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 **Note:** The associated wellness exam is subject to the $10 Specialist visit co-	30% of the MAP, after Deductible **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).**