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Updated: 10/24/2024 10:32 AM

PLAN NAME	Engage LG125-IN25	Engage LS300-IN25	Engage LS500-IN25	Engage LS550-IN25	Engage LB600-IN25	Engage LB650-IN25
PLAN ID	AVIN_HG_1665_0125	AVIN_HS_1666_0125	AVIN_HS_1667_0125	AVIN_HS_1668_0125	AVIN_HB_1663_0125	AVIN_HB_1664_0125
METAL TIER	Gold	Silver	Silver	Silver	Bronze	Bronze
AvMed Confidential Proprietary / Internal Use Only	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network
DEDUCTIBLE: Individual/Family	$2,000 / $4,000	$3,000 / $6,000	$5,500 / $11,000	$6,500 / $13,000	$6,650 / $13,300	$8,200 / $16,400
OUT OF POCKET MAX: Individual/Family	$4,700 / $9,400	$8,650 / $17,300	$8,000 / $16,000	$8,000 / $16,000	$9,000 / $18,000	$8,200 / $16,400
OFFICE SERVICES						
Primary Care Physician (PCP)	No charge for the first 2 visits; $35 copay per visit thereafter	No charge for the first visit; $40 copay per visit thereafter	No charge for the first visit; $45 copay per visit thereafter	No charge for the first visit; $55 copay per visit thereafter	$70 copay per visit	$75 copay per visit
Specialist	$70 copay per visit	$80 copay per visit	$90 copay per visit	$110 copay per visit	$140 copay per visit	No charge after deductible
Telehealth Virtual Visit	No charge	No charge	No charge	No charge	No charge	No charge
PREVENTIVE CARE						
Preventive Wellness Services	No charge	No charge	No charge	No charge	No charge	No charge
IMMEDIATE MEDICAL CARE**						
Retail Clinic	$45 copay per visit	$50 copay per visit	$55 copay per visit	$65 copay per visit	$80 copay per visit	$85 copay per visit
Urgent Care	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	No charge after deductible
Emergency Room	$500 copay per visit after deductible	$500 copay per visit after deductible	$550 copay per visit after deductible	$500 copay per visit after deductible	$500 copay per visit after deductible	No charge after deductible
Ambulance (Ground)	$200 copay per one way ground transport	$200 copay per one way ground transport	$200 copay per one way ground transport	$200 copay per one way ground transport	$200 copay per one way ground transport	No charge after deductible
OUTPATIENT SERVICES						
Outpatient Radiology						
Complex (CT/PET scans, MRIs, etc.)	$250 copay per visit at independent facilities; $500 copay per visit at hospital-owned or affiliated facilities	$300 copay per visit at independent facilities; $600 copay per visit at hospital-owned or affiliated facilities	$300 copay per visit at independent facilities; $600 copay per visit at hospital-owned or affiliated facilities	$325 copay per visit at independent facilities; $650 copay per visit at hospital-owned or affiliated facilities	$250 copay per visit after deductible at independent facilities; $500 copay per visit after deductible at hospital-owned or affiliated facilities	No charge after deductible
Other (X-ray, ultrasound, etc.)	$75 copay per visit at independent facilities; $150 copay per visit at hospital-owned or affiliated facilities	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$75 copay per visit after deductible at independent facilities; $150 copay per visit after deductible at hospital-owned or affiliated facilities	No charge after deductible
Outpatient Routine Lab	$10 copay per visit	$30 copay per visit	$30 copay per visit	$35 copay per visit	$40 copay per visit	No charge after deductible
Outpatient Surgery - facility	$650 copay per visit after deductible	$725 copay per visit after deductible	$750 copay per visit after deductible	$500 copay per visit after deductible	30% coinsurance after deductible	No charge after deductible
Outpatient Surgery - physician services	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible	30% coinsurance after deductible	No charge after deductible
HOSPITAL						
Inpatient	$850 copay per admission after deductible	$900 copay per day for the first 2 days per admission after deductible	$750 copay per day for the first 2 days per admission after deductible	$500 copay per admission after deductible	$500 copay per admission after deductible	No charge after deductible
PRESCRIPTION DRUGS						
Per Prescription (30 day supply): Value Generic/Generic/Preferred Brand/ Non-Preferred Brand/Specialty [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	$15 copay / $30 copay / $60 copay / $120 copay / 50% coinsurance after deductible	$20 copay / $40 copay / $80 copay / $100 copay / 50% coinsurance after deductible	$20 copay / $40 copay / $80 copay / $100 copay / 50% coinsurance after deductible	$25 copay / $45 copay / $65 copay / $105 copay / 50% coinsurance after deductible	$25 copay / $45 copay / $85 copay after deductible / 50% coinsurance after deductible / 50% coinsurance after deductible	$25 copay / $45 copay / No charge after deductible / No charge after deductible / No charge after deductible
Per Prescription (90 day supply): Value Generic/Generic/Preferred Brand/Non-Preferred Brand [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	$37.50 copay / $75 copay / $150 copay / $300 copay	$50 copay / $100 copay / $200 copay / $250 copay	$50 copay / $100 copay / $200 copay / $250 copay	$62.50 copay / $112.50 copay / $162.50 copay / $262.50 copay	$62.50 copay / $112.50 copay / $212.50 copay after deductible / 50% coinsurance after deductible	$62.50 copay / $112.50 copay / No charge after deductible / No charge after deductible
DENTAL / VISION SERVICES						
Pediatric Eye Exam*	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Glasses*	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Dental*	No charge	No charge	No charge	No charge	No charge	No charge
Adult Eye Exam*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Dental*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

*Limitations may apply. Please refer to your contract.

**Coverage does not apply to facility fees (e.g. hospital room) or physician/surgeon fees.

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PLAN NAME	Engage HSAQ LS350-IN25	Empower MG225-IN25			Empower MS300-IN25	
PLAN ID	AVIN_DHS_1662_0125	AVIN_PG_1672_0125			AVIN_PS_1673_0125	
METAL TIER	Silver	Gold			Silver	
AvMed Confidential Proprietary / Internal Use Only	In-Network	Tier A	Tier B	Out-of-Network	Tier A	Tier B
DEDUCTIBLE: Individual/Family	$3,500 / $7,000	$1,400 / $2,800	$1,400 / $2,800	$4,200 / $8,400	$3,000 / $6,000	$3,000 / $6,000
OUT OF POCKET MAX: Individual/Family	$7,500 / $15,000	$5,400 / $10,800	$5,400 / $10,800	$16,200 / $32,400	$8,650 / $17,300	$8,650 / $17,300
OFFICE SERVICES						
Primary Care Physician (PCP)	20% coinsurance after deductible	No charge for the first 2 visits; $20 copay per visit thereafter	$20 copay per visit	50% coinsurance after deductible	No charge for the first visit; $25 copay per visit thereafter	$25 copay per visit
Specialist	20% coinsurance after deductible	$40 copay per visit	$40 copay per visit	50% coinsurance after deductible	$50 copay per visit	$50 copay per visit
Telehealth Virtual Visit	20% coinsurance after deductible	No charge	Not Covered	Not Covered	No charge	Not Covered
PREVENTIVE CARE						
Preventive Wellness Services	No charge	No charge	No charge	50% coinsurance after deductible	No charge	No charge
IMMEDIATE MEDICAL CARE**						
Retail Clinic	20% coinsurance after deductible	$30 copay per visit	$30 copay per visit	$30 copay per visit	$35 copay per visit	$35 copay per visit
Urgent Care	20% coinsurance after deductible	$70 copay per visit at independent facilities; $140 copay per visit at hospital-owned or affiliated facilities	$70 copay per visit at independent facilities; $140 copay per visit at hospital-owned or affiliated facilities	$70 copay per visit at independent facilities; $140 copay per visit at hospital-owned or affiliated facilities	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities
Emergency Room	20% coinsurance after deductible	$350 copay per visit after deductible	$350 copay per visit after deductible	$350 copay per visit after deductible	$500 copay per visit after deductible	$500 copay per visit after deductible
Ambulance (Ground)	20% coinsurance after deductible	$200 copay per one way ground transport	$200 copay per one way ground transport	$200 copay per one way ground transport	$200 copay per one way ground transport	$200 copay per one way ground transport
OUTPATIENT SERVICES						
Outpatient Radiology						
Complex (CT/PET scans, MRIs, etc.)	20% coinsurance after deductible	$150 copay per visit at independent facilities; $300 copay per visit at hospital-owned or affiliated facilities	$150 copay per visit at independent facilities; $300 copay per visit at hospital-owned or affiliated facilities	50% coinsurance after deductible	$275 copay per visit at independent facilities; $550 copay per visit at hospital-owned or affiliated facilities	$275 copay per visit at independent facilities; $550 copay per visit at hospital-owned or affiliated facilities
Other (X-ray, ultrasound, etc.)	20% coinsurance after deductible	$75 copay per visit at independent facilities; $150 copay per visit at hospital-owned or affiliated facilities	$75 copay per visit at independent facilities; $150 copay per visit at hospital-owned or affiliated facilities	50% coinsurance after deductible	$75 copay per visit at independent facilities; $150 copay per visit at hospital-owned or affiliated facilities	$75 copay per visit at independent facilities; $150 copay per visit at hospital-owned or affiliated facilities
Outpatient Routine Lab	20% coinsurance after deductible	$10 copay per visit	$10 copay per visit	50% coinsurance after deductible	$25 copay per visit	$25 copay per visit
Outpatient Surgery - facility	20% coinsurance after deductible	$650 copay per visit after deductible	$650 copay per visit after deductible	50% coinsurance after deductible	$750 copay per visit after deductible	$750 copay per visit after deductible
Outpatient Surgery - physician services	20% coinsurance after deductible	No charge after deductible	No charge after deductible	50% coinsurance after deductible	No charge after deductible	No charge after deductible
HOSPITAL						
Inpatient	20% coinsurance after deductible	$700 copay per day for the first 3 days per admission after deductible	$700 copay per day for the first 3 days per admission after deductible	50% coinsurance after deductible	$750 copay per day for the first 3 days per admission after deductible	$750 copay per day for the first 3 days per admission after deductible
PRESCRIPTION DRUGS						
Per Prescription (30 day supply): Value Generic/Generic/Preferred Brand/ Non-Preferred Brand/Specialty [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	20% coinsurance after deductible	$15 copay / $30 copay / $60 copay / $120 copay / 50% coinsurance after deductible	$15 copay / $30 copay / $60 copay / $120 copay / 50% coinsurance after deductible	Not Covered	$20 copay / $40 copay / $80 copay / $100 copay / 50% coinsurance after deductible	$20 copay / $40 copay / $80 copay / $100 copay / 50% coinsurance after deductible
Per Prescription (90 day supply): Value Generic/Generic/Preferred Brand/Non-Preferred Brand [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	20% coinsurance after deductible	$37.50 copay / $75 copay / $150 copay / $300 copay	$37.50 copay / $75 copay / $150 copay / $300 copay	Not Covered	$50 copay / $100 copay / $200 copay / $250 copay	$50 copay / $100 copay / $200 copay / $250 copay
DENTAL / VISION SERVICES						
Pediatric Eye Exam*	20% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible	No charge	No charge
Pediatric Glasses*	20% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible	No charge	No charge
Pediatric Dental*	No charge	No charge	No charge	No charge	No charge	No charge
Adult Eye Exam*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Dental*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

*Limitations may apply. Please refer to your contract.

