

# Benefit Summary

## POINT-OF-SERVICE SCHEDULE OF BENEFITS

MIAMI-DADE COUNTY & JACKSON HEALTH SYSTEM	COST TO MEMBER	
	In Network	Out-of-Network***
<b>LIFETIME MAXIMUM</b>	Unlimited	\$1,000,000 * benefit maximum to the member
<b>CO-INSURANCE LEVELS</b>	Plan pays 100%; Member Pays 0%	Plan pays 70% of UCR**; Member Pays 30% of the UCR** charge, after Deductible
<b>CASH DEDUCTIBLE</b> Individual (per contract year) Family (per contract year) <i>Deductible does not apply toward the Out-of-Pocket Maximum.</i>  <b>Individual Calculation:</b> Family members meet only their individual deductible and then their claims will be covered under the plan co-insurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan co-insurance.	Not Applicable  Not Applicable	\$200 per individual  \$500 per family
<b>OUT-OF-POCKET MAXIMUM</b> Individual  Family Maximum  <b>Individual Calculation:</b> Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%.	Not Applicable  Not Applicable	\$1500 per individual  Not Applicable
<b>PHYSICIAN SERVICES</b> Services at Physician's offices include, but are not limited to: <ul style="list-style-type: none"> <li>• Primary Care Physician's Office Visit</li> <li>• Surgery in Physician's Office</li> <li>• Specialty Care Physician's Office Visits     Consultant and Referral     Physician's Services</li> <li>• Second Opinion Consultations (provided on a voluntary basis)</li> <li>• Allergy Treatment</li> <li>• Allergy Injections</li> <li>• Allergy Serum (dispensed by the physician in the office)</li> </ul>	\$10 per visit  \$10 per visit  \$10 per visit  \$10 per visit  \$10 per visit  No Charge  No Charge	30% of the UCR charge, after Deductible 30% of the UCR charge, after Deductible 30% of the UCR charge, after Deductible 30% of the UCR charge, after Deductible 30% of the UCR charge, after Deductible 30% of the UCR charge, after Deductible 30% of the UCR charge, after Deductible 30% of the UCR charge, after Deductible

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\*\* Usual, Customary and Reasonable (UCR)

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<b>PREVENTIVE CARE</b>		
Routine Preventive Care: Birth through age 15 (Well-Baby and Well-Child including immunizations)	\$10 per visit	No Charge
Immunizations (birth through age 15)	No Charge	No Charge
Routine Preventive Care: Adult including immunizations	\$10 per visit	In-Network coverage only
Immunizations (age 16 and above)	No Charge	In-Network coverage only
<b>MAMMOGRAMS, PSA, PAP SMEAR</b>		
Preventive care related services (i.e. “routine” services)	No Charge	30% of the UCR charge, after Deductible
	<b>Note:</b> The associated wellness exam is subject to the \$10 Specialist visit co-payment.	<b>Note:</b> The associated wellness exam is not covered.
Diagnostic related services (i.e. “non-routine”)	Subject to the plan’s x-ray and laboratory benefit, based on place of service.	Subject to the plan’s x-ray and laboratory benefit, based on place of service.
<b>ACUPUNCTURE</b>	Out-of-network coverage only	30% of the UCR charge, after Deductible
<b>INPATIENT HOSPITAL SERVICES</b>		
Hospital inpatient care includes:		
• Room and board – unlimited days (semi-private)	No Charge	30% of the UCR charge, after Deductible
• Private Room	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
• Special Care Units (ICU/CCU)	No Charge	30% of the UCR charge, after Deductible
<b>OUTPATIENT FACILITY SERVICES</b>		
Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	No Charge	30% of the UCR charge, after Deductible
Diagnostic Testing	No Charge	30% of the UCR charge, after Deductible
<b>INPATIENT HOSPITAL PHYSICIAN'S VISITS/CONSULTATIONS</b>	No Charge	30% of the UCR charge, after Deductible
<b>INPATIENT/OUTPATIENT HOSPITAL PROFESSIONAL SERVICES</b>	No Charge	30% of the UCR charge, after Deductible

