

Benefit Guide

Freedom to choose...
No Need to Designate a PCP... No Referrals

State of Florida
Health Investor Health Plan

Health plans with **your health** in mind.

AvMED
HEALTH PLANS

Benefit Summary

STATE OF FLORIDA HEALTH INVESTOR HEALTH PLAN	SCHEDULE OF BENEFITS	COST TO MEMBER
DEDUCTIBLE PER CALENDAR YEAR*	INDIVIDUAL/FAMILY	\$1,250/\$2,500
OUT-OF-POCKET MAXIMUM PER CALENDAR YEAR*	INDIVIDUAL/FAMILY (<i>Includes Deductible and Co-insurance</i>)	\$3,000/\$6,000
PREVENTIVE CARE (NOT SUBJECT TO THE DEDUCTIBLE)	Preventive care services provided in a Participating Physician's office include, but are not limited to: <ul style="list-style-type: none"> ▪ Well-woman examinations, including pap smears ▪ Well-child care and immunizations, including vision and hearing screenings by their pediatrician for children under 18 	NO CHARGE
AVMED PRIMARY CARE PHYSICIAN SERVICES	Services in Participating Physicians' offices include, but are not limited to: <ul style="list-style-type: none"> ▪ Routine office visits ▪ Diagnostic imaging, laboratory or other diagnostic services ▪ Minor surgical procedures 	20% of the contracted rate after Deductible
AVMED SPECIALTY CARE PHYSICIAN SERVICES	No referral or Pre-Authorization required for: <ul style="list-style-type: none"> ▪ Office visits including consultations ▪ Diagnostic imaging, laboratory or other diagnostic services ▪ Minor surgical procedures 	20% of the contracted rate after Deductible
ALLERGY TREATMENTS	<ul style="list-style-type: none"> ▪ Skin testing ▪ Office visits, including injections 	20% of the contracted rate after Deductible
HOSPITAL	Pre-Authorization required for all Inpatient care. Inpatient care at 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 ▪ Maternity services 	20% of the contracted rate after Deductible
SURGERY	<ul style="list-style-type: none"> ▪ Outpatient ▪ Inpatient 	20% of the contracted rate after Deductible
OUTPATIENT LAB AND X-RAY	<ul style="list-style-type: none"> ▪ CAT Scan, PET Scan, MRI ▪ Other diagnostic imaging tests ▪ Outpatient laboratory tests ▪ Mammograms (not subject to Deductible) 	20% of the contracted rate after Deductible No Charge

* The Family Deductible and Out-of-Pocket Maximum are non-embedded, meaning no individual in the family has satisfied the Deductible or Out-of-Pocket Maximum until the entire family amount has been satisfied.

Benefit Summary, continued

VISION BENEFITS	<ul style="list-style-type: none"> ▪ Routine annual eye exam ▪ Primary Care Physician services ▪ Specialist services 	20% of the contracted rate after Deductible
EMERGENCY SERVICES	<p>An emergency is the sudden and unexpected onset of a condition requiring immediate medical or surgical care. (Co-insurance waived if admitted)</p> <ul style="list-style-type: none"> ▪ Emergency services at participating Hospitals and Non-participating Hospitals, facilities, Urgent Care 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>	20% of the contracted rate after Deductible
AMBULANCE	<ul style="list-style-type: none"> ▪ Ambulance transport for emergency services and when medically necessary 	20% of the contracted rate after Deductible
FAMILY PLANNING	<ul style="list-style-type: none"> ▪ Voluntary family planning services ▪ Sterilization 	20% of the contracted rate after Deductible
MENTAL HEALTH	<ul style="list-style-type: none"> ▪ Inpatient ▪ Outpatient 	20% of the contracted rate after Deductible
ALCOHOL / DRUG TREATMENT	<ul style="list-style-type: none"> ▪ Inpatient ▪ Outpatient 	20% of the contracted rate after Deductible
DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDER	<ul style="list-style-type: none"> ▪ Applied Behavior Analysis services ▪ Physical, Speech or Occupational Therapy <p>Coverage for all services related to Autism Spectrum Disorder is limited to \$36,000 annually and may not exceed \$200,000 in total benefits.</p>	20% of the contracted rate after Deductible
REHABILITATIVE SERVICES	<ul style="list-style-type: none"> ▪ Outpatient services limited to 60 visits per injury 	20% of the contracted rate after Deductible
SKILLED NURSING FACILITIES	<p>Pre-Authorization required.</p> <ul style="list-style-type: none"> ▪ Up to 60 days maximum per calendar year 	20% of the contracted rate after Deductible
HOME HEALTH CARE	<ul style="list-style-type: none"> ▪ Per occurrence 	20% of the Contracted rate after Deductible
DURABLE MEDICAL EQUIPMENT AND ORTHOTIC APPLIANCES	<ul style="list-style-type: none"> ▪ Per device 	20% of the contracted rate after Deductible
PROSTHETIC DEVICES	<ul style="list-style-type: none"> ▪ Per device 	20% of the contracted rate after Deductible

