2015 BENEFIT GUIDE

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

Miami-Dade County Self-Funded Medical Program

January 1, 2015

AvMed

Embrace better health.

Benefit Guide

For Employees and Pre-65 Retirees (and/or Dependents) of Miami-Dade County
Effective 1/1/15

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Dear Member,

AvMed is proud to be serving Miami-Dade County (MDC) employees. Whether you're new to the AvMed family or a long-time member, you have our commitment that we will provide personalized service focused on your individual needs.

We continue to build on our long tradition of service to help you feel more connected and engaged in your healthcare. Everything we do revolves around you. Our priority is to help you live healthier at every stage of life.

We believe in partnering with you through the entire healthcare experience, regardless of your stage in life or health status. So let us know how we can serve you...and thank you for placing your trust in us.

Sincerely,

James M. Repp,
Senior Vice President, Sales & Marketing

The AvMed **Advantage**

Welcome to AvMed

MDC employees have a dedicated Member Services unit for questions about benefits.

Call **1-800-68AVMED (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**.

When Is It an Emergency?

It's difficult to make clear decisions when you're suddenly experiencing what could be a serious health problem, such as a heart attack. But more than half of all ER visits are for minor, non-urgent problems. A visit to the emergency room can cost three to four times more than a visit to an urgent care center, and your wait could be as long as seven or eight hours. If you're ever unsure of your condition, call 911. Here are some guidelines:

Urgent Care Center *Know where they are*	Emergency Room *Know how to get there fast*	Ambulance *Call 911*
• Ear infections • Bronchitis • Fever	• Sudden, sharp, abdominal pain • Uncontrolled bleeding	• Chest pain • Difficulty breathing • Unconsciousness

Focused On Member Satisfaction

AvMed is a not-for-profit health plan, so we're focused on our members' healthcare rather than shareholders and stock dividends. It's part of the reason AvMed is consistently rated higher than our competitors for overall member satisfaction, according to the National Committee for Quality Assurance (NCQA) in the annual Consumer Assessment of Healthcare Providers and Systems survey (CAHPS)*. And it's why AvMed constantly seeks our members' feedback to make sure we're doing the best job possible. You can participate in the process by completing the survey you receive after enrolling.

Get Your Ounce Of Prevention For Free

One of the best defenses against illness – and high healthcare costs – is prevention. That's why AvMed's benefits include preventive care services at no charge. These include but are not limited to well-woman exams, annual physicals, well-child care, immunizations, colonoscopies, mammograms, obesity screenings, diabetes and cholesterol testing, tests for STDs, and smoking cessation counseling. If you want to know what screenings you're due to receive, visit **www.avmed.org/mdc**.

AvMed **Online**

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 co-payment, review your claims, print temporary ID card, need to find a doctor, or want more information about your benefits, visit **www.avmed.org/mdc**, or call **1-800-68AVMED (1-800-682-8633).**

Your **Coverage**

How Do I Find The Doctors I Want?

Whether you're looking for your family doctor or a highly recommended specialist, you can find out if they're part of AvMed's network by searching for their name, specialty, or locations. To find the physicians you're looking for, go to **www.avmed.org/mdc** or call **1-800-68AVMED (1-800 682-8633)**.

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.

If you're a new enrollee or making changes, please respond to this question when you enroll online in order for us to update our records. If we do not receive the information upon enrollment, we will mail you a COB questionnaire. You can also visit AvMed's website to update this information and submit it electronically. Coordination of Benefits information is necessary for AvMed to process your dependent's claim.

AvMed Embrace better health.

Start With Healthy Living.

Everyone enrolled in AvMed can take advantage of our Health and Wellness Program. These tools and services are offered to help you make wholesome lifestyle choices that can help you lower medical costs and keep you feeling healthy:

- **Personal Health Assessment (PHA)** to help identify health risks and set goals based on health needs
- **Stress Reduction Program** to keep stress levels low over time
- **Nutrition Planner** to help monitor eating habits
- **Weight Watchers® reimbursement program** to encourage healthier living
- **Discounts on services** like fitness centers, yoga, massage therapy, acupuncture, and other alternative solutions

To learn more about the advantages of leading a healthy lifestyle visit **www.avmed.org/mdc** and log into your AvMed account. On the left hand side of the screen, select Health and Wellness and under ***Tools for a Healthier You***, click on ***Wellness Portal powered by Healthyroads®***.

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.

Levels of Care

1

LEVEL 1 - Self-Care

Use a home remedy or first-aid kit, or get help from family members.
Examples: bee sting; minor cut; upset stomach; head cold

2

LEVEL 2 - Doctor

Have your doctor's phone numbers on hand.
Examples: fever; non-life-threatening illnesses; vomiting; skin rash; diarrhea; dehydration

3

LEVEL 3 - Urgent Care Center

Know where they are located.
Examples (if your doctor is unavailable): ear infection; bronchitis; allergic reaction; sprain or suspected fracture; general wound care

4

LEVEL 4 - Emergency Room

Know how to get there fast.
Examples: reasonable belief that your condition is life threatening; sudden, sharp abdominal pain; uncontrolled bleeding; complicated fracture

5

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 AvMed's Member Services or go to AvMed's website at **www.avmed.org/mdc**.

Important Phone Numbers

- Member Services: Call the number listed on your AvMed ID card.
- 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.

AvMed

Embrace better health.

Participating **Retail Clinics**

Staffed by board-certified nurse practitioners and/or physician assistants, retail clinics can be a convenient and affordable choice.

