Department of MANAGEMENT SERVICES
Division of State Group Insurance

2023 Health Plan Enrollment Information

For Employees and Retirees of the State of Florida

AvMed

Embrace better health.®

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SPECIAL MEMBER ENGAGEMENT CENTER FOR STATE EMPLOYEES

If you have any questions about your plan, from benefits, to copayments, to Provider lists, you can call our special State of Florida Member Engagement Center. These specialists are just a phone call away Monday-Friday, 8 am-8 pm; Saturday, 9 am-1 pm. You can reach them at **1-888-762-8633 (TTY 711)** or via email at **StateofFlorida.Members@AvMed.org.**

Join the **WELL**fluent™
GET FIT. EAT RIGHT. CONNECT. GROW.

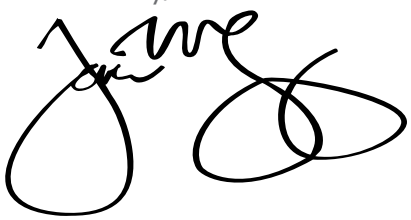
At AvMed, we transform lives to create a **WELL**fluent™ world. What does it mean to be WELLfluent? It means you seek a life rich in what really matters; health and happiness. We go above and beyond to provide extraordinary Member care, service and support.

AvMed is proud to serve the State of Florida employees from our headquarters right down the road and, whether you're new to the AvMed family or a long-time Member, we promise to provide personalized service focused on your individual needs. The team at AvMed are your neighbors, your friends and your family.

Naturally, we go out of our way to make healthcare easier. It all starts the day you enroll. You and your family can choose from one of Florida's strongest networks of doctors and hospitals. You'll have tools that let you compare providers and costs. You'll even receive discounts for helping State of Florida prove that WELLfluent isn't only a concept, it's a way of life. AvMed gives you all this and more, plus access to an AvMed Representative - not a machine - to answer questions about your benefits. We believe in partnering with you through the entire healthcare experience, regardless of your stage in life or health status. Our goal is to be your lifelong partner in health.

You can expect a better member health experience now and for many years to come. Welcome to the AvMed family…the plan that Floridians like you have counted on for 50 years. Thank you for placing your trust in us.

Sincerely,



James M. Repp
President and COO
AvMed

GET THE MOST FROM YOUR PLAN

AvMed has served Florida for 50 years, becoming very familiar with the needs of our Members. So it should come as no surprise that the health plans we offer today include all the benefits you want most:

- **No referral needed to see in-network physicians**
- **Access to a large network of doctors and hospitals that includes an extensive selection of Primary Care Physicians (PCPs), Specialists, top-ranked hospitals and outpatient facilities throughout the state of Florida**
- **Retail Clinic benefit that allows you to pay your Urgent Care Clinic copayment at participating clinics across the state***
- **Member Engagement Center accessible by phone, email or online—to answer questions on every topic from benefits to Providers to payment balances**
- **WELLfluent Living® Program to keep you healthier and reduce your overall healthcare costs**
- **Emergency coverage when you travel outside of AvMed's Network area**
- **24/7 Nurse On Call service that connects you to a Registered Nurse who can answer your important health care questions quickly and confidentially**
- **AvMed's Cost Calculator allows you to see the total cost of a procedure before you schedule an appointment. This unique tool helps you evaluate providers and prices in advance to determine the best value**

*for the Standard HMO option

OUR COMMITMENT TO YOU

AvMed is not only a Florida company, focused on Floridians. We're also a not-for-profit health plan, so we're focused on our Members' healthcare rather than on shareholders and stock dividends. Answering to Members—and no one else—keeps your health our top priority. It encourages innovation and great service. And you're encouraged to participate in the process by completing a survey after enrollment.

MAXIMIZE YOUR MEMBERSHIP and your health

One of the best defenses against illness—and high health care costs—is prevention. That's why AvMed's benefits include preventive care services at no charge. These include, but are not limited to, well-woman exams, annual physicals, well-child care, immunizations, colonoscopies, mammograms, obesity screenings, diabetes testing, cholesterol testing and smoking cessation counseling.

AvMed **WELL**fluent Living® Program makes it easier to live a life rich in happiness and healthiness. We provide you with helpful, health-related tools, information, support, savings and rewards that you can use to reach your personal goals.

- **AvMed's Personal Health Assessment (PHA) to help identify potential health risks and set improvement goals based on your personal health needs**
- **Lifestyle Coaching to help you take the first step toward a healthier you**
- **Stress Reduction Program to keep stress levels low over time**
- **Diet Center to help monitor eating habits**
- **Weight Watchers® reimbursements to encourage healthier living**
- **Discounts on services like fitness center membership, as well as reduced rates from participating massage therapists, acupuncturists and other alternative medicine Providers**
- **Diabetes and cholesterol testing and smoking cessation counseling**
- **Online courses on several health topics**
- **A wellness center including articles on health and prevention topics for all areas of life**
- **Health Resources including educational information on supplements and medicines**

To learn more about what screenings you're due to receive and the AvMed WELLfluent Living® Program, visit **www.AvMed.org/State** and log in to the Member section.

AvMed offers you high-quality care with access to a strong network of doctors, specialists and hospitals. We help connect you with the right team to cater to your individual needs.

FIND THE DOCTORS YOU WANT

Whether you're looking for your family doctor or a highly recommended specialist, you can find out if they're part of AvMed's Network by searching for their name, specialty or location. What's more, AvMed offers access to our partner network for Members within the AvMed service area. To find physicians within your plan, visit **www.AvMed.org/State** or call Monday-Friday, 8 am-8 pm; Saturday, 9 am-1 pm.

TRANSITION YOUR CARE TO AVMED PROVIDERS

If you are new to AvMed and undergoing long-term care for a specific condition, like self-injectables or complex regular treatments, we want to make sure the transition does not interrupt your care. Fill out a Transition of Care form, and AvMed Nurses will work with you to ensure continuity of care. To request a form, visit **www.AvMed.org/State** or call **1-888-762-8633 (TTY 711)** Monday-Friday, 8 am-8 pm; Saturday, 9 am-1 pm.

2 easy ways to **BECOME A MEMBER.**

In this kit, you will find the Benefit Guides for the two AvMed health plans for all State of Florida employees and retirees: our HMO Plan and our High Deductible Health Plan. You can easily enroll in either choice at your convenience.

ONLINE

Click on **PeopleFirst.MyFlorida.com.** Type in your user ID and password.
Click on **Insurance Benefits,** then on **Change My Benefits** and follow the prompts.

BY PHONE

Call the People First Service Center at **1-866-663-4735** to speak with a specialist. They're available Monday-Friday, 8 am-6 pm.

For families with **MULTIPLE INSURANCE CARRIERS.**

If your family has more than one health insurance carrier, you need to complete a Coordination of Benefits (COB) survey to make sure all claims are handled correctly. You can request a hardcopy COB survey from your benefits administrator, AvMed Member Engagement Center or fill out a form at **www.AvMed.org/State**.

AFTER YOU ENROLL

After you enroll, you will receive your yellow AvMed Member ID Card. Remember you'll need your ID to access the majority of your benefits.

