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Large Group Choice CM245-LG24 + MP-6219

Coverage for: Individual or Individual + Family | Plan Type: POS



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-882-8633 or visit [www.avmed.org](http://www.avmed.org) and sign into the Member Portal. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-800-882-8633 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>In-Network:</b> \$2,500 Individual / \$5,000 Family <b>PHCS Network:</b> \$2,500 Individual / \$5,000 Family <b>Out-of-Network:</b> \$7,500 Individual / \$15,000 Family Accumulates across all benefit levels.	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. In-Network <a href="#">preventive care</a> , office visits, certain diagnostic tests, certain imaging, certain <a href="#">prescription drugs</a> , outpatient surgery, <a href="#">urgent care</a> , <a href="#">emergency room</a> , outpatient <a href="#">rehabilitation</a> , and <a href="#">DME</a> are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No. There are no other specific deductibles.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>In-Network:</b> \$6,350 Individual / \$12,700 Family <b>PHCS Network:</b> \$6,350 Individual / \$12,700 Family <b>Out-of-Network:</b> \$19,050 Individual / \$38,100 Family Accumulates across all benefit levels.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limit</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">prescription drug</a> brand additional charges and manufacturer assistance, balance billing charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.avmed.org">www.avmed.org</a> or call 1-800-882-8633 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	PHCS Network (outside AvMed Service Area) (You will pay more)	Out-of-Network (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary Care visit to treat an injury or illness	\$25 <a href="#">copay</a> / visit	\$25 <a href="#">copay</a> / visit	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Additional charges may apply for non-preventive services performed in the Physician's office.
	<a href="#">Specialist</a> visit	\$50 <a href="#">copay</a> / visit	\$50 <a href="#">copay</a> / visit	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Additional charges may apply for non-preventive services performed in the Physician's office.
	<a href="#">Preventive care/screening</a> /immunization	No Charge	No Charge	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	Independent facility: \$100 <a href="#">copay</a> / visit; Hospital-affiliated facility: \$200 <a href="#">copay</a> / visit after <a href="#">deductible</a>	Independent facility: \$100 <a href="#">copay</a> / visit; Hospital-affiliated facility: \$200 <a href="#">copay</a> / visit after <a href="#">deductible</a>	Independent facility: 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> ; Hospital-affiliated facility: 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Charges for office visits may apply if services are performed in a Physician's office. Charges for certain other labs and Specialty labs will be higher.
	Imaging (CT/PET scans, MRIs)	Independent facility: \$200 <a href="#">copay</a> / visit; Hospital-affiliated facility: \$300 <a href="#">copay</a> / visit after <a href="#">deductible</a>	Independent facility: \$200 <a href="#">copay</a> / visit; Hospital-affiliated facility: \$300 <a href="#">copay</a> / visit after <a href="#">deductible</a>	Independent facility: 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> ; Hospital-affiliated facility: 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Charges for office visits or Physician/professional services may also apply depending on where services are received.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.avmed.org">www.avmed.org</a>	Value generic drugs (Tier 1)	30-day supply: \$3 <a href="#">copay</a> / prescription; 90-day supply: \$7.50 <a href="#">copay</a> / prescription	Not Covered	Not Covered	Certain limits may apply, including, for example: prior authorization, step therapy, quantity limits.
	Generic drugs (Tier 2)	30-day supply: \$9 <a href="#">copay</a> / prescription; 90-day supply: \$22.50 <a href="#">copay</a> / prescription	Not Covered	Not Covered	Covered drugs in Tiers 1-4 are available up to a 90-day supply at retail pharmacies; and a 60-90-day supply via mail order.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	PHCS Network (outside AvMed Service Area) (You will pay more)	Out-of-Network (You will pay the most)	
	Preferred brand drugs (Tier 3)	30-day supply: \$25 <a href="#">copay</a> / prescription; 90-day supply: \$62.50 <a href="#">copay</a> / prescription	Not Covered	Not Covered	Drugs in Tier 5 are available up to a 30-day supply, at retail pharmacies only. Brand additional charges may apply. Coupons or any other third-party prescription drug cost-sharing assistance will not apply toward any calendar year deductible or out-of-pocket limit.
	Non-Preferred brand drugs (Tier 4)	30-day supply: \$50 <a href="#">copay</a> / prescription; 90-day supply: \$125 <a href="#">copay</a> / prescription	Not Covered	Not Covered	
	<a href="#">Specialty drugs</a> (Tier 5)	50% <a href="#">coinsurance</a> (Retail only)	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Independent facility: \$400 <a href="#">copay</a> / visit; Hospital-affiliated facility: \$500 <a href="#">copay</a> / visit after <a href="#">deductible</a>	Independent facility: \$400 <a href="#">copay</a> / visit; Hospital-affiliated facility: \$500 <a href="#">copay</a> / visit after <a href="#">deductible</a>	Independent facility: 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> ; Hospital-affiliated facility: 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Prior authorization required.
	Physician/surgeon fees	No Charge	No Charge	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Prior authorization required.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$250 <a href="#">copay</a> / visit	\$250 <a href="#">copay</a> / visit	\$250 <a href="#">copay</a> / visit	AvMed must be notified within 24-hours of inpatient admission following emergency services, or as soon as reasonably possible. Charges are waived if admitted.
	<a href="#">Emergency medical transportation</a>	Ground: \$150 <a href="#">copay</a> / one way ground transport; Air/Water: 50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Ground: \$150 <a href="#">copay</a> / one way ground transport; Air/Water: 50% <a href="#">coinsurance</a> after In-Network <a href="#">deductible</a>	Ground: \$150 <a href="#">copay</a> / one way ground transport; Air/Water: 50% <a href="#">coinsurance</a> after In-Network <a href="#">deductible</a>	None



Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	PHCS Network (outside AvMed Service Area) (You will pay more)	Out-of-Network (You will pay the most)	
	<a href="#">Urgent care</a>	Independent urgent care facility: \$50 <a href="#">copay</a> / visit; Hospital-affiliated urgent care facility: \$50 <a href="#">copay</a> / visit; Retail clinic: \$25 <a href="#">copay</a> / visit	Independent urgent care facility: \$50 <a href="#">copay</a> / visit; Hospital-affiliated urgent care facility: \$50 <a href="#">copay</a> / visit; Retail clinic: \$25 <a href="#">copay</a> / visit	Independent urgent care facility: 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> ; Hospital-affiliated urgent care facility: 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> ; Retail clinic: 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after <a href="#">deductible</a>	No charge after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Prior authorization required.
	Physician/surgeon fees	No charge after <a href="#">deductible</a>	No charge after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <a href="#">copay</a> / visit	\$25 <a href="#">copay</a> / visit	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Prior authorization may be required.
	Inpatient services	No charge after <a href="#">deductible</a>	No charge after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Prior authorization may be required.
If you are pregnant	Office visits	Routine OB or midwife: Visit 1 - 1: \$25 <a href="#">copay</a> / visit; Visit 2 and after: No Charge	Routine OB or midwife: Visit 1 - 1: \$25 <a href="#">copay</a> / visit; Visit 2 and after: No Charge	Routine OB or midwife: 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Childbirth/delivery professional services	No charge after <a href="#">deductible</a>	No charge after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth/delivery facility services	Hospital: No charge after <a href="#">deductible</a> ; Birthing center: Same as routine OB	Hospital: No charge after <a href="#">deductible</a> ; Birthing center: Same as routine OB	Hospital: 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Prior authorization required.
If you need help recovering or have	<a href="#">Home health care</a>	\$50 <a href="#">copay</a> / visit after <a href="#">deductible</a>	\$50 <a href="#">copay</a> / visit after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Limited to 20 skilled visits per calendar year. Approved treatment plan required.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	PHCS Network (outside AvMed Service Area) (You will pay more)	Out-of-Network (You will pay the most)	
<b>other special health needs</b>	<a href="#">Rehabilitation services</a>	Independent facility: \$50 <a href="#">copay</a> / visit; Hospital-affiliated facility: \$50 <a href="#">copay</a> / visit after <a href="#">deductible</a> ; Chiropractic services: \$25 <a href="#">copay</a> / visit	Independent facility: \$50 <a href="#">copay</a> / visit; Hospital-affiliated facility: \$50 <a href="#">copay</a> / visit after <a href="#">deductible</a> ; Chiropractic services: \$25 <a href="#">copay</a> / visit	Independent facility: 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> ; Hospital-affiliated facility: 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> ; Chiropractic services: 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Limited to 35 visits per calendar year for outpatient rehabilitative PT, OT, ST, cardiac rehab, pulmonary rehab, and chiropractic services combined. Cardiac and pulmonary rehab require prior authorization.
	<a href="#">Habilitation services</a>	Independent facility: \$50 <a href="#">copay</a> / visit; Hospital-affiliated facility: \$50 <a href="#">copay</a> / visit after <a href="#">deductible</a>	Independent facility: \$50 <a href="#">copay</a> / visit; Hospital-affiliated facility: \$50 <a href="#">copay</a> / visit after <a href="#">deductible</a>	Independent facility: 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> ; Hospital-affiliated facility: 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Habilitative PT, OT, and ST, when provided for the treatment of autism spectrum disorder and Down syndrome, are limited to a combined maximum of 100 visits per calendar year.
	<a href="#">Skilled nursing care</a>	Day 1 - 5: \$250 <a href="#">copay</a> / day per admission after <a href="#">deductible</a> ; Day 6 and after: No Charge	Day 1 - 5: \$250 <a href="#">copay</a> / day per admission after <a href="#">deductible</a> ; Day 6 and after: No Charge	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Limited to 60 days post-hospitalization care per calendar year. Prior authorization required.
	<a href="#">Durable medical equipment</a>	\$250 <a href="#">copay</a> / episode of illness	\$250 <a href="#">copay</a> / episode of illness	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Excludes vehicle modifications, home modifications, exercise equipment, and bathroom equipment.
	<a href="#">Hospice services</a>	No charge after <a href="#">deductible</a>	No charge after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Physician certification required.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$35 <a href="#">copay</a> / exam	\$35 <a href="#">copay</a> / exam	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Limited to one exam per calendar year to determine the need for sight correction.
	Children's glasses	Not Covered	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	Not Covered	None