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PLAN NAME		Empower MS400-IN25			
PLAN ID		AVIN_PS_1674_0125			
METAL TIER		Silver			
AvMed Confidential Proprietary / Internal Use Only	Out-of-Network	Tier A	Tier B	Out-of-Network	Tier A
DEDUCTIBLE: Individual/Family	$9,000 / $18,000	$4,500 / $9,000	$4,500 / $9,000	$13,500 / $27,000	$5,500 / $11,000
OUT OF POCKET MAX: Individual/Family	$25,950 / $51,900	$8,000 / $16,000	$8,000 / $16,000	$24,000 / $48,000	$8,000 / $16,000
OFFICE SERVICES					
Primary Care Physician (PCP)	50% coinsurance after deductible	No charge for the first visit; $30 copay per visit thereafter	$30 copay per visit	50% coinsurance after deductible	No charge for the first visit; $30 copay per visit thereafter
Specialist	50% coinsurance after deductible	$60 copay per visit	$60 copay per visit	50% coinsurance after deductible	$60 copay per visit
Telehealth Virtual Visit	Not Covered	No charge	Not Covered	Not Covered	No charge
PREVENTIVE CARE					
Preventive Wellness Services	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible	No charge
IMMEDIATE MEDICAL CARE**					
Retail Clinic	$35 copay per visit	$40 copay per visit	$40 copay per visit	$40 copay per visit	$40 copay per visit
Urgent Care	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities	$110 copay per visit at independent facilities; $220 copay per visit at hospital-owned or affiliated facilities
Emergency Room	$500 copay per visit after deductible	$500 copay per visit after deductible	$500 copay per visit after deductible	$500 copay per visit after deductible	$550 copay per visit after deductible
Ambulance (Ground)	$200 copay per one way ground transport	$200 copay per one way ground transport	$200 copay per one way ground transport	$200 copay per one way ground transport	$200 copay per one way ground transport
OUTPATIENT SERVICES					
Outpatient Radiology					
Complex (CT/PET scans, MRIs, etc.)	50% coinsurance after deductible	$275 copay per visit at independent facilities; $550 copay per visit at hospital-owned or affiliated facilities	$275 copay per visit at independent facilities; $550 copay per visit at hospital-owned or affiliated facilities	50% coinsurance after deductible	$300 copay per visit at independent facilities; $600 copay per visit at hospital-owned or affiliated facilities
Other (X-ray, ultrasound, etc.)	50% coinsurance after deductible	$75 copay per visit at independent facilities; $150 copay per visit at hospital-owned or affiliated facilities	$75 copay per visit at independent facilities; $150 copay per visit at hospital-owned or affiliated facilities	50% coinsurance after deductible	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities
Outpatient Routine Lab	50% coinsurance after deductible	$30 copay per visit	$30 copay per visit	50% coinsurance after deductible	$30 copay per visit
Outpatient Surgery - facility	50% coinsurance after deductible	$750 copay per visit after deductible	$750 copay per visit after deductible	50% coinsurance after deductible	$750 copay per visit after deductible
Outpatient Surgery - physician services	50% coinsurance after deductible	No charge after deductible	No charge after deductible	50% coinsurance after deductible	No charge after deductible
HOSPITAL					
Inpatient	50% coinsurance after deductible	$800 copay per day for the first 3 days per admission after deductible	$800 copay per day for the first 3 days per admission after deductible	50% coinsurance after deductible	$950 copay per admission after deductible
PRESCRIPTION DRUGS					
Per Prescription (30 day supply): Value Generic/Generic/Preferred Brand/ Non-Preferred Brand/Specialty [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	Not Covered	$20 copay / $40 copay / $80 copay / $100 copay / 50% coinsurance after deductible	$20 copay / $40 copay / $80 copay / $100 copay / 50% coinsurance after deductible	Not Covered	$20 copay / $40 copay / $80 copay / $100 copay / 50% coinsurance after deductible
Per Prescription (90 day supply): Value Generic/Generic/Preferred Brand/Non-Preferred Brand [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	Not Covered	$50 copay / $100 copay / $200 copay / $250 copay	$50 copay / $100 copay / $200 copay / $250 copay	Not Covered	$50 copay / $100 copay / $200 copay / $250 copay
DENTAL / VISION SERVICES					
Pediatric Eye Exam*	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible	No charge
Pediatric Glasses*	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible	No charge
Pediatric Dental*	No charge	No charge	No charge	No charge	No charge
Adult Eye Exam*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Dental*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

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PLAN NAME	Empower MS500-IN25		Empower MB600-IN25		
PLAN ID	AVIN_PS_1675_0125		AVIN_PB_1670_0125		
METAL TIER	Silver		Bronze		
AvMed Confidential Proprietary / Internal Use Only	Tier B	Out-of-Network	Tier A	Tier B	Out-of-Network
DEDUCTIBLE: Individual/Family	$5,500 / $11,000	$16,500 / $33,000	$7,900 / $15,800	$7,900 / $15,800	$23,700 / $47,400
OUT OF POCKET MAX: Individual/Family	$8,000 / $16,000	$24,000 / $48,000	$8,900 / $17,800	$8,900 / $17,800	$26,700 / $53,400
OFFICE SERVICES					
Primary Care Physician (PCP)	$30 copay per visit	50% coinsurance after deductible	$50 copay per visit	$50 copay per visit	50% coinsurance after deductible
Specialist	$60 copay per visit	50% coinsurance after deductible	$100 copay per visit	$100 copay per visit	50% coinsurance after deductible
Telehealth Virtual Visit	Not Covered	Not Covered	No charge	Not Covered	Not Covered
PREVENTIVE CARE					
Preventive Wellness Services	No charge	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible
IMMEDIATE MEDICAL CARE**					
Retail Clinic	$40 copay per visit	$40 copay per visit	$60 copay per visit	$60 copay per visit	$60 copay per visit
Urgent Care	$110 copay per visit at independent facilities; $220 copay per visit at hospital-owned or affiliated facilities	$110 copay per visit at independent facilities; $220 copay per visit at hospital-owned or affiliated facilities	$60 copay per visit at independent facilities; $120 copay per visit at hospital-owned or affiliated facilities	$60 copay per visit at independent facilities; $120 copay per visit at hospital-owned or affiliated facilities	$60 copay per visit at independent facilities; $120 copay per visit at hospital-owned or affiliated facilities
Emergency Room	$550 copay per visit after deductible	$550 copay per visit after deductible	$300 copay per visit after deductible	$300 copay per visit after deductible	$300 copay per visit after deductible
Ambulance (Ground)	$200 copay per one way ground transport	$200 copay per one way ground transport	$200 copay per one way ground transport	$200 copay per one way ground transport	$200 copay per one way ground transport
OUTPATIENT SERVICES					
Outpatient Radiology					
Complex (CT/PET scans, MRIs, etc.)	$300 copay per visit at independent facilities; $600 copay per visit at hospital-owned or affiliated facilities	50% coinsurance after deductible	$250 copay per visit after deductible at independent facilities; $300 copay per visit after deductible at hospital-owned or affiliated facilities	$250 copay per visit after deductible at independent facilities; $300 copay per visit after deductible at hospital-owned or affiliated facilities	50% coinsurance after deductible
Other (X-ray, ultrasound, etc.)	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities	50% coinsurance after deductible	$65 copay per visit after deductible at independent facilities; $130 copay per visit after deductible at hospital-owned or affiliated facilities	$65 copay per visit after deductible at independent facilities; $130 copay per visit after deductible at hospital-owned or affiliated facilities	50% coinsurance after deductible
Outpatient Routine Lab	$30 copay per visit	50% coinsurance after deductible	$40 copay per visit	$40 copay per visit	50% coinsurance after deductible
Outpatient Surgery - facility	$750 copay per visit after deductible	50% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient Surgery - physician services	No charge after deductible	50% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
HOSPITAL					
Inpatient	$950 copay per admission after deductible	50% coinsurance after deductible	$300 copay per admission after deductible	$300 copay per admission after deductible	50% coinsurance after deductible
PRESCRIPTION DRUGS					
Per Prescription (30 day supply): Value Generic/Generic/Preferred Brand/ Non-Preferred Brand/Specialty [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	$20 copay / $40 copay / $80 copay / $100 copay / 50% coinsurance after deductible	Not Covered	$25 copay / $45 copay / $85 copay after deductible / 50% coinsurance after deductible / 50% coinsurance after deductible	$25 copay / $45 copay / $85 copay after deductible / 50% coinsurance after deductible / 50% coinsurance after deductible	Not Covered
Per Prescription (90 day supply): Value Generic/Generic/Preferred Brand/Non-Preferred Brand [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	$50 copay / $100 copay / $200 copay / $250 copay	Not Covered	$62.50 copay / $112.50 copay / $212.50 copay after deductible / 50% coinsurance after deductible	$62.50 copay / $112.50 copay / $212.50 copay after deductible / 50% coinsurance after deductible	Not Covered
DENTAL / VISION SERVICES					
Pediatric Eye Exam*	No charge	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible
Pediatric Glasses*	No charge	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible
Pediatric Dental*	No charge	No charge	No charge	No charge	No charge
Adult Eye Exam*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Dental*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

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PLAN NAME	Empower MB650-IN25			Empower HSAQ MS350-IN25	
PLAN ID	AVIN_PB_1671_0125			AVIN_DPS_1669_0125	
METAL TIER	Bronze			Silver	
AvMed Confidential Proprietary / Internal Use Only	Tier A	Tier B	Out-of-Network	Tier A	Tier B
DEDUCTIBLE: Individual/Family	$8,200 / $16,400	$8,200 / $16,400	$24,600 / $49,200	$3,500 / $7,000	$3,500 / $7,000
OUT OF POCKET MAX: Individual/Family	$8,200 / $16,400	$8,200 / $16,400	$24,600 / $49,200	$7,000 / $14,000	$7,000 / $14,000
OFFICE SERVICES					
Primary Care Physician (PCP)	$75 copay per visit	$75 copay per visit	No charge after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Specialist	No charge after deductible	No charge after deductible	No charge after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Telehealth Virtual Visit	No charge	Not Covered	Not Covered	20% coinsurance after deductible	Not Covered
PREVENTIVE CARE					
Preventive Wellness Services	No charge	No charge	No charge after deductible	No charge	No charge
IMMEDIATE MEDICAL CARE**					
Retail Clinic	$85 copay per visit	$85 copay per visit	$85 copay per visit	20% coinsurance after deductible	20% coinsurance after deductible
Urgent Care	No charge after deductible	No charge after deductible	No charge after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Emergency Room	No charge after deductible	No charge after deductible	No charge after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Ambulance (Ground)	No charge after deductible	No charge after deductible	No charge after deductible	20% coinsurance after deductible	20% coinsurance after deductible
OUTPATIENT SERVICES					
Outpatient Radiology					
Complex (CT/PET scans, MRIs, etc.)	No charge after deductible	No charge after deductible	No charge after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Other (X-ray, ultrasound, etc.)	No charge after deductible	No charge after deductible	No charge after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient Routine Lab	No charge after deductible	No charge after deductible	No charge after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient Surgery - facility	No charge after deductible	No charge after deductible	No charge after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient Surgery - physician services	No charge after deductible	No charge after deductible	No charge after deductible	20% coinsurance after deductible	20% coinsurance after deductible
HOSPITAL					
Inpatient	No charge after deductible	No charge after deductible	No charge after deductible	20% coinsurance after deductible	20% coinsurance after deductible
PRESCRIPTION DRUGS					
Per Prescription (30 day supply): Value Generic/Generic/Preferred Brand/ Non-Preferred Brand/Specialty [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	$25 copay / $45 copay / No charge after deductible / No charge after deductible / No charge after deductible	$25 copay / $45 copay / No charge after deductible / No charge after deductible / No charge after deductible	Not Covered	20% coinsurance after deductible	20% coinsurance after deductible
Per Prescription (90 day supply): Value Generic/Generic/Preferred Brand/Non-Preferred Brand [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	$62.50 copay / $112.50 copay / No charge after deductible / No charge after deductible	$62.50 copay / $112.50 copay / No charge after deductible / No charge after deductible	Not Covered	20% coinsurance after deductible	20% coinsurance after deductible
DENTAL / VISION SERVICES					
Pediatric Eye Exam*	No charge	No charge	No charge after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Pediatric Glasses*	No charge	No charge	No charge after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Pediatric Dental*	No charge	No charge	No charge	No charge	No charge
Adult Eye Exam*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Dental*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

*Limitations may apply. Please refer to your contract.

