SCHEDULE OF BENEFITS

Individual and Family Plan
AvMed Entrust Silver 350
Adult Dental + Vision 94% AV
IN-149006

This Schedule of Benefits outlines your cost-sharing and limitations that apply to specific covered services under your Plan. It is intended only to highlight your benefits. Your Medical and Hospital Service Contract provides a detailed description of coverage and the limitations and exclusions to these benefits. Please review your Contract for a complete explanation of your benefits and the terms and conditions of coverage. In general, benefits and services are not covered out-of-network except for Urgent and Emergency Medical Services and Care, and must be received at participating providers. See your AvMed online directory. Note: you may receive bills from one or more providers per visit or service. This Schedule of Benefits replaces any Schedule of Benefits previously in use.

SCHEDULE OF SERVICES	COST-TO-MEMBER
DEDUCTIBLE	**IN-NETWORK**
• **Individual / Family**	$0 / $0
The deductible is the amount you owe each calendar year for covered services before AvMed begins to pay. It may not apply to all services. Amounts paid toward the individual deductible apply toward any applicable family deductible. The most any covered family member will pay toward the family deductible is the individual deductible amount.	
OUT-OF-POCKET MAXIMUM	
• **Individual / Family**	$1,000 / $2,000
The out-of-pocket maximum is the most you pay each calendar year for covered services, such as deductible payments, copayments, and coinsurances. Once you reach the out-of-pocket maximum, AvMed will pay for your covered services for the rest of the year. Amounts paid toward the individual out-of-pocket maximum apply toward any applicable family out-of-pocket maximum. The most any covered family member will pay toward the family out-of-pocket maximum is the individual out-of-pocket maximum amount.	
PRIMARY CARE PHYSICIAN SERVICES	
• **Office visits** (including consultations)	No Charge
• **Services in Physicians' office include:**	
o Minor surgical procedures	No Charge
o Diagnostic imaging, radiology and laboratory services	No Charge
• **Virtual Visits** (services are available from AvMed designated Telehealth providers only)	No Charge
Additional charges may apply for other non-preventive services performed in the Physician's office. Office visit charges may also apply.	
SPECIALTY PHYSICIAN SERVICES	
• **Office visits** (including consultations)	$10 copay per visit
• **Services in Physicians' office include:**	
o Minor surgical procedures	$10 copay per visit
o Diagnostic laboratory services	No additional charge
o Simple diagnostic imaging	$10 copay per visit
o Complex diagnostic imaging	$10 copay per visit
Additional charges may apply for other non-preventive services performed in the Physician's office. Office visit charges may also apply.	
OTHER PHYSICIAN SERVICES	
• **Allergy injections and allergy skin testing**	$10 copay per visit
• **Podiatry services** o Routine foot care is limited to medically necessary services for individuals with diabetes, peripheral circulatory or neurovascular disease	No Charge
• **Diabetes self-management** o Includes care, education, and nutritional counseling	$10 copay per visit
Counseling by licensed nutritionist limited to 3 visits per calendar year. Additional charges may apply for other non-preventive services performed in the Physician's office. Office visit charges may also apply.	

