

RESOLUTION NO. 2009- 1904

**A RESOLUTION OF THE TOWN COMMISSION FOR THE TOWN OF SURFSIDE, FLORIDA, APPROVING A HEALTH PLANS GROUP MEDICAL AND HOSPITAL SERVICE CONTRACT BETWEEN THE TOWN OF SURFSIDE, FLORIDA QUALIFIED SUBSCRIBERS AND AVMED, INC. D/B/A AVMED HEALTH PLANS**

**WHEREAS**, the Town Commission of the Town of Surfside, Florida (“TOWN”) wishes to enter into a contract with; AVMED, Inc. d/b/a AVMED Health Plans (“AVMED”); and

**WHEREAS**, the Town of Surfside; wishes to engage AVMED Health Plans to arrange for the delivery of Medical Services for qualified Town of Surfside Subscribers (“Subscribing Group”); and

**WHEREAS**, the Town Commission believes that it is in the best interest of the Town to enter into the agreement attached as (Composite Attachment “A”); and

**NOW THEREFORE, BE IT RESOLVED BY THE TOWN COMMISSION OF THE TOWN OF SURFSIDE, FLORIDA, AS FOLLOWS:**

**Section 1. Recitals.** The above and foregoing recitals are true and correct and are incorporated herein by reference.

**Section 2. Authorization.** The Town Commission hereby authorizes the execution of the Master Application of the Subscribing Group for group medical and hospital services between AVMED, Inc. d/b/a AVMED Health Plans (“AVMED”) and the Subscribing Group attached hereto as (Composite Attachment “A”) and authorizes the Town Manager to do all things necessary to effectuate this Contract.

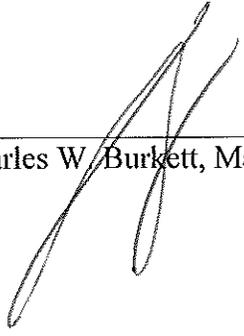
**Section 3. Effective Date.** This Resolution shall become effective immediately upon its adoption.

**PASSED and ADOPTED** on this 8th day of September, 2009.

Motion by Commissioner Imberman, second by Commissioner Levine.

**FINAL VOTE ON ADOPTION**

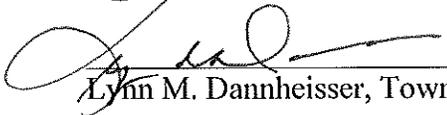
Commissioner Elizabeth Calderon	<u>yes</u>
Commissioner Steven Levine	<u>yes</u>
Commissioner Howard Weinberg	<u>yes</u>
Vice Mayor Marc Imberman	<u>yes</u>
Mayor Charles Burkett	<u>yes</u>

  
\_\_\_\_\_  
Charles W. Burkett, Mayor

Attest:

  
\_\_\_\_\_  
Debra E. Eastman, MMC  
Town Clerk

**APPROVED AND TO FORM AND  
LEGAL SUFFICIENCY FOR THE TOWN OF SURFSIDE ONLY:**

  
\_\_\_\_\_  
Lynn M. Dannheisser, Town Attorney

AVMED, INC. d/b/a AVMED Health Plans  
Group Medical and Hospital Service Contract  
Group Master Application



Contract Number(s): 108005  
 Subscribing Group Name: Town of Surfside  
 Effective Date: 10/01/09

**Group Contract**

This Group Contract provides the benefits listed below:

<u>Identifier</u>	<u>Description</u>
AV-LG-15/250/1500/20%-07	Summary of Benefits
AV-Open Access-06	<u>Open Access</u>
AV-Deductible/Co-insurance Amendment-08	Ded & Co-ins
AV-LG-RX-2x-15/30/50/75/50%-OC-07	Prescription Drug
AV-G100-MH/PH-\$250 per day-04	IP Mental Health
AV-SA-98	Substance Abuse
AV-G100-ETP-R-97	ETOP
AV-Mammogram-05	Mammogram

Eligibility

Active Employees (Class 1) are required to work 30 hours per week to become eligible for coverage under this Contract. Employees will become eligible for coverage on the first of the month following 30 days of employment.

Management Employees (Class 1) are required to work 25 hours per week to become eligible for coverage under this Contract. Employees will become eligible for coverage on the first of the month following the first day of employment.

Termination

For Active Employees (Class 1), termination of coverage under this Contract shall become effective End of Month.

For Management Employees (Class 1), termination of coverage under this Contract shall become effective End of Month.

Monthly Membership Charges

Subscriber Only .....	\$382.05
Subscriber plus Spouse .....	\$771.82
Subscriber plus One Dependent (No Spouse) .....	\$733.27
Subscriber plus Two or More Dependents .....	\$733.27
Subscriber plus Spouse and One or More Dependents .....	\$1,234.93

**AVMED, INC. d/b/a AVMED Health Plans  
Group Medical and Hospital Service Contract  
Group Master Application, continued**

**Agreement**

This Contract is issued in consideration of the Master Application of the Subscribing Group for group medical and hospital services and the monthly prepayment subscription charges and the mutual promises and benefits between AVMED, Inc. d/b/a AVMED Health Plans and the Subscribing Group. This Contract shall remain in effect for a period of twelve (12) months from the effective date of **October 1, 2009** and may be renewed annually, not later than the anniversary date, upon mutual agreement of the parties. This Contract period begins at 12:01 a.m. Eastern Standard Time on the effective date or on the anniversary date, if a renewal. The Contract shall be governed by Chapter 641, Florida Statutes, and other applicable State and Federal laws.

The first monthly payment is due on **October 1, 2009**. Subsequent payments are due on the 1st day of each month thereafter.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

The provisions contained in the Schedule of Benefits applicable to this Contract and all Exhibits and Amendments executed by the parties and attached hereto are, by reference, made a part of this Contract.

AGREED TO AND ACCEPTED BY the parties the day and year hereinafter written.

The Effective Date of this Contract is **October 1, 2009**.

Subscribing Group:

**Town of Surfside**

**AVMED, Inc. d/b/a AVMED Health Plans**

By: \_\_\_\_\_  
Signature

By: \_\_\_\_\_  
Signature

\_\_\_\_\_  
Name

\_\_\_\_\_  
Patricia Nelson  
Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Director of Client Services  
Title

Date: \_\_\_\_\_

Date: \_\_\_\_\_

# Benefit Summary

LARGE GROUP \$15/\$250/\$1,500/20%	SCHEDULE OF BENEFITS	COST TO MEMBER
<b>CALENDAR YEAR DEDUCTIBLE</b>	INDIVIDUAL / FAMILY <i>The Deductible does not apply toward the Out-of-Pocket Maximum</i>	\$250/\$750 annually
<b>OUT-OF-POCKET MAXIMUM Per Calendar Year</b>	INDIVIDUAL / FAMILY <i>The Out-of-Pocket Maximum includes Co-payments and Co-insurance amounts unless otherwise excluded</i>	\$1,500/\$3,000 annually
<b>AVMED PRIMARY CARE PHYSICIAN</b>	Services at Participating Physicians' offices include, but are not limited to: <ul style="list-style-type: none"> <li>▪ Routine office visits/annual gynecological examination when performed by Primary Care Physician</li> <li>▪ Pediatric care and well-child care</li> <li>▪ Periodic health evaluation and immunizations</li> <li>▪ Diagnostic imaging, laboratory or other diagnostic services</li> <li>▪ Minor surgical procedures</li> <li>▪ Vision and hearing examinations for children under 18</li> </ul>	\$15 per visit
<b>MATERNITY CARE</b>	<ul style="list-style-type: none"> <li>▪ Initial visit</li> <li>▪ Subsequent visits</li> </ul>	\$15 Co-payment <b>NO CHARGE</b>
<b>AVMED SPECIALISTS' SERVICES</b>	<ul style="list-style-type: none"> <li>▪ Office visits</li> <li>▪ Annual gynecological examination when performed by a participating Specialty Health Care Physician</li> </ul> <p>Additional Co-payments will apply if Outpatient Diagnostic Test are performed in the Specialist Office.</p>	\$25 per visit
<b>HOSPITAL</b>	Inpatient care at Participating Hospitals includes: <ul style="list-style-type: none"> <li>▪ Room and board – unlimited days (semi-private)</li> <li>▪ Physicians', specialists' and surgeons' services</li> <li>▪ Anesthesia, use of operating and recovery rooms, oxygen, drugs and medication</li> <li>▪ Intensive care unit and other special units, general and special duty nursing</li> <li>▪ Laboratory and diagnostic imaging</li> <li>▪ Required special diets</li> <li>▪ Radiation and inhalation therapies</li> </ul>	\$250 per day for the first 5 days, per admission; 100% coverage thereafter
<b>OUTPATIENT SERVICES</b>	<ul style="list-style-type: none"> <li>▪ Outpatient surgeries, including cardiac catheterizations and angioplasty</li> <li>▪ Outpatient therapeutic services, including: <ul style="list-style-type: none"> <li>• Drug infusion therapy</li> <li>• Injectable Drugs (Co-payment for Injectable Drug waived if incidental to same-day drug infusion therapy)</li> </ul> </li> </ul>	\$250 Co-payment \$100 Co-payment \$75 Co-payment
<b>OUTPATIENT DIAGNOSTIC TESTS</b>	<ul style="list-style-type: none"> <li>▪ CAT Scan, PET Scan, MRI</li> <li>▪ Other diagnostic imaging tests</li> </ul> <p>Co-payments for office visits will also apply if services are performed in a Specialist's office.</p>	20% of the contracted rate after Deductible
<b>EMERGENCY SERVICES</b>	An emergency is the sudden and unexpected onset of a condition requiring immediate medical or surgical care. (Co-payment waived if admitted) <ul style="list-style-type: none"> <li>▪ Emergency services at Participating Hospitals</li> <li>▪ Emergency services at non-participating Hospitals, facilities and/or physicians</li> </ul> <p><b>AvMed must be notified within 24 hours of inpatient admission following emergency services or as soon as reasonably possible</b></p>	\$100 Co-payment