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PLAN NAME		Entrust Platinum 25 (2025)	Entrust Platinum 25 (2025)	Entrust Platinum 25 Zero Cost Share (2025)	Entrust Platinum 25 Limited Cost Share (2025)	
PLAN ID		AVIN_HP_1654_0125	AVIN_HP_1654_0125	AVIN_HP_165402_0125	AVIN_HP_165403_0125	
METAL TIER		Platinum	Platinum	Platinum	Platinum	
AvMed Confidential Proprietary / Internal Use Only	Out-of-Network	In-Network	In-Network	IHCP	IHCP	Non-IHCP In-Network
DEDUCTIBLE: Individual/Family	$10,500 / $21,000	$0 / $0	$0 / $0	$0 / $0	$0 / $0	$0 / $0
OUT OF POCKET MAX: Individual/Family	$21,000 / $42,000	$4,350 / $8,700	$4,350 / $8,700	$0 / $0	$0 / $0	$4,350 / $8,700
OFFICE SERVICES						
Primary Care Physician (PCP)	50% coinsurance after deductible	$10 copay per visit	$10 copay per visit	No charge	No charge	$10 copay per visit
Specialist	50% coinsurance after deductible	$20 copay per visit	$20 copay per visit	No charge	No charge	$20 copay per visit
Telehealth Virtual Visit	Not Covered	No charge	No charge	No charge	No charge	No charge
PREVENTIVE CARE						
Preventive Wellness Services	50% coinsurance after deductible	No charge	No charge	No charge	No charge	No charge
IMMEDIATE MEDICAL CARE**						
Retail Clinic	20% coinsurance after deductible	$20 copay per visit	$20 copay per visit	No charge	No charge	$20 copay per visit
Urgent Care	20% coinsurance after deductible at independent facilities; 50% coinsurance after deductible at hospital-owned or affiliated facilities	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	No charge	No charge	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities
Emergency Room	20% coinsurance after deductible	$100 copay per visit	$100 copay per visit	No charge	No charge	$100 copay per visit
Ambulance (Ground)	20% coinsurance after deductible	$200 copay per one way ground transport	$200 copay per one way ground transport	No charge	No charge	$200 copay per one way ground transport
OUTPATIENT SERVICES						
Outpatient Radiology						
Complex (CT/PET scans, MRIs, etc.)	50% coinsurance after deductible	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities	No charge	No charge	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities
Other (X-ray, ultrasound, etc.)	50% coinsurance after deductible	$10 copay per visit at independent facilities; $20 copay per visit at hospital-owned or affiliated facilities	$10 copay per visit at independent facilities; $20 copay per visit at hospital-owned or affiliated facilities	No charge	No charge	$10 copay per visit at independent facilities; $20 copay per visit at hospital-owned or affiliated facilities
Outpatient Routine Lab	50% coinsurance after deductible	No charge	No charge	No charge	No charge	No charge
Outpatient Surgery - facility	50% coinsurance after deductible	$200 copay per visit	$200 copay per visit	No charge	No charge	$200 copay per visit
Outpatient Surgery - physician services	50% coinsurance after deductible	No charge	No charge	No charge	No charge	No charge
HOSPITAL						
Inpatient	50% coinsurance after deductible	$350 copay per day for the first 3 days per admission	$350 copay per day for the first 3 days per admission	No charge	No charge	$350 copay per day for the first 3 days per admission
PRESCRIPTION DRUGS						
Per Prescription (30 day supply): Value Generic/Generic/Preferred Brand/ Non-Preferred Brand/Specialty [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	Not Covered	No charge / $5 copay / $20 copay / $60 copay / 50% coinsurance	No charge / $5 copay / $20 copay / $60 copay / 50% coinsurance	No charge	No charge	No charge / $5 copay / $20 copay / $60 copay / 50% coinsurance
Per Prescription (90 day supply): Value Generic/Generic/Preferred Brand/Non-Preferred Brand [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	Not Covered	No charge / $12.50 copay / $50 copay / $150 copay	No charge / $12.50 copay / $50 copay / $150 copay	No charge	No charge	No charge / $12.50 copay / $50 copay / $150 copay
DENTAL / VISION SERVICES						
Pediatric Eye Exam*	50% coinsurance after deductible	No charge	No charge	No charge	No charge	No charge
Pediatric Glasses*	50% coinsurance after deductible	No charge	No charge	No charge	No charge	No charge
Pediatric Dental*	No charge	No charge	No charge	No charge	No charge	No charge
Adult Eye Exam*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Dental*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

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PLAN NAME	Entrust Platinum Standard (2025)	Entrust Platinum Standard (2025)	Entrust Platinum Standard Zero Cost Share (2025)	Entrust Platinum Standard Limited Cost Share (2025)		Entrust Gold 125 (2025)
PLAN ID	AVIN_HP_1656_0125	AVIN_HP_1656_0125	AVIN_HP_165602_0125	AVIN_HP_165603_0125		AVIN_HG_1651_0125
METAL TIER	Platinum	Platinum	Platinum	Platinum		Gold
AvMed Confidential Proprietary / Internal Use Only	In-Network	In-Network	IHCP	IHCP	Non-IHCP In-Network	In-Network
DEDUCTIBLE: Individual/Family	$0 / $0	$0 / $0	$0 / $0	$0 / $0	$0 / $0	$2,000 / $4,000
OUT OF POCKET MAX: Individual/Family	$4,300 / $8,600	$4,300 / $8,600	$0 / $0	$0 / $0	$4,300 / $8,600	$4,700 / $9,400
OFFICE SERVICES						
Primary Care Physician (PCP)	$10 copay per visit	$10 copay per visit	No charge	No charge	$10 copay per visit	$35 copay per visit
Specialist	$20 copay per visit	$20 copay per visit	No charge	No charge	$20 copay per visit	$70 copay per visit
Telehealth Virtual Visit	No charge	No charge	No charge	No charge	No charge	No charge
PREVENTIVE CARE						
Preventive Wellness Services	No charge	No charge	No charge	No charge	No charge	No charge
IMMEDIATE MEDICAL CARE**						
Retail Clinic	$15 copay per visit	$15 copay per visit	No charge	No charge	$15 copay per visit	$45 copay per visit
Urgent Care	$15 copay per visit	$15 copay per visit	No charge	No charge	$15 copay per visit	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities
Emergency Room	$100 copay per visit	$100 copay per visit	No charge	No charge	$100 copay per visit	$500 copay per visit after deductible
Ambulance (Ground)	$200 copay per one way ground transport	$200 copay per one way ground transport	No charge	No charge	$200 copay per one way ground transport	$200 copay per one way ground transport
OUTPATIENT SERVICES						
Outpatient Radiology						
Complex (CT/PET scans, MRIs, etc.)	$100 copay per visit	$100 copay per visit	No charge	No charge	$100 copay per visit	$250 copay per visit at independent facilities; $500 copay per visit at hospital-owned or affiliated facilities
Other (X-ray, ultrasound, etc.)	$30 copay per visit	$30 copay per visit	No charge	No charge	$30 copay per visit	$75 copay per visit at independent facilities; $150 copay per visit at hospital-owned or affiliated facilities
Outpatient Routine Lab	$30 copay per visit	$30 copay per visit	No charge	No charge	$30 copay per visit	$10 copay per visit
Outpatient Surgery - facility	$150 copay per visit	$150 copay per visit	No charge	No charge	$150 copay per visit	$650 copay per visit after deductible
Outpatient Surgery - physician services	$150 copay per visit	$150 copay per visit	No charge	No charge	$150 copay per visit	No charge after deductible
HOSPITAL						
Inpatient	$350 copay per admission	$350 copay per admission	No charge	No charge	$350 copay per admission	$850 copay per admission after deductible
PRESCRIPTION DRUGS						
Per Prescription (30 day supply): Value Generic/Generic/Preferred Brand/ Non-Preferred Brand/Specialty [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	$5 copay / $10 copay / $50 copay / $150 copay	$5 copay / $10 copay / $50 copay / $150 copay	No charge	No charge	$5 copay / $10 copay / $50 copay / $150 copay	$15 copay / $30 copay / $60 copay / $120 copay / 50% coinsurance after deductible
Per Prescription (90 day supply): Value Generic/Generic/Preferred Brand/Non-Preferred Brand [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	$12.50 copay / $25 copay / $125 copay	$12.50 copay / $25 copay / $125 copay	No charge	No charge	$12.50 copay / $25 copay / $125 copay	$37.50 copay / $75 copay / $150 copay / $300 copay
DENTAL / VISION SERVICES						
Pediatric Eye Exam*	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Glasses*	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Dental*	No charge	No charge	No charge	No charge	No charge	No charge
Adult Eye Exam*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Dental*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

