Schedule of Benefits

AvMED Health Plans

INDIVIDUAL HDHP PLAN	COST TO MEMBER	
NETWORK	**In-Network**	**Out-of-Network**
LIFE TIME MAXIMUM	$5,000,000	
CALENDAR YEAR DEDUCTIBLE* INDIVIDUAL / FAMILY *The Deductible apply toward the Out-of-Pocket Maximum*	$2,500/$5,000	$5,000/$10,000
OUT-OF-POCKET MAXIMUM (PER CALENDAR YEAR)* INDIVIDUAL / FAMILY *The Out-of-Pocket Maximum includes Deductibles and Coinsurance. Co-payments do not apply*	$5,000/$10,000	$10,000/$20,000
PREVENTIVE CARE (Coverage is limited to a maximum benefit of $300 per calendar year) Preventive care services include but are not limited to: ▪ Well-woman examinations ▪ Preventive care provided in a Physician's office ▪ Periodic health evaluations and immunizations ▪ Mammography (not subject to the Deductible)	$35 Primary Care Physician Co-payment OR $50 Specialist Co-payment No Charge	40% of the UCR ** charge, No Charge
CHILD HEALTH SUPERVISION SERVICES (not subject to Deductible) Services include but are not limited to: ▪ Pediatric care and well-child care ▪ Periodic health evaluations and immunizations	$35 Primary Care Physician Co-payment OR $50 Specialist Co-payment	40% of the UCR charge
AVMED PRIMARY CARE PHYSICIAN Additional charges will apply for Outpatient Diagnostic Tests performed in the Physician's office	20% of the contracted rate, after Deductible	40% of the UCR charge, after Deductible
AVMED SPECIALISTS' SERVICES Additional charges will apply for Outpatient Diagnostic Tests performed in the Specialist's office	20% of the contracted rate, after Deductible	40% of the UCR charge, after Deductible
HOSPITAL (Prior authorization required for inpatient care) Inpatient care at Participating Hospitals includes: ▪ Room and board – unlimited days (semi-private) ▪ Physicians', specialists' and surgeons' services ▪ Anesthesia, use of operating and recovery rooms, oxygen, drugs and medication ▪ Intensive care units and other special units, general and special duty nursing ▪ Laboratory and diagnostic imaging ▪ Required special diets ▪ Radiation and inhalation therapies	20% of the contracted rate, after Deductible	40% of the UCR charge, after Deductible
TRANSPLANT (Prior authorization required for Transplant care) Coverage is limited to a Lifetime Maximum of $100,000 for all Out-of-Network Tranplant Services	20% of the contracted rate, after Deductible	40% of the UCR charge, after Deductible
OUTPATIENT SERVICES ▪ Outpatient surgeries, including cardiac catheterizations and angioplasty ▪ Outpatient therapeutic services, including Drug infusion therapy	20% of the contracted rate, after Deductible	40% of the UCR charge, after Deductible

** Usual, Customary and Reasonable (UCR)

*The Family Deductible and Out-of-Pocket Maximum are non-embedded, meaning no individual in the family has satisfied the Deductible or Out-of-Pocket Maximum until the entire family amount has been satisfied.

AV-IND-HDHP-$35/$2,500/$5,000/20%-09
IP-1002(01/09)

