



2017 BENEFIT GUIDE

Miami-Dade County

Self-Funded Medical Program

**For Employees and Pre-65
Retirees (and/or Dependents)**



Embrace better health.®


For Employees and Pre-65 Retirees (and/or Dependents) of Miami-Dade County Effective 1/1/17

Table of Contents:

Caring for Miami-Dade County	3
Get the Most from your Plan	4
AvMed Virtual Visits	5
AvMed SmartShopper™	6
Stay Connected	8
Your Coverage	8
MDC Wellness Works	9
When is it an Emergency?	10
MDC Select HMO	11
MDC Jackson First HMO	21
MDC Redesign High HMO	31
MDC Redesign POS	41
No Redesign High HMO	51
No Redesign Low HMO	61
No Redesign POS	71
Pre-Enrollment	81
Notice of Privacy Practices	91

If you have any questions about your plan, from benefits, to copayments, to Provider lists, you can call your MDC Dedicated Member Engagement Center. These specialists are just a phone call away 24-hours a day, 7 days a week. You can reach them at **1-800-682-8633** or via email at **MDC.Members@AvMed.org**.

Caring for Miami-Dade County



AvMed is proud to serve Miami-Dade County employees from our headquarters right down the road and, whether you're new to the AvMed family or a long-time Member, we promise to provide personalized service focused on your individual needs. The people at AvMed are your neighbors, your friends, and your family.

Naturally, we want to go out of our way to make healthcare easier for you. To streamline access to preventive care and treatments. It all starts the day you enroll. You and your family can choose from one of Florida's strongest networks of doctors and hospitals. You'll have tools that let you compare healthcare providers and estimated costs that factor in year-to-date variables such as your deductible and out-of-pocket limits. And we'll be with you every step of the way through the all new MDC Wellness Works, which also includes discounts for maintaining a healthy lifestyle.

AvMed gives you all this and more, plus 24-hour access to an AvMed Representative - not a machine - to answer questions about your benefits. We believe in partnering with you through the entire healthcare experience, regardless of your stage in life or health status.

Welcome to the AvMed family...the plan that Floridians like you have counted on for nearly 50 years. You, too, can count on AvMed to help you live healthier and happier. To serve you with every opportunity you give us to help you live healthier. Just let us know how we can help...and thank you for placing your trust in us.

Sincerely,



James M. Repp,
President and Chief Operating Officer

AvMed



I Get the Most from **Your Plan**

AvMed has served Floridians for nearly 50 years, becoming very familiar with the needs of our Members. So it should come as no surprise that the health plans we offer today include all the benefits you want most.

- **No referrals to see any in-network physician, except for Low HMO.**
- **Access to a large Network of doctors and hospitals that includes an extensive selection of Primary Care Physicians (PCPs), Specialists, top-ranked hospitals, and outpatient facilities throughout Florida**
- **Retail Clinic care that allows you to pay your PCP copayment at participating clinics across the state**
- **AvMed Virtual Visits, powered by MDLIVE, provides anytime remote access to board-certified doctors from your home, your office, or on the go**
- **AvMed SmartShopper™, a powerful, free shopping tool that sends you cash back when you choose the best value for your care**
- **MDC Dedicated Member Engagement Center accessible all day, every day by phone, email, or online—to answer questions on every topic from benefits to Providers to payment balances**
- **MDC Wellness Works to keep you healthier and reduce your overall healthcare costs**
- **Emergency coverage when you travel outside of AvMed's Network area**
- **24/7 Nurse On Call service that connects you to a Registered Nurse who can answer your important healthcare questions quickly and confidentially**
- **Tools for comparing costs keep you healthier and reduce the amount you're spending**

Call the Miami-Dade County Dedicated Member Engagement Center, Live 24/7, at **1-800-682-8633**, or email us at **MDC.Members@AvMed.org**

What if You're Traveling?

We provide emergency coverage regardless of the plan you choose when traveling outside of AvMed's Network area.

AvMed's Nurse On Call

Our 24/7 Nurse On Call connects you to a Registered Nurse who can answer your important healthcare questions quickly and confidentially. Call **1-888-866-5432**.



POWERED BY

MDLIVE

Virtual Visits, Anywhere.

24/7/365 ACCESS TO HEALTHCARE PROVIDERS

AvMed Virtual Visits, powered by MDLIVE, provides anytime remote access to board-certified doctors from your home, your office, or on the go. Just 15 minutes after a simple sign-up, Members can speak with a doctor about non-emergency medical issues by phone or by secure video using a computer, tablet, or smartphone, for the cost of a PCP visit. It's healthcare that works for AvMed Members, wherever and whenever they need it.

- Acne
- Allergies
- Constipation
- Cold/Flu
- Cough
- Diarrhea
- Ear Problems
- Fever
- Headache
- Insect Bites
- Nausea
- Pink eye
- Rash
- Respiratory problems
- Sore throats
- Urinary problems/ UTI
- Vaginitis
- Vomiting
- And more



GET SET

Register online: bit.ly/AvMedVirtualVisits

By phone: **1-888-632-2738**

Or by downloading the
"MDLIVE" app



GET CARE

Visit with a board-certified
doctor... without the drive!
Your choice from a large
network of physicians will see
you within 15 minutes.



GET WELL

Fast relief is always on call.
And on your time, anytime.

Get ready for a new kind of house call with AvMed Virtual Visits.

AvMed Virtual Visits handles only non-emergency medical issues. If you are experiencing a medical emergency, you should not use AvMed Virtual Visits and should dial 911 immediately. AvMed Virtual Visits should not replace your PCP's care for common or chronic conditions. Some state laws require that a doctor can only prescribe medication in certain situations and subject to certain limitations.

MDLIVE does not replace the primary care physician. MDLIVE is not an insurance product nor a prescription fulfillment warehouse. MDLIVE operates subject to state regulation and may not be available in certain states. MDLIVE does not guarantee that a prescription will be written. MDLIVE does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. MDLIVE physicians reserve the right to deny care for potential misuse of services. MDLIVE and the MDLIVE logo are registered trademarks of MDLIVE, Inc. and may not be used without written permission. For complete terms of use visit mdlive.com/mdl/terms_of_use.



smartshopper[™]
Powered by **vitals**

KNOW BEFORE YOU GO AND EARN CASH BACK

Introducing AvMed SmartShopper; a Rewarding Path to Better Health

Prices for the exact same quality medical services, such as MRIs, CT Scans, and lab tests, can vary from hundreds to thousands of dollars depending on location and often aren't published. You can use this to your advantage.

How AvMed SmartShopper works



Your doctor recommends a qualifying procedure.



Call SmartShopper and a Health Cost Adviser will provide information on cost-effective locations in your area for the service your doctor has recommended. You will need to have your Member ID for verification. You can also shop online at **AvMed.VitalsSmartShopper.com**



Then, contact your doctor to schedule the service.

Please note: In order to qualify for incentives, you must contact AvMed SmartShopper AT LEAST 24 hours before the procedure.



If you choose to use a cost-effective location, as identified by AvMed SmartShopper, you will receive an incentive check in the mail no later than 60 days after your claim has been paid.

AvMed SmartShopper adds Cash Back to 2017 MDC Select HMO, High HMO, and POS plans

In 2017, AvMed is offering SmartShopper, giving you a chance to earn cash back while saving on healthcare costs.

- Medical procedures or diagnostic tests can qualify you or your dependents for \$25 - \$500 CASH BACK when you shop with SmartShopper!
- Se habla español.
- To access SmartShopper, go to **AvMed.VitalsSmartShopper.com** and easily shop healthcare services in your area.
- Earn CASH BACK when you choose a cost-effective location!

*SmartShopper not offered to Jackson First HMO Members

Visit us anytime at
AvMed.VitalsSmartShopper.com
or call **1-855-869-2133**

Monday-Thursday from 8:30 am-8 pm,
Friday from 8:30 am-5 pm

SEE HEALTHCARE DIFFERENTLY

Save money and earn cash back on healthcare services!

Services	Incentive Amounts		
	most cost-effective	2nd most cost-effective	3rd most cost-effective
Bladder repair for incontinence (sling)	\$150	\$75	\$50
Bone density study	\$50	\$25	N/A
Bone Imaging	\$50	\$25	N/A
Breast Biopsy	\$150	\$75	\$50
Bunion Repair (Bunionectomy)	\$150	\$75	\$50
Cardiac Echocardiogram	\$75	\$50	\$25
Carpal Tunnel	\$150	\$75	\$50
Cataract removal	\$150	\$75	\$50
Colonoscopy	\$150	\$75	\$50
CT Scan	\$150	\$75	\$50
ENT - Ear Surgery (Tympanoplasty, Mastoidectomy, Myringotomy/Ear Drum)	\$150	\$75	\$50
ENT - Nasal/Sinus and Deviated Septum Surgery (Septoplasty)	\$150	\$75	\$50
ENT - Tonsillectomy & Adenoidectomy	\$150	\$75	\$50
Gallbladder removal (laparoscopic)	\$150	\$75	\$50
Hammertoe Repair	\$150	\$75	\$50
Hernia Repair	\$150	\$75	\$50
Hip Replacement	\$500	\$250	N/A
Hysterectomy	\$500	\$250	N/A
Hysteroscopy (uteroscopy)	\$150	\$75	\$50
Kidney Stone Fragmentation (Lithotripsy)	\$150	\$75	\$50
Knee Replacement	\$500	\$250	N/A
Knee surgery (arthroscopic)	\$150	\$75	\$50
Liver Biopsy	\$150	\$75	\$50
Low Back Surgery	\$150	\$75	\$50
Mammogram	\$50	\$25	N/A
MRI	\$150	\$75	\$50
Oophorectomy (Removal of Ovaries)/Tubal ligation	\$150	\$75	\$50
Removal of Prostate Gland and Surrounding Tissue	\$500	\$250	N/A
Shoulder surgery (arthroscopic)	\$150	\$75	\$50
Sleep Study	\$100	N/A	N/A
Spinal Fusion (Anterior)	\$500	\$250	N/A
Spinal Fusion (Posterior)	\$500	\$250	N/A
Ultrasound	\$50	\$25	N/A
Upper GI endoscopy	\$150	\$75	\$50
Urethra and bladder scope	\$150	\$75	\$50
X Ray	\$25	N/A	N/A



Embrace better health.®

Visit us anytime at AvMed.VitalsSmartShopper.com or call 1-855-869-2133
Monday-Thursday from 8:30 am-8 pm or Friday from 8:30 am-5 pm.

WELLNESS PROGRAMS

PERSONAL
HEALTH ASSESSMENT

HEALTHDAY TV

MEDICATION DATABASE

INTERACTION DATABASE

HEALTH BLOG

HEALTH CHECK-IN

GAPS IN CARE

ONLINE CLASSES

HEALTH EDUCATION
RESOURCES

PUBLICATIONS

CARE MANAGEMENT



WELLNESSWORKS
MIAMI-DADE COUNTY

Wellness Works is what we call our Wellness Program, especially designed for Miami-Dade County Members. More than just a program, it is a way of life that inspires our Members to be as healthy and happy as they can be by providing resources on nutrition, fitness, spiritual and emotional well-being to help them lead a truly balanced life.

INCENTIVES & REWARDS



MOTIVATION & SUPPORT



Stay Connected

Helpful Online Tools - Visit www.AvMed.org/MDC any time you want to:

- Learn About Your Health
- Find a Doctor
- Choose a Hospital
- Learn What Treatments Cost
- Review Your Benefits
- Check Your Claims History
- Look Up the Medication List
- Print a Temporary ID Card

Need More Information?

Get It Online at www.AvMed.org/MDC

Whether you need to know your copayment, review your claims, need to find a doctor, or want more information about your benefits, visit www.AvMed.org/MDC, or call the Miami-Dade County Dedicated Member Engagement Center, Live 24/7 at **1-800-682-8633**.

Your Coverage

Is Your Family Covered by More Than One Health Plan?

If this is the case, it is important for AvMed to have this information prior to processing a claim. It helps us determine who is the primary health plan for your dependents and how much each health plan should pay. This process, called Coordination of Benefits (COB), is based on national industry guidelines.

During the plan year, we may mail you a COB questionnaire. Please make sure you respond so that we are able to process your claims correctly.

THE POWER OF ONE



“Healthy” is not one and done. It’s a journey.

Wherever you find yourself on the health continuum — taking a walk in the neighborhood or signing up for a marathon — choosing the stairs over the elevator or the carrot instead of the cookie — it’s about taking that next step, that one step to creating *YOU, improved*.

