

# Schedule of Benefits



INDIVIDUAL VALUE PLAN	COST TO MEMBER	
	In-Network	Out-of-Network
<b>NETWORK</b>		
<b>LIFE TIME MAXIMUM</b>		\$5,000,000
<b>CALENDAR YEAR DEDUCTIBLE</b>		
INDIVIDUAL / FAMILY	\$5,000/\$10,000	\$10,000/\$20,000
<i>The Deductible does not apply toward the Out-of-Pocket Maximum</i>		
<b>OUT-OF-POCKET MAXIMUM (PER CALENDAR YEAR)</b>		
INDIVIDUAL / FAMILY	\$4,000/\$8,000	\$8,000/\$16,000
<i>The Out-of-Pocket Maximum excludes Deductibles and Co-payments</i>		
<b>PREVENTIVE CARE (Coverage is limited to a maximum benefit of \$300 per calendar year)</b>		
Preventive care services include but are not limited to:	\$35 Primary Care Physician Co-payment OR \$50 Specialist Co-payment	50% of the UCR * charge, after Deductible
<ul style="list-style-type: none"> <li>▪ Well-woman examinations</li> <li>▪ Preventive care provided in a Physician's office</li> <li>▪ Periodic health evaluations and immunizations</li> <li>▪ Mammography (not subject to the Deductible)</li> </ul>	No Charge	No Charge
Additional charges will apply for Outpatient Diagnostic Tests performed in the Physician's office	30% of the contracted rate, after Deductible	50% of the UCR charge, after Deductible
<b>CHILD HEALTH SUPERVISION SERVICES (not subject to Deductible)</b>		
Services include but are not limited to:	\$35 Primary Care Physician Co-payment OR \$50 Specialist Co-payment	50% of the UCR charge
<ul style="list-style-type: none"> <li>▪ Pediatric care and well-child care</li> <li>▪ Periodic health evaluations and immunizations</li> </ul>		
Additional charges will apply for Outpatient Diagnostic Tests performed in the Physician's office	30% of the contracted rate	
<b>AVMED PRIMARY CARE PHYSICIAN</b>		
Additional charges will apply for Outpatient Diagnostic Tests performed in the Physician's office	\$35 Co-payment for the first 4 office visits per family then, 30% of the contracted rate, after Deductible	50% of the UCR charge, after Deductible
<b>AVMED SPECIALISTS' SERVICES</b>		
Additional charges will apply for Outpatient Diagnostic Tests performed in the Specialist's office	30% of the contracted rate, after Deductible	50% of the UCR charge, after Deductible
<b>HOSPITAL (Prior authorization required for inpatient care)</b>		
Inpatient care at Participating Hospitals includes:		
<ul style="list-style-type: none"> <li>▪ Room and board – unlimited days (semi-private)</li> <li>▪ Physicians', specialists' and surgeons' services</li> <li>▪ Anesthesia, use of operating and recovery rooms, oxygen, drugs and medication</li> <li>▪ Intensive care units and other special units, general and special duty nursing</li> <li>▪ Laboratory and diagnostic imaging</li> <li>▪ Required special diets</li> <li>▪ Radiation and inhalation therapies</li> </ul>	30% of the contracted rate, after Deductible	50% of the UCR charge, after Deductible
<b>TRANSPLANT (Prior authorization required for Transplant care)</b>		
Coverage is limited to a Lifetime Maximum of \$100,000 for all Out-of-Network Transplant Services	30% of the contracted rate, after Deductible	50% of the UCR charge, after Deductible
<b>OUTPATIENT SERVICES</b>		
<ul style="list-style-type: none"> <li>▪ Outpatient surgeries, including cardiac catheterizations and angioplasty</li> <li>▪ Outpatient therapeutic services, including Drug infusion therapy</li> </ul>	30% of the contracted rate, after Deductible	50% of the UCR charge, after Deductible