FOR ADDITIONAL INFORMATION, PLEASE CALL: 1-800-88-AVMED (1-800-882-8633)

THIS SCHEDULE OF BENEFITS IS NOT A CONTRACT. FOR SPECIFIC INFORMATION ON BENEFITS, EXCLUSIONS AND LIMITATIONS, PLEASE CONSULT YOUR STATE OF FLORIDA EMPLOYEES' GROUP INSURANCE POLICY – HEALTH INVESTOR HEALTH PLAN.

**STATE OF FLORIDA
HEALTH INVESTOR HEALTH PLAN**

DEFINITIONS

“Brand” drug means a Prescription Drug that is usually manufactured and sold under a name or trademark by a drug manufacturer or a drug that is identified as a Brand drug by AvMed. AvMed delegates determination of Generic/Brand status to our Pharmacy Benefits Manager.

“Brand Additional Charge” means the additional charge that must be paid if you or your physician choose a Brand drug when a Generic equivalent is available. The charge is the difference between the cost of the Brand drug and the Generic drug. This charge must be paid in addition to the applicable Brand Co-insurance (Preferred or Non-Preferred). However, if the prescribing physician or other participating provider authorized to prescribe drugs within the scope of his or her license indicates on the prescription “Brand name medically necessary” or “dispense as written” for a drug for which there is a Generic equivalent, the Brand drug shall be dispensed for the applicable Brand Co-insurance only.

“Generic” drug means a drug that has the same active ingredient as a Brand drug or is identified as a Generic drug by AvMed’s Pharmacy Benefits Manager.

“Injectable Drug” is a medication that has been approved by the Food and Drug Administration (FDA) for administration by one or more of the following routes: intramuscular injection, intravenous injection, intravenous infusion, subcutaneous injection, intrathecal injection, intrarticular injection, intracavernous injection or intraocular injection. Pre-Authorization is required for all Injectable Drugs.

“Participating Pharmacy” means a pharmacy (either Retail, Mail Order or Specialty Pharmacy) that has entered into an agreement with AvMed to provide Prescription Drugs to AvMed Members and has been designated by AvMed as a Participating Pharmacy.

“Preferred Drug List” means the listing of preferred medications as determined by AvMed’s Pharmacy and Therapeutics Committee based on clinical efficacy, relative safety and cost in comparison to similar medications within a therapeutic class. As new medications become available, they may be considered excluded until they have been reviewed by AvMed’s Pharmacy and Therapeutics Committee.

“Prescription Drug” means a medication that has been approved by the Food and Drug Administration and that can only be dispensed pursuant to a prescription according to state and federal law.

“Pre-Authorization” means the process of obtaining approval for certain Prescription Drugs (prior to dispensing) according to AvMed’s guidelines. The prescribing physician must obtain approval from AvMed. The list of Prescription Drugs requiring Pre-Authorization is subject to periodic review and modification by AvMed. A copy of the list of medications requiring authorization and the applicable criteria are available from Member Services or from the AvMed website.

“Self-Administered Injectable Drug” is a medication that has been approved by the Food and Drug Administration (FDA) for self-injection and is administered by subcutaneous injection or a medication for which there are instructions to the patient for self-injection in the manufacturer’s prescribing information (package insert). Pre-Authorization is required for all Self-Administered Injectable Drugs.

HOW DOES YOUR PRESCRIPTION COVERAGE WORK?