The journey to a healthy lifestyle begins with ONE step. Change starts with ONE decision.

Get started with ONE program. Get on the road to *YOU, improved*.

Everyone enrolled in a MDC health plan can take that one step with Wellness Works. With AvMed, you get the help you need to make healthier lifestyle choices—choices that can keep you feeling good and reduce your overall healthcare costs. These tools and services can be found on the online Wellness Portal and include:

- **AvMed’s Personal Health Assessment to help identify potential health risks and set improvement goals. This feature also connects you to program components such as:**
 - Biometric screening results and a customized action plan
 - E-courses, tips, and tools
 - Quarterly challenges and incentives
 - Activity trackers
- **Onsite Health Coaches, Nutritionist, and Prenatal Advisor offer:**
 - One-on-one coaching
 - Stress reduction techniques
 - Nutrition counseling
 - Weight management
 - Tobacco cessation
 - Onsite seminars, events, and activities
- **Telephonic chronic condition and Disease Management Programs for Asthma, Coronary Artery Disease, Diabetes, Chronic Obstructive Pulmonary Disease (COPD), and Congestive Heart Failure**
- **Discounts on fitness center membership**
- **Reduced fees for alternative medicine services such as massage therapy and acupuncture**
- **Newsletters, educational information and online courses on health, and prevention topics for all areas of life**
- **Prescriptions for Healthy Living, which may reduce your cost for certain diabetes medications**
- **Onsite annual flu shots and wellness fairs throughout the year**
- **Weight Watchers® reimbursement to encourage healthier living**

Learn more about MDC Wellness Works and how you can earn incentives by visiting www.AvMed.org/MDC/WellnessWorks beginning **ONE/ONE (1/1/17)**.

WHEN IS IT AN **EMERGENCY**?

Urgent Care, Emergency Care...which one, when?

Accidents happen. Understanding what choices you have and creating a personal emergency care plan are the keys to getting the most appropriate treatment, in the best setting, with the least hassle. Knowing when to go to an urgent care center or an emergency room can save you time, money and stress.

LEVEL 1 - SELF CARE	<i>Use a home remedy or first-aid kit, or get help from family members. Examples: bee sting; minor cut; upset stomach; head cold</i>
LEVEL 2 - DOCTOR	<i>Have your doctor's phone numbers on hand. Examples: fever; non-life-threatening illnesses; vomiting; skin rash; diarrhea; dehydration</i>
LEVEL 3 - URGENT CARE CENTER	<i>Know where they are located, in case your doctor is unavailable. Examples: ear infection; bronchitis; allergic reaction; sprain or suspected fracture; general wound care</i>
LEVEL 4 - EMERGENCY ROOM	<i>Know how to get there fast. Examples: reasonable belief that your condition is life-threatening; sudden, sharp abdominal pain; uncontrolled bleeding; complicated fracture</i>
LEVEL 5 - AMBULANCE	Call 911. Examples: chest pain; difficulty breathing; suspected heart attack or stroke; extended loss of consciousness

To find a listing of Urgent Care Centers look in your AvMed Provider Directory, call the MDC Dedicated Member Engagement Center or visit AvMed's website at www.AvMed.org/MDC.

Important numbers

- MDC Dedicated Member Engagement Center, Live 24/7 at 1-800-682-8633.
- TTY assistance is available: (TTY 711)
In Miami 1-305-671-4948
All other areas 1-877-442-8633
- AvMed's Nurse On Call: 1-888-866-5432
24 hours a day, 7 days a week

JANUARY 2017

Benefit Summary

Miami-Dade County Select HMO

Miami-Dade County

Dedicated Member Engagement Center, Live 24/7:

1-800-682-8633

www.AvMed.org/MDC





This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.avmed.org/mdc or by calling 1-800-682-8633.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the chart starting on page 2 for other costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$2,500 individual/ \$5,000 dependent coverage.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, prescription drug brand additional charges, and services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See www.avmed.org/mdc or call 1-800-682-8633 for a list of participating providers. Participants must use MDC Select Network Providers and must reside in Miami-Dade, Broward, or Palm Beach County.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u> ?	No. You do not need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

Questions: Call 1-800-682-8633 or visit us at www.avmed.org/mdc. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.ccio.cms.gov or call 1-800-682-8633 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Select network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a MDC Select Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$15 copay/visit	Not Covered	Additional charges may apply for non-preventive services performed in the physician's office.
	Specialist visit	\$30 copay/visit	Not Covered	Additional charges may apply for non-preventive services performed in the physician's office.
	Other practitioner office visit	\$15 copay/visit for chiropractic services; \$15 copay/visit for podiatry services; \$15 copay/visit for allergy injections; \$30 copay/visit for allergy skin testing; \$30 copay/visit for infertility treatment	Not Covered	Infertility coverage is limited to diagnostic testing and procedures performed specifically to determine the cause of infertility. Infertility treatment limited to one sequence per participant lifetime for the following: sperm count, endometrial biopsy, hysterosalpingography (HSG), and diagnostic laparoscopy. Artificial insemination, In-vitro fertilizations, GIFT, ZIFT, and other infertility treatments not covered.
	Preventive care/screening/immunization	No Charge	Not Covered	-----None-----
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Charges for office visits may also apply if services are performed in a physician's office.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Charges for office visits may also apply if services are performed in a physician's office. Certain services require prior authorization.

Common Medical Event	Services You May Need	Your Cost If You Use a MDC Select Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.avmed.org/mdc	Generic drugs	\$15 copay/prescription (retail); \$30 copay/prescription (mail order)	Not Covered	Retail copay applies per 30-day supply. 60-90 day supply via mail order. Certain drugs may require prior authorization.
	Preferred brand drugs	\$25 copay/prescription (retail); \$50 copay/prescription (mail order)	Not Covered	Brand additional charges may apply. Certain drugs may require prior authorization.
	Non-preferred brand drugs	\$35 copay/prescription (retail); \$70 copay/prescription (mail order)	Not Covered	Brand additional charges may apply. Certain drugs may require prior authorization.
	Specialty drugs	Copays for Generic, Preferred brand and Non-preferred brand drugs also apply to Specialty drugs	Not Covered	Not available via mail order. Brand additional charges may apply. Certain drugs may require prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Charges for office visits may also apply if services are performed in a physician's office. Prior authorization required.
	Physician/surgeon fees	No Charge	Not Covered	Charges for office visits may also apply if services are performed in a physician's office. Prior authorization required.
If you need immediate medical attention	Emergency room services	\$50 copay/visit (waived if admitted)	Same as In-Network	AvMed must be notified within 24 hours of emergency admission or as soon as reasonably possible.
	Emergency medical transportation	No Charge	Same as In-Network	When pre-authorized, or in the case of emergency.
	Urgent care	\$25 copay/visit at urgent care facility; \$15 copay/visit at retail clinic	Same as In-Network	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Prior authorization required.
	Physician/surgeon fee	No Charge	Not Covered	Prior authorization required.

Common Medical Event	Services You May Need	Your Cost If You Use a MDC Select Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$15 copay/visit	Not Covered	Includes applied behavior analysis for treatment of Autism Spectrum Disorder.
	Mental/Behavioral health inpatient services	No Charge	Not Covered	Prior authorization required.
	Substance use disorder outpatient services	\$15 copay/visit	Not Covered	-----None-----
	Substance use disorder inpatient services	No Charge	Not Covered	Prior authorization required.
If you are pregnant	Prenatal and postnatal care	\$30 copay/1 st visit only	Not Covered	Subsequent visits at no charge.
	Delivery and all inpatient services	No Charge	Not Covered	Prior authorization required.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Approved treatment plan required.
	Rehabilitation services	\$30 copay/visit for physical, occupational, speech & respiratory therapies; \$30 copay/visit for cardiac rehab	Not Covered	Limited to 60 visits per calendar year for rehabilitative, physical, occupational, speech & respiratory therapies combined; 36 visits per calendar year for cardiac rehab.
	Habilitation services	\$15 copay/visit for physical, occupational & speech therapy to treat Autism Spectrum Disorder and Down syndrome	Not Covered	Habilitative physical, occupational, & speech therapy services, when provided for the treatment of Autism Spectrum Disorder and Down syndrome, are covered to a combined maximum of 100 visits per calendar year.
	Skilled nursing care	No Charge	Not Covered	Limited to 60 days per calendar year. Prior authorization required.
	Durable medical equipment	\$50 copay/episode of illness for DME or orthotic appliances; No charge/device for prosthetic devices	Not Covered	Some limitations apply. Please see your Summary Plan Description for details.
	Hospice service	No Charge	Not Covered	Limited to 360 day per participant lifetime maximum. Physician certification required.



MDC Select HMO

Coverage Period: 01/01/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: All Coverage Tiers | Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost If You Use a MDC Select Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	\$15 copay/visit	Not Covered	Limited to 1 exam per year to determine the need for sight correction.
	Glasses	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.
	Dental check-up	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)	
<ul style="list-style-type: none">AcupunctureChild Dental Check UpChild GlassesCosmetic surgery	<ul style="list-style-type: none">Private duty nursingRoutine eye care (Adult)Routine foot careWeight loss programs
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)	
<ul style="list-style-type: none">Bariatric surgery services (limited to JHS Centers of Excellence)	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-682-8633. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccoio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact AvMed's Member Services Department at 1-800-682-8633.

For plans subject to ERISA, you may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccoio.cms.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Para obtener asistencia en Español, llame al 1-800-682-8633.

_____To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

■ **Amount owed to providers:** \$7,540
 ■ **Plan pays** \$7,470
 ■ **Patient pays** \$70
Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540
Patient pays:	
Deductibles	\$0
Copays	\$70
Coinsurance	\$0
Limits or exclusions	\$0
Total	\$70

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

■ **Amount owed to providers:** \$5,400
 ■ **Plan pays** \$4,080
 ■ **Patient pays** \$1,320
Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400
Patient pays:	
Deductibles	\$0
Copays	\$1,280
Coinsurance	\$0
Limits or exclusions	\$40
Total	\$1,320

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.



Lined area for taking notes, consisting of multiple horizontal lines.

JANUARY 2017

Benefit Summary

Miami-Dade County Jackson First HMO

Miami-Dade County

Dedicated Member Engagement Center, Live 24/7:

1-800-682-8633

www.AvMed.org/MDC





This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.avmed.org/mdc or by calling 1-800-682-8633.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the chart starting on page 2 for other costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$2,500 individual/ \$5,000 dependent coverage.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, prescription drug brand additional charges, and services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See www.avmed.org/mdc or call 1-800-682-8633 for a list of participating providers. Participants must use Jackson First Network Providers and must reside in Miami-Dade, Broward, or Palm Beach County.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u> ?	No. You do not need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

Questions: Call 1-800-682-8633 or visit us at www.avmed.org/mdc. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.ccio.cms.gov or call 1-800-682-8633 to request a copy.

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Select network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Jackson First Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 copay/visit	Not Covered	Additional charges may apply for non-preventive services performed in the physician's office.
	Specialist visit	\$30 copay/visit	Not Covered	Additional charges may apply for non-preventive services performed in the physician's office.
	Other practitioner office visit	\$15 copay/visit for chiropractic services; \$15 copay/visit for podiatry services; \$15 copay/visit for allergy injections; \$30 copay/visit for allergy skin testing; \$30 copay/visit for infertility treatment	Not Covered	Infertility coverage is limited to diagnostic testing and procedures performed specifically to determine the cause of infertility. Infertility treatment limited to one sequence per participant lifetime for the following: sperm count, endometrial biopsy, hysterosalpingography (HSG), and diagnostic laparoscopy. Artificial insemination, In-vitro fertilizations, GIFT, ZIFT, and other infertility treatments not covered.
	Preventive care/screening/immunization	No Charge	Not Covered	-----None-----
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Charges for office visits may also apply if services are performed in a physician's office.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Charges for office visits may also apply if services are performed in a physician's office. Certain services require prior authorization.

