SCHEDULE OF BENEFITS

Individual and Family Plan
Empower MS400-IN21
IN-1480

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. 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 TIER A**	**IN-NETWORK TIER B**	**OUT-OF-NETWORK**
• **Individual / Family**	$4,500 / $9,000	$4,500 / $9,000	$13,500 / $27,000
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	$7,000 / $14,000	$21,000 / $42,000
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	$60 copay per visit	50% coinsurance after deductible
• **Services in Physicians' office include:**			
o Minor surgical procedures	No additional charge	No additional charge	50% coinsurance after deductible
o Diagnostic imaging, radiology and laboratory services	No additional charge	No additional charge	50% coinsurance after deductible
• **Virtual Visits** (services are available from AvMed designated Telehealth providers only)	No Charge	Not Covered	Not Covered
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	$120 copay per visit	50% coinsurance after deductible
• **Services in Physicians' office include:**			
o Minor surgical procedures	$60 copay per visit	$120 copay per visit	50% coinsurance after deductible
o Diagnostic laboratory services	No additional charge	No additional charge	50% coinsurance after deductible
o Simple diagnostic imaging	$60 copay per visit	$120 copay per visit	50% coinsurance after deductible
o Complex diagnostic imaging	$60 copay per visit	$120 copay per visit	50% coinsurance after deductible
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	$120 copay per visit	50% coinsurance after deductible

SCHEDULE OF SERVICES	COST-TO-MEMBER IN-NETWORK TIER A	IN-NETWORK TIER B	OUT-OF-NETWORK
• **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	$60 copay per visit	50% coinsurance after deductible
• **Diabetes self-management** o Includes care, education, and nutritional counseling	$60 copay per visit	$120 copay per visit	50% coinsurance after deductible
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.			
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	No Charge	50% coinsurance after deductible
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)	$750 copay per visit after deductible	50% coinsurance after deductible	50% coinsurance after deductible
o **Physician charges for surgical and medical services**	No charge after deductible	50% coinsurance after deductible	50% coinsurance after deductible
o **Dialysis services**	$750 copay per visit after deductible	50% coinsurance after deductible	Not Covered
o **Radiation therapy** (covers administration and facility charges)	$750 copay per course of treatment after deductible	50% coinsurance after deductible	50% coinsurance after deductible
• **OUTPATIENT DIAGNOSTIC TESTS**			
o **Routine outpatient laboratory tests and blood work**	$30 copay per visit	$30 copay per visit	50% coinsurance after deductible
o **Specialty labs**	$750 copay per visit after deductible	50% coinsurance after deductible	50% coinsurance after deductible
o **Simple diagnostic tests** (including x-rays, ultrasounds, echocardiograms, fluoroscopes, diagnostic mammography, and other standard radiology services)	$75 copay per visit at independent facilities; $150 copay per visit at hospital-owned or affiliated facilities	50% coinsurance after deductible	50% coinsurance after deductible

SCHEDULE OF SERVICES	COST-TO-MEMBER		
	IN-NETWORK TIER A	IN-NETWORK TIER B	OUT-OF-NETWORK
o **Complex diagnostic tests** (MRI, MRA, PET, CT, Nuclear Medicine)	$275 copay per visit at independent facilities; $550 copay per visit at hospital-owned or affiliated facilities	50% coinsurance after deductible	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)	$20 copay per prescription (retail); $50 copay per prescription (mail order)	Not Covered
• **Tier 2: Generic Drugs**	$40 copay per prescription (retail); $100 copay per prescription (mail order)	$40 copay per prescription (retail); $100 copay per prescription (mail order)	Not Covered
• **Tier 3: Preferred Brand Drugs**	$80 copay per prescription (retail); $200 copay per prescription (mail order)	$80 copay per prescription (retail); $200 copay per prescription (mail order)	Not Covered
• **Tier 4: Non-Preferred Brand Drugs**	$100 copay per prescription (retail); $250 copay per prescription (mail order)	$100 copay per prescription (retail); $250 copay per prescription (mail order)	Not Covered
• **Tier 5: Specialty Drugs**	40% coinsurance after deductible (retail only)	40% coinsurance after deductible (retail only)	Not Covered
• **Tier 6: Non-Preferred Specialty Drugs**	60% coinsurance after deductible (retail only)	60% coinsurance after deductible (retail only)	Not Covered

