AvMed Entrust Off-Exchange Individual & Family Plans - 2026

For agent use only

PLAN NAME	Entrust Platinum 25 (2026)	Entrust Platinum Standard (2026)	Entrust Gold 125 (2026)	Entrust Gold Standard (2026)
PLAN ID	AVIN_HP_1654_0126	AVIN_HP_1656_0126	AVIN_HG_1651_0126	AVIN_HG_1653_0126
METAL TIER	Platinum	Platinum	Gold	Gold
AvMed Confidential Proprietary / Internal Use Only	In-Network	In-Network	In-Network	In-Network
DEDUCTIBLE: Individual/Family	$0 / $0	$0 / $0	$2,000 / $4,000	$2,000 / $4,000
OUT OF POCKET MAX: Individual/Family	$5,500 / $11,000	$5,200 / $10,400	$5,850 / $11,700	$8,200 / $16,400
OFFICE SERVICES				
Primary Care Physician (PCP)	$10 copay per visit	$10 copay per visit	$35 copay per visit	$30 copay per visit
Specialist	$20 copay per visit	$20 copay per visit	$70 copay per visit	$60 copay per visit
Telehealth Virtual Visits	No charge	No charge	No charge	No charge
PREVENTIVE CARE				
Preventive Wellness Services	No charge	No charge	No charge	No charge
IMMEDIATE MEDICAL CARE**				
Retail Clinic	$20 copay per visit	$15 copay per visit	$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	$15 copay per visit	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$45 copay per visit
Emergency Room	$100 copay per visit	$100 copay per visit	$500 copay per visit after deductible	25% coinsurance 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
OUTPATIENT SERVICES				
Outpatient Radiology				
Complex (CT/PET scans, MRIs, etc.)	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities	$100 copay per visit	$250 copay per visit at independent facilities; $500 copay per visit at hospital-owned or affiliated facilities	25% coinsurance after deductible
Other (X-ray, ultrasound, etc.)	$10 copay per visit at independent facilities; $20 copay per visit at hospital-owned o r affiliated facilities	$30 copay per visit	$75 copay per visit at independent facilities; $150 copay per visit at hospital-owned or affiliated facilities	25% coinsurance after deductible
Outpatient Routine Lab	No charge	$30 copay per visit	$10 copay per visit	25% coinsurance after deductible
Outpatient Surgery - facility	$200 copay per visit	$150 copay per visit	$650 copay per visit after deductible	25% coinsurance after deductible
Outpatient Surgery - physician services	No charge	$150 copay per visit	No charge after deductible	25% coinsurance after deductible
HOSPITAL				
Inpatient	$350 copay per day for the first 3 days per admission	$350 copay per admission	$850 copay per admission after deductible	25% 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]	No charge / $5 copay / $20 copay / $60 copay / 50% coinsurance	$5 copay / $10 copay / $50 copay / $150 copay	$15 copay / $30 copay / $60 copay / $120 copay / 50% coinsurance after deductible	$15 copay / $30 copay / $60 copay / $250 copay
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]	No charge / $12.50 copay / $50 copay / $150 copay	$12.50 copay / $25 copay / $125 copay	$37.50 copay / $75 copay / $150 copay / $300 copay	$37.50 copay / $75 copay / $150 copay
DENTAL / VISION SERVICES*				
Pediatric Eye Exam	No charge	No charge	No charge	No charge
Pediatric Glasses	No charge	No charge	No charge	No charge
Pediatric Dental	No charge	No charge	No charge	No charge
Adult Eye Exam	Not Covered	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance	Not Covered	Not Covered	Not Covered	Not Covered
Adult Dental	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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AvMed Entrust Off-Exchange Individual & Family Plans - 2026

