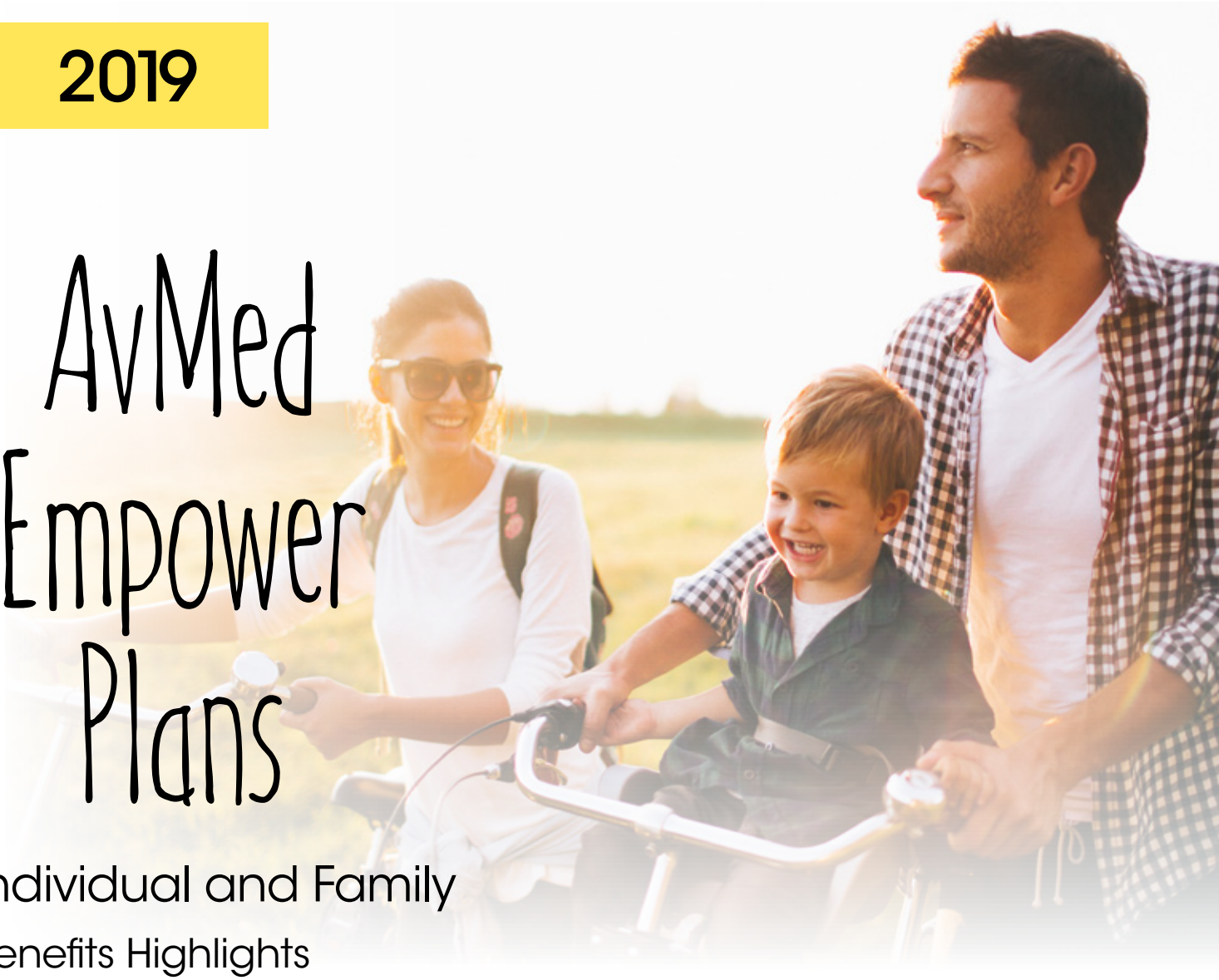
2019

AvMed Empower Plans



Individual and Family

Benefits Highlights

AvMed

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AvMed Empower Plans

Key Benefits for your Plan:	Empower MG225-IN19		
	GOLD		
	In-Network Tier A	In-Network Tier B	Out-of-Network
CALENDAR YEAR DEDUCTIBLE (CYD)			
Individual/Family	$1,400 / $2,800	$1,400 / $2,800	$4,200 / $8,400
	$65 per child for Pediatric Dental***. (Delta Dental PPO℠ Network)	$65 per child for Pediatric Dental***. (Delta Dental PPO℠ Network)	$65 per child for Pediatric Dental***. (Delta Dental PPO℠ Network)
OUT-OF-POCKET MAX (INCLUDES DEDUCTIBLE)			
Individual/Family	$5,400 / $10,800	$5,400 / $10,800	$16,200 / $32,400
OFFICE SERVICES			
Primary Care Physician (PCP)	No charge for the first 2 visits; $20 copay/visit thereafter	$40 copay/visit	50% coinsurance AD**
Specialist	$40 copay/visit	$80 copay/visit	50% coinsurance AD**
IMMEDIATE MEDICAL CARE* **			
Virtual Visits	$20 copay/visit	Not applicable	Not applicable
Retail Clinic	$30 copay/visit	$30 copay/visit	$30 copay/visit AD**
Urgent Care	Independent facilities - $70 copay/visit	Independent facilities - $70 copay/visit	Independent facilities - $70 copay/visit
	Hospital-affiliated facilities - $150 copay/visit	Hospital-affiliated facilities - $150 copay/visit	Hospital-affiliated facilities - $150 copay/visit
Emergency Room	$350 copay per visit AD**	$350 copay per visit AD**	$350 copay per visit AD**
Ambulance (Ground per one way transportation)	$200 copay	$200 copay	$200 copay
OUTPATIENT DIAGNOSTIC SERVICES			
Complex radiology (CT/PET scans, MRIs, etc.)	Independent facilities - $150 copay/visit	Independent facilities - 50% coinsurance AD**	Independent facilities - 50% coinsurance AD**
	Hospital-affiliated facilities - $300 copay/visit	Hospital-affiliated facilities - 50% coinsurance AD**	Hospital-affiliated facilities - 50% coinsurance AD**
Other radiology (x-ray, ultrasound, etc.)	Independent facilities - $75 copay/visit	Independent facilities - 50% coinsurance AD**	Independent facilities - 50% coinsurance AD**
