## AVMED HMO PLANS

**This Schedule of Benefits reflects the higher provider and prescription co-payments for 2014. This is not a contract, it's a summary of the plan highlights 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.**

| SCHEDULE OF BENEFITS | AVMED HMO HIGH<br>COST TO MEMBER | AVMED HMO LOW<br>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 | $6,350 |
| Family | $3,000 | $12,700 |
| **PRIMARY CARE PHYSICIAN** | | |
| Routine office visits | $15 per visit | $30 per visit |
| Preventive care-routine physicals/pediatric well baby care (and other preventive services required by the Patient Protection Affordable Care Act "PPACA") | No Charge | No Charge |
| Pediatrician | $15 per visit | $30 per visit |
| **SPECIALIST'S SERVICES** | Open Access | Referral required for services |
| Office Visits | $30 per visit | $45 per visit |
| Annual gyn exam when performed by participating specialist | No Charge | No Charge |
| **MATERNITY CARE SERVICES** | | |
| Initial visit | $30 per visit | $45 per visit |
| Subsequent visits | No charge | No charge |
| **ALLERGY TREATMENTS** | | |
| Allergy Injections | $15 per visit | $30 per visit |
| Skin testing (per course of treatment) | $30 per visit | $45 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 | |

| AVMED HMO PLANS - SCHEDULE OF BENEFITS | | |
|---|---|---|
| SCHEDULE OF BENEFITS | AVMED HMO HIGH | AVMED HMO LOW |
| | COST TO MEMBER | COST TO MEMBER |
| **CHIROPRACTIC** | $15 per visit | $30 per visit |
| **PODIATRY** | $15 per visit | $30 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 co-payment | $100 co-payment |
| Emergency services - non-participating hospitals, facilities and/or physicians | $25 co-payment | $100 co-payment |
| **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 co-payment | $50 co-payment |
| Medical Services at a participating retail clinic | $15 co-payment | $30 co-payment |
| Medical Services at a non-participating Urgent/ Immediate Care facility or non-participating retail clinic | $50 co-payment | $50 co-payment |
| **AMBULANCE** | | |
| When pre-authorized or in the case of emergency | No charge | No charge |
| **DRUG & ALCOHOL REHABILITATION PROGRAMS** | | |
| Outpatient | $15 per visit | $30 per visit |
| Inpatient | No charge | $150 per day, first 3 days p/admission. No charge thereafter. |
| **MENTAL / NERVOUS DISORDERS** | | |
| Outpatient | $15 per visit | $30 per visit |
| Inpatient | No charge | $150 per day, first 3 days p/admission. No charge thereafter. |

## AVMED HMO PLANS - SCHEDULE OF BENEFITS

| SCHEDULE OF BENEFITS | AVMED HMO HIGH<br>COST TO MEMBER | AVMED HMO LOW<br>COST TO MEMBER |
|---|---|---|
| **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 | $30 per visit | $45 per visit |
| **DURABLE MEDICAL EQUIPMENT** 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** | | |
| Habilitative physical, occupational, & speech therapy services, are covered to a combined maximum of 100 visits per calendar year. | | |
| Applied Behavioral Analysis (ABA) | $15 per visit | $30 per visit |
| Physical, Speech, Occupational Therapy | $15 per visit | $30 per visit |
| **PRESCRIPTION MEDICATION BENEFIT — RETAIL, 30 DAY SUPPLY** (*INCLUDES CONTRACEPTIVES) | | |
| Generic | $15 co-payment | $20 co-payment |
| Preferred Brand | $25 co-payment | $35 co-payment |
| Non-Preferred Brand | $35 co-payment | $55 co-payment |
| NOTE: Specialty Drugs (example: self injectables, etc.) - Available only on a 30-day supply basis from a specialty pharmacy for the applicable copayment. | | |
| **PRESCRIPTION MEDICATIONS - MAIL-ORDER, 90 DAY SUPPLY** (*INCLUDES CONTRACEPTIVES) | | |
| Generic | $30 co-payment | $40 co-payment |
| Preferred Brand | $50 co-payment | $70 co-payment |
| Non-Preferred Brand | $70 co-payment | $110 co-payment |

**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 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 co-payment.

* There is no co-payment for Generic contraceptives, in accordance with provisions of the Patient Protection and Affordable Care Act (PPACA).

**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