

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 LH180-LG23 | Medical Deductible Individual/Family | Out-of-Pocket Limit Individual/Family | PCP (per visit) | Specialist (per visit) | Inpatient Hospital (per admission) |
|---|--|---|--------------------|---------------------------|---------------------------------------|
| AVLG_H_7881_0723 | \$3,500 / \$7,000 | \$6,350 / \$12,700 | \$25 copay | \$50 copay | \$0 copay 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 **R6214** to view this medical plan with Pharmacy Benefit:

Value Generic: \$20 copay, Generic: \$20 copay, Preferred: \$75 copay, Non-Preferred: 50% coinsurance AD*, 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 | |
| R6214 | combined with medical | \$20 copay | \$20 copay | \$75 copay | 50% coinsurance AD* | 50% coinsurance AD* | AVLG_H_7881_R6214_0723 |
| R6217 | combined with medical | \$15 copay | \$15 copay | \$40 copay | \$80 copay | 50% coinsurance AD* | AVLG_H_7881_R6217_0723 |
| R6218 | not applicable | \$20 copay | \$20 copay | \$50 copay | \$100 copay | 50% coinsurance | AVLG_H_7881_R6218_0723 |
| R6219 | not applicable | \$3 copay | \$3 copay | \$25 copay | \$50 copay | 50% coinsurance | AVLG_H_7881_R6219_0723 |
| R6527 | not applicable | \$10 copay | \$10 copay | 100% coinsurance | 100% coinsurance | 100% coinsurance | AVLG_H_7881_R6527_0723 |
| R6535 | not applicable | \$10 copay | \$10 copay | \$50 copay | \$125 copay | \$150 copay | AVLG_H_7881_R6535_0723 |
| R6536 | not applicable | \$15 copay | \$15 copay | \$60 copay | \$125 copay | \$160 copay | AVLG_H_7881_R6536_0723 |
| R7248 | \$250 individual / \$500 family | \$5 copay | \$5 copay | 50% coinsurance AD* | 100% coinsurance AD* | 100% coinsurance AD* | AVLG_H_7881_R7248_0723 |
| R7477 | \$500 individual / \$1,000 family | \$10 copay | \$10 copay | 25% coinsurance AD* | 40% coinsurance AD* | 40% coinsurance AD* | AVLG_H_7881_R7477_0723 |
| R7478 | \$500 individual / \$1,000 family | \$10 copay | \$10 copay | \$50 copay | 35% coinsurance AD* | 35% coinsurance AD* | AVLG_H_7881_R7478_0723 |
| R7479 | \$500 individual / \$1,000 family | \$10 copay | \$10 copay | \$50 copay | \$100 copay | 30% coinsurance AD* | AVLG_H_7881_R7479_0723 |

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.