AvMed Embrace better health **JHS POS Option**

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 1-844-439-5378 or visit www.avmed.org/jhs. 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.cciio.cms.gov or call 1-844-439-5378 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$0** individual/ **$0** dependent coverage Out-of-Network: **$200** individual/ **$500** dependent coverage Applies to Out-of-Network services only.	Generally, you must pay all of the costs from providers up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your deductible?	This plan has no deductible In-Network.	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost-sharing** and before you meet your **deductible**. See a list of covered **preventive services** at **https://www.healthcare.gov/coverage/preventive-care-benefits/**.
Are there other deductibles for specific services?	Yes. **$200** individual for external Prosthetics (see DME benefits). Doesn't apply to overall **deductible**. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this **plan** begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-Network: **$1,500** individual/ **$4,500** dependent coverage (does not include prescription drug cost-sharing); Out-of-Network: **$1,500** per individual; In-Network Prescription Drugs: **$1,500** individual/ **$3,000** dependent coverage (does not include medical cost-sharing).	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	Premiums, out-of-network prescription drug cost sharing, prescription drug brand additional charges, out-of-network balance billing, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

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(HHS - OMB control number: 0938-1146/Expiration DATE: 10/31/2022)

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See **www.avmed.org/jhs or call 1-844-439-5378** 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 you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a **referral**.