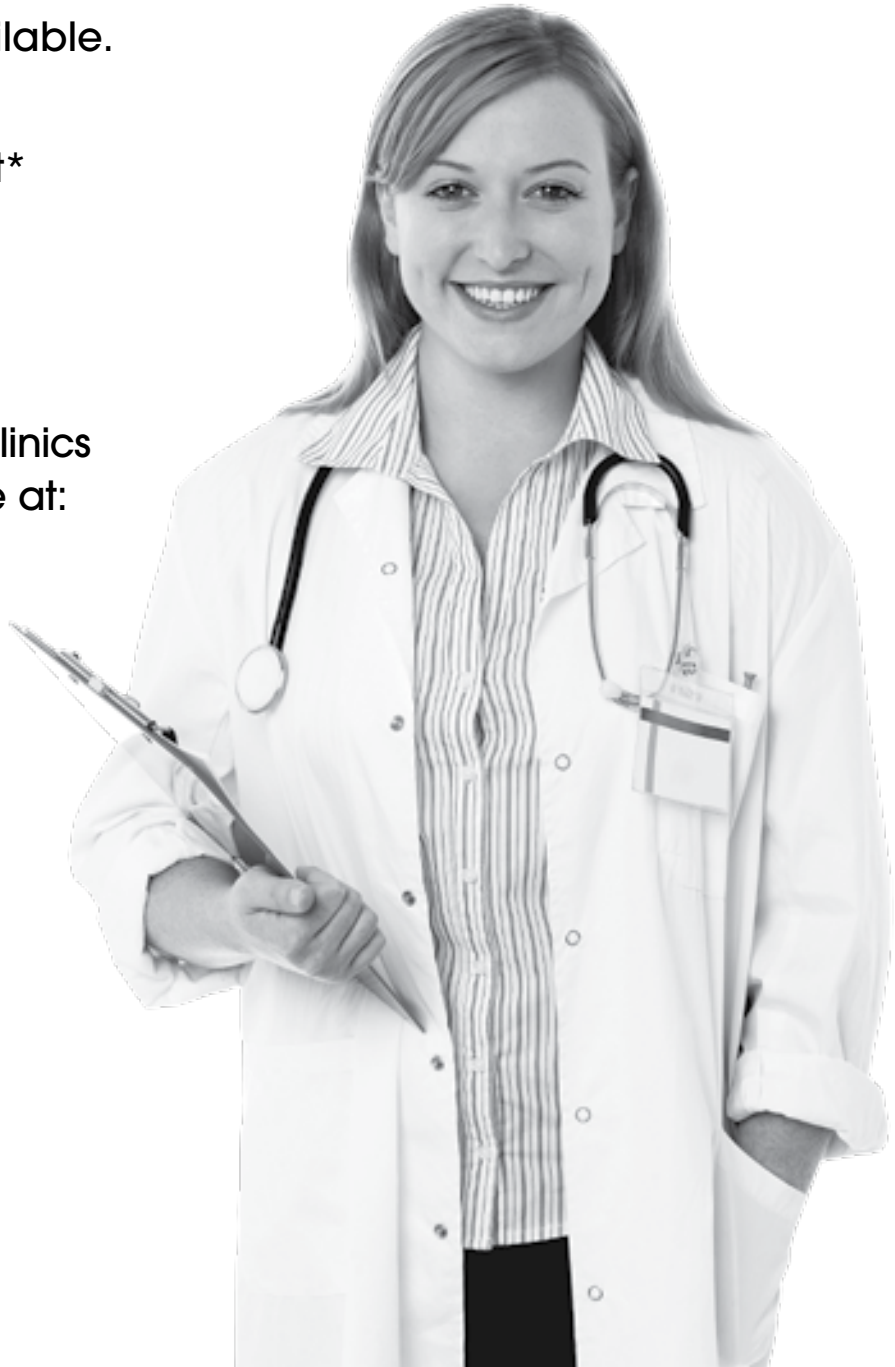
Conveniently located in a neighborhood store near you, retail clinics offer quality, basic medical care after hours, on weekends and when your doctor isn't available.

- Pay your PCP co-payment*
- No appointment needed
- Open seven days a week

A complete, statewide listing of clinics is available on AvMed's website at: **www.avmed.org/mdc**.

AvMed's Member Services is always available to help you. Call them at the number listed on your AvMed ID card.

* To pay your PCP co-payment, you must choose a retail clinic that is an AvMed participating clinic in Florida. Otherwise, you will pay your urgent care co-payment.



Benefit Summary

Miami-Dade County

Plan Redesign

AvMed Select MDC HMO

JANUARY 2015

Member Services: 1-800-682-8633

www.avmed.org/mdc

AvMed Embrace better health.

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 out–of–pocket limit 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 out–of–pocket limit?	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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.avmed.org/mdc or call 1-800-682-8633** for a list of participating providers. Participants must use **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 specialist?	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**.

- **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 Select 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 treatment limited to one sequence per member lifetime for the following: sperm count, endometrial biopsy, hysterosalpingography (HSG), and diagnostic laparoscopy. Artifical 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 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 **prescription drug coverage** 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 require prior authorization.
	Preferred brand drugs	$25 copay/ prescription (retail); $50 copay/ prescription (mail order)	Not Covered	Brand additional charges may apply. Certain drugs 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 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 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	Same as Select network	AvMed must be notified within 24 hours of emergency admission or as soon as reasonably possible.
	Emergency medical transportation	No Charge	Same as Select 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 Select 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 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/ 1st 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/ visit	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	Not Covered	Habilitative physical, occupational, & speech therapy services, when provided for the treatment of Autism Spectrum Disorder, are covered to a combined maximum of 100 visits per calendar year.
	Skilled nursing care	No Charge/ visit	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 contract for details.
	Hospice service	No Charge/ visit	Not Covered	Limited to 360 day per member lifetime maximum. Physician certification required.

Common Medical Event	Services You May Need	Your Cost If You Use a 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 excluded services.)

- Acupuncture
- Bariatric surgery
- Child Dental Check Up
- Child Glasses
- Cosmetic surgery
- 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.)

- Chiropractic care
- Infertility treatment (limited)

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** $1,280

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.

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.cciio.cms.gov or call 1-800-682-8633 to request a copy.

Notes

Miami-Dade County

Plan Redesign

High Option HMO

JANUARY 2015

Member Services: 1-800-682-8633

www.avmed.org/mdc

AvMed Embrace better health.

AvMed Embrace better health

MDC High Option HMO Redesign

Coverage Period: 01/01/2015 – 12/31/2015

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

Coverage for: All Coverage Tiers | **Plan Type:** HMO

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 out-of-pocket limit 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 out-of-pocket limit?	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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. **See www.avmed.org/mdc or call 1-800-682-8633** for a list of participating 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 specialist?	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 3. 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.cciio.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 treatment is limited to one sequence per member 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)	$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.
	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 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
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)	Not Covered	Retail copay applies per 30-day supply. 60-90 day supply via mail order. Certain drugs 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 AvMed network	AvMed must be notified within 24 hours of emergency admission or as soon as reasonably possible.
	Emergency medical transportation	No Charge	Same as AvMed 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 AvMed network	----------None----------
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.

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	$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/ 1st 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	Not Covered	Habilitative physical, occupational, & speech therapy services, when provided for the treatment of Autism Spectrum Disorder, 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 contract for details.
	Hospice service	No Charge	Not Covered	Limited to 360 day per member 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 excluded services.)

- Acupuncture
- Bariatric surgery
- Child Dental Check Up
- Child Glasses
- Cosmetic surgery
- 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.)

- Chiropractic care
- Infertility treatment (limited)

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.

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.cciio.cms.gov or call 1-800-682-8633 to request a copy.

Notes

Benefit Summary

Miami-Dade County

Plan Redesign

POS

JANUARY 2015

Member Services: 1-800-682-8633
www.avmed.org/mdc

AvMed Embrace better health.

