



SCHEDULE OF BENEFITS

Individual and Family Plan
 AvMed Entrust Silver 350
 Adult Dental + Vision
 Limited Cost Share
 IN-149003

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		
	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)

<ul style="list-style-type: none"> Individual / Family 	\$3,500 / \$7,000	\$3,500 / \$7,000	Not Applicable
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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

<ul style="list-style-type: none"> Individual / Family 	\$7,000 / \$14,000	\$7,000 / \$14,000	Not Applicable
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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

<ul style="list-style-type: none"> Office visits (including consultations) 	No Charge	\$30 copay per visit	Not Covered
<ul style="list-style-type: none"> Services in Physicians' office include: <ul style="list-style-type: none"> Minor surgical procedures Diagnostic imaging, radiology and laboratory services 	No Charge	No additional charge	Not Covered
<ul style="list-style-type: none"> 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

<ul style="list-style-type: none"> Office visits (including consultations) 	No Charge	\$60 copay per visit	Not Covered
<ul style="list-style-type: none"> Services in Physicians' office include: <ul style="list-style-type: none"> Minor surgical procedures Diagnostic laboratory services Simple diagnostic imaging Complex diagnostic imaging 	No Charge	\$60 copay per visit	Not Covered
	No Charge	No additional charge	Not Covered
	No Charge	\$60 copay per visit	Not Covered
	No Charge	\$60 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

<ul style="list-style-type: none"> Allergy injections and allergy skin testing 	No Charge	\$60 copay per visit	Not Covered
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<ul style="list-style-type: none"> • Podiatry services <ul style="list-style-type: none"> ○ Routine foot care is limited to medically necessary services for individuals with diabetes, peripheral circulatory or neurovascular disease 	No Charge	\$30 copay per visit	Not Covered
<ul style="list-style-type: none"> • Diabetes self-management <ul style="list-style-type: none"> ○ Includes care, education, and nutritional counseling 	No Charge	\$60 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

<ul style="list-style-type: none"> • Preventive care services: <ul style="list-style-type: none"> ○ Annual physical examinations and immunizations ○ Lactation support/counseling and breast pump supplies ○ Colorectal cancer screening, including colonoscopies ○ HIV screening ○ Preventive radiology and laboratory services ○ Prostate specific antigen (PSA) testing ○ Routine screening mammograms ○ Voluntary family planning services ○ Well-child care and immunizations, including routine vision and hearing screenings by a pediatrician ○ Well-woman examinations, including Pap smears 	No Charge	No Charge	Not Covered
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For a comprehensive list of covered preventive services, visit <https://www.healthcare.gov/coverage/preventive-care-benefits/>.

OUTPATIENT FACILITY SERVICES & DIAGNOSTIC TESTS

<ul style="list-style-type: none"> • OUTPATIENT FACILITY SERVICES <ul style="list-style-type: none"> ○ Outpatient surgeries (include cardiac catheterizations and angioplasty) ○ Physician charges for surgical and medical services ○ Dialysis services ○ Radiation therapy (covers administration and facility charges) 	No Charge	50% coinsurance after deductible	Not Covered
<ul style="list-style-type: none"> • OUTPATIENT DIAGNOSTIC TESTS <ul style="list-style-type: none"> ○ Routine outpatient laboratory tests and blood work ○ Specialty labs 	No Charge	\$30 copay per visit	Not Covered
	No Charge	50% coinsurance after deductible	Not Covered



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<ul style="list-style-type: none"> ○ Simple diagnostic tests (including x-rays, ultrasounds, echocardiograms, fluoroscopes, diagnostic mammography, and other standard radiology services) 	No Charge	50% coinsurance after deductible	Not Covered
<ul style="list-style-type: none"> ○ Complex diagnostic tests (MRI, MRA, PET, CT, Nuclear Medicine) 	No Charge	50% coinsurance after deductible	Not Covered

Outpatient facility services require prior authorization. Please see your Contract for details.

