

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 LH030-LG23	Medical Deductible Individual/Family	Out-of-Pocket Limit Individual/Family	PCP (per visit)	Specialist (per visit)	Inpatient Hospital (per admission)
AVLG_H_7870_0723	\$0 / \$0	\$6,000 / \$12,000	\$30 copay	\$60 copay	\$1,500 copay

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 **R6214** to view this medical plan with Pharmacy Benefit:

Value Generic: \$20 copay, Generic: \$20 copay, Preferred: \$75 copay, Non-Preferred: 50% coinsurance, and Specialty: 50% coinsurance

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	
R6214	not applicable	\$20 copay	\$20 copay	\$75 copay	50% coinsurance	50% coinsurance	<a href="#">AVLG_H_7870_R6214_0723</a>
R6217	not applicable	\$15 copay	\$15 copay	\$40 copay	\$80 copay	50% coinsurance	<a href="#">AVLG_H_7870_R6217_0723</a>
R6218	not applicable	\$20 copay	\$20 copay	\$50 copay	\$100 copay	50% coinsurance	<a href="#">AVLG_H_7870_R6218_0723</a>
R6219	not applicable	\$3 copay	\$3 copay	\$25 copay	\$50 copay	50% coinsurance	<a href="#">AVLG_H_7870_R6219_0723</a>
R6527	not applicable	\$10 copay	\$10 copay	100% coinsurance	100% coinsurance	100% coinsurance	<a href="#">AVLG_H_7870_R6527_0723</a>
R6535	not applicable	\$10 copay	\$10 copay	\$50 copay	\$125 copay	\$150 copay	<a href="#">AVLG_H_7870_R6535_0723</a>
R6536	not applicable	\$15 copay	\$15 copay	\$60 copay	\$125 copay	\$160 copay	<a href="#">AVLG_H_7870_R6536_0723</a>
R7248	\$250 individual / \$500 family	\$5 copay	\$5 copay	50% coinsurance AD*	100% coinsurance AD*	100% coinsurance AD*	<a href="#">AVLG_H_7870_R7248_0723</a>
R7477	\$500 individual / \$1,000 family	\$10 copay	\$10 copay	25% coinsurance AD*	40% coinsurance AD*	40% coinsurance AD*	<a href="#">AVLG_H_7870_R7477_0723</a>
R7478	\$500 individual / \$1,000 family	\$10 copay	\$10 copay	\$50 copay	35% coinsurance AD*	35% coinsurance AD*	<a href="#">AVLG_H_7870_R7478_0723</a>
R7479	\$500 individual / \$1,000 family	\$10 copay	\$10 copay	\$50 copay	\$100 copay	30% coinsurance AD*	<a href="#">AVLG_H_7870_R7479_0723</a>

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.