\* Usual, Customary and Reasonable (UCR)

# Schedule of Benefits



## INDIVIDUAL VALUE PLAN

## COST TO MEMBER

NETWORK	In-Network	Out-of-Network
<b>OUTPATIENT DIAGNOSTIC TESTS</b> <ul style="list-style-type: none"> <li>Complex diagnostic testing (Prior Authorization is Required)</li> <li>Other diagnostic imaging tests</li> <li>Outpatient laboratory tests</li> </ul> <p>Charges for office visits will also apply if services are performed in a Physician's or Specialist's office</p>	30% of the contracted rate, after Deductible	50% of the UCR charge, after Deductible
<b>EMERGENCY SERVICES</b> An emergency is the sudden and unexpected onset of a condition requiring immediate medical or surgical care. (Co-payment waived if admitted) <ul style="list-style-type: none"> <li>Illness</li> <li>Injury</li> </ul> <p>AvMed must be notified within 24 hours of inpatient admission following emergency services or as soon as reasonably possible</p>	30% of the contracted rate, after Deductible plus \$100 Co-payment when due to illness (Co-payment waived if admitted)	Subject to In-Network Deductible and cost sharing
<b>URGENT/IMMEDIATE CARE</b> Medical services at an Urgent/Immediate Care facility or services rendered after hours in your Primary Care Physician's office	30% of the contracted rate, after Deductible	Subject to In-Network Deductible and cost sharing
<b>ALLERGY TREATMENTS</b> <ul style="list-style-type: none"> <li>Injections</li> </ul>	30% of the contracted rate, after Deductible	50% of the UCR charge, after Deductible
<b>HOSPICE</b> Coverage is limited to a Lifetime Maximum of \$10,000	30% of the contracted rate, after Deductible	50% of the UCR charge, after Deductible
<b>AMBULANCE (Prior Authorization required for Non-emergent ambulance services)</b> <ul style="list-style-type: none"> <li>Ambulance transport for emergency services</li> <li>Non-emergent ambulance services are covered when the skill of medically trained personnel is required and the Member cannot be safely transported by other means.</li> </ul> <p>Benefit is limited to \$500 per day for Ground transport. Benefit is limited to \$4,000 per calendar year for Air and Water transport.</p>	30% of the contracted rate, after Deductible	50% of the UCR charge, after Deductible
<b>PHYSICAL, SPEECH AND OCCUPATIONAL THERAPIES, CARDIAC REHABILITATION AND SPINAL MANIPULATION</b> Coverage is limited to a maximum of 10 visits per calendar year for all services combined.	30% of the contracted rate, after Deductible	50% of the UCR charge, after Deductible
<b>SKILLED NURSING FACILITIES and REHABILITATION CENTERS (Prior authorization required)</b> Up to 20 days post-hospitalization care per calendar year when prescribed by physician and authorized by AvMed.	30% of the contracted rate, after Deductible	50% of the UCR charge, after Deductible
<b>HOME HEALTH CARE</b> Limited to 30 skilled visits per calendar year with an approved treatment plan.	30% of the contracted rate, after Deductible	50% of the UCR charge, after Deductible
<b>DURABLE MEDICAL EQUIPMENT, ORTHOTIC APPLIANCES AND PROSTHETIC DEVICES</b> Benefit is limited to \$2,500 per calendar year for all equipment, appliances and devices combined.	30% of the contracted rate, after Deductible	50% of the UCR charge, after Deductible
<b>OTHER COVERED SERVICES</b>	30% of the contracted rate, after Deductible	50% of the UCR charge, after Deductible

**PRIOR AUTHORIZATION IS REQUIRED FOR SPECIFIC COVERED SERVICES. THE PENALTY FOR NON-NOTIFICATION IS \$500. FOR ADDITIONAL INFORMATION, PLEASE CALL: 1-800-447-8768**

For specific information on benefits, exclusions and limitations, please see your Contract.