For agent use only

PLAN NAME	Entrust Silver 350 (2026)	Entrust Silver 550 - Off Exchange (2026)	Entrust Silver 550 (2026)	Entrust Silver Standard (2026)
PLAN ID	AVIN_HS_1658_0126	AVIN_HS_1682_0126	AVIN_HS_1660_0126	AVIN_HS_1657_0126
METAL TIER	Silver	Silver	Silver	Silver
AvMed Confidential Proprietary / Internal Use Only	In-Network	In-Network	In-Network	In-Network
DEDUCTIBLE: Individual/Family	$3,500 / $7,000	$6,250 / $12,500	$6,250 / $12,500	$6,000 / $12,000
OUT OF POCKET MAX: Individual/Family	$9,250 / $18,500	$8,000 / $16,000	$8,000 / $16,000	$8,900 / $17,800
OFFICE SERVICES				
Primary Care Physician (PCP)	$30 copay per visit	$55 copay per visit	$55 copay per visit	$40 copay per visit
Specialist	$60 copay per visit	$110 copay per visit	$110 copay per visit	$80 copay per visit
Telehealth Virtual Visits	No charge	No charge	No charge	No charge
PREVENTIVE CARE				
Preventive Wellness Services	No charge	No charge	No charge	No charge
IMMEDIATE MEDICAL CARE**				
Retail Clinic	$40 copay per visit	$65 copay per visit	$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	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$60 copay per visit
Emergency Room	50% coinsurance after deductible	$500 copay per visit after deductible	$500 copay per visit after deductible	40% coinsurance 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
OUTPATIENT SERVICES				
Outpatient Radiology				
Complex (CT/PET scans, MRIs, etc.)	50% coinsurance after deductible	$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	40% coinsurance after deductible
Other (X-ray, ultrasound, etc.)	50% coinsurance after deductible	$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	40% coinsurance after deductible
Outpatient Routine Lab	$30 copay per visit	$35 copay per visit	$35 copay per visit	40% coinsurance after deductible
Outpatient Surgery - facility	50% coinsurance after deductible	$500 copay per visit after deductible	$500 copay per visit after deductible	40% coinsurance after deductible
Outpatient Surgery - physician services	50% coinsurance after deductible	No charge after deductible	No charge after deductible	40% coinsurance after deductible
HOSPITAL				
Inpatient	50% coinsurance after deductible	$500 copay per admission after deductible	$500 copay per admission after deductible	40% 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 / $45 copay / $80 copay / 50% coinsurance after deductible	$25 copay / $45 copay / $65 copay / $105 copay / 50% coinsurance after deductible	$25 copay / $45 copay / $65 copay / $105 copay / 50% coinsurance after deductible	$20 copay / $40 copay / $80 copay after deductible / $350 copay after deductible
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 / $112.50 copay / $200 copay / 50% coinsurance after deductible	$62.50 copay / $112.50 copay / $162.50 copay / $262.50 copay	$62.50 copay / $112.50 copay / $162.50 copay / $262.50 copay	$50 copay / $100 copay / $200 copay after deductible
DENTAL / VISION SERVICES*				
Pediatric Eye Exam	No charge	No charge	No charge	No charge
Pediatric Glasses	No charge	No charge	No charge	No charge
Pediatric Dental	No charge	No charge	No charge	No charge
Adult Eye Exam	Not Covered	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance	Not Covered	Not Covered	Not Covered	Not Covered
Adult Dental	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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AvMed Entrust Off-Exchange Individual & Family Plans - 2026