AvMed Embrace better health

MDC POS Option Redesign

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

Coverage Period: 01/01/2015 – 12/31/2015
Coverage for: All Coverage Tiers | **Plan Type:** POS

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?	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 deductibles 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 out–of–pocket limit on my expenses?	Yes. In-Network: **$3,000** individual / **$6,000** dependent coverage Out-of Network: **$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 out–of–pocket limit?	Premiums, prescription drug brand additional charges, out-of-network balance-billed 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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. **See www.avmed.org/mdc or call 1-800-682-8633** for a list of participating 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 specialist?	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 6. 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.eciio.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 contract year.
	Preventive care/ screening/ immunization	No Charge	30% coinsurance after deductible	----------None----------
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	30% coinsurance after deductible	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
	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 require prior authorization.
	Preferred brand drugs	$40 copay/ prescription (retail); $80 copay/ prescription (mail order)	30% coinsurance, not subject to deductible	Certain drugs require prior authorization.
	Non-preferred brand drugs	$55 copay/ prescription (retail); $110 copay/ prescription (mail order)	30% coinsurance, not subject to deductible	Certain drugs require prior authorization.
	Specialty drugs	$100 copay/ prescription (retail)	30% coinsurance, not subject to deductible	Not available via mail order. Certain drugs 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.
If you need immediate medical attention	Emergency room services	$100 copay/ visit (waived if admitted)	Same as AvMed network	AvMed must be notified within 24 hours of emergency admission or as soon as reasonably possible.
	Emergency medical transportation	No Charge	Same as AvMed 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 AvMed 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.

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
	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/ 1st 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 visits maximum per contract 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	30% coinsurance after deductible	Habilitative physical, occupational, & speech therapy services, when provided for the treatment of Autism Spectrum Disorder, 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 contract year deductible	30% coinsurance after deductible for DME and orthotics	Some limitations apply. Please see your contract for details. External prosthetic appliances are not covered Out-of-Network.
	Hospice service	No Charge	30% coinsurance after deductible	Limited to 360 day per member 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 excluded services.)

- Child Dental Check Up
- Child Glasses
- Cosmetic surgery
- 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.)

- Acupuncture (limited to out-of-network)
- Bariatric surgery (for morbid obesity)
- Chiropractic care
- Infertility treatment (limited)

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.
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Does this Coverage Provide Minimum Essential Coverage?

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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** $4,130
- **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.

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.

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Notes

Benefit Summary

Miami-Dade County
Without Plan Redesign
High Option HMO

JANUARY 2015

Member Services: 1-800-682-8633
www.avmed.org/mdc

AvMed Embrace better health.

AvMed Embrace better health

MDC High Option HMO

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

Coverage Period: 01/01/2015 – 12/31/2015

Coverage for: All Coverage Tiers | **Plan Type:** HMO

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 out–of–pocket limit 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 out–of–pocket limit?	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 *specific* covered services, such as office visits.**
Does this plan use a network of providers?	Yes. **See www.avmed.org/mdc or call 1-800-682-8633** for a list of participating 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 specialist?	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.cciio.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 treatment is limited to one sequence per member 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.

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.	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 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	Same as AvMed network	AvMed must be notified within 24 hours of emergency admission or as soon as reasonably possible.
	Emergency medical transportation	No Charge	Same as AvMed 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/ 1st 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/ visit	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	Not Covered	Habilitative physical, occupational, & speech therapy services, when provided for the treatment of Autism Spectrum Disorder, are covered to a combined maximum of 100 visits per calendar year.
	Skilled nursing care	No Charge/ visit	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 contract for details.
	Hospice service	No Charge/ visit	Not Covered	Limited to 360 day per member 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 excluded services.)

- Acupuncture
- Bariatric surgery
- Child Dental Check Up
- Child Glasses
- Cosmetic surgery
- 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.)

- Chiropractic care
- Infertility treatment (limited)

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.

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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.

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Notes

Benefit Summary

Miami-Dade County
Without Plan Redesign
Low Option HMO

JANUARY 2015

Member Services: 1-800-682-8633
www.avmed.org/mdc

AvMed Embrace better health.

AvMed Embrace better health

MDC Low Option HMO

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

Coverage Period: 01/01/2015 – 12/31/2015
Coverage for: All Coverage Tiers | **Plan Type:** HMO

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 out–of–pocket limit on my expenses?	Yes. **$6,350** individual/**$12,700** 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 out–of–pocket limit?	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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.avmed.org/mdc or call 1-800-682-8633** for a list of participating 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 specialist?	Yes.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
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.cciio.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 treatment is limited to one sequence per member 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.

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.	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 require prior authorization.
	Preferred brand drugs	$35 copay/ prescription (retail); $70 copay/ prescription (mail order)	Not Covered	Brand additional charges may apply. Certain drugs 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 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 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	Same as AvMed network	AvMed must be notified within 24 hours of emergency admission or as soon as reasonably possible.
	Emergency medical transportation	No Charge	Same as AvMed 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.

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/ 1st 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.
If you need help recovering or have other special health needs	Home health care	No Charge/ visit	Not Covered	Approved treatment plan required.
	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	Not Covered	Habilitative physical, occupational, & speech therapy services, when provided for the treatment of Autism Spectrum Disorder, are covered to a combined maximum of 100 visits per calendar year.
	Skilled nursing care	No Charge/ visit	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 contract for details.
	Hospice service	No Charge/ visit	Not Covered	Limited to 360 day per member 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 excluded services.)

- Acupuncture
- Bariatric surgery
- Child Dental Check Up
- Child Glasses
- Cosmetic surgery
- 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.)

- Chiropractic care
- Infertility treatment (limited)

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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.**

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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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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** $7,320
- **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.

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.

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.cciio.cms.gov or call 1-800-682-8633 to request a copy.

Notes

Benefit Summary

Miami-Dade County
Without Plan Redesign
POS

JANUARY 2015

Member Services: 1-800-682-8633
www.avmed.org/mdc

AvMed Embrace better health.

AvMed Embrace better health. **MDC POS Option**

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

Coverage Period: 01/01/2015 – 12/31/2015
Coverage for: All Coverage Tiers | **Plan Type:** POS

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?	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 deductibles 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 out-of-pocket limit 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)	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 out-of-pocket limit?	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.	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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. **See www.avmed.org/mdc or call 1-800-682-8633** for a list of participating 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 specialist?	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.cciio.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 contract year.
	Preventive care/ screening/ immunization	No Charge	30% coinsurance after deductible	----------None----------
If you have a test	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
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 require prior authorization.
	Preferred brand drugs	$25 copay/ prescription (retail); $50 copay/ prescription (mail order)	30% coinsurance, not subject to deductible	Certain drugs require prior authorization.
	Non-preferred brand drugs	$35 copay/ prescription (retail); $70 copay/ prescription (mail order)	30% coinsurance, not subject to deductible	Certain drugs 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 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.
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 AvMed 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.

