Benefit Summary

SMALL GROUP HM-OA-5057	SCHEDULE OF BENEFITS	COST TO MEMBER
CALENDAR YEAR DEDUCTIBLE	INDIVIDUAL/ FAMILY *The Deductible does not apply toward the Out-of-Pocket Maximum*	**$500 / $1,000 annually**
OUT-OF-POCKET MAXIMUM	INDIVIDUAL/ FAMILY per Calendar Year *The Out-of-Pocket Maximum includes Co-payments and Co-insurance amounts unless otherwise excluded*	**$1,500 / $3,000 annually**
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 Physicians' offices include, but are not limited to: ▪ Office visits ▪ Minor surgical procedures	$50 per visit
MATERNITY CARE	▪ Initial visit ▪ Subsequent visits	$50 Co-payment **NO CHARGE**
AVMED SPECIALTY HEALTH CARE PHYSICIAN SERVICES	▪ Office visits Additional charges will apply if complex outpatient diagnostic tests are performed in the Specialist's office.	$75 per visit
HOSPITAL	Inpatient care at Hospitals includes: ▪ Room and board – unlimited days (semi-private) ▪ Physicians', specialists' and surgeons' 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 day for the first 5 days, per admission; 100% coverage thereafter

OUTPATIENT SERVICES	▪ Outpatient surgeries, including cardiac catheterizations and angioplasty
	▪ Outpatient therapeutic services, including:
	  ▪ Drug infusion therapy
	  ▪ Injectable Drugs (Co-payment for Injectable Drug waived if incidental to same-day drug infusion therapy)
		$250 Co-payment
		
		$100 Co-payment
		$75 Co-payment

OUTPATIENT DIAGNOSTIC TESTS	▪ CAT Scan, PET Scan, MRI ▪ Other diagnostic imaging tests Charges for office visits will also apply if services are performed in a Specialist's office.	20% of the contracted rate, after Deductible
EMERGENCY SERVICES	An emergency is the sudden and unexpected onset of a condition requiring immediate medical or surgical care. (Co-payment waived if admitted) ▪ Emergency services at participating or non-participating Hospitals, facilities and/or physicians **AvMed must be notified within 24 hours of inpatient admission following emergency services or as soon as reasonably possible.**	$200 Co-payment

Benefit Summary, continued

Benefit	Description	Cost
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	$40 Co-payment $50 per visit $60 Co-payment
MENTAL HEALTH	▪ 20 outpatient visits	$75 per visit
INPATIENT MENTAL HEALTH AND PARTIAL HOSPITALIZATION	▪ Inpatient treatment of mental/nervous disorders shall be provided for up to 30 days per Calendar Year when a Member is admitted to a Hospital or Other Health Care Facility ▪ Partial hospitalization for mental health services is covered when provided in lieu of inpatient hospitalization and is combined with the inpatient hospital benefit. Two days of partial hospitalization will count as one day toward the inpatient mental health benefit	$250 per day for the first 5 days, per admission; 100% coverage thereafter
FAMILY PLANNING	▪ Voluntary family planning services ▪ Sterilization (In addition to any Outpatient Facility charge)	$50 per visit $250 Co-payment
ALLERGY TREATMENTS	▪ Injections ▪ Skin testing	$50 per visit $50 per course of testing
AMBULANCE	▪ Ambulance transport for emergency services ▪ Non-emergent ambulance services are covered when the skill of medically trained personnel is required and the Member cannot be safely transported by other means	$100 Co-payment
PHYSICAL, SPEECH AND OCCUPATIONAL THERAPIES	▪ Short-term physical, speech or occupational therapy for acute conditions **Coverage is limited to 30 visits per Calendar Year for all services combined**	$50 Co-payment
SKILLED NURSING FACILITIES AND REHABILITATION CENTERS	▪ Up to 20 days post-hospitalization care per Calendar Year when prescribed by physician and authorized by AvMed	20% of the contracted rate, after Deductible
CARDIAC REHABILITATION	Cardiac rehabilitation is covered for the following conditions: ▪ Acute myocardial infarction ▪ Percutaneous transluminal coronary angioplasty (PTCA) ▪ Repair or replacement of heart valves ▪ Coronary artery bypass graft (CABG), or ▪ Heart transplant **Coverage is limited to 18 visits per Calendar Year**	$50 per visit
HOME HEALTH CARE	▪ Limited to 60 skilled visits per Calendar Year	20% of the contracted rate, after Deductible
DURABLE MEDICAL EQUIPMENT AND ORTHOTIC APPLIANCES	Equipment includes: ▪ Hospital beds ▪ Walkers ▪ Crutches ▪ Wheelchairs Orthotic appliances are limited to: ▪ Leg, arm, back and neck custom-made braces	20% of the contracted rate, after Deductible **Benefits limited to $2,000 per Calendar Year**
PROSTHETIC DEVICES	Prosthetic devices are limited to: ▪ Artificial limbs ▪ Artificial joints ▪ Ocular prostheses	20% of the contracted rate, after Deductible

FOR ADDITIONAL INFORMATION, PLEASE CALL: 1-800-88-AVMED (1-800-882-8633)

This Schedule of Benefits is not a contract. For specific information on benefits, Exclusions and Limitations, please consult your AvMed Group Medical and Hospital Service Contract.

