



2015 BENEFIT GUIDE

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

Miami-Dade County Self-Funded Medical Program

January 1, 2015



Embrace better health.

Benefit Guide

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

Table of Contents:

Welcome to AvMed	3
AvMed Overview	4
AvMed Online	5
Your Coverage	5
Healthy Living	6
Emergency Room vs Urgent Care	7
Retail Clinics	8
MDC Plan Redesign:	
AvMed Select MDC HMO	9
Redesign High Option HMO	19
Redesign POS	29
MDC Without Plan Redesign:	
High Option HMO	39
Low Option HMO	49
POS	59
HMO Limitations & Exclusions	69
POS Limitations & Exclusions	77
Pre-Enrollment Kit	87
Notice of Privacy Practices	97



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, nonurgent 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	Emergency Room	Ambulance
Center Know where they are	Know how to get there fast	Call 911
 Ear infections Bronchitis Fever	 Sudden, sharp, abdominal pain Uncontrolled 	Chest painDifficulty breathing
	bleeding	 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.





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

23

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

LEVEL 2 - Doctor *Have your doctor's phone numbers on hand.* Examples: fever; non-life-threatening illnesses; vomiting; skin rash; diarrhea; dehydration

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

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

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.



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



document at www	document at www.avmed.org/mdc of by caling 1-800-062-5055.	
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 <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-</u> 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 <u>out-of-pocket</u> <u>limit</u> ?	Premiums, prescription drug brand additional charges, and services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-</u> pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>spedit</i> 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 <u>specialist</u> ?	No. You do not need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Ycs.	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.

see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-682-8633 to request a copy. AVSF_H_3575_0115

Summary of Ben	AvMed Select MDC HMC nefits and coverage: What this Plan	Summary of Benefits and Coverage: What this Plan Covers & What it Costs	Covera	Coverage Period: 01/01/2015 – 12/31/2015 Coverage for: All Coverage Tiers Plan Type: HMO
Copay Coinsi the plat	ments are fixed dollar trance is <i>your</i> share of n's <u>allowed amount</u> fo	Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service. Coinsurance is <i>your</i> share of the costs of a covered service, calculated as a percent of the <u>allowed amount</u> for the service. For the plan's <u>allowed amount</u> for an overnight hospital stay is \$1,000, your <u>coinsurance</u> payment of 20% would be \$200. This m	overed health care, usu s a percent of the <u>allo</u> r <u>coinsurance</u> payme	Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service. Coinsurance is <i>your</i> share of the costs of a covered service, calculated as a percent of the <u>allowed amount</u> for the service. For example, if the plan's <u>allowed amount</u> for an overnight hospital stay is \$1,000, your <u>coinsurance</u> payment of 20% would be \$200. This may change if
You na The an <u>allowe</u> the <u>all</u>	you haven t met your <u>deductible</u> . The amount the plan pays for cov allowed amount, you may have to the allowed amount is \$1,000, yo This plan may encourage you to u	you naven t met your <u>deductione</u> . The amount the plan pays for covered services is based on the <u>allowed amount</u> . If an out-of-network <u>provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay the <u>allowed amount</u> is \$1,000, you may have to pay the \$500 difference. (This is called <u>balance billing</u> .) This plan may encourage you to use Select network <u>providers</u> by charging you lower <u>deductibles</u> , <u>copayments</u> and <u>coinsurance</u> amo	amount. If an out-of- n out-of-network hos e. (This is called <u>balan</u> ng you lower <u>deducti</u>	you naven t met your <u>deductions</u> . The amount the plan pays for covered services is based on the <u>allowed amount</u> . If an out-of-network <u>provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the <u>allowed amount</u> is \$1,000, you may have to pay the \$500 difference. (This is called <u>balance billing</u> .) This plan may encourage you to use Select network <u>providers</u> by charging you lower <u>deductibles</u> , <u>copayments</u> and <u>coinsurance</u> 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
	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.
If you visit a health care <u>provider's</u> office or clinic	Other practitioner office visit	S15 copay/ visit for chiropractic services; S15 copay/ visit for podiatry services; S15 copay/visit for allergy injections; S30 copay/visit for allergy skin testing; S30 copay/ visit for infertility treatment	Not Covered	Infertility treatment limited to one sequence per member lifetime for the following: sperm count, endometrial biopsy, hysterosalpingo- graphy (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
	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.
If you have a test	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.

Ave Embroce Summary of Ben	AvMed Select MDC HM nefits and Coverage: What this Pla	Ave Emergence Summary of Benefits and Coverage: What this Plan Covers & What it Costs	Covera	Coverage Period: 01/01/2015 – 12/31/2015 Coverage for: All Coverage Tiers Plan Type: HMO
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	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.
condition	Preferred brand drugs	\$25 copay/ prescription (retail); \$50 copay/ prescription (mail order)	Not Covered	Brand additional charges may apply. Certain drugs require prior authorization.
More information about	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.
prescription drug coverage is available at <u>www.avmed.org/</u> mdc	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	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.
surgery	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	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.
immediate medical attention	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	Facility fee (e.g., hospital room)	No Charge	Not Covered	Prior authorization required.
hospital stay	Physician/surgcon fee	No Charge	Not Covered	Prior authorization required.

Ave Emproce Summary of Bene	AvMed Select MDC HM nefits and Coverage: What this Pla	Ave Emergence 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
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
	Mental/Behavioral health outpatient services	\$15 copay/ visit	Not Covered	Includes applied behavior analysis for treatment of Autism Spectrum Disorder.
If you have mental health, behavioral	Mental/Behavioral health inpatient services	No Charge	Not Covered	Prior authorization required.
health, or substance abuse needs	Substance use disorder outpatient services	\$15 copay/ visit	Not Covered	Nonc
	Substance use disorder inpatient services	No Charge	Not Covered	Prior authorization required.
If you are	Prenatal and postnatal care	$30 \operatorname{copay} / 1^{st} \operatorname{visit} \operatorname{only}$	Not Covered	Subsequent visits at no charge.
pregnant	Delivery and all inpatient services	No Charge	Not Covered	Prior authorization required.
	Home health care	No Charge/ visit	Not Covered	Approved treatment plan required.
	Rehabilitation services	\$30 copay/ visit for physical, occupational, speech & respiratory therapics; \$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.
If you need help recovering or have other	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.
special nearth	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.

14	Ave Betterheam Summary of Bene	AvMed Select MDC HMC efits and Coverage: What this Pla	AMO Enternation AvMed Select MDC 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
	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
	10. T. T. T.	Eye exam	\$15 copay/ visit	Not Covered	Limited to 1 exam per year to determine the need for sight correction.
	It your child needs dental or	Glasses	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.
	eye care	Dental check-up	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.
	Excluded Serv	ices & Other Co	Excluded Services & Other Covered Services:		
	Services Your Pl	an Does NOT Cov	Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)	ur policy or plan doc	ument for other excluded services.)
	 Acupuncture 		 Dental care (Adult) 		 Private duty nursing
	 Bariatric surgery Child Daniel Charle 11. 	ands I fee	 Hearing aids 		 Routine eye care (Adult)
	Child Classes	cen up	 Long-term care 		 Routine foot care
	 Cosmetie surgery 	~	 Non-emergency care when traveling outside the U.S. 	ng outside the U.S.	 Weight loss programs
	Other Covered S services.)	ervices (This isn't	a complete list. Check your policy or pl	an document for oth	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 If you lose coverage coverage. Any such while covered under For more informatic U.S. Department of Human Services at 1 Your Grievanc If you have a compli- questions about you For plans subject to <u>www.dol.gov/ebsa</u> ,	Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending coverage. Any such rights may be limited in duration while covered under the plan. Other limitations on y For more information on your rights to continue con U.S. Department of Labor, Employee Benefits Secur Human Services at 1-877-267-2323 x61565 or <u>www</u> . Four Grievance and Appeals Rights: If you have a complaint or are dissatisfied with a den questions about your rights, this notice, or assistance For plans subject to ERISA, you may also contact th <u>www.dol.gov/febsa</u> , or the U.S. Department of Healt	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 keel 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 y 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 may also apply. U.S. Department of Labor, Employee Benefits Security Administration at 1-806-444-3272 or <u>www.dol.gov/ebsa</u> , or the U.S. Department of Health Human Services at 1-877-2023 x61565 or <u>www.ectio.erns.gov</u> . Your Grievance and Appeals Rights: If you have a complaint or are dissuisfied with a denial of coverage for claims under your plan, you may be able to <u>appeal</u> or file a <u>grievance</u> . 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 1-877-267-2523 x61565 or <u>www.ectio.erns.gov</u> .	d and State laws may p emium, which may he may also apply. -682-8633. You may al -3272 or <u>wow.dol.gov</u> -3272 or <u>wow.dol.gov</u> sour plan, you may he pour plan, you may he iber Services Departm nployee Benefits Secur 267-2323 x61565 or <u>w</u>	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 may also apply. To more information on your rights to continue coverage may also apply. U.S. Department of Labor, Employee Benefits Security Administration at 1-800-682-8633. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-806-444-3272 or <u>www.dol.gov/ebsa</u> , or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or <u>www.ccito.cms.gon</u> . Your Grievance at 1-800-682-8633. You may also contact you may be able to <u>appeal</u> or file a <u>grievance</u> . For questions about your rights, this notice, or assistance, you can connact AMed'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 1-800-682-8633.

16	Average Examples	C HMO	Coverag	Coverage Period: 01/01/2015 – 12/31/2015 Coverage for: All Coverage Tiers Plan Type: HMO	31/2015 e: HMO
	About these Coverage Examples:	Having a baby (normal delivery)		Managing type 2 diabetes (routine maintenance of a well-controlled condition)	les
	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	 Amount owed to providers: \$7,540 Plan pays \$7,470 Patient pays \$70 Sample care costs: 	540	 Amount owed to providers: \$5,400 Plan pays \$4,080 Patient pays \$1,280 Sample care costs: 	400
	covered under different plans.	Hospital charges (mother)	\$2,700	Prescriptions	\$2,900
		Routine obstetric care	\$2,100	Medical Equipment and Supplies	\$1,300
		Hospital charges (baby)	\$900	Office Visits and Procedures	\$700
	This is	Anesthesia	\$900	Education	\$300
		Laboratory tests	\$500	Laboratory tests	\$100
		Prescriptions	\$200	Vaccines, other preventive	\$100
	estimator.	Radiology	\$200	Total	\$5,400
	Don't use these examples to	Vaccines, other preventive	\$40		
	estimate vour actual costs	Total	\$7,540	Patient pays:	
	under this plan. The actual			Deductibles	\$0
	care you receive will be	Patient pays:		Copays	\$1,280
	different from these	Deductibles	\$0	Coinsurance	50
	examples, and the cost of	Copays	S70	Limits or exclusions	\$40
	that care will also be	Coinsurance	\$0	Total	\$1,320
	different.	Limits or exclusions	\$0		
	See the next page for	Total	\$70		
	important information about				
	tnese examples.				

Questions and answers abo	Questions and answers about the Coverage Examples:	
What are some of the assumptions behind the	What does a Coverage Example show?	Can I use Coverage Examples to compare plans?
 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 	For each treatment situation, the Coverage Example helps you see how <u>deductibles</u> , <u>copayments</u> , and <u>coinsurance</u> 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.	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 particular geographic area or health plan. The patient's condition was not an excluded or preexisting condition. 	Does the Coverage Example predict my own care needs?	are plan provides. Are there other costs I should
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-	X 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.	consider when comparing plans? <u>Yes</u>. 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 consyments.
network providers . If the patient had received care from out-of-network providers , costs would have been higher.	Does the Coverage Example predict my future expenses?	deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts
	★ 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.	(HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.



