Medical

SCHEDULE OF BENEFITS	AVMED POS PLAN In-Network	AvMed HMO HIGH In-Network Only	AvMed MDC Select HMO In-Network Only	AvMed MDC Jackson First HMO - In-Network Only
	COST TO MEMBER	COST TO MEMBER	COST TO MEMBER	COST TO MEMBER
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Co-Insurance Levels	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Calendar Year Deductible	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Out-Of-Pocket Maximum (Per Calendar Year) Individual/Dependent Maximum**	$3,000/$6,000	$3,000/$6,000	$2,500/$5,000	$2,500/$5,000
Physician Office Visits	$15 per visit	$15 per visit	$15 per visit	$15 per visit
Specialists Office Visits	$30 per visit	$30 per visit	$30 per visit	$30 per visit
Pediatrician	$15 per visit	$15 per visit	$15 per visit	$15 per visit
Chiropractic	$15 per visit	$15 per visit	$15 per visit	$15 per visit
Preventive Care	No Charge	No Charge	No Charge	No Charge
Mammogram, PSA, Pap Smear	No Charge	No Charge	No Charge	No Charge
Inpatient Hospital Services*	$200 copay per admission	$200 copay per admission	No Charge	No Charge
Outpatient Facility Services*	$100 copay	$100 copay	No Charge	No Charge
Emergency Room (copay waived if admitted)	$100 copay	$100 copay	$50 copay	$50 copay
Urgent Care Facility or Outpatient Facility***	$50 per visit/$15 copay	$25 copay/$15 copay	$25 copay/$15 copay	$25 copay/$15 copay
Maternity Care Services				
Initial Visit	$30 copay	$30 copay	$30 copay	$30 copay
Subsequent Visits	No charge	No charge	No charge	No Charge
Prescription Medication Benefit — Retail, 30 Day Supply (Includes Contraceptives)				
Generic	$15	$15	$15	$15
Preferred Brand	$40	$40	$25	$25
Non-Preferred Brand	$55	$55	$35	$35
Specialty (30-Day Supply Through Specialty Pharmacy)	$100	$100	$15/$25/$35	$15/$25/$35
Prescription Medications - Mail-Order, 90 Day Supply (Includes Contraceptives)				
Generic	$30	$30	$30	$30
Preferred Brand	$80	$80	$50	$50
Non-Preferred Brand	$110	$110	$70	$70

* Copay waived at Jackson Health System Facility.
** Pharmacy copays will count towards the Out-of-Pocket maximum
*** Urgent Care facility/visit at retail facility

Dental

SCHEDULE OF BENEFITS	Delta Dental PPO - Standard	Delta Dental PPO - Enriched	DeltaCare DHMO - Standard	DeltaCare DHMO - Enriched
	Plan Pays	**Plan Pays**	***You Pay**	***You Pay**
Choice Of Dentist	Choose any dentist you wish for services and receive applicable benefits. Save the most with a Delta Dental PPO network participating dentist. Percentages below are based on Delta's applicable allowances and not the dentist's actual charge. Payments to non-Delta Dental dentists are based on the PPO fee schedule.		Limited to participating Dentists within the DeltaCare USA Network.	
Maximum Benefit / Deductible	$1,000 per year per person	$2,250 per year per person	No Maximum / No Deductible	
	$50 deduct. per yr per person	$50 deduct. per yr per person		
	$150 family maximum	$150 family maximum		
		$50 Lifetime deductible for orthodontics		
Type I			**General/Specialist**	
0150 Comp. Oral Evaluation -New Or Established	100%	100%	No charge/No charge	No charge
0120 Periodic Oral Exam	100%	100%	No charge/No charge	No charge
X-Rays				
1110/20 Prophylaxis	100% (3X calendar year)	100% (3X calendar year)	No charge/No charge	No charge
1206 Fluoride Treatment (Children Up To The Age 19)	100%, 2x per year	100%, 2x per year	No charge/No charge	No charge
1351 Sealant - Per Tooth	100% to age 16	100% to age 16	No charge/No charge	No charge
0210 - Intraoral, Complete Series	100% (1 every 3 yrs.)	100% (1 every 3 yrs.)	100% (1 every 3 yrs.)	100% (1 every 3 yrs.)
0364-68/0380-86 Cone Beam X-rays	75%	75%	75%	75%
1510 Space Maintainers	100% to age 19	100% to age 19	No charge/No charge	$25
Type II Filings			**General/Specialist**	
2330 - One Surface	100% PDP/ 75% NON PDP	100% PDP/ 75% NON PDP	$10/$28	No charge
2331 - Two Surfaces	100% PDP/ 75% NON PDP	100% PDP/ 75% NON PDP	$18/$35	No charge
2390 - Resin Crown, Anterior	100% PDP/ 75% Non PDP	100% PDP/ 75% Non PDP	$30/$90	$30
2394 - Resin, Four Or More Surfaces	100% PDP/ 75% Non PDP	100% PDP/ 75% Non PDP	$65/$115	$65
Root Canals				
3310 - Anterior	75%	75%	$90/$110	$45
3330 - Molar	75%	75%	$200/$245	$145
Extractions				
7111 - Single Tooth	75%	75%	No charge/$45	No charge
4210 - Gingivectomy / Gingivoplasty-Per Quadrant	75%	75%	$120/$165	$90
9230 - Inhalation of Nitrous Oxide	75%	75%	75%	75%

