Point of Service (POS) Chart

Smartshopper benefits are available. Visit our website at www.avmed.org/jhs.

This plan allows you to use both in and out of network providers. For purposes of this summary, the two will be discussed separately.

	In-Network	
COVERAGE PLAN DESCRIPTION	AvMed offers Jackson Health System employees, covered dependents and retirees under age 65 "no referral" access to an expanded network of providers in the state of Florida. In addition, AvMed offers a nationwide network for those residing outside of the service area. The plan provides 100% benefits for covered charges, after applicable copayments. Members are required, to select a primary care physician. AvMed offers Member Service, Nurse on Call hot lines, discounted health and wellness programs, discounted Mail Order Prescriptions and more.	
DEDUCTIBLES/COPAYMENTS	**SELECT IN NETWORK COPAYS**	**REDUCED COPAYS AT JHS PROVIDERS**
	\$15 Primary Care Physician Office Visit Office Visit /Services. \$30 Specialist Office Visit/Services. \$100 Copayment for Outpatient Surgery. \$200 Copayment for Inpatient Facility Services. \$100 Copayment Emergency Room (waived if admitted). \$25/\$50 Copayment Urgent Care. \$15/\$40/\$55 Prescription for 30-Day Supply Based on Formulary. \$30/\$80/\$110 Mail Order Prescription Available for 90-Day Supply.	\$5 Primary Care Physician Office Visit /Services. \$15 Specialty Office Visit/Services. \$0 Copayment for Outpatient Surgery. \$0 Copayment for Inpatient Facility Services.
PHYSICIANS	Access any primary care physician or specialist from the Elite Access Network. Members are equired 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 hospitals and rendered by participating physicians.	
B. OUTPATIENT PHYSICIAN SERVICES	**SELECT IN NETWORK COPAYS**	**REDUCED COPAYS AT JHS PROVIDERS**
PCP Office Visits Specialist Office Visits Preventive Services Pediatrician Routine Physical Obstetrical/Gynecological Maternity Preventive Services Mammogram/Pap Smears	\$15 Copayment/Visit \$30 Copayment/Visit No Charge \$15 Copayment/Visit No Charge \$30 Copayment/Visit \$30 Copayment/Visit; Subsequent Visits No Charge No Charge	\$5 Copayment/Visit \$15 Copayment/Visit No Charge \$5 Copayment/Visit No Charge \$15 Copayment/Visit \$15 Copayment/Visit; Subsequent Visits No Charge No Charge
HOSPITALIZATION	Benefits payable at 100% after \$200 copayment at affiliated hospitals when admitted with PCP authorization. **\$0 copayment if admitted at Jackson**.	
HOSPITAL/SURGICAL REQUIREMENTS Pre-certification of hospital confinements	Handled by admitting physician.	
DRUG & ALCOHOL TREATMENT Inpatient Outpatient	\$200; **\$0 for Inpatient at Jackson** \$15 Per Visit; **\$5 Per Visit Copay At JHS Providers**	
MENTAL & NERVOUS DISORDERS Inpatient Outpatient	\$200; **\$0 for Inpatient at Jackson** \$15 Per Visit; **\$5 Per Visit Copay At JHS Providers**	
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 copayment. 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/\$40 Brand/\$55 Non-Preferred for 30 day supply, including prescription contraceptives, at participating pharmacies nationwide. See plan literature for other participating pharmacies. Mail order: 2x copay for 90-day supply. Generic contraceptives will be no charge. \$100 Specialty RX for 30-day supply through Specialty Pharmacy.	
DURABLE MEDICAL EQUIPMENT (DME)	DME and Orthotic covered at 100%. External prosthetic appliance - No charge after \$200 deductible per contract year.	
OUT-OF-AREA 1) Emergency 2) Non-Emergency	\$100 copayment, waived if admitted/100% thereafter. Out-of-network applies: 70% of maximum allowable payment (MAP) after deductible is met.	

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.

Point of Service (POS) Chart

Smartshopper benefits are available. Visit our website at www.avmed.org/jhs.

This plan allows you to use both in and out of network providers. For purposes of this summary, the two will be discussed separately.

	Out-Of-Network
COVERAGE PLAN DESCRIPTION	A fee for service program that provides you the freedom to use any physician or accredited hospital of your choice outside of the network. Payments are based on maximum allowable payment (MAP) charges. Providers who do not participate in the network may balance bill you for the amount which exceeds MAP. Coverage is subject to deductibles and coinsurance.
DEDUCTIBLES/COPAYMENTS	$200 per individual; $500 per family, $100 Emergency Room copayment (waived if admitted). Same in-network prescription benefits apply if participating, pharmacy is used. Benefits payable at 70% of coinsurance after deductible is met.
PHYSICIANS	Choose any licensed physician; covered charges payable at MAP after deductible is met.
A. IN-HOSPITAL PHYSICIAN SERVICES Surgery/Visits and Consultations Anesthesiologist	30% coinsurance after deductible.
B. OUTPATIENT PHYSICIAN SERVICES Office Visits for Illness Office Visits for Injury Diagnostic X-Rays, Lab Tests, X-Ray Treatments Pediatrician 1) Medically Necessary 2) Preventive Care Birth through age 15 (Well-Baby) Routine Preventive Care for children and adults Obstetrical/Gynecological	 Plan pays 70% coinsurance, after deductible is met. Plan pays 70% coinsurance, after deductible is met. Plan pays 70% coinsurance, after deductible is met. 1) 70% of MAP, after deductible is met. 2) Plan pays 70% of MAP, after deductible is met. Plan pays 70% coinsurance, after deductible is met. Plan pays 70% coinsurance, after deductible is met.
HOSPITALIZATION	Plan pays 70% coinsurance, after deductible is met. Plan must be notified within 24 hours after date of admission.
HOSPITAL/SURGICAL REQUIREMENTS Pre-certification of hospital confinements	 Pre-certification is required.
DRUG & ALCOHOL TREATMENT Inpatient Outpatient	 Plan pays 70% coinsurance, after deductible is met.* Plan pays 70% coinsurance, after deductible is met.*
MENTAL & NERVOUS DISORDERS Inpatient Outpatient	 Plan pays 70% coinsurance, after deductible is met..* Plan pays 70% coinsurance, after deductible is met.*
OTHER SERVICES Ambulance Vision	 Plan pays 70% coinsurance, after deductible is met. Coverage provided for diseases and/or injuries of the eye subject to deductible/coinsurance.
PRESCRIPTION DRUGS	$15 Generic Drug/$40 Preferred Brand/$55 Non-Preferred Brand up to a 30-day supply at any participating network pharmacy. 90 day supply at Mail Order available fro 2x copayment. Generic contraceptives no charge. See plan literature or visit website for more information. $100 Specialty RX for 30-day supply through Specialty Pharmacy.
DURABLE MEDICAL EQUIPMENT (DME)	Plan pays 70% of MAP after deductible for DME and orthotics. External prosthetic appliance not covered out of network.
OUT-OF-AREA 1) Emergency 2) Non-Emergency	 100% after $100 copayment, waived if admitted (worldwide). Plan pays 70% coinsurance, after deductible is met.

*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 and out-of-network. Non-participating out-of-network providers have not agreed to accept AvMed's MAP as payment in full for covered services. Therefore, if a nonparticipating provider is used the member is also responsible for the difference between MAP and the non-participating provider's actual charges.