Schedule of Benefits

AvMed Health Plans

INDIVIDUAL HDHP PLAN	COST TO MEMBER	
NETWORK	**In-Network**	**Out-of-Network**
OUTPATIENT DIAGNOSTIC TESTS ▪ Complex diagnostic testing (Prior Authorization is Required) ▪ Other diagnostic imaging tests ▪ Outpatient laboratory tests Charges for office visits will also apply if services are performed in a Physician's or Specialist's office	20% of the contracted rate, after Deductible	40% of the UCR charge, after Deductible
EMERGENCY SERVICES An emergency is the sudden and unexpected onset of a condition requiring immediate medical or surgical care. AvMed must be notified within 24 hours of inpatient admission following emergency services or as soon as reasonably possible	20% of the contracted rate, after Deductible	Subject to In-Network Deductible and cost sharing
URGENT/IMMEDIATE CARE Medical services at an Urgent/Immediate Care facility or services rendered after hours in your Primary Care Physician's office	20% of the contracted rate, after Deductible	Subject to In-Network Deductible and cost sharing
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES ▪ Outpatient office visits (benefits limited to $600 per calendar year) ▪ Inpatient treatment and partial hospitalization (benefits limited to $2,500 per calendar year) Coverage is limited to a Lifetime Maximum of $10,000 for all Inpatient and Outpatient Services combined	20% of the contracted rate, after Deductible	40% of the UCR charge, after Deductible
ALLERGY TREATMENTS ▪ Injections	20% of the contracted rate, after Deductible	40% of the UCR charge, after Deductible
HOSPICE Coverage is limited to a Lifetime Maximum of $10,000	20% of the contracted rate, after Deductible	40% of the UCR charge, after Deductible
AMBULANCE (Prior Authorization required for Non-emergent ambulance services) ▪ Ambulance transport for emergency services ▪ 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. Benefit is limited to $500 per day for Ground transport. Benefit is limited to $4,000 per calendar year for Air and Water transport.	20% of the contracted rate, after Deductible	40% of the UCR charge, after Deductible
PHYSICAL, SPEECH AND OCCUPATIONAL THERAPIES, CARDIAC REHABILITATION AND SPINAL MANIPULATION Coverage is limited to a maximum of 25 visits per calendar year for all services combined.	20% of the contracted rate, after Deductible	40% of the UCR charge, after Deductible
SKILLED NURSING FACILITIES and REHABILITATION CENTERS (Prior authorization required) Up to 30 days post-hospitalization care per calendar year when prescribed by physician and authorized by AvMed.	20% of the contracted rate, after Deductible	40% of the UCR charge, after Deductible
HOME HEALTH CARE Limited to 60 skilled visits per calendar year with an approved treatment plan.	20% of the contracted rate, after Deductible	40% of the UCR charge, after Deductible
DURABLE MEDICAL EQUIPMENT, ORTHOTIC APPLIANCES AND PROSTHETIC DEVICES Benefit is limited to $2,500 per calendar year for all equipment, appliances and devices combined.	20% of the contracted rate, after Deductible	40% of the UCR charge, after Deductible
OTHER COVERED SERVICES	20% 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: 1-800-447-8768

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

*The Family Deductible and Out-of-Pocket Maximum are non-embedded, meaning no individual in the family has satisfied the Deductible or Out-of-Pocket Maximum until the entire family amount has been satisfied.

AV-IND-HDHP-$35/$2,500/$5,000/20%-09
IP-1002(01/09)

Prescription Drug Benefits

AvMed Health Plans

High Deductible Health Plan-$2500/$5000 Deductible

DEFINITIONS

"Brand" medication means a Prescription Drug that is usually manufactured and sold under a name or trademark by a pharmaceutical manufacturer or a medication that is identified as a Brand medication by AvMed. AvMed delegates determination of Generic/Brand status to our Pharmacy Benefits Manager.

"Brand Additional Charge" means the additional charge that must be paid if you or your physician choose a Brand medication when a Generic equivalent is available. The charge is the difference between the cost of the Brand medication and the Generic medication. This charge must be paid in addition to the applicable Co-insurance.

"Dental-specific Medication" is medication used for dental-specific purposes, including but not limited to fluoride medications and medications packaged and labeled for dental-specific purposes.

"Generic" medication means a medication that has the same active ingredient as a Brand medication or is identified as a Generic medication by AvMed's Pharmacy Benefits Manager.

"Injectable Medication" is a medication that has been approved by the Food and Drug Administration (FDA) for administration by one or more of the following routes: intramuscular injection, intravenous injection, intravenous infusion, subcutaneous injection, intrathecal injection, intrarticular injection, intracavernous injection or intraocular injection. Pre-Authorization is required for all Injectable Medications.