# Benefit Summary, continued

<b>URGENT/IMMEDIATE CARE</b>	<ul style="list-style-type: none"><li>▪ Medical Services at a participating Urgent/Immediate Care facility or services rendered after hours in your Primary Care Physician's office</li><li>▪ Medical Services at a non-participating Urgent/Immediate Care facility</li></ul>
<b>FAMILY PLANNING</b>	<ul style="list-style-type: none"><li>▪ Voluntary family planning services</li><li>▪ Sterilization (In addition to any Outpatient Facility Co-payment)</li></ul>
<b>MENTAL HEALTH</b>	<ul style="list-style-type: none"><li>▪ 20 outpatient visits</li></ul>
<b>ALLERGY TREATMENTS</b>	<ul style="list-style-type: none"><li>▪ Injections</li><li>▪ Skin testing</li></ul>
<b>AMBULANCE</b>	<ul style="list-style-type: none"><li>▪ Ambulance transport for emergency services</li><li>▪ Non-emergent ambulance services are covered when the skill of medically trained personnel is required and the Member cannot be safely transported by other means</li></ul>
<b>PHYSICAL, SPEECH AND OCCUPATIONAL THERAPIES</b>	<ul style="list-style-type: none"><li>▪ Short-term physical, speech or occupational therapy for acute conditions</li></ul> <p>Coverage is limited to 30 visits per calendar year for all services combined</p>
<b>SKILLED NURSING FACILITIES AND REHABILITATION CENTERS</b>	<ul style="list-style-type: none"><li>▪ Up to 20 days post-hospitalization care per calendar year when prescribed by physician and authorized by AvMed</li></ul>
<b>GARDIAC REHABILITATION</b>	<p>Cardiac rehabilitation is covered for the following conditions:</p> <ul style="list-style-type: none"><li>▪ Acute myocardial infarction</li><li>▪ Percutaneous transluminal coronary angioplasty (PTCA)</li><li>▪ Repair or replacement of heart valves</li><li>▪ Coronary artery bypass graft (CABG), or</li><li>▪ Heart transplant</li></ul> <p>Coverage is limited to 18 visits per calendar year</p>
<b>HOME HEALTH CARE</b>	<ul style="list-style-type: none"><li>▪ Limited to 60 skilled visits per calendar year</li></ul>
<b>DURABLE MEDICAL EQUIPMENT AND ORTHOTIC APPLIANCES</b>	<p>Equipment includes:</p> <ul style="list-style-type: none"><li>▪ Hospital beds</li><li>▪ Walkers</li><li>▪ Crutches</li><li>▪ Wheelchairs</li></ul> <p>Orthotic appliances are limited to:</p> <ul style="list-style-type: none"><li>▪ Leg, arm, back and neck custom-made braces</li></ul>
<b>PROSTHETIC DEVICES</b>	<p>Prosthetic devices are limited to:</p> <ul style="list-style-type: none"><li>▪ Artificial limbs</li><li>▪ Artificial joints</li><li>▪ Ocular prostheses</li></ul>

**FOR ADDITIONAL INFORMATION, PLEASE CALL: 1-800-88-AVMED (1-800-88**

**THIS SCHEDULE OF BENEFITS IS NOT A CONTRACT. FOR SPECIFIC BENEFITS, EXCLUSIONS AND LIMITATIONS, PLEASE CONSULT YOUR MEDICAL AND HOSPITAL SERVICE CONTRACT.**

## *Benefit Summary, continued*

<b>URGENT/IMMEDIATE CARE</b>	<ul style="list-style-type: none"> <li>▪ Medical Services at a participating Urgent/Immediate Care facility or services rendered after hours in your Primary Care Physician's office</li> </ul>	\$40 Co-payment
	<ul style="list-style-type: none"> <li>▪ Medical Services at a non-participating Urgent/Immediate Care facility</li> </ul>	\$60 Co-payment
<b>FAMILY PLANNING</b>	<ul style="list-style-type: none"> <li>▪ Voluntary family planning services</li> </ul>	\$15 per visit
	<ul style="list-style-type: none"> <li>▪ Sterilization (In addition to any Outpatient Facility Co-payment)</li> </ul>	\$250 Co-payment
<b>MENTAL HEALTH</b>	<ul style="list-style-type: none"> <li>▪ 20 outpatient visits</li> </ul>	\$25 per visit
<b>ALLERGY TREATMENTS</b>	<ul style="list-style-type: none"> <li>▪ Injections</li> </ul>	\$15 per visit
	<ul style="list-style-type: none"> <li>▪ Skin testing</li> </ul>	\$50 per course of testing
<b>AMBULANCE</b>	<ul style="list-style-type: none"> <li>▪ Ambulance transport for emergency services</li> </ul>	\$100 Co-payment
	<ul style="list-style-type: none"> <li>▪ Non-emergent ambulance services are covered when the skill of medically trained personnel is required and the Member cannot be safely transported by other means</li> </ul>	
<b>PHYSICAL, SPEECH AND OCCUPATIONAL THERAPIES</b>	<ul style="list-style-type: none"> <li>▪ Short-term physical, speech or occupational therapy for acute conditions</li> </ul>	\$15 per visit
	Coverage is limited to 30 visits per calendar year for all services combined	
<b>SKILLED NURSING FACILITIES AND REHABILITATION CENTERS</b>	<ul style="list-style-type: none"> <li>▪ Up to 20 days post-hospitalization care per calendar year when prescribed by physician and authorized by AvMed</li> </ul>	20% of the contracted rate after Deductible
<b>CARDIAC REHABILITATION</b>	Cardiac rehabilitation is covered for the following conditions:	\$15 per visit
	<ul style="list-style-type: none"> <li>▪ Acute myocardial infarction</li> <li>▪ Percutaneous transluminal coronary angioplasty (PTCA)</li> <li>▪ Repair or replacement of heart valves</li> <li>▪ Coronary artery bypass graft (CABG), or</li> <li>▪ Heart transplant</li> </ul>	Benefits limited to \$1,500 per calendar year
Coverage is limited to 18 visits per calendar year		
<b>HOME HEALTH CARE</b>	<ul style="list-style-type: none"> <li>▪ Limited to 60 skilled visits per calendar year</li> </ul>	20% of the contracted rate after Deductible
<b>DURABLE MEDICAL EQUIPMENT AND ORTHOTIC APPLIANCES</b>	Equipment includes:	20% of the contracted rate after Deductible
	<ul style="list-style-type: none"> <li>▪ Hospital beds</li> <li>▪ Walkers</li> <li>▪ Crutches</li> <li>▪ Wheelchairs</li> </ul>	Benefits limited to \$2,000 per calendar year
Orthotic appliances are limited to:		
<ul style="list-style-type: none"> <li>▪ Leg, arm, back and neck custom-made braces</li> </ul>		
<b>PROSTHETIC DEVICES</b>	Prosthetic devices are limited to:	20% of the contracted rate after Deductible
	<ul style="list-style-type: none"> <li>▪ Artificial limbs</li> <li>▪ Artificial joints</li> <li>▪ Ocular prostheses</li> </ul>	

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

THIS SCHEDULE OF BENEFITS IS NOT A CONTRACT. FOR SPECIFIC INFORMATION ON BENEFITS, EXCLUSIONS AND LIMITATIONS, PLEASE CONSULT YOUR AVMED GROUP MEDICAL AND HOSPITAL SERVICE CONTRACT.

**Open Access to Specialty Healthcare Physicians**

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As of the Effective Date, the following section of the Group Medical and Hospital Service Contract is amended as follows:

- 10.03 Each Member may select one Primary Care Physician (PCP) upon enrollment, but is not required to do so. In the event that you do choose a PCP, the Health Plan must be notified and you must receive approval prior to changing your PCP. Such change will become effective on the first day of the month after you notify Health Plan. You cannot change your PCP selection more than once per month.

