



SCHEDULE OF BENEFITS

Small Group
Flex S120-SG21
SG-1406

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	OUT-OF-NETWORK

- | | | |
|---|-------------------|---------------------|
| <ul style="list-style-type: none">Individual / Family | \$4,600 / \$9,200 | \$13,800 / \$27,600 |
|---|-------------------|---------------------|

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 | \$7,900 / \$15,800 | \$23,700 / \$47,400 |
|---|--------------------|---------------------|

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) | \$35 copay per visit | 50% coinsurance after deductible |
| <ul style="list-style-type: none">Services in Physicians' office include:<ul style="list-style-type: none">Minor surgical proceduresDiagnostic imaging, radiology and laboratory services | No additional charge | 50% coinsurance after deductible |
| <ul style="list-style-type: none">Virtual Visits (services are available from AvMed designated Telehealth providers only) | 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) | \$70 copay per visit | 50% coinsurance after deductible |
| <ul style="list-style-type: none">Services in Physicians' office include:<ul style="list-style-type: none">Minor surgical proceduresDiagnostic laboratory servicesSimple diagnostic imagingComplex diagnostic imaging | \$70 copay per visit | 50% coinsurance after deductible |
| | No additional charge | 50% coinsurance after deductible |
| | \$70 copay per visit | 50% coinsurance after deductible |
| | \$70 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

- | | | |
|---|----------------------|----------------------------------|
| <ul style="list-style-type: none">Allergy injections and allergy skin testing | \$70 copay per visit | 50% coinsurance after deductible |
|---|----------------------|----------------------------------|



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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 	\$35 copay per visit	50% coinsurance after deductible
<ul style="list-style-type: none"> Diabetes self-management <ul style="list-style-type: none"> Includes care, education, and nutritional counseling 	\$70 copay per visit	50% coinsurance after deductible
<i>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.</i>		
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	50% coinsurance after deductible
<i>For a comprehensive list of covered preventive services, visit https://www.healthcare.gov/coverage/preventive-care-benefits/.</i>		
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) 	\$500 copay per visit at independent facilities; 30% coinsurance after deductible at hospital-owned or affiliated facilities No Charge \$500 copay per visit at independent facilities; 30% coinsurance after deductible at hospital-owned or affiliated facilities \$500 copay per course of treatment at independent facilities; 30% coinsurance after deductible at hospital-owned or affiliated facilities	50% coinsurance after deductible 50% coinsurance after deductible Not Covered 50% coinsurance after deductible
<ul style="list-style-type: none"> OUTPATIENT DIAGNOSTIC TESTS <ul style="list-style-type: none"> Routine outpatient laboratory tests and blood work Specialty labs 	\$35 copay per visit \$500 copay per visit at independent facilities; 30% coinsurance after deductible at hospital-owned or affiliated facilities	50% coinsurance after deductible 50% coinsurance after deductible



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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) 	\$60 copay per visit at independent facilities; 30% coinsurance after deductible at hospital-owned or affiliated facilities	50% coinsurance after deductible
<ul style="list-style-type: none"> ○ Complex diagnostic tests (MRI, MRA, PET, CT, Nuclear Medicine) 	\$500 copay per visit at independent facilities; 30% coinsurance after deductible at hospital-owned or affiliated facilities	50% coinsurance after deductible

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

PRESCRIPTION DRUGS		
<ul style="list-style-type: none"> • Tier 1: Value Generic Drugs 	\$20 copay per prescription (retail); \$50 copay per prescription (mail order)	Not Covered
<ul style="list-style-type: none"> • Tier 2: Generic Drugs 	\$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 	\$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 	50% coinsurance after deductible (retail & mail order)	Not Covered
<ul style="list-style-type: none"> • Tier 5: Specialty Drugs 	50% 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.

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 	\$70 copay per visit \$35 copay per visit \$140 copay per visit at independent facilities; 50% coinsurance after deductible at hospital-owned or affiliated facilities	50% coinsurance after deductible 50% coinsurance after deductible 50% coinsurance after deductible
<ul style="list-style-type: none"> • Chemotherapy (covers administration and facility charges) 	50% coinsurance after deductible	50% coinsurance after deductible