For agent use only

PLAN NAME	Entrust Bronze 600 (2026)	Entrust Bronze 650 (2026)	Entrust Expanded Bronze Standard (2026)	Entrust Platinum 25 Dental+Vision (2026)
PLAN ID	AVIN_HB_1649_0126	AVIN_HB_1650_0126	AVIN_HB_1648_0126	AVIN_HP_1655_0126
METAL TIER	Bronze	Bronze	Bronze	Platinum
AvMed Confidential Proprietary / Internal Use Only	In-Network	In-Network	In-Network	In-Network
DEDUCTIBLE: Individual/Family	$6,500 / $13,000	$10,150 / $20,300	$7,500 / $15,000	$0 / $0
OUT OF POCKET MAX: Individual/Family	$9,500 / $19,000	$10,150 / $20,300	$10,000 / $20,000	$5,500 / $11,000
OFFICE SERVICES				
Primary Care Physician (PCP)	$70 copay per visit	$75 copay per visit	$50 copay per visit	$10 copay per visit
Specialist	$140 copay per visit	No charge after deductible	$100 copay per visit	$20 copay per visit
Telehealth Virtual Visits	No charge	No charge	No charge	No charge
PREVENTIVE CARE				
Preventive Wellness Services	No charge	No charge	No charge	No charge
IMMEDIATE MEDICAL CARE**				
Retail Clinic	$80 copay per visit	$85 copay per visit	$50 copay per visit	$20 copay per visit
Urgent Care	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	No charge after deductible	$75 copay per visit	$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	No charge after deductible	50% coinsurance after deductible	$100 copay per visit
Ambulance (Ground)	$200 copay per one way ground transport	No charge after deductible	$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; $500 copay per visit after deductible at hospital-owned or affiliated facilities	No charge after deductible	50% coinsurance after deductible	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities
Other (X-ray, ultrasound, etc.)	$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	50% coinsurance after deductible	$10 copay per visit at independent facilities; $20 copay per visit at hospital-owned or affiliated facilities
Outpatient Routine Lab	$40 copay per visit	$55 copay per visit	50% coinsurance after deductible	No charge
Outpatient Surgery - facility	30% coinsurance after deductible	No charge after deductible	50% coinsurance after deductible	$200 copay per visit
Outpatient Surgery - physician services	30% coinsurance after deductible	No charge after deductible	50% coinsurance after deductible	No charge
HOSPITAL				
Inpatient	$500 copay per admission after deductible	No charge after deductible	50% coinsurance after deductible	$350 copay per day for the first 3 days per admission
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 afte rdeductible / 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 / $50 copay after deductible / $100 copay after deductible / $500 copay after deductible	No charge / $5 copay / $20 copay / $60 copay / 50% coinsurance
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 / No charge after deductible / No charge after deductible	$62.50 copay / $125 copay after deductible / $250 copay after deductible	No charge / $12.50 copay / $50 copay / $150 copay
DENTAL / VISION SERVICES*				
Pediatric Eye Exam	No charge	No charge	No charge	No charge
Pediatric Glasses	No charge	No charge	No charge	No charge
Pediatric Dental	No charge	No charge	No charge	No charge
Adult Eye Exam	Not Covered	Not Covered	Not Covered	No charge
Adult Glasses Allowance	Not Covered	Not Covered	Not Covered	$150
Adult Dental	Not Covered	Not Covered	Not Covered	No charge

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

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AvMed Entrust Off-Exchange Individual & Family Plans - 2026