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PREVENTIVE CARE AND SERVICES	
• **Preventive care services:** o Annual physical examinations and immunizations o Lactation support/counseling and breast pump supplies o Colorectal cancer screening, including colonoscopies o HIV screening o Preventive radiology and laboratory services o Prostate specific antigen (PSA) testing o Routine screening mammograms o Voluntary family planning services o Well-child care and immunizations, including routine vision and hearing screenings by a pediatrician o Well-woman examinations, including Pap smears	No Charge
For a comprehensive list of covered preventive services, visit https://www.healthcare.gov/coverage/preventive-care-benefits/.	
OUTPATIENT FACILITY SERVICES & DIAGNOSTIC TESTS	
• **OUTPATIENT FACILITY SERVICES**	
o **Outpatient surgeries** (include cardiac catheterizations and angioplasty)	25% coinsurance
o **Physician charges for surgical and medical services**	25% coinsurance
o **Dialysis services**	25% coinsurance
o **Radiation therapy** (covers administration and facility charges)	25% coinsurance
• **OUTPATIENT DIAGNOSTIC TESTS**	
o **Routine outpatient laboratory tests and blood work**	No Charge
o **Specialty labs**	25% coinsurance
o **Simple diagnostic tests** (including x-rays, ultrasounds, echocardiograms, fluoroscopes, diagnostic mammography, and other standard radiology services)	25% coinsurance
o **Complex diagnostic tests** (MRI, MRA, PET, CT, Nuclear Medicine)	25% coinsurance
Outpatient facility services require prior authorization. Please see your Contract for details.	
PRESCRIPTION DRUGS	
• **Tier 1: Preferred Generic Drugs**	No Charge (retail & mail order)
• **Tier 2: Generic Drugs**	$5 copay per prescription (retail); $12.50 copay per prescription (mail order)
• **Tier 3: Preferred Brand Drugs**	$20 copay per prescription (retail); $50 copay per prescription (mail order)
• **Tier 4: Non-Preferred Brand Drugs**	50% coinsurance (retail & mail order)
• **Tier 5: Specialty Drugs**	40% coinsurance (retail only)
• **Tier 6: Non-Preferred Specialty Drugs**	60% coinsurance (retail only)
Brand additional charge may apply if a Brand is selected when a Generic is available. Certain drugs require prior authorization. AvMed does not apply manufacturer or provider cost-share assistance program payments (e.g. manufacturer cost-share assistance, manufacturer discount plans, and/or manufacturer coupons) to the deductible or out-of-pocket maximums. Retail charge applies per 30-day supply. Mail-order charge applies per 60-90 day supply. AvMed's commercial Formulary List is available at www.avmed.org under the Preferred Medication Lists section.	

SCHEDULE OF SERVICES	COST-TO-MEMBER IN-NETWORK
INFUSION AND OTHER DRUG THERAPY	
• **Drug therapy administered by a medical professional**	
o in a Physician's office	$10 copay per visit
o in the home	No Charge
o in an outpatient facility	$20 copay per visit at independent facilities; 50% coinsurance at hospital-owned or affiliated facilities
Requires prior authorization	
• **Chemotherapy** (covers administration and facility charges)	50% coinsurance
Requires prior authorization	
IMMEDIATE / EMERGENCY CARE	
• **Emergency room services at participating or non-participating hospitals**	25% coinsurance
Charges for Physician services may also apply, and may be billed separately. AvMed must be notified within 24 hours of inpatient admission following emergency services or as soon as reasonably possible.	
• **Ambulance transport for emergency services**	
o Ground transport	$200 copay per one way ground transport
o Air and water transport	50% coinsurance
• **Non-emergent ambulance services** o Covered when the skill of medically trained personnel is required and the Member cannot be safely transported by other means	$200 copay per one way ground transport
Requires prior authorization	
• **Medical services at urgent/immediate care facilities**	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities
• **Medical services at retail clinics**	No Charge
INPATIENT HOSPITAL	
• **Inpatient services at hospitals includes:** o Room and board - unlimited days (semi-private) o Anesthesia, use of operating and recovery rooms, oxygen, drugs and medication o Intensive care unit and other special units, general and special duty nursing o Laboratory and diagnostic imaging o Required special diets o Radiation and inhalation therapies o Acute rehabilitation services (limited to 30 days per calendar year)	25% coinsurance
• **Physician charges for surgical and medical services**	25% coinsurance
Inpatient services require prior authorization.	
MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT	
• **Office visits**	No Charge
• **Partial hospitalization**	No Charge
• **Inpatient services**	
o Acute care for mental health and substance use disorders	25% coinsurance
o Intermediate care at residential treatment facilities	25% coinsurance
Inpatient and partial hospitalization services require prior authorization.	