REPLACING A LOST AVMED ID

If you lose your AvMed Member ID Card, you can print out a temporary ID by logging in to your account at **www.AvMed.org/State** or call AvMed Member Engagement and we'll send you a new one.

AvMed complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, sexual orientation, gender, gender identity, disability, or age, in its programs and activities, including in admission or access to, or treatment or employment in, its programs and activities. The following person has been designated to handle inquiries regarding AvMed's nondiscrimination policies: AvMed's Regulatory Correspondence Coordinator, P.O. Box 569008, Miami, FL 33256, by phone 1-800-882-8633 (TTY 711), or by email to Regulatory.Correspondence@AvMed.org.

BENEFIT SUMMARY
State of Florida Standard HMO Plan

January 2023

AvMed Member Engagement Center: **1-888-762-8633 (TTY 711)**
Monday-Friday, 8 am-8 pm; Saturday, 9 am-1 pm.
www.AvMed.org/State

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Embrace better health.®

AvMed Embrace better health® **State of Florida Standard HMO Plan** **Coverage for:** Individual or Individual + Family| **Plan Type: HMO**

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 1-888-762-8633 or visit www.avmed.org/state. 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 1-888-762-8633 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0** individual/ **$0** family	See the Common Medical Event chart below for your costs for services this **plan** covers.
Are there services covered before you meet your deductible?	Yes. This plan has no deductible.	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?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services your plan covers.
What is the out-of-pocket limit for this plan?	Medical: **$1,500** individual/ **$3,000** family Global: **$9,100** individual/ **$18,200** family (met by medical and prescription copays or prescription copays only).	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 and services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. See **www.avmed.org/state or call 1-888-762-8633** for a list of participating providers. No coverage out-of-network.	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
		In-Network (You will pay the least)	Out-of-Network (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	$20 copay/ visit; No charge for Telehealth via MDLive; $20 copay/ visit for Telehealth via an AvMed provider	Not Covered	Additional charges may apply for non-preventive services performed in the Physician's office.
	Specialist visit	$40 copay/ visit	Not Covered	Additional charges may apply for non-preventive services performed in the Physician's office.
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Charges for office visits may apply if services are performed in a Physician's office.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Charge for office visits or Physician/professional services may also apply depending where services are received.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com/sofrxplan	Generic drugs (Tier 1)	$7 copay/ prescription (retail)/ 30 day supply; $14 copay/ prescription (participating retail pharmacy or mail order)/ 90 day supply	Not Covered	Prescription drug coverage is provided through CVS/Caremark. For a list of participating pharmacies, go tot www.caremark.com/sofrxplan or call 1-888-766-5490. Generic & brand drugs: covers up to a 90-day supply at retail pharmacies and a 60-90 day supply via mail order. Certain drugs in all tiers require prior authorization. Brand additional charge may apply. Specialty and cost-sharing drugs available in 30-day supply only; not available via mail order.
	Preferred brand drugs (Tier 2)	$30 copay/ prescription (retail)/ 30 day supply; $60 copay/ prescription (participating retail pharmacy or mail order)/ 90 day supply	Not Covered	
	Non-preferred brand drugs (Tier 3)	$50 copay/ prescription (retail)/ 30 day supply; $100 copay/ prescription (participating retail pharmacy or mail-order)/ 90 day supply	Not Covered	
	Specialty drugs (Tier 4)	Preferred brand Specialty drugs: $30 copay/ prescription (retail)/ 30 day supply; $60 copay/ prescription (participating retail pharmacy or mail order)/ 90 day supply Non-preferred brand Specialty drugs: $50 copay/ prescription (retail)/ 30 day supply; $100 copay/ prescription (participating retail pharmacy or mail order)/ 90 day supply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Charges for office visits may also apply if services are performed in any Physician's office. Prior authorization required.
	Physician/surgeon fees	No Charge	Not Covered	Charges for office visits may also apply if services are performed in any Physician's office. Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need immediate medical attention	Emergency room care	$100 copay/ visit	$100 copay/ visit	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	$25 copay/ visit at urgent care facility or retail clinic	$25 copay/ visit at urgent care facility or retail clinic	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/ admission	Not Covered	Prior authorization required.
	Physician/surgeon fees	No Charge	Not Covered	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/ visit	Not Covered	Prior authorization required.
	Inpatient services	Hospital stay: $250 copay/ admission; Residential stay: No Charge	Not Covered	Prior authorization required.
If you are pregnant	Office visits	Routine OB & Midwife services: $40 copay/ 1st visit only; subsequent visits at no charge	Not Covered	----------None----------
	Childbirth/delivery professional services	No Charge	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth/delivery facility services	Hospital stay: $250 copay/ admission Birthing center: Same as Routine OB	Not Covered	Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Approved treatment plan required.
	Rehabilitation services	$40 copay/ visit for physical, occupational, speech therapy, and chiropractic services	Not Covered	Rehabilitative physical, speech and occupational therapy to treat injuries is limited to 60 visits per injury. Chiropractic services is limited to 60 visits per injury.
	Habilitation services	$40 copay/ visit	Not Covered	Habilitative occupational therapy is limited to home health care, hospice care, treatment of Autism Spectrum Disorder, treatment of Developmental Disabilities, and Down syndrome.
	Skilled nursing care	No Charge	Not Covered	Limited to 60 days post-hospitalization care per calendar year. Prior authorization required.
	Durable medical equipment	No Charge	Not Covered	----------None----------
	Hospice services	No Charge	Not Covered	Limited to lifetime max of 210 days. Physician certification required.
If your child needs dental or eye care	Children's eye exam	$20 copay/ visit at PCP; $40 copay/ visit at Specialist	Not Covered	Limited to 1 eye exam per calendar year to determine the need for sight correction.
	Children's glasses	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.
	Children's dental check-up	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.

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
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Dental Care (Child)
- Glasses
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- 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.)

- Chiropractic Care
- Routine Eye Care (Adult)

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, the U.S. Department of Labor, Employee Benefits Security Administration, at 1-866-444-3272 or 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. 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 1-800-682-8633. 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. 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.

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 1-888-762-8633.

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)

The plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility) copayment	$250
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	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$360

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	$40
Hospital (facility) copayment	$250
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	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$920

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

The plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility) copayment	$250
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	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$400

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

BENEFIT SUMMARY
High Deductible Health Plan

January 2023

AvMed Member Engagement Center: **1-888-762-8633 (TTY 711)**
Monday-Friday, 8 am-8 pm; Saturday, 9 am-1 pm.
www.AvMed.org/State

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Embrace better health.®

AvMed Embrace better health® **State of Florida High Deductible Health Plan** **Coverage for:** Individual or Individual + Family| **Plan Type: HMO**