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PLAN NAME	Entrust Gold 125 (2025)	Entrust Gold 125 Zero Cost Share (2025)	Entrust Gold 125 Limited Cost Share (2025)		Entrust Gold Standard (2025)	Entrust Gold Standard (2025)
PLAN ID	AVIN_HG_1651_0125	AVIN_HG_165102_0125	AVIN_HG_165103_0125		AVIN_HG_1653_0125	AVIN_HG_1653_0125
METAL TIER	Gold	Gold	Gold		Gold	Gold
AvMed Confidential Proprietary / Internal Use Only	In-Network	IHCP	IHCP	Non-IHCP In-Network	In-Network	In-Network
DEDUCTIBLE: Individual/Family	$2,000 / $4,000	$0 / $0	$0 / $0	$2,000 / $4,000	$1,500 / $3,000	$1,500 / $3,000
OUT OF POCKET MAX: Individual/Family	$4,700 / $9,400	$0 / $0	$0 / $0	$4,700 / $9,400	$7,800 / $15,600	$7,800 / $15,600
OFFICE SERVICES						
Primary Care Physician (PCP)	$35 copay per visit	No charge	No charge	$35 copay per visit	$30 copay per visit	$30 copay per visit
Specialist	$70 copay per visit	No charge	No charge	$70 copay per visit	$60 copay per visit	$60 copay per visit
Telehealth Virtual Visit	No charge	No charge	No charge	No charge	No charge	No charge
PREVENTIVE CARE						
Preventive Wellness Services	No charge	No charge	No charge	No charge	No charge	No charge
IMMEDIATE MEDICAL CARE**						
Retail Clinic	$45 copay per visit	No charge	No charge	$45 copay per visit	$40 copay per visit	$40 copay per visit
Urgent Care	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	No charge	No charge	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$45 copay per visit	$45 copay per visit
Emergency Room	$500 copay per visit after deductible	No charge	No charge	$500 copay per visit after deductible	25% coinsurance after deductible	25% coinsurance after deductible
Ambulance (Ground)	$200 copay per one way ground transport	No charge	No charge	$200 copay per one way ground transport	$200 copay per one way ground transport	$200 copay per one way ground transport
OUTPATIENT SERVICES						
Outpatient Radiology						
Complex (CT/PET scans, MRIs, etc.)	$250 copay per visit at independent facilities; $500 copay per visit at hospital-owned or affiliated facilities	No charge	No charge	$250 copay per visit at independent facilities; $500 copay per visit at hospital-owned or affiliated facilities	25% coinsurance after deductible	25% coinsurance after deductible
Other (X-ray, ultrasound, etc.)	$75 copay per visit at independent facilities; $150 copay per visit at hospital-owned or affiliated facilities	No charge	No charge	$75 copay per visit at independent facilities; $150 copay per visit at hospital-owned or affiliated facilities	25% coinsurance after deductible	25% coinsurance after deductible
Outpatient Routine Lab	$10 copay per visit	No charge	No charge	$10 copay per visit	25% coinsurance after deductible	25% coinsurance after deductible
Outpatient Surgery - facility	$650 copay per visit after deductible	No charge	No charge	$650 copay per visit after deductible	25% coinsurance after deductible	25% coinsurance after deductible
Outpatient Surgery - physician services	No charge after deductible	No charge	No charge	No charge after deductible	25% coinsurance after deductible	25% coinsurance after deductible
HOSPITAL						
Inpatient	$850 copay per admission after deductible	No charge	No charge	$850 copay per admission after deductible	25% coinsurance after deductible	25% coinsurance after deductible
PRESCRIPTION DRUGS						
Per Prescription (30 day supply): Value Generic/Generic/Preferred Brand/ Non-Preferred Brand/Specialty [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	$15 copay / $30 copay / $60 copay / $120 copay / 50% coinsurance after deductible	No charge	No charge	$15 copay / $30 copay / $60 copay / $120 copay / 50% coinsurance after deductible	$15 copay / $30 copay / $60 copay / $250 copay	$15 copay / $30 copay / $60 copay / $250 copay
Per Prescription (90 day supply): Value Generic/Generic/Preferred Brand/Non-Preferred Brand [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	$37.50 copay / $75 copay / $150 copay / $300 copay	No charge	No charge	$37.50 copay / $75 copay / $150 copay / $300 copay	$37.50 copay / $75 copay / $150 copay	$37.50 copay / $75 copay / $150 copay
DENTAL / VISION SERVICES						
Pediatric Eye Exam*	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Glasses*	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Dental*	No charge	No charge	No charge	No charge	No charge	No charge
Adult Eye Exam*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Dental*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

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PLAN NAME	Entrust Gold Standard Zero Cost Share (2025)	Entrust Gold Standard Limited Cost Share (2025)		Entrust Silver 350 (2025)	Entrust Silver 350 (2025)	Entrust Silver 350 Zero Cost Share (2025)
PLAN ID	AVIN_HG_165302_0125	AVIN_HG_165303_0125		AVIN_HS_1658_0125	AVIN_HS_1658_0125	AVIN_HS_165802_0125
METAL TIER	Gold	Gold		Silver	Silver	Silver
AvMed Confidential Proprietary / Internal Use Only	IHCP	IHCP	Non-IHCP In-Network	In-Network	In-Network	IHCP
DEDUCTIBLE: Individual/Family	$0 / $0	$0 / $0	$1,500 / $3,000	$3,500 / $7,000	$3,500 / $7,000	$0 / $0
OUT OF POCKET MAX: Individual/Family	$0 / $0	$0 / $0	$7,800 / $15,600	$8,000 / $16,000	$8,000 / $16,000	$0 / $0
OFFICE SERVICES						
Primary Care Physician (PCP)	No charge	No charge	$30 copay per visit	$30 copay per visit	$30 copay per visit	No charge
Specialist	No charge	No charge	$60 copay per visit	$60 copay per visit	$60 copay per visit	No charge
Telehealth Virtual Visit	No charge	No charge	No charge	No charge	No charge	No charge
PREVENTIVE CARE						
Preventive Wellness Services	No charge	No charge	No charge	No charge	No charge	No charge
IMMEDIATE MEDICAL CARE**						
Retail Clinic	No charge	No charge	$40 copay per visit	$40 copay per visit	$40 copay per visit	No charge
Urgent Care	No charge	No charge	$45 copay per visit	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	No charge
Emergency Room	No charge	No charge	25% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	No charge
Ambulance (Ground)	No charge	No charge	$200 copay per one way ground transport	$200 copay per one way ground transport	$200 copay per one way ground transport	No charge
OUTPATIENT SERVICES						
Outpatient Radiology						
Complex (CT/PET scans, MRIs, etc.)	No charge	No charge	25% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	No charge
Other (X-ray, ultrasound, etc.)	No charge	No charge	25% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	No charge
Outpatient Routine Lab	No charge	No charge	25% coinsurance after deductible	$30 copay per visit	$30 copay per visit	No charge
Outpatient Surgery - facility	No charge	No charge	25% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	No charge
Outpatient Surgery - physician services	No charge	No charge	25% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	No charge
HOSPITAL						
Inpatient	No charge	No charge	25% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	No charge
PRESCRIPTION DRUGS						
Per Prescription (30 day supply): Value Generic/Generic/Preferred Brand/ Non-Preferred Brand/Specialty [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	No charge	No charge	$15 copay / $30 copay / $60 copay / $250 copay	$20 copay / $45 copay / $80 copay / 50% coinsurance after deductible / 50% coinsurance after deductible	$20 copay / $45 copay / $80 copay / 50% coinsurance after deductible / 50% coinsurance after deductible	No charge
Per Prescription (90 day supply): Value Generic/Generic/Preferred Brand/Non-Preferred Brand [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	No charge	No charge	$37.50 copay / $75 copay / $150 copay	$50 copay / $112.50 copay / $200 copay / 50% coinsurance after deductible	$50 copay / $112.50 copay / $200 copay / 50% coinsurance after deductible	No charge
DENTAL / VISION SERVICES						
Pediatric Eye Exam*	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Glasses*	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Dental*	No charge	No charge	No charge	No charge	No charge	No charge
Adult Eye Exam*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Dental*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

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PLAN NAME	Entrust Silver 350 Limited Cost Share (2025)		Entrust Silver 350 73% AV (2025)	Entrust Silver 350 87% AV (2025)	Entrust Silver 350 94% AV (2025)	Entrust Silver 550 (2025)
PLAN ID	AVIN_HS_165803_0125		AVIN_HS_165804_0125	AVIN_HS_165805_0125	AVIN_HS_165806_0125	AVIN_HS_1660_0125
METAL TIER	Silver		Silver	Silver	Silver	Silver
AvMed Confidential Proprietary / Internal Use Only	IHCP	Non-IHCP In-Network	In-Network	In-Network	In-Network	In-Network
DEDUCTIBLE: Individual/Family	$0 / $0	$3,500 / $7,000	$3,000 / $6,000	$0 / $0	$0 / $0	$6,250 / $12,500
OUT OF POCKET MAX: Individual/Family	$0 / $0	$8,000 / $16,000	$7,250 / $14,500	$3,050 / $6,100	$1,500 / $3,000	$7,250 / $14,500
OFFICE SERVICES						
Primary Care Physician (PCP)	No charge	$30 copay per visit	$15 copay per visit	$15 copay per visit	No charge	$55 copay per visit
Specialist	No charge	$60 copay per visit	$30 copay per visit	$30 copay per visit	$10 copay per visit	$110 copay per visit
Telehealth Virtual Visit	No charge	No charge	No charge	No charge	No charge	No charge
PREVENTIVE CARE						
Preventive Wellness Services	No charge	No charge	No charge	No charge	No charge	No charge
IMMEDIATE MEDICAL CARE**						
Retail Clinic	No charge	$40 copay per visit	$25 copay per visit	$25 copay per visit	No charge	$65 copay per visit
Urgent Care	No charge	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities
Emergency Room	No charge	50% coinsurance after deductible	50% coinsurance after deductible	40% coinsurance	25% coinsurance	$500 copay per visit after deductible
Ambulance (Ground)	No charge	$200 copay per one way ground transport	$200 copay per one way ground transport	$200 copay per one way ground transport	$200 copay per one way ground transport	$200 copay per one way ground transport
OUTPATIENT SERVICES						
Outpatient Radiology						
Complex (CT/PET scans, MRIs, etc.)	No charge	50% coinsurance after deductible	50% coinsurance after deductible	40% coinsurance	25% coinsurance	$325 copay per visit at independent facilities; $650 copay per visit at hospital-owned or affiliated facilities
Other (X-ray, ultrasound, etc.)	No charge	50% coinsurance after deductible	50% coinsurance after deductible	40% coinsurance	25% coinsurance	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities
Outpatient Routine Lab	No charge	$30 copay per visit	$30 copay per visit	$15 copay per visit	No charge	$35 copay per visit
Outpatient Surgery - facility	No charge	50% coinsurance after deductible	50% coinsurance after deductible	40% coinsurance	25% coinsurance	$500 copay per visit after deductible
Outpatient Surgery - physician services	No charge	50% coinsurance after deductible	50% coinsurance after deductible	40% coinsurance	25% coinsurance	No charge after deductible
HOSPITAL						
Inpatient	No charge	50% coinsurance after deductible	50% coinsurance after deductible	40% coinsurance	25% coinsurance	$500 copay per admission after deductible
PRESCRIPTION DRUGS						
Per Prescription (30 day supply): Value Generic/Generic/Preferred Brand/ Non-Preferred Brand/Specialty [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	No charge	$20 copay / $45 copay / $80 copay / 50% coinsurance after deductible / 50% coinsurance after deductible	$20 copay / $45 copay / $80 copay / 50% coinsurance after deductible / 50% coinsurance after deductible	$15 copay / $30 copay / $40 copay / 50% coinsurance / 50% coinsurance	No charge / $5 copay / $20 copay / 50% coinsurance / 50% coinsurance	$25 copay / $45 copay / $65 copay / $105 copay / 50% coinsurance after deductible
Per Prescription (90 day supply): Value Generic/Generic/Preferred Brand/Non-Preferred Brand [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	No charge	$50 copay / $112.50 copay / $200 copay / 50% coinsurance after deductible	$50 copay / $112.50 copay / $200 copay / 50% coinsurance after deductible	$37.50 copay / $75 copay / $100 copay / 50% coinsurance	No charge / $12.50 copay / $50 copay / 50% coinsurance	$62.50 copay / $112.50 copay / $162.50 copay / $262.50 copay
DENTAL / VISION SERVICES						
Pediatric Eye Exam*	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Glasses*	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Dental*	No charge	No charge	No charge	No charge	No charge	No charge
Adult Eye Exam*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Dental*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

*Limitations may apply. Please refer to your contract.