	Hospital-affiliated facilities - $150 copay/visit	Hospital-affiliated facilities - 50% coinsurance AD**	Hospital-affiliated facilities - 50% coinsurance AD**
Outpatient Routine Lab	$10 copay/visit for lab work at certain participating labs	$10 copay/visit for lab work at certain participating labs	50% coinsurance AD**
HOSPITAL			
Inpatient	$700 copay/day for first 3 days per admission AD**	50% coinsurance AD**	50% coinsurance AD**
Outpatient Surgery (facility)	$650 copay/visit AD**	50% coinsurance AD**	50% coinsurance AD**
PRESCRIPTION DRUGS			
Rx (Retail) per prescription: Value Generic/Generic/ Preferred/Non-Preferred/ Specialty Drugs	$15/$30/$60/$120/ 50% coinsurance AD**	$15/$30/$60/$120/ 50% coinsurance AD**	Not covered
Rx (Mail Order, Up to 90-Day Supply): Value Generic/Generic/Preferred/Non Preferred	$37.50/$75/$150/$300	$37.50/$75/$150/$300	Not covered
PEDIATRIC DENTAL/VISION SERVICES			
Dental*	No charge for preventive care limited to 1 exam every 6 months****	No charge for preventive care limited to 1 exam every 6 months****	50% coinsurance**** AD**
Eye Exam*	No charge limited to 1 exam per calendar year	No charge limited to 1 exam per calendar year	50% coinsurance AD**
Glasses*	No charge limited to 1 pair per calendar year	No charge limited to 1 pair per calendar year	50% coinsurance AD**

This schedule is not a contract. It is a brief summary of benefits. For more information on benefits, exclusions and limitations, refer to the Detailed Schedule of Benefits (DSoB), the Individual and Family Medical and Hospital Service Contract, or contact your AvMed Sales/Service representative.
*Limitations may apply. Please refer to your contract.
**AD – After Deductible.
***Coverage does not apply to facility fees (e.g. hospital room) or physician/surgeon fees.
**** Dental services are subject to a calendar year deductible of $65 per child and out of pocket maximum of $350 per child, or $700 for two or more children. Does not apply toward medical deductible and out-of-pocket costs.