PRESCRIPTION DRUGS			
<ul style="list-style-type: none"> • Tier 1: Preferred Generic Drugs 	No Charge	\$20 copay per prescription (retail); \$50 copay per prescription (mail order)	Not Covered
<ul style="list-style-type: none"> • Tier 2: Generic Drugs 	No Charge	\$45 copay per prescription (retail); \$112.50 copay per prescription (mail order)	Not Covered
<ul style="list-style-type: none"> • Tier 3: Preferred Brand Drugs 	No Charge	\$80 copay per prescription (retail); \$200 copay per prescription (mail order)	Not Covered
<ul style="list-style-type: none"> • Tier 4: Non-Preferred Brand Drugs 	No Charge	50% coinsurance after deductible (retail & mail order)	Not Covered
<ul style="list-style-type: none"> • Tier 5: Specialty Drugs 	No Charge	40% coinsurance after deductible (retail only)	Not Covered
<ul style="list-style-type: none"> • 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			
<ul style="list-style-type: none"> Drug therapy administered by a medical professional <ul style="list-style-type: none"> in a Physician's office in the home in an outpatient facility 	No Charge No Charge No Charge	\$60 copay per visit \$30 copay per visit \$120 copay per visit at independent facilities; 50% coinsurance after deductible at hospital-owned or affiliated facilities	Not Covered Not Covered Not Covered
<i>Requires prior authorization</i>			
<ul style="list-style-type: none"> Chemotherapy (covers administration and facility charges) 	No Charge	50% coinsurance after deductible	Not Covered
<i>Requires prior authorization</i>			
IMMEDIATE / EMERGENCY CARE			
<ul style="list-style-type: none"> Emergency room services at participating or non-participating hospitals 	No Charge	50% coinsurance after deductible	50% coinsurance after In-Network deductible
<i>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.</i>			
<ul style="list-style-type: none"> Ambulance transport for emergency services <ul style="list-style-type: none"> Ground transport Air and water transport 	No Charge No Charge	\$200 copay per one way ground transport 50% coinsurance after deductible	\$200 copay per one way ground transport 50% coinsurance after In-Network deductible
<ul style="list-style-type: none"> Non-emergent ambulance services <ul style="list-style-type: none"> 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
<i>Requires prior authorization</i>			
<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> Medical services at retail clinics 	No Charge	\$40 copay per visit	Not Covered



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INPATIENT HOSPITAL

<ul style="list-style-type: none"> Inpatient services at hospitals includes: <ul style="list-style-type: none"> Room and board - unlimited days (semi-private) 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 Acute rehabilitation services (limited to 30 days per calendar year) 	No Charge	50% coinsurance after deductible	Not Covered
<ul style="list-style-type: none"> Physician charges for surgical and medical services <i>Inpatient services require prior authorization.</i> 	No Charge	50% coinsurance after deductible	Not Covered

MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT

<ul style="list-style-type: none"> Office visits 	No Charge	\$30 copay per visit	Not Covered
<ul style="list-style-type: none"> Partial hospitalization 	No Charge	No Charge	Not Covered
<ul style="list-style-type: none"> Inpatient services <ul style="list-style-type: none"> Acute care for mental health and substance use disorders Intermediate care at residential treatment facilities 	No Charge	50% coinsurance after deductible	Not Covered
	No Charge	50% coinsurance after deductible	Not Covered

Inpatient and partial hospitalization services require prior authorization.

MATERNITY

<ul style="list-style-type: none"> Pre- and post-natal care <ul style="list-style-type: none"> Routine office visits (including obstetrical and midwife services) Specialist office visits 	No Charge	\$30 copay for first visit only; subsequent visits at no charge	Not Covered
	No Charge	\$60 copay per visit	Not Covered
<ul style="list-style-type: none"> Childbirth/delivery professional services <ul style="list-style-type: none"> Routine OB (including obstetrical and midwife services) 	No Charge	50% coinsurance after deductible	Not Covered
<ul style="list-style-type: none"> Childbirth/delivery facility services <ul style="list-style-type: none"> Hospital Birth center 	No Charge	50% coinsurance after deductible	Not Covered
	No Charge	\$30 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.

RECOVERY

<ul style="list-style-type: none"> Home health care 	No Charge	\$60 copay per visit after deductible	Not Covered
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Coverage is limited to 20 skilled visits per calendar year. Approved treatment plan and prior authorization required.



