Benefit Summary

STATE OF FLORIDA	SCHEDULE OF COPAYMENTS	COST TO MEMBER
OUT-OF-POCKET MAXIMUM		$1,500 INDIVIDUAL $3,000 FAMILY
PREVENTIVE CARE **NOT SUBJECT TO DEDUCTIBLE**	Preventive care services include, but are not limited to: ▪ Well-woman examinations, including Pap smears ▪ Annual physical examinations ▪ Immunizations ▪ Well-child care and immunizations, including routine vision and hearing screenings by a pediatrician for children under 18 ▪ Screening mammograms ▪ Colorectal cancer screening, including colonoscopies ▪ HIV screening	**NO CHARGE**
AVMED PRIMARY CARE PHYSICIAN	Services at participating doctors' offices include, but are not limited to: ▪ Routine office visits ▪ Minor surgical procedures ▪ Hearing examinations	$20 per visit
AVMED SPECIALIST'S SERVICES	No referral or Pre-Authorization required for: ▪ Office visits, consultation, diagnosis, and treatment	$40 per visit
HOSPITAL	Pre-Authorization required for Inpatient care. Inpatient care at participating hospitals includes: ▪ Room and board - unlimited days (semi-private) ▪ Physician's, specialist's and surgeon's services ▪ Anesthesia, use of operating and recovery rooms, oxygen, drugs and medication ▪ Intensive care unit and other special units, general and special duty nursing ▪ Laboratory and diagnostic imaging ▪ Required special diets ▪ Radiation and inhalation therapies	$250 per admission; 100% coverage thereafter
SURGERY	▪ Outpatient ▪ Inpatient	**NO CHARGE** $250 per admission; 100% coverage thereafter

VISION BENEFITS	▪ Routine annual eye exam
	  ▪ Primary Care Physician Services
	  ▪ Specialist Services
		
		$20 Co-payment
		$40 Co-payment

OUTPATIENT LAB AND X-RAY	▪ Diagnostic tests	**NO CHARGE**
EMERGENCY SERVICES	An emergency is the sudden and unexpected onset of a condition requiring immediate medical or surgical care. (Copayment waived if admitted.) ▪ Emergency room at participating hospitals and non-participating hospitals, facilities and/or Physicians Plan must be notified within 24 hours of emergency admission or as soon as reasonably possible.	$100 Co-payment
URGENT/IMMEDIATE CARE	▪ Medical Services at a participating Urgent/Immediate Care facility or services rendered after hours in your Primary Care Physician's office ▪ Medical Services at a participating retail clinic ▪ Medical Services at a non-participating Urgent/Immediate Care facility or non-participating retail clinic	$25 Co-payment

Benefit Summary

MENTAL HEALTH	▪ Inpatient	$250 per admission; 100% coverage thereafter
	▪ Outpatient	$20 per visit
ALCOHOL / DRUG TREATMENT	▪ Inpatient	$250 per admission; 100% coverage thereafter
	▪ Outpatient	$20 per visit
FAMILY PLANNING	▪ Family planning services	
	▪ Primary Care Physician services	$20 per visit
	▪ Specialist services	$40 per visit
	▪ Maternity care	
	▪ Outpatient	**NO CHARGE**
	▪ Inpatient	$250 per admission; 100% coverage thereafter
ALLERGY TREATMENTS	▪ Injections	
	▪ Primary Care Physician services	$20 per visit
	▪ Specialist services	$40 per visit
	▪ Skin testing	
	▪ Primary Care Physician services	$20 per course of testing
	▪ Specialist services	$40 per course of testing
AMBULANCE	▪ When pre-authorized or in the case of emergency	**NO CHARGE**
DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDER	▪ Applied Behavior Analysis services ▪ Physical, speech or occupational therapy Coverage for all services related to Autism Spectrum Disorder is limited to $36,000 annually and may not exceed $200,000 in total benefits.	$40 per visit
HOME HEALTH CARE	▪ Per occurrence	**NO CHARGE**
DURABLE MEDICAL EQUIPMENT	▪ Per device	**NO CHARGE**
REHABILITATIVE SERVICES	▪ Outpatient services limited to 60 visits per injury	$40 per visit
SKILLED NURSING FACILITIES	Pre-Authorization required. ▪ Up to 60 days maximum per calendar year	**NO CHARGE**
PROSTHETIC OR ORTHOTIC DEVICES	▪ Per device	**NO CHARGE**

FOR FURTHER INFORMATION, PLEASE CALL: 1-888-762-8633

This Schedule of Copayments is not a contract.
For specific information on benefits, exclusions and limitations, please see your State of Florida Employees' Group Insurance Policy.

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