# Benefit Summary

This Schedule of Benefits is not a Contract. It contains highlights only and is subject to change. For specific information on Benefits, Exclusions and Limitations please see your Summary Plan Description. FOR ADDITIONAL INFORMATION, PLEASE CALL: 1-800-68-AVMED (1-800-682-8633), or visit the AvMed website at www.avmed.org/go/mdpht .

## AVMED POINT-OF-SERVICE (POS) SCHEDULE OF BENEFITS

| | COST TO MEMBER In-Network | COST TO MEMBER Out-of-Network* |
|---|---|---|
| **LIFETIME MAXIMUM** | Unlimited | Unlimited |
| **CO-INSURANCE LEVELS** | Plan pays 100%; Member Pays 0% | Plan pays 70% of Maximum Allowable Payment (MAP); Member Pays 30% of the MAP after Deductible |
| **CALENDAR YEAR DEDUCTIBLE** | | |
| Individual (per contract year) | Not Applicable | $200 per individual |
| Family (per contract year) | Not Applicable | $500 per family |

***Deductible does not apply toward the Out-of-Pocket Maximum***

**Individual Calculation:** Family members meet only their individual deductible and then their claims will be covered under the plan co-insurance; if the family deductible was met prior to their individual deductible being met, their claims will be paid at the plan co-insurance.

| **OUT-OF-POCKET MAXIMUM (Per Calendar Year)** | | |
|---|---|---|
| Individual Maximum | Not Applicable | $1500 per individual |
| Family Maximum | Not Applicable | Not Applicable |

**Individual Calculation:** Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%.

| **PHYSICIAN SERVICES** | | |
|---|---|---|
| Services at Physician's offices include, but are not limited to: | | |
| Primary Care Physician's Office Visit | $10 per visit | 30% of the MAP, after Deductible |
| Surgery in Physician's Office | $10 per visit | 30% of the MAP, after Deductible |
| Specialty Care Physician's Office Visits, Consultant and Referral Physician's Services | $10 per visit | 30% of the MAP, after Deductible |
| Allergy Treatment | $10 per visit | 30% of the MAP, after Deductible |
| Allergy Injections | No charge | 30% of the MAP, after Deductible |
| Allergy Serum (dispensed by the physician in the office) | No charge | 30% of the MAP, after Deductible |
| **PREVENTIVE CARE** | | |
| Routine Preventive Care: Birth through age 15 (Well-Baby and Well-Child including immunizations) | $10 per visit | No charge |
| Immunizations (birth through age 15) | No charge | No charge |
| Routine Preventive Care: Adult including immunizations | $10 per visit | In-Network coverage only |
| Immunizations (age 16 and above) | No charge | In-Network coverage only |
| **MAMMOGRAM, PSA, PAP SMEAR** | | |
| Preventive care related services (i.e. "routine" services) | No charge<br>**Note:** The associated wellness exam is subject to the $10 Specialist visit co- | 30% of the MAP, after Deductible<br>**Note:** The associated wellness exam is not covered |
| Diagnostic related services (i.e. "non-routine") | Subject to the plan's x-ray and laboratory benefit, based on place of service | Subject to the plan's x-ray and laboratory benefit, based on place of service |