Common Medical Event	Services You May Need	Your Cost If You Use a Jackson First Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.avmed.org/mdc	Generic drugs	\$15 copay/prescription (retail); \$30 copay/prescription (mail order)	Not Covered	Retail copay applies per 30-day supply. 60-90 day supply via mail order. Certain drugs may require prior authorization.
	Preferred brand drugs	\$25 copay/prescription (retail); \$50 copay/prescription (mail order)	Not Covered	Brand additional charges may apply. Certain drugs may require prior authorization.
	Non-preferred brand drugs	\$35 copay/prescription (retail); \$70 copay/prescription (mail order)	Not Covered	Brand additional charges may apply. Certain drugs may require prior authorization.
	Specialty drugs	Copays for Generic, Preferred brand and Non-preferred brand drugs also apply to Specialty drugs	Not Covered	Not available via mail order. Brand additional charges may apply. Certain drugs may require prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Charges for office visits may also apply if services are performed in a physician's office. Prior authorization required.
	Physician/surgeon fees	No Charge	Not Covered	Charges for office visits may also apply if services are performed in a physician's office. Prior authorization required.
If you need immediate medical attention	Emergency room services	\$50 copay/visit (waived if admitted)	Same as In-Network	AvMed must be notified within 24 hours of emergency admission or as soon as reasonably possible.
	Emergency medical transportation	No Charge	Same as In-Network	When pre-authorized, or in the case of emergency.
	Urgent care	\$25 copay/visit at urgent care facility; \$15 copay/visit at retail clinic	Same as In-Network	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Prior authorization required.
	Physician/surgeon fee	No Charge	Not Covered	Prior authorization required.

Common Medical Event	Services You May Need	Your Cost If You Use a Jackson First Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$15 copay/visit	Not Covered	Includes applied behavior analysis for treatment of Autism Spectrum Disorder.
	Mental/Behavioral health inpatient services	No Charge	Not Covered	Prior authorization required.
	Substance use disorder outpatient services	\$15 copay/visit	Not Covered	-----None-----
	Substance use disorder inpatient services	No Charge	Not Covered	Prior authorization required.
If you are pregnant	Prenatal and postnatal care	\$30 copay/1 st visit only	Not Covered	Subsequent visits at no charge.
	Delivery and all inpatient services	No Charge	Not Covered	Prior authorization required.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Approved treatment plan required.
	Rehabilitation services	\$30 copay/visit for physical, occupational, speech & respiratory therapies; \$30 copay/visit for cardiac rehab	Not Covered	Limited to 60 visits per calendar year for rehabilitative, physical, occupational, speech & respiratory therapies combined; 36 visits per calendar year for cardiac rehab.
	Habilitation services	\$15 copay/visit for physical, occupational & speech therapy to treat Autism Spectrum Disorder and Down syndrome	Not Covered	Habilitative physical, occupational, & speech therapy services, when provided for the treatment of Autism Spectrum Disorder and Down syndrome, are covered to a combined maximum of 100 visits per calendar year.
	Skilled nursing care	No Charge	Not Covered	Limited to 60 days per calendar year. Prior authorization required.
	Durable medical equipment	\$50 copay/episode of illness for DME or orthotic appliances; no charge/device for prosthetic devices	Not Covered	Some limitations apply. Please see your Summary Plan Description for details.
	Hospice service	No Charge	Not Covered	Limited to 360 day per participant lifetime maximum. Physician certification required.



MDC Jackson First HMO

Coverage Period: 01/01/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: All Coverage Tiers | Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost If You Use a Jackson First Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	\$15 copay/visit	Not Covered	Limited to 1 exam per year to determine the need for sight correction.
	Glasses	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.
	Dental check-up	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)	
<ul style="list-style-type: none">AcupunctureChild Dental Check UpChild GlassesCosmetic surgery	<ul style="list-style-type: none">Dental care (Adult)Hearing aidsLong-term careNon-emergency care when traveling outside the U.S.Private duty nursingRoutine eye care (Adult)Routine foot careWeight loss programs
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)	
<ul style="list-style-type: none">Bariatric surgery services (limited to JHS Centers of Excellence)	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-682-8633. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccoio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact AvMed's Member Services Department at 1-800-682-8633.

For plans subject to ERISA, you may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccoio.cms.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Para obtener asistencia en Español, llame al 1-800-682-8633.

_____To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is
not a cost
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

■ **Amount owed to providers:** \$7,540
■ **Plan pays** \$7,470
■ **Patient pays** \$70
Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540
Patient pays:	
Deductibles	\$0
Copays	\$70
Coinsurance	\$0
Limits or exclusions	\$0
Total	\$70

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

■ **Amount owed to providers:** \$5,400
■ **Plan pays** \$4,080
■ **Patient pays** \$1,320
Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400
Patient pays:	
Deductibles	\$0
Copays	\$1,280
Coinsurance	\$0
Limits or exclusions	\$40
Total	\$1,320

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Can I use Coverage Examples to compare plans?

- ✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Does the Coverage Example predict my own care needs?

- ✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

JANUARY 2017

Benefit Summary

Miami-Dade County Redesign High HMO

Miami-Dade County

Dedicated Member Engagement Center, Live 24/7:

1-800-682-8633

www.AvMed.org/MDC





This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.avmed.org/mdc or by calling 1-800-682-8633.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the chart starting on page 2 for other costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$3,000 individual/ \$6,000 dependent coverage	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, prescription drug brand additional charges, and services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See www.avmed.org/mdc or call 1-800-682-8633 for a list of participating providers. Participants must use the Elite Network Providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u> ?	No. You do not need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

Questions: Call 1-800-682-8633 or visit us at www.avmed.org/mdc. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.ccio.cms.gov or call 1-800-682-8633 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use AvMed network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an AvMed Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 copay/visit	Not Covered	Additional charges may apply for non-preventive services performed in the physician's office.
	Specialist visit	\$30 copay/visit	Not Covered	Additional charges may apply for non-preventive services performed in the physician's office.
	Other practitioner office visit	\$15 copay/visit for chiropractic services; \$15 copay/visit for podiatry services; \$15 copay/visit for allergy injections; \$30 copay/visit for allergy treatment and skin testing; \$30 copay/visit for infertility treatment	Not Covered	Infertility coverage is limited to diagnostic testing and procedures performed specifically to determine the cause of infertility. Infertility treatment is limited to one sequence per participant lifetime for the following: sperm count, endometrial biopsy, hysterosalpingography (HSG), and diagnostic laparoscopy. Artificial insemination, In-vitro fertilizations, GIFT, ZIFT, and other infertility treatments are not covered.
If you have a test	Preventive care/screening/immunization	No Charge	Not Covered	-----None-----
	Diagnostic test (x-ray, blood work)	\$100 copay/test at hospital based facility; No charge at Jackson Health System or independent/non-hospital based facility; No charge for blood work at capitated lab	Not Covered	Charges for office visits may also apply if services are performed in a physician's office.

Common Medical Event	Services You May Need	Your Cost If You Use an AvMed Network Provider		Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.avmed.org/mdc	Imaging (CT/PET scans, MRIs)	\$100 copay/test at hospital based facility; No charge at Jackson Health System or independent/ non-hospital based facility		Not Covered	Charges for office visits may also apply if services are performed in a physician's office. Certain services may require prior authorization.
	Generic drugs	\$15 copay/prescription (retail); \$30 copay/prescription (mail order)		Not Covered	Retail copay applies per 30-day supply. 60-90 day supply via mail order. Certain drugs may require prior authorization.
	Preferred brand drugs	\$40 copay/prescription (retail); \$80 copay/prescription (mail order)		Not Covered	Brand additional charges may apply. Certain drugs may require prior authorization.
	Non-preferred brand drugs	\$55 copay/prescription (retail); \$110 copay/prescription (mail order)		Not Covered	Brand additional charges may apply. Certain drugs may require prior authorization.
	Specialty drugs	\$100 copay/prescription (retail)		Not Covered	Not available via mail order. Brand additional charges may apply. Certain drugs may require prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 copay/visit at hospital based facility; No charge at Jackson Health System or independent/ non-hospital based facility		Not Covered	Charges for office visits may also apply if services are performed in a physician's office. Prior authorization required.
	Physician/surgeon fees	No Charge		Not Covered	Charges for office visits may also apply if services are performed in a physician's office. Prior authorization required.
If you need immediate medical attention	Emergency room services	\$100 copay/visit; waived if admitted		Same as In-Network	AvMed must be notified within 24 hours of emergency admission or as soon as reasonably possible.
	Emergency medical transportation	No Charge		Same as In-Network	When pre-authorized, or in the case of emergency.
	Urgent care	\$25 copay/visit at urgent care facility; \$15 copay/visit at retail clinic		Same as In-Network	-----None-----

Common Medical Event	Services You May Need	Your Cost If You Use an AvMed Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 copay/admission; No charge at Jackson Health System	Not Covered	Prior authorization required.
	Physician/surgeon fee	No Charge	Not Covered	Prior authorization required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$15 copay/visit	Not Covered	Includes applied behavior analysis for treatment of Autism Spectrum Disorder.
	Mental/Behavioral health inpatient services	\$200 copay/admission; No charge at Jackson Health System	Not Covered	Prior authorization required.
	Substance use disorder outpatient services	\$15 copay/visit	Not Covered	-----None-----
	Substance use disorder inpatient services	\$200 copay/admission; No charge at Jackson Health System	Not Covered	Prior authorization required.
If you are pregnant	Prenatal and postnatal care	\$30 copay/1 st visit only	Not Covered	Subsequent visits at no charge.
	Delivery and all inpatient services	\$200 copay/admission; No charge at Jackson Health System	Not Covered	Prior authorization required.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Approved treatment plan required.
	Rehabilitation services	\$30 copay/visit for physical, occupational, speech & respiratory therapies; \$30 copay/visit for cardiac rehab	Not Covered	Limited to 60 visits per calendar year for rehabilitative physical, occupational, speech & respiratory therapies combined; 36 visits per calendar year for cardiac rehab.
	Habilitation services	\$15 copay/visit for physical, occupational & speech therapy to treat Autism Spectrum Disorder and Down syndrome	Not Covered	Habilitative physical, occupational, & speech therapy services, when provided for the treatment of Autism Spectrum Disorder and Down syndrome, are covered to a combined maximum of 100 visits per calendar year.

Common Medical Event	Services You May Need	Your Cost If You Use an AvMed Network Provider		Your Cost If You Use an Out of Network Provider		Limitations & Exceptions
If your child needs dental or eye care	Skilled nursing care	No Charge		Not Covered		Limited to 60 days per calendar year. Prior authorization required.
	Durable medical equipment	\$50 copay/episode of illness for DME or orthotic appliances; No charge/device for prosthetic devices		Not Covered		Some limitations apply. Please see your Summary Plan Description for details.
	Hospice service	No Charge		Not Covered		Limited to 360 day per participant lifetime maximum. Physician certification required.
	Eye exam	\$15 copay/visit		Not Covered		Limited to 1 exam per year to determine the need for sight correction.
	Glasses	Not Covered		Not Covered		Not covered under this medical and pharmacy benefits plan.
	Dental check-up	Not Covered		Not Covered		Not covered under this medical and pharmacy benefits plan.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)	
<ul style="list-style-type: none"> Acupuncture Child Dental Check Up Child Glasses Cosmetic surgery 	<ul style="list-style-type: none"> Private duty nursing Routine eye care (Adult) Routine foot care Weight loss programs
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)	
<ul style="list-style-type: none"> Bariatric surgery services (limited to JHS Centers of Excellence) 	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-682-8633. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact AvMed's Member Services Department at 1-800-682-8633.

For plans subject to ERISA, you may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en Español, llame al 1-800-682-8633.

_____To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is
not a cost
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers: \$7,540**
- **Plan pays \$7,470**
- **Patient pays \$70**

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

deductibles	\$0
Copays	\$70
Coinurance	\$0
Limits or exclusions	\$0
Total	\$70

Managing type 2 diabetes

(routine maintenance of
a well-controlled condition)

- **Amount owed to providers: \$5,400**
- **Plan pays \$4,080**
- **Patient pays \$1,320**

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

deductibles	\$0
Copays	\$1,280
Coinurance	\$0
Limits or exclusions	\$40
Total	\$1,320

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Can I use Coverage Examples to compare plans?

- ✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Does the Coverage Example predict my own care needs?

- ✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

JANUARY 2017

Benefit Summary

Miami-Dade County Redesign POS

Miami-Dade County

Dedicated Member Engagement Center, Live 24/7:

1-800-682-8633

www.AvMed.org/MDC





This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.avmed.org/mdc or by calling 1-800-682-8633.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Out-of Network: \$200 individual/ \$500 dependent coverage Applies to Out-of-Network services only.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	Yes. \$200 individual for external Prosthetics (see DME benefits). Doesn't apply to overall deductible. There are no other specific <u>deductibles</u> . Yes. In-Network: \$3,000 individual/ \$6,000 dependent coverage Out-of Network: \$3,000 individual/ \$6,000 dependent coverage	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Premiums, prescription drug brand additional charges, out-of-network balance-billed charges, and services this plan doesn't cover. No.	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?		Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?		The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See www.avmed.org/mdc or call 1-800-682-8633 for a list of participating providers. Participants must use the Elite Network Providers.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. You do not need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <u>excluded services</u> .

