

Benefit Summary

HIGH OPTION HMO SCHEDULE OF BENEFITS

MIAMI-DADE COUNTY & JACKSON HEALTH SYSTEM

COST TO MEMBER

CALENDAR YEAR DEDUCTIBLE	INDIVIDUAL / FAMILY	N/A
OUT-OF-POCKET MAXIMUM Per Calendar Year	INDIVIDUAL / FAMILY	\$1500/\$3000
LIFETIME MAXIMUM		UNLIMITED
PRIMARY CARE PHYSICIAN	Services at participating doctors' offices include, but are not limited to: <ul style="list-style-type: none"> Routine office visits / annual gyn examination when performed by primary care physician Pediatric care and well-baby care Periodic health evaluation and immunizations Diagnostic imaging, laboratory or other diagnostic services Minor surgical procedures Vision and hearing examinations for children under 18 	\$10 per visit
SPECIALIST'S SERVICES	<ul style="list-style-type: none"> Office visits Annual gyn examination when performed by participating specialist 	\$10 per visit
MATERNITY CARE	<ul style="list-style-type: none"> Initial visit Subsequent visits 	\$10 per visit No charge
ALLERGY TREATMENTS	<ul style="list-style-type: none"> Visits and/or Injections Skin testing (per course of treatment) 	\$10 per visit
CHIROPRACTIC PODIATRY	<ul style="list-style-type: none"> Chiropractic Podiatry 	\$10 per visit \$10 per visit
HOSPITAL	Inpatient care at participating hospitals includes: <ul style="list-style-type: none"> Room and board - unlimited days (semi-private) Physicians', specialists' and surgeons' services Anesthesia, use of operating and recovery rooms, oxygen, drugs and medication Intensive care unit and other special units, general and special duty nursing Laboratory and diagnostic imaging Required special diets Radiation and inhalation therapies 	No charge
OUTPATIENT SERVICES	<ul style="list-style-type: none"> Outpatient surgeries, including cardiac catheterizations and angioplasty 	No charge
OUTPATIENT DIAGNOSTIC TESTS	<ul style="list-style-type: none"> Complex radiological imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging) Other diagnostic imaging tests and Laboratory Mammogram 	No charge No charge No charge
EMERGENCY SERVICES	An emergency is the sudden and unexpected onset of a condition requiring immediate medical or surgical care. <ul style="list-style-type: none"> Emergency services at participating hospitals Emergency services - non-participating hospitals, facilities and/or physicians <p>AvMed must be notified within 24 hours of inpatient admission following emergency services or as soon as reasonably possible.</p>	\$25 Co-payment (waived if admitted) \$50 Co-payment (waived if admitted)

