Miami-Dade County
Benefits Redesign and Select Network
Frequently Asked Questions (FAQ's)

1. **Q: What is the Select Network?**
   A: The **Miami-Dade County Select Network** is comprised of conveniently located hospitals, facilities, physicians and other healthcare providers. *Eligible Miami-Dade employees, retirees (under 65), and covered dependents who enroll in the Select Network option must receive all medical care, except emergencies and urgent care services, through an **AvMed contracted Select Network provider**.

   - *Note: Employee eligibility is determined in accordance with the employee's respective Collective Bargaining Agreement.

2. **Q: Is the Select Network a "Jackson Only" Plan?**
   A: **No**. There are numerous Hospitals plus additional non-hospital affiliated providers included in the Select Network.

3. **Q: What is the Jackson Health System (JHS)?**
   A: Jackson Health System is an internationally recognized, academic health system composed of six hospitals, 12 specialty care centers and two long term care centers, health clinics and pharmacies. Visit http://www.jacksonhealth.org/locations.asp to learn more about these providers.

4. **Q: If I choose the Select Network Option, can I receive services at an out-of-network provider/physician?**
   A: No. You must use participating providers and facilities for non-emergency services. In order to receive services from out-of-network providers you need to choose the Point of Service (POS) plan.

5. **Q: Do I need a referral to see a specialist in the Select Network?**
   A: No.

6. **Q: Are the participating Pharmacies and Urgent Care Centers still the same under the Select Network?**
   A: Yes.

7. **Q: My child attends college outside of the tri-county area. Will the Select Network Option cover medical services outside of the tri-county area?**
   A: Yes. During Open Enrollment (or at the time your child is scheduled to go away to college) you must complete an "Away from Home" request with the Benefits Administration Unit, Human Resources Department. The "Away from Home" program allows college students with a temporary arrangement to be able to receive services while away at college.

8. Q: What hospitals are in the Select Network?

A: The following hospitals are included in the Select Network:

Miami-Dade County:

- Baptist Hospital of Miami
- Doctor's Hospital
- Holtz Children's Hospital
- Homestead Hospital
- Jackson Memorial Hospital
- Jackson South Community Hospital
- Jackson North Hospital
- Kendall Regional Medical Center
- Miami Children's Hospital – ***NEW in 2015 for MDC***
- Mt. Sinai Medical Center
- South Miami Hospital
- University of Miami Hospital - ***NEW in 2015 for MDC***
  - *Sylvester Comprehensive Cancer Center*
  - *Bascom Palmer Eye Institute*
- West Kendall Baptist Hospital

Broward County:

- Broward Health Medical Center
  - *Chris Evert Children's Hospital*
- Holy Cross Hospital
- Joe DiMaggio Children's Hospital
- Memorial Hospital West
- Memorial Hospital Miramar
- Memorial Hospital Pembroke
- Memorial Regional Hospital
- Memorial Regional Hospital South
- Northwest Medical Center

Palm Beach County:

- Bethesda Hospital West
- Bethesda Memorial Hospital
- Boca Raton Regional Hospital
- Palms West Hospital
- West Palm Hospital

9. **Q: How do I know if my physician is in the Select Network?**

   A: Visit the website below and enter your physician's information.

   http://avmed.prismisp.com/?tab=doctor&plan=mdcs&visitor=member

   For the best search results, it is recommended to indicate the doctor's specialty or category of Primary Care Physician to enhance the search results. You may also search by city, state, or zip code without specifying the doctor's name.

   Notes:

   - If you enter the doctor's name alone and do not spell it correctly you may not get the desired results.
   - As a result of additional enhancements to the MDC Select Network, additional doctors will be added to the directory. The link above currently does not include these additional doctors. The complete list of providers will be available in time for the County's Open Enrollment period.

   If you have any questions or are having difficulty with the search, please contact the AvMed Dedicated Service Unit at **1-800-682-8633**, 24 hours a day, 7 days a week.

10. **Q: What if my physician is not in the Select Network… can he/she be added?**

    A: In order to be in the Select Network, the physician must be an AvMed contracted physician **and** have privileges at a participating Select Hospital. A physician may decide to apply for "privileging" at a participating Select Hospital in order to become part of the Network.