AvMed Empower Plans

Key Benefits for your Plan:	Empower MS400-IN19		
	SILVER		
	In-Network Tier A	In-Network Tier B	Out-of-Network
CALENDAR YEAR DEDUCTIBLE (CYD)			
Individual/Family	$4,500 / $9,000	$4,500 / $9,000	$13,500 / $27,000
	$65 per child for Pediatric Dental***. (Delta Dental PPO℠ Network)	$65 per child for Pediatric Dental***. (Delta Dental PPO℠ Network)	$65 per child for Pediatric Dental***. (Delta Dental PPO℠ Network)
OUT-OF-POCKET MAX (INCLUDES DEDUCTIBLE)			
Individual/Family	$7,000 / $14,000	$7,000 / $14,000	$21,000 / $42,000
OFFICE SERVICES			
Primary Care Physician (PCP)	No charge for the first visit $30 copay/visit thereafter	$60 copay/visit	50% coinsurance AD**
Specialist	$60 copay/visit	$120 copay/visit	50% coinsurance AD**
IMMEDIATE MEDICAL CARE* **			
Virtual Visits	$30 copay/visit	Not applicable	Not applicable
Retail Clinic	$40 copay/visit	$40 copay/visit	$40 copay/visit AD**
Urgent Care	Independent facilities - $100 copay/visit	Independent facilities - $100 copay/visit	Independent facilities - $100 copay/visit
	Hospital-affiliated facilities - $200 copay/visit	Hospital-affiliated facilities - $200 copay/visit	Hospital-affiliated facilities - $200 copay/visit
Emergency Room	$500 copay per visit AD**	$500 copay per visit AD**	$500 copay per visit AD**
Ambulance (Ground per one way transportation)	$200 copay	$200 copay	$200 copay
OUTPATIENT DIAGNOSTIC SERVICES			
Complex (CT/PET scans, MRIs, etc.)	Independent facilities - $275 copay/visit	Independent facilities - 50% coinsurance AD**	Independent facilities - 50% coinsurance AD**
	Hospital-affiliated facilities - $550 copay/visit	Hospital-affiliated facilities - 50% coinsurance AD**	Hospital-affiliated facilities - 50% coinsurance AD*
Other radiology (x-ray, ultrasound, etc.)	Independent facilities - $75 copay/visit	Independent facilities - 50% coinsurance AD**	Independent facilities - 50% coinsurance AD**
	Hospital-affiliated facilities - $150 copay/visit	Hospital-affiliated facilities - 50% coinsurance AD**	Hospital-affiliated facilities - 50% coinsurance AD**
Outpatient Routine Lab	$30 copay/visit for lab work at participating labs	$30 copay/visit for lab work at participating labs	50% coinsurance AD**
HOSPITAL			
Inpatient	$800 copay/day for first 3 days per admission AD**	50% coinsurance AD**	50% coinsurance AD**
Outpatient Surgery (facility)	$750 copay/visit AD**	50% coinsurance AD**	50% coinsurance AD**
PRESCRIPTION DRUGS			
Rx (Retail) per prescription: Value Generic/Generic/ Preferred/Non-Preferred/ Specialty Drugs	$20/$40/$80/$100/ 50% coinsurance AD**	$20/$40/$80/$100/ 50% coinsurance AD**	Not covered
Rx (Mail Order, Up to 90-Day Supply):Value Generic/Generic/ Preferred/Non Preferred	$50/$100/$200/$250	$50/$100/$200/$250	Not covered
PEDIATRIC DENTAL/VISION SERVICES			
Dental*	No charge for preventive care limited to 1 exam every 6 months****	No charge for preventive care limited to 1 exam every 6 months****	50% coinsurance**** AD**
Eye Exam*	No charge limited to 1 exam per calendar year	No charge limited to 1 exam per calendar year	50% coinsurance AD**
Glasses*	No charge limited to 1 pair per calendar year	No charge limited to 1 pair per calendar year	50% coinsurance AD**

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**AD – After Deductible.
***Coverage does not apply to facility fees (e.g. hospital room) or physician/surgeon fees.
**** Dental services are subject to a calendar year deductible of $65 per child and out of pocket maximum of $350 per child, or $700 for two or more children. Does not apply toward medical deductible and out-of-pocket costs.