SCHEDULE OF SERVICES	COST-TO-MEMBER IN-NETWORK
MATERNITY	
• **Pre- and post-natal care**	
o Routine office visits (including obstetrical and midwife services)	No Charge
o Specialist office visits	$10 copay per visit
• **Childbirth/delivery professional services**	
o Routine OB (including obstetrical and midwife services)	25% coinsurance
• **Childbirth/delivery facility services**	
o Hospital	25% coinsurance
o Birthing center	No Charge
Inpatient services require prior authorization. Maternity care may include tests and services described elsewhere in this document (e.g., ultrasound). For lactation support/counseling and breast pump supply benefits, please see the Preventive Care and Services section.	
RECOVERY	
• **Home health care**	$10 copay per visit
Coverage is limited to 20 skilled visits per calendar year. Approved treatment plan and prior authorization required.	
• **Rehabilitation services**	
o Short-term physical, occupational and speech therapies for acute conditions	$10 copay per visit
o Cardiac rehabilitation for the following conditions: ▪ Acute myocardial infarction ▪ Percutaneous transluminal coronary angioplasty (PTCA) ▪ Repair or replacement of heart valves ▪ Coronary artery bypass graft (CABG) ▪ Heart transplant	$10 copay per visit
o Pulmonary rehabilitation	$10 copay per visit
• **Chiropractic services**	No Charge
Coverage is limited to 35 visits per calendar year for outpatient rehabilitative PT, OT, ST, cardiac rehabilitation, pulmonary rehabilitation and chiropractic services combined. Cardiac and pulmonary rehabilitation require prior authorization.	
• **Habilitation services** o Physical, occupational and speech therapies	$10 copay per visit
Coverage is limited to a combined maximum of 35 visits per calendar year for outpatient habilitative physical, occupational and speech therapies.	
• **Skilled nursing facility**	$250 copay per admission
Coverage is limited to 60 days post-hospitalization care per calendar year. Requires prior authorization.	
• **Durable medical equipment** includes: o Standard hospital beds o Walkers o Crutches o Wheelchairs	$100 copay per episode of illness
Excludes vehicle modifications, home modifications, exercise equipment, and bathroom equipment.	
• **Orthotic appliances**	$100 copay per device
Coverage is limited to custom-made leg, arm, back, and neck braces.	
• **Prosthetic devices**	$100 copay per device
Coverage is limited to artificial limbs, artificial joints, cochlear implants, and ocular prostheses. Please see your Contract for more details.	
• **Hospice** o Inpatient and outpatient services	No Charge
Physician certification required	

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PEDIATRIC VISION AND DENTAL SERVICES	
• **Pediatric Vision**	
o One exam per calendar year to determine the need for sight correction	No Charge
o One pair of eye glasses per calendar year (Includes standard lenses and frames. Members may choose from a pre-selected group of frames.)	No Charge
• **Pediatric Dental** o Cost-sharing for dental services from Delta Dental Network providers is limited to a separate out-of-pocket maximum of $350 per child, or $700 for 2 or more children. The out-of-pocket maximum does not apply to Out-of-Network benefits. o Exams are limited to one every 6 months. Please see your Contract for details regarding benefits and cost-sharing.	No charge for preventive care from Delta Dental Network providers
ADULT DENTAL SERVICES	
• Exams are limited to one every 6 months. Please see your Contract for details regarding benefits and cost-sharing.	No charge for preventive care from Delta Dental Network providers
ADULT VISION SERVICES	
• One exam per calendar year to determine the need for sight correction	No Charge
• Members can use their allowance or maximize the benefit by choosing a frame from the iCare Grand Lux collection and select lenses for no out-of-pocket cost.	$150 allowance per calendar year
TEMPOROMANDIBULAR JOINT (TMJ) SYNDROME	
• Medically necessary treatment for conditions caused by congenital or developmental deformity, disease or injury.	Same as any other condition based on type of provider and location of services
Requires prior authorization	
TRANSPLANT SERVICES	
• AvMed In-Network Center of Excellence facilities in the State of Florida.	Same as any other condition based on type of provider and location of services
Requires prior authorization - Limitations apply - please see your Contract for details.	

ALL OTHER COVERED SERVICES

For cost-sharing information about items or services not listed in this document, please see your Contract, or call AvMed's Member Engagement Center at 1-800-477-8768. Please also call Member Engagement for assistance regarding claims, resolving a complaint, or for information about covered services. You may also log onto your secure Member portal at www.avmed.org which includes a health care cost estimator and information regarding Plan details.

DISCLAIMER:

This Schedule of Benefits is not a contract. Please see your AvMed Entrust Plan Medical and Hospital Service Contract for specific information on benefits, exclusions and limitations. This Plan will be administered in accordance with the requirements of state and federal law, including the Patient Protection and Affordable Care Act.