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<ul style="list-style-type: none"> • Rehabilitation services <ul style="list-style-type: none"> ○ Short-term physical, occupational and speech therapies for acute conditions ○ Cardiac rehabilitation for the following conditions: <ul style="list-style-type: none"> ▪ Acute myocardial infarction ▪ Percutaneous transluminal coronary angioplasty (PTCA) ▪ Repair or replacement of heart valves ▪ Coronary artery bypass graft (CABG) ▪ Heart transplant ○ Pulmonary rehabilitation 	No Charge	\$60 copay per visit at independent facilities; \$60 copay per visit after deductible at hospital-owned or affiliated facilities	Not Covered
	No Charge	\$60 copay per visit at independent facilities; \$60 copay per visit after deductible at hospital-owned or affiliated facilities	Not Covered
	No Charge	\$60 copay per visit at independent facilities; \$60 copay per visit after deductible at hospital-owned or affiliated facilities	Not Covered
<ul style="list-style-type: none"> • Chiropractic services 	No Charge	\$30 copay per visit	Not Covered
<i>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.</i>			
<ul style="list-style-type: none"> • Habilitation services <ul style="list-style-type: none"> ○ Physical, occupational and speech therapies 	No Charge	\$60 copay per visit	Not Covered
<i>Coverage is limited to a combined maximum of 35 visits per calendar year for outpatient habilitative physical, occupational and speech therapies.</i>			
<ul style="list-style-type: none"> • Skilled nursing facility 	No Charge	\$250 copay per day for the first 5 days per admission after deductible	Not Covered
<i>Coverage is limited to 60 days post-hospitalization care per calendar year. Requires prior authorization.</i>			
<ul style="list-style-type: none"> • Durable medical equipment includes: <ul style="list-style-type: none"> ○ Standard hospital beds ○ Walkers ○ Crutches ○ Wheelchairs 	No Charge	\$100 copay per episode of illness after deductible	Not Covered
<i>Excludes vehicle modifications, home modifications, exercise equipment, and bathroom equipment.</i>			
<ul style="list-style-type: none"> • Orthotic appliances 	No Charge	\$100 copay per device after deductible	Not Covered
<i>Coverage is limited to custom-made leg, arm, back, and neck braces.</i>			



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<ul style="list-style-type: none"> Prosthetic devices 	No Charge	\$100 copay per device after deductible	Not Covered
<i>Coverage is limited to artificial limbs, artificial joints, cochlear implants, and ocular prostheses. Please see your Contract for more details.</i>			
<ul style="list-style-type: none"> Hospice <ul style="list-style-type: none"> Inpatient and outpatient services 	No Charge	No charge after deductible	Not Covered
<i>Physician certification required</i>			
PEDIATRIC VISION AND DENTAL SERVICES			
<ul style="list-style-type: none"> Pediatric Vision <ul style="list-style-type: none"> One exam per calendar year to determine the need for sight correction 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
<ul style="list-style-type: none"> Pediatric Dental <ul style="list-style-type: none"> 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
ADULT DENTAL SERVICES			
<ul style="list-style-type: none"> Exams are limited to one every 6 months. Please see your Contract for details regarding benefits and cost-sharing. 	No Charge	No charge for preventive care from Delta Dental Network providers	Not Covered
ADULT VISION SERVICES			
<ul style="list-style-type: none"> One exam per calendar year to determine the need for sight correction Members can use their allowance or maximize the benefit by choosing a frame from the iCare Grand Lux collection and select lenses for no out-of-pocket cost. 	No Charge	No Charge	Not Covered
<ul style="list-style-type: none"> Members can use their allowance or maximize the benefit by choosing a frame from the iCare Grand Lux collection and select lenses for no out-of-pocket cost. 	\$150 allowance per calendar year		
TEMPOROMANDIBULAR JOINT (TMJ) SYNDROME			
<ul style="list-style-type: none"> 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
<i>Requires prior authorization</i>			



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TRANSPLANT SERVICES			
<ul style="list-style-type: none"> 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 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.