SCHEDULE OF BENEFITS

Individual and Family Plan
AvMed Entrust Silver 550
Limited Cost Share
IN-149303

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	**INDIAN HEALTH CARE PROVIDER (IHCP)**	**NON-IHCP IN-NETWORK PROVIDER (YOU WILL PAY MORE THAN IHCP TIER)**	**NON-IHCP OUT-OF-NETWORK PROVIDER(YOU WILL PAY THE MOST)**
• **Individual / Family**	$6,500 / $13,000	$6,500 / $13,000	Not Applicable
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	Not Applicable
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	$55 copay per visit	Not Covered
• **Services in Physicians' office include:**			
o Minor surgical procedures	No Charge	No additional charge	Not Covered
o Diagnostic imaging, radiology and laboratory services	No Charge	No additional charge	Not Covered
• **Virtual Visits** (services are available from AvMed designated Telehealth providers only)	No Charge	No Charge	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)	No Charge	$110 copay per visit	Not Covered
• **Services in Physicians' office include:**			
o Minor surgical procedures	No Charge	$110 copay per visit	Not Covered
o Diagnostic laboratory services	No Charge	No additional charge	Not Covered
o Simple diagnostic imaging	No Charge	$110 copay per visit	Not Covered
o Complex diagnostic imaging	No Charge	$110 copay per visit	Not Covered
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**	No Charge	$110 copay per visit	Not Covered

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• **Podiatry services** o Routine foot care is limited to medically necessary services for individuals with diabetes, peripheral circulatory or neurovascular disease	No Charge	$55 copay per visit	Not Covered
• **Diabetes self-management** o Includes care, education, and nutritional counseling	No Charge	$110 copay per visit	Not Covered
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	Not Covered
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)	No Charge	$500 copay per visit after deductible	Not Covered
o **Physician charges for surgical and medical services**	No Charge	No charge after deductible	Not Covered
o **Dialysis services**	No Charge	$500 copay per visit after deductible	Not Covered
o **Radiation therapy** (covers administration and facility charges)	No Charge	$500 copay per course of treatment after deductible	Not Covered
• **OUTPATIENT DIAGNOSTIC TESTS**			
o **Routine outpatient laboratory tests and blood work**	No Charge	$35 copay per visit	Not Covered
o **Specialty labs**	No Charge	$500 copay per visit after deductible	Not Covered

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o **Simple diagnostic tests** (including x-rays, ultrasounds, echocardiograms, fluoroscopes, diagnostic mammography, and other standard radiology services)	No Charge	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	Not Covered
o **Complex diagnostic tests** (MRI, MRA, PET, CT, Nuclear Medicine)	No Charge	$325 copay per visit at independent facilities; $650 copay per visit at hospital-owned or affiliated facilities	Not Covered
Outpatient facility services require prior authorization. Please see your Contract for details.			
PRESCRIPTION DRUGS			
• **Tier 1: Preferred Generic Drugs**	No Charge	$25 copay per prescription (retail); $62.50 copay per prescription (mail order)	Not Covered
• **Tier 2: Generic Drugs**	No Charge	$45 copay per prescription (retail); $112.50 copay per prescription (mail order)	Not Covered
• **Tier 3: Preferred Brand Drugs**	No Charge	$65 copay per prescription (retail); $162.50 copay per prescription (mail order)	Not Covered
• **Tier 4: Non-Preferred Brand Drugs**	No Charge	$105 copay per prescription (retail); $262.50 copay per prescription (mail order)	Not Covered
• **Tier 5: Specialty Drugs**	No Charge	40% coinsurance after deductible (retail only)	Not Covered
• **Tier 6: Non-Preferred Specialty Drugs**	No Charge	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.			

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INFUSION AND OTHER DRUG THERAPY			
• **Drug therapy administered by a medical professional**			
o in a Physician's office	No Charge	$110 copay per visit	Not Covered
o in the home	No Charge	$55 copay per visit	Not Covered
o in an outpatient facility	No Charge	$220 copay per visit at independent facilities; 50% coinsurance after deductible at hospital-owned or affiliated facilities	Not Covered
Requires prior authorization			
• **Chemotherapy** (covers administration and facility charges)	No Charge	50% coinsurance after deductible	Not Covered
Requires prior authorization			
IMMEDIATE / EMERGENCY CARE			
• **Emergency room services at participating or non-participating hospitals**	No Charge	$500 copay per visit after deductible	$500 copay per visit 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	No Charge	$200 copay per one way ground transport	$200 copay per one way ground transport
o Air and water transport	No Charge	50% after deductible	50% 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	No Charge	$200 copay per one way ground transport	$200 copay per one way ground transport
Requires prior authorization			
• **Medical services at urgent/immediate care facilities**	No Charge	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities
• **Medical services at retail clinics**	No Charge	$65 copay per visit	Not Covered

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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)	No Charge	$500 copay per admission after deductible	Not Covered
• **Physician charges for surgical and medical services**	No Charge	No charge after deductible	Not Covered
Inpatient services require prior authorization.			
MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT			
• **Office visits**	No Charge	$55 copay per visit	Not Covered
• **Partial hospitalization**	No Charge	No Charge	Not Covered
• **Inpatient services**			
o Acute care for mental health and substance use disorders	No Charge	$500 copay per admission after deductible	Not Covered
o Intermediate care at residential treatment facilities	No Charge	$500 copay per admission after deductible	Not Covered
Inpatient and partial hospitalization services require prior authorization.			
MATERNITY			
• **Pre- and post-natal care**			
o Routine office visits (including obstetrical and midwife services)	No Charge	$55 copay for first visit only; subsequent visits at no charge	Not Covered
o Specialist office visits	No Charge	$110 copay per visit	Not Covered
• **Childbirth/delivery professional services**			
o Routine OB (including obstetrical and midwife services)	No Charge	No charge after deductible	Not Covered
• **Childbirth/delivery facility services**			
o Hospital	No Charge	$500 copay per admission after deductible	Not Covered
o Birthing center	No Charge	$55 copay per visit	Not Covered
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.			

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RECOVERY			
• **Home health care**	No Charge	$110 copay per visit after deductible	Not Covered
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	No Charge	$110 copay per visit at independent facilities; $110 copay per visit after deductible at hospital-owned or affiliated facilities	Not Covered
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	No Charge	$110 copay per visit at independent facilities; $110 copay per visit after deductible at hospital-owned or affiliated facilities	Not Covered
o Pulmonary rehabilitation	No Charge	$110 copay per visit at independent facilities; $110 copay per visit after deductible at hospital-owned or affiliated facilities	Not Covered
• **Chiropractic services**	No Charge	$55 copay per visit	Not Covered
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	No Charge	$110 copay per visit	Not Covered
Coverage is limited to a combined maximum of 35 visits per calendar year for outpatient habilitative physical, occupational and speech therapies.			
• **Skilled nursing facility**	No Charge	$250 copay per day for the first 2 days per admission after deductible	Not Covered
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	No Charge	$100 copay per episode of illness after deductible	Not Covered
Excludes vehicle modifications, home modifications, exercise equipment, and bathroom equipment.			
• **Orthotic appliances**	No Charge	$100 copay per device after deductible	Not Covered

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Coverage is limited to custom-made leg, arm, back, and neck braces.			
• **Prosthetic devices**	No Charge	$100 copay per device after deductible	Not Covered
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	No charge after deductible	Not Covered
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	Not Covered
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	Not Covered
• **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	No charge for preventive care from Delta Dental Network providers	Not Covered
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	Not Covered
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.			

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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.