AvMed Empower Plans

Key Benefits for your Plan:	Empower MS500-IN19 SILVER		
	In-Network Tier A	In-Network Tier B	Out-of-Network
CALENDAR YEAR DEDUCTIBLE (CYD)			
Individual/Family	$5,500 / $11,000	$5,500 / $11,000	$16,500 / $33,000
	$65 per child for Pediatric Dental***. (Delta Dental PPO℠ Network)	$65 per child for Pediatric Dental***. (Delta Dental PPO℠ Network)	$65 per child for Pediatric Dental***. (Delta Dental PPO℠ Network)
OUT-OF-POCKET MAX (INCLUDES DEDUCTIBLE)			
Individual/Family	$7,000 / $14,000	$7,000 / $14,000	$21,000 / $42,000
OFFICE SERVICES			
Primary Care Physician (PCP)	No charge for the first visit; $30 copay/visit thereafter	$60 copay/visit	50% coinsurance AD**
Specialist	$60 copay/visit	$120 copay/visit	50% coinsurance AD**
IMMEDIATE MEDICAL CARE* **			
Virtual Visits	$30 copay/visit	Not applicable	Not applicable
Retail Clinic	$40 copay/visit	$40 copay/visit	$40 copay/visit
Urgent Care	Independent facilities - $110 copay/visit	Independent facilities - $110 copay/visit	Independent facilities - $110 copay/visit
	Hospital-affiliated facilities - $220 copay/visit	Hospital-affiliated facilities - $220 copay/visit	Hospital-affiliated facilities - $220 copay/visit
Emergency Room	$550 copay/visit AD**	$550 copay/visit AD**	$550 copay/visit AD**
Ambulance (Ground per one way transportation)	$200 copay	$200 copay	$200 copay
OUTPATIENT DIAGNOSTIC SERVICES			
Complex (CT/PET scans, MRIs, etc.)	Independent facilities - $300 copay/visit	Independent facilities - 50% coinsurance AD**	Independent facilities - 50% coinsurance AD**
	Hospital-affiliated facilities - $600 copay/visit	Hospital-affiliated facilities - 50% coinsurance AD**	Hospital-affiliated facilities - 50% coinsurance AD**
Other radiology (x-ray, ultrasound, etc.)	Independent facilities - $100 copay/visit	Independent facilities - 50% coinsurance AD**	Independent facilities - 50% coinsurance AD**
	Hospital-affiliated facilities - $200 copay/visit	Hospital-affiliated facilities - 50% coinsurance AD**	Hospital-affiliated facilities - 50% coinsurance AD**
Outpatient Routine Lab	$30 copay/visit for lab work at participating labs	$30 copay/visit for lab work at participating labs	50% coinsurance AD**
HOSPITAL			
Inpatient	$950 copay per admission AD**	50% coinsurance AD**	50% coinsurance AD**
Outpatient Surgery (facility)	$750 copay/visit AD**	50% coinsurance AD**	50% coinsurance AD**
PRESCRIPTION DRUGS			
Rx (Retail) per prescription: Value Generic/Generic/ Preferred/Non-Preferred/ Specialty Drugs	$20/$40/$80/$100/ 50% coinsurance AD**	$20/$40/$80/$100/ 50% coinsurance AD**	Not covered
Rx (Mail Order, Up to 90-Day Supply):Value Generic/Generic/ Preferred/Non Preferred	$50/$100/$200/$250	$50/$100/$200/$250	Not covered
PEDIATRIC DENTAL/VISION SERVICES			
Dental*	No charge for preventive care limited to 1 exam every 6 months****	No charge for preventive care limited to 1 exam every 6 months****	50% coinsurance**** AD**
Eye Exam*	No charge limited to 1 exam per calendar year	No charge limited to 1 exam per calendar year	50% coinsurance AD**
Glasses*	No charge limited to 1 pair per calendar year	No charge limited to 1 pair per calendar year	50% coinsurance AD**

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*Limitations may apply. Please refer to your contract.
**AD – After Deductible.
***Coverage does not apply to facility fees (e.g. hospital room) or physician/surgeon fees.
**** Dental services are subject to a calendar year deductible of $65 per child and out of pocket maximum of $350 per child, or $700 for two or more children. Does not apply toward medical deductible and out-of-pocket costs.