Questions: Call 1-800-682-8633 or visit us at www.avmed.org/mdc. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.ccio.cms.gov or call 1-800-682-8633 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use AvMed network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an AvMed Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 copay/visit	30% coinsurance after deductible	Additional charges may apply for non-preventive services performed in the physician's office.
	Specialist visit	\$30 copay/visit	30% coinsurance after deductible	Additional charges may apply for non-preventive services performed in the physician's office.
	Other practitioner office visit	\$15 copay/visit for chiropractic services; \$15 copay/visit for podiatry services; \$30 copay/visit for allergy treatment and skin testing; No additional charge for allergy injections; \$30 copay/visit for infertility treatment	30% coinsurance after deductible for chiropractic services infertility treatment, and acupuncture; 30% coinsurance after deductible for allergy treatment, including allergy injections, skin testing, and allergy serum	Coverage for infertility treatment is limited to testing and treatment for services performed in conjunction with an underlying medical condition, testing performed exclusively to determine the cause of infertility, and treatment and/or procedures exclusively to restore fertility (e.g. procedures to correct infertility condition). Artificial insemination, In-vitro fertilizations, GIFT, ZIFT, and other infertility treatments are not covered. Chiropractic services, combined with pulmonary rehabilitation, physical, speech, occupational, cognitive, and respiratory therapies, are limited to 60 days per plan year.
	Preventive care/screening/immunization	No Charge	30% coinsurance after deductible	-----None-----

Common Medical Event	Services You May Need	Your Cost If You Use an AvMed Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	\$100 copay/test at hospital based facility; No charge at Jackson Health System or at independent/non-hospital based facility; No charge for blood work at In-Network lab	30% coinsurance after deductible	Charges for office visits may also apply if services are performed in a physician's office.
	Imaging (CT/PET scans, MRIs)	\$100 copay/test at hospital based facility; No charge at Jackson Health System or at independent/non-hospital based facility	30% coinsurance after deductible	Charges for office visits may also apply if services are performed in a physician's office. Certain services require prior authorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.avmed.org/mdc	Generic drugs	\$15 copay/prescription (retail); \$30 copay/prescription (mail order)	30% coinsurance, not subject to deductible	Retail copay applies per 30-day supply. 60-90 day supply via mail order. Certain drugs may require prior authorization.
	Preferred brand drugs	\$40 copay/prescription (retail); \$80 copay/prescription (mail order)	30% coinsurance, not subject to deductible	Certain drugs may require prior authorization.
	Non-preferred brand drugs	\$55 copay/prescription (retail); \$110 copay/prescription (mail order)	30% coinsurance, not subject to deductible	Certain drugs may require prior authorization.
	Specialty drugs	\$100 copay/prescription (retail)	30% coinsurance, not subject to deductible	Not available via mail order. Certain drugs may require prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 copay/visit at hospital based facility; No charge at Jackson Health System or at independent/non-hospital based facility	30% coinsurance after deductible	Charges for office visits may also apply if services are performed in a physician's office. Prior authorization required.
	Physician/surgeon fees	No charge, except \$200 surgical copay applies for infertility surgery	30% coinsurance after deductible	Charges for office visits may also apply if services are performed in a physician's office. Prior authorization required.

Common Medical Event	Services You May Need	Your Cost If You Use an AvMed Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	\$100 copay/visit (waived if admitted)	Same as In-Network	AvMed must be notified within 24 hours of emergency admission or as soon as reasonably possible.
	Emergency medical transportation	No Charge	Same as In-Network	When pre-authorized, or in the case of emergency.
	Urgent care	\$50 copay/visit at urgent care facility; \$15 copay/visit at retail clinic	Same as In-Network	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 copay/admission; No charge at Jackson Health System	30% coinsurance after deductible	Prior authorization required.
	Physician/surgeon fee	No charge, except \$200 surgical copay applies for infertility surgery	30% coinsurance after deductible	Prior authorization required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$15 copay/visit	30% coinsurance after deductible	Includes applied behavior analysis for treatment of Autism Spectrum Disorder.
	Mental/Behavioral health inpatient services	\$200 copay/admission; No charge at Jackson Health System	30% coinsurance after deductible	Prior authorization required.
	Substance use disorder outpatient services	\$15 copay/visit	30% coinsurance after deductible	-----None-----
	Substance use disorder inpatient services	\$200 copay/admission; No charge at Jackson Health System	30% coinsurance after deductible	Prior authorization required.
If you are pregnant	Prenatal and postnatal care	\$30 copay/1 st visit only	30% coinsurance after deductible	Subsequent visits at no charge when performed in AvMed network.
	Delivery and all inpatient services	\$200 copay/admission; No charge at Jackson Health System	30% coinsurance after deductible	Prior authorization required.

Common Medical Event	Services You May Need	Your Cost If You Use an AvMed Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	30% coinsurance after deductible	Approved treatment plan required. Out-of-Network home health care limited to 60 skilled visits maximum per plan year.
	Rehabilitation services	\$30 copay/visit for pulmonary rehabilitation, physical, occupational, speech, cognitive, & respiratory therapies; \$30 copay/visit for cardiac rehab	30% coinsurance after deductible	Limited to 60 visits per calendar year for chiropractic services, rehabilitative pulmonary, physical, speech, occupational, cognitive, and respiratory therapies combined; 36 visits per calendar year for cardiac rehab.
	Habilitation services	\$15 copay/visit for physical, occupational & speech therapy to treat Autism Spectrum Disorder and Down syndrome	30% coinsurance after deductible	Habilitative physical, occupational, & speech therapy services, when provided for the treatment of Autism Spectrum Disorder and Down syndrome, are covered to a combined maximum of 100 visits per calendar year.
	Skilled nursing care	No Charge	30% coinsurance after deductible	Limited to 60 days per calendar year. Prior authorization required.
	Durable medical equipment	No charge/device for DME and orthotics; No charge for external prosthetic appliance, after \$200 plan year deductible	30% coinsurance after deductible for DME and orthotics	Some limitations apply. Please see your Summary Plan Description for details. External prosthetic appliances are not covered Out-of-Network.
	Hospice service	No Charge	30% coinsurance after deductible	Limited to 360 day per Participant lifetime maximum. Physician certification required.
If your child needs dental or eye care	Eye exam	\$15 copay/visit	30% coinsurance after deductible	Limited to 1 exam per year to determine the need for sight correction.
	Glasses	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.
	Dental check-up	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.



MDC POS Option Redesign

Coverage Period: 01/01/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: All Coverage Tiers | Plan Type: POS

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- | | | |
|--|---|---|
| <ul style="list-style-type: none">• Child Dental Check Up• Child Glasses• Cosmetic surgery• Dental care (Adult) | <ul style="list-style-type: none">• Hearing aids• Long-term care• Non-emergency care when traveling outside the U.S.• Private duty nursing | <ul style="list-style-type: none">• Routine eye care (Adult)• Routine foot care• Weight loss programs |
|--|---|---|

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (limited to out-of-network)
- Bariatric surgery (for morbid obesity)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-682-8633. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

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The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

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The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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_____*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



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not a cost
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$7,470
- **Patient pays** \$70

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

deductibles	\$0
Copays	\$70
Coinsurance	\$0
Limits or exclusions	\$0
Total	\$70

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$4,130
- **Patient pays** \$1,270

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

deductibles	\$0
Copays	\$1,230
Coinsurance	\$0
Limits or exclusions	\$40
Total	\$1,270

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Can I use Coverage Examples to compare plans?

- ✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Does the Coverage Example predict my own care needs?

- ✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

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JANUARY 2017

Benefit Summary

Miami-Dade County No Redesign High HMO

Miami-Dade County

Dedicated Member Engagement Center, Live 24/7:

1-800-682-8633

www.AvMed.org/MDC





This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.avmed.org/mdc or by calling 1-800-682-8633.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the chart starting on page 2 for other costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. Medical: \$1,500 individual/ \$3,000 dependent coverage (does not include prescription drug cost-sharing); Prescription Drugs: \$1,500 individual/ \$3,000 dependent coverage (does not include medical cost-sharing)	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, prescription drug brand additional charges, and services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See www.avmed.org/mdc or call 1-800-682-8633 for a list of participating providers. Participants must use the Elite Network Providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u> ?	No. You do not need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

Questions: Call 1-800-682-8633 or visit us at www.avmed.org/mdc. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.ccio.cms.gov or call 1-800-682-8633 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use AvMed network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an AvMed Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 copay/visit	Not Covered	Additional charges may apply for non-preventive services performed in the physician's office.
	Specialist visit	\$30 copay/visit	Not Covered	Additional charges may apply for non-preventive services performed in the physician's office.
	Other practitioner office visit	\$15 copay/visit for chiropractic services; \$15 copay/visit for podiatry services; \$15 copay/visit for allergy injections; \$30 copay/visit for allergy treatment and skin testing; \$30 copay/visit for infertility treatment	Not Covered	Infertility coverage is limited to diagnostic testing and procedures performed specifically to determine the cause of infertility. Infertility treatment is limited to one sequence per participant lifetime for the following: sperm count, endometrial biopsy, hysterosalpingography (HSG), and diagnostic laparoscopy. Artificial insemination, In-vitro fertilizations, GIFT, ZIFT, and other infertility treatments are not covered.
If you have a test	Preventive care/screening/immunization	No Charge	Not Covered	-----None-----
	Diagnostic test (x-ray, lab work)	No Charge	Not Covered	Charges for office visits may also apply if services are performed in a physician's office.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Charges for office visits may also apply if services are performed in a physician's office. Certain services require prior authorization.



MDC High Option HMO

Coverage Period: 01/01/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: All Coverage Tiers | Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost If You Use an AvMed Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.avmed.org/mdc .	Generic drugs	\$15 copay/prescription (retail); \$30 copay/prescription (mail order)	Not Covered	Retail copay applies per 30-day supply. 60-90 day supply via mail order. Certain drugs may require prior authorization.
	Preferred brand drugs	\$25 copay/prescription (retail); \$50 copay/prescription (mail order)	Not Covered	Brand additional charges may apply. Certain drugs may require prior authorization.
	Non-preferred brand drugs	\$35 copay/prescription (retail); \$70 copay/prescription (mail order)	Not Covered	Brand additional charges may apply. Certain drugs may require prior authorization.
	Specialty drugs	Cost-sharing for Generic, Preferred brand and Non-preferred brand drugs also apply to Specialty drugs	Not Covered	Not available via mail order. Brand additional charges may apply. Certain drugs may require prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Charges for office visits may also apply if services are performed in a physician's office. Prior authorization required.
	Physician/surgeon fees	No Charge	Not Covered	Charges for office visits may also apply if services are performed in a physician's office. Prior authorization required.
If you need immediate medical attention	Emergency room services	\$25 copay/visit (waived if admitted)	Same as In-Network	AvMed must be notified within 24 hours of emergency admission or as soon as reasonably possible.
	Emergency medical transportation	No Charge	Same as In-Network	When pre-authorized, or in the case of emergency.
	Urgent care	\$25 copay/visit at urgent care facility; \$15 copay/visit at retail clinic	\$50 copay/visit at urgent care facility or retail clinic	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Prior authorization required.
	Physician/surgeon fee	No Charge	Not Covered	Prior authorization required.

Common Medical Event	Services You May Need	Your Cost If You Use an AvMed Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$15 copay/visit	Not Covered	Includes applied behavior analysis for treatment of Autism Spectrum Disorder.
	Mental/Behavioral health inpatient services	No Charge	Not Covered	Prior authorization required.
	Substance use disorder outpatient services	\$15 copay/visit	Not Covered	-----None-----
	Substance use disorder inpatient services	No Charge	Not Covered	Prior authorization required.
If you are pregnant	Prenatal and postnatal care	\$30 copay/1 st visit only	Not Covered	Subsequent visits at no charge.
	Delivery and all inpatient services	No Charge	Not Covered	Prior authorization required.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Approved treatment plan required.
	Rehabilitation services	\$30 copay/visit for physical, occupational, speech & respiratory therapies; \$30 copay/visit for cardiac rehab	Not Covered	Limited to 60 visits per calendar year for rehabilitative physical, occupational, speech & respiratory therapies combined; 36 visits per calendar year for cardiac rehab.
	Habilitation services	\$15 copay/visit for physical, occupational & speech therapy to treat Autism Spectrum Disorder and Down syndrome	Not Covered	Habilitative physical, occupational, & speech therapy services, when provided for the treatment of Autism Spectrum Disorder and Down syndrome, are covered to a combined maximum of 100 visits per calendar year.
	Skilled nursing care	No Charge	Not Covered	Limited to 60 days per calendar year. Prior authorization required.
	Durable medical equipment	\$50 copay/episode of illness for DME or orthotic appliances; No charge/device for prosthetic devices	Not Covered	Some limitations apply. Please see your Summary Plan Description for details.
	Hospice service	No Charge	Not Covered	Limited to 360 day per participant lifetime maximum. Physician certification required.