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Updated: 10/24/2024 10:32 AM

PLAN NAME	Entrust Silver 550 - Off Exchange (2025)	Entrust Silver 550 (2025)	Entrust Silver 550 Zero Cost Share (2025)	Entrust Silver 550 Limited Cost Share (2025)		Entrust Silver 550 73% AV (2025)
PLAN ID	AVIN_HS_1682_0125	AVIN_HS_1660_0125	AVIN_HS_166002_0125	AVIN_HS_166003_0125		AVIN_HS_166004_0125
METAL TIER	Silver	Silver	Silver	Silver		Silver
AvMed Confidential Proprietary / Internal Use Only	In-Network	In-Network	IHCP	IHCP	Non-IHCP In-Network	In-Network
DEDUCTIBLE: Individual/Family	$6,250 / $12,500	$6,250 / $12,500	$0 / $0	$0 / $0	$6,250 / $12,500	$6,000 / $12,000
OUT OF POCKET MAX: Individual/Family	$7,250 / $14,500	$7,250 / $14,500	$0 / $0	$0 / $0	$7,250 / $14,500	$6,000 / $12,000
OFFICE SERVICES						
Primary Care Physician (PCP)	$55 copay per visit	$55 copay per visit	No charge	No charge	$55 copay per visit	$40 copay per visit
Specialist	$110 copay per visit	$110 copay per visit	No charge	No charge	$110 copay per visit	$80 copay per visit
Telehealth Virtual Visit	No charge	No charge	No charge	No charge	No charge	No charge
PREVENTIVE CARE						
Preventive Wellness Services	No charge	No charge	No charge	No charge	No charge	No charge
IMMEDIATE MEDICAL CARE**						
Retail Clinic	$65 copay per visit	$65 copay per visit	No charge	No charge	$65 copay per visit	$50 copay per visit
Urgent Care	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	No charge	No charge	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities
Emergency Room	$500 copay per visit after deductible	$500 copay per visit after deductible	No charge	No charge	$500 copay per visit after deductible	No charge after deductible
Ambulance (Ground)	$200 copay per one way ground transport	$200 copay per one way ground transport	No charge	No charge	$200 copay per one way ground transport	$200 copay per one way ground transport
OUTPATIENT SERVICES						
Outpatient Radiology						
Complex (CT/PET scans, MRIs, etc.)	$325 copay per visit at independent facilities; $650 copay per visit at hospital-owned or affiliated facilities	$325 copay per visit at independent facilities; $650 copay per visit at hospital-owned or affiliated facilities	No charge	No charge	$325 copay per visit at independent facilities; $650 copay per visit at hospital-owned or affiliated facilities	$300 copay per visit at independent facilities; $600 copay per visit at hospital-owned or affiliated facilities
Other (X-ray, ultrasound, etc.)	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	No charge	No charge	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities
Outpatient Routine Lab	$35 copay per visit	$35 copay per visit	No charge	No charge	$35 copay per visit	$30 copay per visit
Outpatient Surgery - facility	$500 copay per visit after deductible	$500 copay per visit after deductible	No charge	No charge	$500 copay per visit after deductible	No charge after deductible
Outpatient Surgery - physician services	No charge after deductible	No charge after deductible	No charge	No charge	No charge after deductible	No charge after deductible
HOSPITAL						
Inpatient	$500 copay per admission after deductible	$500 copay per admission after deductible	No charge	No charge	$500 copay per admission after deductible	No charge after deductible
PRESCRIPTION DRUGS						
Per Prescription (30 day supply): Value Generic/Generic/Preferred Brand/ Non-Preferred Brand/Specialty [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	$25 copay / $45 copay / $65 copay / $105 copay / 50% coinsurance after deductible	$25 copay / $45 copay / $65 copay / $105 copay / 50% coinsurance after deductible	No charge	No charge	$25 copay / $45 copay / $65 copay / $105 copay / 50% coinsurance after deductible	$25 copay / $45 copay / $65 copay / $105 copay / 50% coinsurance after deductible
Per Prescription (90 day supply): Value Generic/Generic/Preferred Brand/Non-Preferred Brand [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	$62.50 copay / $112.50 copay / $162.50 copay / $262.50 copay	$62.50 copay / $112.50 copay / $162.50 copay / $262.50 copay	No charge	No charge	$62.50 copay / $112.50 copay / $162.50 copay / $262.50 copay	$62.50 copay / $112.50 copay / $162.50 copay / $262.50 copay
DENTAL / VISION SERVICES						
Pediatric Eye Exam*	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Glasses*	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Dental*	No charge	No charge	No charge	No charge	No charge	No charge
Adult Eye Exam*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Dental*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

*Limitations may apply. Please refer to your contract.

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Updated: 10/24/2024 10:32 AM

PLAN NAME	Entrust Silver 550 87% AV (2025)	Entrust Silver 550 94% AV (2025)	Entrust Silver Standard (2025)	Entrust Silver Standard (2025)	Entrust Silver Standard Zero Cost Share (2025)	Entrust Silver Standard Li
PLAN ID	AVIN_HS_166005_0125	AVIN_HS_166006_0125	AVIN_HS_1657_0125	AVIN_HS_1657_0125	AVIN_HS_165702_0125	AVIN_HS_165
METAL TIER	Silver	Silver	Silver	Silver	Silver	Silv
AvMed Confidential Proprietary / Internal Use Only	In-Network	In-Network	In-Network	In-Network	IHCP	IHCP
DEDUCTIBLE: Individual/Family	$1,850 / $3,700	$800 / $1,600	$5,000 / $10,000	$5,000 / $10,000	$0 / $0	$0 / $0
OUT OF POCKET MAX: Individual/Family	$1,850 / $3,700	$800 / $1,600	$8,000 / $16,000	$8,000 / $16,000	$0 / $0	$0 / $0
OFFICE SERVICES						
Primary Care Physician (PCP)	$40 copay per visit	$5 copay per visit	$40 copay per visit	$40 copay per visit	No charge	No charge
Specialist	$80 copay per visit	$10 copay per visit	$80 copay per visit	$80 copay per visit	No charge	No charge
Telehealth Virtual Visit	No charge	No charge	No charge	No charge	No charge	No charge
PREVENTIVE CARE						
Preventive Wellness Services	No charge	No charge	No charge	No charge	No charge	No charge
IMMEDIATE MEDICAL CARE**						
Retail Clinic	$50 copay per visit	$15 copay per visit	$50 copay per visit	$50 copay per visit	No charge	No charge
Urgent Care	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$60 copay per visit	$60 copay per visit	No charge	No charge
Emergency Room	No charge after deductible	No charge after deductible	40% coinsurance after deductible	40% coinsurance after deductible	No charge	No charge
Ambulance (Ground)	$200 copay per one way ground transport	$200 copay per one way ground transport	$200 copay per one way ground transport	$200 copay per one way ground transport	No charge	No charge
OUTPATIENT SERVICES						
Outpatient Radiology						
Complex (CT/PET scans, MRIs, etc.)	$300 copay per visit at independent facilities; $600 copay per visit at hospital-owned or affiliated facilities	$75 copay per visit at independent facilities; $150 copay per visit at hospital-owned or affiliated facilities	40% coinsurance after deductible	40% coinsurance after deductible	No charge	No charge
Other (X-ray, ultrasound, etc.)	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities	$25 copay per visit at independent facilities; $50 copay per visit at hospital-owned or affiliated facilities	40% coinsurance after deductible	40% coinsurance after deductible	No charge	No charge
Outpatient Routine Lab	$30 copay per visit	$5 copay per visit	40% coinsurance after deductible	40% coinsurance after deductible	No charge	No charge
Outpatient Surgery - facility	No charge after deductible	No charge after deductible	40% coinsurance after deductible	40% coinsurance after deductible	No charge	No charge
Outpatient Surgery - physician services	No charge after deductible	No charge after deductible	40% coinsurance after deductible	40% coinsurance after deductible	No charge	No charge
HOSPITAL						
Inpatient	No charge after deductible	No charge after deductible	40% coinsurance after deductible	40% coinsurance after deductible	No charge	No charge
PRESCRIPTION DRUGS						
Per Prescription (30 day supply): Value Generic/Generic/Preferred Brand/ Non-Preferred Brand/Specialty [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	$15 copay / $30 copay / $40 copay / $80 copay / 50% coinsurance	No charge / $5 copay / $20 copay / $60 copay / 50% coinsurance	$20 copay / $40 copay / $80 copay after deductible / $350 copay after deductible	$20 copay / $40 copay / $80 copay after deductible / $350 copay after deductible	No charge	No charge
Per Prescription (90 day supply): Value Generic/Generic/Preferred Brand/Non-Preferred Brand [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	$37.50 copay / $75 copay / $100 copay / $200 copay	No charge / $12.50 copay / $50 copay / $150 copay	$50 copay / $100 copay / $200 copay after deductible	$50 copay / $100 copay / $200 copay after deductible	No charge	No charge
DENTAL / VISION SERVICES						
Pediatric Eye Exam*	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Glasses*	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Dental*	No charge	No charge	No charge	No charge	No charge	No charge
Adult Eye Exam*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Dental*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