Miami-Dade County Plan Redesign High Option HMO JANUARY 2015

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



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

Questions: Call 1-800-682-8633 or visit us at www.avmed.org/mdc. If you arcn't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.eccilo.cons.gov or call 1-800-682-8633 to request a copy. AVSF_H_3576_0115

ample, \$15) you pay for covered health care, usual wered service, calculated as a percent of the allows hospital stay is \$1,000, your coinsurance payment sis based on the allowed amount. If an out-of-no fference. For example, if an out-of-network hospit to pay the \$500 difference. (This is called balance no pay the \$500 difference. (This is called balance no pay the \$500 difference. (This is called balance no pay the \$500 difference. (This is called balance no pay the \$500 difference. (This is called balance no pay the \$500 difference. (This is called balance network Provider Not Covered sit for Ulse an Not Covered sit for chiropractic Not Covered sit for allergy injections; Not Covered no; for allergy injections; Not Covered sit for allergy injections; Not Covered Instead no; for allergy injections; Not Covered Instead no; for allergy injections; Not Covered Instead Instead			amounts (for example, \$15) you pay for o he costs of a covered service, calculated	covered health care, usu	
Promotic the plan point accusation. Proceed amount, you may have to pay the fiftherate: For example, if an out-of-network hospial charges \$1,300 for work amount, you may have to pay the fiftherate: For example, if an out-of-network hospial charges \$1,300 for work amount, you may have to pay the \$500 difference. (This is called balance billing.) • This plan may encourage you oue x Model network. Provider Wour Gost If You Limitations & E Common Services You Xour Cost If You Use an Out of Notwork Provider Multitional charges \$1,500 for the allowed network provider. Common Services You Xour Cost If You Use an Out of Notwork Provider Multitional charges \$1,500 for the allowed network Provider Multitional charges \$1,500 for other service and the allowed network Provider Multitional charges \$1,500 for other allowed network \$1,500 for other \$1,500 for other \$1,500 for other \$1,500	Copay Coinsi the plan	ments are fixed dollar a <u>trance</u> is <i>your</i> share of t n's <u>allowed amount</u> fo	r an overnight hospital stay is \$1,000, yo	as a percent of the <u>allov</u> ur <u>coinsurance</u> paymer	any when you receive the service. wed amount for the service. For example, if int of 20% would be \$200. This may change if
Services You May NeedYour Cost If You Use an Out of AvMed Network ProviderYour Cost If You Use an Out of Network ProviderPrimary care visit to treat an injury or illnessS15 copay/ visit S15 copay/ visit for chiropracticNot GoveredSpecialist visitS30 copay/ visit for chiropractic servicesNot CoveredS15 copay/ visit for allergy injections office visitNot CoveredS15 copay/ visit for allergy injections soffice visitNot CoveredS16 copay/ visit for allergy injections soffice visitNot CoveredS17 copay/ visit for allergy injections soffice visitNot CoveredS18 copay/ visit for allergy injections soffice visitNot CoveredS10 copay/ visit for infertilityNot CoveredImmunizationS100 copay/ visit for infertilityImaging (CT/PETStolen or independent/ non-hospital based facilityImaging (CT/PETStolen or independent/ non-hospital based facilityImaging (CT/PETStolen or independent/ non-hospital based facilityImaging (CT/PETStolen or independent/ non-hospital based facility	You na The an <u>allowe</u> the <u>all</u>	ven t met your <u>deductu</u> hount the plan pays for <u>d amount</u> , you may ha <u>bwed amount</u> is \$1,000 an may encourage you	DIC. covered services is based on the <u>allower</u> ve to pay the difference. For example, if), you may have to pay the \$500 difference to use AvMed network providers by cha	<u>1 amount</u> . If an out-of- an out-of-network hosp ce. (This is called <u>balan</u> urging you lower <u>deduct</u>	network provider charges more than the bital charges \$1,500 for an overnight stay and ce billing .) tibles, copayments and coinsurance amounts.
Primary care visit to treat an injury or illnessS15 copay/ visitNot CoveredSpecialist visitS30 copay/ visit for chiropractic striccs;Not CoveredSpecialist visitS30 copay/ visit for chiropractic serviccs;Not CoveredOther practitioner services;S15 copay/ visit for allergy injections; so copay/ visit for infertility treatmentNot CoveredPreventive immunizationS10 copay/ visit for infertility treatmentNot CoveredDiagnostic test scens, blood work)S100 copay/ visit for infertility treatmentNot CoveredDiagnostic test scens, blood work)S100 copay/ visit for infertility blood work)Not CoveredDiagnostic test scens, MRIs)S100 copay/ test at hospital based facility. No charge at Jackson Health blood facility Sistem or independent/non-hospital based facilityNot CoveredDiagning (CT/PETS100 copay/ test at hospital based blood work)Not CoveredSistem or independent/non-hospital based facility.Not CoveredSistem or independent/non-hospital blood work)Sistem or independent/non-hospital basedSistem or independent/non-hospital blood work)Sistem or independent/non-hospital basedSistem or independent/non-hospital blood work)Sistem or independent/non-hospital based	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
Specialist visit30 copay/ visitNot CoveredS15 copay/ visitNot CoveredNot CoveredS15 copay/ visitS15 copay/ visitNot CoveredS15 copay/ visitNot CoveredNot CoveredS15 copay/ visitS16 copay/ visitNot CoveredS15 copay/ visitNot CoveredNot CoveredS15 copay/ visitS10 copay/ visitNot CoveredS15 copay/ visitNot CoveredNot CoveredS16 copay/ visitNot CoveredNot CoveredS17 copay/ visitNot CoveredNot CoveredS18 copay/ visitS100 copay/ test at hospital basedNot CoveredImaging (CT/PETS100 copay/ test at hospital basedNot CoveredS200 copay/ test at hospital basedS100 copay/ test at hospital basedNot CoveredS100 copay/ test at hospital basedS100 copay/ test at hospital basedNot CoveredS100 copay/ test at hospital basedS100 copay/ test at hospital basedNot CoveredS100 copay/ test at hospital basedS100 copay/ test at hospital basedNot CoveredS200 copay/ test at hospital basedS100 copay/ test at hospital basedNot CoveredS200 copay/ test at hospital basedS100 copay/ test at hospital basedNot CoveredS200 copay/ test at hospital basedS100 copay/ test at hospital basedNot CoveredS200 copay/ test at hospital based </th <td></td> <td>Primary care visit to treat an injury or illness</td> <td>S15 copay/ visit</td> <td>Not Covered</td> <td>Additional charges may apply for non- preventive services performed in the physician's office.</td>		Primary care visit to treat an injury or illness	S15 copay/ visit	Not Covered	Additional charges may apply for non- preventive services performed in the physician's office.
S15 copay/ visit for chiropractic services; S15 copay/ visit for podiatry services; S15 copay/ visit for allergy injections; S15 copay/visit for infentility teratmentNot CoveredPreventive care/screening/ munizationNot Covered Not CoveredNot CoveredDiagnostic test (s-ray, blood work) based facility; No charge at Jackson Health System or independent/non-hospital based facility; No charge at Jackson Health System or independent/non-hospital based facility; No charge at Jackson Health based facility; No charge at Jackson Health 		Specialist visit	\$30 copay/ visit	Not Covered	Additional charges may apply for non- preventive services performed in the physician's office.
Preventive care/screening/ immunizationNo Charge care/screening/ Not CoveredNot CoveredDiagnostic test (x-ray, blood work)\$100 copay/ test at hospital based facility, No charge at Jackson Health 	If you visit a health care <u>provider's</u> office or clinic	Other practitioner office visit	S15 copay/ visit for chiropractic services; S15 copay/ visit for podiatry services; S15 copay/visit for allergy injections; S30 copay/visit for allergy treatment and skin testing; S30 copay/ visit for infertility treatment	Not Covered	Infertility treatment is limited to one sequence per member lifetime for the following: sperm count, endometrial biopsy, hysterosalpingo- graphy (HSG), and diagnostic laparoscopy. Artificial insemination, In-vitro fertilizations, GIFT, ZIFT, and other infertility treatments are not covered.
Diagnostic test \$100 copay/ test at hospital based facility; No charge at Jackson Health (x-ray, blood work) Not Covered System or independent/non-hospital based facility Not Covered Imaging (CT/PET scans, MRIs) \$100 copay/ test at hospital based System or independent/non-hospital based facility		Preventive care/screening/ immunization	No Charge	Not Covered	None
Imaging (CT/PET \$100 copay/ test at hospital based scans, MRIs) System or independent/non-hospital Not Covered Not Covered		Diagnostic test (x-ray, blood work)	S100 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.
	II you nave a test	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.

AVSF_H_3576_0115

vices You / Need eric drugs erred brand s erred brand b r-preferred d drugs d drugs iny fee (e.g., ulatory surgery er) sician/surgeon			
u need s to treat illness or lition c information t information c information c information c information c information drugs brand drugs brand drugs brand drugs brand drugs brand drugs bread drugs bread drugs c information brand drugs brand drugs brand drugs c information brand drugs c information c informatio	Your Cost If You Use an AvMed Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
ition Preferred brand cinformation t cription drugs rage is able at atmed orge, brand drugs preferred brand drugs preferred brand drugs preferred prand drugs preferred prand drugs cription drugs attent t preferred prand drugs preferred prand drugs prand	\$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.
e information t cription drug rage is able at armed.org/ secialty drugs specialty drugs able at armed.org/ Fracility fee (e.g., ambulatory surgery center) Physician/surgeon	\$40 copay/ prescription (retail); \$80 copay/ prescription (mail order)	Not Covered	Brand additional charges may apply. Certain drugs may require prior authorization.
trage is able at avmed.org/ Specialty drugs avmed.org/ Fracility fee (e.g., ambulatory surgery center) u have ery ery Physician/surgeon	S55 copay/ prescription (retail); S110 copay/ prescription (mail order)	Not Covered	Brand additional charges may apply. Certain drugs may require prior authorization.
Facility fee (e.g., ambulatory surgery center) Physician/surgeon	\$100 copay/ prescription (retail)	Not Covered	Not available via mail order. Brand additional charges may apply. Certain drugs may require prior authorization.
Physician/surgeon	S100 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.
Iccs	No Charge	Not Covered	Charges for office visits may also apply if services are performed in a physician's office. Prior authorization required.
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 S25 copa facility; S clinic	\$25 copay/ visit at urgent care facility; \$15 copay/ visit at retail clinic	Same as AvMed network	None-
If you have a Pacility fee (e.g., \$200 cop hospital room) No charg	\$200 copay/ admission; No charge at Jackson Health System	Not Covered	Prior authorization required.
hospital stay Physician/surgeon No Char, fee	No Charge	Not Covered	Prior authorization required.

Ave Embroce Summary of Ben	Ave Embrace MDC High Option HMO Summary of Benefits and Coverage: What this P	AMO Better MDC High Option HMO 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: HMO
Common Medical Event	Services You May Need	Your Cost If You Use an AvMed Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
	Mental/Behavioral health outpatient services	\$15 copay/ visit	Not Covered	Includes applied behavior analysis for treatment of Autism Spectrum Disorder.
If you have mental health, behavioral	Mental/Behavioral health inpatient services	\$200 copay/ admission; No charge at Jackson Health System	Not Covered	Prior authorization required.
health, or substance abuse needs	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	Prenatal and postnatal care	$30 \operatorname{copay} / 1^{st} \operatorname{visit} \operatorname{only}$	Not Covered	Subsequent visits at no charge.
pregnant	Delivery and all inpatient services	\$200 copay/ admission; No charge at Jackson Health System	Not Covered	Prior authorization required.
	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.
If you need help recovering or have other	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.
special nearth	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.