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
		an In-Network Provider (You will pay the least)	an Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 copay/ visit for PCP at JHS employed provider; $15 copay/ visit at all other; No additional charge for allergy injections at JHS employed provider; $5 copay/ visit for chiropractic services at JHS employed provider; $15 copay/ visit at all other; $5 copay/ visit for podiatry services at JHS employed provider; $15 copay/ visit at all other	30% coinsurance after deductible	Additional charges may apply for non-preventive services performed in the Physician's office. Chiropractic services has a combined limit of 60 days per calendar year with rehabilitative services.
	Specialist visit	$15 copay/ visit for specialist at JHS employed provider; $30 copay/ visit at all other; $15 copay/ visit for allergy treatment and skin testing at JHS employed provider; $30 copay/ visit at all other;	30% coinsurance after deductible; 30% coinsurance after deductible for acupuncture	Additional charges may apply for non-preventive services performed in the Physician's office. 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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an In-Network Provider (You will pay the least)	an Out-of-Network Provider (You will pay the most)	
		$15 copay/ visit for infertility treatment at JHS employed provider; $30 copay/ visit at all other		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.
	Preventive care/screening/ immunization	No Charge	30% coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	30% coinsurance after deductible	Charges for office visits may apply if services are performed in a Physician's office.
	Imaging (CT/PET scans, MRIs)	No Charge	30% coinsurance after deductible	Charges for office visits or Physician/professional services may also apply depending where services are received.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.avmed.org/jhs	Generic drugs (Tier 1)	$15 copay/ prescription (retail); $30 copay/ prescription (mail order)	30% coinsurance, not subject to deductible	This Plan uses the Preferred Pharmacy Network. Retail charge applies per 30-day supply. Generic & brand drugs: covers up to a 90-day supply at retail pharmacies; and 60-90 day supply via mail order. Certain drugs in all tiers require prior authorization. Brand additional charges may apply. Specialty drugs available in 30-day supply only; not available via mail order.
	Preferred brand drugs (Tier 2)	$50 copay/ prescription (retail);); $90 copay/ prescription (mail order)	30% coinsurance, not subject to deductible	
	Non-preferred brand drugs (Tier 3)	$65 copay/ prescription (retail); $120 copay/ prescription (mail order)	30% coinsurance, not subject to deductible	
	Specialty Drugs (Tier 4)	$100 copay/ prescription (retail only)	30% coinsurance, not subject to deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an In-Network Provider (You will pay the least)	an Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay/ visit; No charge at JHS	30% coinsurance after deductible	Prior authorization required.
	Physician/surgeon fees	No charge, except $200 surgical copay applies for infertility surgery	30% coinsurance after deductible	Prior authorization required.
If you need immediate medical attention	Emergency room care	$200 copay/ visit (waived if admitted); $100 copay/ visit for age 17 and under	$200 copay/ visit (waived if admitted); $100 copay/ visit for age 17 and under	AvMed must be notified within 24-hours of inpatient admission following emergency services, or as soon as reasonably possible.
	Emergency medical transportation	No Charge	No Charge	When pre-authorized or in the case of emergency.
	Urgent care	$5 copay/ visit at UHealth/ Jackson Urgent Care Centers; $100 copay/ visit at other in-network urgent care facilities; $10 copay/ visit at UHealth Clinic at Walgreens; $15 copay/ visit at retail clinics	$100 copay/ visit at urgent care facilities or retail clinics	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay/ admission (waived if admitted); No charge at JHS	30% coinsurance after deductible	Prior authorization required.
	Physician/surgeon fees	No charge, except $200 surgical copay applies for infertility surgery	30% coinsurance after deductible	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$5 copay/ visit at JHS employed provider; $15 copay/ visit at all other	30% coinsurance after deductible	----------None----------
	Inpatient services	Hospital stay: $200 copay/ admission; No charge at JHS Residential stay: No Charge	30% coinsurance after deductible	Prior authorization required. Residential stay is limited to 60 days per calendar year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an In-Network Provider (You will pay the least)	an Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	Routine OB: $15 copay/ visit at JHS employed provider; $30 copay/ 1st visit only at all other; subsequent visits at no charge	30% coinsurance after deductible	----------None----------
	Childbirth/delivery professional services	Routine OB & Midwife services: $15 copay/ visit at JHS employed provider; $30 copay/ 1st visit only; subsequent visits at no charge	30% coinsurance after deductible	Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth/delivery facility services	Hospital stay: $200 copay/ admission; No charge at JHS Birthing center: Same as Routine OB	30% coinsurance after deductible	Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an In-Network Provider (You will pay the least)	an Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No Charge	30% coinsurance after deductible	Limited to Out-of-Network home health care to 60 skilled visits maximum per calendar year. Approved treatment plan required.
	Rehabilitation services	$30 copay/ visit	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 rehabilitation. Cardiac rehabilitation requires prior authorization.
	Habilitation services	$15 copay/ visit	30% coinsurance after deductible	Habilitative physical, occupational, & speech therapies, when provided for the treatment of autism spectrum disorder and Down syndrome, are limited to a combined maximum of 100 visits per calendar year.
	Skilled nursing care	No Charge	30% coinsurance after deductible	Limited to 60 days post-hospitalization care per calendar year. Prior authorization required.
	Durable medical equipment	No charge/ device for DME and orthotics; No charge for external prosthetic appliances, after $200 calendar year deductible	30% coinsurance after deductible for DME and orthotics	Some limitations apply. Please see your Summary Plan Description for details. External prosthetic appliances are not covered Out-of-Network.
	Hospice services	No Charge	30% coinsurance after deductible	Limited to 360 days per member lifetime maximum. Physician certification required.
If your child needs dental or eye care	Children's eye exam	$5 copay/ exam at JHS employed provider; $15 copay/ exam at all other	30% coinsurance after deductible	Limited to one eye exam per calendar year to determine the need for sight correction.
	Children's glasses	Not Covered	Not Covered	----------None----------
	Children's dental check-up	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.)

- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

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

- Acupuncture (limited to out-of-network)
- Bariatric Surgery (for morbid obesity)
- Chiropractic Care
- Infertility Treatment (limited to testing and treatment)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information is: the U.S. Department of Health and Human Services at 1-877-267- 2323 x61565 or 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** 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 on how 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 1-844-439-5378.

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 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 1-844-439-5378.

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)

The plan's overall deductible	**$0**
Specialist copayment	**$15**
Hospital (facility) copayment	**$200**
Other payment	**$0**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/delivery professional services
Childbirth/delivery facility services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$260

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$0**
Specialist copayment	**$15**
Hospital (facility) copayment	**$200**
Other payment	**$0**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,220

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$0**
Specialist copayment	**$15**
Hospital (facility) copayment	**$200**
Other copayment	**$0**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$500

The **plan** would be responsible for the other costs of these EXAMPLE covered services.