Requires prior authorization

Requires prior authorization

SCHEDULE OF SERVICES	COST-TO-MEMBER	
	IN-NETWORK	OUT-OF-NETWORK
IMMEDIATE / EMERGENCY CARE		
<ul style="list-style-type: none">Emergency room services at participating or non-participating hospitals (copay waived if admitted) <p><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></p>	\$500 copay per visit after deductible	\$500 copay per visit after In-Network deductible
<ul style="list-style-type: none">Ambulance transport for emergency services<ul style="list-style-type: none">Ground transportAir and water transport	\$150 copay per one way ground transport after deductible 50% coinsurance after deductible	\$150 copay per one way ground transport after In-Network deductible 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 <p><i>Requires prior authorization</i></p>	\$150 copay per one way ground transport after deductible	\$150 copay per one way ground transport after deductible
<ul style="list-style-type: none">Medical services at urgent/immediate care facilities	\$125 copay per visit at independent facilities; 30% coinsurance after deductible at hospital-owned or affiliated facilities	\$125 copay per visit after deductible at independent facilities; 50% coinsurance after deductible at hospital-owned or affiliated facilities
<ul style="list-style-type: none">Medical services at retail clinics	\$45 copay per visit	\$45 copay per visit after deductible
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 medicationIntensive care unit and other special units, general and special duty nursingLaboratory and diagnostic imagingRequired special dietsRadiation and inhalation therapiesAcute rehabilitation services (limited to 30 days per calendar year)Physician charges for surgical and medical services <p><i>Inpatient services require prior authorization.</i></p>	\$750 copay per day for the first 3 days per admission after deductible No charge after deductible	50% coinsurance after deductible 50% coinsurance after deductible
MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT		
<ul style="list-style-type: none">Office visits	\$35 copay per visit	50% coinsurance after deductible
<ul style="list-style-type: none">Partial hospitalization	No Charge	50% coinsurance after deductible



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<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 	<p>\$750 copay per day for the first 3 days per admission after deductible</p> <p>\$750 copay per day for the first 3 days per admission after deductible</p>	<p>50% coinsurance after deductible</p> <p>50% coinsurance after deductible</p>

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 	<p>\$35 copay for first visit only; subsequent visits at no charge</p> <p>\$70 copay per visit</p>	<p>50% coinsurance after deductible</p> <p>50% coinsurance after deductible</p>
<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 after deductible	50% coinsurance after deductible
<ul style="list-style-type: none"> Childbirth/delivery facility services <ul style="list-style-type: none"> Hospital Birth center 	<p>\$750 copay per day for the first 3 days per admission after deductible</p> <p>\$35 copay per visit</p>	<p>50% coinsurance after deductible</p> <p>50% coinsurance after deductible</p>

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 	\$70 copay per visit after deductible	50% coinsurance after deductible
<i>Coverage is limited to 20 skilled visits per calendar year. Approved treatment plan and prior authorization required.</i>		
<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 	<p>\$70 copay per visit at independent facilities; \$70 copay per visit after deductible at hospital-owned or affiliated facilities</p> <p>\$70 copay per visit at independent facilities; \$70 copay per visit after deductible at hospital-owned or affiliated facilities</p> <p>\$70 copay per visit at independent facilities; \$70 copay per visit after deductible at hospital-owned or affiliated facilities</p>	<p>50% coinsurance after deductible</p> <p>50% coinsurance after deductible</p> <p>50% coinsurance after deductible</p>



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<ul style="list-style-type: none"> Chiropractic services <p><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></p>	\$35 copay per visit	50% coinsurance after deductible
<ul style="list-style-type: none"> Habilitation services <ul style="list-style-type: none"> Physical, occupational and speech therapies <p><i>Coverage is limited to a combined maximum of 35 visits per calendar year for outpatient habilitative physical, occupational and speech therapies.</i></p>	\$70 copay per visit	50% coinsurance after deductible
<ul style="list-style-type: none"> Skilled nursing facility <p><i>Coverage is limited to 60 days post-hospitalization care per calendar year. Requires prior authorization.</i></p>	\$250 copay per day for the first 5 days per admission after deductible	50% coinsurance after deductible
<ul style="list-style-type: none"> Durable medical equipment includes: <ul style="list-style-type: none"> Standard hospital beds Walkers Crutches Wheelchairs <p><i>Excludes vehicle modifications, home modifications, exercise equipment, and bathroom equipment.</i></p>	\$100 copay per episode of illness after deductible	50% coinsurance after deductible
<ul style="list-style-type: none"> Orthotic appliances <p><i>Coverage is limited to custom-made leg, arm, back, and neck braces.</i></p>	\$100 copay per device after deductible	50% coinsurance after deductible
<ul style="list-style-type: none"> Prosthetic devices <p><i>Coverage is limited to artificial limbs, artificial joints, cochlear implants, and ocular prostheses. Please see your Contract for more details.</i></p>	\$100 copay per device after deductible	50% coinsurance after deductible
<ul style="list-style-type: none"> Hospice <ul style="list-style-type: none"> Inpatient and outpatient services <p><i>Physician certification required</i></p>	No charge after deductible	50% coinsurance after deductible
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	50% coinsurance after deductible
<ul style="list-style-type: none"> Pediatric Dental <ul style="list-style-type: none"> Dental services are subject to a separate calendar year deductible of \$65 per child. 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. 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	Preventive care may be subject to cost-sharing if billed charges exceed allowed amount.
TEMPOROMANDIBULAR JOINT (TMJ) SYNDROME		
<ul style="list-style-type: none"> Medically necessary treatment for conditions caused by congenital or developmental deformity, disease or injury. <p><i>Requires prior authorization</i></p>	Same as any other condition based on type of provider and location of services	50% coinsurance after deductible



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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	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 1-800-376-6651. 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 Small Group Flex 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.