## AVMED POINT-OF-SERVICE (POS) SCHEDULE OF BENEFITS

| | COST TO MEMBER In-Network | COST TO MEMBER Out-of-Network* |
|---|---|---|
| **INPATIENT HOSPITAL SERVICES** | | |
| Pre-Certification of Hospital Confinements | Handled by admitting physician | Pre-certification required or benefits will result in a $500 penalty. This is the responsibility of the member, not the |
| Hospital inpatient care includes: Room and board – unlimited days (semi-private) | No charge | 30% of the MAP, after Deductible |
| Private Room | Limited to the semi-private room negotiated | Limited to the semi-private room rate |
| Special Care Units (ICU/CCU) | No charge | 30% of the MAP, after Deductible |
| Inpatient Hospital Physician's Visits/Consultations | No charge | 30% of the MAP, after Deductible |
| Inpatient/Outpatient Hospital Professional Services | No charge | 30% of the MAP, after Deductible |
| **OUTPATIENT FACILITY SERVICES** | | |
| Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room | No charge | 30% of the MAP, after Deductible |
| Diagnostic Testing | No charge | 30% of the MAP, after Deductible |
| **EMERGENCY AND URGENT CARE SERVICES** | | |
| Physician's Office | $10 per visit | $10 per visit |
| Hospital Emergency Room | $50 per visit (waived if admitted) | $50 per visit (waived if admitted) |
| Outpatient Professional Services (radiology, pathology, ER physician) | No charge | No charge |
| Urgent Care Facility or Outpatient Facility | $50 per visit (waived if admitted) | $50 per visit (waived if admitted) |
| **LABORATORY/ RADIOLOGY SERVICES** | | |
| (includes pre-admission testing) | | |
| Physician's office visit | No charge | 30% of the MAP, after Deductible |
| Outpatient hospital facility | No charge | 30% of the MAP, after Deductible |
| Independent x-ray and/or laboratory facility | No charge | 30% of the MAP, after Deductible |
| **ADVANCED RADIOLOGICAL IMAGING** | | |
| (i.e. MRI, MRA, CAT scan , PET scan, etc.) The scan co-payment/deductible applies per type of scan per day | | |
| Outpatient Facility | No charge | 30% of the MAP, after Deductible |
| Inpatient Facility | No charge | 30% of the MAP, after Deductible |
| Physician's Office | No charge | 30% of the MAP, after Deductible |
| **OUTPATIENT SHORT-TERM REHABILITATIVE THERAPY AND CHIROPRACTIC SERVICES** | | |
| Contract Year Maximum: 60 days for all therapy combined Includes: | | |
| Physical Therapy, Speech Therapy, Occupational Therapy, Pulmonary Rehabilitation, Cognitive Therapy, Chiropractic Therapy (includes Chiropractors), Respiratory Therapy | $10 per visit | 30% of the MAP, after Deductible |

**Note:** The Outpatient short term rehabilitation Co-payment does not apply to services provided as part of a Home Health Care visit.

## AVMED POINT-OF-SERVICE (POS) SCHEDULE OF BENEFITS

| | COST TO MEMBER In-Network | COST TO MEMBER Out-of-Network* |
|---|---|---|
| **MATERNITY CARE SERVICES** | | |
| Initial visit | $10 per visit | 30% of the MAP, after Deductible |
| All subsequent prenatal visits, postnatal visits and Physician's delivery charges (i.e. global maternity fee) | No charge | 30% of the MAP, after Deductible |
| Delivery facility (inpatient hospital, birthing center) | No charge | 30% of the MAP, after Deductible |
| **DURABLE MEDICAL EQUIPMENT** | | |
| Contract Year Maximum: Unlimited | No charge | 30% of the MAP, after Deductible |
| **ACUPUNCTURE** | Out-of-network coverage only | 30% of the MAP, after Deductible |
| **MENTAL HEALTH** | | |
| Outpatient | $10 per visit | 30% of the MAP, after Deductible |
| Inpatient | No charge | 30% of the MAP, after Deductible |
| Intensive Outpatient | $10 per visit | 30% of the MAP, after Deductible |
| **SUBSTANCE ABUSE** | | |
| Outpatient | $10 per visit | 30% of the MAP, after Deductible |
| Inpatient | No charge | 30% of the MAP, after Deductible |
| Intensive Outpatient | $10 per visit | 30% of the MAP, after Deductible |
| **DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDER** | | |
| Applied Behavioral Analysis (ABA) | $10 per visit | 30% of the MAP, after Deductible |
| Physical, Speech, Occupational Therapy | $10 per visit | 30% of the MAP, after Deductible |
| **Calendar Year Maximum: $36,000—in and out of network, Lifetime Maximum: $200,000—in and out of network** | | |
| **PRESCRIPTION MEDICATION BENEFIT — RETAIL, 30 DAY SUPPLY** (INCLUDES CONTRACEPTIVES) | | |
| Generic | $5 | 30% of charges |
| Preferred Brand | $10 | 30% of charges |
| Non-Preferred Brand | $15 | 30% of charges |
| **SPECIALTY (30-DAY SUPPLY AT PARTICIPATING PHARMACY)** | | |
| Generic | $3.33 | 30% of charges |
| Preferred Brand | $6.66 | 30% of charges |
| Non-Preferred Brand | $10 | 30% of charges |
| **PRESCRIPTION MEDICATIONS - MAIL-ORDER, 90 DAY SUPPLY** (INCLUDES CONTRACEPTIVES) | | |
| Generic | $10 | 30% of charges |
| Preferred Brand | $20 | 30% of charges |
| Non-Preferred Brand | $30 | 30% of charges |