You are entitled to see participating Specialty Health Care Physicians without a referral from your PCP. Self-referral is not permitted to participating Specialty Health Care Physicians designated as "Requires Special Consultation between your Doctor and the AvMed Medical Director" in the written or electronic Provider Directories at the time of service.

Health Professionals may from time to time cease their affiliation with Health Plan. In such cases, you will be required to receive services from another Participating Health Professional.

**Large Group - Deductible and Co-insurance**

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These provisions of the policy are amended as follows:

Part III. DEFINITIONS, has been amended to add the following definitions:

- “Calendar Year” means the twelve-month period beginning January 1 and ending December 31.
- “Co-insurance” means the amount a covered Member must pay, once the Deductible has been met, and is expressed as a percentage of the allowed amount for the covered benefit.
- “Deductible” means the first payments up to a specified dollar amount, excluding Co-payments, that a Member must make in the applicable Calendar Year for covered benefits. The Deductible applies to each Member, subject to any family Deductible listed on the Schedule of Benefits. For purposes of the Deductible, “family” means the Subscriber and Covered Dependents. The Deductible must be satisfied once each Calendar Year, except for:
  - the Common Accident Provision: if the Deductible applies to accident expenses and if 2 or more Members of any family receive covered benefits because of disabilities resulting from injuries sustained in any one accident, the Deductible will be applied only once with respect to all covered benefits received as a result of the accident.
  - the Deductible Credit Provision: any expense incurred by a Member while covered under the group’s prior carrier will be credited toward satisfaction of the Deductible under this Plan if:
    - the expenses were incurred during the 90-day period before the effective date of the Group Plan;
    - the expenses were applied toward satisfaction of the Deductible under the prior coverage during the 90-day period before the effective date of this Group Plan; and
    - the expenses would be considered eligible expenses under this Group Plan.However, in order to receive credit, you must supply evidence of satisfaction of the Deductible under the prior coverage by providing AvMed Health Plans written proof of what has been paid by prior carrier.
  - the Carryover Provision: if any part or all of the Deductible has been satisfied during the last 3 months of the preceding Calendar Year, the Deductible for the next Calendar year will be reduced by the amount satisfied.

Under Part VII. MONTHLY PAYMENTS AND CO-PAYMENTS, has been amended as follows:

- 7.03 Annual Maximum Out-of-Pocket Limits (as described in your Schedule of Benefits). Co-insurance and Co-payments you pay for benefits received during any Calendar Year are accumulated toward your annual maximum out-of-pocket limit. Once you meet your individual or family annual maximum out-of-pocket limit in any Calendar Year, AvMed will pay 100% of the allowable charges for all covered services for the remainder of that Calendar Year. Expenses that do not count toward the annual maximum out-of-pocket limit are expenses used to satisfy the individual or family Deductible and any services provided under the Prescription Drug, Mental Health, Substance Abuse, Vision and other supplemental riders.
- 7.04 Member shall pay premiums, applicable supplemental charges, Deductibles, Co-payments and/or Co-insurance as provided in this Contract. If the Member fails to do so, upon ten (10) days written notice from AvMed to Member, the Member’s rights hereunder shall be terminated. Consideration for reinstatement with AvMed shall require a new application, and any re-enrollment shall be at the sole discretion of AvMed and shall not be retroactive.
- 7.07 A Member will be entitled to covered benefits after the Member has satisfied the Deductible amount, if any, specified on the Schedule of Benefits. After satisfying the Deductible, the Member must pay any applicable Co-insurance for covered benefits. Covered benefits to which the Deductible applies are shown in the Schedule of Benefits. The Deductible does not apply to certain covered benefits. In those instances, the Member must pay any applicable Co-payments for covered benefits to which the Deductible does not apply.

**\$15/30/50/75/50% CO-PAYMENT with Contraceptives**

**DEFINITIONS**

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

“Brand Additional Charge” means the additional charge that must be paid if you or your physician choose a Brand medication when a Generic equivalent is available. The charge is the difference between the cost of the Brand medication and the Generic medication. This charge must be paid in addition to the applicable Non-Preferred Brand Co-payment.

“Cost-sharing Medications” are those medications, as designated by AvMed, which were designed to improve the quality of life by treating relatively minor non-life threatening conditions. Such medications are subject to Co-insurance and coverage is limited as outlined below.

“Dental-specific Medication” is medication used for dental-specific purposes, including but not limited to fluoride medications and medications packaged and labeled for dental-specific purposes.

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

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

“Maintenance Medication” is a medication that has been approved by the FDA, for which the duration of therapy can reasonably be expected to exceed one year.

“Participating Pharmacy” means a pharmacy (either retail, mail order or specialty pharmacy) that has entered into an agreement with AvMed to provide Prescription Drugs to AvMed Members and has been designated by AvMed as a Participating Pharmacy.

“Preferred Medication List” means the listing of preferred medications as determined by AvMed’s Pharmacy and Therapeutics Committee based on clinical efficacy, relative safety and cost in comparison to similar medications within a therapeutic class. This multi-tiered list establishes different levels of Co-payment for medications within therapeutic classes. As new medications become available, they may be considered excluded until they have been reviewed by AvMed’s Pharmacy and Therapeutics Committee.

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

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

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

**HOW DOES YOUR RETAIL PRESCRIPTION COVERAGE WORK?**

To obtain your Prescription Drug, take your prescription to, or have your physician call, an AvMed Participating Pharmacy. Your physician should submit prescriptions for Self-Administered Injectable Medications to AvMed’s specialty pharmacy. Present your prescription along with your AvMed identification card. Pay the following Co-payment (as well as the Brand Additional Charge if you or your physician choose a Brand product when a Generic equivalent is available).

Tier 1	Preferred Generic Medications:	\$ 15.00 Co-payment
Tier 2	Preferred Brand Medications:	\$ 30.00 Co-payment
Tier 3	Non-Preferred Brand or Generic Medications:	\$ 50.00 Co-payment
Tier 4	Self-Administered Injectable Medications:	\$ 75.00 Co-payment
Tier 5	Cost-sharing Medications	50% Co-insurance

**ORDERING YOUR PRESCRIPTIONS THROUGH THE MAIL**

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

Tier 1	Preferred Generic Medications:	\$ 30.00 Co-payment
Tier 2	Preferred Brand Medications:	\$ 60.00 Co-payment
Tier 3	Non-Preferred Brand or Generic Medications:	\$ 100.00 Co-payment
Tier 4	Self-Administered Injectable Medications are not available through mail service	
Tier 5	Cost-sharing Medications are not available through mail service	

# Prescription Drug Benefits, continued

## WHAT IS COVERED?

- Your Prescription Drug coverage includes outpatient medications (including contraceptives) that require a prescription and are prescribed by your AvMed physician in accordance with AvMed's coverage criteria. AvMed reserves the right to make changes in coverage criteria for covered products and services. Coverage criteria are medical and pharmaceutical protocols used to determine payment of products and services and are based on independent clinical practice guidelines and standards of care established by government agencies and medical/pharmaceutical societies.
- Your retail Prescription Drug coverage includes up to a 30-day supply of a medication for the listed Co-payment. Your prescription may be refilled via retail or mail order after 75% of your previous fill has been used and subject to a maximum of 13 refills per year. You also have the opportunity to obtain a 90-day supply of medications used for chronic conditions including, but not limited to asthma, cardiovascular disease, and diabetes from the retail pharmacy for the applicable Co-payment per 30-day supply. However, Pre-Authorization may be required for covered medications.
- Your mail-order Prescription Drug coverage includes up to a 90-day supply of a routine maintenance medication for the listed Co-payment. If the amount of medication is less than a 90-day supply, you will still be charged the listed mail order Co-payment.
- Your Self-Administered Injectable Medication coverage extends to many injectable medications approved by the FDA. These medications must be prescribed by a physician and dispensed by a retail or specialty pharmacy. The Co-payment levels for Self-Administered Injectable Medications apply regardless of provider. This means that you are responsible for the appropriate Co-payment whether you receive your Self-Administered Injectable Medication from the pharmacy, at the physician's office or during home health visits. Self-Administered Injectable Medications are limited to a 30-day supply.
- Your Tier 5 coverage is limited to Terbinafine (Lamisil®) and Itraconazole (Sporanox®), in oral form, when prescribed by your physician for the treatment of documented fungal infections. Pre-authorization is not required.
- Your Prescription Drug coverage includes coverage for injectable contraceptives. There is a Co-payment of \$30 for each injection. If there is an office visit associated with the injection, there will be an additional Co-payment required for the office visit.
- Quantity limits are set in accordance with FDA approved prescribing limitations, general practice guidelines supported by medical specialty organizations, and/or evidence-based, statistically valid clinical studies without published conflicting data. This means that a medication-specific quantity limit may apply for medications that have an increased potential for over-utilization or an increased potential for a Member to experience an adverse effect at higher doses.