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 1-888-762-8633 or visit www.avmed.org/state. 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 1-888-762-8633 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Self-only: **$1,500** Family: **$3,000**	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**, the overall family **deductible** limit must be met.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	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?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	Self-only: **$3,000** Family: **$6,000**	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**, the overall family **out-of-pocket limit** must be met.
What is not included in the out-of-pocket limit?	Premiums and services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. See **www.avmed.org/state or call 1-888-762-8633** for a list of participating providers. No coverage out-of-network.	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
		In-Network (You will pay the least)	Out-of-Network (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	20% coinsurance after deductible; No charge after deductible/ visit for Telehealth via MDLive; No charge after deductible/ visit for Telehealth via an AvMed Provider	Not Covered	Additional charges may apply for non-preventive services performed in the Physician's office.
	Specialist visit	20% coinsurance after deductible	Not Covered	Additional charges may apply for non-preventive services performed in the Physician's office.
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask you provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	Not Covered	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)	20% coinsurance after deductible	Not Covered	Charges for office visits of Physician/professional services may also apply depending where services are received.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com/sofrxplan	Generic drugs (Tier 1)	30% coinsurance after deductible/ prescription (participating retail pharmacy or mail-order)	Not Covered	Prescription drug coverage is provided through CVS/Caremark. For a list of participating pharmacies go to www.caremark.com/sofrxplan or call 1-888-766-5490. Generic & Brand drugs: covers up to a 90-day supply at retail pharmacies and a 60-90 day supply via mail order. Certain drugs in all tiers require prior authorization. Brand additional charges may apply. Specialty and cost-sharing drugs available in 30-day supply only; not available via mail order.
	Preferred brand drugs (Tier 2)	30% coinsurance after deductible/ prescription (participating retail pharmacy or mail-order)	Not Covered	
	Non-preferred brand drugs (Tier3)	50% coinsurance after deductible/ prescription (participating retail pharmacy or mail-order)	Not Covered	
	Specialty drugs (Tier 4)	Preferred brand Specialty drugs: 30% coinsurance after deductible/ prescription (participating retail pharmacy or mail order); Non-preferred brand Specialty drugs: 50% coinsurance after deductible/ prescription (participating retail pharmacy or mail order)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	Not Covered	Charges for office visits may also apply if services are performed in a Physician's office. Prior authorization required.
	Physician/surgeon fees	20% coinsurance after deductible	Not Covered	Charges for office visits may also apply if services are performed in a Physician's office. Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible	20% coinsurance after deductible	AvMed must be notified within 24-hours of inpatient admission following emergency services, or as soon as reasonably possible.
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	----------None----------
	Urgent care	20% coinsurance after deductible at urgent care facility or retail clinic	20% coinsurance after deductible at urgent care facility or retail clinic	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	Not Covered	Prior authorization required.
	Physician/surgeon fees	20% coinsurance after deductible	Not Covered	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	Not Covered	Prior authorization required.
	Inpatient services	Hospital stay: 20% coinsurance after deductible; Residential stay: 20% coinsurance after deductible	Not Covered	Prior authorization required.
If you are pregnant	Office visits	Routine OB & Midwife services: 20% coinsurance after deductible	Not Covered	----------None----------
	Childbirth/delivery professional services	20% coinsurance after deductible	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	Hospital stay: 20% coinsurance after deductible Birthing center: Same as Routine OB	Not Covered	Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	Not Covered	Approved treatment plan required.
	Rehabilitation services	20% coinsurance after deductible; 20% coinsurance after deductible for chiropractic services	Not Covered	Rehabilitative physical, speech and occupational therapy to treat injuries is limited to 60 visits per injury. Chiropractic services is limited to 60 visits per injury.
	Habilitation services	20% coinsurance after deductible	Not Covered	Habilitative occupational therapy is limited to home health care, hospice care, treatment of Autism Spectrum disorder, treatment of Developmental Disabilities, and Down syndrome.
	Skilled nursing care	20% coinsurance after deductible	Not Covered	Limited to 60 days post-hospitalization care per calendar year. Prior authorization required.
	Durable medical equipment	20% coinsurance after deductible	Not Covered	Some limitation apply. Please see your Summary Plan Description for details.
	Hospice services	20% coinsurance after deductible	Not Covered	Limited to a lifetime max of 210 days. Physician certification required.
If your child needs dental or eye care	Children's eye exam	20% coinsurance after deductible	Not Covered	Limited to 1 eye exam per calendar year to determine the need for sight correction.
	Children's glasses	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.
	Children's dental check-up	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.

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
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Dental Care (Child)
- Glasses
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- 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.)

- Chiropractic Care
- Routine Eye Care (Adult)

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, the U.S. Department of Labor, Employee Benefits Security Administration, at 1-866-444-3272 or 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. 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 1-800-682-8633. 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. 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.

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 1-888-762-8633.

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)

The plan's overall deductible	**$1,500**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$1,500
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,060

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

The plan's overall deductible	**$1,500**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$1,500
Copayments	$0
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,260

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

The plan's overall deductible	**$1,500**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$1,500
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,800

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

GET THE MOST FROM YOUR HEALTHCARE

AvMed provides Members with lots of options and plenty of guidance, to help you get the most out of your healthcare. Our benefit plans are designed with you in mind. AvMed improves access with an extensive provider network (in some cases, nationwide), lower out-of-pocket costs for in-network services, a simplified claims process, plus our **WELL**fluent Living® Program and preventive care.

You also get these programs and services:

- **AvMed Member Engagement Center: Monday-Friday, 8 am-8 pm; Saturday, 9 am-1 pm**
- **24-hour, toll-free Nurse On Call staffed by Registered Nurses**
- **Savings on alternative health services**
- **Discounts on eyeglasses and contact lenses**
- **AvMed.org/State, your online resource for health and benefits information**
- **AvMed Online Provider Directory**
- **AvMed Decision Support Tools, a comprehensive set of resources designed to help you become a more informed healthcare consumer**
- **Disease and Complex Case Management programs for high-risk and chronic conditions**

MEDICAL EXCELLENCE

AVMED PHYSICIANS

AvMed is committed to quality healthcare. We have a broad network of physicians who also work hard to keep you healthy. AvMed contracts with physicians who are in private practice and see AvMed Members within certain time frames, depending upon the Member's condition. They also agree to certain standards of care for our Members with regard to wait times and accessibility. To view AvMed's standards, go to the AvMed website at **www.AvMed.org/State**.

AvMed considers Board Certification a significant credential in evaluating physicians. Our Network Physicians have completed advanced training in an approved hospital residency and/or fellowship program. Requirements for physicians to become Board Certified are established by each specialty board. Our Network Physicians are identified within this online directory with a star for 'Board Certified.'

HOSPITALS, FACILITIES & ALLIED SERVICES

AvMed Members have access to one of the most versatile facility Networks in the state, made up of hospitals, skilled nursing facilities, diagnostic centers, laboratories, ambulatory surgical centers, home health, urgent care centers, pharmacies, vision companies, durable medical equipment providers, and much, much more.

To be a participating provider for AvMed, healthcare facilities must meet rigorous credentialing standards based on quality. Quality of care standards are developed from those of nationally recognized professional organizations, and are monitored for all providers. AvMed supports our providers in their efforts to meet or exceed quality standards.

HOW AVMED CHOOSES PROVIDERS

We carefully assess the need for particular specialties in each of our service areas to make sure we have enough physicians to meet the medical needs of our Members. To be a participating AvMed Provider, medical professionals and healthcare facilities must meet thorough credentialing standards. This includes the examination of practice experience, licenses, certifications, hospital privileges, education and medical record keeping.