For agent use only

PLAN NAME	Entrust Gold 125 Dental+Vision (2026)	Entrust Silver 350 Dental+Vision (2026)	Entrust Silver 550 Dental+Vision (2026)	Entrust Plus Gold 2040 (2026)
PLAN ID	AVIN_HG_1652_0126	AVIN_HS_1659_0126	AVIN_HS_1661_0126	AVIN_PG_1683_0126
METAL TIER	Gold	Silver	Silver	Gold
AvMed Confidential Proprietary / Internal Use Only	In-Network	In-Network	In-Network	In-Network
DEDUCTIBLE: Individual/Family	$2,000 / $4,000	$3,500 / $7,000	$6,250 / $12,500	$0 / $0
OUT OF POCKET MAX: Individual/Family	$5,850 / $11,700	$9,250 / $18,500	$8,000 / $16,000	$9,000 / $18,000
OFFICE SERVICES				
Primary Care Physician (PCP)	$35 copay per visit	$30 copay per visit	$55 copay per visit	$20 copay per visit
Specialist	$70 copay per visit	$60 copay per visit	$110 copay per visit	$40 copay per visit
Telehealth Virtual Visits	No charge	No charge	No charge	No charge
PREVENTIVE CARE				
Preventive Wellness Services	No charge	No charge	No charge	No charge
IMMEDIATE MEDICAL CARE**				
Retail Clinic	$45 copay per visit	$40 copay per visit	$65 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	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$60 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities
Emergency Room	$500 copay per visit after deductible	50% coinsurance after deductible	$500 copay per visit after deductible	$500 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	$150 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	50% coinsurance after deductible	$325 copay per visit at independent facilities; $650 copay per visit at hospital-owned or affiliated facilities	$400 copay per visit at independent facilities; $800 copay per visit at hospital-owned or affiliated facilities
Other (X-ray, ultrasound, etc.)	$75 copay per visit at independent facilities; $150 copay per visit at hospital-owned or affiliated facilities	50% coinsurance after deductible	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$50 copay per visit at independent facilities; $100 copay per visit at hospital-owned or affiliated facilities
Outpatient Routine Lab	$10 copay per visit	$30 copay per visit	$35 copay per visit	$30 copay per visit
Outpatient Surgery - facility	$650 copay per visit after deductible	50% coinsurance after deductible	$500 copay per visit after deductible	$1,000 copay per visit at independent facilities; $2,000 copay per visit at hospital-owned or affiliated facilities
Outpatient Surgery - physician services	No charge after deductible	50% coinsurance after deductible	No charge after deductible	No charge
HOSPITAL				
Inpatient	$850 copay per admission after deductible	50% coinsurance after deductible	$500 copay per admission after deductible	$1,500 copay per admission
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	$20 copay / $45 copay / $80 copay / 50% coinsurance after deductible / 50% coinsurance after deductible	$25 copay / $45 copay / $65 copay / $105 copay / 50% coinsurance after deductible	$10 copay / $15 copay / $40 copay / $75 copay / 50% coinsurance
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	$50 copay / $112.50 copay / $200 copay / 50% coinsurance after deductible	$62.50 copay / $112.50 copay / $162.50 copay / $262.50 copay	$25 copay / $37.50 copay / $100 copay / $187.50 copay
DENTAL / VISION SERVICES*				
Pediatric Eye Exam	No charge	No charge	No charge	No charge
Pediatric Glasses	No charge	No charge	No charge	No charge
Pediatric Dental	No charge	No charge	No charge	No charge
Adult Eye Exam	No charge	No charge	No charge	Not Covered
Adult Glasses Allowance	$150	$150	$150	Not Covered
Adult Dental	No charge	No charge	No charge	Not Covered

*Limitations may apply. Please refer to your contract.
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AvMed Entrust Off-Exchange Individual & Family Plans - 2026

For agent use only

PLAN NAME	Entrust Plus Silver 2550 (2026)	Entrust Plus Silver 4080 (2026)	Entrust Plus Gold 2040 Dental+Vision (2026)	Entrust Plus Silver 2550 Dental+Vision (2026)
PLAN ID	AVIN_PS_1685_0126	AVIN_PS_1687_0126	AVIN_PG_1684_0126	AVIN_PS_1686_0126
METAL TIER	Silver	Silver	Gold	Silver
AvMed Confidential Proprietary / Internal Use Only	In-Network	In-Network	In-Network	In-Network
DEDUCTIBLE: Individual/Family	$3,000 / $6,000	$0 / $0	$0 / $0	$3,000 / $6,000
OUT OF POCKET MAX: Individual/Family	$9,500 / $19,000	$9,500 / $19,000	$9,000 / $18,000	$9,500 / $19,000
OFFICE SERVICES				
Primary Care Physician (PCP)	$25 copay per visit	$40 copay per visit	$20 copay per visit	$25 copay per visit
Specialist	$50 copay per visit	$80 copay per visit	$40 copay per visit	$50 copay per visit
Telehealth Virtual Visits	No charge	No charge	No charge	No charge
PREVENTIVE CARE				
Preventive Wellness Services	No charge	No charge	No charge	No charge
IMMEDIATE MEDICAL CARE**				
Retail Clinic	$35 copay per visit	$50 copay per visit	$40 copay per visit	$35 copay per visit
Urgent Care	$100 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 at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	$100 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities
Emergency Room	$500 copay per visit after deductible	$1,000 copay per visit	$500 copay per visit	$500 copay per visit after deductible
Ambulance (Ground)	$200 copay per one way ground transport	$150 copay per one way ground transport	$150 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	$750 copay per visit at independent facilities; $1,500 copay per visit at hospital-owned or affiliated facilities	$400 copay per visit at independent facilities; $800 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.)	$75 copay per visit at independent facilities; $150 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 copay per visit at independent facilities; $100 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	$25 copay per visit	$40 copay per visit	$30 copay per visit	$25 copay per visit
Outpatient Surgery - facility	$750 copay per visit after deductible	$1,500 copay per visit at independent facilities; $3,000 copay per visit at hospital-owned or affiliated facilities	$1,000 copay per visit at independent facilities; $2,000 copay per visit at hospital-owned or affiliated facilities	$750 copay per visit after deductible
Outpatient Surgery - physician services	No charge after deductible	$60 copay per visit	No charge	No charge after deductible
HOSPITAL				
Inpatient	$750 copay per day for the first 3 days per admission after deductible	$2,000 copay per admission	$1,500 copay per admission	$750 copay per day for the first 3 days per admission 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	$25 copay / $45 copay / $115 copay / 50% coinsurance / 50% coinsurance	$10 copay / $15 copay / $40 copay / $75 copay / 50% coinsurance	$20 copay / $40 copay / $80 copay / $100 copay / 50% coinsurance after deductible
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	$62.50 copay / $112.50 copay / $287.50 copay / 50% coinsurance	$25 copay / $37.50 copay / $100 copay / $187.50 copay	$50 copay / $100 copay / $200 copay / $250 copay
DENTAL / VISION SERVICES*				
Pediatric Eye Exam	No charge	No charge	No charge	No charge
Pediatric Glasses	No charge	No charge	No charge	No charge
Pediatric Dental	No charge	No charge	No charge	No charge
Adult Eye Exam	Not Covered	Not Covered	No charge	No charge
Adult Glasses Allowance	Not Covered	Not Covered	$150	$150
Adult Dental	Not Covered	Not Covered	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 Entrust Off-Exchange Individual & Family Plans - 2026