Common Medical Event	Services You May Need	Your Cost If You Use an AvMed Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	\$15 copay/visit	Not Covered	Limited to 1 exam per year to determine the need for sight correction.
	Glasses	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.
	Dental check-up	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)	
<ul style="list-style-type: none"> Acupuncture Child Dental Check Up Child Glasses Cosmetic surgery 	<ul style="list-style-type: none"> Dental care (Adult) Hearing aids Long-term care Non-emergency care when traveling outside the U.S. Private duty nursing Routine eye care (Adult) Routine foot care Weight loss programs
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)	
<ul style="list-style-type: none"> Bariatric surgery services (limited to JHS Centers of Excellence) 	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-682-8633. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact AvMed's Member Services Department at 1-800-682-8633.

For plans subject to ERISA, you may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en Español, llame al 1-800-682-8633.

_____To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is
not a cost
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers: \$7,540**
- **Plan pays \$7,470**
- **Patient pays \$70**

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

deductibles	\$0
Copays	\$70
Coinsurance	\$0
Limits or exclusions	\$0
Total	\$70

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers: \$5,400**
- **Plan pays \$4,080**
- **Patient pays \$1,320**

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

deductibles	\$0
Copays	\$1,280
Coinsurance	\$0
Limits or exclusions	\$40
Total	\$1,320

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.



Lined area for taking notes, consisting of multiple horizontal lines.

JANUARY 2017

Benefit Summary

Miami-Dade County No Redesign Low HMO

Miami-Dade County

Dedicated Member Engagement Center, Live 24/7:

1-800-682-8633

www.AvMed.org/MDC





This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.avmed.org/mdc or by calling 1-800-682-8633.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$0	See the chart starting on page 2 for other costs for services this plan covers.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$6,350 individual/ \$12,700 dependent coverage	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, prescription drug brand additional charges, and services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <u>specific</u> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See www.avmed.org/mdc or call 1-800-682-8633 for a list of participating providers. Participants must use the Elite Network Providers.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	Yes.	This plan will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have the plan's permission before you see the <u>specialist</u> .
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .

Questions: Call 1-800-682-8633 or visit us at www.avmed.org/mdc. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.ccio.cms.gov or call 1-800-682-8633 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use AvMed network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an AvMed Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 copay/visit	Not Covered	Additional charges may apply for non-preventive services performed in the physician's office.
	Specialist visit	\$45 copay/visit	Not Covered	Additional charges may apply for non-preventive services performed in the physician's office.
	Other practitioner office visit	\$30 copay/visit for chiropractic services; \$30 copay/visit for podiatry services; \$30 copay/visit for allergy injections; \$45 copay/visit for allergy treatment and skin testing; \$45 copay/visit for infertility treatment	Not Covered	Infertility coverage is limited to diagnostic testing and procedures performed specifically to determine the cause of infertility. Infertility treatment is limited to one sequence per participant lifetime for the following: sperm count, endometrial biopsy, hysterosalpingography (HSG), and diagnostic laparoscopy. Artificial insemination, In-vitro fertilizations, GIFT, ZIFT, and other infertility treatments are not covered.
	Preventive care/screening/immunization	No Charge	Not Covered	-----None-----
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Charges for office visits may also apply if services are performed in a physician's office.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Charges for office visits may also apply if services are performed in a physician's office. Certain services require prior authorization.



MDC Low Option HMO

Coverage Period: 01/01/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: All Coverage Tiers | Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost If You Use an AvMed Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.avmed.org/mdc .	Generic drugs	\$20 copay/prescription (retail); \$40 copay/prescription (mail order)	Not Covered	Retail copay applies per 30-day supply. 60-90 day supply via mail order. Certain drugs may require prior authorization.
	Preferred brand drugs	\$35 copay/prescription (retail); \$70 copay/prescription (mail order)	Not Covered	Brand additional charges may apply. Certain drugs may require prior authorization.
	Non-preferred brand drugs	\$55 copay/prescription (retail); \$110 copay/prescription (mail order)	Not Covered	Brand additional charges may apply. Certain drugs may require prior authorization.
	Specialty drugs	Cost-sharing for Generic, Preferred brand and Non-preferred brand drugs also apply to Specialty drugs	Not Covered	Brand additional charges may apply. Not available via mail order. Certain drugs may require prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Charges for office visits may also apply if services are performed in a physician's office. Prior authorization required.
	Physician/surgeon fees	No Charge	Not Covered	Charges for office visits may also apply if services are performed in a physician's office. Prior authorization required.
If you need immediate medical attention	Emergency room services	\$100 copay/visit (waived if admitted)	Same as In-Network	AvMed must be notified within 24 hours of emergency admission or as soon as reasonably possible.
	Emergency medical transportation	No Charge	Same as In-Network	When pre-authorized, or in the case of emergency.
	Urgent care	\$50 copay/visit at urgent care facility; \$30 copay/visit at retail clinic	\$50 copay/visit at urgent care facility or retail clinic	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$150/day for first 3 days, per admission	Not Covered	Prior authorization required.
	Physician/surgeon fee	No Charge	Not Covered	Prior authorization required.



MDC Low Option HMO

Coverage Period: 01/01/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: All Coverage Tiers | Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost If You Use an AvMed Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$30 copay/visit	Not Covered	Includes applied behavior analysis for treatment of Autism Spectrum Disorder.
	Mental/Behavioral health inpatient services	\$150/day for first 3 days, per admission	Not Covered	Prior authorization required.
	Substance use disorder outpatient services	\$30 copay/visit	Not Covered	-----None-----
	Substance use disorder inpatient services	\$150/day for first 3 days, per admission	Not Covered	Prior authorization required.
If you are pregnant	Prenatal and postnatal care	\$45 copay/1 st visit only	Not Covered	Subsequent visits at no charge.
	Delivery and all inpatient services	\$150/day for first 3 days, per admission	Not Covered	Prior authorization required.
	Home health care	No Charge	Not Covered	Approved treatment plan required.
If you need help recovering or have other special health needs	Rehabilitation services	\$45 copay/visit for physical, occupational, speech & respiratory therapies; \$45 copay/visit for cardiac rehab	Not Covered	Limited to 60 visits per calendar year for rehabilitative physical, occupational, speech & respiratory therapies combined; 36 visits per calendar year for cardiac rehab.
	Habilitation services	\$30 copay/visit for physical, occupational & speech therapy to treat Autism Spectrum Disorder and Down syndrome	Not Covered	Habilitative physical, occupational, & speech therapy services, when provided for the treatment of Autism Spectrum Disorder and Down syndrome, are covered to a combined maximum of 100 visits per calendar year.
	Skilled nursing care	No Charge	Not Covered	Limited to 60 days per calendar year. Prior authorization required.
	Durable medical equipment	\$50 copay/episode of illness for DME or orthotic appliances; No charge/device for prosthetic devices	Not Covered	Some limitations apply. Please see your Summary Plan Description for details.
	Hospice service	No Charge	Not Covered	Limited to 360 day per participant lifetime maximum. Physician certification required.

Common Medical Event	Services You May Need	Your Cost If You Use an AvMed Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	\$30 copay/visit	Not Covered	Limited to one exam per year to determine the need for sight correction.
	Glasses	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.
	Dental check-up	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)	
<ul style="list-style-type: none"> Acupuncture Child Dental Check Up Child Glasses Cosmetic surgery 	<ul style="list-style-type: none"> Dental care (Adult) Hearing aids Long-term care Non-emergency care when traveling outside the U.S. Private duty nursing Routine eye care (Adult) Routine foot care Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)	
<ul style="list-style-type: none"> Bariatric surgery services (limited to JHS Centers of Excellence) 	

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The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy **does provide** minimum essential coverage.

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The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage **does meet** the minimum value standard for the benefits it provides.

Language Access Services:

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_____To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



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estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,320
- Patient pays \$220

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

deductibles	\$0
Copays	\$220
Coinsurance	\$0
Limits or exclusions	\$0
Total	\$220

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,680
- Patient pays \$1,720

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

deductibles	\$0
Copays	\$1,680
Coinsurance	\$0
Limits or exclusions	\$40
Total	\$1,720

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Can I use Coverage Examples to compare plans?

- ✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Does the Coverage Example predict my own care needs?

- ✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

JANUARY 2017

Benefit Summary

Miami-Dade County No Redesign POS

Miami-Dade County

Dedicated Member Engagement Center, Live 24/7:

1-800-682-8633

www.AvMed.org/MDC





This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.avmed.org/mdc or by calling 1-800-682-8633.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Out-of-Network: \$200 individual/ \$500 dependent coverage Applies to Out-of-Network services only.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> for specific services?	Yes, \$200 individual for external Prosthetics (see DME benefits). Doesn't apply to overall deductible. There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes In-Network Medical: \$1,500 individual/ \$4,500 dependent coverage (does not include prescription drug cost-sharing); Out-of-Network Medical: \$1,500 per individual; Prescription Drugs: \$1,500 individual/ \$3,000 dependent coverage (does not include medical cost-sharing) Premiums, out-of-network prescription drug cost sharing, prescription drug brand additional charges, out-of-network balance-billed charges, and services this plan doesn't cover.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	No.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See www.avmed.org/mdc or call 1-800-682-8633 for a list of participating providers. Participants must use the Elite Network Providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u> ?	No. You do not need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

Questions: Call 1-800-682-8633 or visit us at www.avmed.org/mdc. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.ccio.cms.gov or call 1-800-682-8633 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use AvMed network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an AvMed Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 copay/visit	30% coinsurance after deductible	Additional charges may apply for non-preventive services performed in the physician's office.
	Specialist visit	\$30 copay/visit	30% coinsurance after deductible	Additional charges may apply for non-preventive services performed in the physician's office.
	Other practitioner office visit	\$15 copay/visit for chiropractic services; \$15 copay/visit for podiatry services; \$30 copay/visit for allergy treatment and skin testing; No additional charge for allergy injections; \$30 copay/visit for infertility treatment	30% coinsurance after deductible for chiropractic services 30% coinsurance after deductible for allergy treatment, including allergy injections, skin testing, and allergy serum	Coverage for infertility treatment is limited to testing and treatment for services performed in conjunction with an underlying medical condition, testing performed exclusively to determine the cause of infertility, and treatment and/or procedures exclusively to restore fertility (e.g. procedures to correct infertility condition). Artificial insemination, In-vitro fertilizations, GIFT, ZIFT, and other infertility treatments are not covered. Chiropractic services, combined with pulmonary rehabilitation, physical, speech, occupational, cognitive, and respiratory therapies, are limited to 60 days per plan year.
If you have a test	Preventive care/screening/immunization	No Charge	30% coinsurance after deductible	-----None-----
	Diagnostic test (x-ray, blood work)	No Charge	30% coinsurance after deductible	Charges for office visits may also apply if services are performed in a physician's office.
	Imaging (CT/PET scans, MRIs)	No Charge	30% coinsurance after deductible	Charges for office visits may also apply if services are performed in a physician's office. Certain services require prior authorization.

Common Medical Event	Services You May Need	Your Cost If You Use an AvMed Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.avmed.org/mdc.</p>	Generic drugs	\$15 copay/prescription (retail); \$30 copay/prescription (mail order)	30% coinsurance, not subject to deductible	Retail copay applies per 30-day supply. 60-90 day supply via mail order. Certain drugs may require prior authorization.
	Preferred brand drugs	\$25 copay/prescription (retail); \$50 copay/prescription (mail order)	30% coinsurance, not subject to deductible	Certain drugs may require prior authorization.
	Non-preferred brand drugs	\$35 copay/prescription (retail); \$70 copay/prescription (mail order)	30% coinsurance, not subject to deductible	Certain drugs may require prior authorization.
	Specialty drugs	Generic drugs: \$10 copay/prescription; Preferred brand drugs: \$16.66 copay/prescription; Non-preferred brand drugs: \$23.33 copay/prescription	30% coinsurance, not subject to deductible	Not available via mail order. Certain drugs may require prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	30% coinsurance after deductible	Charges for office visits may also apply if services are performed in a physician's office. Prior authorization required.
	Physician/surgeon fees	No Charge, except \$200 surgical copay applies for infertility surgery	30% coinsurance after deductible	Charges for office visits may also apply if services are performed in a physician's office. Prior authorization required.