ACCESSING CARE

In an effort to keep you informed, we are providing you with this general information about accessing care, and terms you should know. Your plan's Benefit Summary, at the beginning of this guide, details a summary of the covered benefits and the out-of-pocket costs associated with each of those services. For specific exclusions and limitations about your plan, please refer to your Certificate of Coverage or Summary Plan Description. In general, you will receive care from AvMed participating Providers. Emergency and urgently needed care is always covered in or outside the AvMed Network or service areas.

If you have any questions, please call our Member Engagement Center at **1-888-762-8633 (TTY 711)**. Our representatives are available to assist you **Monday-Friday, 8 am-8 pm; Saturday 9 am-1 pm.** You may also e-mail us at **StateofFlorida.Members@AvMed.org**.

THE ROLE OF PRIMARY CARE PHYSICIAN (PCP)

The role of a Primary Care Physician (PCP) is to provide routine and preventive care, as well as to assist you in making important medical decisions. Your PCP should know your medical history and can be a valuable resource for information and treatment. Your plan may not require you to designate a PCP, but AvMed encourages you to choose a physician in this role so that he or she can take the time to know you and your health issues well, and coordinate your care.

CHOOSING A PCP AND CHANGING A PCP

Primary Care Physicians (PCPs) can perform physicals, see you for most of your healthcare needs and help coordinate your care if you need to see specialists or access behavioral healthcare. Each covered Member of your family may select the same or different PCP. You can find a list of doctors in the Provider Directory or on AvMed's website at **www.AvMed.org/State**.

VISITS TO SPECIALIST PROVIDERS

Primary Care Physicians (PCPs) know your medical history and are best qualified to determine if a specialist's care is needed, and if so, which specialist would be best for you. In most instances, AvMed does not require a referral for a visit to specialists. However, depending on your plan, certain services require prior authorization from AvMed or a referral from your PCP.

WHAT IS AN AUTHORIZATION?

An authorization is coordinated through your physician and your health plan. It is a formal process requiring a Provider to obtain prior approval from the patient's health plan before providing a particular service or procedure.

The following require prior authorization from your health plan:

- Inpatient care
- Observation
- Outpatient surgical procedures
- CT, MRI, MRA and PET scans
- Nuclear cardiac imaging
- Dialysis
- Transplant services
- Select medications, including injectable medications

BEHAVIORAL HEALTH SERVICES

AvMed provides its Members with high-quality behavioral health programs. Depending on your plan, you may have direct access to behavioral health Providers throughout the state without having to contact your PCP. Behavioral health diagnosis and treatment services are covered on an outpatient basis. Additional behavioral health services or substance abuse services may be available. For more detailed information about your coverage, please refer to your Benefit Summary and Amendment. Members must use AvMed's participating providers for all inpatient and outpatient services.

EMERGENCY, URGENT CARE AND RETAIL CLINIC OPTIONS

Talk to your doctor about what to do if you need immediate medical care. Be sure to discuss after-hours care and weekend accessibility, and if there is another number you can call. If your doctor isn't available or if an accident or injury calls for immediate attention, you should know your options. Knowing the difference can save you time, money and stress.

WHEN IS IT AN EMERGENCY?

If you have an emergency (your condition is life-threatening; loss of consciousness; sudden, sharp abdominal pain; uncontrolled bleeding; complicated fractures) you should go to the nearest hospital or call 9-1-1 for emergency medical assistance. You may be responsible for a portion of the cost and non-covered supplies or services (refer to your Benefit Summary for more information). For a detailed definition of an emergency, please refer to your Group Medical and Hospital Service Contract (Certificate of Coverage) or Summary Plan Description.

Urgent Care Center *Know where they are*	• Ear infections • Bronchitis • Fever
Emergency Room *Know how to get there fast*	• Sudden, sharp abdominal pain • Uncontrolled bleeding
Ambulance *Call 9-1-1*	• Chest pain • Difficulty breathing • Unconsciousness
Retail Clinic *Basic medical care*	• After hours and weekends, when the doctor can't fit you in

Urgent Care Center

If you encounter a minor medical emergency (sprained ankle, minor cuts or high fever), an Urgent Care Center (UCC) may be a more convenient, and often a more cost-effective, alternative to the emergency room. The facilities handle non-emergency visits during and after regular physician office hours. Most are open seven days a week, with extended hours, and do not require an appointment. They are staffed with qualified physicians and offer a wide array of healthcare services, including radiology, laboratory, pharmacy and procedure rooms for lacerations and fracture care. AvMed currently contracts with a number of UCCs throughout the state. For a complete list of UCCs in your area, you can refer to the Provider Directory or visit our website at **www.AvMed.org/State**.

Retail Clinic Care

Another option is retail clinic care, staffed by Board-Certified practitioners (nurse practitioners and/or physician assistants); a clinic can be a convenient and affordable choice. Clinics offer quality, basic medical care after hours, on weekends and when your doctor's office can't get you in.

- **No appointment needed**
- **Open seven days a week**
- **Pay your applicable Urgent Care Clinic copayment at participating clinics across the state**

To find a participating clinic near you, access AvMed's website at **www.AvMed.org/State**. AvMed's Member Engagement Center is always available to help you. Call them at **1-888-762-8633 (TTY 711)** or email us at **StateofFlorida.Members@AvMed.org.**

TERMS YOU SHOULD KNOW

Coinsurance: An amount you may be required to pay as your share of the cost for service after you pay any deductibles.

Copayment (Copay): A specific, fixed dollar amount that you pay each time you use a covered service or buy a covered product. Different services/products require different copays.

Deductible: The amount you must pay for healthcare or prescriptions before AvMed or your other insurance begins to pay.

Out-of-Pocket Maximum: The maximum dollar amount of copayments and coinsurance the Member will have to pay in a calendar year, including the deductible. Once the out-of-pocket maximum has been met, AvMed pays 100 percent of covered expenses for the remainder of that calendar year.

Premium: A regular payment to cover a Member's healthcare and prescription drug coverage.

SERVICES & PROGRAMS

AvMed adds value to your Membership by providing the following services.

MEMBER ENGAGEMENT CENTER: MON.-FRI., 8 AM-8 PM; SAT., 9 AM-1 PM

AvMed Member Engagement Center is available to answer questions regarding benefits, claims, changing physicians or anything involving your AvMed membership. AvMed takes pride in providing excellent customer service.

You can call the Member Engagement Center toll-free at **1-888-762-8633 (TTY 711)** from anywhere in the United States. You may also visit our website at **www.AvMed.org/State** or email the Member Engagement Center at **StateofFlorida.Members@AvMed.org**.

With Language Line Services, we have the ability to speak 140 languages. If you need to speak with a Member Engagement Center representative in another language, AvMed accesses Language Line Services and connects you with a translator who relays your questions or concerns back to AvMed. There is no charge to you.

AVMED NURSE ON CALL – 24 HOURS A DAY, 7 DAYS A WEEK

At AvMed, we continue to build on our long tradition of service to keep you engaged with your healthcare. Our priority is to help you live healthier. And with Nurse On Call, you'll get expert confidential advice and live-healthy support 24 hours a day, 7 days a week. Members can choose to speak to a registered nurse or listen to pre-recorded health information from AvMed's Audio Healthy Library on more than 500 topics.