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PLAN NAME	mited Cost Share (2025)	Entrust Silver Standard 73% AV (2025)	Entrust Silver Standard 87% AV (2025)	Entrust Silver Standard 94% AV (2025)	Entrust Bronze 600 (2025)	Entrust Bronze 600 (2025)
PLAN ID	5703_0125	AVIN_HS_165704_0125	AVIN_HS_165705_0125	AVIN_HS_165706_0125	AVIN_HB_1649_0125	AVIN_HB_1649_0125
METAL TIER	er	Silver	Silver	Silver	Bronze	Bronze
AvMed Confidential Proprietary / Internal Use Only	Non-IHCP In-Network	In-Network	In-Network	In-Network	In-Network	In-Network
DEDUCTIBLE: Individual/Family	$5,000 / $10,000	$3,000 / $6,000	$500 / $1,000	$0 / $0	$6,500 / $13,000	$6,500 / $13,000
OUT OF POCKET MAX: Individual/Family	$8,000 / $16,000	$6,400 / $12,800	$3,000 / $6,000	$2,000 / $4,000	$8,500 / $17,000	$8,500 / $17,000
OFFICE SERVICES						
Primary Care Physician (PCP)	$40 copay per visit	$40 copay per visit	$20 copay per visit	No charge	$70 copay per visit	$70 copay per visit
Specialist	$80 copay per visit	$80 copay per visit	$40 copay per visit	$10 copay per visit	$140 copay per visit	$140 copay per visit
Telehealth Virtual Visit	No charge	No charge	No charge	No charge	No charge	No charge
PREVENTIVE CARE						
Preventive Wellness Services	No charge	No charge	No charge	No charge	No charge	No charge
IMMEDIATE MEDICAL CARE**						
Retail Clinic	$50 copay per visit	$40 copay per visit	$30 copay per visit	No charge	$80 copay per visit	$80 copay per visit
Urgent Care	$60 copay per visit	$60 copay per visit	$30 copay per visit	$5 copay per visit	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities
Emergency Room	40% coinsurance after deductible	40% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance	$500 copay per visit after deductible	$500 copay per visit after deductible
Ambulance (Ground)	$200 copay per one way ground transport	$200 copay per one way ground transport	$200 copay per one way ground transport	$200 copay per one way ground transport	$200 copay per one way ground transport	$200 copay per one way ground transport
OUTPATIENT SERVICES						
Outpatient Radiology						
Complex (CT/PET scans, MRIs, etc.)	40% coinsurance after deductible	40% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance	$250 copay per visit after deductible at independent facilities; $500 copay per visit after deductible at hospital-owned or affiliated facilities	$250 copay per visit after deductible at independent facilities; $500 copay per visit after deductible at hospital-owned or affiliated facilities
Other (X-ray, ultrasound, etc.)	40% coinsurance after deductible	40% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance	$75 copay per visit after deductible at independent facilities; $150 copay per visit after deductible at hospital-owned or affiliated facilities	$75 copay per visit after deductible at independent facilities; $150 copay per visit after deductible at hospital-owned or affiliated facilities
Outpatient Routine Lab	40% coinsurance after deductible	40% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance	$40 copay per visit	$40 copay per visit
Outpatient Surgery - facility	40% coinsurance after deductible	40% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance	30% coinsurance after deductible	30% coinsurance after deductible
Outpatient Surgery - physician services	40% coinsurance after deductible	40% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance	30% coinsurance after deductible	30% coinsurance after deductible
HOSPITAL						
Inpatient	40% coinsurance after deductible	40% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance	$500 copay per admission after deductible	$500 copay per admission after deductible
PRESCRIPTION DRUGS						
Per Prescription (30 day supply): Value Generic/Generic/Preferred Brand/ Non-Preferred Brand/Specialty [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	$20 copay / $40 copay / $80 copay after deductible / $350 copay after deductible	$20 copay / $40 copay / $80 copay after deductible / $350 copay after deductible	$10 copay / $20 copay / $60 copay after deductible / $250 copay after deductible	No charge / $15 copay / $50 copay / $150 copay	$25 copay / $45 copay / $85 copay after deductible / 50% coinsurance after deductible / 50% coinsurance after deductible	$25 copay / $45 copay / $85 copay after deductible / 50% coinsurance after deductible / 50% coinsurance after deductible
Per Prescription (90 day supply): Value Generic/Generic/Preferred Brand/Non-Preferred Brand [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	$50 copay / $100 copay / $200 copay after deductible	$50 copay / $100 copay / $200 copay after deductible	$25 copay / $50 copay / $150 copay after deductible	No charge / $37.50 copay / $125 copay	$62.50 copay / $112.50 copay / $212.50 copay after deductible / 50% coinsurance after deductible	$62.50 copay / $112.50 copay / $212.50 copay after deductible / 50% coinsurance after deductible
DENTAL / VISION SERVICES						
Pediatric Eye Exam*	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Glasses*	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Dental*	No charge	No charge	No charge	No charge	No charge	No charge
Adult Eye Exam*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Dental*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

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PLAN NAME	Entrust Bronze 600 Zero Cost Share (2025)	Entrust Bronze 600 Limited Cost Share (2025)		Entrust Bronze 650 (2025)	Entrust Bronze 650 (2025)	Entrust Bronze 650 Zero Cost Share (2025)
PLAN ID	AVIN_HB_164902_0125	AVIN_HB_164903_0125		AVIN_HB_1650_0125	AVIN_HB_1650_0125	AVIN_HB_165002_0125
METAL TIER	Bronze	Bronze		Bronze	Bronze	Bronze
AvMed Confidential Proprietary / Internal Use Only	IHCP	IHCP	Non-IHCP In-Network	In-Network	In-Network	IHCP
DEDUCTIBLE: Individual/Family	$0 / $0	$0 / $0	$6,500 / $13,000	$8,750 / $17,500	$8,750 / $17,500	$0 / $0
OUT OF POCKET MAX: Individual/Family	$0 / $0	$0 / $0	$8,500 / $17,000	$8,750 / $17,500	$8,750 / $17,500	$0 / $0
OFFICE SERVICES						
Primary Care Physician (PCP)	No charge	No charge	$70 copay per visit	$75 copay per visit	$75 copay per visit	No charge
Specialist	No charge	No charge	$140 copay per visit	No charge after deductible	No charge after deductible	No charge
Telehealth Virtual Visit	No charge	No charge	No charge	No charge	No charge	No charge
PREVENTIVE CARE						
Preventive Wellness Services	No charge	No charge	No charge	No charge	No charge	No charge
IMMEDIATE MEDICAL CARE**						
Retail Clinic	No charge	No charge	$80 copay per visit	$85 copay per visit	$85 copay per visit	No charge
Urgent Care	No charge	No charge	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	No charge after deductible	No charge after deductible	No charge
Emergency Room	No charge	No charge	$500 copay per visit after deductible	No charge after deductible	No charge after deductible	No charge
Ambulance (Ground)	No charge	No charge	$200 copay per one way ground transport	No charge after deductible	No charge after deductible	No charge
OUTPATIENT SERVICES						
Outpatient Radiology						
Complex (CT/PET scans, MRIs, etc.)	No charge	No charge	$250 copay per visit after deductible at independent facilities; $500 copay per visit after deductible at hospital-owned or affiliated facilities	No charge after deductible	No charge after deductible	No charge
Other (X-ray, ultrasound, etc.)	No charge	No charge	$75 copay per visit after deductible at independent facilities; $150 copay per visit after deductible at hospital-owned or affiliated facilities	No charge after deductible	No charge after deductible	No charge
Outpatient Routine Lab	No charge	No charge	$40 copay per visit	No charge after deductible	No charge after deductible	No charge
Outpatient Surgery - facility	No charge	No charge	30% coinsurance after deductible	No charge after deductible	No charge after deductible	No charge
Outpatient Surgery - physician services	No charge	No charge	30% coinsurance after deductible	No charge after deductible	No charge after deductible	No charge
HOSPITAL						
Inpatient	No charge	No charge	$500 copay per admission after deductible	No charge after deductible	No charge after deductible	No charge
PRESCRIPTION DRUGS						
Per Prescription (30 day supply): Value Generic/Generic/Preferred Brand/ Non-Preferred Brand/Specialty [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	No charge	No charge	$25 copay / $45 copay / $85 copay after deductible / 50% coinsurance after deductible / 50% coinsurance after deductible	$25 copay / $45 copay / No charge after deductible / No charge after deductible / No charge after deductible	$25 copay / $45 copay / No charge after deductible / No charge after deductible / No charge after deductible	No charge
Per Prescription (90 day supply): Value Generic/Generic/Preferred Brand/Non-Preferred Brand [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	No charge	No charge	$62.50 copay / $112.50 copay / $212.50 copay after deductible / 50% coinsurance after deductible	$62.50 copay / $112.50 copay / No charge after deductible / No charge after deductible	$62.50 copay / $112.50 copay / No charge after deductible / No charge after deductible	No charge
DENTAL / VISION SERVICES						
Pediatric Eye Exam*	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Glasses*	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Dental*	No charge	No charge	No charge	No charge	No charge	No charge
Adult Eye Exam*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Dental*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

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PLAN NAME	Entrust Bronze 650 Limited Cost Share (2025)		Entrust Expanded Bronze Standard (2025)	Entrust Expanded Bronze Standard (2025)	Entrust Expanded Bronze Standard Zero Cost Share (2025)	Entrust Expanded Bronze Stand
PLAN ID	AVIN_HB_165003_0125		AVIN_HB_1648_0125	AVIN_HB_1648_0125	AVIN_HB_164802_0125	AVIN_HB_16
METAL TIER	Bronze		Bronze	Bronze	Bronze	Bron
AvMed Confidential Proprietary / Internal Use Only	IHCP	Non-IHCP In-Network	In-Network	In-Network	IHCP	IHCP
DEDUCTIBLE: Individual/Family	$0 / $0	$8,750 / $17,500	$7,500 / $15,000	$7,500 / $15,000	$0 / $0	$0 / $0
OUT OF POCKET MAX: Individual/Family	$0 / $0	$8,750 / $17,500	$9,200 / $18,400	$9,200 / $18,400	$0 / $0	$0 / $0
OFFICE SERVICES						
Primary Care Physician (PCP)	No charge	$75 copay per visit	$50 copay per visit	$50 copay per visit	No charge	No charge
Specialist	No charge	No charge after deductible	$100 copay per visit	$100 copay per visit	No charge	No charge
Telehealth Virtual Visit	No charge	No charge	No charge	No charge	No charge	No charge
PREVENTIVE CARE						
Preventive Wellness Services	No charge	No charge	No charge	No charge	No charge	No charge
IMMEDIATE MEDICAL CARE**						
Retail Clinic	No charge	$85 copay per visit	$60 copay per visit	$60 copay per visit	No charge	No charge
Urgent Care	No charge	No charge after deductible	$75 copay per visit	$75 copay per visit	No charge	No charge
Emergency Room	No charge	No charge after deductible	50% coinsurance after deductible	50% coinsurance after deductible	No charge	No charge
Ambulance (Ground)	No charge	No charge after deductible	$200 copay per one way ground transport	$200 copay per one way ground transport	No charge	No charge
OUTPATIENT SERVICES						
Outpatient Radiology						
Complex (CT/PET scans, MRIs, etc.)	No charge	No charge after deductible	50% coinsurance after deductible	50% coinsurance after deductible	No charge	No charge
Other (X-ray, ultrasound, etc.)	No charge	No charge after deductible	50% coinsurance after deductible	50% coinsurance after deductible	No charge	No charge
Outpatient Routine Lab	No charge	No charge after deductible	50% coinsurance after deductible	50% coinsurance after deductible	No charge	No charge
Outpatient Surgery - facility	No charge	No charge after deductible	50% coinsurance after deductible	50% coinsurance after deductible	No charge	No charge
Outpatient Surgery - physician services	No charge	No charge after deductible	50% coinsurance after deductible	50% coinsurance after deductible	No charge	No charge
HOSPITAL						
Inpatient	No charge	No charge after deductible	50% coinsurance after deductible	50% coinsurance after deductible	No charge	No charge
PRESCRIPTION DRUGS						
Per Prescription (30 day supply): Value Generic/Generic/Preferred Brand/ Non-Preferred Brand/Specialty [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	No charge	$25 copay / $45 copay / No charge after deductible / No charge after deductible / No charge after deductible	$25 copay / $50 copay after deductible / $100 copay after deductible / $500 copay after deductible	$25 copay / $50 copay after deductible / $100 copay after deductible / $500 copay after deductible	No charge	No charge
Per Prescription (90 day supply): Value Generic/Generic/Preferred Brand/Non-Preferred Brand [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	No charge	$62.50 copay / $112.50 copay / No charge after deductible / No charge after deductible	$62.50 copay / $125 copay after deductible / $250 copay after deductible	$62.50 copay / $125 copay after deductible / $250 copay after deductible	No charge	No charge
DENTAL / VISION SERVICES						
Pediatric Eye Exam*	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Glasses*	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Dental*	No charge	No charge	No charge	No charge	No charge	No charge
Adult Eye Exam*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Dental*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

