SCHEDULE OF BENEFITS

Individual and Family Plan
AvMed Entrust Silver 350
IN-1489

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**	$3,500 / $7,000
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**	$7,000 / $14,000
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 for first non-preventive visit; $30 copay per visit thereafter
• **Services in Physicians' office include:**	
o Minor surgical procedures	No additional charge
o Diagnostic imaging, radiology and laboratory services	No additional 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)	$60 copay per visit
• **Services in Physicians' office include:**	
o Minor surgical procedures	$60 copay per visit
o Diagnostic laboratory services	No additional charge
o Simple diagnostic imaging	$60 copay per visit
o Complex diagnostic imaging	$60 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**	$60 copay per visit
• **Podiatry services** o Routine foot care is limited to medically necessary services for individuals with diabetes, peripheral circulatory or neurovascular disease	$30 copay per visit
• **Diabetes self-management** o Includes care, education, and nutritional counseling	$60 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)	50% coinsurance after deductible
o **Physician charges for surgical and medical services**	50% coinsurance after deductible
o **Dialysis services**	50% coinsurance after deductible
o **Radiation therapy** (covers administration and facility charges)	50% coinsurance after deductible
• **OUTPATIENT DIAGNOSTIC TESTS**	
o **Routine outpatient laboratory tests and blood work**	$30 copay per visit
o **Specialty labs**	50% coinsurance after deductible
o **Simple diagnostic tests** (including x-rays, ultrasounds, echocardiograms, fluoroscopes, diagnostic mammography, and other standard radiology services)	50% coinsurance after deductible
o **Complex diagnostic tests** (MRI, MRA, PET, CT, Nuclear Medicine)	50% coinsurance after deductible
Outpatient facility services require prior authorization. Please see your Contract for details.	
PRESCRIPTION DRUGS	
• **Tier 1: Preferred Generic Drugs**	$20 copay per prescription (retail); $50 copay per prescription (mail order)
• **Tier 2: Generic Drugs**	$45 copay per prescription (retail); $112.50 copay per prescription (mail order)
• **Tier 3: Preferred Brand Drugs**	$80 copay per prescription (retail); $200 copay per prescription (mail order)
• **Tier 4: Non-Preferred Brand Drugs**	50% coinsurance after deductible (retail & mail order)
• **Tier 5: Specialty Drugs**	40% coinsurance after deductible (retail only)
• **Tier 6: Non-Preferred Specialty Drugs**	60% coinsurance after deductible (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.	

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INFUSION AND OTHER DRUG THERAPY	
• **Drug therapy administered by a medical professional**	
o in a Physician's office	$60 copay per visit
o in the home	$30 copay per visit
o in an outpatient facility	$120 copay per visit at independent facilities; 50% coinsurance after deductible at hospital-owned or affiliated facilities
Requires prior authorization	
• **Chemotherapy** (covers administration and facility charges)	50% coinsurance after deductible
Requires prior authorization	
IMMEDIATE / EMERGENCY CARE	
• **Emergency room services at participating or non-participating hospitals**	50% coinsurance after deductible
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 after deductible
• **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**	$40 copay per visit
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)	50% coinsurance after deductible
• **Physician charges for surgical and medical services**	50% coinsurance after deductible
Inpatient services require prior authorization.	
MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT	
• **Office visits**	$30 copay per visit
• **Partial hospitalization**	No Charge
• **Inpatient services**	
o Acute care for mental health and substance use disorders	50% coinsurance after deductible
o Intermediate care at residential treatment facilities	50% coinsurance after deductible
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)	$30 copay for first visit only; subsequent visits at no charge
o Specialist office visits	$60 copay per visit
• **Childbirth/delivery professional services**	
o Routine OB (including obstetrical and midwife services)	50% coinsurance after deductible
• **Childbirth/delivery facility services**	
o Hospital	50% coinsurance after deductible
o Birthing center	$30 copay per visit
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**	$60 copay per visit after deductible
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	$60 copay per visit at independent facilities; $60 copay per visit after deductible at hospital-owned or affiliated facilities
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	$60 copay per visit at independent facilities; $60 copay per visit after deductible at hospital-owned or affiliated facilities
o Pulmonary rehabilitation	$60 copay per visit at independent facilities; $60 copay per visit after deductible at hospital-owned or affiliated facilities
• **Chiropractic services**	$30 copay per visit
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	$60 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 day for the first 5 days per admission after deductible
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 after deductible
Excludes vehicle modifications, home modifications, exercise equipment, and bathroom equipment.	
• **Orthotic appliances**	$100 copay per device after deductible
Coverage is limited to custom-made leg, arm, back, and neck braces.	
• **Prosthetic devices**	$100 copay per device after deductible
Coverage is limited to artificial limbs, artificial joints, cochlear implants, and ocular prostheses. Please see your Contract for more details.	

SCHEDULE OF SERVICES	COST-TO-MEMBER IN-NETWORK
• **Hospice** o Inpatient and outpatient services *Physician certification required*	No charge after deductible
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
TEMPOROMANDIBULAR JOINT (TMJ) SYNDROME	
• Medically necessary treatment for conditions caused by congenital or developmental deformity, disease or injury. *Requires prior authorization*	Same as any other condition based on type of provider and location of services
TRANSPLANT SERVICES	
• AvMed In-Network Center of Excellence facilities in the State of Florida. *Requires prior authorization - Limitations apply - please see your Contract for details.*	Same as any other condition based on type of provider and location of services
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.	