AvMed Engage Individual & Family Plans - 2026

For agent use only

PLAN NAME	Engage LG125-IN26	Engage LS300-IN26	Engage LS500-IN26	Engage LS550-IN26
PLAN ID	AVIN_HG_1665_0126	AVIN_HS_1666_0126	AVIN_HS_1667_0126	AVIN_HS_1668_0126
METAL TIER	Gold	Silver	Silver	Silver
AvMed Confidential Proprietary / Internal Use Only	In-Network	In-Network	In-Network	In-Network
DEDUCTIBLE: Individual/Family	$2,000 / $4,000	$3,000 / $6,000	$5,500 / $11,000	$6,500 / $13,000
OUT OF POCKET MAX: Individual/Family	$4,700 / $9,400	$8,650 / $17,300	$8,000 / $16,000	$8,000 / $16,000
OFFICE SERVICES				
Primary Care Physician (PCP)	No charge for the first 2 visits; $35 copay per visit thereafter	No charge for the first visit; $40 copay per visit thereafter	No charge for the first visit; $45 copay per visit thereafter	No charge for the first visit; $55 copay per visit thereafter
Specialist	$70 copay per visit	$80 copay per visit	$90 copay per visit	$110 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	$50 copay per visit	$55 copay per visit	$65 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	$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	$500 copay per visit after deductible	$550 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	$200 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	$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	$325 copay per visit at independent facilities; $650 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	$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	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities
Outpatient Routine Lab	$10 copay per visit	$30 copay per visit	$30 copay per visit	$35 copay per visit
Outpatient Surgery - facility	$650 copay per visit after deductible	$725 copay per visit after deductible	$750 copay per visit after deductible	$500 copay per visit after deductible
Outpatient Surgery - physician services	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
HOSPITAL				
Inpatient	$850 copay per admission after deductible	$900 copay per day for the first 2 days per admission after deductible	$750 copay per day for the first 2 days per admission after deductible	$500 copay 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]	$15 copay / $30 copay / $60 copay / $120 copay / 50% coinsurance after deductible	$20 copay / $40 copay / $80 copay / $100 copay / 50% coinsurance after deductible	$20 copay / $40 copay / $80 copay / $100 copay / 50% coinsurance after deductible	$25 copay / $45 copay / $65 copay / $105 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]	$37.50 copay / $75 copay / $150 copay / $300 copay	$50 copay / $100 copay / $200 copay / $250 copay	$50 copay / $100 copay / $200 copay / $250 copay	$62.50 copay / $112.50 copay / $162.50 copay / $262.50 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	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.

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 Engage Individual & Family Plans - 2026

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PLAN NAME	Engage LB600-IN26	Engage LB650-IN26	Engage HSAQ LS350-IN26
PLAN ID	AVIN_HB_1663_0126	AVIN_HB_1664_0126	AVIN_DHS_1662_0126
METAL TIER	Bronze	Bronze	Silver
AvMed Confidential Proprietary / Internal Use Only	In-Network	In-Network	In-Network
DEDUCTIBLE: Individual/Family	$6,650 / $13,300	$8,200 / $16,400	$3,500 / $7,000
OUT OF POCKET MAX: Individual/Family	$9,000 / $18,000	$8,200 / $16,400	$7,500 / $15,000
OFFICE SERVICES			
Primary Care Physician (PCP)	$70 copay per visit	$75 copay per visit	20% coinsurance after deductible
Specialist	$140 copay per visit	No charge after deductible	20% coinsurance after deductible
Telehealth Virtual Visits	No charge	No charge	20% coinsurance after deductible
PREVENTIVE CARE			
Preventive Wellness Services	No charge	No charge	No charge
IMMEDIATE MEDICAL CARE**			
Retail Clinic	$80 copay per visit	$85 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	No charge after deductible	20% coinsurance after deductible
Emergency Room	$500 copay per visit after deductible	No charge after deductible	20% coinsurance after deductible
Ambulance (Ground)	$200 copay per one way ground transport	No charge after deductible	20% coinsurance after deductible
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	20% coinsurance after deductible
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	20% coinsurance after deductible
Outpatient Routine Lab	$40 copay per visit	$40 copay per visit	20% coinsurance after deductible
Outpatient Surgery - facility	30% coinsurance after deductible	No charge after deductible	20% coinsurance after deductible
Outpatient Surgery - physician services	30% coinsurance after deductible	No charge after deductible	20% coinsurance after deductible
HOSPITAL			
Inpatient	$500 copay per admission after deductible	No charge after deductible	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 / $85 copay after deductible / 50% coinsuranceafter deductible / 50% coinsurance after deductible	$25 copay / $45 copay / No charge after deductible / No charge after deductible / No charge after deductible	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 / $212.50 copay after deductible / 50% coinsurance after deductible	$62.50 copay / $112.50 copay / No charge after deductible / No charge after deductible	20% coinsurance after deductible
DENTAL / VISION SERVICES*			
Pediatric Eye Exam	No charge	No charge	20% coinsurance after deductible
Pediatric Glasses	No charge	No charge	20% 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

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