PLEASE NOTE: This benefit plan will be administered in accordance with the requirements of Health Care Reform.

Prescription Medication Benefits

$20/40/60/75 CO-PAYMENT with Contraceptives

DEFINITIONS

Brand medication means a Prescription Medication that is usually manufactured and sold under a name or trademark by a pharmaceutical manufacturer or a medication that is identified as a Brand medication by AvMed. AvMed delegates determination of Generic/Brand status to our Pharmacy Benefits Manager.

Brand Additional Charge means the additional charge that must be paid if you or your physician choose a Brand medication when a Generic equivalent is available. The charge is the difference between the cost of the Brand medication and the Generic medication. This charge must be paid in addition to the Non-Preferred Brand Co-payment.

Dental-specific Medication is medication used for dental-specific purposes, including but not limited to fluoride medications and medications packaged and labeled for dental-specific purposes.

Formulary List means the listing of preferred and non-preferred medications as determined by AvMed's Pharmacy and Therapeutics Committee based on clinical efficacy, relative safety and cost in comparison to similar medications within a therapeutic class. This multi-tiered list establishes different levels of Co-payment for medications within therapeutic classes. As new medications become available, they may be considered excluded until they have been reviewed by AvMed's Pharmacy and Therapeutics Committee.

Generic medication means a medication that has the same active ingredient as a Brand medication or is identified as a Generic medication by AvMed's Pharmacy Benefits Manager.

Maintenance Medication is a medication that has been approved by the FDA, for which the duration of therapy can reasonably be expected to exceed one year.

Participating Pharmacy means a pharmacy (retail, mail order or specialty pharmacy) that has entered into an agreement with AvMed to provide Prescription Medications to AvMed Members and has been designated by AvMed as a Participating Pharmacy.

Prescription Medication means a medication that has been approved by the FDA and that can only be dispensed pursuant to a prescription according to state and federal law.

Prior Authorization means the process of obtaining approval for certain Prescription Medications (prior to dispensing) according to AvMed's guidelines. The prescribing physician must obtain approval from AvMed. The list of Prescription Medications requiring Prior Authorization is subject to periodic review and modification by AvMed. A copy of the list of medications requiring Prior Authorization and the applicable criteria are available from Member Services or from the AvMed website.

Specialty Medications are high cost medications that are self-administered by members. These medications may be limited in distribution to participating specialty pharmacies and Prior Authorization is often required.

HOW DOES YOUR RETAIL PRESCRIPTION COVERAGE WORK?

To obtain your Prescription Medication, take your prescription to, or have your physician call, an AvMed Participating Pharmacy. Your physician should submit prescriptions for Specialty Medications to AvMed's specialty pharmacy. Present your prescription along with your AvMed identification card. Pay the following Co-payment (as well as the Brand Additional Charge if you or your physician choose a Brand product when a Generic equivalent is available).

Tier 1	Preferred Generic Medications:	$ 20.00	Co-payment
Tier 2	Preferred Brand Medications:	$ 40.00	Co-payment
Tier 3	Non-Preferred Brand or Generic Medications:	$ 60.00	Co-payment
Tier 4	Specialty Medications:	$ 75.00	Co-payment

ORDERING YOUR PRESCRIPTIONS THROUGH THE MAIL

Mail service is a benefit option for maintenance medications needed for chronic or long-term health conditions. It is best to get an initial prescription filled at your retail pharmacy. Ask your physician for an additional prescription for up to a 90-day supply of your medication to be ordered through mail service. Up to 3 refills are allowed per prescription. Pay the following Co-payment (as well as the Brand Additional Charge if you or your physician choose a Brand product when a Generic equivalent is available).

Tier 1	Preferred Generic Medications:	$ 40.00	Co-payment
Tier 2	Preferred Brand Medications:	$ 80.00	Co-payment
Tier 3	Non-Preferred Brand or Generic Medications:	$ 120.00	Co-payment
Tier 4	Specialty Medications are not available through mail service		

Prescription Medication Benefits, continued

WHAT IS COVERED?

- Your Prescription Medication coverage includes outpatient medications (including contraceptives) that require a prescription and are prescribed by your AvMed physician in accordance with AvMed's coverage criteria. AvMed reserves the right to make changes in coverage criteria for covered products and services. Coverage criteria are medical and pharmaceutical protocols used to determine payment of products and services and are based on independent clinical practice guidelines and standards of care established by government agencies and medical/pharmaceutical societies.

