AVMED POS PLAN

This Schedule of Benefits reflects the higher provider and prescription copayments for 2015. 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/mdc.

SCHEDULE OF BENEFITS	COST TO MEMBER	COST TO MEMBER
	In-Network	Out-of-Network*
LIFETIME MAXIMUM	Unlimited	Unlimited
CO-INSURANCE LEVELS	Not Applicable	Plan pays 70% of Maximum Allowable Payment (MAP); member pays 30% co-insurance after deductible
CALENDAR YEAR DEDUCTIBLE		
Individual (per contract year)	Not Applicable	$200
Dependent Coverage (per contract year)	Not Applicable	$500
OUT-OF-POCKET MAXIMUM (Per Calendar Year)		
Individual Maximum	$3,000	$3,000
Dependent Coverage Maximum	$6,000	$6,000
PHYSICIAN SERVICES		
Services at Physician's offices include, but are not limited to:		
Primary Care Physician's Office Visit	$15 per visit	30% co-insurance after deductible
Specialty Care Physician's Office Visits, Consultant and Referral Physician's Services	$30 per visit	30% co-insurance after deductible
Allergy Injections	No charge	30% co-insurance after deductible
Allergy Skin Testing	$30 per visit	30% co-insurance after deductible
PREVENTIVE CARE		
Preventive Care (as required by the Patient Protection Affordable Care Act "PPACA")	No charge	30% co-insurance after deductible
MAMMOGRAM, PSA, PAP SMEAR		
Preventive care related services (i.e. "routine" services)	No charge	30% co-insurance after deductible
Diagnostic related services (i.e. "non-routine")	$100 copay/ tests at hospital based facility; no charge at Jackson Health Systems, or independent\ non-hospital based facility	30% co-insurance after deductible

AVMED POS PLAN		
SCHEDULE OF BENEFITS	COST TO MEMBER	COST TO MEMBER
	In-Network	Out-of-Network*
INPATIENT HOSPITAL SERVICES		
Pre-Certification of Hospital Confinements	Handled by admitting physician	Pre-certification required
Hospital inpatient care includes: Room and board – unlimited days (semi-private)	$200 copay per admission (no charge at JHS facility)	30% co-insurance after deductible
Private Room	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	No charge	30% co-insurance after deductible
Inpatient Hospital Physician's Visits/Consultations	No charge	30% co-insurance after deductible
Inpatient/Outpatient Hospital Professional Services	No charge	30% co-insurance after deductible
OUTPATIENT FACILITY SERVICES		
Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	$100 copay\ no charge at Jackson Health Systems, or independent\ non-hospital based facility	30% co-insurance after deductible
EMERGENCY AND URGENT CARE SERVICES		
PCP's Office	$15 per visit	30% co-insurance after deductible
Specialist's Office	$30 per visit	30% co-insurance after deductible
Hospital Emergency Room	$100 per visit (waived if admitted)	$100 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	$50 per visit
DIAGNOSTIC\ LABORATORY AND RADIOLOGY SERVICES		
(includes pre-admission testing)		
Physician's office visit	No charge	30% co-insurance after deductible
Hospital facility	$100 copay (no charge at JHS facility)	30% co-insurance after deductible
Outpatient hospital facility	$100 copay (no charge at JHS facility)	30% co-insurance after deductible
Independent x-ray and/or laboratory facility	No charge at participating lab/ facility	30% co-insurance after deductible
ADVANCED RADIOLOGICAL IMAGING		
(i.e. MRI, MRA, CAT scan , PET scan, etc.) The scan copayment/deductible applies per type of scan per day		
Hospital Affiliated Facility	$100 copay (no charge at JHS facility)	30% co-insurance after deductible
Non-Hospital Affiliated Facility	No charge at participating facility	30% co-insurance after deductible
Physician's Office	No charge	30% co-insurance after deductible
OUTPATIENT SHORT-TERM REHABILITATIVE THERAPY AND CHIROPRACTIC SERVICES		
IN \OUT: Limited to 60 visits per calendar year: chiro services, rehab pulmonary, physical, speech, occupational, cognitive, and respiratory therapies combined; 36 visits per calendar year for cardiac rehab.		
Chiropractor	$15 per visit	30% co-insurance after deductible
Physical\ Speech\ Occupational Therapies, Pulmonary Rehab, Cognitive Therapy, Resp.Therapy	$30 per visit	30% co-insurance after deductible

2015 Medical Plan Summary - Redesign

AVMED POS PLAN		
SCHEDULE OF BENEFITS	COST TO MEMBER	COST TO MEMBER
	In-Network	**Out-of-Network***
MATERNITY CARE SERVICES		
Initial visit	$30 per visit	30% co-insurance after deductible
All subsequent prenatal visits, postnatal visits and Physician's delivery charges (i.e. global maternity fee)	No charge	30% co-insurance after deductible
Delivery facility (inpatient hospital, birthing center)	$200 copay\per admission, no charge at Jackson Health Systems	30% co-insurance after deductible
DURABLE MEDICAL EQUIPMENT		
Contract Year Maximum: Unlimited	No charge/ device for DME and Orthotics. External prosthetic appliance in network: no charge after $200 contract year deductible.	Not Covered
ACUPUNCTURE	Out-of-network coverage only	30% co-insurance after deductible
MENTAL HEALTH		
Outpatient	$15 per visit	30% co-insurance after deductible
Inpatient	$200 copay\per admission, no charge at Jackson Health Systems	30% co-insurance after deductible
Intensive Outpatient	$15 per visit	30% co-insurance after deductible
SUBSTANCE ABUSE		
Outpatient	$15 per visit	30% co-insurance after deductible
Inpatient		30% co-insurance after deductible
Intensive Outpatient	$15 per visit	30% co-insurance after deductible
DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDER (See plan limitations)		
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% co-insurance after deductible
Physical, Speech, Occupational Therapy	$15 per visit	30% co-insurance after deductible
PRESCRIPTION MEDICATION BENEFIT — RETAIL, 30 DAY SUPPLY (**INCLUDES CONTRACEPTIVES)		
Generic	$15	30% of charges
Preferred Brand	$40	30% of charges
Non-Preferred Brand	$55	30% of charges
SPECIALTY (30-DAY SUPPLY THROUGH SPECIALTY PHARMACY)		
Cost Sharing	$100.00	30% of charges
PRESCRIPTION MEDICATIONS - MAIL-ORDER, 90 DAY SUPPLY (**INCLUDES CONTRACEPTIVES)		
Generic	$30	30% of charges
Preferred Brand	$80	30% of charges
Non-Preferred Brand	$110	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). Charges in excess of MAP cannot be applied to out-of pocket maximum.		
**There is no copayment for Generic contraceptives, in accordance with provisions of the Patient Protection and Affordable Care Act (PPACA).		

