AvMed Empower Individual & Family Plans - 2026

For agent use only

PLAN NAME	Empower MG225-IN26		
PLAN ID	AVIN_PG_1672_0126		
METAL TIER	Gold		
AvMed Confidential Proprietary / Internal Use Only	Tier A	Tier B	Out-of-Network
DEDUCTIBLE: Individual/Family	$1,400 / $2,800	$1,400 / $2,800	$4,200 / $8,400
OUT OF POCKET MAX: 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 per visit thereafter	$20 copay per visit	50% coinsurance after deductible
Specialist	$40 copay per visit	$40 copay per visit	50% coinsurance after deductible
Telehealth Virtual Visits	No charge	Not Covered	Not Covered
PREVENTIVE CARE			
Preventive Wellness Services	No charge	No charge	50% coinsurance after deductible
IMMEDIATE MEDICAL CARE**			
Retail Clinic	$30 copay per visit	$30 copay per visit	$30 copay per visit
Urgent Care	$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
Emergency Room	$350 copay per visit after deductible	$350 copay per visit after deductible	$350 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
OUTPATIENT SERVICES			
Outpatient Radiology			
Complex (CT/PET scans, MRIs, etc.)	$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
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	50% coinsurance after deductible
Outpatient Routine Lab	$10 copay per visit	$10 copay per visit	50% coinsurance after deductible
Outpatient Surgery - facility	$650 copay per visit after deductible	$650 copay per visit after deductible	50% coinsurance after deductible
Outpatient Surgery - physician services	No charge after deductible	No charge after deductible	50% coinsurance after deductible
HOSPITAL			
Inpatient	$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
PRESCRIPTION DRUGS			
Per Prescription (30 day supply): Preferred Generic/Generic/Preferred Brand/ Non-Preferred Brand/Specialty [No Preferred 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	Not Covered
Per Prescription (90 day supply): Preferred Generic/Generic/Preferred Brand/Non-Preferred Brand [No Preferred 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	Not Covered
DENTAL / VISION SERVICES*			
Pediatric Eye Exam	No charge	No charge	50% coinsurance after deductible
Pediatric Glasses	No charge	No charge	50% coinsurance after deductible
Pediatric Dental	No charge	No charge	No charge
Adult Eye Exam	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance	Not Covered	Not Covered	Not Covered
Adult Dental	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.

This schedule is not a contract. It is a brief Summary of benefits. For more information on benefits, exclusions and limitations, refer to the summary of benefits and coverage (SBC).

AvMed Empower Individual & Family Plans - 2026

For agent use only

PLAN NAME	Empower MS300-IN26		
PLAN ID	AVIN_PS_1673_0126		
METAL TIER	Silver		
AvMed Confidential Proprietary / Internal Use Only	Tier A	Tier B	Out-of-Network
DEDUCTIBLE: Individual/Family	$3,000 / $6,000	$3,000 / $6,000	$9,000 / $18,000
OUT OF POCKET MAX: Individual/Family	$9,350 / $18,700	$9,350 / $18,700	$28,050 / $56,100
OFFICE SERVICES			
Primary Care Physician (PCP)	No charge for the first visit; $25 copay per visit thereafter	$25 copay per visit	50% coinsurance after deductible
Specialist	$50 copay per visit	$50 copay per visit	50% coinsurance after deductible
Telehealth Virtual Visits	No charge	Not Covered	Not Covered
PREVENTIVE CARE			
Preventive Wellness Services	No charge	No charge	50% coinsurance after deductible
IMMEDIATE MEDICAL CARE**			
Retail Clinic	$35 copay per visit	$35 copay per visit	$35 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
Emergency Room	$500 copay per visit after deductible	$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
OUTPATIENT SERVICES			
Outpatient Radiology			
Complex (CT/PET scans, MRIs, etc.)	$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
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	50% coinsurance after deductible
Outpatient Routine Lab	$25 copay per visit	$25 copay per visit	50% coinsurance after deductible
Outpatient Surgery - facility	$750 copay per visit after deductible	$750 copay per visit after deductible	50% coinsurance after deductible
Outpatient Surgery - physician services	No charge after deductible	No charge after deductible	50% coinsurance after deductible
HOSPITAL			
Inpatient	$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	50% coinsurance after deductible
PRESCRIPTION DRUGS			
Per Prescription (30 day supply): Preferred Generic/Generic/Preferred Brand/ Non-Preferred Brand/Specialty [No Preferred Generic tier in Standard plans] [Separate Rx deductible may apply]	$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
Per Prescription (90 day supply): Preferred Generic/Generic/Preferred Brand/Non-Preferred Brand [No Preferred Generic tier in Standard plans] [Separate Rx deductible may apply]	$50 copay / $100 copay / $200 copay / $250 copay	$50 copay / $100 copay / $200 copay / $250 copay	Not Covered
DENTAL / VISION SERVICES*			
Pediatric Eye Exam	No charge	No charge	50% coinsurance after deductible
Pediatric Glasses	No charge	No charge	50% coinsurance after deductible
Pediatric Dental	No charge	No charge	No charge
Adult Eye Exam	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance	Not Covered	Not Covered	Not Covered
Adult Dental	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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AvMed Empower Individual & Family Plans - 2026