Common Medical Event	Services You May Need	Your Cost If You Use an AvMed Network Provider		Your Cost If You Use an Out of Network Provider		Limitations & Exceptions
		an AvMed Network Provider	Provider	Use an Out of Network Provider	Network Provider	
If you need immediate medical attention	Emergency room services	\$50 copay/visit (waived if admitted)		\$50 copay/visit (waived if admitted)		AvMed must be notified within 24 hours of emergency admission or as soon as reasonably possible.
	Emergency medical transportation	No Charge		Same as In-Network		When pre-authorized, or in the case of emergency.
	Urgent care	\$50 copay/visit at urgent care facility (waived if admitted); \$15 copay/visit at retail clinic		\$50 copay/visit at urgent care facility (waived if admitted), or at retail clinic		-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge		30% coinsurance after deductible		Prior authorization required.
	Physician/surgeon fee	No Charge, except \$200 surgical copay applies for infertility surgery		30% coinsurance after deductible		Prior authorization required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$15 copay/visit		30% coinsurance after deductible		Includes applied behavior analysis for treatment of Autism Spectrum Disorder.
	Mental/Behavioral health inpatient services	No Charge		30% coinsurance after deductible		Prior authorization required.
	Substance use disorder outpatient services	\$15 copay/visit		30% coinsurance after deductible		-----None-----
	Substance use disorder inpatient services	No Charge		30% coinsurance after deductible		Prior authorization required.
If you are pregnant	Prenatal and postnatal care	\$30 copay/1 st visit only		30% coinsurance after deductible		Subsequent visits at no charge when performed In-Network.
	Delivery and all inpatient services	No Charge		30% coinsurance after deductible		Prior authorization required.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Common Medical Event	Services You May Need	Your Cost If You Use an AvMed Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	30% coinsurance after deductible	Approved treatment plan required. Out-of-Network home health care limited to 60 skilled visits maximum per plan year.
	Rehabilitation services	\$30 copay/visit for pulmonary rehabilitation, physical, occupational, speech, cognitive, & respiratory therapies; \$30 copay/visit for cardiac rehab	30% coinsurance after deductible	Limited to 60 visits per calendar year for chiropractic services, rehabilitative pulmonary, physical, speech, occupational, cognitive, and respiratory therapies combined; 36 visits per calendar year for cardiac rehab.
	Habilitation services	\$15 copay/visit for physical, occupational & speech therapy to treat Autism Spectrum Disorder and Down syndrome	30% coinsurance after deductible	Habilitative physical, occupational, & speech therapy services, when provided for the treatment of Autism Spectrum Disorder and Down syndrome, are covered to a combined maximum of 100 visits per calendar year.
	Skilled nursing care	No Charge	30% coinsurance after deductible	Limited to 60 days per calendar year. Prior authorization required.
	Durable medical equipment	No Charge/device for DME and orthotics; No Charge for external prosthetic appliance, after \$200 plan year deductible	30% coinsurance after deductible for DME and orthotics	Some limitations apply. Please see your Summary Plan Description for details. External prosthetic appliances are not covered Out-of-Network.
	Hospice service	No Charge	30% coinsurance after deductible	Limited to 360 day per participant lifetime maximum. Physician certification required.
If your child needs dental or eye care	Eye exam	\$15 copay/visit	30% coinsurance after deductible	Limited to 1 exam per year to determine the need for sight correction.
	Glasses	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.
	Dental check-up	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded</u> services.)	
<ul style="list-style-type: none"> Child Dental Check Up Child Glasses Cosmetic surgery Dental care (Adult) 	<ul style="list-style-type: none"> Hearing aids Long-term care Non-emergency care when traveling outside the U.S. Private duty nursing Routine eye care (Adult) Routine foot care Weight loss programs
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)	
<ul style="list-style-type: none"> Acupuncture (limited to out-of-network) Bariatric surgery (for morbid obesity) 	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-682-8633. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact AvMed's Member Services Department at 1-800-682-8633.

For plans subject to ERISA, you may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en Español, llame al 1-800-682-8633.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is
not a cost
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,470
- Patient pays \$70

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

deductibles	\$0
Copays	\$70
Coinurance	\$0
Limits or exclusions	\$0
Total	\$70

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,130
- Patient pays \$1,270

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

deductibles	\$0
Copays	\$1,230
Coinurance	\$0
Limits or exclusions	\$40
Total	\$1,270

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.



Lined area for taking notes, consisting of multiple horizontal lines.

JANUARY 2017

Pre-Enrollment

The following information is intended to provide a summary of services and programs offered by AvMed. The Benefit Guide is not a contract. For specific information on benefits, exclusions and limitations, please consult the Miami-Dade County Summary Plan Description or Summary of Benefits and Coverage (SBC).

Miami-Dade County

Dedicated Member Engagement Center , Live 24/7:

1-800-682-8633

www.AvMed.org/MDC



Welcome to AvMed

AvMed provides its Members with personalized service and flexibility when choosing healthcare. Our benefit plans are designed with you in mind. AvMed believes in maximizing access to care by providing you with a robust Provider Network (in some cases, nationwide), lower out-of-pocket costs for in-network services, a simplified claims process, plus wellness and preventive care.

You also get these programs and services:

- MDC Dedicated Member Engagement Center, Live 24/7
- 24-hour, toll-free Nurse On Call program staffed by AvMed registered nurses
- Savings on alternative health services
- AvMed SmartShopper™, a powerful, free shopping tool that sends cash back when you choose the best values for your care.
- MDC Wellness Works to keep you healthier and reduce your overall healthcare costs
- Discounts on eyeglasses and contact lenses
- Dedicated MDC website, your online resource for health and benefits information
- MDC Online Provider directories based on your chosen plan's network
- AvMed Virtual Visits - you can access a doctor from your home, office, or on the go- 24/7/365
- Decision Support Tools, your comprehensive set of resources designed to help you become a more informed healthcare consumer

Medical Excellence

AvMed Virtual Visits powered by MDLIVE

AvMed Virtual Visits provide anytime remote access to board-certified doctors from your home, your office, or on the go. Just 15 minutes after a simple sign-up, Members can speak with a doctor about non-emergency medical issues by phone or by secure video using a computer, tablet, or smartphone. It's healthcare that works for AvMed Members, wherever and whenever they need it.

AvMed Physicians

AvMed is committed to quality healthcare. We have a broad network of physicians who also work hard to keep you healthy. AvMed contracts with physicians who are in private practice and see AvMed Members within certain time frames, depending upon the Member's condition. They also agree to certain standards of care for our Members with regard to wait times and accessibility. To find a participating provider, visit **www.AvMed.org/MDC** and click on your plan's network.

AvMed considers board certification a significant credential in evaluating physicians. Our network physicians have completed advanced training in an approved hospital residency and/or fellowship program. Requirements for physicians to become board certified are established by each specialty board. Our network physicians are identified within this online directory with a star for 'Board Certified.'

Hospitals, Facilities & Allied Services

AvMed Members have access to one of the most versatile facility networks in the state, made up of hospitals, skilled nursing facilities, diagnostic centers, laboratories, ambulatory surgical centers, home health, urgent care centers, pharmacies, vision companies, durable medical equipment providers and much, much more. To be a participating Provider for AvMed, healthcare facilities must meet rigorous credentialing standards based on quality. Quality of care standards are developed from those of nationally recognized professional organizations, and are monitored for all providers. AvMed supports our Providers in their efforts to meet or exceed quality standards.

How AvMed Chooses Providers

We carefully assess the need for particular specialties in each of our service areas to make sure we have enough physicians

to meet the medical needs of our Members. To be a participating AvMed Provider, medical professionals and healthcare facilities must meet thorough credentialing standards. This includes the examination of practice experience, licenses, certifications, hospital privileges, education and medical record keeping.

Accessing Care

In an effort to keep you informed, we are providing you with this general information about accessing care, and terms you should know. Your plan's Benefit Summary, at the beginning of this guide, details a summary of the covered benefits and the out-of-pocket costs associated with each of those services. For specific exclusions and limitations about your plan, please refer to your Summary Plan Description or Summary of Benefits and Coverage. In general, you will receive care from AvMed participating providers. Emergency and Urgently needed care is always covered in or outside the AvMed Network or service areas. If your plan provides out-of-network coverage, you can also receive routine care from non-participating providers. In this case, higher out-of-network expenses may apply.

If you have any questions, please call the Miami-Dade County Dedicated Member Engagement Center, Live 24/7, at **1-800-682-8633**. You may also email us at **MDC.Members@AvMed.org**. Our representatives are available to assist you 24 hours a day, 7 days a week.

The Role of Primary Care Physician (PCP)

The role of a PCP is to provide routine and preventive care as well as to assist you in making important medical decisions. Your PCP should know your medical history and can be a valuable resource for information and treatment. Your plan may not require you to designate a PCP, but AvMed encourages you to choose a physician in this role so that he or she can take the time to know you and your health issues well, and coordinate your care.

Choosing and Changing a PCP

Primary Care Physicians (PCPs) can perform physicals, see you for most of your healthcare needs and help coordinate your care if you need to see specialists or access behavioral healthcare. Each covered member of your family may select the same or different PCP. You can find a list of doctors in the Provider Directory or on AvMed's website at **www.AvMed.org/MDC**.

Visits to Specialist Providers

PCPs know your medical history and are best qualified to determine if a specialist's care is needed, and if so, which specialist would be best for you. In most instances, AvMed does not require a referral for a visit to specialists. However, depending on your plan, certain services require prior authorization from AvMed or a referral from your PCP.

What is an authorization?

An authorization is coordinated through your physician and your health plan. It is a formal process requiring a provider to obtain prior approval from the patient's health plan before providing a particular service or procedure.

The following require prior authorization from your health plan:

- Inpatient care
- Observation
- Outpatient surgical procedures
- CT, MRI, MRA and PET scans
- Nuclear cardiac imaging
- Dialysis
- Transplant services
- Select medications, including injectable medications

Please note: POS and Choice plans may have different authorization rules for out-of-network services. Please refer to your Summary Plan Description or Summary of Benefits and Coverage.

Behavioral Health Services

AvMed provides its Members with a high quality behavioral health program. Depending on your plan, you may have direct access to behavioral health providers throughout the state without having to contact your PCP. Behavioral health diagnosis and treatment services are covered on an outpatient basis. Additional behavioral health services or substance abuse services may be available. For more detailed information about your coverage, please refer to your Benefit Summary and Amendment. Members must use AvMed's participating providers for all inpatient and outpatient services. Choice and POS Members may utilize out-of-network benefits. Please refer to your Summary Plan Description or Summary of Benefits and Coverage.

Emergency, Urgent Care and Retail Clinic Options

Talk to your doctor about what to do if you need immediate medical care. Be sure to discuss after-hours care and weekend accessibility, and if there is another number you can call. If your doctor isn't available or if an accident or injury calls for immediate attention, you should know your options. Knowing the difference can save you time, money and stress.

- **When is it an emergency?**

If you have an emergency (your condition is life-threatening; loss of consciousness; sudden, sharp abdominal pain; uncontrolled bleeding; complicated fractures) you should go to the nearest hospital or call 911 for emergency medical assistance. You may be responsible for a portion of the cost and non-covered supplies or services (refer to your Benefit Summary for more information). For a detailed definition of an emergency, please refer to your Summary Plan Description or Summary of Benefits and Coverage.

Urgent Care Center Know where they are	Emergency Room Know how to get there fast	Ambulance Call 911	Retail Clinic Basic medical care
<ul style="list-style-type: none">• Ear Infections• Minor cuts• Fever	<ul style="list-style-type: none">• Sudden, sharp abdominal pain• Uncontrolled bleeding	<ul style="list-style-type: none">• Chest pain• Difficulty breathing• Loss of consciousness	<ul style="list-style-type: none">• After hours and weekends, when the doctor can't fit you in.

- **Urgent Care Center**

If you encounter a minor medical emergency (sprained ankle, minor cuts or high fever), an urgent care center (UCC) may be a more convenient, and often a more cost-effective, alternative to the emergency room. The facilities handle non-emergency visits during and after regular physician office hours. Most are open seven days a week, with extended hours and do not require an appointment. They are staffed with qualified physicians and offer a wide array of healthcare services, including radiology, laboratory, pharmacy and procedure rooms for lacerations and fracture care. AvMed currently contracts with a number of UCCs throughout the state. For a complete list of urgent care centers in your area, you can refer to the Provider Directory or visit our website at **www.AvMed.org/MDC**.

