

Select (HMO) Chart

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COVERAGE PLAN DESCRIPTION	HMO plan offered to Jackson Health System employees, covered dependents and retirees under 65 who reside in Miami-Dade, Broward and Palm Beach counties. Members who enroll in the Select Network plan must receive all medical care except for emergency and urgent care services through an AvMed contracted Jackson Health System Select Provider Network.
DEDUCTIBLES/CO-PAYMENTS	CO-PAYMENTS \$15 Primary Care Physician/\$30 Specialty office visit/services. 100% Hospital admission coverage - no co-payment. \$25 co-payment Emergency Room (waived if admitted). \$25/\$50 co-payment Urgent Care. \$15/ \$25/ \$35 prescription for 30-day supply based on formulary. \$30/\$50/\$70 Mail order prescription available for 90-day supply based on formulary.
PHYSICIANS	Access any primary care physician or specialist from the Select Network. Members are encouraged but not required to select a primary care physician. Covered family members may choose their own primary care physician.
A. IN-HOSPITAL PHYSICIAN SERVICES Surgery/Visits and Consultations Anesthesiologist	Benefits payable at 100% when received at participating AvMed Select Jackson Health System hospitals and rendered by participating physicians.
B. OUTPATIENT PHYSICIAN SERVICES PCP Office Visits Specialist Office Visits Preventive Services Pediatrician Routine Physical Obstetrical/Gynecological Maternity Preventive Services Mammogram/Pap Smears	\$15 co-payment/visit \$30 co-payment/visit No charge \$15 co-payment/visit No charge \$30 co-payment/visit \$30 co-payment/visit; subsequent visits no charge No charge
HOSPITALIZATION	Benefits payable at 100%. *Please confirm provider has hospital privileges at a Select Jackson Health System participating hospital.
HOSPITAL/SURGICAL REQUIREMENTS Pre-certification of hospital confinements	Handled by admitting physician.
DRUG & ALCOHOL TREATMENT Inpatient Outpatient	No charge \$15 per visit
MENTAL & NERVOUS DISORDERS Inpatient Outpatient	No charge \$15 per visit
OTHER SERVICES Ambulance Vision	No charge when pre-authorized or in case of emergency. Coverage provided for diseases of the eye and/or injuries to the eye. Eye exams for children under age 18 covered 100%, after \$15 co-payment. AvMed offers adult vision discounts through a preferred network of providers listed in the Provider Directory. Eye exams, glasses, contact lenses not covered.
PRESCRIPTION DRUGS	\$15 Generic/\$25 Brand/\$35 Non-Preferred for 30-day supply, including prescription contraceptives, at participating pharmacies nationwide. If member/physician select Brand when Generic is available, member pays difference in cost plus Brand co-payment. See plan literature for other participating pharmacies. Mail order: 2x co-pay for 90-day supply. Generic contraceptives will be no charge.
DURABLE MEDICAL EQUIPMENT (DME)	\$50 co-payment per episode of illness. Please refer to brochure for limitations and restrictions.
OUT-OF-AREA 1) Emergency 2) Non-Emergency	\$25 co-payment, waived if admitted, \$25 participating urgent care, \$50 non-participating urgent care, 100% thereafter. Not covered if provider is out-of-network.

Note: This comparison is not a contract. For specific information on benefits, exclusions and limitations, please see the Summary of Benefits & Coverage (SBC). Maximum lifetime benefits is unlimited in-network.