For agent use only

PLAN NAME	Empower MS400-IN26		
PLAN ID	AVIN_PS_1674_0126		
METAL TIER	Silver		
AvMed Confidential Proprietary / Internal Use Only	Tier A	Tier B	Out-of-Network
DEDUCTIBLE: Individual/Family	$4,500 / $9,000	$4,500 / $9,000	$13,500 / $27,000
OUT OF POCKET MAX: Individual/Family	$8,550 / $17,100	$8,550 / $17,100	$25,650 / $51,300
OFFICE SERVICES			
Primary Care Physician (PCP)	No charge for the first visit; $30 copay per visit thereafter	$30 copay per visit	50% coinsurance after deductible
Specialist	$60 copay per visit	$60 copay per visit	50% coinsurance after deductible
Telehealth Virtual Visits	No charge	Not Covered	Not Covered
PREVENTIVE CARE			
Preventive Wellness Services	No charge	No charge	50% coinsurance after deductible
IMMEDIATE MEDICAL CARE**			
Retail Clinic	$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
Emergency Room	$500 copay per visit after deductible	$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
OUTPATIENT SERVICES			
Outpatient Radiology			
Complex (CT/PET scans, MRIs, etc.)	$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
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	50% coinsurance after deductible
Outpatient Routine Lab	$30 copay per visit	$30 copay per visit	50% coinsurance after deductible
Outpatient Surgery - facility	$750 copay per visit after deductible	$750 copay per visit after deductible	50% coinsurance after deductible
Outpatient Surgery - physician services	No charge after deductible	No charge after deductible	50% coinsurance after deductible
HOSPITAL			
Inpatient	$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
PRESCRIPTION DRUGS			
Per Prescription (30 day supply): Preferred Generic/Generic/Preferred Brand/ Non-Preferred Brand/Specialty [No Preferred Generic tier in Standard plans] [Separate Rx deductible may apply]	$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
Per Prescription (90 day supply): Preferred Generic/Generic/Preferred Brand/Non-Preferred Brand [No Preferred Generic tier in Standard plans] [Separate Rx deductible may apply]	$50 copay / $100 copay / $200 copay / $250 copay	$50 copay / $100 copay / $200 copay / $250 copay	Not Covered
DENTAL / VISION SERVICES*			
Pediatric Eye Exam	No charge	No charge	50% coinsurance after deductible
Pediatric Glasses	No charge	No charge	50% coinsurance after deductible
Pediatric Dental	No charge	No charge	No charge
Adult Eye Exam	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance	Not Covered	Not Covered	Not Covered
Adult Dental	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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AvMed Empower Individual & Family Plans - 2026

