AvMed HEALTH PLANS

Benefit Summary

SCHEDULE OF BENEFITS				
	AvMed Choice Network	AvMed Expanded Choice Network	PHCS Network	Out-of-Network
	HIGH	MID		LOW
Where Services are Rendered	In AvMed's Service Area	In AvMed's Service Area	Out of AvMed's Service Area	In or Out of Service Area
CASH DEDUCTIBLE (accumulates across all benefit levels) **INDIVIDUAL (per calendar year)** **FAMILY (per calendar year)** *The Deductible does not apply toward the Out-of-Pocket Maximum.*	$250 $500	$500 $1,000	$500 $1,000	$1,000 $2,000
OUT-OF-POCKET MAXIMUM (accumulates across all benefit levels) **INDIVIDUAL (per calendar year)** **FAMILY (per calendar year)** *The Out-of-Pocket Maximum includes Co-payments and Co-insurance amounts unless otherwise excluded.*	$1,500 $3,000	$2,500 $5,000	$2,500 $5,000	$5,000 $10,000
LIFETIME MAXIMUM	Unlimited		$2,000,000	
PREVENTIVE CARE Preventive care services include but are not limited to: • Well-child care and immunizations • Well-woman examinations, including pap smears • Preventive care provided in a physician's office	$10 per Primary Care Office Visit OR $25 per Specialist Office Visit	$20 per Primary Care Office Visit OR $40 per Specialist Office Visit	$20 per Primary Care Office Visit OR $40 per Specialist Office Visit	40% of the UCR charge, not subject to the Deductible Calendar year maximum benefit of $300
PRIMARY CARE PHYSICIAN Services at doctors' offices include, but are not limited to: • Routine office visits • Diagnostic imaging, laboratory or other diagnostic services • Minor surgical procedures • Vision & Hearing examinations for children under 18	$10 per visit	$20 per visit	$20 per visit	40% of the UCR charge, after Deductible
SPECIALIST'S SERVICES Office visits or procedures	$25 per visit	$40 per visit	$40 per visit	40% of the UCR charge, after Deductible
MATERNITY CARE All obstetrical care and services, including pre-natal care, office visits and delivery	15% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	40% of the UCR charge, after Deductible
SECOND MEDICAL OPINION Office visits – not subject to the Deductible	$25 per visit	$40 per visit	$40 per visit	40% of the UCR charge

HOSPITAL **(Prior Authorization Required for Inpatient Care)** Hospital inpatient care includes: • Room & board – unlimited days (semi-private) • Physician's, specialist's & surgeon's services • Anesthesia, use of operating & recovery rooms, oxygen, drugs & medication • Intensive care unit & other special units, general & special duty nursing • Laboratory & diagnostic imaging • Required special diets • Radiation & inhalation therapies Hospital outpatient care includes: • Outpatient surgery • Outpatient diagnostic tests • Outpatient laboratory tests	15% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	40% of the UCR charge, after Deductible
OUTPATIENT SURGERY • Outpatient surgeries, including Cardiac Catheterizations and Angioplasty	15% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	40% of the UCR charge, after Deductible
OUTPATIENT DIAGNOSTIC TESTS • CAT Scan, PET Scan, MRI • Other diagnostic imaging tests	15% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	40% of the UCR charge, after Deductible
• Outpatient laboratory tests	No Charge	30% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	Mammography subject to Preventive Care maximum benefit of $300
• Mammography (not subject to the Deductible)	No Charge	No Charge	No Charge	
EMERGENCY SERVICES An emergency is the sudden and unexpected onset of a condition requiring immediate medical or surgical care. (Co-payment waived if admitted) AVMED MUST BE NOTIFIED WITHIN 24 HOURS OF INPATIENT ADMISSION FOLLOWING EMERGENCY SERVICES OR AS SOON AS REASONABLY POSSIBLE.	$100 Co-payment	$100 Co-payment	$100 Co-payment	$100 Co-payment
URGENT/IMMEDIATE CARE Medical services at an Urgent/Immediate Care facility or services rendered after hours in your Primary Care Physician's office.	$40 Co-payment	$60 Co-payment	$60 Co-payment	$60 Co-payment
OUTPATIENT MENTAL HEALTH 20 outpatient visits	$25 per visit	$40 per visit	$40 per visit	40% of the UCR charge, after Deductible

FAMILY PLANNING • Voluntary family planning services • Sterilization	15% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	40% of the UCR charge, after Deductible
ALLERGY TREATMENTS • Injections • Skin testing • Office visits	15% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	40% of the UCR charge, after Deductible
AMBULANCE • Ambulance transport for Emergency Services	15% of the Contracted Rate, after Deductible	Same as Choice Network Benefit	Same as Choice Network Benefit	Same as Choice Network Benefit
• 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.	15% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	40% of the UCR charge, after Deductible
PHYSICAL & OCCUPATIONAL THERAPIES • Short-term Physical or Occupational Therapy for acute conditions • Coverage is limited to 30 visits per calendar year for all services combined.	15% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	40% of the UCR charge, after Deductible
SPEECH THERAPIES • Benefit limited to 24 visits per calendar year	15% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	40% of the UCR charge, after Deductible
SKILLED NURSING FACILITIES & REHABILITATION CENTERS (Prior Authorization Required) • Up to 20 days post-hospitalization care per calendar year when prescribed by physician & authorized by AvMed	15% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	40% of the UCR charge, after Deductible
HOSPICE SERVICES (Prior Authorization Required)	15% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	40% of the UCR charge, after Deductible
CARDIAC REHABILITATION • Cardiac rehabilitation is covered for the following conditions: acute myocardial infarction, percutaneous transluminal coronary angioplasty (PTCA), repair or replacement of heart valve(s), CABG, or heart transplant. • Coverage is limited to a maximum of 18 visits per calendar year or $1,500, whichever is exhausted first.	15% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	40% of the UCR charge, after Deductible

HOME HEALTH CARE • Limited to 60 visits per calendar year	15% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	40% of the UCR charge, after Deductible
DURABLE MEDICAL EQUIPMENT AND ORTHOTIC & ORTHOPEDIC APPLIANCES Equipment includes: • Hospital beds • Walkers • Crutches • Wheelchairs Orthotic appliances are limited to: • Custom-made leg, arm, back, and neck braces Benefits limited to combined $3,000 per calendar year	15% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	40% of the UCR charge, after Deductible
PROSTHETIC DEVICES Prosthetic devices are limited to: • Artificial limbs • Artificial joints • Ocular prostheses	15% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	40% of the UCR charge, after Deductible
ALL OTHER COVERED SERVICES	15% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	30% of the Contracted Rate, after Deductible	40% 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: 1-800-88-AVMED (1-800-882-8633)

For specific information on benefits, exclusions and limitations, please see your AvMed Choice Group Medical and Hospital Service Contract with Point of Service Rider.