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	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/ 1st visit only	30% coinsurance after deductible	Subsequent visits at no charge when performed in AvMed network.
	Delivery and all inpatient services	No Charge	30% coinsurance after deductible	Prior authorization required.
If you need help recovering or have other special health needs	Home health care	No Charge/ visit	30% coinsurance after deductible	Approved treatment plan required. Out-of-Network home health care limited to 60 visits maximum per contract 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	30% coinsurance after deductible	Habilitative physical, occupational, & speech therapy services, when provided for the treatment of Autism Spectrum Disorder, are covered to a combined maximum of 100 visits per calendar year.
	Skilled nursing care	No Charge/ visit	30% coinsurance after deductible	Limited to 60 days per calendar year. 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
	Durable medical equipment	No Charge/ device for DME and orthotics; No Charge for external prosthetic appliance, after $200 contract year deductible	30% coinsurance after deductible for DME and orthotics	Some limitations apply. Please see your contract for details. External prosthetic appliances are not covered Out-of-Network.
	Hospice service	No Charge/ visit	30% coinsurance after deductible	Limited to 360 day per member 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 excluded services.)

- Child Dental Check Up
- Child Glasses
- Cosmetic surgery
- 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.)

- Acupuncture (limited to out-of-network)
- Bariatric surgery (for morbid obesity)
- Chiropractic care
- Infertility treatment (limited)

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** $4,130
- **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.

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.

Notes

Limitations & Exclusions

Miami-Dade County HMO

JANUARY 2015

Member Services: 1-800-682-8633
www.avmed.org/mdc

AvMed Embrace better health.

The following is an excerpt from the Summary Plan Descriptions for the Miami-Dade County HMO Health Plans

IX. LIMITATIONS OF BASIC BENEFITS

The rights of Members and obligations of Participating Providers hereunder are subject to the following Limitations:

9.01 In the event of any major disaster, Participating Providers shall render Hospital and Medical Services provided under this Contract insofar as practical, according to their best judgment, within the limitations of such facilities and personnel as are then available, but AvMed and Participating Providers shall have no liability or obligation for delay or failure to provide or arrange for such services due to lack of available facilities or personnel if such lack is the result of any major disaster.

9.02 In the event of circumstances not reasonably within the control of AvMed or the County, such as complete or partial destruction of facilities, an act of God, war, riot, civil insurrection, disability of a significant part of Hospital or participating medical personnel or similar causes, if the rendition of Medical Services and Hospital Services provided under this Contract is delayed or rendered impractical, neither AvMed, Participating Providers, nor any physician shall have any liability or obligation on account of such delay or failure to provide services; however, AvMed shall make a good faith effort to arrange for the timely provision of covered services during such event.

9.03 Periodic physical examinations are limited to those that, in the judgment of the Member's Primary Care Physician, are essential to the maintenance of the Member's good health.

9.04 Visits to licensed dietitians/nutritionists for treatment of obesity control shall be limited to three outpatient visits per contract year and each visit requires a Co-payment.

9.05 Spinal manipulations (Chiropractic) will be covered only when Medically Necessary and prescribed by a Participating Physician or by self-referral to a Participating Physician.

9.06 The total benefit for Ventilator Dependent Care is limited to 100 contract days lifetime maximum.

9.07 In the event that a Member is confined in a participating or Non-participating facility after receiving Emergency Medical Services and Care, AvMed must be notified by the Hospital, Member or designee, within 24 hours following the day of admission if reasonably possible.

9.08 Other Health Care Facility (ies). All routine inpatient services of Other Health Care Facilities (see Section 2.37), (including physician visits, physiotherapy, diagnostic imaging and laboratory work), are covered for a maximum of 60 days per calendar year when a Member is admitted to such a facility, following discharge from a Hospital, for a condition that cannot be adequately treated with Home Health Care Services or on an ambulatory basis.

9.09 Abortion covered when medically necessary.

9.10 Hospice Care is limited to 360 days lifetime.

9.11 Durable Medical Equipment includes, but is not limited to: hospital beds, walkers, crutches, wheelchairs, apnea monitors, oxygen and its administration, fetal heart rate monitors, external cardiac defibrillator vests, vacuum assisted closure devices, and insulin pumps. Upon meeting medical criteria, the cost of insulin pumps as well as oxygen and its administration will not count toward the DME annual maximum. Vacuum assisted closure devices and external cardiac defibrillator vests will count toward the DME annual maximum but will continue to be covered by the Plan.

9.11.01 Orthotic Appliances are limited to the following and are covered as part of the same contract year maximum as Durable Medical Equipment:

Nonfoot orthoses – only the following nonfoot orthoses are covered:

- Rigid and semirigid custom fabricated orthoses;.
- Semirigid prefabricated and flexible orthoses; and
- Rigid prefabricated orthoses including preparation, fitting and basic additions such as bars and joints.

Coverage is limited to the first such item; replacement is covered only when Medically Necessary due to a change in bodily configuration. Replacement for damage due to abuse or misuse by the person will not be covered.

9.12 Prosthetic Devices for Deluxe, Myo-electric and electronic prosthetic devices are not covered.

9.13 Cardiac Rehabilitation is covered for the following conditions and is limited to 36 visits per contract year:

- Acute myocardial infarction
- Percutaneous transluminal coronary angioplasty (PTCA)
- Repair or replacement of heart valves
- Coronary artery bypass graft (CABG), or
- Heart transplant

9.14 Physical, Occupational, Respiratory and Speech Therapy have a combined limit of 60 visits per calendar year for short term therapy for acute condition.

9.15 Surgical or non-surgical procedures, which are undertaken to improve or otherwise modify the Member's external appearance, shall be limited to reconstructive surgery to correct and repair a functional disorder as a result of a disease, injury, or congenital defect or initial implanted prosthesis and reconstructive surgery incident to a mastectomy for cancer of the breast.

9.16 Hyperbaric oxygen treatments are limited to 40 treatments per condition as appropriate pursuant to the Centers for Medicare and Medicaid Services (CMS) guidelines, subject to applicable Co-payments as listed for physical, speech and occupational therapies.

9.17 Wigs/Cranial Prosthesis is limited to a lifetime maximum of $300 when related to restoration after cancer or brain tumor treatment.

9.18 Infertility coverage is limited to diagnostic testing and procedures performed specifically to determine the cause of infertility. Diagnostic procedures are limited to sperm count, endometrial biopsy, hysterosalpingography (HSG) and diagnostic laparoscopy (limited to one sequence per Member per lifetime).

9.19 Transplant Services. Transportation benefits for transplant services are administered through Optum Health, an AvMed third party partner. Benefits are limited to $200 per day up to $10,000 lifetime maximum for a companion to accompany the Member (or two companions when the patient is a minor) and the member has to travel greater than a 50 mile radius to receive the transplant. This is a benefit available only when the transplant is authorized at one of AvMed's transplant contracted facilities nationwide.

9.20 Habilitative physical, occupational, & speech therapy services, when provided for the treatment of Autism Spectrum Disorder, are covered to a combined maximum of 100 visits per calendar year.