For agent use only

PLAN NAME	Empower MS500-IN26		
PLAN ID	AVIN_PS_1675_0126		
METAL TIER	Silver		
AvMed Confidential Proprietary / Internal Use Only	Tier A	Tier B	Out-of-Network
DEDUCTIBLE: Individual/Family	$5,500 / $11,000	$5,500 / $11,000	$16,500 / $33,000
OUT OF POCKET MAX: Individual/Family	$8,350 / $16,700	$8,350 / $16,700	$25,050 / $50,100
OFFICE SERVICES			
Primary Care Physician (PCP)	No charge for the first visit; $30 copay per visit thereafter	$30 copay per visit	50% coinsurance after deductible
Specialist	$60 copay per visit	$60 copay per visit	50% coinsurance after deductible
Telehealth Virtual Visits	No charge	Not Covered	Not Covered
PREVENTIVE CARE			
Preventive Wellness Services	No charge	No charge	50% coinsurance after deductible
IMMEDIATE MEDICAL CARE**			
Retail Clinic	$40 copay per visit	$40 copay per visit	$40 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	$110 copay per visit at independent facilities; $220 copay per visit at hospital-owned or affiliated facilities
Emergency Room	$550 copay per visit after deductible	$550 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
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	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	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities	50% coinsurance after deductible
Outpatient Routine Lab	$30 copay per visit	$30 copay per visit	50% coinsurance after deductible
Outpatient Surgery - facility	$750 copay per visit after deductible	$750 copay per visit after deductible	50% coinsurance after deductible
Outpatient Surgery - physician services	No charge after deductible	No charge after deductible	50% coinsurance after deductible
HOSPITAL			
Inpatient	$950 copay per admission after deductible	$950 copay per admission after deductible	50% coinsurance after deductible
PRESCRIPTION DRUGS			
Per Prescription (30 day supply): Preferred Generic/Generic/Preferred Brand/ Non-Preferred Brand/Specialty [No Preferred Generic tier in Standard plans] [Separate Rx deductible may apply]	$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
Per Prescription (90 day supply): Preferred Generic/Generic/Preferred Brand/Non-Preferred Brand [No Preferred Generic tier in Standard plans] [Separate Rx deductible may apply]	$50 copay / $100 copay / $200 copay / $250 copay	$50 copay / $100 copay / $200 copay / $250 copay	Not Covered
DENTAL / VISION SERVICES*			
Pediatric Eye Exam	No charge	No charge	50% coinsurance after deductible
Pediatric Glasses	No charge	No charge	50% coinsurance after deductible
Pediatric Dental	No charge	No charge	No charge
Adult Eye Exam	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance	Not Covered	Not Covered	Not Covered
Adult Dental	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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AvMed Empower Individual & Family Plans - 2026

For agent use only

PLAN NAME	Empower MB600-IN26		
PLAN ID	AVIN_PB_1670_0126		
METAL TIER	Bronze		
AvMed Confidential Proprietary / Internal Use Only	Tier A	Tier B	Out-of-Network
DEDUCTIBLE: Individual/Family	$7,900 / $15,800	$7,900 / $15,800	$23,700 / $47,400
OUT OF POCKET MAX: Individual/Family	$9,250 / $18,500	$9,250 / $18,500	$27,750 / $55,500
OFFICE SERVICES			
Primary Care Physician (PCP)	$50 copay per visit	$50 copay per visit	50% coinsurance after deductible
Specialist	$100 copay per visit	$100 copay per visit	50% coinsurance after deductible
Telehealth Virtual Visits	No charge	Not Covered	Not Covered
PREVENTIVE CARE			
Preventive Wellness Services	No charge	No charge	50% coinsurance after deductible
IMMEDIATE MEDICAL CARE**			
Retail Clinic	$60 copay per visit	$60 copay per visit	$60 copay per visit
Urgent Care	$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	$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
OUTPATIENT SERVICES			
Outpatient Radiology			
Complex (CT/PET scans, MRIs, etc.)	$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.)	$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	$40 copay per visit	$40 copay per visit	50% coinsurance after deductible
Outpatient Surgery - facility	30% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient Surgery - physician services	30% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
HOSPITAL			
Inpatient	$300 copay per admission after deductible	$300 copay per admission after deductible	50% coinsurance after deductible
PRESCRIPTION DRUGS			
Per Prescription (30 day supply): Preferred Generic/Generic/Preferred Brand/ Non-Preferred Brand/Specialty [No Preferred Generic tier in Standard plans] [Separate Rx deductible may apply]	$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): Preferred Generic/Generic/Preferred Brand/Non-Preferred Brand [No Preferred Generic tier in Standard plans] [Separate Rx deductible may apply]	$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	No charge	50% coinsurance after deductible
Pediatric Glasses	No charge	No charge	50% coinsurance after deductible
Pediatric Dental	No charge	No charge	No charge
Adult Eye Exam	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance	Not Covered	Not Covered	Not Covered
Adult Dental	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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AvMed Empower Individual & Family Plans - 2026

