Please select from the list below to view the Summary of Benefits and Coverage (SBC) and Detailed Schedule of Benefits documents for this medical plan with Pharmacy Benefit Options.

AvMed Large Group Achieve LH650-LG24	**Medical Deductible Individual/Family**	**Out-of-Pocket Limit Individual/Family**	**PCP (per visit)**	**Specialist (per visit)**	**Inpatient Hospital (per admission)**
AVLG_H_8077_0724	$6,000 / $12,000	$7,900 / $15,800	$35 copay	$70 copay	30% coinsurance after deductible

You may use the chart below a guide to help you choose the SBC with the Pharmacy Benefit you'd like to see.
For example, choose document ending in **R6217** to view this medical plan with Pharmacy Benefit:
Value Generic: $15 copay, Generic: $15 copay, Preferred: $40 copay, Non-Preferred: $80 copay, and Specialty: 50% coinsurance AD*

Pharmacy Benefit	Pharmacy Deductible	Medication Tiers: Member cost-share at in-network retail pharmacy (per prescription)					Summary of Benefits and Coverage (SBC)
		Value Generic	Generic	Preferred	Non-Preferred	Specialty	
R6217	combined with medical	$15 copay	$15 copay	$40 copay	$80 copay	50% coinsurance AD*	AVLG_H_8077_R6217_0724
R6218	not applicable	$20 copay	$20 copay	$50 copay	$100 copay	50% coinsurance	AVLG_H_8077_R6218_0724
R6219	not applicable	$3 copay	$3 copay	$25 copay	$50 copay	50% coinsurance	AVLG_H_8077_R6219_0724
R6527	not applicable	$10 copay	$10 copay	100% coinsurance	100% coinsurance	100% coinsurance	AVLG_H_8077_R6527_0724
R6535	not applicable	$10 copay	$10 copay	$50 copay	$125 copay	$150 copay	AVLG_H_8077_R6535_0724
R8012	not applicable	$10 copay	$10 copay	$75 copay	25% coinsurance	50% coinsurance	AVLG_H_8077_R8012_0724
R8013	not applicable	$10 copay	$10 copay	$40 copay	$80 copay	30% coinsurance	AVLG_H_8077_R8013_0724
R7248	$250 individual / $500 family	$5 copay	$5 copay	50% coinsurance AD*	100% coinsurance AD*	100% coinsurance AD*	AVLG_H_8077_R7248_0724
R7477	$500 individual / $1,000 family	$10 copay	$10 copay	25% coinsurance AD*	40% coinsurance AD*	40% coinsurance AD*	AVLG_H_8077_R7477_0724
R7479	$500 individual / $1,000 family	$10 copay	$10 copay	$50 copay	$100 copay	30% coinsurance AD*	AVLG_H_8077_R7479_0724

AD*: after deductible

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), the Detailed Schedule of Benefits, the Large Group Medical and Hospital Service Contract, or contact your AvMed Sales or Service representative.