

AvMed Health Plans
BASIC HMO CO-PAYMENT PLAN
SCHEDULE of BENEFIT Option 2

INDIVIDUAL LIFETIME MAXIMUM BENEFIT

\$2 Million Dollars

OUT-OF-POCKET MAXIMUM EXPENSE LIMITS

\$7,500 Single
 \$15,000 Family

The Covered Services set forth in this Schedule must be provided by and/or authorized by the Member's Primary Care Physician. Some services are subject to authorization by AvMed. Please consult the Certificate of Coverage for complete details regarding benefits, exclusions and limitations.

Hospital Services (including Maternity Care) <i>All Hospital care must be authorized by the Member's Primary Care Physician and AvMed.</i>	Member Responsibility <i>Co-payment paid at time of service</i>
Inpatient Hospital Care	\$750 Co-payment per day of an authorized Hospital Confinement
Outpatient Surgical Care	\$500 Co-payment per surgical procedure

Emergency Services and Care	Member Responsibility <i>Co-payment paid at time of service</i>
Emergency Room Visit At Hospital	\$250 Co-payment per visit (waived if admitted)
Ambulance	\$100 Co-payment per transport
Urgent Care	\$75 Co-payment per visit
<i>If the use of a Participating or Non-Participating Hospital Emergency Room is not due to an Emergency Medical Condition for a Condition covered by this Group Plan, the only payment made will be for the determination of whether an Emergency Medical Condition existed. If an Emergency Medical Condition did not exist, no further benefits will be paid.</i>	

Outpatient Medical Treatment and Services <i>must be provided by and/or authorized by the Member's Primary Care Physician.</i>	Member Responsibility <i>Co-payment paid at time of service</i>
Primary Care Physician Office Visit	\$25 Co-payment per visit
Specialist Office Visit	\$75 Co-payment per visit
Surgical Care in Ambulatory Surgical Center or other Outpatient Medical Treatment Facility	\$250 Co-payment per surgical procedure
Diagnostic Procedures (including EKG, lab tests, traditional x-ray exams)	No Co-payment
Imagery Services (including MRI, PET and CT scans)	\$200 Co-payment per service
Outpatient Rehabilitative Services (limited to 10 visits per Calendar Year)	\$25 Co-payment per visit
Non-surgical Spine and Back Disorder Treatment (limited to 10 visits per Calendar Year)	\$25 Co-payment per visit
Durable Medical Equipment, Prosthetics and Orthotics	No Co-payment

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Prescription Drugs * <i>Prescription Drugs and Oral Contraceptives filled or refilled at a Participating Pharmacy.</i>	Member Responsibility <i>Co-payment paid at time of service</i>
Preferred Generic Prescription Drug	\$10 Co-payment per prescription
Preferred Brand Prescription Drug	\$50 Co-payment per prescription
Non-Preferred Prescription Drug	\$100 Co-payment per prescription

Mental And Nervous Disorders <i>Services must be authorized by the Covered Person's Primary Care Physician and AvMed.</i>	Member Responsibility <i>Co-payment paid at time of service</i>
Inpatient Services in a Hospital or Psychiatric Treatment Facility. Maximum inpatient coverage of 5 days per Calendar Year	\$750 Co-payment per day for an authorized confinement
Outpatient Services Maximum outpatient coverage of 10 visits per Calendar Year, with a Maximum Reimbursement of \$50 per visit.	\$25 Co-payment per visit

Alcohol and Substance Abuse Treatment Services <i>must be authorized by the Covered Person's Primary Care Physician and AvMed. Inpatient or outpatient treatment or any combination of the two is limited to a Lifetime Maximum Benefit of \$2,000</i>	Member Responsibility <i>Co-payment paid at time of service</i>
Inpatient Services in a Hospital or Psychiatric Treatment Facility	\$750 Co-payment per day for an authorized confinement
Outpatient Services Maximum outpatient coverage of 44 office visits, with a Maximum Reimbursement of \$35 per visit.	\$25 Co-payment per visit

Special Services <i>All special services, as described in the Covered Services section, are subject to special conditions and limitations as stated below or as noted in the Certificate of Coverage.</i>	Member Responsibility <i>Co-payment paid at time of service</i>
Preventive Medical Care Services	
The following services are covered, subject to the Co-payments and the Calendar Year Maximum stated below. After the Calendar Year Maximum for these services has been reached, all Preventive Medical services are no longer covered under this Plan for the remainder of the Calendar Year. <i>Note: Carrier may waive cost sharing for these services or use an alternative cost sharing mechanism that does not exceed the level of a Primary Care Physician Office Visit.</i>	
CALENDAR YEAR MAXIMUM IS \$250	
Periodic Health Assessment Exam	See Note
Home Health Care (limited to 60 visits per Calendar Year)	\$25 Co-payment per visit
Hospice (in lieu of hospitalization)	No Co-payment
Skilled Nursing Facility (in lieu of hospitalization) Lifetime Benefit Maximum is 100 days.	No Co-payment

*Prescription Drug Co-payments do not contribute towards the Out-of-Pocket Maximum Expense Limit.