- Your Prescription Medication coverage may require Prior Authorization, including the Progressive Medication Program, for certain covered medications. The Progressive Medication Program encourages the use of therapeutically-equivalent lower-cost medications by requiring certain medications to be utilized to treat a medical condition prior to approving another medication for that condition. This includes the first-line use of preferred medications that are proven to be safe and effective for a given condition and can provide the same health benefit as more expensive non-preferred medications at a lower cost.

- Your retail Prescription Medication coverage includes up to a 30-day supply of a medication for the listed Co-payment. Your prescription may be refilled via retail or mail order after 75% of your previous fill has been used and subject to a maximum of 13 refills per year. You also have the opportunity to obtain a 90-day supply of medications used for chronic conditions including, but not limited to asthma, cardiovascular disease and diabetes from the retail pharmacy for the applicable Co-payment per 30-day supply. However, Prior Authorization may be required for covered medications.

- Your mail-order Prescription Medication coverage includes up to a 90-day supply of a routine maintenance medication for the listed Co-payment. If the amount of medication is less than a 90-day supply, you will still be charged the listed mail order Co-payment.

- Your Specialty Medication coverage extends to many injectable and high cost oral medications approved by the FDA. These medications must be prescribed by a physician and dispensed by a participating specialty pharmacy. The Co-payment levels for Specialty Medications apply regardless of provider. This means that you may be responsible for the appropriate Co-payment whether you receive your Specialty Medication from the pharmacy, at the physician's office or during home health visits. Specialty Medications are limited to a 30-day supply.

- Your Prescription Medication coverage includes coverage for injectable contraceptives. There is a Co-payment of $30 for each injection. If there is an office visit associated with the injection, there will be an additional Co-payment required for the office visit.

- Quantity limits are set in accordance with FDA approved prescribing limitations, general practice guidelines supported by medical specialty organizations, and/or evidence-based, statistically valid clinical studies without published conflicting data. This means that a medication-specific quantity limit may apply for medications that have an increased potential for over-utilization or an increased potential for a Member to experience an adverse effect at higher doses.

QUESTIONS? Call your AvMed Member Services Department at: 1-800-88-AvMed (1-800-882-8633)

EXCLUSIONS AND LIMITATIONS

- Medications which do not require a prescription (i.e. over-the-counter medications) or when a non-prescription alternative is available, unless otherwise indicated on AvMed's Formulary List.
- Medications not included on AvMed's Formulary List.
- Medical supplies, including therapeutic devices, dressings, appliances and support garments
- Replacement Prescription Medication products resulting from a lost, stolen, expired, broken or destroyed prescription order or refill
- Diaphragms and other contraceptive devices
- Fertility Medications
- Medications or devices for the diagnosis or treatment of sexual dysfunction
- Dental-specific Medications for dental purposes, including fluoride medications
- Prescription and non-prescription vitamins and minerals except prenatal vitamins
- Nutritional supplements
- Immunizations
- Allergy serums, medications administered by the Attending Physician to treat the acute phase of an illness and chemotherapy for cancer patients are covered in accordance with the Group Medical and Hospital Service Contract and may be subject to Co-payments or Co-insurance as outlined on the Schedule of Benefits
- Investigational and experimental Medications (except as required by Florida statute)
- Cosmetic products, including, but not limited to, hair growth, skin bleaching, sun damage and anti-wrinkle medications
- Nicotine suppressants and smoking cessation products and services
- Prescription and non-prescription appetite suppressants and products for the purpose of weight loss
- Compounded prescriptions, except pediatric preparations
- Medications and immunizations for non-business related travel, including Transdermal Scopolamine

Filling a prescription at a pharmacy is not a claim for benefits and is not subject to the Claims and Appeals procedures under ERISA. However, any medicines that require Prior authorization will be treated as a claim for benefits subject to the Claims and Appeals Procedures, as outlined in the Group Medical and Hospital Service Contract.

Amendment

Prescription Medication Benefits

As of the effective date, the Prescription Medication Benefit Amendment is modified by the addition of the following:

AvMed covers the following Generic preventive medications at no cost, with a written prescription from a member's treating physician and when filled at a participating retail pharmacy (excludes mail-order and specialty pharmacies):

- **Aspirin 80 to 325 mg once a day**, when prescribed for men 45-79 years of age, or women 55-79 years of age;
- **Folic Acid 0.4 to 0.8 mg once a day**, when prescribed for women 15-50 years of age. Prior authorization is required if prescribed for women below the age of 15 or above the age of 50;
- **Iron supplements**, when prescribed for infants through 12 months of age;
- **Fluoride supplements**, when prescribed for children below 18 years of age. Prior authorization is required.

NOTE: These benefits will be administered in accordance with the requirements of Health Care Reform