Each topic includes information on symptoms, self-care, home treatment and prevention. You can access this health information by calling **1-888-866-5432** or on AvMed's website at **www.AvMed.org/State**.

MEDICAL TECHNOLOGY

AvMed keeps pace with changes that provide Members with new developments in technology through our Medical Technology Assessment Committee (MTAC). The technologies presented are composed of medical and behavioral health procedures, pharmaceuticals, devices, and new applications of existing technologies for inclusion in benefit plans. The MTAC includes Board Certified physicians with varied specialties. A new technology or a new development in technology is presented to the MTAC by unbiased Specialists who are experienced in the technology. Prior technology determinations are also revisited as the scientific evidence and/or the medical literature change. In addition, the MTAC is provided with information for review from appropriate government regulatory bodies, such as the FDA and CMS. Relevant scientific evidence from varied sources and professional organizations such as the American Medical Association and scientific journals, such as PubMed are also used to assist in making a determination on the technology.

The variables used to make a determination for approval include:

- A safe and efficient technology
- An improvement of health outcomes
- Potential benefits outweigh potential negative effects; and
- The technology's comparison to those of established alternatives

The coverage guidelines can be found on AvMed's website at www.AvMed.org/State under "About Us." At any time, Members may ask for consideration of a new technology. For these requests or any other question regarding medical technologies, please contact AvMed's Member Engagement Center at **www.AvMed.org/State.**

UTILIZATION MANAGEMENT

The goal of AvMed Utilization Management (UM) program is to validate the medical appropriateness and to coordinate covered services for our Members. Utilization Management has several comprehensive components which include, but are not limited to:

- **Prior-authorization requests from providers prior to providing covered services.**
- **Concurrent review of all patients hospitalized in acute-care, psychiatric, rehabilitation, and skilled nursing facilities, including on-site review when appropriate.**
- **Case management and discharge planning for all inpatients and those requiring continued care in an alternative setting (such as home care or a skilled care facility) and for outpatients when deemed appropriate; and**
- **The Benefit Coordination Program which is designed to conduct prospective reviews for select medical services to ensure that these are covered and medically necessary. The Benefit Coordination Program may also advocate alternative cost-effective settings for the delivery of prescribed care and may identify other options for non-covered healthcare needs.**

AVMED WELLFLUENT LIVING® PROGRAM

AvMed **WELL**fluent Living® Program makes it easier to live a life rich in happiness and healthiness. We provide you with health-related tools, information, support, and savings that you can use to reach your personal goals.

Features include a Personal Health Assessment (PHA), Weight Watchers® reimbursements, services like fitness centers, and other savings on alternative-medicine practices such as acupuncture and massage therapy. You even get healthy tips, nutrition counseling, stress reduction programs, lifestyle coaching and online classes.

For more information about the AvMed WELLfluent Living® Program, visit **www.AvMed.org/State** select **Embrace Better Health** under **Quick Links**.

AVMED CARE SUPPORT PROGRAMS

When you are facing chronic illness, our disease management philosophy is to provide you access to high-tech, high-touch, personalized service that is coordinated to ease your concerns. AvMed's highly trained clinical care team works closely with your doctor and family to answer health-related questions, consider treatment options and assist in coordinating your care. You will receive periodic calls to help you manage your condition.

AvMed's Care Management Programs offer you support to deal with the following conditions:

- Asthma
- CAD – coronary artery disease
- COPD – chronic obstructive pulmonary disease
- Congestive heart failure
- Diabetes

An acute condition is an injury or illness that requires short-term, sometimes intensive, therapy. AvMed's Care Management program can work closely with you, your doctor and family to address these complex health issues:

- Solid organ transplant
- High-risk maternity care
- Bone marrow transplant

For more information, call AvMed's Care Management at **1-800-972-8633 (TTY 711)**.

DISCOUNTS ON EYE EXAMS, GLASSES, LENSES AND CONTACTS

Discounts on eye exams, glasses, lenses and contacts are available through some of AvMed's vision partners. For more information, call AvMed's Member Engagement Center at **1-888-762-8633**.

AVMED WEB SITE

Your best source for fast information on your health plan.

Visit our website, **www.AvMed.org/State**, to access valuable information about which hospitals rate best for care, treatment options for a variety of conditions, and even what to expect after surgery. You can even find healthy recipes and coupons for savings! Visit the website and click on "Recipes & Coupons" to learn more! Our Member portal puts you in control of many of your benefits, with an at-a-glance dashboard view for easy review of your AvMed account and benefits, a secure message center, a "Show Me the Math" tool that helps you easily review your claim details, and so much more. By registering for full access to the website, you can view and do so much more. With Your user ID and password, you're able to obtain your personal health information and interact with AvMed in the following areas:

- **Benefits**
- **Request an AvMed Member ID Card or temporary ID**
- **Information on copayment, deductible and/or coinsurance accumulations**
- **Status changes**
- **Change PCP**
- **Authorization inquiries**
- **Medical claims inquiries**

You can also submit Coordination of Benefits (COB) information and any personal information changes. Our website's extensive Provider Directory offers the names of participating PCPs, hospitals and ancillary facilities, as well as every type of specialist physician. Updated weekly, the online directory contains information on our contracted doctors' backgrounds, office hours, office locations, languages spoken and more. The AvMed website also includes health information and current press releases on company developments and achievements.

ONLINE CONSUMER TOOLS

Research shows that health plan Members who are engaged in choosing and using their health benefits become informed, cost-conscious consumers. AvMed's Online Consumer Tools are available at **www.AvMed.org/State** to help you make effective decisions about your healthcare. These resources can assist you in choosing and determining what physicians and hospitals best meet your needs. Stay connected to stay healthy!

COST CALCULATOR

AvMed's Cost Calculator allows you to see the total cost of a procedure before you schedule an appointment. This unique tools helps AvMed Members evaluate Providers and prices in advance to determine the best value. It allows you to search for specific medical procedures and compiles a comprehensive list of available doctors, locations, coverage and out-of-pocket costs. Other Cost Calculator features include:

- Estimated costs for Members and overall costs for AvMed, translating to savings for you.
- Complete cost breakdown of anticipated charges to members.
- Detailed information on Providers.

To get started:

1 Log into your AvMed Account
2 Select "Cost Calculator" under "Tools & Resources"
3 Click "View Calculator"

FIND A HIGH-QUALITY PHYSICIAN

Search for physicians by name, location and specialty. Physician profiles include such useful details as education, Board Certification, sanctions and malpractice issues. You also can learn about estimated treatment costs and view affiliated hospitals and patient satisfaction survey results. With this information, you'll be able to compare doctors and find the one who's right for you.

FIND A HIGH-QUALITY HOSPITAL

Search hospitals by name, location, procedure/condition or overall quality. Ratings and cost estimates are easy to understand, with side-by-side comparisons and detailed profiles. This tool can help you manage your healthcare costs and avoid complications associated with poor care.