AVSF_H_3576_0115

Services You Your Cost If You Use an Out of AvMed Network Provider Your Cost If You Use an Out of Network Provider Eye exam 815 copay/ visit Not Covered Not Cover	mmon edical EventServices You May NeedYour Cost If You Use an Out of Network Providerwith May NeedAvMed Network ProviderUse an Out of Network Provideryour childEye exam\$15 copay/ visitNot Coveredyour childEye exam\$15 copay/ visitNot Coveredded dental or eds dental or e careBenal check-upNot CoveredNot CoveredDental check-upNot CoveredNot CoveredNot CoveredAvmuntNot CoveredServices & Other CoveredNot CoveredCluded Services & Other Covered Services:Dental check UpEventing aidsArupunctureDental Check UpEventing aidsChild ClassesOut-comerciesNon-complete list. Check your policy or plan docuAcupunctureDental Check UpEventing aidsConnerie surgeryNon-complete list. Check your policy or plan docuConnerie surgeryNon-complete list. Check your policy or plan document for otherBrinatrie surgeryNon-complete list. Check your policy or plan document for otherConnerie surgeryNon-complete list. Check your policy or plan document for otherChild ClassesNon-complete list. Check your policy or plan document for otherConnerie surgeryNon-complete list. Check your policy or plan document for otherChild ClassesNon-complete list. Check your policy or plan document for otherConnerie surgeryInferdity reatment (limited)Child ClassesInferdity treatment (limited)	Summary of Be	Summary of Benefits and Coverage: What this Pl	Summary of Benefits and Coverage: What this Plan Covers & What it Costs	Coverag	Coverage Period: 01/01/2015 – 12/31/2015 Coverage for: All Coverage Tiers Plan Type: HMO
Eye exam \$15 copay/ visit Not Covered eds dental or eds dental or bental check-up Not Covered Not Covered Dental check-up Not Covered Not Covered Dental check-up Not Covered Not Covered Dental check-up Not Covered Not Covered Cluded Services & Other Covered Services: Not Covered Not Covered Acupuncture Emetal check Up Not Covered Services: Not Covered Acupuncture Emetal check Up Emetal care (Adult) Hearing aids Child Dental Check Up Emetal care (Adult) Hearing aids Emetal care (Adult) Child Dental Check Up Emetal care (Adult) Emetal care (Adult) Emetal care (Adult) Bariatrie surgery Emetal care (Adult) Emetal care (Adult) Emetal care (Adult) Bariatrie surgery Emetal care (Adult) Emetal care (Adult) Emetal care (Adult) Bariatrie surgery Emetal care (Adult) Emetal care (Adult) Emetal care (Adult) Child Dental Check Up Emetal care (Adult) Emetal care (Adult) Emetal care (Adult) Child Dental Check	Byour child ceds dental or ceds dental or de care Eye exam S15 copay/ visit Not Covered Glasses Not Covered Not Covered Not Covered Not Covered Dental check-up Not Covered Not Covered Not Covered Not Covered Acupancian Not Covered Not Covered Not Covered Not Covered Acupancian Not Covered Not Covered Not Covered Not Covered Acupancian Not Covered Not Covered Not Covered Not Covered Acupancian Not Covered Not Covered Not Covered Not Covered Acupancian Not Covered Not Covered Not Covered Not Covered Acupancian Not Covered Not Covered Not Covered Not Covered Acupancian Not Covered Not Covered Not Covered Not Covered Acupancian Not Covered Not Covered Not Covered Not Covered Acupancian Not Covered Not Covered Not Covered Not Covered Colid Demal Check Up Not Covered Ser	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
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Dental check-up Not Covered Dental check-up Not Covered Scluded Services & Other Covered Services: Tryices Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan docu Acupuncture Dental care (Adult) Bariatrie surgery Dental care (Adult) Child Dental Check Up Dental care (Adult) Child Dental Check Up Don-emergency care Child Glasses Non-emergency care when traveling outside the U.S. Child Glasses Non-emergency care when traveling outside the U.S. Child Check Up Don-emergency care when traveling outside the U.S. Child Classes Non-emergency care when traveling outside the U.S. Child Classes Infertility treatment (limited)	Dental check-up Not Covered Dental check-up Not Covered Xcluded Services & Other Covered Services: Not Covered Xcluded Services & Other Covered Services: Not Covered Services: Acupuncture Dental care (Mult) Bariatrie surgery Eneral care (Mult) Child Dental Check Up Dental care (Mult) Child Dental Check Up Non-emergency care when traveling outside the U.S. Child Glasses One-emergency care when traveling outside the U.S. Cosmetic surgery Non-emergency care when traveling outside the U.S. Cosmetic surgery Infertility treatment (limited) Chitopractic care Infertility treatment (limited)	It your child needs dental or	Glasses	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 Bartatrie surgery Child Dental Check Up Entance surgery Hearing aids Child Dental Check Up Hearing aids Child Glasses Non-emergency care when traveling outside the U.S. 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 the services.) Child Stasses Example the U.S. Reatine foot care Neight loss programs Cosmetic surgery Infertility treatment (limited) 	 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 s Acupuncture Acupuncture Acutine stoper Acutine stoper Acutine foot care Connect state Acutine foot care Acutine foot care<td>cyc care</td><td>Dental check-up</td><td>Not Covered</td><td>Not Covered</td><td>Not covered under this medical and pharmacy benefits plan.</td>	cyc care	Dental check-up	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.
 Acupuncture Bariatric surgery Bariatric surgery Child Dental Check Up Hearing aids Child Glasses Child Glasses Child Glasses Bourine cyc care (Adult) Routine cyc care (Adult) Routine cyc care (Adult) Child Glasses Child Glasses Non-emergency care when traveling outside the U.S. Weight loss programs Cherolices (This isn't a complete list. Check your policy or plan document for other covered services and your costs for the services.) Chicopractic care Infertility treatment (limited) 	 Acupuncture Bariatrie surgery Bariatrie surgery Bariatrie surgery Bariatrie surgery Bariatrie surgery Bariatrie surgery Child Dental Check Up Hearing aids Child Dental Check Up Exonine eye care (/ Child Classes Child Glasses Long-term care Long-term care Non-termegency care when traveling outside the U.S. Weight loss progra to the Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and you services.) Chiropractic care Chiropractic care Chiropractic care Infertility treatment (limited) 	Excluded Ser Services Your P	vices & Other Co lan Does NOT Cove	vered Services: er (This isn't a complete list. Check y	our policy or plan doc	ument for other excluded services.)
 Child Dental Check Up Child Dental Check Up Child Dental Check Up Child Basses Child Glasses Dom-entroper care Non-emergency care when traveling outside the U.S. 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 the services.) Chicopractic care Chicopractic care Infertility treatment (limited) 	 Child Dental Check Up Child Dental Check Up Child Glasses Child Glasses Cosmetic surgery Long-term care Non-emergency care when traveling outside the U.S. Routine foot care Non-emergency care when traveling outside the U.S. Weight loss progra Cosmetic surgery Index Constructs Non-emergency care when traveling outside the U.S. Weight loss progra Weight loss progra Weight loss progra Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and you services.) Chiropractic care Information (Innited) 	 Acupuncture Bariatric surger 		Dental care (Adult)		 Private duty nursing
 Child Glasses Cosmetic surgery Cosmetic surgery Cosmetic surgery Non-emergency care when traveling outside the U.S. Weight loss programs Cosmetic surgery Cosmetic surgery Cosmetic surgery Infer Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for the services.) Chicopractic care Infertility treatment (limited) 	 Child Glasses Cosmetic surgery Non-emergency care when traveling outside the U.S. Weight loss progra Cosmetic surgery Cosmetic surgery Infection to the covered services and you services. Chicopractic care Infectility treatment (limited) 	Child Dental C	heck Up	 Hearing aids Lone-term care 		 Routine eye care (Adult) Routine foot care
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for thes services.) • Chicopractic care • Infertility treatment (limited)	Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and you services.) • Chiropractic care • Infertility treatment (limited)	 Child Glasses Cosmetic surge 	ά.	 Non-emergency care when 	traveling outside the U.	•
Chiropractic care	Chiropractic care	Other Covered (services.)	Services (This isn't a	complete list. Check your policy or J	plan document for othe	r covered services and your costs for these
			rc rc		(pc	

 Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending upon the circumstances, Federal and Stare 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 coverage under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage may also apply. Department of Labor, Employce Benefits Security Administration at 1-866-444-3272 or <u>www.del.gov/ebss</u>, or the U.S. Department, the U.S. Department of Labor, Employce Benefits Security Administration at 1-866-444-3272 or <u>www.del.gov/ebss</u>, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or <u>www.celio.crms.gov</u>. Your Grievance and Appeals Rights: If you have a complaint or are dissnifted with a denial of coverage for claims under your plan, you may be able to <u>appeal</u> or file a <u>grievance</u>. For questions about your rights, this notice, or assistance, you can contact AMed's Member Services Department at 1-806-6444-3272 or <u>www.del.gov/ebss</u>, or the U.S. Department of Hauha and Foro have a complaint or are dissnifted with a denial of coverage for claims under your plan, you may be able to <u>appeal</u> or file a <u>grievance</u>. For questions about your rights, this notice, or assistance, you can contact AMed's Member Services Department at 1-806-6444-3272 or <u>www.del.gov/ebss</u>, or the U.S. Department of Hauha. For plans subject to FIRISA, you may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <u>www.del.gov/ebss</u>, or the U.S. Department of the ath the and sections about your rights, this notice, or cassistance, you can contact AMed's Member Services Department at 1-806-6444-3272 or <u>www.del.gov/ebss</u>, or the U.S. Department of Labor, Endes of the assistere at 1-877-267-2523 x61565 or <u>www.del.go</u>
 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. 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 plans subject to ERISA, you may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 www.dol.gov/ebsa. or the U.S. Department of Human Services at 1-877-267-2323 x61565 or <u>www.ccito.cms.gov</u>. 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 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
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%6 (actuarial value). This health coverage <u>does meet</u> the minimum value standard for the benefits it provides.
Language Access Services: Para obtener asistencia en Español, llame al 1-800-682-8633.

 Coverage Examples		fipiano	COVERAGE IOL: All COVERAGE THEIS FIALL 1 MPC. THIN O	
	Having a baby		Managing type 2 diabetes	
About these Coverage Examples:	(normal delivery)		(routine maintenance of a well-controlled condition)	
These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial memory as simple region might not if they are	 Amount owed to providers: \$7,540 Plan pays \$7,470 Patient pays \$70 	40	 Amount owed to providers: \$5,400 Plan pays \$4,080 Patient pays \$1,320 	g
covered under different plans.	Sample care costs:		Sample care costs:	
	her)	\$2,700		\$2,900
		\$2,100	Medical Equipment and Supplies	\$1,300
This is	Hospital charges (baby)	\$900	Office Visits and Procedures	\$700
	Anesthesia	\$900	Education	\$300
	Laboratory tests	\$500	Laboratory tests	\$100
estimator.	Prescriptions	\$200	Vaccines, other preventive	\$100
Don't use these examples to	Radiology	\$200		\$5,400
estimate your actual costs	Vaccines, other preventive	S40		
under this plan. The actual	Total	\$7,540	Patient pays:	
care you receive will be			deductibles	S0
different from these	Patient pays:		Copays	S1,280
examples, and the cost of	deductibles	\$0	Coinsurance	\$0
that care will also be	Copays	S70	Limits or exclusions	S40
different.	Coinsurance	\$0	Total \$	\$1,320
See the next base for	Limits or exclusions	\$0		
important information about	Total	\$70		
these examples.				

	Questions and answers about the Coverage Examples:	
What are some of the assumptions behind the	What does a Coverage Example show?	Can I use Coverage Examples to compare plans?
Coverage Examples?	For each treatment situation, the Coverage Example helps you see how deductibles .	\checkmark Yes. When you look at the Summary of
Costs don't include premiums. Sample care costs are based on national averages supplied by the U.S. Department of Health and Human	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.	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
Services, and aren't specific to a particular geographic area or health plan. The parient's condition was not an	Does the Coverage Example	smaller that number, the more coverage the plan provides.
excluded or preexisting condition.	predict my own care needs?	Are there other costs I should
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 metion received all case feast in-	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.	plans? <u>Yes.</u> An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-premium.
network providers. If the patient had received care from out-of-network providers, costs would have been higher.	Does the Coverage Example predict my future expenses?	present costs, such as <u>copresses</u> , <u>deductibles</u> , and <u>coinsurance</u> . You should also consider contributions to accounts such as health savinas accounts
	X 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.	(HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.



Benefit Summary

Miami-Dade County

Plan Redesign



JANUARY 2015

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



document at www	document at www.avmed.org/mdc or by calling 1-800-682-8633	800-682-8633.
Important Questions Answers	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 <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	Yes. \$200 individual for external Prosthetics (see DME benefits). Doesn't apply to overall deductible. There are no other specific deductibles .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-</u> <u>pocket limit</u> 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 <u>out-of-pocket</u> 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 <u>out-of-</u> pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a 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 <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u> ?	No. You do not need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Ycs.	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.

Summary of Be	nefits and Coverag	Summary of Benefits and Coverage: What this Plan Covers & What it Costs		Coverage for: All Coverage Tiers Plan Type: POS
Copar - Coins plan's	Copayments are fixed dollar. Coinsurance is your share of t plan's allowed amount for an	amounts (for example, \$15) you the costs of a covered service, c n overnight hospital stay is \$1,00	t pay for covered health care, u alculated as a percent of the <u>a</u> 00, your coinsurance paymen	Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service. Coinsurance is <i>your</i> share of the costs of a covered service, calculated as a percent of the <u>allowed amount</u> 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's mer wore deducted.
The ar amou amou	This plan may encourage the plan pays for covered services amount , you may have to pay the difference. F amount is \$1,000, you may have to pay the \$50 This plan may encourage you to use AvMed ne	The amount the plan pays for covered services is based on the <u>allowed amount</u> . If an out- earnount, you may have to pay the difference. For example, if an out-of-network hospital ch <u>amount</u> is \$1,000, you may have to pay the \$500 difference. (This is called <u>balance billing</u> .) This plan may encourage you to use AvMed network providers by charging you lower ded u	e <u>allowed amount</u> . If an out- an out-of-network hospital ch This is called <u>balance billing</u> ers by charging you lower ded	The amount the plan pays for covered services is based on the <u>allowed amount</u> . If an out-of-network <u>provider</u> charges more than the <u>allowed</u> 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 <u>allowed</u> <u>amount</u> is \$1,000, you may have to pay the \$500 difference. (This is called <u>balance billing</u> .) 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
	Primary care visit to treat an injury or illness	S15 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.
If you visit a health care <u>provider's</u> office or clinic	Other practitioner office visit	 \$15 copay/ visit for chiropractic services; \$15 copay/ visit for podiary services; \$30 copay/visit for allergy treatment and skin testing, no additional charge for allergy injections; \$30 copay/ visit for infernility 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 semm	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.