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## QUESTIONS?

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

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## EXCLUSIONS AND LIMITATIONS

- Medications which do not require a prescription (i.e. over-the-counter medications) or when a non-prescription alternative is available
- Medical supplies, including therapeutic devices, dressings, appliances, and support garments
- Replacement Prescription Drug products resulting from a lost, stolen, expired, broken, or destroyed prescription order or refill
- Diaphragms and other contraceptive devices
- Fertility drugs
- Medications or devices for the diagnosis or treatment of sexual dysfunction
- Dental-specific Medications for dental purposes, including fluoride medications
- Prescription and non-prescription vitamins and minerals except prenatal vitamins
- Nutritional supplements
- Immunizations
- Allergy serums, medications administered by the Attending Physician to treat the acute phase of an illness and chemotherapy for cancer patients are covered in accordance with the Group Medical and Hospital Service Contract and may be subject to Co-payments or Co-insurance as outlined on the Schedule of Benefits
- Investigational and experimental drugs (except as required by Florida statute)
- Cosmetic products, including, but not limited to, hair growth, skin bleaching, sun damage and anti-wrinkle medications
- Nicotine suppressants and smoking cessation products and services
- Prescription and non-prescription appetite suppressants and products for the purpose of weight loss
- Compounded prescriptions, except pediatric preparations
- Medications and immunizations for non-business related travel, including Transdermal Scopolamine

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*Filling a prescription at a pharmacy is not a claim for benefits and is not subject to the Claims and Appeals procedures under ERISA. However, any medicines that require Pre-Authorization will be treated as a claim for benefits subject to the Claims and Appeals Procedures, as outlined in the Group Medical and Hospital Service Contract.*



## *Amendment*

### **Inpatient Mental Health and Partial Hospitalization Benefits**

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As of the effective date, Inpatient Mental Health and Partial Hospitalization Benefits are being provided for an additional premium.

- Inpatient treatment of mental/nervous disorders for up to 30 days per patient, subject to a member copayment of \$250 per day for the first 5 days of each admission, shall be provided by the Plan when a member is admitted to a Participating Hospital or Participating Health Care Facility as a registered bed patient.
- Partial Hospitalization for mental health services is a Covered Service when it is provided in lieu of inpatient hospitalization and is combined with the inpatient hospital benefit. Two days of Partial Hospitalization will count as one day toward the inpatient Mental Health Benefit subject to member copayment as noted above.

**Substance Abuse Benefits**

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As of the effective date, the following Substance Abuse Benefits have been added for an additional premium.

- **INPATIENT** Inpatient treatment of alcohol and drug abuse is not provided except for acute detoxification.
  
- **OUTPATIENT** An intensive treatment program(s) of one or more weeks by Plan Physicians, subject to a member copayment of \$50 per week. Coverage is limited to a maximum of six weeks per contract year.



## *Addendum*

### **Coverage for Mammograms – Waiver of Co-payment**

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If selected, the following provision is hereby modified for an additional premium:

Section 10.28 of the AvMed Health Plans Group Medical and Hospital Service Contract is amended to state:

Mammograms are covered in accordance with *Florida Statutes*: one baseline mammogram is covered for female Members between the ages of 35 and 39; a mammogram is available every two years for female Members between the ages of 40 and 49; and a mammogram is available every year for female Members aged 50 and older.

In addition, one or more mammograms a year are available when based upon a physician's recommendation for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, because of having a history of biopsy-proven benign breast disease, because of having a mother, sister, or daughter who has had breast cancer, or because a woman has not given birth before the age of 30. This coverage will not be subject to diagnostic imaging Co-payments.



## *Amendment*

### **ELECTIVE TERMINATION OF PREGNANCY**

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If selected, the following optional coverage is hereby added:

The AvMed Health Plan Group Medical and Hospital Service Contract is amended to state:

- Elective termination of pregnancy will be a covered benefit if the services and treatment are provided by an AvMed participating provider in an AvMed participating facility. There shall be a physician copayment of \$100.00 in addition to the applicable facility copayment.

AVMED, INC. d/b/a AVMED Health Plans  
Group Medical and Hospital Service Contract  
Group Master Application



Contract Number(s): 106364  
 Subscribing Group Name: Town of Surfside  
 Effective Date: 10/01/09

**Group Contract**

This Group Contract provides the benefits listed below:

<u>Identifier</u>	<u>Description</u>
AV-BASIC/15-250A-07	Summary of Benefits
POS-250-30-3000	POS Summary of Benefits
AV-POS Open Access-05	Open Access
AV-Open Access-06	Open Access
AV-LG-RX-2x-15/30/50/75/50%-OC-07	Prescription Drug
AV-G100-MH/PH-\$250 per admit-04	IP Mental Health
AV-SA-98	Substance Abuse
AV-G100-DME-2000-R-06	Durable Med. Equip.
AV-G100-ETP-R-97	ETOP
AV-Mammogram-05	Mammogram

**Eligibility**

Active Employees (Class 1) are required to work 30 hours per week to become eligible for coverage under this Contract. Employees will become eligible for coverage on the first of the month following 30 days of employment.

Management Employees (Class 1) are required to work 25 hours per week to become eligible for coverage under this Contract. Employees will become eligible for coverage on the first of the month following the first day of employment.

**Termination**

For Active Employees (Class 1), termination of coverage under this Contract shall become effective End of Month.

For Management Employees (Class 1), termination of coverage under this Contract shall become effective End of Month.

**Monthly Membership Charges**

Subscriber Only .....	\$509.90
Subscriber plus Spouse .....	\$1,030.11
Subscriber plus One Dependent (No Spouse) .....	\$978.66
Subscriber plus Two or More Dependents .....	\$978.66
Subscriber plus Spouse and One or More Dependents .....	\$1,648.21

**AVMED, INC. d/b/a AVMED Health Plans  
Group Medical and Hospital Service Contract  
Group Master Application, continued**

**Agreement**

This Contract is issued in consideration of the Master Application of the Subscribing Group for group medical and hospital services and the monthly prepayment subscription charges and the mutual promises and benefits between AVMED, Inc. d/b/a AVMED Health Plans and the Subscribing Group. This Contract shall remain in effect for a period of twelve (12) months from the effective date of **October 1, 2009** and may be renewed annually, not later than the anniversary date, upon mutual agreement of the parties. This Contract period begins at 12:01 a.m. Eastern Standard Time on the effective date or on the anniversary date, if a renewal. The Contract shall be governed by Chapter 641, Florida Statutes, and other applicable State and Federal laws.

The first monthly payment is due on **October 1, 2009**. Subsequent payments are due on the 1st day of each month thereafter.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

The provisions contained in the Schedule of Benefits applicable to this Contract and all Exhibits and Amendments executed by the parties and attached hereto are, by reference, made a part of this Contract.

AGREED TO AND ACCEPTED BY the parties the day and year hereinafter written.

The Effective Date of this Contract is **October 1, 2009**.

Subscribing Group:

**Town of Surfside**

**AVMED, Inc. d/b/a AVMED Health Plans**

By: \_\_\_\_\_  
Signature

\_\_\_\_\_  
Name

\_\_\_\_\_  
Title

By: \_\_\_\_\_  
Signature

\_\_\_\_\_  
Patricia Nelson  
Name

\_\_\_\_\_  
Director of Client Services  
Title

Date: \_\_\_\_\_

Date: \_\_\_\_\_

# Benefit Summary

BASIC/15 OPTION 250-ADMIT	SCHEDULE OF BENEFITS	COST TO MEMBER
<b>OUT-OF-POCKET MAXIMUM</b> Per Calendar Year		\$1,500 INDIVIDUAL \$3,000 FAMILY
<b>AVMED PRIMARY CARE PHYSICIAN</b>	Services at Participating Physicians' offices include, but are not limited to: <ul style="list-style-type: none"> <li>▪ Routine office visits / annual gynecological examination when performed by Primary Care Physician</li> <li>▪ Pediatric care and well-child care</li> <li>▪ Periodic health evaluation and immunizations</li> <li>▪ Diagnostic imaging, laboratory or other diagnostic services</li> <li>▪ Minor surgical procedures</li> <li>▪ Vision and hearing examinations for children under 18</li> </ul>	\$15 per visit
<b>MATERNITY CARE</b>	<ul style="list-style-type: none"> <li>▪ Initial visit</li> <li>▪ Subsequent visits</li> </ul>	\$15 Co-payment <b>NO CHARGE</b>
<b>AVMED SPECIALISTS' SERVICES</b>	<ul style="list-style-type: none"> <li>▪ Office visits</li> <li>▪ Annual gynecological examination when performed by a participating Specialty Health Care Physician</li> </ul> <p>Additional co-payments will apply if Outpatient Diagnostic Test are performed in the Specialist office.</p>	\$15 per visit
<b>HOSPITAL</b>	<p>Inpatient care at Participating Hospitals includes:</p> <ul style="list-style-type: none"> <li>▪ Room and board - unlimited days (semi-private)</li> <li>▪ Physicians', specialists' and surgeons' services</li> <li>▪ Anesthesia, use of operating and recovery rooms, oxygen, drugs and medication</li> <li>▪ Intensive care unit and other special units, general and special duty nursing</li> <li>▪ Laboratory and diagnostic imaging</li> <li>▪ Required special diets</li> <li>▪ Radiation and inhalation therapies</li> </ul>	\$250 per admission; 100% coverage thereafter
<b>OUTPATIENT SERVICES</b>	<ul style="list-style-type: none"> <li>▪ Outpatient surgeries, including cardiac catheterizations and angioplasty</li> <li>▪ Outpatient therapeutic services, including: <ul style="list-style-type: none"> <li>• Drug infusion therapy</li> <li>• Injectable Drugs (Co-payment for Injectable Drug waived if incidental to same-day drug infusion therapy)</li> </ul> </li> </ul>	\$250 Co-payment
<b>OUTPATIENT DIAGNOSTIC TESTS</b>	<ul style="list-style-type: none"> <li>▪ CAT Scan, PET Scan, MRI</li> <li>▪ Other diagnostic imaging tests</li> </ul> <p>Co-payments for office visits will also apply if services are performed in a Specialist office.</p>	\$25 per test \$10 per test
<b>EMERGENCY SERVICES</b>	<p>An emergency is the sudden and unexpected onset of a condition requiring immediate medical or surgical care. (Co-payment waived if admitted)</p> <ul style="list-style-type: none"> <li>▪ Emergency services at Participating Hospitals</li> <li>▪ Emergency services at non-participating Hospitals, facilities and/or physicians</li> </ul>	\$75 Co-payment
	<p>AvMed must be notified within 24 hours of inpatient admission following emergency services or as soon as reasonably possible</p>	\$100 Co-payment

## *Benefit Summary, continued*

<b>URGENT/IMMEDIATE CARE</b>	▪ Medical Services at a participating Urgent/Immediate Care facility or services rendered after hours in your Primary Care Physician's office	\$40 Co-payment
	▪ Medical Services at a non-participating Urgent/Immediate Care facility	\$60 Co-payment
<b>MENTAL HEALTH</b>	▪ 20 outpatient visits	\$25 per visit
<b>FAMILY PLANNING</b>	▪ Voluntary family planning services	\$15 per visit
	▪ Sterilization (In addition to any Outpatient Facility Co-payment)	\$250 Co-payment
<b>ALLERGY TREATMENTS</b>	▪ Injections	\$10 per visit
	▪ Skin testing	\$50 per course of testing
<b>AMBULANCE</b>	▪ Ambulance transport for emergency services	\$100 Co-payment
	▪ Non-emergent ambulance services are covered when the skill of medically trained personnel is required and the Member cannot be safely transported by other means	
<b>PHYSICAL, SPEECH AND OCCUPATIONAL THERAPIES</b>	▪ Short-term physical, speech or occupational therapy for acute conditions	\$15 per visit
Coverage is limited to 30 visits per calendar year for all services combined		
<b>SKILLED NURSING FACILITIES AND REHABILITATION CENTERS</b>	▪ Up to 20 days post-hospitalization care per calendar year when prescribed by physician and authorized by AvMed	\$50 per day
<b>CARDIAC REHABILITATION</b>	Cardiac rehabilitation is covered for the following conditions:	\$20 per visit
	<ul style="list-style-type: none"> <li>▪ Acute myocardial infarction</li> <li>▪ Percutaneous transluminal coronary angioplasty (PTCA)</li> <li>▪ Repair or replacement of heart valves</li> <li>▪ Coronary artery bypass graft (CABG), or</li> <li>▪ Heart transplant</li> </ul>	Benefits limited to \$1,500 per calendar year
Coverage is limited to 18 visits per contract year		
<b>HOME HEALTH CARE</b>	▪ Limited to 60 skilled visits per calendar year	NO CHARGE
<b>DURABLE MEDICAL EQUIPMENT AND ORTHOTIC APPLIANCES</b>	Equipment includes:	\$50 per episode of illness
	<ul style="list-style-type: none"> <li>▪ Hospital beds</li> <li>▪ Walkers</li> <li>▪ Crutches</li> <li>▪ Wheelchairs</li> </ul>	Benefits limited to \$500 per calendar year
	Orthotic appliances are limited to:	
	▪ Leg, arm, back and neck custom-made braces	
<b>PROSTHETIC DEVICES</b>	Prosthetic devices are limited to:	NO CHARGE
	<ul style="list-style-type: none"> <li>▪ Artificial limbs</li> <li>▪ Artificial joints</li> <li>▪ Ocular prostheses</li> </ul>	

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

THIS SCHEDULE OF BENEFITS IS NOT A CONTRACT.  
FOR SPECIFIC INFORMATION ON BENEFITS, EXCLUSIONS AND LIMITATIONS, PLEASE SEE YOUR AVMED GROUP MEDICAL AND HOSPITAL SERVICE CONTRACT.

## *Open Access Point-of-Service Amendment*

AvMed Health Plans Group Medical and Hospital Service Contract is hereby amended and supplemented by the terms and conditions of this Amendment.

Nothing contained in this Amendment will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, Exclusions or Limitations of the HMO Contract to which this Amendment is attached, other than as specifically stated herein. Furthermore, when additional benefit riders are selected, those benefits are subject to the POS Amendment Deductible and Co-insurance arrangements when using Non-participating Providers unless services are specifically excluded herein.

Additionally, this Amendment in no way extends benefits beyond what has been stated in this Amendment and the Schedule of Point of Service Benefits or in the HMO Contract and Schedule of Benefits in terms of specific service limits or benefit maximums. This Amendment does not create any duplication of coverage or coordination of benefits contained in the HMO Contract or any other riders the Subscribing Group may elect.

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### **Point-of-Service Benefits**

A Member is eligible to receive medical care and services including medical, surgical, diagnostic, therapeutic and preventive services. Coverage is provided for health services that are:

- Received while you are covered under this Group Plan;
- Performed, prescribed or directed by a physician;
- Medically Necessary (except for preventive services as stated herein) for the diagnosis and treatment of injury or illness, as determined by AvMed Health Plans; and
- Not excluded under Parts XI. and XII. or any other provision, rider or amendment made a part of this Group Plan.

This Point-of-Service (POS) Amendment allows you to receive benefits for covered services and supplies outside the AvMed HMO network. When medical services are needed, you are free to obtain care from your HMO Primary Care Physician (PCP) or you may also consult with the Health Professional of your choice. However, your responsibilities for payment and claim filing will be greater when covered services and supplies are accessed outside the HMO system.

You are free to choose any Health Professional when health care services are needed. By using a Health Professional who has contracted with the AvMed Provider Network (a Participating Provider), the benefit payment level will often be higher than that for services or supplies provided by a Health Professional who has not contracted with the AvMed Provider Network (a Non-participating Provider). See the HMO and POS Schedules for more details on how these options can work best for you.

# *Open Access*

## *Point-of-Service Amendment, continued*

This Point-of-Service Amendment does not eliminate the requirement that each Member choose a PCP as outlined in the HMO Group Medical and Hospital Service Contract. If you do not choose a PCP, one will be chosen for you at the time of enrollment. You must continue to have certain HMO network services authorized by AvMed in order to obtain maximum benefits under the HMO coverage. Under the POS Amendment, some services will require your Non-participating Provider to request prior authorization as described herein.

### **Benefit Payment Levels**

This Point-of-Service Amendment has several special features that can influence how much you pay out-of-pocket for medical care. Your choice of a Health Professional may result in lower or higher costs and you will be required to follow certain procedures to avoid additional costs. Your choice of a Health Professional and wise use of these benefits can save you money.

This POS Amendment to the HMO Group Medical and Hospital Service Contract creates two benefit payment levels; one for services provided by AvMed HMO Participating Providers and a second for services provided by Non-participating Providers. The benefit level this Group Plan will pay depends on the Health Professional you select to provide covered health care services:

1. If the Health Professional used is part of the AvMed Health Plans Participating Provider Network, benefits for covered services are payable at the Participating Provider benefit level shown in the HMO Schedule of Co-payments. Although you are entitled to see most participating Specialty Health Care Physicians without a referral from your PCP, certain services rendered by a Specialty Health Care Physician require prior authorization, including some services performed in the physician's office. If you receive other covered services through a Participating Provider which require prior authorization or special authorization but have not been authorized by your PCP or AvMed, benefits may not be payable under the HMO Participating Provider benefit. Those services may be payable under the POS Non-participating Provider benefit if the service or supply is covered as specified in this POS Amendment and Schedule.
2. If the Health Professional used is not part of AvMed Health Plans' Participating Provider network, benefits for services covered under this POS Amendment are payable at the Non-participating Provider benefit level specified in the POS Amendment Schedule.