LEARN ABOUT YOUR HEALTH

AvMed's online medical encyclopedia is a valuable reference tool containing comprehensive medical information designed to keep you informed and proactive in your health decisions. Find out how common your condition is among people in your age group. Learn about treatment options and find out how quickly you can expect to recover.

MEMBERS' RIGHTS AND RESPONSIBILITIES

Members have a right to:

- Considerate, courteous, and dignified treatment by all participating providers without regard to race, religion, gender, national origin, or disability and a reasonable response to a request for services, evaluation and/or referral for specialty care.
- Receive information about AvMed, our products and services, our contracted practitioners and providers, and Members' rights and responsibilities.
- Be informed of the health services covered and available to them or excluded from coverage, including a clear explanation of how to obtain services and applicable charges.
- Access quality care, receive preventive health services and know the identity and professional status of individuals providing services to them.
- The right to be treated with respect and recognition of your dignity and your right to privacy.
- To participate in making decisions about your healthcare with practitioners or other healthcare professionals.
- Participate in a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage. To refuse medical treatment, including treatment considered experimental, and to be informed of the medical consequences of this decision.
- Have available and reasonable access to service during regular hours and to after-hours and emergency coverage, including how to obtain out-of-area coverage.
- To voice complaints or appeals about the organization or the care it provides.
- To make recommendations regarding the Plan's Members' rights and responsibilities policies.

Members have the responsibility to:

- Choose an AvMed participating Primary Care Physician and establish yourselves with this physician.*
- Become knowledgeable about your health plan coverage including covered benefits, limitations and exclusions, procedures regarding use of participating providers and referrals.
- Take part in improving your health by maximizing healthy habits.
- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- Participate in understanding your health problems and in developing mutually agreed-upon treatment goals, to the degree possible.

- **Follow any plans and instructions for care that you have agreed to with your practitioners.**
- **Keep appointments reliably, and promptly notify the provider when unable to do so.**
- **Fulfill financial obligations for receiving care, as required by your health plan agreement, in a timely manner.**
- **Show consideration and respect to providers and provider staff.**

* Certain AvMed Plans do not require that you choose a Primary Care Physician. However, AvMed encourages all Members to **establish a relationship with** a Primary Care Physician, to help coordinate your care.

Member Inquiries and Concerns

- We want to ensure that your concerns are addressed promptly. If at any time you have complaints, you can log into your account at **AvMed.org/State**, select **"Message Center"** on the top right hand corner. You will be directed to our secure email message area where you can send Member Engagement Center an online message. If you have a concern regarding the quality of medical care or service you are receiving, we encourage you to first discuss it directly with your Provider.

For complete information regarding AvMed's grievance procedure, please refer to your Group Medical and Hospital Service Contract (Certificate of Coverage) or Summary Plan Description.

Claims

In most cases, Providers will file claims directly with AvMed. However, if you feel that you have incurred charges that should be considered for payment or reimbursement, you will need to submit an itemized statement of charges, date(s) of service, including diagnostic and procedure codes, together with proof of payment to the AvMed Claims Center at:

P.O. Box 569000
Miami, Florida 33256-9000

Please note: For specific claim filing requirements, please refer to your Group Medical and Hospital Service Contract (Certificate of Coverage) or Summary Plan Description.

ADVANCE DIRECTIVES

YOUR RIGHTS

AvMed wishes to inform you of Florida law regarding Living Wills and Advance Directives. Under Florida law, every adult has the right to make certain decisions concerning his or her medical treatment. The law also allows for your rights and personal wishes to be respected even if you are too sick to make decisions yourself. You have the right, under certain conditions, to decide whether to accept or reject medical treatment, including whether to continue medical treatment and other procedures that would prolong your life artificially.

You may also designate another person, or surrogate, who may make decisions for you if you become mentally or physically unable to do so. This surrogate may function on your behalf for a brief time or longer, for a life-threatening or a non-life-threatening illness. Any limits to the power of the surrogate in making decisions for you should be clearly expressed.

Your healthcare Provider will furnish you with written information about its policy regarding Advance Directives. The legal basis for these rights can be found in the Florida Statutes: Health Care Advance Directives, Chapter 765; Durable Power of Attorney Section 709.08; and guardianship, Chapter 744; and in the Florida Supreme Court decision on the constitutional right of privacy, *Guardianship of Estelle Browning, 1990.*

WHAT IS AN ADVANCE DIRECTIVE?

An Advance Directive is a "written instruction, such as a Living Will or Durable Power of Attorney for healthcare, recognized under State law (whether statutory or as recognized by the courts of the state) and relating to the provision of such care when the individual is incapacitated." The law of Florida provides three ways to express your *written desires*, in advance, so your doctor and family will know how you want to be treated in the event you become unable to tell them.

LIVING WILL

A Living Will is a written personal statement made by you that lets others know your wishes for medical care at the end of life. You must be 18 years of age and of sound mind to write a Living Will. Most Living Wills direct physicians to limit or forego certain treatments, for example, connecting a person to a respirator/breathing machine. The Living Will is used only in situations where you are both terminally ill and unable to take part in mental decisions. A Living Will does not cover all situations that may present themselves, so you may want to have other documents prepared.

HEALTHCARE SURROGATE

A Healthcare Surrogate is a person you choose to make healthcare decisions for you when you are no longer able to do so. Your surrogate should be someone who knows your wishes and will make decisions based on what he/she believes you would want. A Healthcare Surrogate is usually a family member or close friend who can be readily available to your physician. You are encouraged to appoint a Healthcare Surrogate even if you have made other written expressions of your wishes, since it is difficult to address every possible situation in a Living Will.

DURABLE POWER OF ATTORNEY

A Durable Power of Attorney is a document by which you give another person – your "agent" – the authority to make decisions about the financial aspects of your life. In Florida, you can also give your

agent the authority to make decisions about your medical treatment. A Durable Power of Attorney remains in effect even if you become incapacitated. For example, you can authorize your agent to consent to medical and surgical procedures for you under certain circumstances (*usually* when you are unable to make these decisions). You must be 18 years old and you can revoke or change your Durable Power of Attorney at any time before you become incompetent.

COMMON QUESTIONS:

Q. Are Living Wills, Healthcare Surrogates and Durable Powers of Attorney just for senior citizens?

A. No. A severe illness or serious accident can happen to any person at any age. If you have strong feelings about what choices you would want in such a situation, regardless of your age, you are encouraged to consider an Advance Directive. However, parents of minors under the age of 18 will be responsible for the healthcare decisions of their children (unless special facts apply).

Q. May I change my Living Will, name a different Healthcare Surrogate or Durable Power of Attorney?

A. Yes, you may make changes at any time. If you do make changes to your Living Will, name a new Healthcare Surrogate or Durable Power of Attorney be sure to destroy all of the outdated copies and provide copies of the updated information to your physician, family members and others whom you think need to know your wishes.

Q. May I request that I not be given food or water artificially (tube feedings, IVs)?

A. Yes. Florida law gives you the right to refuse food and water. A Living Will usually allows you to do this when your medical condition is terminal and such efforts only serve to prolong the process of dying. A Healthcare Surrogate or Durable Power of Attorney, appointed independent of your Living Will, is able to direct that IVs and tube feedings be discontinued in situations where no recovery is deemed possible.