AVSF_P_3572_0115

2 of 8

Summary of Ben	MDC POS Option Redesign nefits and Coverage: What this Pla	AvMed Enternant 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
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	Generic drugs	S15 copay/ prescription (retail); S30 copay/ prescription (mail order)	30% coinsurance, not subject to deductible	Retail copay applies per 30-day supply. 60-90 day supply via mail order. Cettain drugs require prior authorization.
condition More information	Preferred brand drugs	\$40 copay/ prescription (retail); \$80 copay/ prescription (mail order)	30% coinsurance, not subject to deductible	Certain drugs require prior authorization.
about prescription drug coverage is available at	Non-preferred brand drugs	\$55 copay/ prescription (retail); \$110 copay/ prescription (mail order)	30% coinsurance, not subject to deductible	Certain drugs require prior authorization.
www.avmed.org/mdc	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 deducrible	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.
	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.
If you need immediate medical	Emergency medical transportation	No Charge	Same as AvMed network	When pre-authorized, or in the case of emergency.
attention	Urgent care	\$50 copay/ visit at urgent care facility; \$15 copay/ visit at retail clinic	Same as AvMed network	NDHC
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.

AVSF_P_3572_0115

3 of 8

3 of 8

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MDC F
Embrace better health
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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

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%6 coinsurance after deductible	Prior authorization required.
	Mental/Behavioral health outpatient services	\$15 copay/ visit	30% coinsurance after deductible	Includes applied behavior analysis for treatment of Autism Spectrum Disorder.
If you have mental health, behavioral	Mental/Behavioral health inpatient services	\$200 copay/ admission; No charge at Jackson Health System	30% coinsurance after deduccible	Prior authorization required.
health, or substance abuse needs	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.
	Prenatal and postnatal care	\$30 copay/ $1^{\rm st}$ visit only	30% coinsurance after deductible	Subsequent visits at no charge when performed in AvMed network.
If you are pregnant	Delivery and all inpatient services	\$200 copay/ admission; No charge at Jackson Health System	30% coinsurance after deductible	Prior authorization required.

AvMed Emprove Summary of Ber	AvMed Entropy MDC POS Option Redesign Summary of Benefits and Coverage: What this Plan	AvMed Entropeen 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
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
	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.
It you need help recovering or have other special health needs	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.
	Eye exam	\$15 copay/ visit	30% coinsurance after deductible	Limited to 1 exam per year to determine the need for sight correction.
If your child needs dental or eye care	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: view Your Plan Does NOT Cover (This iart a complete list. Check your policy or plan document for other excluded services) view Sourd Dack Up . Item gais Child Dand Check Up . Routine eye care (Adah) Child Classe Condict Sarse Condict Sarse			Coverage for: All Coverage Hers Plan Type: POS
 Your Plan Does NOT Cover (This isn't a con Dental Check Up Dental Check Up Glasses Classes Classes Classes I care (Adult) Prino I care (Adult) Prino Prino<	Excluded Services & Other Cover	ed Services:	
 India Domal Check Up I Learing adds I Jong corrent carea I J	vices Your Plan Does NOT Cover (This	isn't a complete list. Check your policy or plat	n document for other excluded services.)
Indi Glasses • Long term care Construction • Non-emergency care when traveling outside the U.S. • Weight loss programs Construction • Non-emergency care when traveling outside the U.S. • Non-emergency care when traveling outside the U.S. • Non-emergency care and your costs for these Construction • Non-emergency care when traveling outside the U.S. • Non-emergency care when traveling outside the traveling outside the U.S. • Non-emergency care when traveling outside the traveling outside traveling outside traveling outside traveling outside traveling outside traveli	Child Dental Check Up	Hearing aids	
Ostimic sugery • Non-envergency care when traveling outside the U.S. • weight loss programs Detel care (Addh) • Private duty nursing • Non-envergency care when traveling outside the U.S. • weight loss programs exclosed Striction • Private duty nursing • Envirate duty nursing • Non-enverted services and your costs for these exclosed Striction • Outputerent (funited to out of nerwork) • Chicipractic care • Infertility ureatment (funited) Margineeure (funited to out of nerwork) • Chicipractic care • Outputerent for version out of nerwork) • Chicipractic care Margines as grapery (for mothol obesity) • Chicipractic care • Infertility ureatment (funited) Margine coverage under the plan, thus, depending upon the circumstances, Federal and State laws may poolide protections that allow you to see phealt disc coverage under the plan. Other limitations on your rights to continue coverage may also opply. • Infertility ureatment (finited) Gur Rights to Continue coverage context the plan at 1.800-682.863.5. You may also contact your state instances department, the disc mote information on your rights to contact your state instance department, the disc mote information on your rights to contact your state instance department, the disc mote information on your rights to contact your state instances department, the disc care for plan and plan at 1.800-682.863.5. You may also contact your state instances department, the disc on has a solution of plan at 1.800-682.863.5. You m	Child Glasses	 Long-term care 	
Dand Care (Multi) • Private dury narsing	Cosmetic surgery	 Non-emergency care when traveling outsit 	•••
er Covered Services (This iar\t a complete list. Check your policy or plan document for other covered services and your costs for these lises). Vergnueeure (limited to on of network) Vergnueeure Vergnueeure (limited to on of network) Vergnueeure Vergnueeure (limited to plan, depending upon the circumstances, Federal and State laws may provide protections that allow you to poss Vergnueeure the plan, depending upon the circumstances, Federal and State laws may provide protections that allow you to poss Vergnueeure the plan. Other limitations on your rights to continue Coverage may also apply. Vergnueeur of Lakot, Employee Benetits Security Administration at 1-806-444-327 or saxwadolagez/efebsa, or the U.S. Department of Haah and Verture information on your rights to contact where Science Almonte Almonte Securice Almonte Almonte Security Administration at 1-806-444-327 or saxwadolagez/efebsa, or the U.S. Department of Haah and Verture and Appeals Rights: Verture for the U.S. Department of Labor, Employee Renetis Security Administration at 1-806-444-3272 or saxwadolagez/efebsa, or the U.S. Department of Haan. Services and state secures at 1-877-207-2323 sof 56 or saxwadolagez/efebsa, or the U.S. Department of Habor, Employee Renetis Security Administration at 1-806-444-3272 or saxwadolagez/efebsa, or the U.S. Department of Habor, Employee Renetis Security Administration at 1-806-444-3272 or saxwadolagez/efebsa, or the U.S. Department of Habor, Employee Renetis Security Administration at 1-806-444-3272 or saxwadolagez/efebsa, or the U.S. Department of Habor, Employee Renetis Security Administration at 1-806-444-3272 or saxwadolagez/efebsa, or the U.S. Department of Habor,	Dental care (Adult)	 Private duty nursing 	
vurpmenter (finnied to out-of-network) • Chitopractic care • Infertility treatment (finnied) Ariantic surgery (for monbial obseity) • Chitopractic care • Infertility treatment (finnied) Ariantic surgery (for monbial obseity) • Chitopractic care • Infertility treatment (finnied) Aroun Rights to Continue Coverage: fou lose coverage under the plan, then, depending upon the circumstances. Federal and State laws may poorlde protections that allow you to keep healt overage. May such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the permium you pay overage. May such rights may be limited in duration and valin require you to pay a premium, which may be significantly higher than the permium you pay where coverage under the plan. then, then, dynamistration at 1.866-414-3273 or susceeding acceleration at 1.866-414-3272 or susceeding acceleration at 1.866-414-3272 or susceeding acceleration at 1.866-414-3273 or susceeding acceleration at 1.806-444-3272 or susceeding acceleration at 1.806-444-3273 or susceeding acceleration at 1.806-444-3272 or susceeding acceleration at 1.807-207-2333 xol1565 or susceeding acceleration at 1.806-444-3272 or susceeding acceleration at 1.877-207-2323 xol1565 or susceeding acce	Other Covered Services (This isn't a comple services.)	te list. Check your policy or plan document fo	or other covered services and your costs for these
Four Rights to Continue Coverage: Four Rights to Continue Coverage: Four loss coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep healt overage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the permium you pay this coverage through the plan. Other limitations on your rights to continue coverage, contact the plan. I + 800, 682-8633. You may also contact your state insurance department, th taum Xevries at 1-877-267-2323 s61565 or <u>www.ceinc.mss.gov.</u> Four Grievance and Appeals Rights: Four Grievance and Appeals Rights: Four Breve complaint or are disstifted with a denial of coverage for claims under your plan, you may be able to <u>appeal</u> or file a <u>grievance</u>. For previous about your rights, this notic, or assistance, you can contact. Model's Member Services Department at 1-800-682-8633. Four Breve and Appeals Rights: Four Breve a complaint or are disstifted with a denial of coverage for claims under your plan, you may be able to <u>appeal</u> or file a <u>grievance</u>. For previous about your rights, this notic, or assistance, you can contact. Model's Member Services Department at 1-800-682-8633. Four barse a complaint or are disstifted with a denial of coverage for claims under your plan, you may be able to <u>appeal</u> or file a <u>grievance</u>. For the two subject to ERISA, you may also contact the U.S. Department of Health and the and Hearan Services at 1-877-207-233 s61565 or <u>www.ceinc.ms.gov.</u> Four Break Break Brieford Minimum Essential Coverage for claims under your plan, you may be able to <u>appeal</u> or file a <u>grievance</u>. For two distributions on the U.S. Department of Hearan Services at 1-877-207-233 s61565 or <u>www.ceinc.ms.gov.</u> Four Break Break	Acupuncture (limited to out-of-network) Bariatric surgery (for morbid obesity)		
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 coverage. Any such 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 <u>waxwedolgeor/efess</u> , or the U.S. Department of Health and Human Services at 1-877-267-2323 AG565 or <u>waxwedolocms.goo</u> . To be a state insurance department, the U.S. Department of Labor. Employee Benefits Security Administration at 1-806-644-3372 or <u>waxwedolgeor/efess</u> , or the U.S. Department of Health and Human Services at 1-877-267-2323 AG1565 or <u>waxwedolocms.goo</u> . For gues so solved to ERISA, you may also contact your state insurance department, the questions about your rights in notice, or assistance, you can contact AMMed's Member Services Department at 1-800-682-8633. To a <u>waw.colo.coms.goo</u> . For gues solved to ERISA, you may also contact the U.S. Department of Labor, Employee Benefits Sections Department at 1-800-682-8633. The Affordable Care Net requires most people to have a compare the U.S. Department of Labor, Employee Benefits Sections and the Minimum Essential Coverage for clains under your plan, you may be able to <u>appeal</u> or file a <u>trievance</u> . For www.dolggoor/ebsa, or the U.S. Department of Human Services at 1-877-207-233 x01565 or <u>waw.colo.coms.goo</u> . The Affordable Care Net requires most people to have health and Human Services Department at 1-800-682-8653. The Affordable Care Net requires most people to have health and Benefits as "minimum essential coverage." This plan or policy <u>does</u> weeking to the U.S. Department of headth and the Affordable Care Act ceatable to have standard for the benefits in provides. The Affordable Care Act ceatables a minimum valu	Your Rights to Continue Coverage		
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 1-806-444-3272 or <u>wave-dol.gov/ebsa</u> , or the U.S. Department of Health and Human Secretices at 1-877-207-2323 stol 565 or <u>wave-celino-emsgons</u> . 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 <u>appeal</u> or file a <u>grievance</u> . For questions about your rights, this notice, or assistance, you can contact AvMed's Member Services Department at 1-800-682-8653. For plans subject to ERLSA, you may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <u>www.dolgov/ebsa</u> , or the U.S. Department of Health and Human Services at 1-877-267-2323 sol1565 or <u>www.celino-msgon</u> . For plans subject to ERLSA, you may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <u>www.dolgov/ebsa</u> , or the U.S. Department of Health and Human Services at 1-877-267-2323 sol1565 or <u>www.celino-msgon</u> . Does this Coverage Provide Minimum Essential Coverage? The Affordable Care Act requires most people to have health coverage that qualifies as "minimum essential coverage." This plan or policy <u>does</u> provide minimum essential coverage. Does this Coverage Meet the Minimum Value Standard? The Affordable Care Act establishes a minimum value standard for the benefits of a health plan. The minimum value standard for the benefits it provides. Language Access Services: Par obtener astrated are the minimum value standard for the benefits it provides.	If you lose coverage under the plan, then, depen coverage. Any such rights may be limited in dura while covered under the plan. Other limitations	ding upon the circumstances, Federal and State la ation and will require you to pay a premium , whit on your rights to continue coverage may also appl	we may provide protections that allow you to keep healt ch may be significantly higher than the premium you pay by.
 Your Grievance and Appeals Rights: f 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 pressions 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, Employce Benefits Security Administration at 1-866-444-3272 or exw.dol.gov/ebsa, or the U.S. Department of Human Services at 1-877-267-2323 x61565 or <u>www.celio.cms.gov</u>. Does this Coverage Provide Minimum Essential Coverage? The Mfordable Care Act requires most people to have health eare coverage that qualifies as "minimum essential coverage." This plan or policy <u>does world</u> the Mfordable Care Act cetablishes a minimum value Standard? Does this Coverage Meet the Minimum Value Standard? The Mfordable Care Act cetablishes a minimum value standard of heartifis it provides. 	For more information on your rights to continu- U.S. Department of Labor, Employee Benefits 5 Human Services at $1-877-267-2323$ x61565 or <u>w</u>	e coverage, contact the plan at 1-800-682-8633. Ye security Administration at 1-866-444-3272 or <u>www</u> www.celio.ems.gow.	on may also contact your state insurance department, th <u>wdol.gov/ebsa</u> , or the U.S. Department of Health and
Or plans subject to EMISA, you may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or usw.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or <u>www.ccilio.ems.gov</u> . 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 <u>does</u> movide minimum essential coverage. Does this Coverage Meet the Minimum Value Standard? The Affordable Care Act resultshes a minimum value Standard? The Affordable Care Act establishes a minimum value standard for the benefits it provides. The affordable Care Act establishes a minimum value standard for the benefits it provides.	Your Grievance and Appeals Righ If you have a complaint or are dissatisfied with a questions about your rights, this notice, or assist	its: denial of coverage for claims under your plan, yo ance, you can contact AvMed's Member Services	a grievance.
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 <u>does</u> <u>wovide</u> minimum essential coverage. Does this Coverage Meet the Minimum Value Standard? The Affordable Care Act establishes a minimum value standard of henefits of a health plan. The minimum value standard is <i>00%</i> (actuarial value). This nealth coverage <u>does meet</u> the minimum value standard for the benefits it provides. anguage Access Services: ^{Act} obtener asistencia on Español. Hame at 1-800-682-8633.	For plans subject to ERISA, you may also conta www.dol.gov/ebsa, or the U.S. Department of F	et the U.S. Department of Labor, Employee Bene fealth and Human Services at 1-877-267-2323 x61	Efits Security Administration at 1-866-444-3272 or 1565 or www.ccilo.ems.gov.
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 realth coverage <u>does meet</u> the minimum value standard for the benefits it provides. -anguage Access Services: ^{Aure} obtener asistencia on Español. Hame al 1-800-682-8633.	Does this Coverage Provide Minin The Affordable Care Act requires most people t provide minimum essential coverage.	num Essential Coverage? o have health care coverage that qualifies as "mini	imum essential coverage." Th is plan or policy <u>does</u>
-anguage Access Services: 2019 obtener asistencia en Español, llame al 1-800-682-8633.	Does this Coverage Meet the Mini The Affordable Care Act establishes a minimum health coverage does meet the minimum val	mum Value Standard? • value standard of heacfits of a health plan. The n we standard for the benefits it provides.	ninimum value standard is 60% (actuarial value). This
	Language Access Services: Para obtener asistencia en Español, llame al 1-800-682-8633.	0.682-8633.	