# *Open Access*

## *Point-of-Service Amendment, continued*

### **Cost-Sharing Information**

**Deductible.** Before AvMed Health Plans will begin paying expenses for services covered under this POS Amendment, you must satisfy the annual Deductible specified in the POS Schedule. The Deductible means the amount a Member must pay each calendar year for covered services from his or her own pocket before AvMed Health Plans will make payments for eligible expenses. The individual Deductible or family Deductible must be satisfied each calendar year before any payment will be made by AvMed Health Plans for any claim.

If two or more covered members of a family incur injury due to the same accident, the Deductible applies only once for all such expenses. If during a calendar year, the covered members of a family incur eligible expenses for which no benefits are payable because of the Deductible requirements and the amount of such eligible expense equals the family Deductible limit, then no further Deductible will apply to the covered members of the family during the remainder of such calendar year.

Any eligible expenses credited by AvMed Health Plans towards your Deductible requirement during the last three months of this Group Plan's prior calendar year, will be reduced to the extent of such application for the next ensuing calendar year.

Only those eligible expenses submitted on claims to AvMed Health Plans will be credited toward the Deductible. Expenses that are **not** eligible will not be counted toward the satisfaction of the Deductible. Eligible expenses are only those expenses which are Usual, Customary, and Reasonable as described below.

**Co-insurance.** Once the calendar year Deductible has been met, you are responsible for paying a percentage of eligible expenses. The coverage percentage, hereinafter called "Co-insurance" is specified in the Schedule. You will be responsible for paying any charges not considered an eligible expense.

**Usual, Customary, and Reasonable** means the usual charge made by a physician or supplier of services, medicines, or supplies. The charge will not exceed the general level of charges made by others rendering or furnishing such services, medicines, or supplies within an area in which the charge is incurred for sickness or injuries comparable in severity and nature to the sickness or injury being treated. The term "area" as it would apply to any particular service, medicine, or supply means: a county or such greater areas as is needed to obtain a representative cross section of level of charges.

**Annual Co-insurance Maximum Out-of-Pocket Limits.** Co-insurance and Co-payments you pay for benefits received during any calendar year under this Amendment are accumulated toward your annual Co-insurance maximum out-of-pocket. Once you meet your individual or family Co-insurance maximum out-of-pocket limit in any calendar year,

# *Open Access*

## *Point-of-Service Amendment, continued*

the Plan will pay 100% of the Usual, Customary, and Reasonable charges for all covered services for the remainder of that calendar year.

Expenses that do not count toward the annual Co-insurance maximum out-of-pocket are expenses related to charges for services not covered by this POS Amendment, additional charges incurred for failure to pre-authorize a service requiring prior authorization, expenses that relate to services that exceed any specific treatment limitations noted in the Schedules, expenses used to satisfy the individual or family Deductible, and Co-payments paid by you for services provided exclusively under the Group Medical and Hospital Service Contract.

**Lifetime Maximum Benefit.** While this Group Plan stays in force, the eligible expenses incurred by a Member are limited to the applicable maximum shown in the POS Schedule. When benefits in such amount have been paid or are payable under this Amendment, all coverage under this Amendment will terminate for the Member.

**Effect of Prior Coverage.** The following provision applies to Members who, on the day before this Group Plan Effective Date, were covered under prior coverage. Prior coverage means the policyholder's group medical plan that this Group Plan replaced. AvMed Health Plans will automatically cover any such person under this Group Plan on its Effective Date, subject to the following provision.

Those persons eligible according to the terms of this Group Plan will be covered at the level of benefits of this Group Plan. This includes persons who were covered under a continuation provision of the prior coverage to the extent it was required by state or federal law. This continued coverage under this Group Plan will terminate on the date that coverage would have terminated according to the law under the prior coverage, had the prior coverage remained in force.

**Deductible Carryover.** Any expenses incurred by a Member while covered under the prior coverage will be credited toward satisfaction of the Deductible under this Plan if:

- The expenses were incurred during the 90-day period before the Effective Date of the Group Plan;
- The expenses were applied toward satisfaction of the Deductible under the prior coverage during the 90-day period before the Effective Date of this Group Plan; and
- The expenses would be considered eligible expenses under this Group Plan.

However, in order to receive credit, you must supply evidence of satisfaction of the Deductible under the prior coverage by providing AvMed Health Plans written proof of what has been paid by prior coverage.

# *Open Access*

## *Point-of-Service Amendment, continued*

### **Prior Authorization of Covered Services**

In order to determine whether services and supplies are Medically Necessary, certain covered services require prior authorization from AvMed Health Plans. Prior authorization ensures a Member of receiving the most appropriate medical care available, in the most appropriate setting. If your physician is a Participating Provider, then he or she will handle all authorizations, notifications and utilization reviews with AvMed Health Plans.

If your doctor is not a Participating Provider, you are responsible for making sure your physician or Health Professional calls AvMed Health Plans to obtain prior authorization for a covered service when it is required. Please refer to your Member ID card for the telephone number where authorization may be obtained, or have your physician call 1-800-443-4103.

Before the service is performed, you should verify with your provider that the service has received prior authorization. If you are unable to secure verification from your provider, you may also call AvMed Health Plans. Please remember that failure to receive prior authorization of a service will result in a reduction in coverage. The amount of the reduction can be found in the POS Schedule.

The following services require prior authorization:

- Inpatient admissions (Hospital, Skilled Nursing Facility, and/or acute rehabilitation).
- Inpatient and outpatient surgery, including cardiac catheterization and percutaneous transluminal coronary angioplasty (PTCA).
- PET Scans.

It is important to remember that benefits for Hospital admissions not authorized in advance will be reduced by the amount shown in the POS Schedule. This reduction will occur regardless of whether such confinements are deemed Medically Necessary. If hospitalization is extended without authorization beyond the number of days approved, benefits for the extra days will be similarly reduced.

### **Exclusions and Limitations**

The benefit Exclusions and Limitations specified in the HMO Group Medical and Hospital Service Contract are also applicable to the benefits specified in this POS Amendment. Additionally, services not covered under this Point-of-Service Amendment include:

- Services provided exclusively under the HMO Group Medical and Hospital Service Contract.
- Second medical opinions are covered exclusively through the HMO portion of the benefits and are not available as point-of-service benefits.

# *Open Access*

## *Point-of-Service Amendment, continued*

- Transplantation services must be authorized by AvMed and provided exclusively through the HMO network. However, any follow-up care managed by a Participating Provider outside of the AvMed Service Area will be subject to the out-of-network benefit and reimbursement.
- Any applicable prescription benefits are available only under the HMO portion of coverage. They are not available as out-of-network benefits.
- Hospice services.
- Dialysis care.
- Ambulance services.
- Voluntary family planning services, sterilization, infertility evaluation and medical treatment, surgery for the enhancement of fertility and genetic counseling.
- Emergency Medical Services and Care for an Emergency Medical Condition. Emergency services administered by any provider will be covered under the HMO Contract benefits. In order for the care to be covered under the HMO, AvMed must be notified as described in Section 10.12 of the HMO Group Medical and Hospital Service Contract. If notification is not provided as specified under the HMO contract, services may be payable under the POS Amendment if the service or supply received is a covered service as specified in this POS Amendment and Schedule.
- Durable medical equipment, orthotic appliances and prosthetic devices are limited to those items specified in the POS Schedule. In addition, custom wheelchairs, electric wheelchairs and scooters must be authorized by AvMed and provided by the HMO network.

### **Payment of Claims**

When you receive services from a Non-participating Provider, the provider must bill AvMed Health Plans directly for the services rendered, and you will pay the physician directly all or part of the annual Deductible if not satisfied, and the required percentage of Co-insurance. You must also comply with the following claim filing procedures when receiving covered services from Non-participating Providers.

**Notice of Claim.** Notice of a claim for benefits must be given to AvMed Health Plans. The notice must be in writing, and any claim will be based on that written notice. The notice must be received by AvMed within six months after the start of the loss on which the claim is based. If notice is not given in time, the claim may be reduced or invalidated. If it can be shown that it was not reasonably possible to submit the notice within the six-month period and that notice was given as soon as possible, the claim will not be reduced or invalidated.

# *Open Access*

## *Point-of-Service Amendment, continued*

When written notice is required under this Plan, it shall be mailed to:

AvMed Health Plans  
P. O. Box 560844  
Miami, Florida 33156

You should call 1-800-882-8633 if assistance is needed regarding a claim or information about coverage.

**Proof of Loss.** Written proof of loss must be given to AvMed Health Plans within six months after the date of injury or sickness for which claim is made. If it was not reasonably possible to give written proof in the time required, AvMed will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible.

**Legal Actions.** No legal action may be brought to recover under this Amendment until at least 60 days after written proof of claim has been filed with AvMed Health Plans. If such action is taken after the 60-day period, it must be taken prior to the expiration of the statute of limitations from the date written proof of claim was required to be filed.