The following is an excerpt from the Summary Plan Descriptions for the Miami-Dade County HMO Health Plans

X. EXCLUSIONS FROM BASIC BENEFITS

Medical Services and benefits for the following classifications and conditions are not covered and are excluded from this Benefit Plan:

10.01 Treatment of a condition resulting from:

(a) Participation in a riot or rebellion;

(b) Engagement in an illegal occupation;

(c) Commission, or attempted commission, of an assault; commission or attempted commission of a crime punishable as a felony.

10.02 Cosmetic, surgical or non-surgical procedures which are undertaken primarily to improve or otherwise modify the Member's external appearance. Also excluded are surgical excision or reformation of any sagging skin of any part of the body, including, but not limited to: the eyelids, face, neck, abdomen, arms, legs, or buttocks; any services performed in connection with the enlargement, reduction, implantation or change in appearance of a portion of the body, including, but not limited to: the face, lips, jaw, chin, nose, ears, breasts, or genitals (including circumcision, except newborns for up to one year from date of birth); hair transplantation, chemical face peels or abrasion of the skin, electrolysis depilation, removal of tattooing; or any other surgical or non-surgical procedures which are primarily for cosmetic purposes or to create body symmetry. Additionally, all medical complications as a result of cosmetic, surgical or non-surgical procedures are excluded.

10.03 Medical care or surgery not authorized by a Participating Provider, except for Emergency Medical Services and Care, or not within the benefits covered by AvMed.

10.04 Dental Care for any condition except:

(a) When such services are for the treatment of trauma related fractures of the jaw or facial bones or for the treatment of tumors;

(b) Reconstructive jaw surgery for the treatment of deformities that are present and apparent at birth;

(c) Full mouth extraction when required before radiation therapy; or

(d) Treatment following injury to sound natural teeth started within six months of accident.

10.05 Services related to the diagnosis/treatment of temporomandibular joint (TMJ) dysfunction except when Medically Necessary; all dental treatment for TMJ.

10.06 Mandibular and maxillary osteotomies except when Medically Necessary to treat conditions caused by congenital or developmental deformity, disease, or injury.

10.07 Except for ostomy supplies, urinary catheter bags and certain wound care supplies, medical supplies including, but not limited to pre-fabricated splints, Thromboemboletic/Support hose and all other bandages are not covered.

10.08 Home monitoring devices and measuring devices (other than apnea monitors), and any other equipment or devices for use outside the Hospital.

10.09 Surgically implanted devices and any associated external devices, except for cardiac pacemakers, intraocular lenses, cochlear implants in deaf children based on the likelihood for a successful outcome, artificial joints and orthopedic hardware, vascular grafts, neurostimulators, and implantable pain pumps.

10.10 Over-the-counter medications.

10.11 Travel expenses including expenses for ambulance services to and from a physician or Hospital except for emergency care or when authorized by the health plan.

10.12 Treatment for armed forces service-connected medical care (for both sickness and injury).

10.13 Custodial Care.

10.14 Experimental and/or investigational procedures, except for bone marrow transplants, as approved per Florida Administrative Code, Section 59B-12.001. For the purposes of this Plan, a medication, treatment, device, surgery or procedure may be determined to be experimental and/or investigational if any of the following applies:

(a) The FDA has not granted the approval for general use;

(b) There are insufficient outcomes data available from controlled clinical trials published in peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved;

(c) There is no consensus among practicing physicians that the medication, treatment, therapy, procedure or device is safe or effective for the treatment in question or such medication, treatment, therapy, procedure or device is not the standard treatment, therapy, procedure or device utilized by practicing physicians in treating other patients with the same or a similar condition; or

(d) Such medication, treatment, procedure or device is the subject of an ongoing Phase I or Phase II clinical investigation, or experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosages, toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the condition in question.

10.15 Personal comfort items not Medically Necessary for proper medical care as part of the therapeutic plan to treat or arrest the progression of an illness or injury. This Exclusion includes, but is not limited to: wigs (including partial hair pieces, weaves, and toupees) except following treatment of cancer or a brain tumor, personal care kits, guest meals and accommodations, maid services, televisions/radios, telephone charges, photographs, complimentary meals, birth announcements, take home supplies, travel expenses (other than Medically Necessary ambulance services), air conditioners, humidifiers, dehumidifiers, and air purifiers or filters.

10.16 Physical examinations or tests, such as premarital blood tests or tests for continuing employment, education, licensing, or insurance or that are otherwise required by a third party.

10.17 Eye care including:

(a) Eye examinations for Members 18 years of age or older for the purpose of determining the need for sight correction (such as eye glasses or contact lenses);

(b) Training or orthoptics, including eye exercises; or

(c) Radial keratotomy, refractory keratoplasty, Lasik surgery or any other corneal surgical procedure to correct refractive error.

10.18 Hearing examinations for Members 18 years of age or older for the purpose of determining the need for hearing correction.

10.19 Cosmetics, dietary supplements, health or beauty aids, and nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.

10.20 Gastric stapling, gastric bypass, gastric banding, gastric bubbles, and other procedures for the treatment of obesity or morbid obesity, as well as any related evaluations or diagnostic tests. Ongoing visits other than establishing a program of obesity control.

10.21 Gender reassignment surgery as well as any service, supply, or medical care associated with gender reassignment or gender identity disorders.

10.22 Sexual Dysfunction benefits are not available for sex therapy and drug therapies except certain drugs approved by the Plan and only to treat erectile dysfunction due to an organic cause.

10.23 Artificial Insemination Services including: In-vitro, GIFT, ZIFT, etc.

10.24 Reversal of sterilization procedures.

10.25 Immunizations and medications for the purpose of foreign travel or employment.

10.26 Acupuncture, biofeedback, hypnotherapy, massage therapy, sleep therapy, sex therapy, behavioral training, cognitive therapy, and vocational rehabilitation.

10.27 Foot supports are not covered. These include orthopedic or specialty shoes, shoe build-ups, shoe orthotics, foot orthotics, shoe braces, and shoe supports. Also excluded is routine foot care, including trimming of corns, calluses, and nails.

10.28 The Medical Services and Hospital Services for a donor or prospective donor who is covered under this Plan or another Plan sponsored by this Plan Sponsor when the recipient of an organ transplant is not covered by this Plan Sponsor. Coverage is provided for costs associated with the bone marrow donor-patients to the same extent as the covered recipient. The reasonable costs of searching for the bone marrow donor is limited to family Members and the National Bone Marrow Donor Program. Post-transplant donor complications will not be covered.

10.29 Diagnostic testing and treatment related to mental retardation or deficiency, learning disabilities, behavioral problems, developmental delays. Expenses for remedial or special education, counseling, or therapy including evaluation and treatment of the above listed conditions or behavioral training whether or not associated with manifest mental disorders or other disturbances.

10.30 Emergency room services for non-emergency purposes.

10.31 Hospital Services that are associated with excluded surgery or Dental Care

10.32 Any treatment or service from a Non-participating Provider, except in the case of an emergency or when specifically pre-authorized by AvMed.