36	Average Examples		overag	Coverage Period: 01/01/2015 – 12/31/2015 Coverage for: All Coverage Tiers Plan Type: POS	2015 POS
	About these Coverage Examples:	Having a baby (normal delivery)		Managing type 2 diabetes (routine maintenance of a well-controlled condition)	
	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.	 Amount owed to providers: \$7,540 Plan pays \$7,470 Patient pays \$70 Sample care costs 	0	 Amount owed to providers: \$5,400 Plan pays \$4,130 Patient pays \$1,270 Sample care costs 	0
		her)	\$2,700		\$2,900
			\$2,100	pment and Supplies	\$1,300
	This is	Hospital charges (baby)	\$900		S700
		Anesthesia	S900	Education	S300
	not a cost	Laboratory tests	\$500	r tests	\$100
	estimator.	Prescriptions	\$200	preventive	\$100
	Don't use these examples to	Radiology	\$200		\$5,400
	estimate vour actual costs	Vaccines, other preventive	\$40		
	under this plan. The actual		\$7,540	Patient pays:	
	care you receive will be			deductibles	\$0
	different from these	Patient pays:		Copays \$1	\$1,230
	examples, and the cost of	deductibles	\$0	ance	80
	that care will also be	Copays	\$70	Lâmits or exclusions	S40
	different.	Coinsurance	\$0		\$1,270
	See the next base for	Limits or exclusions	ŝ		
	important information about	Total	\$70		
	incor couldino:		-		

	Questions and answers about the Coverage Examples:	
What are some of the assumptions behind the	What does a Coverage Example show?	Can I use Coverage Examples to compare plans?
 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 	For each treatment situation, the Coverage Example helps you see how <u>deductibles</u> , <u>copayments</u> , and <u>coinsurance</u> 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.	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 above coverage.
 particular geographic area or health plan. The patient's condition was not an excluded or preexisting condition. 	Does the Coverage Example predict my own care needs?	Are there other costs I should
 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- 	X 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.	consider when comparing plans? <u>Yes</u> . 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 consyments.
network providers . If the patient had received care from out-of-network providers , costs would have been higher,	Does the Coverage Example predict my future expenses?	deductibles, and coinsurance. You should also consider contributions to accounts such as health savines accounts
	★ 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.	(HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.



Benefit Summary

Miami-Dade County Without Plan Redesign High Option HMO

JANUARY 2015

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



Summary of Benefits and Coverage: What this P	Summary of Benefits and Coverage: What this Plan Covers & What it Costs	iat it Costs Coverage for: All Coverage Tiers Plan Type: HMO
This is only document at www	This is only a summary. If you want more detail about you document at www.avmed.org/mdc or by calling 1-800-682-8633.	detail about your coverage and costs, you can get the complete terms in the policy or plan 800-682-8633.
Important Questions Answers	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 <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-</u> <u>pocket limit</u> on my expenses?	Yes. Medical: \$1,500 individual/ \$3,000 dependent coverage (does not include prescription drug cost-sharing); Prescription Drugs: \$1,500 individual/ \$3,000 dependent coverage (does not include medical cost-sharing)	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the 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 <u>out-of-</u> pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a 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 <u>specialist</u> ?	No. You do not need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.

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1 of 8

Summary of Ber	Summary of Benefits and Coverage: What this P	Summary of Benefits and Coverage: What this Plan Covers & What it Costs	Coverag	Coverage for: All Coverage Tiers Plan Type: HMO
 Copay Consumption the plan the plan 	ments are fixed dollar a irance is your share of t n's allowed amount fo	Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service. Coinsurance is <i>your</i> share of the costs of a covered service, calculated as a percent of the <u>allowed amount</u> for the service. For the plan's <u>allowed amount</u> for an overnight hospital stay is \$1,000, your <u>coinsurance</u> payment of 20% would be \$200. This m wow here the receive the service.	covered health care, usu as a percent of the <u>allov</u> ur <u>coinsurance</u> paymen	Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service. Coinsurance is <i>your</i> share of the costs of a covered service, calculated as a percent of the <u>allowed amount</u> for the service. For example, if the plan's <u>allowed amount</u> for an overnight hospital stay is \$1,000, your <u>coinsurance</u> payment of 20% would be \$200. This may change if
 The arr allowe This plice 	you haven three your <u>deductions</u> . The amount the plan pays for cov allowed amount, you may have to the allowed amount is \$1,000, yo This plan may encourage you to u	you naven that your <u>accueutor</u> . The amount the plan pays for covered services is based on the <u>allowed amount</u> . If an out-of-network <u>p</u> <u>allowed amount</u> , you may have to pay the difference. For example, if an out-of-network hospital charge the <u>allowed amount</u> is \$1,000, you may have to pay the \$500 difference. (This is called <u>balance billing</u> .) This plan may encourage you to use AvMed network providers by charging you lower <u>deductibles</u> , <u>cop</u>	<u>1 amount</u> . If an out-of- an out-of-network hosp :e. (This is called balanc rging you lower <u>deduct</u>	you nave t that your <u>deuteuote</u> . The amount the plan pays for covered services is based on the <u>allowed amount</u> . If an out-of-network <u>provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the <u>allowed amount</u> is \$1,000, you may have to pay the \$500 difference. (This is called <u>balance billing</u> .) This plan may encourage you to use AvMed network <u>providers</u> by charging you lower <u>deductibles</u> , <u>copayments</u> and <u>coinsurance</u> 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
	Primary care visit to treat an injury or illness	S15 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.
If you visit a health care <u>provider's</u> office or clinic	Other practitioner office visit	S15 copay/ visit for chiropractic services, S15 copay/ visit for podiatry services; S15 copay/visit for allergy injections; S30 copay/visit for allergy treatment and skin testing; S30 copay/ visit for infertility treatment	Not Covered	Infertility treatment is limited to one sequence per member lifetime for the following; sperm count, endometrial biopsy, hysterosalpingo- graphy (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
	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.
If you have a test	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.

Avmed betterheath Summary of Ben	AvMed Enternation MDC High Option HMO Summary of Benefits and Coverage: What this Pl	AvMed Enternant MDC High Option HMO Summary of Benefits and Coverage: What this Plan Covers & What it Costs	Coverag	Coverage Period: 01/01/2015 – 12/31/2015 Coverage for: All Coverage Tiers Plan Type: HMO
Common Medical Event	Services You May Need	Your Cost If You Use an AvMed Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or	Generie 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.
condition	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.
More information about	Non-preferred brand drugs	S35 copay/ prescription (retail); S70 copay/ prescription (mail order)	Not Covered	Brand additional charges may apply. Certain drugs may require prior authorization.
prescription drug coverage is available at www.avmed.org/ mdc.	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	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.
ourpauent surgery	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.
	Emergency room services	S25 copay/ visit	Same as AvMed network	AvMed must be notified within 24 hours of emergency admission or as soon as reasonably possible.
II you need immediate	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	Facility fee (e.g., hospital room)	No Charge	Not Covered	Prior authorization required.
hospital stay	Physician/surgeon fee	No Charge	Not Covered	Prior authorization required.

Avned Enternation Summary of Ben	Ave Emproveming MDC High Option HMO Summary of Benefits and Coverage: What this P	Ave Between 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
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
	Mental/Behavioral health outpatient services	\$15 copay/ visit	Not Covered	Includes applied behavior analysis for treatment of Autism Spectrum Disorder.
If you have mental health, behavioral	Mental/Behavioral health inpatient services	No Charge	Not Covered	Prior authorization required.
health, or substance abuse needs	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	Prenatal and postnatal care	\$30 copay/ $1^{\rm st}$ visit only	Not Covered	Subsequent visits at no charge.
pregnant	Delivery and all inpatient services	No Charge	Not Covered	Prior authorization required.
	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.
If you need help recovering or have other	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.
spectat neatth needs	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.

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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
11.11.1	Eye exam	\$15 copay/ visit	Not Covered	Limited to 1 exam per year to determine the need for sight correction.
It your child needs dental or	Glasses	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.
cyc care	Dental check-up	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.
Excluded Serv	Excluded Services & Other Covered Services:	vered Services:		
Services Your Pla	an Does NOT Cove	Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)	your policy or plan doci	iment for other excluded services.)
 Acupuncture 		Dental care (Adult)		 Private doty norsing
 Bariatric surgery Chat Docud Chat 	and a line	 Hearing aids 		 Routine eye care (Adule)
Child Planar Creek OP	ack op	 Long-term care 		 Routine foot care
Cosmetic surgery		 Non-emergency care when traveling outside the U.S. 	a traveling outside the U.	 Weight loss programs
Other Covered Se services.)	Other Covered Services (This isn't a complete list. (services.)	complete list. Check your policy or J	plan document for othe	Check your policy or plan document for other covered services and your costs for these
 Chiropractic care 		 Infertility treatment (limited) 	(he	