For agent use only

PLAN NAME	Empower MB650-IN26		
PLAN ID	AVIN_PB_1671_0126		
METAL TIER	Bronze		
AvMed Confidential Proprietary / Internal Use Only	Tier A	Tier B	Out-of-Network
DEDUCTIBLE: Individual/Family	$8,200 / $16,400	$8,200 / $16,400	$24,600 / $49,200
OUT OF POCKET MAX: Individual/Family	$8,200 / $16,400	$8,200 / $16,400	$24,600 / $49,200
OFFICE SERVICES			
Primary Care Physician (PCP)	$75 copay per visit	$75 copay per visit	No charge after deductible
Specialist	No charge after deductible	No charge after deductible	No charge after deductible
Telehealth Virtual Visits	No charge	Not Covered	Not Covered
PREVENTIVE CARE			
Preventive Wellness Services	No charge	No charge	No charge after deductible
IMMEDIATE MEDICAL CARE**			
Retail Clinic	$85 copay per visit	$85 copay per visit	$85 copay per visit
Urgent Care	No charge after deductible	No charge after deductible	No charge after deductible
Emergency Room	No charge after deductible	No charge after deductible	No charge after deductible
Ambulance (Ground)	No charge after deductible	No charge after deductible	No charge after deductible
OUTPATIENT SERVICES			
Outpatient Radiology			
Complex (CT/PET scans, MRIs, etc.)	No charge after deductible	No charge after deductible	No charge after deductible
Other (X-ray, ultrasound, etc.)	No charge after deductible	No charge after deductible	No charge after deductible
Outpatient Routine Lab	$40 copay per visit	$40 copay per visit	No charge after deductible
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): Preferred Generic/Generic/Preferred Brand/ Non-Preferred Brand/Specialty [No Preferred 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
Per Prescription (90 day supply): Preferred Generic/Generic/Preferred Brand/Non-Preferred Brand [No Preferred 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
DENTAL / VISION SERVICES*			
Pediatric Eye Exam	No charge	No charge	No charge after deductible
Pediatric Glasses	No charge	No charge	No charge after deductible
Pediatric Dental	No charge	No charge	No charge
Adult Eye Exam	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance	Not Covered	Not Covered	Not Covered
Adult Dental	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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AvMed Empower Individual & Family Plans - 2026

For agent use only

PLAN NAME	Empower HSAQ MS350-IN26		
PLAN ID	AVIN_DPS_1669_0126		
METAL TIER	Silver		
AvMed Confidential Proprietary / Internal Use Only	Tier A	Tier B	Out-of-Network
DEDUCTIBLE: Individual/Family	$3,500 / $7,000	$3,500 / $7,000	$10,500 / $21,000
OUT OF POCKET MAX: Individual/Family	$7,000 / $14,000	$7,000 / $14,000	$21,000 / $42,000
OFFICE SERVICES			
Primary Care Physician (PCP)	20% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible
Specialist	20% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible
Telehealth Virtual Visits	20% coinsurance after deductible	Not Covered	Not Covered
PREVENTIVE CARE			
Preventive Wellness Services	No charge	No charge	50% coinsurance after deductible
IMMEDIATE MEDICAL CARE**			
Retail Clinic	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Urgent Care	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Emergency Room	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Ambulance (Ground)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
OUTPATIENT SERVICES			
Outpatient Radiology			
Complex (CT/PET scans, MRIs, etc.)	20% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible
Other (X-ray, ultrasound, etc.)	20% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible
Outpatient Routine Lab	20% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible
Outpatient Surgery - facility	20% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible
Outpatient Surgery - physician services	20% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible
HOSPITAL			
Inpatient	20% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible
PRESCRIPTION DRUGS			
Per Prescription (30 day supply): Preferred Generic/Generic/Preferred Brand/ Non-Preferred Brand/Specialty [No Preferred Generic tier in Standard plans] [Separate Rx deductible may apply]	20% coinsurance after deductible	20% coinsurance after deductible	Not Covered
Per Prescription (90 day supply): Preferred Generic/Generic/Preferred Brand/Non-Preferred Brand [No Preferred Generic tier in Standard plans] [Separate Rx deductible may apply]	20% coinsurance after deductible	20% coinsurance after deductible	Not Covered
DENTAL / VISION SERVICES*			
Pediatric Eye Exam	20% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible
Pediatric Glasses	20% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible
Pediatric Dental	No charge	No charge	No charge
Adult Eye Exam	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance	Not Covered	Not Covered	Not Covered
Adult Dental	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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