- **Retail Clinic Care**

Another option is retail clinic care, staffed by board-certified practitioners (nurse practitioners and/or physician assistants); a clinic can be a convenient and affordable choice. Clinics offer quality, basic medical care after hours, on weekends and when your doctor's office can't get you in.

- No appointment needed
- Open seven days a week
- Pay your applicable PCP copayment, coinsurance or deductible*

Pharmacy Information

If you have prescription drug coverage through AvMed, you must purchase your prescriptions through our nationwide network of participating pharmacies. Please refer to your Provider Directory or visit our website at **www.AvMed.org/MDC** for the participating pharmacies in your service area and for the latest list of covered drugs. For participating pharmacies outside your local service area, contact our Member Engagement Center. You must present your AvMed Member ID Card at the pharmacy in order for your prescription to be processed correctly. If you need

a prescription filled before you receive your identification card, you may take your enrollment form to the pharmacy, as it contains the required information, or you may print a temporary ID Card by going to our website. For complete information regarding your pharmacy benefits, please refer to your Summary Plan Description or Summary of Benefits and Coverage.

Generics...Real Savings

One of the easiest ways to keep prescription drug expense down is to choose generic medications. Generic drugs are typically sold at substantial discounts. Most people believe that if something costs more, it has to be of better quality. The standards of quality are the same for generics and brand name. The Food and Drug Administration (FDA) requires that all drugs be safe and effective. When a generic drug product is approved and on the market, it has met the rigorous standards established by the FDA with respect to identity, strength, quality, purity and potency. Generics provide high quality and cost savings to you. For a list of generic medications, go to AvMed's website at **www.AvMed.org/MDC**. Click on Preferred Medication Lists at the left side of the home page.

For a complete list of:

- **Participating pharmacies**
- **Retail clinics**
- **Urgent Care Centers in your area,**

Visit www.AvMed.org/MDC and click on your plan's network

Services and Programs

AvMed adds value to your membership by providing the following services.

Dedicated Member Engagement Center, Live 24/7

AvMed's Member Engagement Representatives are available to you to answer questions regarding benefits, claims, changing physicians or anything involving your AvMed membership. AvMed takes pride in providing excellent customer service.

You can call the Miami-Dade County Dedicated Member Engagement Center, Live 24/7, at 1-800-682-8633 (TTY 711), or you may also visit our website at **www.AvMed.org/MDC** or email Member Engagement at **MDC.Members@AvMed.org**.

With Language Line Services, we have the ability to speak 140 languages. If you need to speak with a Member Services Representative in another language, AvMed accesses Language Line Services and connects you with a translator who relays your questions or concerns back to AvMed. There is no charge to you.

Medical Technology

AvMed's Medical Technology Assessment program is designed to evaluate and assess new and existing technologies for the purpose of safe and effective healthcare. If you have questions regarding medical technologies, including procedures, medications, or devices, please contact your Primary Care Physician (PCP) or call AvMed's Nurse On Call at **1-888-866-5432**, 24 hours a day, 7 days a week.

Our medical directors work with practicing physician-consultants to continuously review and evaluate published medical scientific studies and information from the U.S. Food and Drug Administration and other federal agencies to ensure safe and effective treatment. By carefully assessing new approaches in medicine, we live up to our commitment of improving our Members' health.

AvMed's Nurse On Call – 24 Hours a Day, 7 Days a Week

By calling AvMed's Nurse On Call, you can speak confidentially with an AvMed registered nurse about health concerns any time you need to. Our nurses can help you make an informed decision about an appropriate course of action related to an illness or injury, including when to call your physician.

You also have the option to listen to pre-recorded health information from AvMed's Audio Health Library on more than 500 health topics. Each topic includes information on symptoms, self-care, home treatment and prevention. You can find this health information on AvMed's website at **www.AvMed.org/MDC**.

Utilization Management

The goal of AvMed's Utilization Management (UM) program is to validate the medical appropriateness and to coordinate covered services for our Members. Utilization Management has several comprehensive components which include, but are not limited to:

- Prior-authorization requests from Providers prior to providing covered services.
- Concurrent review of all patients hospitalized in acute-care, psychiatric, rehabilitation, and skilled nursing facilities, including on-site review when appropriate.
- Case management and discharge planning for all inpatients and those requiring continued care in an alternative setting (such as home care or a skilled care facility) and for outpatients when deemed appropriate; and
- The Benefit Coordination Program which is designed to conduct prospective reviews for select medical services to ensure that these are covered and medically necessary. The Benefit Coordination Program may also advocate alternative cost-effective settings for the delivery of prescribed care and may identify other options for non-covered healthcare needs.

MDC Wellness Works

The Power of One

"Healthy" is not one and done. It's a journey.

Wherever you find yourself on the health continuum – taking a walk in the neighborhood or signing up for a marathon- choosing the stairs over the elevator or the carrot instead of the cookie- it's about taking that next step, that one step to creating YOU, *improved*.

The journey to a healthy lifestyle begins with ONE step. Change starts with ONE decision, Get started with ONE program. Get on the road to YOU, *improved*.

Learn more about MDC Wellness Works and how you can earn incentives by visiting **www.AvMed.org/MDC/WellnessWorks** beginning ONE/ONE (1/1/17).

Discounts on Eye Exams, Glasses, Lenses and Contacts

Discounts on eye exams, glasses, lenses and contacts are available through some of AvMed's vision partners. For more information, call the MDC Dedicated Member Engagement Center at 1-800-682-8633.

AvMed's Website

Your Best Source for Fast Information on Your Health Plan

Visit our website at **www.AvMed.org/MDC** to access a vast amount of information and a great number of resources that are available to you as an AvMed Member. Some areas are immediately accessible, such as Online Consumer Tools, AvMed's Provider Directory and MDC's Preferred Medication Lists. You can view and do so much more, however, by registering for full access to the website. With your user ID and password, you're able to obtain your personal health information and interact with AvMed in the following areas:

- Benefits
- Request an AvMed Member ID Card or temporary ID
- Eligibility
- Information on copayment, deductible and/or coinsurance accumulations
- Status changes
- Change PCP, address, phone
- Authorization inquiries
- Medical and pharmacy claims inquiries

You can also submit Coordination of Benefits (COB) information and any personal information changes. Our website's

extensive Provider Directory offers the names of participating PCPs, hospitals and ancillary facilities, as well as every type of specialist physician. Updated weekly, the online directory contains information on our contracted doctors' backgrounds, office hours, office locations, languages spoken and more. The AvMed website also includes health information and current press releases on company developments and achievements.

Online Consumer Tools

Research shows that health plan Members who are engaged in choosing and using their health benefits become informed, cost-conscious consumers. AvMed's Online Consumer Tools are available at **www.AvMed.org/MDC** to help you make effective decisions about your healthcare. These resources can assist you in choosing and determining what prescription drugs, physicians and hospitals best meet your needs. Stay connected to stay healthy!

AvMed SmartShopper™ powered by Vitals

Members can become smarter healthcare consumers by taking advantage of AvMed SmartShopper, a powerful, free shopping tool that sends you cash back when you choose the best values for your care. Live healthier, save money, and earn cash for your smart choices. AvMed SmartShopper puts you in control.

AvMed SmartShopper goes further for Members, with:

- A toll-free, call-center concierge
- 24/7 service, online, with quick and easy registration
- Mobile-enabled shopping
- Total costs for services, plus Member out-of-pocket costs
- Helpful, online Member alerts and messaging

For more details visit AvMed.VitalsSmartShopper.com anytime or call 1-855-869-2133 Monday-Thursday, 8:30 am-8 pm and Friday, 8:30 am-5 pm.

AvMed's Cost Calculator

Our Cost Calculator allows you to see the total cost of a procedure before you schedule an appointment. This unique tool helps AvMed Members evaluate Providers and prices in advance to determine the best value. It allows you to search for specific medical procedures and compiles a comprehensive list of available doctors, locations, coverage and out-of-pocket costs.

To log in:

- 1 - Access the Member portal at **www.AvMed.org/MDC**
- 2 - From the "My account" menu, select "Cost Calculator Tool"
- 3 - Agree to "Leave AvMed" website
- 4 - Under "Find the Care You Need" select "Cost Estimate"
- 5 - Navigate according to your personal needs

Learn About Your Health.

AvMed's online medical encyclopedia is a valuable reference tool containing comprehensive medical information designed to keep you informed and proactive in your health decisions. Find out how common your condition is among people your age group. Learn about treatment options and find out how quickly you can expect to recover.

Find a High-Quality Physician.

Search for physicians by name, location and specialty. Physician profiles include such useful details as education, board certification, sanctions and malpractice issues. You also can learn about estimated treatment costs and view affiliated hospitals and patient satisfaction survey results. With this information, you'll be able to compare doctors and find the one who's right for you.

Find a High-Quality Hospital.

Search hospitals by name, location, procedure/condition or overall quality. Ratings and cost estimates are easy to understand, with side-by-side comparisons and detailed profiles. This tool can help you manage your healthcare costs and avoid complications associated with poor care.

Members' Rights and Responsibilities

Members have a right to:

- Considerate, courteous, and dignified treatment by all participating providers without regard to race, religion, gender, national origin, or disability and a reasonable response to a request for services, evaluation and/or referral for specialty care.
- Receive information about AvMed, our products and services, our contracted practitioners and providers, and Members' rights and responsibilities.
- Be informed of the health services covered and available to them or excluded from coverage, including a clear explanation of how to obtain services and applicable charges.
- Access quality care, receive preventive health services and know the identity and professional status of individuals providing services to them.
- The right to be treated with respect and recognition of your dignity and your right to privacy.
- To participate in making decisions about your healthcare with practitioners or other healthcare professionals.
- Participate in a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage. To refuse medical treatment, including treatment considered experimental, and to be informed of the medical consequences of this decision.
- Have available and reasonable access to service during regular hours and to after-hours and emergency coverage, including how to obtain out-of-area coverage.
- To voice complaints or appeals about the organization or the care it provides.
- To make recommendations regarding the Plan's Members' rights and responsibilities policies.

Members have the responsibility to:

- Choose an AvMed participating Primary Care Physician and establish themselves with this physician.*
- Become knowledgeable about your health plan coverage including covered benefits, limitations and exclusions, procedures regarding use of participating providers and referrals.
- Take part in improving your health by maximizing healthy habits.
- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- Participate in understanding your health problems and in developing mutually agreed-upon treatment goals, to the degree possible.
- Follow any plans and instructions for care that you have agreed to with your practitioners.
- Keep appointments reliably, and promptly notify the provider when unable to do so.
- Fulfill financial obligations for receiving care, as required by your health plan agreement, in a timely manner.
- Show consideration and respect to providers and provider staff.

*Certain AvMed Plans do not require that you choose a Primary Care Physician. However, AvMed encourages all Members to establish a relationship with a Primary Care Physician, to help coordinate your care.

Member Inquires and Concerns

We want to ensure that your concerns are addressed promptly. If at any time you have complaints, you may call the Miami-Dade County Dedicated Member Engagement Center, Live 24/7, at **1-800-682-8633**. You may also contact Member Services by writing us at **MDC.Members@AvMed.org**. If you have a concern regarding the quality of medical care or service you are receiving, we encourage you to first discuss it directly with your Provider.

For complete information regarding AvMed's grievance procedure, please refer to your Summary Plan Description or Summary of Benefits and Coverage.

Claims

In most cases, Providers will file claims directly with AvMed. However, if you feel that you have incurred charges that should be considered for payment or reimbursement, you will need to submit an itemized statement of charges, date(s) of service, including diagnostic and procedure codes, together with proof of payment to the AvMed Claims Center at:

P.O. Box 569000
Miami, Florida 33256-9000

Please note: For specific claim filing requirements, please refer to your Group Medical and Hospital Service Contract (Certificate of Coverage) or Summary Plan Description.

Advance Directives

Your Rights

AvMed wishes to inform you of Florida law regarding Living Wills and Advance Directives. Under Florida law, every adult has the right to make certain decisions concerning his or her medical treatment. The law also allows for your rights and personal wishes to be respected even if you are too sick to make decisions yourself.

You have the right, under certain conditions, to decide whether to accept or reject medical treatment, including whether to continue medical treatment and other procedures that would prolong your life artificially.