Your Rights to Continue Coverage: If your segrets and the fam, then, denothing upon the circumstances, Federal and Stare have may provide portections that allow you to keep health coverage have stripts 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 unformation on your rights to continue coverage, contact the plan at 1-800.662.86(3), your may be significantly higher than the premium, the U.S. Department of Labor, Employee Braciffs Security Administration at 1-800.662.86(3), your may be able to appeal or file a griterance. For thum acverces at 1-877-267-2235 solisio or maxecine. Further and Appeals Rights: If you have a complaint or are dissuisified with a denial of coverage for claims under your plan, you may be able to appeal or file a griterance. For questions about your rights, this notice, or assistance, you can contact AMed's Member Services Department at 1-800-662.86(3). For plans subject to ERISA, you may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-806-4441-3272 or wascaddgoor/cleas, or the U.S. Department of Health and Human Services at 1-877-267-223 sol1565 or wasweeding or for 4441-3272 or wascaddgoor/cleas, or the U.S. Department of Health and Human Services at 1-877-267-223 sol1565 or yasweeding or for 4441-3272 or wascaddgoor/cleas, or the U.S. Department of Health and Human Services at 1-877-267-2233 sol1565 or yasweeding or for 4441-3272 or wascaddgoor/cleas, or the U.S. Department of Health State (Souther Security Administration at 1-866-4441-3272 or wascaddgoor/cleas, or the U.S. Department of Health State (Souther Security Administration at 1-866-4441-3272 or wascaddgoor/cleas, or the U.S. Department of Health T.C. Does this Coverage Provide Minimum Essential Coverage? The Affredable Care Act requires more the value standard of thealth coverage does meet the min	 Your Rights to Continue Coverage: If you lase coverage under the plan, then, depending theon the circumstances, Federal and Stare have may provide protections that allow you to keep health overage. Any such rights may be limited in duration and well require you to pay a premium, which may be significantly higher than the premium you pay while coverage under the plan. Other limited in durations and well require you to pay a premium, which may be significantly higher than the permonent on your rights to continue coverage, router to constance your state insurance department, the part more information on your rights to continue coverage, router (the Jint 1-327 cor waveledgeper/edgs), or the U.S. Department of Hauh and Haum Serveces at 1-877-307. 2033 x01506 or wavecedior the plan at 1-800. 414-327 cor waveledgeper/edgs, or the U.S. Department of Hauh and Haum Serveces at 1-877-307. 2033 x01506 or wavecedior the plan at 1-800. 414-327 or your base a compliant or are dissusticed with a deal of overage for claims under your plan, you may be able to appeal or file a <u>priceasment</u>. For the plane subject to ERRA, you may also constant the U.S. Department at 1-800. 414-327 or waved lagoely claims. Any or the U.S. Department of Lahon. Employee Reattife Security Administration at 1-806. 414-327 or waved lagoely claims or order U.S. Department of Hahuh and the maximum services at 1-877-307-3733 x01566 or waveceditor the U.S. Department at the Moduble Care. Acc requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy <u>does</u> provide infinitum essential coverage. Does this Coverage Meet the Minimum Value Standard? The Moduble Care. Acc establess a anihoum value standard for the benefits it provides. Language Access Services: Jar Rootedge <u>does meet</u> the minimum value standard for the benefits it provides. Jar Rootedge <u>does meet</u> the minimum value standard for the benefits it provides. Jar Rootedge <u>does meet</u> the minimum v	AvMed Enternan 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
 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 <u>appeal</u> or file a <u>grievance</u>. 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 1-866-441-3272 or www.dol.gov/febs. or the U.S. Department of Health and Human Services at 1-877-207-2323 x61565 or <u>www.ccito.cms.gov</u>. 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 <u>does</u> 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 for the benefits it provides. The Affordable Care Act establishes a minimum value standard for the benefits it provides. The Affordable Care Act establishes a minimum value standard for the benefits it provides. The Affordable Care Act establishes a minimum value standard for the benefits it provides. The Affordable Care Act establishes and not benefits of a health plan. The minimum value standard for the benefits it provides. The Affordable Care Services: Par obtener asticencia on Español, Ilane at 1-800.682.8633. 	Your Grievance and Appeals Right: If you have a complaint or are dissustified with a denial of coverage for claims under your plue, you may be able to <u>appeal</u> or file a <u>grievance</u> . For questions about your rights, this notice, or assistance, you can connact AvMed's Member Services Department at 1-800-602-8633. To plus subject to ERISN, you may also connact the U.S. Department of Labor, Employee Benefits Security Administration at 1-806-643-8633. Deep this Society or the U.S. Department of Health and Human Services at 1-877-267-2323 AG1565 or susvaccino.cms.gov.	Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending upon the circumstances, Federal and St coverage. Any such rights may be limited in duration and will require you to pay a premium, while covered under the plan. Other limitations on your rights to continue coverage may also For more information on your rights to continue coverage, contact the plan at 1-800-682-866 U.S. Department of Labor, Employee Benefits Security Administration at 1-806-444-3272 or Human Services at 1-877-267-2323 x61565 or <u>www.cetio.cms.gov</u> .	ate laws may provide protections that allow you to keep health which may be significantly higher than the premium you pay apply. 3. You may also contact your state insurance department, the www.dol.gov/ebsa, or the U.S. Department of Health and
 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." 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 on Español, llanne al 1-800-682-8633. 	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 <u>does</u> <u>provide</u> minimum essential coverage. Does this Coverage Meet the Minimum Value Standard? The Affordable Care Act establishes a minimum value standard for the benefits it provides. The Affordable Care Act establishes a minimum value standard for the benefits it provides. The Affordable Care Act establishes a minimum value standard for the benefits it provides. The Affordable Care Act establishes a minimum value standard for the benefits it provides. The Affordable Care Act establishes a minimum value standard for the benefits it provides. The Affordable Care Act establishes a minimum value standard for the benefits it provides. The Affordable Care Act establishes a minimum value standard for the benefits it provides. The Affordable Care Act establishes a minimum value standard for the benefits it provides. Language Access Services: Para obsence asistencia on Español, llame al 1-800-682-8633. The secomplet of how this plan might over costs for a tample medical situation, see the next page-	Your Grievance and Appeals Rights: If you have a complaint or are dissuisfied with a denial of coverage for claims under your pla questions about your rights, this notice, or assistance, you can contact AvMed's Member Ser For plans subject to ERISA, you may also contact the U.S. Department of Labor, Employee <u>www.dol.gov/febsa</u> , or the U.S. Department of Health and Human Services at 1-877-267-232	a <mark>grievance</mark> . - 1-866-444-327
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Language Access Services: Para obtener asistencia en Español, llame al 1-800-682-8633.	Language Access Services: Para obtener asistencia en Español, llame al 1-800-682-8633. ———————————————————————————————————	Does this Coverage Meet the Minimum Value Standard? The Affordable Care Act establishes a minimum value standard of benefits of a health plan. ⁷ health coverage <u>does meet</u> the minimum value standard for the benefits it provides.	The minimum value standard is 60% (actuarial value). This
I BACE EXAMPLEE OF DOWN THE PARK WILLIES FOR MULTICE TORE FOR A LAMPLE PREASED ALMATICE. RE FOR DEAY DAYS.		Language Access Services: Para obtener asistencia en Español, llame al 1-800-682-8633. Ta se exambler of how this plan might sorer costs for a sample me	ical attration, see the next page,

46	Average Examples		overage	Coverage Period: 01/01/2015 – 12/31/2015 Coverage for: All Coverage Tiers Plan Type: HMO	2015 HMO
	About these Coverage Examples:	Having a baby (normal delivery)		Managing type 2 diabetes (routine maintenance of a well-controlled condition)	
	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	 Amount owed to providers: \$7,540 Plan pays \$7,470 Patient pays \$70 	0	 Amount owed to providers: \$5,400 Plan pays \$4,080 Patient pays \$1,320 	0
	covered under different plans.	Sample care costs:		Sample care costs:	
		tter)	S2,700	Prescriptions \$2,	\$2,900
			\$2,100	Medical Equipment and Supplies \$1,	\$1,300
	This is	Hospital charges (baby)	\$900	Office Visits and Procedures \$	\$700
		Anesthesia	\$900	Education \$	\$300
	not a cost	Laboratory tests	\$500	Laboratory tests S	\$100
	estimator.	Prescriptions	\$200	Vaccines, other preventive \$	\$100
	Don't use these examples to	Radiology	\$200		\$5,400
	estimate your actual costs	Vaccines, other preventive	\$40		
	under this plan. The actual	Total	\$7,540	Patient pays:	
	care you receive will be			deductibles	20 20
	different from these	Patient pays:		Copays \$1,	\$1,280
	examples, and the cost of	deducribles	\$0	Coinsurance	98 9
	that care will also be	Copays	S70	Limits or exclusions	\$40
	different.	Coinsurance	\$0	Total \$1,	\$1,320
	See the next made for	Limits or exclusions	<u>\$</u> ()		
	important information about	Total	\$70		
	these examples.				

7 of 8

onal	Questions and answers about the Coverage Examples:	
iums. ed on national J.S.	What does a Coverage Example show?	Can I use Coverage Examples to compare plans?
Costs don't include premiums . Sample care costs are based on national averages supplied by the U.S.	For each treatment situation, the Coverage	Yes. When you look at the Summary of
	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.	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 nlan provides.
 The patient's condition was not an 	Does the Coverage Example	
	predict my own care needs?	Are there other costs I should
 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- 	X 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.	consider when comparing plans? <u>Yes</u> . 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.
had	Does the Coverage Example	deductibles, and coinsurance. You
received care from out-of-network providers, costs would have been higher. p	predict my future expenses?	stiould also consider contributions to accounts such as health savings accounts
	▲ 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.	(HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.



Benefit Summary

Miami-Dade County Without Plan Redesign Low Option HMO

JANUARY 2015

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



This is only document at www	This is only a summary. If you want more detail about ye document at www.avmed.org/mdc or by calling 1-800-682-8633.	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 <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-</u> pocket limit on my expenses?	Yes. \$6,350 individual/\$12,700 dependent coverage	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket</u> <u>limit</u> ?	Premiums, prescription drug brand additional charges, and services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-</u> pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a 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 <u>specialist</u> ?	Yes.	This plan will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have the plan's permission before you see the <u>specialist</u> .
Are there services this plan doesn't cover?	Ycs.	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/mde. 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.eeiio.cms.gov or call 1-800-682-8633 to request a copy. AVSF_H_3518_0115

1 of 8

Summary of Ben	Summary of Benefits and Coverage: What this F	Summary of Benefits and Coverage: What this Plan Covers & What it Costs	Covera	Coverage for: All Coverage Tiers Plan Type: HMO
 Copay the plan the plan 	ments are fixed dollar a trance is <i>your</i> share of the area amount for	Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service. Coinsurance is <i>your</i> share of the costs of a covered service, calculated as a percent of the <u>allowed amount</u> for the service. For the plan's <u>allowed amount</u> for an overnight hospital stay is \$1,000, your <u>coinsurance</u> payment of 20% would be \$200. This m service, hence, not your <u>coinsurance</u> payment of 20% would be \$200. This m	vered health care, usu a percent of the <u>allov</u> <u>coinsurance</u> paymen	Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service. Coinsurance is <i>your</i> share of the costs of a covered service, calculated as a percent of the <u>allowed amount</u> for the service. For example, if the plan's <u>allowed amount</u> for an overnight hospital stay is \$1,000, your <u>coinsurance</u> payment of 20% would be \$200. This may change if
• The arr allowe the allo	The amount the plan pays for cov allowed amount, you may have to the allowed amount is \$1,000, yo This plan may encourage you to u	The amount the plan pays for covered services is based on the <u>allowed amount</u> . If an out-of-network <u>provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay the <u>allowed amount</u> is \$1,000, you may have to pay the \$500 difference. (This is called <u>balance billing</u> .) This plan may encourage you to use AvMed network providers by charging you lower <u>deductibles</u> , <u>copayments</u> and <u>coinsurance</u> an	mount. If an out-of- out-of-network hosp (This is called balanc ing you lower <u>deduct</u>	The amount the plan pays for covered services is based on the <u>allowed amount</u> . If an out-of-network <u>provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the <u>allowed amount</u> is \$1,000, you may have to pay the \$500 difference. (This is called <u>balance billing</u> .) This plan may encourage you to use AvMed network <u>providers</u> by charging you lower <u>deductibles</u> , <u>copayments</u> and <u>coinsurance</u> 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
	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.
If you visit a health care <u>provider's</u> office or clinic	Other practitioner office visit	S30 copay/ visit for chiropractic services; S30 copay/ visit for podiatry services; S30 copay/visit for allergy injections; S45 copay/visit for allergy treatment and skin testing; S45 copay/visit for infertility treatment	Not Covered	Infertility treatment is limited to one sequence per member lifetime for the following: sperm count, endometrial biopsy, hysterosalpingo- graphy (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
	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.
If you have a test	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.

Avmed beformatin Summary of Ben	AvMed Entertain MDC Low Option HMO Summary of Benefits and Coverage: What this F	AvMed Betterhoom MDC Low Option HMO Summary of Benefits and Coverage: What this Plan Covers & What it Costs	Covera	Coverage Period: 01/01/2015 – 12/31/2015 Coverage for: All Coverage Tiers Plan Type: HMO
Common Medical Event	Services You May Need	Your Cost If You Use an AvMed Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or	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.
condition	Preferred brand drugs	\$35 copay/ prescription (retail); \$70 copay/ prescription (mail order)	Not Covered	Brand additional charges may apply. Certain drugs require prior authorization.
More information about	Non-preferred brand drugs	S55 copay/ prescription (retail); S110 copay/ prescription (mail order)	Not Covered	Brand additional charges may apply. Certain drugs require prior authorization.
prescription drug coverage is available at www.avmed.org/ mdc.	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	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.
ourpauent surgery	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.
1	Emergency room services	S100 copay/ visit	Same as AvMed network	AvMed must be notified within 24 hours of emergency admission or as soon as reasonably possible.
immediate	Emergency medical transportation	No Charge	Same as AvMed network	When pre-authorized, or in the case of emergency.
Incurca anciuon	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	Facility fee (e.g., hospital room)	\$150/ day for first 3 days, per admission	Not Covered	Prior authorization required.
hospital stay	Physician/surgeon fee	No Charge	Not Covered	Prior authorization required.