### **Overview – Member Responsibilities When Receiving Covered Services**

**Responsibilities when using Participating Providers.** All paperwork is handled by Participating Providers, so there are no bills for you to submit to AvMed Health Plans. However, it is your responsibility to:

1. Verify the participation status of (a) the Health Professional who prescribes the treatment, and (b) the Health Professional who provides the covered service.
2. Pay the applicable Co-payment or Co-insurance at the time of service.

### **Responsibilities when using Non-participating Providers:**

1. Know which covered services require prior authorization and comply with all requirements specified in this Amendment.
2. Pay eligible expenses applied toward satisfaction of the Deductible. The Deductible must be satisfied before benefits begin.
3. Pay the Co-insurance amount required.
4. Pay any amount of eligible expense which exceeds the Usual, Customary, and Reasonable charges.
5. Pay any increase in Co-insurance if prior authorization requirements are not followed as stated in this Amendment.
6. Pay any charges for services and supplies not covered under this Amendment.
7. You must complete and submit claim forms and provider bills to AvMed Health Plans.

**Open Access to Specialty Healthcare Physicians**

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As of the Effective Date, the following section of the Group Medical and Hospital Service Contract is amended as follows:

- 10.03 Each Member may select one Primary Care Physician (PCP) upon enrollment, but is not required to do so. In the event that you do choose a PCP, the Health Plan must be notified and you must receive approval prior to changing your PCP. Such change will become effective on the first day of the month after you notify Health Plan. You cannot change your PCP selection more than once per month.

You are entitled to see participating Specialty Health Care Physicians without a referral from your PCP. Self-referral is not permitted to participating Specialty Health Care Physicians designated as "Requires Special Consultation between your Doctor and the AvMed Medical Director" in the written or electronic Provider Directories at the time of service.

Health Professionals may from time to time cease their affiliation with Health Plan. In such cases, you will be required to receive services from another Participating Health Professional.

# Benefit Summary

POINT-OF-SERVICE BENEFITS	SCHEDULE OF OUT-OF-NETWORK BENEFITS	COST TO MEMBER
<b>DEDUCTIBLE</b>	INDIVIDUAL/FAMILY	\$250/\$750 Annually
<b>CO-INSURANCE OUT-OF-POCKET MAXIMUM</b>	INDIVIDUAL/FAMILY	\$3,000/\$6,000 Annually
<b>LIFETIME MAXIMUM</b>	\$2,000,000 PER MEMBER	
<b>PRIOR AUTHORIZATION</b>	Required for specific covered services. The penalty for not obtaining prior authorization is a 20% reduction in benefits.	
<b>PHYSICIAN</b>	<p>Services in physicians' offices include, but are not limited to:</p> <ul style="list-style-type: none"> <li>▪ Routine office visits/annual gynecological exam when performed by Primary Care Physician</li> <li>▪ Maternity-outpatient visits</li> <li>▪ Pediatric care and well-child care</li> <li>▪ Diagnostic imaging, laboratory or other diagnostic services</li> <li>▪ Minor surgical procedures</li> <li>▪ Vision and hearing examinations for children under 18</li> </ul>	30% of the UCR charge, subject to the Deductible
<b>SPECIALISTS' SERVICES</b>	<ul style="list-style-type: none"> <li>▪ Office visits</li> <li>▪ Annual gynecological examination when performed by a participating Specialty Health Care Physician</li> </ul> <p>Additional Co-payments will apply if Outpatient Diagnostic Test are performed in the Specialist Office.</p>	30% of the UCR charge, subject to the Deductible
<b>HOSPITAL</b>	<p>Inpatient care at Hospitals includes:</p> <ul style="list-style-type: none"> <li>▪ Room and board – unlimited days (semi-private)</li> <li>▪ Physicians', specialists' and surgeons' services</li> <li>▪ Anesthesia, use of operating and recovery rooms, oxygen, drugs and medication</li> <li>▪ Intensive care unit and other special units, general and special duty nursing</li> <li>▪ Laboratory and diagnostic imaging</li> <li>▪ Required special diets</li> <li>▪ Radiation and inhalation therapies</li> </ul>	30% of the UCR charge, subject to the Deductible
<b>OUTPATIENT SERVICES</b>	<ul style="list-style-type: none"> <li>▪ Outpatient surgeries, including cardiac catheterizations and angioplasty</li> <li>▪ Outpatient therapeutic services, including: <ul style="list-style-type: none"> <li>• Drug infusion therapy</li> <li>• Injectable drugs (Co-payment for Injectable Drug waived if incidental to same-day drug infusion therapy)</li> </ul> </li> </ul>	30% of the UCR charge, subject to the Deductible
<b>OUTPATIENT DIAGNOSTIC TESTS</b>	<ul style="list-style-type: none"> <li>▪ CAT Scan, PET Scan, MRI</li> <li>▪ Other diagnostic imaging tests</li> </ul> <p>Co-payments for office visits will also apply if services are performed in a Specialist's office.</p>	30% of the UCR charge, subject to the Deductible
<b>MENTAL HEALTH</b>	<ul style="list-style-type: none"> <li>▪ 20 outpatient visits</li> </ul> <p>If mental health/substance abuse benefit riders are elected, benefits are subject to POS rider Deductible and Co-insurance arrangements when using Non-participating Providers. Specified service limits are the total number of covered visits for both in and out-of-network, combined.</p>	30% of the UCR charge, subject to the Deductible

## *Benefit Summary, continued*

<b>ALLERGY TREATMENTS</b>	<ul style="list-style-type: none"> <li>▪ Injections</li> <li>▪ Skin testing</li> </ul>	30% of the UCR charge, subject to the Deductible
<b>PHYSICAL, SPEECH AND OCCUPATIONAL THERAPIES</b>	<ul style="list-style-type: none"> <li>▪ Short-term physical, speech or occupational therapy for acute conditions</li> </ul> <p>Coverage is limited to 30 visits per calendar year for all services combined</p>	30% of the UCR charge, subject to the Deductible
<b>SKILLED NURSING FACILITIES AND REHABILITATION CENTERS</b>	<ul style="list-style-type: none"> <li>▪ Up to 20 days per calendar year when prescribed by physician and authorized by AvMed</li> </ul>	30% of the UCR charge, subject to the Deductible
<b>CARDIAC REHABILITATION</b>	<p>Cardiac Rehabilitation is covered for the following conditions:</p> <ul style="list-style-type: none"> <li>▪ Acute myocardial infarction</li> <li>▪ Percutaneous transluminal coronary angioplasty (PTCA)</li> <li>▪ Repair or replacement of heart valves</li> <li>▪ Coronary artery bypass graft (CABG), or</li> <li>▪ Heart transplant</li> </ul> <p>Coverage is limited to 18 visits per calendar year</p>	<p>\$20 per visit</p> <p><b>Benefits limited to \$1,500 per calendar year</b></p>
<b>HOME HEALTH CARE</b>	<ul style="list-style-type: none"> <li>▪ Limited to 60 skilled visits per calendar year</li> </ul>	30% of the UCR charge, subject to the Deductible
<b>DURABLE MEDICAL EQUIPMENT AND ORTHOTIC APPLIANCES</b>	<p>Equipment includes:</p> <ul style="list-style-type: none"> <li>▪ Hospital beds</li> <li>▪ Walkers</li> <li>▪ Crutches</li> <li>▪ Wheelchairs</li> </ul> <p>Orthotic appliances are limited to:</p> <ul style="list-style-type: none"> <li>▪ Leg, arm, back and neck custom-made braces</li> </ul>	<p>\$50 per episode of illness.</p> <p><b>Benefits limited to \$500 per calendar year</b></p>
<b>PROSTHETIC DEVICES</b>	<p>Prosthetic devices are limited to:</p> <ul style="list-style-type: none"> <li>▪ Artificial limbs</li> <li>▪ Artificial joints</li> <li>▪ Ocular prostheses</li> </ul>	30% of the UCR charge, subject to the Deductible

THIS SCHEDULE IS NOT A CONTRACT.

FOR SPECIFIC INFORMATION ON BENEFITS, EXCLUSIONS AND LIMITATIONS PLEASE CONSULT YOUR GROUP MEDICAL AND HOSPITAL SERVICE CONTRACT AND POINT-OF-SERVICE AMENDMENT.

**\$15/30/50/75/50% CO-PAYMENT with Contraceptives**

**DEFINITIONS**

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

“Brand Additional Charge” means the additional charge that must be paid if you or your physician choose a Brand medication when a Generic equivalent is available. The charge is the difference between the cost of the Brand medication and the Generic medication. This charge must be paid in addition to the applicable Non-Preferred Brand Co-payment.

“Cost-sharing Medications” are those medications, as designated by AvMed, which were designed to improve the quality of life by treating relatively minor non-life threatening conditions. Such medications are subject to Co-insurance and coverage is limited as outlined below.

“Dental-specific Medication” is medication used for dental-specific purposes, including but not limited to fluoride medications and medications packaged and labeled for dental-specific purposes.

