

Small Group Open Access POS Plans* (First-dollar Co-payments / Co-insurance after Deductible)

Member Benefits	PS-OA-3278-81		PS-OA-3279-82		PS-OA-3280-83	
	In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network
Deductible (Individual/Family)	\$250 / \$500	\$500 / \$1,000	\$750 / \$1,500	\$1,500 / \$3,000	\$1,000 / \$2,000	\$2,000 / \$4,000
Out of Pocket Maximum	\$2,500 / \$5,000	\$5,000 / \$10,000	\$4,000 / \$8,000	\$8,000 / \$16,000	\$5,000 / \$10,000	\$10,000 / \$20,000
PCP Office Visit	\$20 Co-payment	30% of the Maximum Allowable Payment, after Deductible	\$25 Co-payment	40% of the Maximum Allowable Payment, after Deductible	\$30 Co-payment	50% of the Maximum Allowable Payment, after Deductible
Specialist Office Visit	\$30 Co-payment	30% of the Maximum Allowable Payment, after Deductible	\$40 Co-payment	40% of the Maximum Allowable Payment, after Deductible	\$50 Co-payment	50% of the Maximum Allowable Payment, after Deductible
Hospital Inpatient	10% of the contracted rate, after Deductible	30% of the Maximum Allowable Payment, after Deductible	20% of the contracted rate, after Deductible	40% of the Maximum Allowable Payment, after Deductible	20% of the contracted rate, after Deductible	50% of the Maximum Allowable Payment, after Deductible
Outpatient Surgery	10% of the contracted rate, after Deductible	30% of the Maximum Allowable Payment, after Deductible	20% of the contracted rate, after Deductible	40% of the Maximum Allowable Payment, after Deductible	20% of the contracted rate, after Deductible	50% of the Maximum Allowable Payment, after Deductible
Complex Diagnostic Imaging (MRI, MRA, CAT, PET)	10% of the contracted rate, after Deductible	30% of the Maximum Allowable Payment, after Deductible	20% of the contracted rate, after Deductible	40% of the Maximum Allowable Payment, after Deductible	20% of the contracted rate, after Deductible	50% of the Maximum Allowable Payment, after Deductible
Other Diagnostic Tests (X-ray, Ultrasound, Tomography, Venography)	10% of the contracted rate, after Deductible	30% of the Maximum Allowable Payment, after Deductible	20% of the contracted rate, after Deductible	40% of the Maximum Allowable Payment, after Deductible	20% of the contracted rate, after Deductible	50% of the Maximum Allowable Payment, after Deductible
Emergency Room	\$200 Co-payment	\$200 Co-payment	\$200 Co-payment	\$200 Co-payment	\$200 Co-payment	\$200 Co-payment
Urgent Care	\$50 Co-payment	\$75 Co-payment	\$50 Co-payment	\$75 Co-payment	\$50 Co-payment	\$75 Co-payment
Rx (Retail)**	\$10/\$25/\$40/\$75		\$20/\$35/\$50/\$75		\$20/\$35/\$50/\$75	
Rx (Mail-order, up to 90-day supply)	\$30/\$75/\$120		\$60/\$105/\$150		\$60/\$105/\$150	

* This schedule is not a contract. It is a brief summary of benefits. For more specific information on benefits, exclusions and limitations refer to the Small Group Medical and Hospital Service Contract or contact your AvMed Sales/Service representative. The dollar co-payment and percentage co-insurance amounts listed indicate what the member is required to pay.

** You must use a participating pharmacy for prescription drugs.

Note: Deductibles and Prescription Drug Co-payments are not included in Out of Pocket Maximum.

MP- 3882 (8/11) AvMed Health Plans (health benefit plan) is the brand name used for products and services provided by AvMed, Inc. Plans include limitations and exclusions.

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Terms to Know

Co-payment: A fixed fee paid by the member to the provider for covered medical services.

Deductible: An annual dollar amount that you must pay for covered services before AvMed begins paying for eligible expenses, based on a calendar year.

Co-insurance: The percentage a member must pay toward the cost of covered services once the deductible has been met. The co-insurance amount will vary depending on the network selected.

Out-of-Pocket Maximum: The maximum dollar amount of co-payments and co-insurance the member will have to pay in a calendar year, not including the deductible. Once the out-of-pocket maximum has been met, AvMed pays 100 percent of covered expenses for the remainder of that calendar year.

Brand Additional Charge: 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 Non-Preferred Brand Co-payment.