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 TIER A	IN-NETWORK TIER B	OUT-OF-NETWORK
INFUSION AND OTHER DRUG THERAPY			
• **Drug therapy administered by a medical professional**			
o in a Physician's office	$60 copay per visit	$120 copay per visit	50% coinsurance after deductible
o in the home	$30 copay per visit	$60 copay per visit	50% coinsurance after deductible
o in an outpatient facility	$120 copay per visit at independent facilities; 50% coinsurance after deductible at hospital-owned or affiliated facilities	$240 copay per visit at independent facilities; 50% coinsurance after deductible at hospital-owned or affiliated facilities	50% coinsurance after deductible
Requires prior authorization			
• **Chemotherapy** (covers administration and facility charges)	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible
Requires prior authorization			
IMMEDIATE / EMERGENCY CARE			
• **Emergency room services at participating or non-participating hospitals** (copay waived if admitted)	$500 copay per visit after deductible	$500 copay per visit after deductible	$500 copay per visit after In-Network 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	$200 copay per one way ground transport	$200 copay per one way ground transport
o Air and water transport	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after In-Network 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	$200 copay per one way ground transport	$200 copay per one way ground transport
Requires prior authorization			
• **Medical services at urgent/immediate care facilities**	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities
• **Medical services at retail clinics**	$40 copay per visit	$40 copay per visit	$40 copay per visit

SCHEDULE OF SERVICES	COST-TO-MEMBER IN-NETWORK TIER A	IN-NETWORK TIER B	OUT-OF-NETWORK
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)	$800 copay per day for the first 3 days per admission after deductible	50% coinsurance after deductible	50% coinsurance after deductible
• **Physician charges for surgical and medical services** *Inpatient services require prior authorization.*	No charge after deductible	50% coinsurance after deductible	50% coinsurance after deductible
MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT			
• **Office visits**	$30 copay per visit	$60 copay per visit	50% coinsurance after deductible
• **Partial hospitalization**	No Charge	No Charge	50% coinsurance after deductible
• **Inpatient services**			
o Acute care for mental health and substance use disorders	$800 copay per day for the first 3 days per admission after deductible	50% coinsurance after deductible	50% coinsurance after deductible
o Intermediate care at residential treatment facilities	$800 copay per day for the first 3 days per admission after deductible	50% coinsurance after deductible	50% coinsurance after deductible
Inpatient and partial hospitalization services require prior authorization.			
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	$60 copay for first visit only; subsequent visits at no charge	50% coinsurance after deductible
o Specialist office visits	$60 copay per visit	$120 copay per visit	50% coinsurance after deductible
• **Childbirth/delivery professional services**			
o Routine OB (including obstetrical and midwife services)	No charge after deductible	50% coinsurance after deductible	50% coinsurance after deductible
• **Childbirth/delivery facility services**			
o Hospital	$800 copay per day for the first 3 days per admission after deductible	50% coinsurance after deductible	50% coinsurance after deductible
o Birthing center	$30 copay per visit	$60 copay per visit	50% coinsurance after deductible
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.			

SCHEDULE OF SERVICES	COST-TO-MEMBER IN-NETWORK TIER A	IN-NETWORK TIER B	OUT-OF-NETWORK
RECOVERY			
• **Home health care**	$60 copay per visit after deductible	50% coinsurance after deductible	50% coinsurance 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; $120 copay per visit after deductible at hospital-owned or affiliated facilities	$60 copay per visit at independent facilities; $120 copay per visit after deductible at hospital-owned or affiliated facilities	50% coinsurance after deductible
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; $120 copay per visit after deductible at hospital-owned or affiliated facilities	$60 copay per visit at independent facilities; $120 copay per visit after deductible at hospital-owned or affiliated facilities	50% coinsurance after deductible
o Pulmonary rehabilitation	$60 copay per visit at independent facilities; $120 copay per visit after deductible at hospital-owned or affiliated facilities	$60 copay per visit at independent facilities; $120 copay per visit after deductible at hospital-owned or affiliated facilities	50% coinsurance after deductible
• **Chiropractic services**	$30 copay per visit	$60 copay per visit	50% coinsurance after deductible
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	$120 copay per visit	50% coinsurance after deductible
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	50% coinsurance after deductible	50% coinsurance 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	50% coinsurance after deductible	50% coinsurance after deductible
Excludes vehicle modifications, home modifications, exercise equipment, and bathroom equipment.			
• **Orthotic appliances**	$100 copay per device after deductible	50% coinsurance after deductible	50% coinsurance after deductible
Coverage is limited to custom-made leg, arm, back, and neck braces.			

SCHEDULE OF SERVICES	COST-TO-MEMBER IN-NETWORK TIER A	IN-NETWORK TIER B	OUT-OF-NETWORK
• **Prosthetic devices**	$100 copay per device after deductible	50% coinsurance after deductible	50% coinsurance after deductible
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 after deductible	No charge after deductible	50% coinsurance after deductible
Physician certification required			
PEDIATRIC VISION AND DENTAL SERVICES			
• **Pediatric Vision**			
o One exam per calendar year to determine the need for sight correction	No Charge	No Charge	50% coinsurance after deductible
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	No Charge	50% coinsurance after deductible
• **Pediatric Dental** o Dental services are subject to a separate calendar year deductible of $65 per child. 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	No charge for preventive care from Delta Dental Network providers	Preventive care may be subject to cost-sharing if billed charges exceed allowed amount.
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	Same as any other condition based on type of provider and location of services	50% coinsurance after deductible
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	Same as any other condition based on type of provider and location of services	Not Covered
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 Individual and Family Plan Empower 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.