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SF-AV-MIAMI-DADE COUNTY- POS-08

SF-3403(1/08)

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	In Network	Out-of-Network***
<b>EMERGENCY AND URGENT CARE SERVICES</b>		
Physician's Office	\$10 per visit	\$10 per visit
Hospital Emergency Room	\$50 per visit (waived if admitted)	\$50 per visit (waived if admitted)
Outpatient Professional Services (radiology, pathology, ER physician)	No Charge	No Charge
Urgent Care Facility or Outpatient Facility	\$50 per visit (waived if admitted)	\$50 per visit (waived if admitted)
X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	No Charge	No Charge
Independent X-ray and/or Lab Facility in conjunction with an ER visit	No Charge	No Charge
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) The scan co-payment applies per type of scan per day	No Charge	No Charge
Ambulance	No Charge	No Charge
<b>INPATIENT SERVICES AT OTHER HEALTH CARE FACILITIES</b>		
Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities		
Contract Year Maximum: 60 days combined	No Charge	30% of the UCR charge, after Deductible
No prior hospitalization required		
<b>LABORATORY/RADIOLOGY SERVICES</b>		
(includes pre-admission testing)		
Physician's Office Visit	No Charge	30% of the UCR charge, after Deductible
Outpatient Hospital Facility	No Charge	30% of the UCR charge, after Deductible
Independent X-ray and/or Laboratory Facility	No Charge	30% of the UCR charge, after Deductible

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<p><b>ADVANCED RADIOLOGICAL IMAGING</b> (i.e. MRIs, MRAs, CAT scans and PET scans) The scan co-payment/deductible applies per type of scan per day.</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Office</p>	<p>No Charge</p> <p>No Charge</p> <p>No Charge</p>	<p>30% of the UCR charge, after Deductible</p> <p>30% of the UCR charge, after Deductible</p> <p>30% of the UCR charge, after Deductible</p>
<p><b>OUTPATIENT SHORT-TERM REHABILITATIVE THERAPY AND CHIROPRACTIC SERVICES</b> Contract Year Maximum: 60 days for all therapies combined Includes: Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehabilitation Cognitive Therapy Chiropractic Therapy (includes Chiropractors) Respiratory Therapy</p>	<p>\$10 per visit</p> <p><b>Note:</b> The Outpatient Short Term Rehabilitation co-payment does not apply to services provided as part of a Home Health Care visit.</p>	<p>30% of the UCR charge, after Deductible</p>
<p><b>CARDIAC REHABILITATION</b> Contract Year Maximum: 36 visits</p> <p>Cardiac Rehabilitation is covered for the following conditions:</p> <ul style="list-style-type: none"> <li>▪ Acute myocardial infarction</li> <li>▪ Percutaneous transluminal coronary angioplasty (PTCA)</li> <li>▪ Repair or replacement of heart valves</li> <li>▪ Coronary artery bypass graft (CABG), or Heart transplant</li> </ul>	<p>\$10 per visit</p>	<p>30% of the UCR charge, after Deductible</p>
<p><b>HOME HEALTH CARE</b> Contract Year Maximum:</p> <p>(including outpatient private nursing when approved as medically necessary)</p>	<p>Unlimited Days</p> <p>No Charge</p>	<p>60 visits</p> <p>30% of the UCR charge, after Deductible</p>
<p><b>HOSPICE</b> Inpatient/Outpatient Services</p> <p>Limited to 360 day lifetime limit</p>	<p>No Charge</p>	<p>30% of the UCR charge, after Deductible</p>

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<b>BEREAVEMENT COUNSELING</b>		
Services provided as part of Hospice Care		
Inpatient	No Charge	In-Network coverage only
Outpatient	No Charge	In-Network coverage only
Services provided by Mental Health Professional	Covered under Mental Health benefit	In-Network coverage only
<b>MATERNITY CARE SERVICES</b>		
Initial Visit to Confirm Pregnancy	\$10 per visit	30% of the UCR charge, after Deductible
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	No Charge	30% of the UCR charge, after Deductible
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	\$10 per visit	30% of the UCR charge, after Deductible
Delivery-Facility (Inpatient Hospital, Birthing Center)	No Charge	30% of the UCR charge, after Deductible
<b>ABORTION</b>		
Includes Non-elective procedures only		
Physician's Office Visit	\$10 per visit	30% of the UCR charge, after Deductible
Inpatient Facility	No Charge	30% of the UCR charge, after Deductible
Outpatient Facility	No Charge	30% of the UCR charge, after Deductible
Physician's Services	No Charge	30% of the UCR charge, after Deductible