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PLAN NAME	ard Limited Cost Share (2025)	Entrust Platinum 25 Dental+Vision (2025)	Entrust Platinum 25 Dental+Vision (2025)	Entrust Platinum 25 Dental+Vision Zero Cost Share (2025)	Entrust Platinum 25 Dental+Vision Limited Cost Share (2025)	
PLAN ID	4803_0125	AVIN_HP_1655_0125	AVIN_HP_1655_0125	AVIN_HP_165502_0125	AVIN_HP_165503_0125	
METAL TIER	ze	Platinum	Platinum	Platinum	Platinum	
AvMed Confidential Proprietary / Internal Use Only	Non-IHCP In-Network	In-Network	In-Network	IHCP	IHCP	Non-IHCP In-Network
DEDUCTIBLE: Individual/Family	$7,500 / $15,000	$0 / $0	$0 / $0	$0 / $0	$0 / $0	$0 / $0
OUT OF POCKET MAX: Individual/Family	$9,200 / $18,400	$4,350 / $8,700	$4,350 / $8,700	$0 / $0	$0 / $0	$4,350 / $8,700
OFFICE SERVICES						
Primary Care Physician (PCP)	$50 copay per visit	$10 copay per visit	$10 copay per visit	No charge	No charge	$10 copay per visit
Specialist	$100 copay per visit	$20 copay per visit	$20 copay per visit	No charge	No charge	$20 copay per visit
Telehealth Virtual Visit	No charge	No charge	No charge	No charge	No charge	No charge
PREVENTIVE CARE						
Preventive Wellness Services	No charge	No charge	No charge	No charge	No charge	No charge
IMMEDIATE MEDICAL CARE**						
Retail Clinic	$60 copay per visit	$20 copay per visit	$20 copay per visit	No charge	No charge	$20 copay per visit
Urgent Care	$75 copay per visit	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	No charge	No charge	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities
Emergency Room	50% coinsurance after deductible	$100 copay per visit	$100 copay per visit	No charge	No charge	$100 copay per visit
Ambulance (Ground)	$200 copay per one way ground transport	$200 copay per one way ground transport	$200 copay per one way ground transport	No charge	No charge	$200 copay per one way ground transport
OUTPATIENT SERVICES						
Outpatient Radiology						
Complex (CT/PET scans, MRIs, etc.)	50% coinsurance after deductible	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities	No charge	No charge	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities
Other (X-ray, ultrasound, etc.)	50% coinsurance after deductible	$10 copay per visit at independent facilities; $20 copay per visit at hospital-owned or affiliated facilities	$10 copay per visit at independent facilities; $20 copay per visit at hospital-owned or affiliated facilities	No charge	No charge	$10 copay per visit at independent facilities; $20 copay per visit at hospital-owned or affiliated facilities
Outpatient Routine Lab	50% coinsurance after deductible	No charge	No charge	No charge	No charge	No charge
Outpatient Surgery - facility	50% coinsurance after deductible	$200 copay per visit	$200 copay per visit	No charge	No charge	$200 copay per visit
Outpatient Surgery - physician services	50% coinsurance after deductible	No charge	No charge	No charge	No charge	No charge
HOSPITAL						
Inpatient	50% coinsurance after deductible	$350 copay per day for the first 3 days per admission	$350 copay per day for the first 3 days per admission	No charge	No charge	$350 copay per day for the first 3 days per admission
PRESCRIPTION DRUGS						
Per Prescription (30 day supply): Value Generic/Generic/Preferred Brand/ Non-Preferred Brand/Specialty [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	$25 copay / $50 copay after deductible / $100 copay after deductible / $500 copay after deductible	No charge / $5 copay / $20 copay / $60 copay / 50% coinsurance	No charge / $5 copay / $20 copay / $60 copay / 50% coinsurance	No charge	No charge	No charge / $5 copay / $20 copay / $60 copay / 50% coinsurance
Per Prescription (90 day supply): Value Generic/Generic/Preferred Brand/Non-Preferred Brand [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	$62.50 copay / $125 copay after deductible / $250 copay after deductible	No charge / $12.50 copay / $50 copay / $150 copay	No charge / $12.50 copay / $50 copay / $150 copay	No charge	No charge	No charge / $12.50 copay / $50 copay / $150 copay
DENTAL / VISION SERVICES						
Pediatric Eye Exam*	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Glasses*	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Dental*	No charge	No charge	No charge	No charge	No charge	No charge
Adult Eye Exam*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance*	Not Covered	1 exam per calendar year	1 exam per calendar year	1 exam per calendar year	1 exam per calendar year	1 exam per calendar year
Adult Dental*	Not Covered	No charge	No charge	No charge	No charge	No charge

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PLAN NAME	Entrust Gold 125 Dental+Vision (2025)	Entrust Gold 125 Dental+Vision (2025)	Entrust Gold 125 Dental+Vision Zero Cost Share (2025)	Entrust Gold 125 Dental+Vision Limited Cost Share (2025)		Entrust Silver 350 Dental+Vision (2025)
PLAN ID	AVIN_HG_1652_0125	AVIN_HG_1652_0125	AVIN_HG_165202_0125	AVIN_HG_165203_0125		AVIN_HS_1659_0125
METAL TIER	Gold	Gold	Gold	Gold		Silver
AvMed Confidential Proprietary / Internal Use Only	In-Network	In-Network	IHCP	IHCP	Non-IHCP In-Network	In-Network
DEDUCTIBLE: Individual/Family	$2,000 / $4,000	$2,000 / $4,000	$0 / $0	$0 / $0	$2,000 / $4,000	$3,500 / $7,000
OUT OF POCKET MAX: Individual/Family	$4,700 / $9,400	$4,700 / $9,400	$0 / $0	$0 / $0	$4,700 / $9,400	$8,000 / $16,000
OFFICE SERVICES						
Primary Care Physician (PCP)	$35 copay per visit	$35 copay per visit	No charge	No charge	$35 copay per visit	$30 copay per visit
Specialist	$70 copay per visit	$70 copay per visit	No charge	No charge	$70 copay per visit	$60 copay per visit
Telehealth Virtual Visit	No charge	No charge	No charge	No charge	No charge	No charge
PREVENTIVE CARE						
Preventive Wellness Services	No charge	No charge	No charge	No charge	No charge	No charge
IMMEDIATE MEDICAL CARE**						
Retail Clinic	$45 copay per visit	$45 copay per visit	No charge	No charge	$45 copay per visit	$40 copay per visit
Urgent Care	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	No charge	No charge	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities
Emergency Room	$500 copay per visit after deductible	$500 copay per visit after deductible	No charge	No charge	$500 copay per visit after deductible	50% coinsurance after deductible
Ambulance (Ground)	$200 copay per one way ground transport	$200 copay per one way ground transport	No charge	No charge	$200 copay per one way ground transport	$200 copay per one way ground transport
OUTPATIENT SERVICES						
Outpatient Radiology						
Complex (CT/PET scans, MRIs, etc.)	$250 copay per visit at independent facilities; $500 copay per visit at hospital-owned or affiliated facilities	$250 copay per visit at independent facilities; $500 copay per visit at hospital-owned or affiliated facilities	No charge	No charge	$250 copay per visit at independent facilities; $500 copay per visit at hospital-owned or affiliated facilities	50% coinsurance after deductible
Other (X-ray, ultrasound, etc.)	$75 copay per visit at independent facilities; $150 copay per visit at hospital-owned or affiliated facilities	$75 copay per visit at independent facilities; $150 copay per visit at hospital-owned or affiliated facilities	No charge	No charge	$75 copay per visit at independent facilities; $150 copay per visit at hospital-owned or affiliated facilities	50% coinsurance after deductible
Outpatient Routine Lab	$10 copay per visit	$10 copay per visit	No charge	No charge	$10 copay per visit	$30 copay per visit
Outpatient Surgery - facility	$650 copay per visit after deductible	$650 copay per visit after deductible	No charge	No charge	$650 copay per visit after deductible	50% coinsurance after deductible
Outpatient Surgery - physician services	No charge after deductible	No charge after deductible	No charge	No charge	No charge after deductible	50% coinsurance after deductible
HOSPITAL						
Inpatient	$850 copay per admission after deductible	$850 copay per admission after deductible	No charge	No charge	$850 copay per admission after deductible	50% coinsurance after deductible
PRESCRIPTION DRUGS						
Per Prescription (30 day supply): Value Generic/Generic/Preferred Brand/ Non-Preferred Brand/Specialty [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	$15 copay / $30 copay / $60 copay / $120 copay / 50% coinsurance after deductible	$15 copay / $30 copay / $60 copay / $120 copay / 50% coinsurance after deductible	No charge	No charge	$15 copay / $30 copay / $60 copay / $120 copay / 50% coinsurance after deductible	$20 copay / $45 copay / $80 copay / 50% coinsurance after deductible / 50% coinsurance after deductible
Per Prescription (90 day supply): Value Generic/Generic/Preferred Brand/Non-Preferred Brand [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	$37.50 copay / $75 copay / $150 copay / $300 copay	$37.50 copay / $75 copay / $150 copay / $300 copay	No charge	No charge	$37.50 copay / $75 copay / $150 copay / $300 copay	$50 copay / $112.50 copay / $200 copay / 50% coinsurance after deductible
DENTAL / VISION SERVICES						
Pediatric Eye Exam*	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Glasses*	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Dental*	No charge	No charge	No charge	No charge	No charge	No charge
Adult Eye Exam*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance*	1 exam per calendar year	1 exam per calendar year	1 exam per calendar year	1 exam per calendar year	1 exam per calendar year	1 exam per calendar year
Adult Dental*	No charge	No charge	No charge	No charge	No charge	No charge