**Generic**: medication on the Prescription medication list - **Preferred Brand:** medication designated as preferred on the prescription medication list with no Generic equivalent - **Non-Preferred Brand**: medication with a Generic equivalent and/or medication designated as non-preferred on the Prescription medication list

*** Member may be responsible for all Out-Of-Network charges in excess of the Maximum Allowable Payment (MAP).**

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## HMO SCHEDULE OF BENEFITS

| | AVMED HIGH OPT HMO | AVMED LOW OPT HMO |
|---|---|---|
| FOR ADDITIONAL INFORMATION, CONTACT THE PLAN DIRECTLY. | **(800) 682-8633** www.avmed.org/go/mdpht | **(800) 682-8633** www.avmed.org/go/mdpht |
| **HMO SCHEDULE OF BENEFITS** | **COST TO MEMBER** | **COST TO MEMBER** |
| **LIFETIME MAXIMUM** | Unlimited | Unlimited |
| **CALENDAR YEAR DEDUCTIBLE** | | |
| Individual /Family | Not Applicable | Not Applicable |
| **OUT-OF-POCKET MAXIMUM (Per Calendar Year)** | | |
| Individual | $1,500 | Not Applicable |
| Family | $3,000 | Not Applicable |
| **PRIMARY CARE PHYSICIAN** | | |
| Routine office visits / annual gyn examination when performed by primary care physician | $10 per visit | $25 per visit |
| Pediatric care and well-baby care | $10 per visit | $25 per visit |
| Periodic health evaluation and immunizations | $10 per visit | $25 per visit |
| Diagnostic imaging, lab/or other diagnostic services | $10 per visit | $25 per visit |
| Minor surgical procedures | $10 per visit | $25 per visit |
| Vision and hearing exams for children under 18 | $10 per visit | $25 per visit |
| **SPECIALIST'S SERVICES** | Open Access | Referral Required For Most Services |
| Office Visits | $10 per visit | $25 per visit |
| Annual gyn exam when performed by participating specialist | $10 per visit | $25 per visit (may self-refer) |
| **MATERNITY CARE SERVICES** | | |
| Initial visit | $10 per visit | $25 per visit |
| Subsequent visits | No charge | No charge |
| **ALLERGY TREATMENTS** | | |
| Visits and/or Injections | $10 per visit | $25 per visit |
| Skin testing (per course of treatment) | $10 per visit | $25 per visit |
| **HOSPITAL SERVICES -** Inpatient care at participating hospitals includes: | | |
| Room and board - unlimited days (semi-private) | No charge | $150 per day for the first 3 days, per admission. No charge thereafter. |
| Physicians', specialists' and surgeons' svces | No charge | |
| Anesthesia, use of operating and recovery rooms, oxygen, drugs and medication | No charge | |
| Intensive care unit and other special units, general and special duty nursing | No charge | |
| Laboratory and diagnostic imaging | No charge | |