AvMed Empower Plans

Key Benefits for your Plan:	Empower MB600-IN19 BRONZE		
	In-Network Tier A	In-Network Tier B	Out-of-Network
CALENDAR YEAR DEDUCTIBLE (CYD)			
Individual/Family	$6,500 / $13,000	$6,500 / $13,000	$19,500 / $39,000
	$65 per child for Pediatric Dental***. (Delta Dental PPO℠ Network)	$65 per child for Pediatric Dental***. (Delta Dental PPO℠ Network)	$65 per child for Pediatric Dental***. (Delta Dental PPO℠ Network)
OUT-OF-POCKET MAX (INCLUDES DEDUCTIBLE)			
Individual/Family	$7,000 / $14,000	$7,000 / $14,000	$21,000 / $42,000
OFFICE SERVICES			
Primary Care Physician (PCP)	$40 copay/visit	50% coinsurance AD**	50% coinsurance AD**
Specialist	$80 copay/visit	50% coinsurance AD**	50% coinsurance AD**
IMMEDIATE MEDICAL CARE* **			
Virtual Visit	$40 copay/visit	Not applicable	Not applicable
Retail Clinic	$50 copay/visit	$50 copay/visit	$50 copay/visit AD**
Urgent Care	Independent facilities - $125 copay/visit	Independent facilities - $125 copay/visit	Independent facilities - $125 copay/visit
	Hospital-affiliated facilities - $250 copay/visit	Hospital-affiliated facilities - $250 copay/visit	Hospital-affiliated facilities - $250 copay/visit
Emergency Room	$500 copay/visit AD**	$500 copay/visit AD**	$500 copay/visit AD**
Ambulance (Ground per one way transportation)	$200 copay	$200 copay	$200 copay
OUTPATIENT DIAGNOSTIC SERVICES			
Complex (CT/PET scans, MRIs, etc.)	Independent facilities - $250 copay/visit AD**	Independent facilities - 50% coinsurance AD**	Independent facilities - 50% coinsurance AD**
	Hospital-affiliated facilities - $500 copay/visit AD**	Hospital-affiliated facilities - 50% coinsurance AD**	Hospital-affiliated facilities - 50% coinsurance AD**
Other radiology (x-ray, ultrasound, etc.)	Independent facilities*** - $65 copay/visit AD**	Independent facilities - 50% coinsurance AD**	Independent facilities - 50% coinsurance AD**
	Hospital-affiliated facilities*** - $130 copay/visit AD**	Hospital-affiliated facilities - 50% coinsurance AD**	Hospital-affiliated facilities - 50% coinsurance AD**
Outpatient Routine Lab	$40 copay/visit for lab work at participating labs	$40 copay/visit for lab work at participating labs	50% coinsurance AD**
HOSPITAL			
Inpatient	$500 copay per admission AD**	50% coinsurance AD**	50% coinsurance AD**
Outpatient Surgery (facility)	30% coinsurance AD**	50% coinsurance AD**	50% coinsurance AD**
PRESCRIPTION DRUGS			
Rx (Retail) per prescription: Value Generic/Generic/ Preferred/Non-Preferred/ Specialty Drugs	$25/$45/$85 AD** 50% coinsurance AD** 50% coinsurance AD**	$25/$45/$85 AD** 50% coinsurance AD** 50% coinsurance AD**	Not covered
Rx (Mail Order, Up to 90-Day Supply):Value Generic/Generic/ Preferred/Non Preferred	$62.50/$112.50/$212.50 AD** 50% coinsurance AD**	$62.50/$112.50/$212.50 AD** 50% coinsurance AD**	Not covered
PEDIATRIC DENTAL/VISION SERVICES			
Dental*	No charge for preventive care limited to 1 exam every 6 months****	No charge for preventive care limited to 1 exam every 6 months****	50% coinsurance**** AD**
Eye Exam*	No charge limited to 1 exam per calendar year	No charge limited to 1 exam per calendar year	50% coinsurance AD**
Glasses*	No charge limited to 1 pair per calendar year	No charge limited to 1 pair per calendar year	50% coinsurance AD**

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**AD – After Deductible.
***Coverage does not apply to facility fees (e.g. hospital room) or physician/surgeon fees.
**** Dental services are subject to a calendar year deductible of $65 per child and out of pocket maximum of $350 per child, or $700 for two or more children. Does not apply toward medical deductible and out-of-pocket costs.