Ave Embrace Summary of Ben	Ave Better MDC Low Option HMO Summary of Benefits and Coverage: What this F	Ave Emergent 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
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
	Mental/Behavioral health outpatient services	\$30 copay/ visit	Not Covered	Includes applied behavior analysis for treatment of Autism Spectrum Disorder.
If you have mental health, behavioral	Mental/Behavioral health inpatient services	\$150/ day for first 3 days, per admission	Not Covered	Prior authorization required.
health, or substance abuse needs	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	Prenatal and postnatal care	$45 \ copay/ \ 1^{*t} \ visit \ only$	Not Covered	Subsequent visits at no charge.
pregnant	Delivery and all inpatient services	\$150/ day for first 3 days, per admission	Not Covered	Prior authorization required.
	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.
If you need help recovering or have other special health	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.
needs	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.

AVSF_H_3518_0115

4 of 8

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
	Eye exam	\$30 copay/ visit	Not Covered	Limited to one exam per year to determine the need for sight correction.
If your child needs dental or	Glasses	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.
cye care	Dental check-up	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.
Excluded Sen	Excluded Services & Other Covered Services: Services Your Plan Does NOT Cover (This isn't a count	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.)	r nolicy or nian door	ment for other excluded services)
 Acupuncture Bariatric surgery 	-	Dental care (Adult)		 Private duty nursing
Child Dental Check Up	reck Up	 Icong-term care 		 Routine eye care (Aout) Routine foot care
 Cosmetic surgery 	5. 2	 Non-emergency care when traveling outside the U.S. 	ling outside the U.S.	 Weight loss programs
Other Covered S services.)	Other Covered Services (This isn't a complete list. services.)	complete list. Check your policy or pla	in document for othe	Check your policy or plan document for other covered services and your costs for these
 Chiropractic care 	e.	 Infertility treatment (limited) 		

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Cove	Coverage Period: 01/01/2015 – 12/31/2015 Coverage for: All Coverage Tiers Plan Type: HMO
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 may also apply. U.S. Department of Labor, Employee Benefits Security Administration at 1-806-444-3272 or <u>www.dol.gov/cbsa</u> , or the U.S. Department, the Human Services at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u> .	s may provide protections that allow you to keep health may be significantly higher than the premium you pay a may also contact your state insurance department, the dol.gov/cbsa, or the U.S. Department of Health and
Your Grievance and Appeals Rights: If you have a complaint or are dissuisfied with a denial of coverage for claims under your plan, you may be able to <u>appeal</u> or file a <u>grievance</u> . 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 1-866-444-327 www.dol.gov/ebsa, or the U.S. Department of Human Services at 1-877-267-2323 x61565 or <u>www.ccito.ems.gov</u> .	poverage for claims under your plan, you may be able to appeal or file a grievance. For can contact AvMed's Member Services Department at 1-800-682-8633. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or Human Services at 1-877-267-2323 x61565 or <u>www.ccito.ems.gov</u> .
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Language Access Services: Para obtener asistencia en Español, llame al 1-800-682-8633.	
To see examples of how this plan might over costs for a sample medical situation, see the next page	ation, see the next page-

56	Average Examples		overag	Coverage Period: 01/01/2015 – 12/31/2015 Coverage for: All Coverage Tiers Plan Type: HMO	1/2015 :: HMO
	About these Coverage Examples:	Having a baby (normal delivery)		Managing type 2 diabetes (routine maintenance of a well-controlled condition)	S
	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.	 Amount owed to providers: S7,540 Plan pays S7,320 Patient pays \$220 Sample care costs 		 Amount owed to providers: \$5,400 Plan pays \$3,680 Patient pays \$1,720 Sample care costs 	400
		her)	\$2.700	Prescriptions	\$2.900
			\$2,100	Medical Equipment and Supplies	\$1,300
	This is	~	\$900	Office Visits and Procedures	\$700
			\$900	Education	\$300
	not a cost	Laboratory tests	\$500	Laboratory tests	\$100
	estimator.		\$200	Vaccines, other preventive	\$100
	Don't use these examples to		\$200	Total	\$5,400
	estimate your actual costs	Vaccines, other preventive	\$40		
	under this plan. The actual		\$7,540	Patient pays:	
	care you receive will be			deductibles	\$0
	different from these	Patient pays:		Copays	\$1,680
	examples, and the cost of	deductibles	\$0	Coinsurance	\$0
	that care will also be	Copays	\$220	Limits or exclusions	\$40
	different.	Coinsurance	ŝ	Total	\$1,720
	See the next base for	Limits or exclusions	ŝ		
	important information about	Total	\$220		
	these examples.				

7 of 8

What are some of the assumptions behind the ssumptions behind the scoreage Examples? Ferrore Coverage Examples? Ferrore costs are based on national all averages supplied by the U.S.		
iums. ed on national J.S.	What does a Coverage Example show?	Can I use Coverage Examples to compare plans?
Costs don't include premiums. Sample care costs are based on national averages supplied by the U.S.	For each treatment situation, the Coverage	Yes. When you look at the Summary of
luman o a	Example netps you see now deductiones , 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.	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.
 The patient's condition was not an 	Does the Coverage Example	
	predict my own care needs?	Are there other costs I should
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-	X 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.	<pre>consider when comparing plans? </pre> <pre> <pre> <pre> <pre> <pre> <pre> <pre> <pre> <pre> <pre> <pre> <pre> <pre> <pre> <pre> <pre> <pre> <pre> <pre> <pre> <pre> <pre> <pre> <pre> <pre> <pre> <pre> <pre> <pre> <pre> <pre></pre></pre></pre></pre></pre></pre></pre></pre></pre></pre></pre></pre></pre></pre></pre></pre></pre></pre></pre></pre></pre></pre></pre></pre></pre></pre></pre></pre></pre></pre></pre>
had	Does the Coverage Example	deductibles, and coinsurance. You
providers, costs would have been higher.	predict my future expenses?	sticuld also consider contributions to accounts such as health savings accounts
	▲ 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.	(HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.



Benefit Summary

Miami-Dade County Without Plan Redesign POS

JANUARY 2015

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



AvMed Enternation MDC POS Option Summary of Benefits and Coverage: V	AvMed Enterneon MDC POS Option Summary of Benefits and Coverage: What this Plan Covers & What it Costs	Coverage Period: 01/01/2015 – 12/31/2015 (hat it Costs Coverage for: All Coverage Tiers Plan Type: POS
This is only document at www	This is only a summary. If you want more detail about y document at www.avmed.org/mdc or by calling 1-800-682-8633.	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	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 dechuctible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the dechacilisle starts over (usually, but not always, January 1st). See the drant starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> for specific services?	Yes. \$200 individual for external Prosthetics (see DME benefits). Doesn't apply to overall dechetible. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific dechectible amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket</u> <u>limit</u> on my expenses?	Yes. In-Network Macket: \$1,500 individual / \$4,500 dependent coverage (does not induke prescription drug exteribring); Out-of Network Meekcal: \$1,500 per individual;	The <u>our-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expertses.
	Prescription Drugs \$1,500 included \$3,000 dependent coverage (does not include modeal cost- straing)	
What is not included in the out-of-pocket limit?	Premiums, our of network prescription chargeost shuring, prescription drug brand additional charges, our of- network balance-falled charges, and services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	Na	The chart starting on page 2 describes any limits on what the plan will pay for graft-covered services, such as office visits.
Does this plan use a <u>retwork</u> of providers?	Yes. See www.avmed.org/mdc.or.call 1-800-682- 8633 for a list of participaling 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 deesn't cover are listed on page 5. See your policy or plan decument for additional information about excluded services.
Questions: Call 1-800-682-8633 or visit us at www.avmed.org/mde. If you aren't clear about any of the und	2-8633 or visit us at www.avmed.org/mdc. If ye	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,

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ed dollar amounts (for example, \$15) you pay for covered health care, share of the costs of a covered service, calculated as a percent of the mount for an overnight hospital stay is \$1,000, your <u>coinsurrance</u> pay i deductible . In pays for covered services is based on the <u>allowed amount</u> . If an ou to may have to pay the difference. For example, if an out-of-network it is \$1,000, you may have to pay the \$500 difference. (This is called by trage you to use AvMed network providers by charging you lower de- nage you to use AvMed network providers by charging you lower de- trage you to use AvMed Network providers by charging you lower de- nage you to use AvMed Network Providers by the an Out of Provider \$15 copay/ visit for allerey accinsurance after bury or \$15 copay/ visit for allerey acquirentiality treatment, and solve coinsurance after the deductible interes: \$15 copay/ visit for allerey acquinenture: \$15 copay/ visit for allerey acquinenture: \$20% coinsurance after acquinenture: \$20% coinsurance after and allerey injections, skin treatment, including \$20 copay/ visit for infertility treatment, and allerey injections: \$20 copay/ visit for infertility treatment, and set to allerey and allerey services and allerey injections. \$20 copay/ visit for infertility treatment, and set to allerey and allerey services and the or allerey and allerey services and be achuerible for allerey and allerey services and be achuerible and allerey and allerey and allerey injections. Averter and allerey and allerey and allerey and allerey injections and a deductible and allerey and allerey and allerey injections and a deductible and allerey and allerey and allerey infections and a deductible and allerey and allerey and allerey and and anot a deductible and an an an and allerey and allere	summary or benefits and coverage: what this Plan Covers & what it costs			What it Costs Coverage for: All Coverage Hers Plan Type: PUS	
The amount the plan pays for correct services is based on the allowed amount, you may have to pay the difference. For example, if an out-of-network the allowed amount, you may have to pay the 5500 difference. (This is called by the allowed amount, you may have to pay the 5500 difference. (This is called by a may encourage you to use AMMed Network providers by charging you lower determed may not allowed amount, you may have to pay the 550 difference. (This is called by a more determed may not allowed amount, you have a may not allowed amount, you may have to pay the 550 difference. (This is called by the allowed amount, you have a services you to use AMMed Network provider an out of an under the provider of the analysis of the anount of a services. The amount is \$1,000, you may have to pay the 550 difference. (This is called by the allowed amount is \$1,000, you may have to pay the 550 difference. (This is called by the anount of a services and the allowed network provider by the anount of a services.) The and the plan may encourage you to use AMMed Network provider provider provider pay visit for allergy interces. 30% coinsurance after deductible for the practitions of the allergy interces and a services. Indice difference in the case of the difference in the case of the difference in the case of the difference in the difference. 30% coinsurance after deductible for the difference in the difference in the difference in the difference in the case of the difference in the difference	Copa the pla	yments are fixed dolla urance is your share of an's allowed amount	r amounts (for example, \$15) you the costs of a covered service, of for an overnight hospital stay is,	u pay for covered health care calculated as a percent of the \$1,000, your coinsurance pa	, usually when you receive the service. allowed amount for the service. For example, if yment of 20% would be \$200. This may change if
Immon Services You Cost If You Use an Your Cost If You Use an Out of Revork Provider Idical Event May Need Primary care visit 30% coinsurance after deductible Primary care visit \$15 copay/visit 30% coinsurance after deductible 30% coinsurance after deductible Specialist visit \$30 copay/visit for hiness 30% coinsurance after deductible 30% coinsurance after deductible Other practitioner \$15 copay/visit for hine 30% coinsurance after deductible 30% coinsurance after deductible Other practitioner \$15 copay/visit for allergy infertility treatment, and acqueres offer deductible 30% coinsurance after deductible Other practitioner \$30 copay/visit for allergy infertility treatment, and acqueres offer deductible 30% coinsurance after deductible Preventive care/ \$30 copay/visit for infertility treatment 30% coinsurance after deductible Preventive care/ No Charge for treatment 30% coinsurance after deductible Diagnostic test No Charge for deductible 30% coinsurance after deductible Diagnostic test No Charge for deductible 30% coinsurance after Diagnostic test No Charge for deductible 30% coinsurance after <th>• The allows the allows</th> <th>mount the plan pays fo mount the plan pays fo ed amount, you may h lowed amount is \$1,00 den may encourage you</th> <th>r covered services is based on th ave to pay the difference. For e 00, you may have to pay the \$50 to use AvMed pervork provid.</th> <th>te <u>allowed amount</u>. If an ou kample, if an out-of-network 0 difference. (This is called <u>b</u> ers by charoing you hower do</th> <th>ut-of-network provider charges more than the hospital charges \$1,500 for an overnight stay and <u>alance billing</u>.)</th>	• The allows the allows	mount the plan pays fo mount the plan pays fo ed amount, you may h lowed amount is \$1,00 den may encourage you	r covered services is based on th ave to pay the difference. For e 00, you may have to pay the \$50 to use AvMed pervork provid .	te <u>allowed amount</u> . If an ou kample, if an out-of-network 0 difference. (This is called <u>b</u> ers by charoing you hower do	ut-of-network provider charges more than the hospital charges \$1,500 for an overnight stay and <u>alance billing</u> .)
Primary care visit to treat an injury or illness S15 copay/ visit s30 copay/ visit 30% coinsurance after deductible Specialist visit \$30 copay/ visit for deductible 30% coinsurance after deductible 30% coinsurance after deductible Duvisit a th care ou visit a th care dedres 30% coinsurance after deductible for for pontactic services 30% coinsurance after deductible for for opay/ visit for podiarty services; 30% coinsurance after deductible for for opay visit for allergy infertility treatment, and acquantence; Diffice visit Diffice visit 30% coinsurance after deductible for for opay visit for allergy infertility treatment, and acquantence; Preventive care/ services S0 copay/ visit for allergy infertility treatment, and acquantence; 30% coinsurance after deductible Diagrostic visit No Charge 30% coinsurance after deductible 30% coinsurance after Diagrostic test No Charge 30% coinsurance after 30% coinsurance after	- iii	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
Specialist visit 530 copay/ visit 30% ocinsurance after and seconsurance after 30% ocinsurance after 30% ocinsurance after and seconsurance after 515 copay/ visit 50% ocinsurance after and seconsurance after 515 copay/ visit 50% ocinsurance after bit care 530 copay/visit 50% ocinsurance after bit care 530% ocinsurance after 50% ocinsurance after bit care 530% ocinsurance after 50% ocinsurance after bit care 50% ocinsurance after 50% ocinsurance after bit care 50% ocinsurance after 50% ocinsurance after bit care		Primary care visit to treat an injury or illness		30% coinsurance after deductible	Additional charges may apply for non-preventive services performed in the physician's office.
an unisit a burvisit a burv		Specialist visit	\$30 copay/ visit	30% coinsurance after deductible	Additional charges may apply for non-preventive services performed in the physician's office.
Preventive care/ screening/ immunization No Charge 30% coinsurance after deductible Diagnostic test (x-ray, blood work) No Charge 30% coinsurance after deductible Du have a Imaging (CT/PET No Charge 30% coinsurance after	If you visit a health care <u>provider's</u> office or clinic	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.
Diagnostic test (x-ray, blood work) No Charge 30% coinsurance after ou have a Imaging (CT/PET No Charge 30% coinsurance after		Preventive care/ screening/ immunization	No Charge	30% coinsurance after deductible	None
Imaging (CT/PET No Charge 30% coinsurance after	10	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.
deductible	II you nave a test	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.