AVMED HMO PLANS

This Schedule of Benefits reflects the higher provider and prescription copayments for 2015**. 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/mdc**.**

SCHEDULE OF BENEFITS	AVMED HMO HIGH	AVMED SELECT
	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	$3,000	$2,500
Dependent coverage	$6,000	$5,000
PRIMARY CARE PHYSICIAN		
Office visits	$15 per visit	$15 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	$15 per visit
SPECIALIST'S SERVICES	Open Access	Open Access
Office Visits	$30 per visit	$30 per visit
Annual gyn exam when performed by participating specialist	No Charge	No Charge
MATERNITY CARE SERVICES		
Initial visit	$30 copay	$30 copay
Subsequent visits	No charge	No charge
ALLERGY TREATMENTS		
Allergy Injections	$15 per visit	$15 per visit
Skin testing (per course of treatment)	$30 per visit	$30 per visit
HOSPITAL SERVICES - Inpatient care at participating hospitals includes:		
Room and board - unlimited days (semi-private)	$200 copay per admission (no charge at JHS facility)	No Charge
Physicians', specialists' and surgeons' svces	No charge	No Charge
Anesthesia, use of operating and recovery rooms, oxygen, drugs and medication	No charge	No Charge
Intensive care unit and other special units, general and special duty nursing	No charge	No Charge
Laboratory and diagnostic imaging	$100 copay; no charge if part of inpatient hospitalization	No Charge

AVMED HMO PLANS		
SCHEDULE OF BENEFITS	AVMED HMO HIGH	AVMED SELECT
	COST TO MEMBER	COST TO MEMBER
CHIROPRACTIC	$15 per visit	$15 per visit
PODIATRY	$15 per visit	$15 per visit
OUTPATIENT SERVICES		
Outpatient surgeries, including cardiac catheterizations and angioplasty	$100 copay; no charge at Jackson Health System facility	No charge
OUTPATIENT DIAGNOSTIC TESTS		
Complex radiological imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging)	$100 copay per test at hospital based facility; no charge at Jackson Health System or an independent/non-hospital based facility	No charge
Other diagnostic imaging tests and Laboratory		No charge
Mammogram		No charge
EMERGENCY SERVICES		
An emergency is the sudden and unexpected onset of a condition requiring immediate medical or surgical care.	Copay waived if admitted. Plan must be notified within 24 hours of emergency inpatient admission.	Copay waived if admitted. Plan notification required within 24 hours of emergency inpatient admission.
Emergency svces at participating hospitals	$100 copay	$50 copay
Emergency services - non-participating hospitals, facilities and/or physicians	$100 copay	$50 copay
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 copay	$25 copay
Medical Services at a participating retail clinic	$15 copay	$15 copay
Medical Services at a non-participating Urgent/ Immediate Care facility or non-participating retail clinic	$25 copay	$25 copay
AMBULANCE		
When pre-authorized or in the case of emergency	No charge	No charge
DRUG & ALCOHOL REHABILITATION PROGRAMS		
Outpatient	$15 per visit	$15 per visit
Inpatient	$200 copay \admission; no charge at Jackson Health Systems	No charge
MENTAL / NERVOUS DISORDERS		
Outpatient	$15 per visit	$15 per visit
Inpatient	$200 copay \admission; no charge at Jackson Health Systems	No charge

AVMED HMO PLANS		
SCHEDULE OF BENEFITS	AVMED HMO HIGH	AVMED SELECT
	COST TO MEMBER	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	$30 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	$15 per visit
Physical, Speech, Occupational Therapy	$15 per visit	$15 per visit
PRESCRIPTION MEDICATION BENEFIT — RETAIL, 30 DAY SUPPLY (*INCLUDES CONTRACEPTIVES)		
Generic	$15 copay	$15 copay
Preferred Brand	$40 copay	$25 copay
Non-Preferred Brand	$55 copay	$35 copay
SPECIALTY DRUGS (30-DAY SUPPLY THROUGH SPECIALTY PHARMACY) Retail		
Generic	$100 copay	$15 copay
Preferred Brand		$25 copay
Non-Preferred Brand		$35 copay
PRESCRIPTION MEDICATIONS - MAIL-ORDER, 90 DAY SUPPLY (*INCLUDES CONTRACEPTIVES)		
Generic	$30 copay	$30 copay
Preferred Brand	$80 copay	$50 copay
Non-Preferred Brand	$110 copay	$70 copay

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 Brand or Non-Preferred Brand copayment.

*There is no copayment 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, Certain Medications Including Injectables