10.33 Speech therapy for delayed or abnormal speech pathology. In cases where a child is born deaf, the Plan would evaluate coverage for treatment options, including speech therapy and implants, based on the likelihood for successful outcome.

10.34 Vocational rehabilitation, pulmonary rehabilitation, or long term rehabilitation.

10.35 Surgery for the augmentation of the size of the breasts except as required for the comprehensive treatment of breast cancer. Surgery for the reduction of the size of the breasts, except as required for the comprehensive treatment of breast cancer, is not covered unless deemed Medically Necessary by the Medical Director.

10.36 Termination of pregnancy unless deemed Medically Necessary by the Medical Director, subject to applicable State and Federal laws.

10.37 Hospital Exclusion. If a Member elects to receive Hospital care from a non-participating Attending Physician or a non-participating Hospital, then coverage is excluded for the entire episode of care, except when the admission was due to an emergency or with the prior written authorization of AvMed.

10.38 Ventilator Dependent Care in excess of 100 days lifetime maximum benefit.

10.39 Private duty nursing services.

10.40 Any sickness or injury for which the covered person is paid benefits, or may be paid benefits if claimed, if the covered person is covered or required to be covered by Workers' Compensation. In addition, if the covered person enters into a settlement giving up rights to recover past or future medical benefits under a Workers' Compensation law, AvMed shall not cover past or future Medical Services that are the subject of or related to that settlement. Furthermore, if the covered person is covered by a Worker's Compensation program that limits benefits if other than specified health care providers are used and the covered person receives care or services from a health care provider not specified by the program, AvMed shall not cover the balance of any costs remaining after the program has paid.

10.41 Complications of any non-covered service, including the evaluation or treatment of any condition that arises as a complication of a non-covered service.

10.42 Any service or supply to eliminate or reduce dependency on or addiction to tobacco, including but not limited to: nicotine withdrawal programs, facilities, and supplies (e.g. transdermal patches, Nicorette gum).

10.43 Services associated with autopsy or postmortem examinations, including the autopsy.

10.44 Exercise programs, gym Memberships, or exercise equipment of any kind, including, but not limited to: exercise bicycles, treadmills, stairmasters, rowing machines, free weights or resistance equipment. Also excluded are massage devices, portable whirlpool pumps, hot tubs, jacuzzis, sauna baths, swimming pools and similar equipment.

10.45 Removal of warts, moles, skin tags, lipomas, keloids, scars, and other benign skin lesions is not covered, even with a recommendation or prescription by a physician, unless AvMed determines that there is sufficient justification for removal.

10.46 Expenses for supplies, care, treatment, or surgery that are not Medically Necessary.

10.47 For or in connection with any injury or sickness resulting from war, declared or undeclared, covered by the state or other governmental entity.

Notes

Limitations & Exclusions

Miami-Dade County POS

JANUARY 2015

Member Services: 1-800-682-8633
www.avmed.org/mdc

AvMed Embrace better health.

The following is an excerpt from the Summary Plan Description for the Miami-Dade County POS Health Plan

IX. LIMITATIONS OF BASIC BENEFITS

9.01 Short-term Rehabilitative Therapy and Spinal Manipulation Services

All therapy services must be restorative in nature in order to be covered. Restorative Therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of injury or sickness. Restorative therapy services do not include therapy designed to acquire levels of function that had not been previously achieved prior to the injury or sickness.

Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an injury or sickness.

9.02 Breast Reconstruction and Breast Prostheses

Covered benefits for reconstructive surgery following a mastectomy include: occupational surgical services for reconstruction of the breast on which surgery was performed; surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance; post-operative breast prostheses; and mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

9.03 Treatment or control of clinically severe (morbid) obesity:

Benefits for medical and surgical services for the treatment or control of clinically severe (morbid) obesity as defined below and if the services are demonstrated, through existing peer reviewed, evidence based, scientific literature and scientifically based guidelines, to be safe and effective for the treatment or control of the condition. Clinically severe (morbid) obesity is defined by the National Heart, Lung and Blood Institute (NHLBI) as a Body Mass Index (BMI) of 40 or greater without comorbidities, or a BMI of 35-39 with comorbidities. The following items are specifically excluded:

- Medical and surgical services to alter appearances or physical changes that are the result of any medical or surgical services performed for the treatment or control of obesity or clinically severe (morbid) obesity; and
- Weight loss programs or treatments, whether or not they are prescribed or recommended by a Physician or under medical supervision.

9.04 Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct, provided that:

- the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
- the orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease or;
- the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review Physician.

9.05 Genetic Testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:

- a person has symptoms or signs of a genetically-linked inheritable disease;
- it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
- the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per contract year for both pre and post genetic testing.

9.06 Nutritional Evaluation made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease.

9.07 Durable Medical Equipment is limited to the lowest-cost alternative as determined by AvMed. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility.

9.08 External Prosthetic Appliances and Devices made or ordered by a Physician for the initial purchase and fitting of external prosthetic appliances and devices available only by prescription necessary for the alleviation or correction of injury, sickness or congenital defect. Coverage for External Prosthetic Appliances is limited to the most appropriate and cost effective alternative as determined by AvMed.

9.09 Replacement of external prosthetic appliances and devices is limited to the following:

- Replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.

Coverage for replacement is limited as follows:

- No more than once every 24 months for persons 19 years of age and older and
- No more than once every 12 months for persons 18 years of age and under.
- Replacement due to a surgical alteration or revision of the site.

9.10 Custom foot orthoses are only covered as follows:

- for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
- when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
- when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and

- for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

Coverage is limited to the first such item; replacement is covered only when Medically Necessary due to a change in bodily configuration. Replacement for damage due to abuse or misuse by the person will not be covered

9.11 Wigs/cranial prostheses are limited to a lifetime maximum of $300 when related to restoration after cancer or brain tumor treatment.

9.12 Other Health Care Facility (ies). All routine services of Other Health Care Facilities (see Section 2.40), including Physician visits, physiotherapy, diagnostic imaging and laboratory work, are covered for a maximum of sixty (60) days per calendar year when a Member is admitted to such a facility, for a condition that cannot be adequately treated with Home Health Care Services, or on an ambulatory basis.

9.13 Abortion Services. Abortion services are covered when medically necessary.

9.14 Transplant Services. Transportation benefits for transplant services are administered through Optum Health, an AvMed third party partner. Benefits are limited to $200 per day up to $10,000 lifetime maximum for a companion to accompany the Member (or two companions when the patient is a minor) and the member has to travel greater than a 50 mile radius to receive the transplant. This is a benefit available only when the transplant is authorized at one of AvMed's transplant contracted facilities nationwide.

9.15 Habilitative physical, occupational, & speech therapy services, when provided for the treatment of Autism Spectrum Disorder, are covered to a combined maximum of 100 visits per calendar year.