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	<b>In Network</b>	<b>Out-of-Network***</b>
<p><b>FAMILY PLANNING SERVICES</b> Physician's Office Visit (testing and counseling)</p> <p>Surgical Sterilization Procedures for Vasectomy/Tubal Ligation (excludes reversals) Inpatient Facility, Outpatient Facility, and Physician's Services</p>	\$10 per visit	30% of the UCR charge, after Deductible
<p><b>INFERTILITY TREATMENT</b> Coverage will be provided for the following services:</p> <ul style="list-style-type: none"> <li>▪ Testing and treatment for services performed in conjunction with an underlying medical condition.</li> <li>▪ Testing performed exclusively to determine the cause of infertility.</li> <li>▪ Treatment and/or procedures performed exclusively to restore fertility (e.g. procedures to correct an infertility condition).</li> </ul> <p>Services Not Covered include: Artificial Insemination, In-vitro, GIFT, ZIFT, etc.</p>	No Charge	30% of the UCR charge, after Deductible
<p>Physician's Office Visit (Lab and Radiology Tests, Counseling)</p> <p>Surgical Procedure Co-payment</p> <p>Inpatient Facility, Outpatient Facility and Physicians' Services</p>	\$10 per visit	30% of the UCR charge, after Deductible
<p><b>ORGAN TRANSPLANTS</b> Includes all medically appropriate, non-experimental transplants Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Inpatient Physician's Services</p> <p>Lifetime Travel Maximum: \$10,000 per transplant</p>	\$200 Surgical Co-payment	30% of the UCR charge, after Deductible
<p><b>DURABLE MEDICAL EQUIPMENT</b> Contract Year Maximum: Unlimited</p>	No Charge	30% of the UCR charge, after Deductible
<p><b>EXTERNAL PROSTHETIC APPLIANCES (EPA)</b> Contract Year Maximum: Unlimited</p>	No Charge	30% of the UCR charge, after Deductible
<p><b>NUTRITIONAL EVALUATION</b> Contract Year Maximum: 3 visits per person</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p>	\$10 per visit	30% of the UCR charge, after Deductible
	No Charge	30% of the UCR charge, after Deductible
	No Charge	30% of the UCR charge, after Deductible
	No Charge	30% of the UCR charge, after Deductible
	No Charge	In-Network coverage only
	No Charge after \$200 EPA deductible; per Contract Year	In-Network coverage only
	\$10 per visit	30% of the UCR charge, after Deductible
	No Charge	30% of the UCR charge, after Deductible
	No Charge	30% of the UCR charge, after Deductible
	No Charge	30% of the UCR charge, after Deductible

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<p><b>DENTAL CARE</b> Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p>	<p>\$10 per visit</p> <p>No Charge</p> <p>No Charge</p> <p>No Charge</p>	<p>30% of the UCR charge, after Deductible</p> <p>30% of the UCR charge, after Deductible</p> <p>30% of the UCR charge, after Deductible</p> <p>30% of the UCR charge, after Deductible</p>
<p><b>TMJ SURGICAL AND NON-SURGICAL</b> Always excludes appliances and orthodontic treatment. Subject to medical necessity.</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p>	<p>\$10 per visit</p> <p>No Charge</p> <p>No Charge</p> <p>No Charge</p>	<p>In-Network coverage only</p> <p>In-Network coverage only</p> <p>In-Network coverage only</p> <p>In-Network coverage only</p>
<p><b>OBESITY/BARIATRIC SURGERY</b> <b>Note:</b> Coverage is provided subject to medical necessity and clinical guidelines subject to any limitations shown in the "Exclusions and Limitations" of your Summary Plan Description.</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p>	<p>\$10 per visit</p> <p>No Charge</p> <p>No Charge</p> <p>No Charge</p>	<p>In-Network coverage only</p> <p>In-Network coverage only</p> <p>In-Network coverage only</p> <p>In-Network coverage only</p>
<p><b>ROUTINE FOOT DISORDERS</b></p>	<p>Not covered except for services associated with foot care for diabetes and peripheral vascular disease.</p>	<p>Not covered except for services associated with foot care for diabetes and peripheral vascular disease.</p>

