

## IFOCUS BENEFIT PLANS

### IFOCUS Plan A-1 E

<b>BASIC BENEFITS</b>	<b>IN-NETWORK<sup>1</sup></b>	<b>OUT-OF-NETWORK<sup>2,3</sup></b>
Deductible (2x for dependent/family coverage)	\$1,000	\$2,000
Coinsurance	80%	60%
Out-of-Pocket Maximum (2x for dependent/family coverage)	\$4,000	\$8,000
Lifetime Maximum	\$5 Million	
Dependent Eligibility	Unmarried dependent children covered until 25th birthday.	
<b>PREVENTIVE CARE</b>	<b>IN-NETWORK<sup>1</sup></b>	<b>OUT-OF-NETWORK<sup>2,3</sup></b>
Routine Adult Physical Examination <sup>4</sup>	\$35 Copay, then covered at 100%	Coinsurance Only (Deductible Waived)
Well Child Care incl. Immunizations (to age 16)	\$35 Copay, then covered at 100%	Coinsurance Only (Deductible Waived)
Well Woman Exam (Annual OB/GYN visit) <sup>4</sup>	\$35 Copay, then covered at 100%	Coinsurance Only (Deductible Waived)
Mammography (Routine)	Covered at 100%	Covered at 100%
<b>PHYSICIAN AND OUTPATIENT CARE</b>	<b>IN-NETWORK<sup>1</sup></b>	<b>OUT-OF-NETWORK<sup>2,3</sup></b>
Primary Care Physician Office Visits	\$35 Copay, then covered at 100%	Deductible & Coinsurance
Specialist Physician Office Visits	\$60 Copay, then covered at 100%	Deductible & Coinsurance
Dermatology (5 visits per calendar year)	\$60 Copay, then covered at 100%	Deductible & Coinsurance
Outpatient Surgery, Pre-Surgical Testing <sup>5</sup>	Deductible & Coinsurance	Deductible & Coinsurance
Second Surgical Opinions	Deductible & Coinsurance	Deductible & Coinsurance
Mammography (Non-routine)	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Non-Surgical Services <sup>5</sup>	Deductible & Coinsurance	Deductible & Coinsurance
Diagnostic X-Rays, Lab Tests and Procedures	Deductible & Coinsurance	Deductible & Coinsurance
Complex Imaging (MRI, MRA, CAT, PET) <sup>5</sup>	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Rehabilitation Services (60 visits per calendar year) <sup>5</sup>	Deductible & Coinsurance	Deductible & Coinsurance
Chiropractic Care (15 visits per calendar year)	Deductible & Coinsurance	Deductible & Coinsurance
<b>EMERGENCY CARE</b>	<b>IN-NETWORK<sup>1</sup></b>	<b>OUT-OF-NETWORK<sup>2,3</sup></b>
Hospital Emergency Room <sup>6</sup>	Deductible & Coinsurance	Deductible & Coinsurance
Urgent Care Facility	\$75 Copay, then covered at 100%	Deductible & Coinsurance
Ambulance Service - Air and Ground (\$2,000 per calendar year) <sup>5</sup>	Deductible & Coinsurance	Deductible & Coinsurance
<b>HOSPITAL INPATIENT CARE</b>	<b>IN-NETWORK<sup>1</sup></b>	<b>OUT-OF-NETWORK<sup>2,3</sup></b>
Inpatient Hospital Services (Semi-private Room)	Deductible & Coinsurance	Deductible & Coinsurance
Physician and Surgeon Services	Deductible & Coinsurance	Deductible & Coinsurance
Surgical Assistant, Anesthesia	Deductible & Coinsurance	Deductible & Coinsurance
Newborn Nursery Care	Deductible & Coinsurance	Deductible & Coinsurance
Skilled Nursing Facility (30 days per calendar year)	Deductible & Coinsurance	Deductible & Coinsurance
Hospice Care (210 days per lifetime)	Deductible & Coinsurance	Deductible & Coinsurance
<b>OTHER</b>	<b>IN-NETWORK<sup>1</sup></b>	<b>OUT-OF-NETWORK<sup>2,3</sup></b>
Home Health Care (30 visits per calendar year) <sup>5</sup>	Deductible & Coinsurance	Deductible & Coinsurance
Home Infusion Therapy <sup>5</sup>	Deductible & Coinsurance	Deductible & Coinsurance
Medical Supplies	Deductible & Coinsurance	Deductible & Coinsurance <sup>5</sup>
Durable Medical Equipment (\$2,000 per calendar year) <sup>5</sup>	Deductible & Coinsurance	Deductible & Coinsurance <sup>5</sup>
Prosthetics and Orthotics (\$2,000 per calendar year) <sup>5</sup>	Deductible & Coinsurance	Deductible & Coinsurance <sup>5</sup>
Allergy Testing & Treatment	Deductible & Coinsurance	Deductible & Coinsurance
Infertility	Not Covered	Not Covered
<b>OPTIONAL RIDERS</b>	<b>IN-NETWORK<sup>1</sup></b>	<b>OUT-OF-NETWORK<sup>2,3</sup></b>
Maternity - Office Visits		Provided by Rider
Maternity - Hospital Delivery		Provided by Rider
Prescription Drugs		Provided by Rider

1. Network varies by region. Services assume regional network provider delivers care.

2. Out-of-network services are those from a provider that does not participate in Avalon's network.

3. Subject to Reasonable & Customary (R&C) limitations. Balance billing by out-of-network providers may occur.

4. Routine Adult Physical Examination: No waiting period applies. Limited to one exam and up to a \$250 Maximum Benefit per Calendar Year.

Annual OB/GYN Exams: Limited to one exam per Calendar Year.

5. Prior Authorization required for certain services. Failure to pre-certify will result in a 50% benefit reduction.

6. Must notify Avalon Medical Management within 24 hours or reasonably thereafter.

NOTE: This is a benefit summary. It is intended for informational purposes only, and does not represent a full description of benefits provided. For a complete description of benefits and exclusions, please refer to the health insurance policy certificate and schedule of benefits.