## HMO SCHEDULE OF BENEFITS

| | AVMED HIGH OPT HMO | AVMED LOW OPT HMO |
|---|---|---|
| **CHIROPRACTIC** | $10 per visit | $25 per visit |
| **PODIATRY** | $10 per visit | $25 per visit |
| **OUTPATIENT SERVICES** | | |
| Outpatient surgeries, including cardiac catheterizations and angioplasty | No charge | No charge |
| **OUTPATIENT DIAGNOSTIC TESTS** | | |
| Complex radiological imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging) Mammogram | No charge | No charge |
| Other diagnostic imaging tests and Laboratory | No charge | No charge |
| Mammogram | No charge | No charge |
| **EMERGENCY SERVICES** | | |
| An emergency is the sudden and unexpected onset of a condition requiring immediate medical or surgical care. | Co-payment waived if admitted. Plan must be notified within 24 hours of emergency inpatient admission. | Co-payment waived if admitted. Plan notification required within 24 hours of emergency inpatient admission. |
| Emergency svces at participating hospitals | $25 copayment | $100 copayment |
| Emergency services - non-participating hospitals, facilities and/or physicians | $50 copayment | $100 copayment |
| **URGENT /IMMEDIATE CARE** | | |
| Medical Services at a participating Urgent/Immediate Care facility or svces rendered after hours in your Primary Care Physician's office | $25 copayment | $50 copayment |
| Medical Services at a participating retail clinic | $10 copayment | $25 copayment |
| Medical Services at a non-participating Urgent/Immediate Care facility or non-participating retail clinic | $50 copayment | $50 copayment |
| **AMBULANCE** | | |
| When pre-authorized or in the case of emergency | No charge | No charge |
| **DRUG AND ALCOHOL REHABILITATION PROGRAMS** | | |
| Outpatient | $10 per visit | $25 per visit |
| Inpatient | No charge | $150 per day, first 3 days p/admission. No charge thereafter. |
| **MENTAL / NERVOUS DISORDERS** | | |
| Outpatient | $10 per visit | $25 per visit |
| Inpatient | No charge | $150 per day, first 3 days p/admission. No charge thereafter. |

## HMO SCHEDULE OF BENEFITS

| | AVMED HIGH OPT HMO | AVMED LOW OPT HMO |
|---|---|---|
| **PHYSICAL, SPEECH, RESPIRATORY & OCCUPATIONAL THERAPIES** | | |
| Short-term Physical, Speech, Respiratory and Occupational therapy for acute conditions. **Coverage is limited to 60 visits combined per Calendar year** | $10 per visit | $25 per visit |
| **DURABLE MEDICAL EQUIPMENT** | Benefits limited to **$2000** per Calendar Year | Benefits limited to **$2000** per Calendar Year |
| Equipment includes but not limited to: Hospital beds, walkers, crutches, wheelchairs | $50 per episode of illness | $50 per episode of illness |
| **DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDER** | | |
| Applied Behavioral Analysis (ABA) | $10 per visit | $25 per visit |
| Physical, Speech, Occupational Therapy | $10 per visit | $25 per visit |
| Calendar Year Maximum:<br>Lifetime Maximum: | $36,000<br>$200,000 | $36,000<br>$200,000 |
| **PRESCRIPTION MEDICATION BENEFIT — RETAIL, 30 DAY SUPPLY** (INCLUDES CONTRACEPTIVES) | | |
| Generic | $10 copayment | $15 copayment |
| Preferred Brand | $20 copayment | $30 copayment |
| Non-Preferred Brand | $30 copayment | $50 copayment |
| **PRESCRIPTION MEDICATIONS - MAIL-ORDER, 90 DAY SUPPLY** (INCLUDES CONTRACEPTIVES) | | |
| Generic | $20 copayment | $30 copayment |
| Preferred Brand | $40 copayment | $60 copayment |
| Non-Preferred Brand | $60 copayment | $100 copayment |

**DEFINITIONS**: **Generic** - medication on the Prescription medication list. **Preferred Brand -** medication designated as preferred on the prescription medication list with no Generic equivalent. **Non-Preferred Brand** - medication with a Generic equivalent and/or medication designated as non-preferred on the Prescription medication list.

**BRAND ADDITIONAL CHARGE - When Brand is requested by member and a generic equivalent is available:** Member pays the difference between the cost of the Brand medication and Generic medication, plus the Non-Preferred Brand copayment.

**PRIOR AUTHORIZATION IS REQUIRED FOR SPECIFIC COVERED SERVICES INCLUDING, BUT NOT LIMITED TO:**

All Inpatient services, Observation Services, Residential Treatment, Outpatient Surgery, Intensive Outpatient Programs, Complex radiological imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging), Non-Emergency Ambulance, Dialysis Services, Transplant Services, Use of Non-Participating Providers, Select Medications Including Injectables