"Maintenance Medication" is a medication that has been approved by the FDA, for which the duration of therapy can reasonably be expected to exceed one year.

"Participating Pharmacy" means a pharmacy (either retail, mail order or specialty pharmacy) that has entered into an agreement with AvMed to provide Prescription Drugs to AvMed Members and has been designated by AvMed as a Participating Pharmacy.

"Preferred Medication List" means the listing of preferred medications as determined by AvMed's Pharmacy and Therapeutics Committee based on clinical efficacy, relative safety and cost in comparison to similar medications within a therapeutic class. This multi-tiered list establishes different levels of Co-payment for medications within therapeutic classes. As new medications become available, they may be considered excluded until they have been reviewed by AvMed's Pharmacy and Therapeutics Committee.

"Prescription Drug" means a medication that has been approved by the FDA and that can only be dispensed pursuant to a prescription according to state and federal law.

"Pre-Authorization" means the process of obtaining approval for certain Prescription Drugs (prior to dispensing) according to AvMed's guidelines. The prescribing physician must obtain approval through AvMed's Pre-Authorization process. The list of Prescription Drugs requiring Pre-Authorization is subject to periodic review and modification by AvMed. A copy of the list of medications requiring Pre-Authorization and the applicable criteria are available from Member Services or from the AvMed website.

"Self-Administered Injectable Medication" is a medication that has been approved by the FDA for self-injection and is administered by subcutaneous injection or a medication for which there are instructions to the patient for self-injection in the manufacturer's prescribing information (package insert). Pre-Authorization is required for all Self-Administered Injectable Medications.

"Quantity Limits" are set in accordance with FDA approved prescribing limitations, general practice guidelines supported by medical specialty organizations, and/or evidence-based, statistically valid clinical studies without published conflicting data. This means that a medication-specific quantity limit may apply for medications that have an increased potential for over-utilization or an increased potential for a Member to experience an adverse effect at higher doses.

HOW DOES YOUR RETAIL PRESCRIPTION COVERAGE WORK?

You can obtain your covered prescription medication from an AvMed Participating Pharmacy or from an Out-of-Network pharmacy. Your cost sharing will be lower if you use a Participating Pharmacy. (Your Physician should submit prescriptions for Self-Administered Injectable Drugs to AvMed's Specialty Pharmacy.) Present your prescription along with your AvMed identification card. Once you meet your Deductible (as outlined on your Schedule of Benefits), you will pay the following Coinsurance for In-Network and Out-of-Network (as well as the Brand Additional Charge if you or your physician choose a Brand product when a Generic equivalent is available).

In-Network (Participating Pharmacy)

Tier 1	Preferred Generic Medications:	20% Co-insurance after Deductible
Tier 2	Preferred Brand Medications:	20% Co-insurance after Deductible
Tier 3	Non-Preferred Brand or Generic Medications:	20% Co-insurance after Deductible
Tier 4	Self-Administered Injectable Medications:	20% Co-insurance after Deductible

Out-of-Network Pharmacy

Tier 1	Preferred Generic Medications:	40% Co-insurance after Deductible
Tier 2	Preferred Brand Medications:	40% Co-insurance after Deductible
Tier 3	Non-Preferred Brand or Generic Medications:	40% Co-insurance after Deductible
Tier 4	Self-Administered Injectable Medications:	40% Co-insurance after Deductible

Prescription Drug Benefits, continued

ORDERING YOUR PRESCRIPTIONS THROUGH THE MAIL

Mail service is a benefit option for maintenance medications needed for chronic or long-term health conditions. It's best to get an initial prescription filled at your retail pharmacy. Ask your physician for an additional prescription for up to a 90-day supply of your medication to be ordered through mail service. Up to 3 refills are allowed per prescription. Once you meet your Deductible (as outlined on your Schedule of Benefits), you will pay the following Coinsurance (as well as the Brand Additional Charge if you or your physician choose a Brand product when a Generic equivalent is available).