For agent use only

PLAN NAME	Entrust Plus Silver 4080 Dental+Vision (2026)	Entrust Plus HSAQ Silver 3500 (2026)
PLAN ID	AVIN_PS_1688_0126	AVIN_DPS_1689_0126
METAL TIER	Silver	Silver
AvMed Confidential Proprietary / Internal Use Only	In-Network	In-Network
DEDUCTIBLE: Individual/Family	$0 / $0	$3,500 / $7,000
OUT OF POCKET MAX: Individual/Family	$9,500 / $19,000	$8,000 / $16,000
OFFICE SERVICES		
Primary Care Physician (PCP)	$40 copay per visit	No charge after deductible
Specialist	$80 copay per visit	No charge after deductible
Telehealth Virtual Visits	No charge	No charge after deductible
PREVENTIVE CARE		
Preventive Wellness Services	No charge	No charge
IMMEDIATE MEDICAL CARE**		
Retail Clinic	$50 copay per visit	20% coinsurance after deductible
Urgent Care	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	20% coinsurance after deductible
Emergency Room	$1,000 copay per visit	20% coinsurance after deductible
Ambulance (Ground)	$150 copay per one way ground transport	20% coinsurance after deductible
OUTPATIENT SERVICES		
Outpatient Radiology		
Complex (CT/PET scans, MRIs, etc.)	$750 copay per visit at independent facilities; $1,500 copay per visit at hospital-owned or affiliated facilities	20% coinsurance after deductible
Other (X-ray, ultrasound, etc.)	$150 copay per visit at independent facilities; $300 copay per visit at hospital-owned or affiliated facilities	20% coinsurance after deductible
Outpatient Routine Lab	$40 copay per visit	No charge after deductible
Outpatient Surgery - facility	$1,500 copay per visit at independent facilities; $3,000 copay per visit at hospital-owned or affiliated facilities	20% coinsurance after deductible
Outpatient Surgery - physician services	$60 copay per visit	20% coinsurance after deductible
HOSPITAL		
Inpatient	$2,000 copay per admission	20% 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 / $115 copay / 50% coinsurance / 50% coinsurance	20% coinsurance after deductible
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 / $287.50 copay / 50% coinsurance	20% coinsurance after deductible
DENTAL / VISION SERVICES*		
Pediatric Eye Exam	No charge	20% coinsurance after deductible
Pediatric Glasses	No charge	20% coinsurance after deductible
Pediatric Dental	No charge	No charge
Adult Eye Exam	No charge	Not Covered
Adult Glasses Allowance	$150	Not Covered
Adult Dental	No charge	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).