11. **Q: What other services are covered in the Select Network?**

    A: The Select network was designed as follows:

    - AvMed directly contracted physicians that have privileges at Select hospitals (this does not include the Private Healthcare Systems Network (PHCS) which is designed for those who do not reside in the AvMed service area);
    - Other AvMed directly contracted Primary Care Physician (PCPs) and specialists that are not hospital-dependent such as:
      - Dermatologists
      - Podiatrists
      - Allergists
      - PCPs (Internal Medicine, Family, General, Pediatrician)
      - Ophthalmologists
    - Other AvMed participating providers in the following categories:
      - Chiropractic care
      - Durable Medical Equipment
      - Independent Diagnostic Testing Facilities
      - Independent Ambulatory Surgery Centers
      - Home Health
      - Laboratory
      - Mental Health (Psychcare)
      - Outpatient therapy
      - Optometry
      - Pharmacies

12. **Q: I will be traveling outside of AvMed's service area, what kind of coverage will I have while I'm gone?**
    A: While you are traveling outside of AvMed's service area, you will only be covered for emergency services, unless you have out of network benefits (Point of Service (POS) option).

13. **Q: Will AvMed pay for hospital charges if I am admitted while I am out of the country?**
    A: AvMed provides coverage for emergency and out-of-the-area urgently needed services, as defined in the Certificate of Coverage. You or your designee should notify AvMed of your emergency within 24 hours or as quickly as possible. Most medical providers in foreign countries will not bill an insurance carrier and you may have to pay out-of-pocket. You will need to provide AvMed with an itemized bill within 90 days or as soon as reasonably possible (no later than 1 year) so they can consider reimbursement.

14. **Q: What is the difference between an urgent care center and an emergency room?**
    A: Knowing the difference between when to go to the Emergency Room (ER), or when an Urgent Care Center is more appropriate, can save you time and money. More than half of all ER visits are for minor, non-urgent problems. That means paying three to four times more than you would if you were to go to an Urgent Care Center. View a list of freestanding Urgent Care Centers in your area at: **http://avmed.prismisp.com/?tab=doctor&plan=mdcs&visitor=member**

15. **Q: When is it an Emergency?**
    A: 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.

16. **Q: I was treated at the emergency room and I was asked to return for follow up; do I have to pay a co-payment?**
    A: Yes, a co-payment applies every time you visit the emergency room. Always contact your Primary Care Physician after visiting the emergency room to see if follow up can be done at the physician's office.

17. **Q: I went to the emergency room and I was triaged, then I felt better and I decided to go home. Do I have to pay a co-payment?**
    A: Yes, triage services were rendered; therefore the emergency copayment applies.

18. **Q: If I were to experience a medical situation that required a visit to an emergency room or emergency clinic outside of the AvMed service area, and the condition required a prescription medication, what should I do?**
    A: If your plan includes prescription coverage, your prescription medications can be filled at any of our participating pharmacies nationwide. As long as it is a covered medication, all applicable limitations and co-payments will apply. For a list of participating pharmacies, please go to our Online Provider Directory. If there is no participating pharmacy in the area, AvMed will reimburse you for the cost of the prescription medication purchased outside the service area, as long as the prescription is related

to the emergency condition. You should submit the receipt to AvMed Member Services with an explanation of why the prescription was purchased outside the service area. Feel free to print an Online Claim Form for easy submission.

19. Q: Why are out-of-pocket maximums being adjusted?

A: In 2015, the *out-of-pocket maximum* will be adjusted for all plans (from $1,500 to $2,500 for the NEW Select Plan, and to $3,000 for the High HMO and POS plans), in order to keep the **same level of benefits** and as a direct result of changes in the **Affordable Care Act** which require pharmacy costs to be applied to out-of-pocket expenses.

20. Q: What does it take to reach the current out-of-pocket maximum <u>today</u>?

A: Example below is **for illustrative purposes only** (High HMO)…..

Out-of-Pocket Example			
	Co-pay	Occurrences	Cost
Primary co-pays	$15	12	$180
Specialist co-pay	$30	34	$1,020
Emergency Room (High HMO)	$25	6	$150
Urgent Care (High HMO)	$25	6	$150
			$1,500

- Note: In 2013, 122 employees (with single coverage) enrolled in the High HMO plan reached their individual $1,500 out-of pocket maximum.