You may also designate another person, or surrogate, who may make decisions for you if you become mentally or physically unable to do so. This surrogate may function on your behalf for a brief time longer, for a life-threatening or a non-life-threatening illness. Any limits to the power of the surrogate in making decisions for you should be clearly expressed.

Your healthcare provider will furnish you written information about its policy regarding Advance Directives.

The legal basis for these rights can be found in the Florida Statutes: Healthcare Advance Directives, Chapter 765; Durable Power of Attorney Section 709.08; and guardianship, Chapter 744; and in the Florida Supreme Court decision on the constitutional right of privacy, *Guardianship of Estelle Browning*, 1990.

What is an Advance Directive?

An Advance Directive is a “written instruction, such as a Living Will or Durable Power of Attorney for healthcare, recognized under State law (whether statutory or as recognized by the courts of the state) and relating to the provision of such care when the individual is incapacitated.”

The law of Florida provides three ways to express your *written desires*, in advance, so your doctor and family will know how you want to be treated in the event you become unable to tell them.

Living Will

A Living Will is a written personal statement made by you that lets others know your wishes for medical care at the end of life. You must be 18 years of age and of sound mind to write a Living Will. Most Living Wills direct physicians to limit or forego certain treatments, for example, connecting a person to a respirator/breathing machine. The Living Will is used only in situations where you are both terminally ill and unable to take part in mental decisions. A Living Will does not cover all situations that may present themselves, so you may want to have other documents prepared.

Healthcare Surrogate

A Healthcare Surrogate is a person you choose to make healthcare decisions for you when you are no longer able to do so. Your surrogate should be someone who knows your wishes and will make decisions based on what he/she believes you would want. A Healthcare Surrogate is usually a family member or close friend who can be readily available to your physician. You are encouraged to appoint a Healthcare Surrogate even if you have made other written expressions of your wishes, since it is difficult to address every possible situation in a Living Will.

Durable Power of Attorney

A Power of Attorney is a document by which you give another person – your “agent” – the authority to make decisions about the financial aspects of your life. In Florida, you can also give your agent the authority to make decisions about your medical treatment. A Durable Power of Attorney remains in effect even if you become incapacitated. For example, you can authorize your agent to consent to medical and surgical procedures for you under certain circumstances (*usually* when you are unable to make these decisions). You must be 18 years old and you can revoke or change your power of attorney at any time before you become incompetent.

Common Questions:

Q. Are Living Wills, Healthcare Surrogates and Durable Powers of Attorney just for senior citizens?

- A. No. A severe illness or serious accident can happen to any person at any age. If you have strong feelings about what choices you would want in such a situation, regardless of your age, you are encouraged to consider an Advance Directive. However, parents of minors under the age of 18 will be responsible for the healthcare decisions of their children (unless special facts apply).

Q. May I change my Living Will, name a different Healthcare Surrogate or Durable Power of Attorney?

- A. Yes, you may make changes at any time. If you do make changes to your Living Will, name a new Healthcare Surrogate or Durable Power of Attorney be sure to destroy all of the outdated copies and provide copies of the updated information to your physician, family members and others whom you think need to know your wishes.

Q. May I request that I not be given food or water artificially (tube feedings, IVs)?

- A. Yes. Florida law gives you the right to refuse food and water. A Living Will usually allows you to do this when your medical condition is terminal and such efforts only serve to prolong the process of dying. A Healthcare Surrogate or Durable Power of Attorney, appointed independent of your Living Will, is able to direct that IVs and tube feedings be discontinued in situations where no recovery is deemed possible.

Q. Are there any limitations on carrying out my instructions?

- A. No. The document need only be signed in the presence of two witnesses. One of the witnesses must be someone who is not your spouse, blood relative, heir or person responsible for paying your medical bills.

Q. What do I do after I complete a Living Will, appoint a Healthcare Surrogate and/or Durable Power of Attorney?

- A. Once you have completed a Living Will, appointed a Healthcare Surrogate and/or Durable Power of Attorney, you should give a copy to your physician, minister, family members, close friends and your Healthcare Surrogate or Durable Power of Attorney. Discuss with them the details of your Advance Directive and ask that they keep a copy to make available if and when needed.

Q. Is it necessary to state my wishes in writing?

- A. It is probably best to put your wishes in writing. There is authority for oral declarations but if you have stated your desires in writing, misunderstandings can be avoided.

Remember...

- It may be best to sign multiple documents because the appointment of a Healthcare Surrogate and Durable Power of Attorney are more flexible and apply to more than just end of life situations.
- An Advance Directive that is valid in another state may not be valid in Florida.
- If you have a healthcare Power of Attorney that you signed in another state you should probably have a local attorney review it to assure its validity.
- Update your document regularly.

JANUARY 2017

Notice of Privacy Practices

Miami-Dade County

Miami-Dade County

Dedicated Member Engagement Center, Live 24/7:

1-800-682-8633

www.AvMed.org/MDC





MIAMI-DADE COUNTY HEALTH BENEFITS NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice describes how Miami-Dade County's (the "County's") medical and flexible spending account benefits programs, collectively referred to as the "Plans," may use and disclose Protected Health Information ("PHI" or "health information"). Protected Health Information is individually identifiable information about your past, present or future health or condition, health care

services provided to you, or the payment for health services, whether that information is written, electronic or oral. This notice also describes your rights under federal law relating to that information. It does not address medical information relating to disability, workers' compensation or life insurance programs, or any other health information not created or received by the Plans.

How The Plans May Use or Disclose Your Health Information

For Treatment. While the Plans generally do not use or disclose your PHI for treatment, the Plans are permitted to do so if necessary. For example, the Plans may disclose PHI if your doctor asks for preauthorization for a medical procedure, the Plan may provide PHI about you to the company that provides preauthorization services to the Plan.

For Payment. The Plans may use and disclose your health information for payment of claims. Such purposes include, but are not limited to, eligibility, claims management, pre-certification or pre-authorization, medical review, utilization review, adjustment of payments, billing, and subrogation. For example, a detailed bill or an "Explanation of Benefits" may be sent to you or to the primary insured or "subscriber" by a third-party payor that may typically include information that identifies you, your diagnosis, and the procedures you received.

For Health Care Operations. The Plans may use and disclose health information about you regarding day-to-day Plan operations. Such purposes include, but are not limited to, business management and administration, business planning and development, cost management, customer service, enrollment, premium rating, care management, case management, audit functions, fraud and abuse detection, performance evaluation, professional training, provider credentialing, formulary development, and quality assurance or other quality initiatives. For example, the Plans may use or disclose information about your claims history for your referral for case management services, project future benefit costs, handle claims appeals or audit the accuracy of the claims processing performed by a third-party payor.

To the Plan Sponsor. The Plans may disclose health information to specifically designated employees of the County, but the County has put protections in place to assure that the information will only be used for plan administration purposes, and never for employment purposes without your express authorization. For example, the County may become involved in resolving claim disputes or customer service issues.

As Required by Law. The Plan may use or disclose health information about you as required by state and federal law. For example, the Plan may disclose information for the following

purposes:

- for judicial and administrative proceedings;
- to report information regarding victims of abuse, neglect, or domestic violence; and
- to assist law enforcement officials in the performance of their law enforcement duties.

To Business Associates. There are some services the Plan provides through contracts with business associates. We may disclose your health information to our business associates so that they can perform the jobs we have asked them to do, for example, claims payment or appeals on behalf of the County by a third-party payor and claims audits by third-party firms to assure contract compliance. To protect the privacy of your health information, we contractually require business associates to appropriately safeguard that information.

For Health-Related Products and Services. The Plans may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

For Public Health. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities in the prevention or control of disease, injury, or disability, or for other activities relating to public health.

For Health Oversight. We may disclose your health information to a health oversight agency for activities authorized by law such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee benefit programs, other government regulatory programs and civil rights laws.

For Research. We may disclose your confidential information for research purposes, subject to strict legal restrictions.

To Personal Representatives and Some Relatives. We may use or disclose your information to a personal representative formally designated by you or designated by law or, under circumstances, to a close relative such as the subscriber primarily responsible for your coverage or the parent of a minor child.

For Health and Safety. Your health information may be disclosed to avert a serious threat to the health or safety of you or another person pursuant to applicable law.

For Governmental Functions. Specialized governmental functions such as the protection of public officials or reporting to various branches of the armed services may require the use or disclosure of your health information.

For Workers Compensation. We may disclose your health information to the extent authorized by and to the extent necessary to comply with laws and regulations relating to workers compensation or other similar programs established by law.

Prohibition on Use or Disclosure of Genetic Information. The Plan is prohibited from using or disclosing your genetic information for underwriting purposes.

No Other Uses. Other uses and disclosures will be made only with your prior written authorization. You may revoke this authorization in writing except to the extent a Plan has already made a disclosure in reliance on such authorization.

Your Legal Rights

The federal privacy regulations give you the right to make certain requests regarding health information about you:

Right to Request Restrictions. You have the right to request that the Plan restrict its uses and disclosures of PHI in relation to treatment, payment, and health care operations. Any such request must be made in writing and must state the specific restriction requested and to whom that restriction would apply. The Plan is not required to agree to a restriction that you request. We are not required to agree to a requested restriction or limitation, unless your request is made to restrict disclosure to an insurance carrier for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment), and the protected health information pertains solely to a health care item or service for which you have paid the healthcare provider out of pocket in full. If we do agree to a restriction or limitation, we must abide by it unless you revoke it in writing.

Right to Request Confidential Communications. You have the right to request that communications involving your PHI be provided to you at a certain location or in a certain way. Any such request must be made in writing. The Plans will accommodate any reasonable request if the normal method of communication would place you in danger.

Right To Access Your Protected Health Information. You have the right to inspect and copy your PHI maintained in a "designated record set" by the Plan. The designated record set consists of records used in making payment, claims adjudication, medical management and other decisions. The

Plan may ask that such requests be made in writing and may charge reasonable fees for producing and mailing the copies. The Plan may deny such requests in certain cases.

Right to Request Amendment. You have the right to request that your PHI created by the Plan and maintained in a

designated record set be amended, if that information is in error. Any such request must be made in writing and must include the reason for the request. If the Plan denies your request for amendment, you may file a written statement of disagreement. The Plan has the right to issue a rebuttal to your statement, in which case, a copy will be provided to you.

Right to Receive An Accounting of Disclosures. You have the right to receive an accounting of all disclosures of your PHI that the Plan has made, if any. This accounting does not include disclosures for payment, health care operations or certain other purposes, or disclosures to you or with your authorization, to friends or family in your presence or due to an emergency, for national security purposes, or incidental to an otherwise permissible use or disclosure. Any such request must be made in writing and must include a time period, not to exceed six (6) years. The Plan is only required to provide an accounting of disclosures made on or after April 14, 2003. If you request an accounting more than once in a 12-month period, the Plan may charge you a reasonable fee. Your request should indicate in what form you want the accounting (for example, paper or electronic).

Right to be Notified of a Breach. You have the right to be notified in the event that the Plan (or a Business Associate) discovers a breach of your unsecured protected health information. Business Associates include the Business Associates themselves and their subcontractors.

All requests listed above should be submitted in writing to the County's Chief Privacy Officer (see Contact Information below).

The Plans' Obligations

The federal privacy regulations require us to keep personal information about you private, to give you notice of our legal duties and privacy practices, and to follow the terms of the notice currently in effect.

This Notice is Subject To Change

We may change the terms of this Notice and our privacy policies at any time. If we do, the new terms and policies will be effective for all of the information that we already have about you, as well as any information that we may receive or hold in the future. Revised Notices will be made available to you in writing as required.

Complaints

You have a right to file a complaint if you believe your privacy rights have been violated. You may file a complaint by writing to the County's Chief Privacy Officer (see Contact Information below). You may also file a complaint with the Department of Health and Human Services. You will not be penalized for filing a complaint.

Contact Information - For any questions or complaints, please contact:

Chief Privacy Officer, Human Resources Department
Stephen P. Clark Center, 111 NW 1st Street, 21st Floor, Miami, FL 33128

Updated 10/2014

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

AvMed:

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

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

If you believe that AvMed has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with AvMed's Regulatory Correspondence Coordinator, P.O. Box 749, Gainesville, FL 32627, by phone 1-800-346-0231 (TTY 711), by fax 1-352-337-8780, or by email to regulatory.correspondence@avmed.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Regulatory Correspondence Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

亿人: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-882-8633 (TTY: 711).

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Count on AvMed
to help you
**live healthier
at every stage
of life!**

For more information,
call the Miami-Dade County
Member Engagement Center,
Live 24/7 at **1-800-682-8633**.

www.AvMed.org/MDC



Embrace better health.®