Facility	No Charge	30% of the U&C charge, after Deductible
Outpatient Facility	No Charge	30% of the U&C charge, after Deductible
Physician Services	No Charge	30% of the U&C charge, after Deductible
<b>TMJ SURGICAL AND NON-SURGICAL</b> Always excludes appliances and orthodontic treatment. Subject to medical necessity.		
Physician's Office Visit	\$10 per visit	In-Network coverage only
Inpatient Facility	No Charge	In-Network coverage only
Outpatient Facility	No Charge	In-Network coverage only
Physician Services	No Charge	In-Network coverage only

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# Benefit Summary

## POINT-OF-SERVICE SCHEDULE OF BENEFITS, CONTINUED

MIAMI-DADE COUNTY & JACKSON HEALTHSYSTEM	COST TO MEMBER	
	In Network	Out-of-Network***
<b>OBESITY/BARIATRIC SURGERY</b>		
<b>Note:</b> Coverage is provided subject to medical necessity and clinical guidelines in addition to any limitations shown in the “Exclusions and Limitations” of your Summary Plan Description.		
Physician’s Office Visit	\$10 per visit	In-Network coverage only
Inpatient Facility	No Charge	In-Network coverage only
Outpatient Facility	No Charge	In-Network coverage only
Physician Services	No Charge	In-Network coverage only
<b>ROUTINE FOOT DISORDERS</b>	Not covered except for services associated with foot care for diabetes and peripheral vascular disease	Not covered except for services associated with foot care for diabetes and peripheral vascular disease
<b>MENTAL HEALTH</b>		
Inpatient	No Charge	30% of the U&C charge, after Deductible
Outpatient	\$10 per visit	30% of the U&C charge, after Deductible
Intensive Outpatient	\$10 per visit	30% of the U&C charge, after Deductible
<b>SUBSTANCE ABUSE</b>		
Inpatient	No Charge	30% of the U&C charge, after Deductible
Outpatient	\$10 per visit	30% of the U&C charge, after Deductible
Intensive Outpatient	\$10 per visit	30% of the U&C charge, after Deductible
<b>AUTISM SERVICES</b>		
Physical, Speech, Occupational Therapy	\$10 per visit	30% of the U&C charge, after Deductible
Applied Behavioral Analysis (ABA)	\$10 per visit	30% of the U&C charge, after Deductible
Calendar Year Maximum: \$36,000—in and out of network		
Lifetime Maximum: \$200,000—in and out of network		

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## POINT-OF-SERVICE SCHEDULE OF BENEFITS, CONTINUED

<b>MIAMI-DADE COUNTY &amp; JACKSON HEALTHSYSTEM</b>	<b>COST TO MEMBER</b>	
	<b>In Network</b>	<b>Out-of-Network***</b>
<b>PRESCRIPTION MEDICATION BENEFIT</b> <b>(Includes Injectables)</b> <b>Prescription Drug Co-payments do not count toward annual out-of-pocket maximum</b>		
<b>PRESCRIPTION MEDICATION – RETAIL, 30 DAY SUPPLY (INCLUDES CONTRACEPTIVES)</b>		
Generic: medication on the Prescription medication list	\$5 Co-payment Generic	30% of charges
Brand Name: medication designated as preferred on the prescription medication list with no Generic equivalent	\$10 Co-payment Preferred Brand	30% of charges
Brand Name: medication with a Generic equivalent and/or medication designated as non-preferred on the Prescription medication list	\$15 Co-payment Non-Preferred Brand	30% of charges
<b>SPECIALTY (30-DAY SUPPLY AT PARTICIPATING PHARMACY)</b>		
Generic: medication on the Prescription medication list	\$3.33 Co-payment Generic	30% of charges
Brand Name: medication designated as preferred on the prescription medication list with no Generic equivalent	\$6.66 Co-payment Preferred Brand	30% of charges
Brand Name: medication with a Generic equivalent and/or medication designated as non-preferred on the Prescription medication list	\$10 Co-payment Non-Preferred Brand	30% of charges
<b>PRESCRIPTION MEDICATIONS - MAIL-ORDER, 90 DAY SUPPLY (INCLUDES CONTRACEPTIVES)</b>		
Generic: medication on the Prescription medication list	\$10 Co-payment Generic	In-Network coverage only
Brand Name: medication designated as preferred on the prescription medication list with no Generic equivalent	\$20 Co-payment Preferred Brand	In-Network coverage only
Brand Name: medication with a Generic equivalent and/or medications designated as non-preferred on the Prescription medication list	\$30 Co-payment Non-Preferred Brand	In-Network coverage only

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## POINT-OF-SERVICE SCHEDULE OF BENEFITS, CONTINUED

<b>MIAMI-DADE COUNTY &amp; JACKSON HEALTHSYSTEM</b>	<b>COST TO MEMBER</b>	
	<b>In Network</b>	<b>Out-of-Network***</b>
<p><b>PRIOR AUTHORIZATION IS REQUIRED FOR SPECIFIC COVERED SERVICES INCLUDING, BUT NOT LIMITED TO:</b></p>	<ul style="list-style-type: none"> <li>• All Inpatient services</li> <li>• Observation services</li> <li>• Residential treatment</li> <li>• Outpatient Surgery</li> <li>• Intensive Outpatient Programs</li> <li>• Complex radiological imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging)</li> <li>• Non-Emergency Ambulance</li> <li>• Hysterectomy</li> <li>• Dialysis Services</li> <li>• Transplant Services</li> <li>• Select Medications Including Injectables</li> </ul>	<ul style="list-style-type: none"> <li>• All Inpatient services</li> <li>• Observation services</li> <li>• Residential treatment</li> <li>• Intensive Outpatient Programs</li> <li>• Non-emergency Ambulance</li> <li>• Complex radiological imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging)</li> <li>• Hysterectomy</li> <li>• Dialysis Services</li> <li>• Transplant Services</li> <li>• Select Medications Including Injectables</li> </ul> <p style="text-align: center;">The Plan must be notified within 72 hours after the date of admission. The Penalty for Non-Notification is \$500</p>

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

THIS SCHEDULE OF CO-PAYMENTS IS NOT A CONTRACT.

THIS SUMMARY CONTAINS HIGHLIGHTS ONLY AND IS SUBJECT TO CHANGE.

FOR SPECIFIC INFORMATION ON BENEFITS, EXCLUSIONS AND LIMITATIONS PLEASE SEE YOUR SUMMARY PLAN DESCRIPTION.

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