Q. Are there any limitations on carrying out my instructions?

A. No. The document need only be signed in the presence of two witnesses. One of the witnesses must be someone who is not your spouse, blood relative, heir or person responsible for paying your medical bills.

Q. What do I do after I complete a Living Will, appoint a Healthcare Surrogate and/or Durable Power of Attorney?

A. Once you have completed a Living Will, appointed a Healthcare Surrogate and/or Durable Power of Attorney, you should give a copy to your physician, minister, family members, close friends and your Healthcare Surrogate or Durable Power of Attorney. Discuss with them the details of your Advance Directive and ask that they keep a copy to make available if and when needed.

Q. Is it necessary to state my wishes in writing?

A. It is probably best to put your wishes in writing. There is authority for oral declarations but if you have stated your desires in writing, misunderstandings can be avoided.

Remember…

- **It may be best to sign multiple documents because the appointment of a Healthcare Surrogate and Durable Power of Attorney are more flexible and apply to more than just end of life situations.**
- **An Advance Directive that is valid in another state may not be valid in Florida.**
- **If you have a healthcare Durable Power of Attorney that you signed in another state you should probably have a local attorney review it to assure its validity.**
- **Update your document regularly.**

AvMed Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices is directed to all members of AvMed's Health Plans. It describes how we may collect, use, and disclose your protected health information, and your rights concerning your protected health information. "Protected health information" ("PHI") is information about you, including demographic information collected from you, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health condition, the provision of health care to you or the payment for that care. It may include nonpublic personal financial information.

We are required by law to maintain the privacy of your protected health information, to provide you this notice about our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices described in this notice while it is in effect. This notice is effective on March 26, 2013, and will remain in effect until we replace or modify it.

Protection of Oral, Written and Electronic Information

AvMed is committed to safeguarding your protected health information in all forms or formats. This includes protected health information that we may have in oral, written and electronic format.

Uses and Disclosures for Payment, Health Care Operations, and Treatment

We use and disclose protected health information in a number of different ways in connection with the payment for your health care, our health care operations, and your treatment. We are prohibited from using or disclosing your genetic information for underwriting purposes. Unless otherwise permitted by applicable laws or rules or by your written authorization, we will not directly or indirectly receive remuneration in exchange for your protected health information. When using or disclosing your protected health information or requesting your protection health information from another covered entity, we will make reasonable efforts to limit such use, disclosure, or request, to the extent practicable, to the minimum necessary to accomplish the intended purpose of such use, disclosure, or request, respectively. The following are only a few examples of the types of uses and disclosures of your protected health information that we are permitted to make without your authorization.

Payment: We will use and disclose your protected health information to administer your health benefits policy or contract, which may involve the determination of eligibility; claims payment; utilization review and management; medical necessity review; coordination of care, benefits and other services; and responding to complaints, appeals and external review requests. For some plans, we may also use and disclose protected health information for purposes of obtaining premiums, underwriting, ratemaking, and determining cost sharing amounts.

Health Care Operations: We will use and disclose your protected health information to support other business activities. Examples include, but are not limited to, the following:

- Quality assessment and improvement activities, such as peer review, credentialing of providers, and accreditation by independent organizations such as the National Committee for Quality Assurance (NCQA).
- Performance measurement and outcomes assessment, health claims analysis and health services research.
- Operation of preventive health, early detection and disease and case management and coordination of care programs in plans that offer these programs, including information about treatment alternatives, therapies, health care providers, settings of care or other health-related benefits and services.

•Underwriting and ratemaking (i.e., determining premiums) and administration of reinsurance, stop loss and excess of loss policies.
•Risk management, auditing and detection and investigation of fraud and other unlawful conduct.
•Transfer of policies or contracts from and to other insurers (e.g., successor carriers), HMOs or third party administrators; and facilitation of any potential sale, transfer, merger, or consolidation of all or part of "Covered Entity" with another covered entity and due diligence related to that activity.
•Conducting or arranging for legal services, auditing, or other functions.
•Other general administrative activities, including data and information systems management and customer service.

We may share your protected health information with affiliates and third party "business associates" and may allow our business associate to create, receive, maintain, or transmit your PHI on our behalf, in order for the business associate to provide services to us, or for the proper management and administration of the business associate. Examples of our business associates include claims processors, records administrators, attorneys, accountants, etc. We may disclose your PHI to our business associates and may allow our business associates to create, receive, maintain or transmit your PHI in order for the business associates to provide services to us, or for the proper management and administration of the business associates. In addition, our business associate may re-disclose your PHI to business associates that are subcontractors in order for the subcontractors to provide services to the business associate. The subcontractors will be subject to the same restrictions and conditions that apply to the business associates. Whenever such an arrangement involves the use or disclosure of your protected health information, we will have a written contract that contains terms designed to protect the privacy of your protected health information.

Treatment: We may disclose your protected health information to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers) who request it in connection with your treatment. In plans that offer these programs, we may also disclose your protected health information to health care providers in connection with preventive health, early detection, and disease and case management programs.
In connection with the foregoing activities, we may collect the following types of information about you:

•Information we receive directly or indirectly from you or your employer or benefits plan sponsor or one of their business associates through applications, surveys, or other forms (e.g., name, address, social security number, date of birth, marital status, dependent information, employment information and medical history).
•Information about your relationships and transactions with us and others (e.g., health care claims and encounters, medical history, eligibility information, payment information and appeal and complaint information).

We may also contact you about treatment alternatives or other health-related benefits and services that may be of interest to you. We may exchange your PHI electronically for treatment and other permissible purposes.

We may, in the case of some group health plans, disclose protected health information to the plan sponsor (e.g., your employer) to permit the plan sponsor to perform plan administration functions. Please see your plan documents, where applicable, for a full explanation of the limited uses and disclosures that the plan sponsor may make of your protected health information in providing plan administration functions for your group health plan.

If we obtain protected health information for underwriting purposes and the policy or contract of health insurance or health benefits is not written with us, we will not use or disclose that protected health information for any other purpose, except as required by law.

We do not destroy protected health information when individuals terminate their coverage with us. The information is necessary and used for many of the purposes described above, even after an individual leaves a plan, and in many cases is subject to legal retention requirements. However, the policies and procedures that

protect that information against inappropriate use and disclosure apply regardless of the status of any individual member.

Some of the uses and disclosures described in this notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

Other Uses and Disclosures

We may also use or disclose your protected health information in the following situations without your consent or authorization.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, the protected health information directly relevant to that person's involvement in your health care or payment for health care. If you are present for such a disclosure (whether in person or on a telephone call), we will either seek your verbal agreement to the disclosure or provide you an opportunity to object to it. We may also make such disclosures to the persons described above in situations where you are not present or you are unable to agree or object to the disclosure, if we determine that the disclosure is in your best interest. For example, if a family member or a caregiver calls our customer service line with basic information about you (address, date of birth, etc.) and with prior knowledge of a claim, we will confirm whether or not the claim has been received and paid, unless you have previously informed us in writing that you do not want us to make any such disclosures to that party. We may also disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Unless we are given an alternative address, we will mail explanation of benefits forms and other mailings containing protected health information to the address we have on record for the subscriber of the health benefits plan. We will not make separate mailings for enrolled dependents of the subscriber, unless it is requested in writing.