## Excluded Services & Other Covered Services:

**Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)**

- |                         |  |                            |
|-------------------------|--|----------------------------|
| • Acupuncture           | • Dental Care (Adult)                                | • Private-Duty Nursing     |
| • Bariatric Surgery     | • Hearing Aids                                       | • Routine Eye Care (Adult) |
| • Child Dental Check Up | • Infertility Treatment                              | • Routine Foot Care        |
| • Child Glasses         | • Long-term Care                                     | • Weight Loss Programs     |
| • Cosmetic Surgery      | • Non-Emergency Care When Traveling Outside the U.S. |                            |

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- Chiropractic Care

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Florida Office of Insurance Regulation at 1-877-693-5236 or [www.floir.com/consumers](http://www.floir.com/consumers), the U.S. Department of Labor, Employee Benefits Security Administration, at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact AvMed's Member Engagement Center at 1-800-882-8633. For plans subject to ERISA, you may also contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Florida Department of Financial Services, Division of Consumer Services, at 1-877-693-5236 or [www.floir.com/consumers](http://www.floir.com/consumers).

**Does this plan provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Para obtener asistencia en Español, llame al 1-800-882-8633.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,500	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,500	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,500
■ <a href="#">Specialist copayment</a>	\$50	■ <a href="#">Specialist copayment</a>	\$50	■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility)	Not Applicable	■ Hospital (facility)	Not Applicable	■ Hospital (facility)	Not Applicable
■ Other <a href="#">copayment</a>	\$25	■ Other <a href="#">copayment</a>	\$25	■ Other <a href="#">copayment</a>	\$25
This EXAMPLE event includes services like: Specialist office visits ( <i>prenatal care</i> ) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests ( <i>ultrasounds and blood work</i> ) Specialist visit ( <i>anesthesia</i> )		This EXAMPLE event includes services like: Primary care physician office visits ( <i>including disease education</i> ) Diagnostic tests ( <i>blood work</i> ) Prescription drugs Durable medical equipment ( <i>glucose meter</i> )		This EXAMPLE event includes services like: Emergency room care ( <i>including medical supplies</i> ) Diagnostic test ( <i>x-ray</i> ) Durable medical equipment ( <i>crutches</i> ) Rehabilitation services ( <i>physical therapy</i> )	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	\$2,500	Deductibles	\$0	Deductibles	\$0
Copayments	\$200	Copayments	\$900	Copayments	\$1,200
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
The total Peg would pay is	\$2,760	The total Joe would pay is	\$920	The total Mia would pay is	\$1,200

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.