The following is an excerpt from the Summary Plan Description for the Miami-Dade County POS Health Plan

X. EXCLUSIONS

Medical Services and benefits for the following classifications and conditions are not covered and are excluded from this Benefit Plan:

10.01 Expenses for supplies, care, treatment, or surgery that are not Medically Necessary.

10.02 To the extent that you or any one of your covered Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.

10.03 To the extent that payment is unlawful where the person resides when the expenses are incurred.

10.04 Charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government:

- unless there is a legal obligation to pay such charges whether or not there is insurance; or
- if such charges are directly related to a military-service-connected Injury or Sickness.

10.05 Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.

10.06 Charges for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:

- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
- the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section of this plan; or
- the subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of this plan.

10.07 Cosmetic surgery and therapies defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.

10.08 Regardless of clinical indication, charges for macromastia surgery; surgical treatment of abdominoplasty/panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.

10.09 Charges for or in connection with treatment of the teeth or periodontium unless such expenses are incurred:

- for a continuous course of dental treatment started within six months of an Injury to sound natural teeth; or
- made by a Hospital for Bed and Board or Necessary Services and Supplies; or
- made by a Free-Standing Surgical Facility or the outpatient department of a Hospital in connection with surgery; or
- charges made by a Physician for any of the following Surgical Procedures: excision of epulis; excision of unerupted impacted tooth, including removal of alveolar bone and sectioning of tooth; removal of residual root (when performed by a Dentist other than the one who

extracted the tooth); intraoral drainage of acute alveolar abscess with cellulitis; alveolectomy; gingivectomy, for gingivitis or periodontitis.

10.10 Medical and surgical services, initial and repeat, intended for the treatment or control of obesity are not covered except for surgery for morbid obesity, as shown in Covered Expenses. Services not covered include medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.

10.11 Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court ordered, forensic or custodial evaluations.

10.12 Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.

10.13 Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.

10.14 Any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation. Sexual dysfunction benefits are not available for drug therapies except certain drugs approved by the Plan and only to treat erectile dysfunction due to organic cause.

10.15 Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.

10.16 Non-medical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, or mental retardation.

10.17 Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.

10.18 Private Hospital rooms unless semi-private rooms are not available and/or private duty nursing except as provided under the Home Health Services provision

10.19 Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.

10.20 Orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs (except under section 9.11).

10.21 Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs), except for cochlear implants in deaf children. A hearing aid is any device that amplifies sound.

10.22 Aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.

10.23 Medical benefits for eyeglasses, contact lenses or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery.

10.24 Charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.

10.25 Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.

10.26 Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.

10.27 Genetic screening or pre-implantations genetic screening. General population-based genetic screening performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.

10.28 Dental implants for any condition.

10.29 Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.

10.30 For or in connection with an Injury or Sickness which is due to war, declared or undeclared.

10.31 Any sickness or injury for or in connection with any injury or sickness arising out of, or in the course of, any employment for wage or profit; including any sickness or injury for which the covered person is covered (or required to be covered) by Workers' Compensation. In addition, if the covered person enters into a settlement giving up rights to recover past or future medical benefits under a Workers' Compensation law, AvMed shall not cover past or future Medical Services that are the subject of or related to that settlement. Furthermore, if the covered person is covered by a Worker's Compensation program that limits benefits if other than specified health care providers are used and the covered person receives care or services from a health care provider not specified by the program, AvMed shall not cover the balance of any costs remaining after the program has paid.

10.32 Telephone, e-mail, and Internet consultations and telemedicine.

10.33 Massage therapy.

10.34 For charges which would not have been made if the person had no insurance.

10.35 To the extent that they are more than Maximum Reimbursable Charges.

10.36 Expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure.

10.37 To the extent of the exclusions imposed by any certification requirement shown in this plan.

10.38 The following are specifically excluded from Mental Health and Substance Abuse Services:

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.
- Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.

- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- Counseling for activities of an educational nature.
- Counseling for borderline intellectual functioning.
- Counseling for occupational problems.
- Counseling related to consciousness raising.
- Vocational or religious counseling.
- I.Q. testing.

10.39 The following charges for Hospice Care Services are not included as Covered Expenses:

- for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- for any period when you or your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the Plan; and
- for services or supplies that are primarily to aid you or your Dependent in daily living.

10.40 Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:

- Bed Related Items: bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including non-power mattresses, custom mattresses and posturepedic mattresses.
- Bath Related Items: bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- Chairs, Lifts and Standing Devices: computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs.
- Fixtures to Real Property: ceiling lifts and wheelchair ramps.
- Car/Van Modifications.
- Air Quality Items: room humidifiers, vaporizers, air purifiers and electrostatic machines.
- Blood/Injection Related Items: blood pressure cuffs, centrifuges, nova pens and needle less injectors
- Other Equipment: heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

10.41 The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- orthoses primarily used for cosmetic rather than functional reasons;
- orthoses primarily for improved athletic performance or sports participation; and

- Copes scoliosis braces.

10.42 The following are specifically excluded external prosthetic appliances and devices:

- External and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- Myoelectric prostheses peripheral nerve stimulators.

10.43 The following are specifically excluded infertility services:

- Artificial insemination
- In vitro fertilization (IVF); gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT) and variations of these procedures;
- Reversal of male and female voluntary sterilization;
- Infertility services when the infertility is caused by or related to voluntary sterilization;
- Donor charges and services;
- Cryopreservation of donor sperm and eggs; and
- Any experimental, investigational or unproven infertility procedures or therapies.

10.44 Short-term Rehabilitative Therapy and Spinal Manipulation Services that are not covered include but are not limited to:

- sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
- treatment for functional articulation disorder such as correction of tongue thrust, lips, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury;
- services that are custodial, instructional, educational or developmental in nature;
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.

10.45 The following are specifically excluded from Spinal Manipulation Services:

- services of a chiropractor which are not within his scope of practice, as defined by state law;
- charges for care not provided in an office setting; and
- vitamin therapy.

10.46 Speech therapy for delayed or abnormal speech pathology. In cases where a child is born deaf, the Plan would evaluate coverage for treatment options, including speech therapy and implants, based on the likelihood for successful outcome.

10.47 Clinical Trials: Routine patient services do not include, and reimbursement will not be provided for: Charges made for routine patient services associated with cancer clinical trials approved and sponsored by the federal government.

In addition, the following criteria must be met:

- the cancer clinical trial is listed on the NIH web site www.clinicaltrials.gov as being sponsored by the federal government;
- the trial investigates a treatment for terminal cancer and: (1) the person has failed standard therapies for the disease; (2) cannot tolerate standard therapies for the disease; or (3) no effective non-experimental treatment for the disease exists;
- the person meets all inclusion criteria for the clinical trial and is not treated "off-protocol";

- the trial is approved by the Institutional Review Board of the institution administering the treatment; and
- coverage will not be extended to clinical trials conducted at nonparticipating facilities if a person is eligible to participate in a covered clinical trial from a Participating Provider.