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental

entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye, or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Fundraising communications: We may contact you to raise funds for our benefit. You have the right to opt out of receiving such communications.

Limited data set and de-identified information**:** We may use or disclose your PHI to create a limited data set or de-identified PHI, and use and disclose such information as permitted by law.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. Seq.

Uses and Disclosures Based Upon Your Written Authorization

The following uses and disclosures will be made only with your special written authorization: (i) most uses and disclosures of psychotherapy notes (to the extent maintained by AvMed); (ii) uses and disclosures of protected health information for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of protected health information; and (iv) other uses and disclosures not described in this Notice. In the event that you are unable to give the required consent (for example, if you are or become legally incompetent), we accept consent from any person legally authorized to give consent on your behalf.

A special authorization may be revoked except to the extent that we have taken action upon it. To revoke a special authorization that you previously gave, you may send us a letter stating that you would like to revoke your special authorization. Please provide your name, address, member identification number, the date the special authorization was given, and a telephone number where you may be reached.

Your Rights Regarding Medical and Health Information About You

Right to Request Restrictions*:* You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are required to agree to a request to restrict the disclosure of your PHI to a health plan if you submit the request to us and: (A) the disclosure is for purposes of carrying out payment or health care operations and is not otherwise required by law; and (B) the PHI pertains solely to a health care item or service for which you, or a person on your behalf other than the health plan, has paid the covered entity out-of-pocket in full. We may not be required to agree to all other restriction requests and, in certain cases, we may deny your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to AvMed. In your request, you must tell us (a) what information you want to limit; (b) whether you want to limit our use, disclosure or both; and (c) to whom you want the limits to apply.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location, if you advise us that communicating with you in the usual manner could endanger you. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to AvMed, stating that communicating with you in the usual manner could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Inspect and Copy: You have the right to inspect and receive copies of medical information that may be used to make decisions about your care. Usually, this includes enrollment, payment, claims adjudication, and case or medical management record systems maintained by AvMed. If you want to access the claims or other related information we maintain concerning you and your dependents, or the identity, if recorded, of those persons to whom personal information has been disclosed, you must submit your request in writing to AvMed. Records will be available for transactions that occur after April 14, 2003.

We will provide you a copy of your protected health information in the form and format requested, if it is readily producible in such form or format, or if not, in a readable hard copy form or such other format as agreed to by

AvMed and you. Where your protected health information is contained in one or more designated records electronically, you have the right to obtain a copy of such information in the electronic form and format requested, if it is readily producible in such form and format; or if not, in a readable electronic form and format as agreed to by AvMed and you. You may request that we transmit the copy of your protected health information directly to another person, provided your request is in writing, signed by you, and you clearly identify the designated person and where to send the copy of the protected health information. We may charge a fee for the costs of copying, mailing, or other administrative expenses associated with your request.

If you want to access medical record information about yourself, or if you have a question regarding your care, you should go to the provider (e.g. doctor, pharmacy, hospital or other caregiver) that generated the original records. We do not have custody of these medical records. If you believe the information in your medical records is wrong or incomplete, contact the provider who was responsible for the service or treatment in question. If we are the source of a confirmed error in our records concerning you, we will correct or amend the records we maintain. We are not able to correct the records created or maintained by your provider or other third parties.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for AvMed.

To request an amendment, your request must be made in writing and submitted to AvMed. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for AvMed;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. This does **not include** uses of information for treatment, payment, or operations (except for disclosures from certain Electronic Health Records); disclosures to you or disclosures made at your request or the request of anyone you appoint as your representative; disclosures to correctional institutions; disclosures for law enforcement, national security, or intelligence purposes if the requesting officer asks for non-disclosure for a specified period of time. Depending on the compliance date required by law for a particular record, an accounting of the disclosures from an Electronic Health Record will include disclosures for treatment, payment, or health care operations. Records of such disclosures from an Electronic Health Record must be maintained for three years. To request this list or accounting of disclosures, you must submit your request in writing to AvMed Health Plan. Your request must state a time-period, which may not be longer than six years prior to the data of your request. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Notification of a Breach: You have the right to receive written notification of a breach where your unsecured protected health information has been accessed, used, acquired, or disclosed to an unauthorized person as a result of such breach, and which compromises the security and privacy of your protected health information. Unless

specified in writing by you to receive the notification by electronic mail, we will provide such written notification by first-class mail or, if necessary, by such other substituted forms of communication allowable under the law.

Right to Receive a Paper Copy: You have the right to receive a paper copy of this notice, upon request, even if you have previously agreed to receive the notice electronically.

Our Privacy Obligations

Federal law requires that we maintain the privacy of Protected Health Information and provide you with this Notice of our legal duties and privacy practices with respect to Protected Health Information. We are required to abide by the terms of this Notice (or other notice in effect at a given time). If we make changes to this Notice we must follow the requirements established by the Privacy Standards. Federal law also requires that we provide an internal **complaint process for privacy issues.**

Distribution and Duration of This Notice*:* We send this Notice to our subscribers or employers who sponsor our plans, as permitted, upon enrollment in any of our health benefits plans, when our privacy practices are materially changed, and annually upon renewal of the member's health plan.

We reserve the right to change the terms of this notice and to make the provisions of the new notice effective for all nonpublic personal health information we maintain at that time. Updates of this Notice are distributed to our subscribers or employers who sponsor our plans, can be requested by contacting our Member Services Department at the phone number on the back of your identification card, and are also available by request on our website, at **www.avmed.org**.

Violation of Privacy Rights: If you believe your privacy rights have been violated, you may file a complaint with AvMed Health Plan. You also have the right to complain to the Secretary of the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint.

How to Contact AvMed if You Feel That Your Information has Been Used Inappropriately

You may file a complaint with AvMed by following the grievance procedures described in your Member Handbook or Explanation of Coverage (EOC). If you wish to remain anonymous or believe an AvMed employee has violated your privacy rights, you may call AvMed's Compliance Hotline at 1-877-286-3889 or write to:

AvMed, Inc.
HIPAA Privacy Officer
P.O. Box 749
Gainesville, FL 32627-0749

If you are a Medicare member and have questions about this privacy notice, please call 1-800-782-8633
TTY users call 1-800-955-8771 (TTY-711). Our representatives look forward to assisting you.

For Commercial members please call our Member Services Department at the number listed on your AvMed ID Card. TTY users call 1-800-955-8771 (TTY-711). You may also visit our website at www.avmed.org to access your account.

Alternatively, you may write to us:

In South Florida:

AvMed
P.O. Box 569000
Miami, FL 33256-9000

All Other Areas:

AvMed
P.O. Box 823
Gainesville, FL 32627-0823

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NEED MORE INFORMATION?

Get it online.

Whether you need to know the difference between a copayment and coinsurance, need to find a doctor, or want more information about your benefits, visit **www.AvMed.org/State**, or call **1-888-762-8633 (TTY 711) Monday-Friday, 8 am-8 pm; Saturday 9 am-1 pm.**

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Scan here to learn more.