 Summary of Be	Summary of Benefits and Coverage: V	Summary of Benefits and Coverage: What this Plan Covers & What it Costs		Coverage for: All Coverage Tiers Plan Type: POS
 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	Generic drugs	\$15 copay/ prescription (retail); \$30 copay/ prescription (mail order)	30% consurance, not subject to deductible	Retail copay applies per 30-day supply, 60-90 day supply via mail order. Certain drugs require prior authorization.
 drugs to treat your illness or condition	Preferred brand drugs	\$25 copay/ prescription (retail); \$50 copay/ prescription (mail order)	30% coinsurance, not subject to deductible	Certain drugs require prior authorization.
 More information about	Non-preferred brand drugs	\$35 copay/ prescription (retail); \$70 copay/ prescription (mail order)	30% coinsurance, not subject to deductible	Certain drugs require prior authorization.
drug coverage is available at www.avmed.org/ mdc.	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	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.
 ourpauent surgery	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.
	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.
 If you need immediate	Emergency medical transportation	No Charge	Same as AvMed network	When pre-authorized, or in the case of emergency.
 attention	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
	Facility fee (e.g., hospital room)	No Charge	30% coinsurance after deductible	Prior authorization required.
 n you nave a hospital stay	Physician/surgeon fee	No Charge, except \$200 surgical copay applies for infertility surgery	30% coinsurance after deductible	Prior authorization required.

Summary of Be	Summary of Benefits and Coverage: V	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
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
	Mental/Behavioral health outpatient services	\$15 copay/ visit	30% coinsurance after deductible	Includes applied behavior analysis for treatment of Autism Spectrum Disorder.
If you have mental health, behavioral	Mental/Behavioral health inpatient services	No Charge	30% coinsurance after deductible	Prior authorization required.
health, or substance abuse needs	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	Prenatal and postnatal care	\$30 copay/ 1st visit only	30% coinsurance after deductible	Subsequent visits at no charge when performed in AvMed network.
pregnant	Delivery and all inpatient services	No Charge	30% coinsurance after deductible	Prior authorization required.
	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.
If you need help recovering or have other special health	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.
110003	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.

64	Ave Betterhed	Average Benefits and Coverage: V	Ave Beneficen 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
	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.
	76 - 1101	Eye exam	\$15 copay/ visit	30% coinsurance after deductible	Limited to 1 exam per year to determine the need for sight correction.
	If your child needs dental or	Glasses	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.
	eye care	Dental check-up	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.
	Excluded Ser Services Your P	vices & Other C lan Does NOT Co	Excluded Services & Other Covered Services: Services Your Plan Does NOT Cover (This isn't a complete list.	. Check your policy or plan	Excluded Services & Other Covered Services: Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)
	 Child Dental Check Up 	heek Up	 Hearing aids 		Routine are care (Adult)
	 Child Glasses 		 Long-term care 		•
	 Cosmetic surgery 	Ty.	 Non-emergency ca 	Non-emergency care when traveling outside the U.S.	•
	 Dental care (Adult) 	lult)	 Private duty nursing 	態	
	Other Covered Services.)	Services (This isn'	t a complete list. Check your p	olicy or plan document fo	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 (li Bariatric surger 	Acupuncture (limited to out-of-network) Bariatric surgery (for morbid obesity)	ork)		 Infertility treatment (limited)
	Your Rights t If you lose coverag coverage. Any such while covered unde For more informat U.S. Department of Human Services ar	Your Rights to Continue Coverage: If you lose coverage under the plan, then, dependit coverage. Any such rights may be limited in duration while covered under the plan. Other limitations on For more information on your rights to continue e U.S. Department of Labor, Employee Benefits See Human Services at L&77.267.2323 x61565 or were	Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws coverage. Any such rights may be limited in duration and will require you to pay a promium, which 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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <u>wawed</u> Human Services at 1-877-267-2333 v61565 or wave ecils cms see	tees, Federal and State laws r to pay a premium , which m e coverage may also apply, an at 1-800-682-8633. You n 1-866-444-3272 or <u>www.do</u>	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 coverage under the plan. Other limitations on your rights to condune coverage may also apply. For more information on your rights to continue coverage may also apply. U.S. Department of Labor, Employee Benefits Security Administration at 1-806-444-3272 or <u>www.dol.gov/ebsa</u> , or the U.S. Department of Health and Education and Scherk security Administration at 1-806-444-3272 or <u>www.dol.gov/ebsa</u> , or the U.S. Department of Health and Education Security Administration at 1-806-444-3272 or <u>www.dol.gov/ebsa</u> , or the U.S. Department of Health and Education Security Administration at the security and security and security and security and security administration at the black security administration at the black security administration at the security administration at the black security administration administration at the black security administration administration at the black security administration administration administration at the black security administration
	AVSF_P_3519_0115	5			5 of 8

Your Grievance and Appeals Rights: To an two some operations are advanted or coverage for claims under your plan, you may be able to appeal or file a grievance. For grant and a non-grant rights, this motice, are assistment, por an connuct Moled's Member Secretics Department at 1866-4444-3272 or the plans subject to ERISA, you may able contact, plan can connect with the main Secreties at 1-877-307-3253 s01566 or <u>wasweedingoreflas</u> . This plan or policy dense models and the U.S. Department of Labor. Employee Barche Secreties Department at 1-866-4444-3272 or sexual agreement and the U.S. Department of Labor. Employee Barche Secreties Department at 1-866-4444-3272 or sexual agreement and the U.S. Department of Labor. Employee Barche Secreties Department at 1-866-4444-3272 or advantage of the U.S. Department of Labor. Employee Barche Secreties Department at 1-866-4444-3272 or advantage of the U.S. Department of Labor. Employee Barche Secreties Department at 1-866-4444-3272 or advantage of the U.S. Department of Labor. Employee Barche Secreties Department at 1-866-4444-3272 or Dese this Coverage Barlin Barlin under Secreties at 1-877-307-3253 s01566 or <u>wasweedingore Recenses</u> . This plan or policy dense provides the Minimum value standard Department of Labor. Employee Barche Secreties Department at 1-860-452. The Mindahle Care Me casabidies a minimum value standard for the benefits at provides. The Mindahle Care Me casabidies a minimum value standard for the benefits at provides. The Mindahle Care Me casabidies a minimum value standard for the benefits it provides. The Mindahle Care Me casabidies a minimum value standard for the benefits it provides. The Mindahle Care Me casabidies a minimum value standard for the benefits it provides. The Mindahle Care Me casabidies a minimum value standard for the benefits it provides. The Mindahle Care Me casabidies a minimum value standard for the benefits it provides. The Mindahle Care Me casabidies of an idea inda indation at the neet part in the next part at	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
Does this Coverage Provide Minimum Essential Coverage? The Minihule Care Are requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage Meet the Minimum Value Standard? The Mioridable Care Are establishes a minimum value standard of benefits it provides. The Mioridable Care Are establishes a minimum value standard of benefits it provides. The Mioridable Care Are establishes a minimum value standard for the benefits it provides. The Mioridable Care Are establishes a minimum value standard for the benefits it provides. The Mioridable Care Are establishes a minimum value standard for the benefits it provides. The Mioridable Care Are establishes a minimum value standard for the benefits it provides. The Mioridable Care Are establishes a minimum value standard for the benefits it provides. The Mioridable Care Are establishes a minimum value standard for the benefits it provides. The Mioridable Care Are establishes a minimum value standard for the benefits it provides. The Mioridable Care Are establishes a minimum value standard for the benefits it provides. The Mioridable Care Are establishes a minimum value standard for the the moridable Care Are establishes a minimum value standard for the benefits it provides. The observer asservices: The an 1-800-682-8033. The establishes are establishes	Your Grievance and Appeals Rights: If you have a complaint or are dissatisfied with a denial of coverage for claims under your pla questions about your rights, this notice, or assistance, you can contact AvMed's Member Ser For plans subject to ERISA, you may also contact the U.S. Department of Labor, Employee www.dol.gov/ebsa, or the U.S. Department of Haman Services at 1-877-267-235	1, you may be able to appeal or file a grievance . For ces Department at 1-800-682-8633. kenefits Security Administration at 1-866-444-3272 or 561565 or <u>www.ceito.ems.gov</u> .
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7 of 8

What are some of the	What does a Coverage Example
assumptions behind the	show?
Coverage Examples?	For each treatment situation, the Coverage
	Example helps you see how <u>deductibles</u> ,
 Costs don't include premiums. 	copayments, and coinsurance can add up. It
 Sample care costs are based on national 	also helps you see what expenses might be left
averages supplied by the U.S.	up to you to pay because the service or
Department of Health and Human	treatment isn't covered or payment is limited.

Questions and answers about the Coverage Examples:

AVMED ENTROPE MDC POS Option

Coverage Examples

Does the Coverage Example predict my own care needs? particular geographic area or health plan.

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

predict my future expenses? Does the Coverage Example

providers, costs would have been higher.

network providers. If the patient had

received care from out-of-network

The patient received all care from in-

on treating the condition in the example.

Out-of-pocket expenses are based only

There are no other medical expenses for

ended in the same coverage period.

any member covered under this plan.

All services and treatments started and

The patient's condition was not an excluded or preexisting condition.

•

Services, and aren't specific to a

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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



Limitations & Exclusions

Miami-Dade County HMO

JANUARY 2015

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



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 dictitians/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.

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

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 nonsurgical 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 peerreviewed 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.

SF-MDC-HMO-Variable-OE-15 SF-3475(01/15)

- 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 donorpatients 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.

SF-MDC-HMO-Variable-OE-15 SF-3475(01/15)

- 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.



Limitations & Exclusions

Miami-Dade County POS

JANUARY 2015

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



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; postoperative 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 peerreviewed, 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.

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.
- LQ. 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, electroniccontrolled 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



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 	 Sudden, sharp 	Chest pain	 After hours and
Minor cuts	abdominal pain	 Difficulty breathing 	weekends, when the
• Fever	Uncontrolled bleeding	Loss of consciousness	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





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

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, precertification 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 thirdparty 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 thirdparty 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 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.

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

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



Embrace better health.

MDC-SF-3633(10/14)