Dental (continued)

SCHEDULE OF BENEFITS	Delta Dental PPO - Standard	Delta Dental PPO - Enriched	DeltaCare DHMO - Standard	DeltaCare DHMO - Enriched
TYPE III CROWN & BRIDGE			**General/Specialist**	
2930 - Prefabricated Stainless Steel Primary Tooth	50%	50%	$25/$35	No charge
2750 - Crown Porcelain Fused To High Noble Metal	50% (1 per tooth within a 5 year period)	50% (1 per tooth within a 5 year period)	$477.50/$485	$355
6750 - Crown Porc. Fused To High Noble Metal	50% (1 per tooth within a 5 year period ge 16+)	50% (1 per tooth within a 5 year period - age 16+)	$477.50/$485	$355
6060/6061 – Implant Related Services	60%	60%	50%	50%
6103/6104 – Bone Replacement Grafts	50%	50%	50%	50%
PROSTHODONTICS				
5110 - Complete Upper	50%	50%	$230/$510	$205
5120 - Complete Lower	50%	50%	$230/$510	$205
ORTHODONTIA				
Consultation	Not Covered			
Evaluation	Not Covered			
Records	Not Covered	Adults & Children covered at 50% after one-time deductible of $50 per person.	Pre-treat. Records - $200 Post-treat. Records - $70 Child to age 19 - $2,100 Adults - $2,250	Pre-treat. Records - $200 Post-treat. Records - $70 Child to age 19 - $1,400 Adults - $1,950
8070/8080 Comp. Treat. Child to Age 19 Normal	Not Covered			
Class II				
8090 Comp. Treat. Adult - Normal Class Ii	Not Covered			
8680 Retention	Not Covered	$1,300 Lifetime Maximum.	Retention - $300	Retention - $275

*All Type II and III charges subject to annual deductible. The above reimbursements are exclusive of gold.
All services must be performed by a DeltaCare USA network provider. A referral is required to see a specialist.

Vision

Out-of-Pocket Costs with Humana Vision		
	Standard (in-network)	**Enriched (in-network)**
Eye Exam	No copayment - every plan year	No copayment - every plan year
Glasses	$10 copayment - every other plan year	$10 copayment - every plan year
Frame	$160 Retail Allowance + 20% off balance, every other plan year	$160 Retail Allowance + 20% off balance, every plan year
Lenses (Single, bifocals, trifocals)	$10 copayment - every plan year	$10 copayment - every plan year
Polycarbonate	Paid in full - children up to age 26 / $40 charge for adults	Covered in full
Transition	$0	$0
Progressive	$0	$0
Ultraviolet Coating	$0	$0
Scratch-Resistant Coating	$15 copayment	$15 copayment
Contact Lens Fitting	Standard up to $40 copay; Premium 10% off	Standard and premium covered in full after material copayment
Elective Contacts (in lieu of frame & lenses)	$120 Retail Allowance every plan year	$120 Retail Allowance every plan year