In-Network (Participating Pharmacy)

Tier 1	Preferred Generic Medications:	20% Co-insurance after Deductible
Tier 2	Preferred Brand Medications:	20% Co-insurance after Deductible
Tier 3	Non-Preferred Brand or Generic Medications:	20% Co-insurance after Deductible
Tier 4	Self-Administered Injectable Medications are not available through mail service	

Out-of-Network Pharmacy

Tier 1	Preferred Generic Medications:	40% Co-insurance after Deductible
Tier 2	Preferred Brand Medications:	40% Co-insurance after Deductible
Tier 3	Non-Preferred Brand or Generic Medications:	40% Co-insurance after Deductible
Tier 4	Self-Administered Injectable Medications are not available through mail service	

WHAT IS COVERED?

- Your Prescription Drug coverage includes outpatient medications (including oral contraceptives) that require a prescription and are prescribed by your AvMed physician in accordance with AvMed's coverage criteria. AvMed reserves the right to make changes in coverage criteria for covered products and services. Coverage criteria are medical and pharmaceutical protocols used to determine payment of products and services and are based on independent clinical practice guidelines and standards of care established by government agencies and medical/pharmaceutical societies.

- Your retail Prescription Drug coverage includes up to a 30-day supply of a medication for the listed Co-payment. Your prescription may be refilled via retail or mail order after 75% of your previous fill has been used and subject to a maximum of 13 refills per year. You also have the opportunity to obtain a 90-day supply of medications used for chronic conditions including, but not limited to asthma, cardiovascular disease and diabetes, from the retail pharmacy for the applicable Co-insurance per 30-day supply. However, Pre-Authorization may be required for covered medications.

- Your mail-order Prescription Drug coverage includes up to a 90-day supply of a routine maintenance medication for the listed Co-insurance. If the amount of medication is less than a 90-day supply, you will still be charged the listed mail order Co-payment.

- Your Self-Administered Injectable Medication coverage extends to many injectable medications approved by the FDA. These medications must be prescribed by a physician and dispensed by a retail or specialty pharmacy. The Co-insurance for Self-Administered Injectable Medications apply regardless of provider. This means that you are responsible for the appropriate Co-insurance whether you receive your Self-Administered Injectable Medication from the pharmacy, at the physician's office or during home health visits. Self-Administered Injectable Medications are limited to a 30-day supply.

QUESTIONS? Call your AvMed Member Services Department at: 1-800-477-8768

EXCLUSIONS AND LIMITATIONS

- Medications which do not require a prescription (i.e. over-the-counter medications) or when a non-prescription alternative is available unless otherwise specified in the Preferred Medication List
- Medical supplies, including therapeutic devices, dressings, appliances and support garments
- Replacement Prescription Drug products resulting from a lost, stolen, expired, broken or destroyed prescription order or refill
- Diaphragms and other contraceptive devices/implants/injectables. Only oral contraceptives are covered.
- Fertility drugs
- Medications or devices for the diagnosis or treatment of sexual dysfunction
- Dental-specific Medications for dental purposes, including fluoride medications
- Prescription and non-prescription vitamins and minerals
- Nutritional supplements
- Immunizations
- Allergy serums, medications administered by the Attending Physician to treat the acute phase of an illness and chemotherapy for cancer patients are covered in accordance with the Group Medical and Hospital Service Contract and may be subject to Co-payments or Co-insurance as outlined on the Schedule of Benefits
- Investigational and experimental medications (except as required by Florida statute)
- Cosmetic products, including, but not limited to, hair growth, skin bleaching, sun damage and anti-wrinkle medications
- Nicotine suppressants and smoking cessation products and services
- Prescription and non-prescription appetite suppressants and products for the purpose of weight loss
- Compounded prescriptions, except pediatric preparations
- Medications and immunizations for non-business related travel, including Transdermal Scopolamine