To obtain your prescription, take to or have your physician call an AvMed Participating Pharmacy. (Your Physician should submit prescriptions for Self-Administered Injectable Drugs to AvMed’s Specialty Pharmacy.) Present your prescription along with your AvMed identification card. Once you meet your Deductible (as outlined on your Schedule of Benefits), you will pay the following Co-insurance amount (as well as the Brand Additional Charge if you choose a Brand product when a Generic equivalent is available).

Tier 1	Generic Drugs:	30% after Deductible
Tier 2	Preferred Brand Drugs (including Self-Administered Injectable Drugs):	30% after Deductible
Tier 3	Non-Preferred Brand Drugs:	50% after Deductible

ORDERING YOUR PRESCRIPTIONS THROUGH THE MAIL

Mail service is a benefit option for maintenance medications needed for chronic or long-term health conditions. It’s best to get an initial prescription filled at your retail pharmacy. Ask your physician for an additional prescription for up to a 90-day supply of your medication to be ordered through mail service. Up to 3 refills are allowed per prescription. Once you meet your Deductible (as outlined on your Schedule of Benefits), you will pay the following Co-insurance amount (as well as the Brand Additional Charge if you choose a Brand product when a Generic equivalent is available).

Tier 1	Generic Drugs:	30% after Deductible
Tier 2	Preferred Brand Drugs: (Self-Administered Injectable Drugs are not available through mail service)	30% after Deductible
Tier 3	Non-Preferred Brand Drugs:	50% after Deductible

Prescription Drug Benefits

WHAT IS COVERED?

- Your prescription drug coverage includes outpatient medications (including contraceptives) that require a prescription and are prescribed by your AvMed physician in accordance with AvMed's coverage criteria. AvMed reserves the right to make changes in coverage criteria for covered products and services. Coverage criteria are medical and pharmaceutical protocols used to determine payment of products and services and are based on independent clinical practice guidelines and standards of care established by government agencies and medical/pharmaceutical societies.
- Your retail prescription drug coverage includes up to a 30-day supply of a medication. The pharmacy will dispense the quantity sufficient to treat an acute phase of illness, or within the drug manufacturer's recommended dosages, but not more than a 30-day supply. Your prescription may be refilled via retail or mail-order after 75% of your previous fill has been used. However, prior authorization may be required for covered medications.
- Your mail-order prescription drug coverage includes up to a 90-day supply of a routine maintenance medication. If the amount of medication is less than a 90-day supply, you will still be charged the listed mail-order Co-insurance after meeting your Deductible.
- Your Prescription Drug coverage includes coverage for injectable contraceptives. There is a Co-insurance of \$30 for each injection. If there is an office visit associated with the injection, there will be an additional Co-insurance required for the office visit.
- Quantity limits are set in accordance with FDA approved prescribing limitations, general practice guidelines supported by medical specialty organizations, and/or evidence-based, statistically valid clinical studies without published conflicting data. This means that a medication-specific quantity limit may apply for medications that have an increased potential for over-utilization or an increased potential for a Member to experience an adverse effect at higher doses.

QUESTIONS?

Call your AvMed Member Services Department at: 1-800-88-AvMed (1-800-882-8633)

EXCLUSIONS AND LIMITATIONS

- Over the counter medications
- Drugs or medications which do not require a prescription or when a non-prescription equivalent is available
- Medical supplies, including therapeutic devices, dressings, appliances, and support garments
- Fertility drugs
- Medications or devices for the diagnosis or treatment of sexual dysfunction
- Medications for dental purposes, including fluoride medications
- Prescription and non-prescription vitamins and minerals except prenatal vitamins
- Nutritional supplements
- Blood, biologicals and immunizations
- Investigational and experimental drugs (except as required by Florida statute)
- Cosmetic products, including hair growth, skin bleaching, sun damage and anti-wrinkle medications
- Nicotine suppressants and smoking cessation products and services
- Prescription and non-prescription appetite suppressants and products for the purpose of weight loss
- Transdermal scopolamine for non-business related purposes

Filling a prescription at a pharmacy is not a claim for benefits and is not subject to the Claims and Appeals procedures under ERISA. However, any medicines that require prior authorization will be treated as a claim for benefits subject to the Claims and Appeals Procedures, as outlined in the State of Florida Employees' Group Insurance Policy.

www.avmed.org/go/state
Our Member Services is available
to you 24/7 at **1-800-882-8633**.