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PLAN NAME	Entrust Silver 350 Dental+Vision (2025)	Entrust Silver 350 Dental+Vision Zero Cost Share (2025)	Entrust Silver 350 Dental+Vision Limited Cost Share (2025)		Entrust Silver 350 Dental+Vision 73% AV (2025)	Entrust Silver 350 Dental+Vision 87% AV (2025)
PLAN ID	AVIN_HS_1659_0125	AVIN_HS_165902_0125	AVIN_HS_165903_0125		AVIN_HS_165904_0125	AVIN_HS_165905_0125
METAL TIER	Silver	Silver	Silver		Silver	Silver
AvMed Confidential Proprietary / Internal Use Only	In-Network	IHCP	IHCP	Non-IHCP In-Network	In-Network	In-Network
DEDUCTIBLE: Individual/Family	$3,500 / $7,000	$0 / $0	$0 / $0	$3,500 / $7,000	$3,000 / $6,000	$0 / $0
OUT OF POCKET MAX: Individual/Family	$8,000 / $16,000	$0 / $0	$0 / $0	$8,000 / $16,000	$7,250 / $14,500	$3,050 / $6,100
OFFICE SERVICES						
Primary Care Physician (PCP)	$30 copay per visit	No charge	No charge	$30 copay per visit	$15 copay per visit	$15 copay per visit
Specialist	$60 copay per visit	No charge	No charge	$60 copay per visit	$30 copay per visit	$30 copay per visit
Telehealth Virtual Visit	No charge	No charge	No charge	No charge	No charge	No charge
PREVENTIVE CARE						
Preventive Wellness Services	No charge	No charge	No charge	No charge	No charge	No charge
IMMEDIATE MEDICAL CARE**						
Retail Clinic	$40 copay per visit	No charge	No charge	$40 copay per visit	$25 copay per visit	$25 copay per visit
Urgent Care	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	No charge	No charge	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities
Emergency Room	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible	50% coinsurance after deductible	40% coinsurance
Ambulance (Ground)	$200 copay per one way ground transport	No charge	No charge	$200 copay per one way ground transport	$200 copay per one way ground transport	$200 copay per one way ground transport
OUTPATIENT SERVICES						
Outpatient Radiology						
Complex (CT/PET scans, MRIs, etc.)	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible	50% coinsurance after deductible	40% coinsurance
Other (X-ray, ultrasound, etc.)	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible	50% coinsurance after deductible	40% coinsurance
Outpatient Routine Lab	$30 copay per visit	No charge	No charge	$30 copay per visit	$30 copay per visit	$15 copay per visit
Outpatient Surgery - facility	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible	50% coinsurance after deductible	40% coinsurance
Outpatient Surgery - physician services	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible	50% coinsurance after deductible	40% coinsurance
HOSPITAL						
Inpatient	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible	50% coinsurance after deductible	40% coinsurance
PRESCRIPTION DRUGS						
Per Prescription (30 day supply): Value Generic/Generic/Preferred Brand/ Non-Preferred Brand/Specialty [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	$20 copay / $45 copay / $80 copay / 50% coinsurance after deductible / 50% coinsurance after deductible	No charge	No charge	$20 copay / $45 copay / $80 copay / 50% coinsurance after deductible / 50% coinsurance after deductible	$20 copay / $45 copay / $80 copay / 50% coinsurance after deductible / 50% coinsurance after deductible	$15 copay / $30 copay / $40 copay / 50% coinsurance / 50% coinsurance
Per Prescription (90 day supply): Value Generic/Generic/Preferred Brand/Non-Preferred Brand [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	$50 copay / $112.50 copay / $200 copay / 50% coinsurance after deductible	No charge	No charge	$50 copay / $112.50 copay / $200 copay / 50% coinsurance after deductible	$50 copay / $112.50 copay / $200 copay / 50% coinsurance after deductible	$37.50 copay / $75 copay / $100 copay / 50% coinsurance
DENTAL / VISION SERVICES						
Pediatric Eye Exam*	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Glasses*	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Dental*	No charge	No charge	No charge	No charge	No charge	No charge
Adult Eye Exam*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance*	1 exam per calendar year	1 exam per calendar year	1 exam per calendar year	1 exam per calendar year	1 exam per calendar year	1 exam per calendar year
Adult Dental*	No charge	No charge	No charge	No charge	No charge	No charge

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Updated: 10/24/2024 10:32 AM

PLAN NAME	Entrust Silver 350 Dental+Vision 94% AV (2025)	Entrust Silver 550 Dental+Vision (2025)	Entrust Silver 550 Dental+Vision (2025)	Entrust Silver 550 Dental+Vision Zero Cost Share (2025)	Entrust Silver 550 Dental+Vision Limited Cost Share (2025)	
PLAN ID	AVIN_HS_165906_0125	AVIN_HS_1661_0125	AVIN_HS_1661_0125	AVIN_HS_166102_0125	AVIN_HS_166103_0125	
METAL TIER	Silver	Silver	Silver	Silver	Silver	
AvMed Confidential Proprietary / Internal Use Only	In-Network	In-Network	In-Network	IHCP	IHCP	Non-IHCP In-Network
DEDUCTIBLE: Individual/Family	$0 / $0	$6,250 / $12,500	$6,250 / $12,500	$0 / $0	$0 / $0	$6,250 / $12,500
OUT OF POCKET MAX: Individual/Family	$1,500 / $3,000	$7,250 / $14,500	$7,250 / $14,500	$0 / $0	$0 / $0	$7,250 / $14,500
OFFICE SERVICES						
Primary Care Physician (PCP)	No charge	$55 copay per visit	$55 copay per visit	No charge	No charge	$55 copay per visit
Specialist	$10 copay per visit	$110 copay per visit	$110 copay per visit	No charge	No charge	$110 copay per visit
Telehealth Virtual Visit	No charge	No charge	No charge	No charge	No charge	No charge
PREVENTIVE CARE						
Preventive Wellness Services	No charge	No charge	No charge	No charge	No charge	No charge
IMMEDIATE MEDICAL CARE**						
Retail Clinic	No charge	$65 copay per visit	$65 copay per visit	No charge	No charge	$65 copay per visit
Urgent Care	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	No charge	No charge	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities
Emergency Room	25% coinsurance	$500 copay per visit after deductible	$500 copay per visit after deductible	No charge	No charge	$500 copay per visit after deductible
Ambulance (Ground)	$200 copay per one way ground transport	$200 copay per one way ground transport	$200 copay per one way ground transport	No charge	No charge	$200 copay per one way ground transport
OUTPATIENT SERVICES						
Outpatient Radiology						
Complex (CT/PET scans, MRIs, etc.)	25% coinsurance	$325 copay per visit at independent facilities; $650 copay per visit at hospital-owned or affiliated facilities	$325 copay per visit at independent facilities; $650 copay per visit at hospital-owned or affiliated facilities	No charge	No charge	$325 copay per visit at independent facilities; $650 copay per visit at hospital-owned or affiliated facilities
Other (X-ray, ultrasound, etc.)	25% coinsurance	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	No charge	No charge	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities
Outpatient Routine Lab	No charge	$35 copay per visit	$35 copay per visit	No charge	No charge	$35 copay per visit
Outpatient Surgery - facility	25% coinsurance	$500 copay per visit after deductible	$500 copay per visit after deductible	No charge	No charge	$500 copay per visit after deductible
Outpatient Surgery - physician services	25% coinsurance	No charge after deductible	No charge after deductible	No charge	No charge	No charge after deductible
HOSPITAL						
Inpatient	25% coinsurance	$500 copay per admission after deductible	$500 copay per admission after deductible	No charge	No charge	$500 copay per admission after deductible
PRESCRIPTION DRUGS						
Per Prescription (30 day supply): Value Generic/Generic/Preferred Brand/ Non-Preferred Brand/Specialty [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	No charge / $5 copay / $20 copay / 50% coinsurance / 50% coinsurance	$25 copay / $45 copay / $65 copay / $105 copay / 50% coinsurance after deductible	$25 copay / $45 copay / $65 copay / $105 copay / 50% coinsurance after deductible	No charge	No charge	$25 copay / $45 copay / $65 copay / $105 copay / 50% coinsurance after deductible
Per Prescription (90 day supply): Value Generic/Generic/Preferred Brand/Non-Preferred Brand [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	No charge / $12.50 copay / $50 copay / 50% coinsurance	$62.50 copay / $112.50 copay / $162.50 copay / $262.50 copay	$62.50 copay / $112.50 copay / $162.50 copay / $262.50 copay	No charge	No charge	$62.50 copay / $112.50 copay / $162.50 copay / $262.50 copay
DENTAL / VISION SERVICES						
Pediatric Eye Exam*	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Glasses*	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Dental*	No charge	No charge	No charge	No charge	No charge	No charge
Adult Eye Exam*	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance*	1 exam per calendar year	1 exam per calendar year	1 exam per calendar year	1 exam per calendar year	1 exam per calendar year	1 exam per calendar year
Adult Dental*	No charge	No charge	No charge	No charge	No charge	No charge

*Limitations may apply. Please refer to your contract.

**Coverage does not apply to facility fees (e.g. hospital room) or physician/surgeon fees.

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AvMed Embrace better health.

Updated: 10/24/2024 10:32 AM

PLAN NAME	Entrust Silver 550 Dental+Vision 73% AV (2025)	Entrust Silver 550 Dental+Vision 87% AV (2025)	Entrust Silver 550 Dental+Vision 94% AV (2025)
PLAN ID	AVIN_HS_166104_0125	AVIN_HS_166105_0125	AVIN_HS_166106_0125
METAL TIER	Silver	Silver	Silver
AvMed Confidential Proprietary / Internal Use Only	In-Network	In-Network	In-Network
DEDUCTIBLE: Individual/Family	$6,000 / $12,000	$1,850 / $3,700	$800 / $1,600
OUT OF POCKET MAX: Individual/Family	$6,000 / $12,000	$1,850 / $3,700	$800 / $1,600
OFFICE SERVICES			
Primary Care Physician (PCP)	$40 copay per visit	$40 copay per visit	$5 copay per visit
Specialist	$80 copay per visit	$80 copay per visit	$10 copay per visit
Telehealth Virtual Visit	No charge	No charge	No charge
PREVENTIVE CARE			
Preventive Wellness Services	No charge	No charge	No charge
IMMEDIATE MEDICAL CARE**			
Retail Clinic	$50 copay per visit	$50 copay per visit	$15 copay per visit
Urgent Care	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities
Emergency Room	No charge after deductible	No charge after deductible	No charge after deductible
Ambulance (Ground)	$200 copay per one way ground transport	$200 copay per one way ground transport	$200 copay per one way ground transport
OUTPATIENT SERVICES			
Outpatient Radiology			
Complex (CT/PET scans, MRIs, etc.)	$300 copay per visit at independent facilities; $600 copay per visit at hospital-owned or affiliated facilities	$300 copay per visit at independent facilities; $600 copay per visit at hospital-owned or affiliated facilities	$75 copay per visit at independent facilities; $150 copay per visit at hospital-owned or affiliated facilities
Other (X-ray, ultrasound, etc.)	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities	$25 copay per visit at independent facilities; $50 copay per visit at hospital-owned or affiliated facilities
Outpatient Routine Lab	$30 copay per visit	$30 copay per visit	$5 copay per visit
Outpatient Surgery - facility	No charge after deductible	No charge after deductible	No charge after deductible
Outpatient Surgery - physician services	No charge after deductible	No charge after deductible	No charge after deductible
HOSPITAL			
Inpatient	No charge after deductible	No charge after deductible	No charge after deductible
PRESCRIPTION DRUGS			
Per Prescription (30 day supply): Value Generic/Generic/Preferred Brand/ Non-Preferred Brand/Specialty [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	$25 copay / $45 copay / $65 copay / $105 copay / 50% coinsurance after deductible	$15 copay / $30 copay / $40 copay / $80 copay / 50% coinsurance	No charge / $5 copay / $20 copay / $60 copay / 50% coinsurance
Per Prescription (90 day supply): Value Generic/Generic/Preferred Brand/Non-Preferred Brand [No Value Generic tier in Standard plans] [Separate Rx deductible may apply]	$62.50 copay / $112.50 copay / $162.50 copay / $262.50 copay	$37.50 copay / $75 copay / $100 copay / $200 copay	No charge / $12.50 copay / $50 copay / $150 copay
DENTAL / VISION SERVICES			
Pediatric Eye Exam*	No charge	No charge	No charge
Pediatric Glasses*	No charge	No charge	No charge
Pediatric Dental*	No charge	No charge	No charge
Adult Eye Exam*	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance*	1 exam per calendar year	1 exam per calendar year	1 exam per calendar year
Adult Dental*	No charge	No charge	No charge

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