In 2015, pharmacy co-pays will count towards the out-of-pocket maximum and thus an adjustment to the out-of-pocket maximum is required to keep the value of the plan constant.

21. Q: What happens if I reach the out-of-pocket maximum?

A: Once the out-of-pocket maximum is reached, the County assumes the cost of remaining co-payments for the calendar year.

Individuals who have high pharmacy usage will be capped in 2015 where today, they are not. This may result in a benefit enhancement for these employees.

22. Q: If I currently have the POS plan and I am considering changing to either the High HMO or the Select Plan, how are pharmacy <u>brand</u> prescriptions covered?

A: The County's HMO options (including the Select Network option), unlike the POS option, provide coverage for <u>generic</u> prescriptions; if generic is available. If you choose an HMO option, and you or your doctor request the brand equivalent when the generic medication is available, you will be required to pay the applicable co-payment and additional charges for the brand medication. Additional charges are the difference between the cost of the Brand medication and the Generic medication, and will not count towards the out-of-pocket maximums.

23. Q: What are "Specialty Drugs"?

A: **Specialty drugs** are high-cost injectable, infused, oral, or inhaled drugs that generally require special storage or handling and close monitoring of the patient's drug therapy. These medications must be prescribed by a physician and are usually dispensed by the participating specialty pharmacy, depending on the medication. Examples: Enbrel, Boniva, Omnitrope (growth hormone), Humira.

- Note: Less than 1% of employees or dependents covered by our plans use specialty drugs.

24. Q: Is Insulin a specialty drug?

A: No.

25. Q: Is acupuncture covered in the Select Network?

A: No, it is not covered in the High HMO today. Acupuncture is covered on the POS plan (out-of network and subject to deductible and coinsurance).

26. Q: Is a CPAP device (continuous positive airway pressure) covered in the Select Network?

A: Yes, as long as the prescribing physician is under the Select Plan and the device is obtained at the participating Durable Medical Equipment (DME) provider.

As a reminder, out-of-network providers, other than for emergency and urgent care services, are only covered in the Point of Service plan.

27. Q: What is the cost of healthcare in the new Healthcare Public Exchanges offered as a result of the Affordable Care Act?

A: The monthly cost for an individual, age 50 for a comparable HMO plan on a Public Marketplace plan ranges from $497 to $636 per month.

28. Q: Is it true that the Benefits Redesign will be providing employees with "less generous" benefits?

A: The actuarial value of a Benefits Plan is a measure of the percent of in-network services that are covered under the plan design that are paid by the plan (Miami-Dade County) rather than the employee.

A plan with an actuarial value of 90% (a **"platinum"** plan under the Affordable Care Act (ACA) definition) would cover, on average, 90% of the cost of in-network services, meaning that the member would pay, on average, 10% of the cost in the form of copays, deductibles, and coinsurance. Currently (in 2014), the High HMO and POS plans are at the "platinum" level.

All three options included in the Benefits Redesign which will be available to employees in 2015 will remain at a "platinum" level.

29. **Q: I am a non-bargaining unit employee under the Mayor's purview; will I be required to continue contributing five percent of my base wages towards the overall cost of the County's healthcare?**
    A: In **FY 2014-15** employees under the Mayor's purview will not be required to contribute the 5% Insurance Contribution towards the overall cost of healthcare.

30. **Q: Is it true that all non-bargaining unit employees will be required to be on the Select Network Option?**
    A: No, the Select Network option is one of three options. Employees will still be able to choose the High HMO or the POS plans.

31. **Q: How do I know if my union is eligible for the Benefits Redesign… and the Select Plan Option?**
    A: Those unions that have ratified agreements for their respective 2014-2017 Collective Bargaining Agreements are eligible for this plan.

32. **Q: When does Open Enrollment begin for 2015?**
    A: Open Enrollment is tentatively scheduled to begin on October 27, 2014 and will run through November 14, 2014.

33. **Q: If I am a retiree, or soon to be retiree… when will premium rates be available?**
    A: Retiree premium rates will be made available during the Retiree Open Enrollment period.

34. **Q: Who can I call if I have additional questions?**
    A: Call **AvMed's Miami-Dade County Dedicated Member Service Unit at 1-800-682-8633**. They are ready to take your call 24 hours a day, 7 days a week.