AvMed Empower Plans

Key Benefits for your Plan:	Empower MB650-IN19 BRONZE		
	In-Network Tier A	In-Network Tier B	Out-of-Network
CALENDAR YEAR DEDUCTIBLE (CYD)			
Individual/Family	$7,500 / $15,000	$7,500 / $15,000	$22,500 / $45,000
	$65 per child for Pediatric Dental***. (Delta Dental PPO℠ Network)	$65 per child for Pediatric Dental***. (Delta Dental PPO℠ Network)	$65 per child for Pediatric Dental***. (Delta Dental PPO℠ Network)
OUT-OF-POCKET MAX (INCLUDES DEDUCTIBLE)			
Individual/Family	$7,500/$15,000	$7,500/$15,000	$22,500/$45,000
OFFICE SERVICES			
Primary Care Physician (PCP)	No charge AD**	No charge AD**	No charge AD**
Specialist	No charge AD**	No charge AD**	No charge AD**
IMMEDIATE MEDICAL CARE* **			
Virtual Visits	No charge AD**	Not applicable	Not applicable
Retail Clinic	No charge AD**	No charge AD**	No charge AD**
Urgent Care	Independent facilities - No charge AD**	Independent facilities - No charge AD**	Independent facilities - No charge AD**
	Hospital-affiliated facilities - No charge AD**	Hospital-affiliated facilities - No charge AD**	Hospital-affiliated facilities - No charge AD**
Emergency Room	No charge AD**	No charge AD**	No charge AD**
Ambulance (Ground per one way transportation)	No charge AD**	No charge AD**	No charge AD**
OUTPATIENT DIAGNOSTIC SERVICES			
Complex radiology (CT/PET scans, MRIs, etc.)	Independent facilities - No charge AD**	Independent facilities - No charge AD**	Independent facilities - No charge AD**
	Hospital-affiliated facilities - No charge AD**	Hospital-affiliated facilities - No charge AD**	Hospital-affiliated facilities - No charge AD**
Other radiology (x-ray, ultrasound, etc.)	Independent facilities - No charge AD**	Independent facilities - No charge AD**	Independent facilities - No charge AD**
	Hospital-affiliated facilities - No charge AD**	Hospital-affiliated facilities - No charge AD**	Hospital-affiliated facilities - No charge AD**
Outpatient Routine Lab	No charge AD**	No charge AD**	No charge AD**
HOSPITAL			
Inpatient	No charge AD**	No charge AD**	No charge AD**
Outpatient Surgery (facility)	No charge AD**	No charge AD**	No charge AD**
PRESCRIPTION DRUGS			
Rx (Retail) per prescription: Value Generic/Generic/ Preferred/Non-Preferred/ Specialty Drugs	No charge AD**	No charge AD**	No charge AD**
Rx (Mail Order, Up to 90-Day Supply): Value Generic/Generic/Preferred/Non Preferred	No charge AD**	No charge AD**	No charge AD**
PEDIATRIC DENTAL/VISION SERVICES			
Dental*	No charge for preventative care limited to 1 exam every 6 months****	No charge for preventative care limited to 1 exam every 6 months****	50% coinsurance**** AD**
Eye Exam*	No charge limited to 1 exam per calendar year	No charge limited to 1 exam per calendar year	50% coinsurance AD**
Glasses*	No charge limited to 1 pair per calendar year	No charge limited to 1 pair per calendar year	50% coinsurance AD**

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For Agent use only - not for dissemination to the public.
For a complete listing of the doctors and hospitals that make up our Partner Network, refer to the directory for the Empower plans at AvMed.org.

Notes

Individual Health Offices:

13450 W. Sunrise Blvd.
Sunrise, FL 33323

9400 S. Dadeland Blvd.
Miami, FL 33156

AvMed's Agent Support Line:
1-800-461-2950

AvMed's Individual Health Sales Center:
1-877-513-9355 (TTY 711)
Monday–Friday from 9 am to 6 pm

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