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<b>PRESCRIPTION MEDICATION BENEFIT (Includes Injectables)</b> <b>Prescription Medication Co-payments and Co-insurance do not count toward annual out-of-pocket maximum</b>		
<p><b>PRESCRIPTION MEDICATION – RETAIL, 30 DAY SUPPLY (INCLUDES CONTRACEPTIVES)</b></p> <p>Generic: medication on the Prescription medication list</p> <p>Brand Name: medication designated as preferred on the prescription medication list with no Generic equivalent</p> <p>Brand Name: medication with a Generic equivalent and/or medication designated as non-preferred on the Prescription medication list</p> <p><b>Specialty (30-day supply at Participating Pharmacy)</b></p> <p>Generic: medication on the Prescription medication list</p> <p>Brand Name: medication designated as preferred on the prescription medication list with no Generic equivalent</p> <p>Brand Name: medication with a Generic equivalent and/or medication designated as non-preferred on the Prescription medication list</p> <p><b>PRESCRIPTION MEDICATION - MAIL-ORDER, 90 DAY SUPPLY (INCLUDES CONTRACEPTIVES)</b></p> <p>Generic: medication on the Prescription medication list</p> <p>Brand Name: medication designated as preferred on the prescription medication list with no Generic equivalent</p> <p>Brand Name: medication with a Generic equivalent and/or medication designated as non-preferred on the Prescription medication list</p>	<p>\$5 Co-payment Generic</p> <p>\$10 Co-payment Preferred Brand</p> <p>\$15 Co-payment Non-Preferred Brand</p> <p>\$3.33 Co-payment for Generic</p> <p>\$6.66 Co-payment for Preferred Brand</p> <p>\$10 Co-payment for Non-Preferred Brand</p> <p>\$10 Co-payment Generic</p> <p>\$20 Co-payment Preferred Brand</p> <p>\$30 Co-payment Non-Preferred Brand</p>	<p>30% of charges</p> <p>30% of charges</p> <p>30% of charges</p> <p>30% of charges</p> <p>30% of charges</p> <p>30% of charges</p> <p>30% of charges</p> <p>In-Network coverage only</p> <p>In-Network coverage only</p> <p>In-Network coverage only</p>

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<b>MIAMI-DADE COUNTY &amp; JACKSON HEALTH SYSTEM</b>		
	<b>In Network</b>	<b>Out-of-Network***</b>
<b>PRIOR AUTHORIZATION IS REQUIRED FOR SPECIFIC COVERED SERVICES INCLUDING, BUT NOT LIMITED TO:</b>	<ul style="list-style-type: none"> <li>• All Inpatient services</li> <li>• Observation services</li> <li>• Residential Treatment</li> <li>• Outpatient Surgery</li> <li>• Intensive Outpatient Programs</li> <li>• Complex radiological imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging)</li> <li>• Non-Emergency Ambulance</li> <li>• Hysterectomy</li> <li>• Dialysis Services</li> <li>• Transplant Services</li> <li>• Select Medications Including Injectables</li> </ul>	<ul style="list-style-type: none"> <li>• All Inpatient services</li> <li>• Observation services</li> <li>• Residential Treatment</li> <li>• Intensive Outpatient Programs</li> <li>• Non-Emergency Ambulance</li> <li>• Complex radiological imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging)</li> <li>• Hysterectomy</li> <li>• Dialysis Services</li> <li>• Transplant Services</li> <li>• Select Medications Including Injectables</li> </ul> <p>The Plan must be notified within 72 hours after the date of admission. The Penalty for Non-Notification is \$500</p>

**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.

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