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URGENT/IMMEDIATE CARE	<ul style="list-style-type: none"> ▪ Medical Services at a participating Urgent/Immediate Care facility or services rendered after hours in your Primary Care Physician's office ▪ Medical Services at a non-participating Urgent/Immediate Care facility 	<p>\$25 Co-payment</p> <p>\$50 Co-payment</p>
HOME HEALTH CARE	<ul style="list-style-type: none"> ▪ Per occurrence 	No charge
DRUG AND ALCOHOL REHABILITATION PROGRAMS	<ul style="list-style-type: none"> ▪ Inpatient: 30 days* per year ▪ Outpatient: Limited to 60 visits per year for individual sessions Lifetime limit of two programs. 	<p>No charge</p> <p>No charge</p>
MENTAL / NERVOUS DISORDERS	<ul style="list-style-type: none"> ▪ Inpatient: 30 days* per year ▪ Outpatient: Limited to 30 visits per year for individual sessions 	<p>No charge</p> <p>\$5 per visit</p>
<p><i>*Coverage for inpatient days for drug/alcohol rehabilitation and for mental/nervous disorder(s) combined is limited to 30 days per contract year.</i></p>		
FAMILY PLANNING	<ul style="list-style-type: none"> ▪ Voluntary family planning services ▪ Sterilization 	<p>\$10 per visit</p> <p>\$100 Co-payment</p>
AMBULANCE	<ul style="list-style-type: none"> ▪ When pre-authorized or in the case of emergency 	No charge
PHYSICAL, SPEECH, RESPIRATORY AND OCCUPATIONAL THERAPIES	<ul style="list-style-type: none"> ▪ Short-term Physical, Speech, Respiratory and Occupational therapy for acute conditions <p>Coverage is limited to 60 visits combined per calendar year</p>	\$10 per visit
SKILLED NURSING FACILITIES AND REHABILITATION CENTERS	<ul style="list-style-type: none"> ▪ Up to 60 days post-hospitalization care per calendar year when prescribed by physician and authorized by AvMed 	No charge
CARDIAC REHABILITATION	<p>Cardiac Rehabilitation is covered for the following conditions:</p> <ul style="list-style-type: none"> ▪ Acute myocardial infarction ▪ Percutaneous transluminal coronary angioplasty (PTCA) ▪ Repair or replacement of heart valves ▪ Coronary artery bypass graft (CABG), or ▪ Heart transplant <p>Coverage is limited to 36 visits per calendar year</p>	\$10 per visit
INFERTILITY TREATMENT	<ul style="list-style-type: none"> ▪ Infertility Treatment (Limited to diagnostic testing and procedures) 	\$10 per visit
DURABLE MEDICAL EQUIPMENT AND ORTHOTIC APPLIANCES	<p>Equipment includes but not limited to:</p> <ul style="list-style-type: none"> ▪ Hospital beds ▪ Walkers ▪ Crutches ▪ Wheelchairs <p>Orthotic appliances are limited to:</p> <ul style="list-style-type: none"> ▪ Leg, arm, back and neck custom-made braces 	<p>\$50 per episode of illness</p> <p>Benefits limited to \$2000 per calendar year</p>

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PROSTHETIC DEVICES

Prosthetic devices are limited to:

No charge

- Artificial limbs
- Artificial joints
- Ocular prostheses

HOSPICE CARE

- Hospice Care (360 day lifetime limit)

No charge

**PRESCRIPTION DRUG BENEFIT
(INCLUDES INJECTABLES)**

**Prescription Drug Co-payments do not count toward
annual out-of-pocket maximum**

**PRESCRIPTION DRUGS-RETAIL
(INCLUDES CONTRACEPTIVES)
(30 DAY SUPPLY)**

\$10 Co-payment
Generic
\$20 Co-payment
Preferred Brand
\$30 Co-payment
Non-Preferred Brand

**PRESCRIPTION DRUGS-MAIL
ORDER (INCLUDES
CONTRACEPTIVES)
(90 DAY SUPPLY)**

\$20 Co-payment
Generic
\$40 Co-payment
Preferred Brand
\$60 Co-payment
Non-Preferred Brand

“Brand Additional Charge” means the additional charge that must be paid if you choose a Brand medication when a Generic equivalent is available. The charge is the difference between the cost of the Brand medication and the Generic medication. This charge must be paid in addition to the applicable Non-Preferred Brand Co-payment.

**PRIOR AUTHORIZATION IS REQUIRED FOR SPECIFIC COVERED SERVICES
INCLUDING, BUT NOT LIMITED TO:**

- All Inpatient services
- Observation Services
- Residential Treatment
- Outpatient Surgery
- Intensive Outpatient Programs
- Complex radiological imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging)
- Non Emergency Ambulance
- Dialysis Services
- Transplant Services
- Use of Non-Participating Providers
- Select Medications Including Injectables

**FOR ADDITIONAL INFORMATION, PLEASE CALL 1-800-68-AVMED
(1-800-682-8633)**

THIS SCHEDULE OF CO-PAYMENTS IS NOT A CONTRACT.
FOR SPECIFIC INFORMATION ON BENEFITS, EXCLUSIONS AND LIMITATIONS PLEASE SEE YOUR SUMMARY PLAN DESCRIPTION.