



SCHEDULE OF BENEFITS

Individual and Family Plan
AvMed Entrust Silver 300
IN-1487

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. In general, benefits and services are not covered out-of-network except for Urgent and Emergency Medical Services and Care, and must be received at participating providers. See your AvMed online directory. 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
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DEDUCTIBLE	IN-NETWORK
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<ul style="list-style-type: none">Individual / Family	\$3,000 / \$6,000
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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
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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 for first non-preventive visit; \$40 copay per visit thereafter
<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 No additional charge
<ul style="list-style-type: none">Virtual Visits (services are available from AvMed designated Telehealth providers only)	No Charge

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)	\$80 copay per visit
<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	\$80 copay per visit No additional charge \$80 copay per visit \$80 copay per visit

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	\$80 copay per visit
<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	\$40 copay per visit
<ul style="list-style-type: none">Diabetes self-management<ul style="list-style-type: none">Includes care, education, and nutritional counseling	\$80 copay per visit

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.



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PREVENTIVE CARE AND SERVICES	
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<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
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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	
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<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) 	<p>\$725 copay per visit after deductible</p> <p>No charge after deductible</p> <p>\$725 copay per visit after deductible</p> <p>\$725 copay per course of treatment after deductible</p>
<ul style="list-style-type: none"> • OUTPATIENT DIAGNOSTIC TESTS <ul style="list-style-type: none"> ○ Routine outpatient laboratory tests and blood work ○ Specialty labs ○ Simple diagnostic tests (including x-rays, ultrasounds, echocardiograms, fluoroscopes, diagnostic mammography, and other standard radiology services) ○ Complex diagnostic tests (MRI, MRA, PET, CT, Nuclear Medicine) 	<p>\$30 copay per visit</p> <p>\$725 copay per visit after deductible</p> <p>\$100 copay per visit at independent facilities; \$200 copay per visit at hospital-owned or affiliated facilities</p> <p>\$300 copay per visit at independent facilities; \$600 copay per visit at hospital-owned or affiliated facilities</p>

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

PRESCRIPTION DRUGS	
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<ul style="list-style-type: none"> • Tier 1: Preferred Generic Drugs 	<p>\$20 copay per prescription (retail); \$50 copay per prescription (mail order)</p>
<ul style="list-style-type: none"> • Tier 2: Generic Drugs 	<p>\$40 copay per prescription (retail); \$100 copay per prescription (mail order)</p>
<ul style="list-style-type: none"> • Tier 3: Preferred Brand Drugs 	<p>\$80 copay per prescription (retail); \$200 copay per prescription (mail order)</p>
<ul style="list-style-type: none"> • Tier 4: Non-Preferred Brand Drugs 	<p>\$100 copay per prescription (retail); \$250 copay per prescription (mail order)</p>



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MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT	
<ul style="list-style-type: none"> • Office visits 	\$40 copay per visit
<ul style="list-style-type: none"> • Partial hospitalization 	No Charge
<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 	\$900 copay per day for the first 2 days per admission after deductible \$900 copay per day for the first 2 days per admission after deductible
<i>Inpatient and partial hospitalization services require prior authorization.</i>	
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 	\$40 copay for first visit only; subsequent visits at no charge \$80 copay per visit
<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
<ul style="list-style-type: none"> • Childbirth/delivery facility services <ul style="list-style-type: none"> ○ Hospital ○ Birthing center 	\$900 copay per day for the first 2 days per admission after deductible \$40 copay per visit
<i>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.</i>	
RECOVERY	
<ul style="list-style-type: none"> • Home health care 	\$80 copay per visit 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 	\$80 copay per visit at independent facilities; \$80 copay per visit after deductible at hospital-owned or affiliated facilities \$80 copay per visit at independent facilities; \$80 copay per visit after deductible at hospital-owned or affiliated facilities \$80 copay per visit at independent facilities; \$80 copay per visit after deductible at hospital-owned or affiliated facilities \$40 copay per visit
<ul style="list-style-type: none"> • Chiropractic services 	\$80 copay per visit
<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 	\$80 copay per visit
<i>Coverage is limited to a combined maximum of 35 visits per calendar year for outpatient habilitative physical, occupational and speech therapies.</i>	



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<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
<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
<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
<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
<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

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
<ul style="list-style-type: none"> Pediatric Dental <ul style="list-style-type: none"> 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

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

TRANSPLANT SERVICES	
<ul style="list-style-type: none"> AvMed In-Network Center of Excellence facilities in the State of Florida. <p><i>Requires prior authorization - Limitations apply - please see your Contract for details.</i></p>	Same as any other condition based on type of provider and location of services

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.