Clinical Trials: Routine patient services do not include, and reimbursement will not be provided for:

- the investigational service or supply itself;
- services or supplies listed herein as Exclusions;
- services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs);
- services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

10.48 Surgery for the augmentation of the size of the breasts except as required for the comprehensive treatment of breast cancer. Surgery for the reduction of the size of the breasts, except as required for the comprehensive treatment of breast cancer, is not covered unless deemed Medically Necessary by the Medical Director.

10.49 Nutritional supplies and formulae except for infant formula needed for the treatment of inborn errors of metabolism.

10.50 Complication of a non-covered service is not covered.

Pre-Enrollment Kit

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 your AvMed Group Medical and Hospital Service Contract or Summary of Benefits and Coverage (SBC).

JANUARY 2015

Member Services: 1-800-682-8633

www.avmed.org/mdc

AvMed Embrace better health.

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:

- Dedicated MDC toll free Member Services
- 24-hour, toll-free Nurse On Call program staffed by AvMed registered nurses
- Savings on alternative health services
- Discounts on eyeglasses and contact lenses
- Dedicated MDC website, your online resource for health and benefits information
- MDC Online Provider Directory
- Decision Support Tools, your comprehensive set of tools designed to help you become a more informed healthcare consumer

Medical Excellence

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 view AvMed's standards, go to the MDC dedicated website at **www.avmed.org/mdc** and click on ***Find a Doctor***.

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 Certificate of Coverage or Summary Plan Description.

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 our Member Services Department at the number listed on your AvMed ID card. 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 a PCP and Changing a PCP
Primary care physicians 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 primary care physician.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
Primary care physicians 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 Certificate of Coverage for specific plan information.

Behavioral Health Services
AvMed provides its members with a high quality mental health program. Depending on your plan, you may have direct access to mental health providers throughout the state without having to contact your PCP. Mental health diagnosis and treatment services are covered on an outpatient basis. Additional mental 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 Certificate of Coverage or Summary Plan Description for specific plan information.

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 Group Medical and Hospital Service Contract (Certificate of Coverage) or Summary Plan Description.

Urgent Care Center Know where they are	**Emergency Room** Know how to get there fast	**Ambulance** Call 911	**Retail Clinic** Basic medical care
• Ear Infections • Minor cuts • Fever	• Sudden, sharp abdominal pain • Uncontrolled bleeding	• Chest pain • Difficulty breathing • Loss of consciousness	• 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 co-payment, co-insurance or deductible*

To find a participating clinic near you, access AvMed's website at **www.avmed.org/mdc**. Follow the instructions under ***Find a Doctor*** on the home page. AvMed's Member Services is always available to help you. Call them at the toll-free number listed on the back of your AvMed ID card or email us at **mdc.members@avmed.org**.

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 Member Services. You must present your AvMed 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 Certificate of Coverage or Summary Plan Description and Prescription Drug Benefits Rider or Amendment.

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 ***Medication Lists*** at the right 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 *Find a Doctor*.

Services and Programs

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

Member Services – 24 Hours a Day, 7 Days a Week
AvMed's Member Services 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 Member Services Department toll-free from anywhere (TTY 711), 24 hours a day, 7 days week. You may also visit our website at **www.avmed.org/mdc** or email Member Services 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 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.

Healthy Living Programs
At AvMed, we're constantly exploring ways to help you maintain good health. To that end, we offer a variety of wellness strategies and programs that can enhance both your well-being and your quality of life, putting you on the road to better health and keeping you there.

If you want to maintain your good health, we give you many options to help you become more proactive and prevent illness. Plus, plenty of support and motivation with programs such as:

- Weight Watchers® reimbursement program
- Discounts on fitness centers
- Nutrition counseling
- Yoga and other alternative health services

To find a practitioner in your area, go to AvMed's website at **www.avmed.org/mdc**. Log in to click on ***Health and Wellness*** from the list at the left of the screen. When you enter through our website, the information you receive is customized for AvMed members. If you don't have Internet access, call AvMed Member Services for assistance.

For more information, call AvMed Member Services at the number listed on your AvMed ID card.

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 AvMed Member Services at the number listed on your AvMed ID card.

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 AvMed's Preferred Medication List. 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 ID card or a temporary ID card
- Eligibility
- Information on co-payment, deductible and/or co-insurance 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!

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.

Estimate Healthcare Costs.
Research and approximate the total cost of the most common inpatient, outpatient and diagnostic testing procedures. The treatment cost calculator helps you understand and manage costs as well as plan for future healthcare expenses. Compare costs through searching by gender, region and age. When finished, you'll receive a summary of anticipated costs.

Things You Should Know

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 preventative health services and know the identity and professional status of individuals providing services to them.
- The confidentiality of information about their medical health condition being maintained by the plan and the right to approve or refuse the release of member specific information including medical records, by AvMed, except when the release is required by law.

- Participate in decisions involving their healthcare and to give informed consent for any procedure after receiving information about risk, length of inactivity, and choices of alternative treatment plans available 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.
- A second opinion from another participating physician or non-participating consultant in the AvMed's service area.*
- Know about any transfer to another hospital, including information about why the transfer is necessary and any alternatives available.
- Be fully informed of the complaint, and grievance processes and use them without fear of interruption of health services.
- To make recommendations regarding the Plan's members' rights and responsibilities policies.
- Written notice of any termination or change in benefits, services or the member's providers.

* *A portion of the cost of a non-participating consultant will be the responsibility of the member. This benefit includes consultation only and does not guarantee continued care with consulting provider.*

Members have the responsibility to:

- Choose an AvMed participating Primary Care Physician and establish themselves with this physician.**
- Become knowledgeable about their health plan coverage including covered benefits, limitations and exclusions, procedures regarding use of participating providers and referrals.
- Take part in improving their health by maximizing healthy habits.
- Provide accurate and complete information about their health.
- Ask any questions and seek any clarification necessary to adequately understand their illness and/or treatment. Follow the recommended and mutually agreed upon treatment plan.
- Keep appointments reliably, and promptly notify the provider when unable to so.
- Fulfill financial obligations for receiving care, as required by their 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 AvMed Member Services at the number listed on your AvMed ID card. 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 Group Medical and Hospital Service Contract (Certificate of Coverage) or Summary Plan Description.

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.

Notice of Privacy Practices

Miami-Dade County

JANUARY 2015

Member Services: 1-800-682-8633
www.avmed.org/mdc

AvMed Embrace better health.

Effective 04/14/2003

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 10/2013

AvMed, we are here to help you

live healthier at every stage of life!

For more information about AvMed, call Member Services at **1-800-682-8633**

www.avmed.org/mdc

AvMed

Embrace better health.

MDC-SF-3633(10/14)