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

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

“Maintenance Medication” is a medication that has been approved by the FDA, for which the duration of therapy can reasonably be expected to exceed one year.

“Participating Pharmacy” means a pharmacy (either retail, mail order or specialty pharmacy) that has entered into an agreement with AvMed to provide Prescription Drugs to AvMed Members and has been designated by AvMed as a Participating Pharmacy.

“Preferred Medication List” means the listing of preferred medications as determined by AvMed’s Pharmacy and Therapeutics Committee based on clinical efficacy, relative safety and cost in comparison to similar medications within a therapeutic class. This multi-tiered list establishes different levels of Co-payment for medications within therapeutic classes. As new medications become available, they may be considered excluded until they have been reviewed by AvMed’s Pharmacy and Therapeutics Committee.

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

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

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

**HOW DOES YOUR RETAIL PRESCRIPTION COVERAGE WORK?**

To obtain your Prescription Drug, take your prescription to, or have your physician call, an AvMed Participating Pharmacy. Your physician should submit prescriptions for Self-Administered Injectable Medications to AvMed’s specialty pharmacy. Present your prescription along with your AvMed identification card. Pay the following Co-payment (as well as the Brand Additional Charge if you or your physician choose a Brand product when a Generic equivalent is available).

Tier 1	Preferred Generic Medications:	\$ 15.00 Co-payment
Tier 2	Preferred Brand Medications:	\$ 30.00 Co-payment
Tier 3	Non-Preferred Brand or Generic Medications:	\$ 50.00 Co-payment
Tier 4	Self-Administered Injectable Medications:	\$ 75.00 Co-payment
Tier 5	Cost-sharing Medications	50% Co-insurance

**ORDERING YOUR PRESCRIPTIONS THROUGH THE MAIL**

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

Tier 1	Preferred Generic Medications:	\$ 30.00 Co-payment
Tier 2	Preferred Brand Medications:	\$ 60.00 Co-payment
Tier 3	Non-Preferred Brand or Generic Medications:	\$ 100.00 Co-payment
Tier 4	Self-Administered Injectable Medications are not available through mail service	
Tier 5	Cost-sharing Medications are not available through mail service	

# Prescription Drug Benefits, continued

## WHAT IS COVERED?

- Your Prescription Drug coverage includes outpatient medications (including contraceptives) that require a prescription and are prescribed by your AvMed physician in accordance with AvMed's coverage criteria. AvMed reserves the right to make changes in coverage criteria for covered products and services. Coverage criteria are medical and pharmaceutical protocols used to determine payment of products and services and are based on independent clinical practice guidelines and standards of care established by government agencies and medical/pharmaceutical societies.
- Your retail Prescription Drug coverage includes up to a 30-day supply of a medication for the listed Co-payment. Your prescription may be refilled via retail or mail order after 75% of your previous fill has been used and subject to a maximum of 13 refills per year. You also have the opportunity to obtain a 90-day supply of medications used for chronic conditions including, but not limited to asthma, cardiovascular disease, and diabetes from the retail pharmacy for the applicable Co-payment per 30-day supply. However, Pre-Authorization may be required for covered medications.
- Your mail-order Prescription Drug coverage includes up to a 90-day supply of a routine maintenance medication for the listed Co-payment. If the amount of medication is less than a 90-day supply, you will still be charged the listed mail order Co-payment.
- Your Self-Administered Injectable Medication coverage extends to many injectable medications approved by the FDA. These medications must be prescribed by a physician and dispensed by a retail or specialty pharmacy. The Co-payment levels for Self-Administered Injectable Medications apply regardless of provider. This means that you are responsible for the appropriate Co-payment whether you receive your Self-Administered Injectable Medication from the pharmacy, at the physician's office or during home health visits. Self-Administered Injectable Medications are limited to a 30-day supply.
- Your Tier 5 coverage is limited to Terbinafine (Lamisil®) and Itraconazole (Sporanox®), in oral form, when prescribed by your physician for the treatment of documented fungal infections. Pre-authorization is not required.
- Your Prescription Drug coverage includes coverage for injectable contraceptives. There is a Co-payment of \$30 for each injection. If there is an office visit associated with the injection, there will be an additional Co-payment required for the office visit.
- Quantity limits are set in accordance with FDA approved prescribing limitations, general practice guidelines supported by medical specialty organizations, and/or evidence-based, statistically valid clinical studies without published conflicting data. This means that a medication-specific quantity limit may apply for medications that have an increased potential for over-utilization or an increased potential for a Member to experience an adverse effect at higher doses.

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## QUESTIONS?

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

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## EXCLUSIONS AND LIMITATIONS

- Medications which do not require a prescription (i.e. over-the-counter medications) or when a non-prescription alternative is available
- Medical supplies, including therapeutic devices, dressings, appliances, and support garments
- Replacement Prescription Drug products resulting from a lost, stolen, expired, broken, or destroyed prescription order or refill
- Diaphragms and other contraceptive devices
- Fertility drugs
- Medications or devices for the diagnosis or treatment of sexual dysfunction
- Dental-specific Medications for dental purposes, including fluoride medications
- Prescription and non-prescription vitamins and minerals except prenatal vitamins
- Nutritional supplements
- Immunizations
- Allergy serums, medications administered by the Attending Physician to treat the acute phase of an illness and chemotherapy for cancer patients are covered in accordance with the Group Medical and Hospital Service Contract and may be subject to Co-payments or Co-insurance as outlined on the Schedule of Benefits
- Investigational and experimental drugs (except as required by Florida statute)
- Cosmetic products, including, but not limited to, hair growth, skin bleaching, sun damage and anti-wrinkle medications
- Nicotine suppressants and smoking cessation products and services
- Prescription and non-prescription appetite suppressants and products for the purpose of weight loss
- Compounded prescriptions, except pediatric preparations
- Medications and immunizations for non-business related travel, including Transdermal Scopolamine

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*Filling a prescription at a pharmacy is not a claim for benefits and is not subject to the Claims and Appeals procedures under ERISA. However, any medicines that require Pre-Authorization will be treated as a claim for benefits subject to the Claims and Appeals Procedures, as outlined in the Group Medical and Hospital Service Contract.*

**Inpatient Mental Health and Partial Hospitalization Benefits**

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As of the effective date, Inpatient Mental Health and Partial Hospitalization Benefits are being provided for an additional premium.

- Inpatient treatment of mental/nervous disorders for up to 30 days per patient, subject to a member copayment of \$250 per admit, shall be provided by the Plan when a member is admitted to a Participating Hospital or Participating Health Care Facility as a registered bed patient.
- Partial Hospitalization for mental health services is a Covered Service when it is provided in lieu of inpatient hospitalization and is combined with the inpatient hospital benefit. Two days of Partial Hospitalization will count as one day toward the inpatient Mental Health Benefit subject to member copayment as noted above.

**Substance Abuse Benefits**

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As of the effective date, the following Substance Abuse Benefits have been added for an additional premium.

- **INPATIENT** Inpatient treatment of alcohol and drug abuse is not provided except for acute detoxification.
  
- **OUTPATIENT** An intensive treatment program(s) of one or more weeks by Plan Physicians, subject to a member copayment of \$50 per week. Coverage is limited to a maximum of six weeks per contract year.

**Coverage for Mammograms – Waiver of Co-payment**

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If selected, the following provision is hereby modified for an additional premium:

Section 10.28 of the AvMed Health Plans Group Medical and Hospital Service Contract is amended to state:

Mammograms are covered in accordance with *Florida Statutes*: one baseline mammogram is covered for female Members between the ages of 35 and 39; a mammogram is available every two years for female Members between the ages of 40 and 49; and a mammogram is available every year for female Members aged 50 and older.

In addition, one or more mammograms a year are available when based upon a physician's recommendation for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, because of having a history of biopsy-proven benign breast disease, because of having a mother, sister, or daughter who has had breast cancer, or because a woman has not given birth before the age of 30. This coverage will not be subject to diagnostic imaging Co-payments.



## *Amendment*

### **Durable Medical Equipment**

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If selected, the following coverage is hereby modified, for an additional premium.

#### **DURABLE MEDICAL EQUIPMENT**

- Benefits are limited to a maximum of \$2,000 per contract year\*.

All other coverage provisions, including co-payment, limitations and exclusions remain as stated in the Certificate of Coverage or Schedule of Co-Payments.

\*For the treatment of diabetes, coverage for an infusion pump will not apply toward the annual maximum limitation and shall not be subject to the durable medical equipment benefit limitation.



## *Amendment*

### **ELECTIVE TERMINATION OF PREGNANCY**

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If selected, the following optional coverage is hereby added:

The AvMed Health Plan Group Medical and Hospital Service Contract is amended to state:

- Elective termination of pregnancy will be a covered benefit if the services and treatment are provided by an AvMed participating provider in an AvMed participating facility. There shall be a physician copayment of \$100.00 in addition to the applicable facility copayment.