AvMed Entrust On-Exchange Individual & Family Plans - 2026

For agent use only

PLAN NAME	Entrust Platinum 25 (2026)	Entrust Platinum 25 Zero Cost Share (2026)	Entrust Platinum 25 Limited Cost Share (2026)	
PLAN ID	AVIN_HP_165401_0126	AVIN_HP_165402_0126	AVIN_HP_165403_0126	
METAL TIER	Platinum	Platinum	Platinum	
AvMed Confidential Proprietary / Internal Use Only	In-Network	IHCP	IHCP	Non-IHCP In-Network
DEDUCTIBLE: Individual/Family	$0 / $0	$0 / $0	$0 / $0	$0 / $0
OUT OF POCKET MAX: Individual/Family	$5,500 / $11,000	$0 / $0	$0 / $0	$5,500 / $11,000
OFFICE SERVICES				
Primary Care Physician (PCP)	$10 copay per visit	No charge	No charge	$10 copay per visit
Specialist	$20 copay per visit	No charge	No charge	$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	$20 copay per visit	No charge	No charge	$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	No charge	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities
Emergency Room	$100 copay per visit	No charge	No charge	$100 copay per visit
Ambulance (Ground)	$200 copay per one way ground transport	No charge	No charge	$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	No charge	No charge	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities
Other (X-ray, ultrasound, etc.)	$10 copay per visit at independent facilities; $20 copay per visit at hospital-owned or affiliated facilities	No charge	No charge	$10 copay per visit at independent facilities; $20 copay per visit at hospital-owned or affiliated facilities
Outpatient Routine Lab	No charge	No charge	No charge	No charge
Outpatient Surgery - facility	$200 copay per visit	No charge	No charge	$200 copay per visit
Outpatient Surgery - physician services	No charge	No charge	No charge	No charge
HOSPITAL				
Inpatient	$350 copay per day for the first 3 days per admission	No charge	No charge	$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]	No charge / $5 copay / $20 copay / $60 copay / 50% coinsurance	No charge	No charge	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]	No charge / $12.50 copay / $50 copay / $150 copay	No charge	No charge	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	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 Entrust On-Exchange Individual & Family Plans - 2026

For agent use only

PLAN NAME	Entrust Platinum Standard (2026)	Entrust Platinum Standard Zero Cost Share (2026)	Entrust Platinum Standard Limited Cost Share (2026)	
PLAN ID	AVIN_HP_165601_0126	AVIN_HP_165602_0126	AVIN_HP_165603_0126	
METAL TIER	Platinum	Platinum	Platinum	
AvMed Confidential Proprietary / Internal Use Only	In-Network	IHCP	IHCP	Non-IHCP In-Network
DEDUCTIBLE: Individual/Family	$0 / $0	$0 / $0	$0 / $0	$0 / $0
OUT OF POCKET MAX: Individual/Family	$5,200 / $10,400	$0 / $0	$0 / $0	$5,200 / $10,400
OFFICE SERVICES				
Primary Care Physician (PCP)	$10 copay per visit	No charge	No charge	$10 copay per visit
Specialist	$20 copay per visit	No charge	No charge	$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	$15 copay per visit	No charge	No charge	$15 copay per visit
Urgent Care	$15 copay per visit	No charge	No charge	$15 copay per visit
Emergency Room	$100 copay per visit	No charge	No charge	$100 copay per visit
Ambulance (Ground)	$200 copay per one way ground transport	No charge	No charge	$200 copay per one way ground transport
OUTPATIENT SERVICES				
Outpatient Radiology				
Complex (CT/PET scans, MRIs, etc.)	$100 copay per visit	No charge	No charge	$100 copay per visit
Other (X-ray, ultrasound, etc.)	$30 copay per visit	No charge	No charge	$30 copay per visit
Outpatient Routine Lab	$30 copay per visit	No charge	No charge	$30 copay per visit
Outpatient Surgery - facility	$150 copay per visit	No charge	No charge	$150 copay per visit
Outpatient Surgery - physician services	$150 copay per visit	No charge	No charge	$150 copay per visit
HOSPITAL				
Inpatient	$350 copay per admission	No charge	No charge	$350 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]	$5 copay / $10 copay / $50 copay / $150 copay	No charge	No charge	$5 copay / $10 copay / $50 copay / $150 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]	$12.50 copay / $25 copay / $125 copay	No charge	No charge	$12.50 copay / $25 copay / $125 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 On-Exchange Individual & Family Plans - 2026

For agent use only

PLAN NAME	Entrust Gold 125 (2026)	Entrust Gold 125 Zero Cost Share (2026)	Entrust Gold 125 Limited Cost Share (2026)	
PLAN ID	AVIN_HG_165101_0126	AVIN_HG_165102_0126	AVIN_HG_165103_0126	
METAL TIER	Gold	Gold	Gold	
AvMed Confidential Proprietary / Internal Use Only	In-Network	IHCP	IHCP	Non-IHCP In-Network
DEDUCTIBLE: Individual/Family	$2,000 / $4,000	$0 / $0	$0 / $0	$2,000 / $4,000
OUT OF POCKET MAX: Individual/Family	$5,850 / $11,700	$0 / $0	$0 / $0	$5,850 / $11,700
OFFICE SERVICES				
Primary Care Physician (PCP)	$35 copay per visit	No charge	No charge	$35 copay per visit
Specialist	$70 copay per visit	No charge	No charge	$70 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	No charge	No charge	$45 copay per visit
Urgent Care	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	No charge	No charge	$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	No charge	$500 copay per visit after deductible
Ambulance (Ground)	$200 copay per one way ground transport	No charge	No charge	$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	No charge	No charge	$250 copay per visit at independent facilities; $500 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	No charge	No charge	$75 copay per visit at independent facilities; $150 copay per visit at hospital-owned or affiliated facilities
Outpatient Routine Lab	$10 copay per visit	No charge	No charge	$10 copay per visit
Outpatient Surgery - facility	$650 copay per visit after deductible	No charge	No charge	$650 copay per visit after deductible
Outpatient Surgery - physician services	No charge after deductible	No charge	No charge	No charge after deductible
HOSPITAL				
Inpatient	$850 copay per admission after deductible	No charge	No charge after deductible	$850 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	No charge	No charge	$15 copay / $30 copay / $60 copay / $120 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	No charge	No charge	$37.50 copay / $75 copay / $150 copay / $300 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 On-Exchange Individual & Family Plans - 2026

For agent use only

PLAN NAME	Entrust Gold Standard (2026)	Entrust Gold Standard Zero Cost Share (2026)	Entrust Gold Standard Limited Cost Share (2026)	
PLAN ID	AVIN_HG_165301_0126	AVIN_HG_165302_0126	AVIN_HG_165303_0126	
METAL TIER	Gold	Gold	Gold	
AvMed Confidential Proprietary / Internal Use Only	In-Network	IHCP	IHCP	Non-IHCP In-Network
DEDUCTIBLE: Individual/Family	$2,000 / $4,000	$0 / $0	$0 / $0	$2,000 / $4,000
OUT OF POCKET MAX: Individual/Family	$8,200 / $16,400	$0 / $0	$0 / $0	$8,200 / $16,400
OFFICE SERVICES				
Primary Care Physician (PCP)	$30 copay per visit	No charge	No charge	$30 copay per visit
Specialist	$60 copay per visit	No charge	No charge	$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	$40 copay per visit	No charge	No charge	$40 copay per visit
Urgent Care	$45 copay per visit	No charge	No charge	$45 copay per visit
Emergency Room	25% coinsurance after deductible	No charge	No charge	25% coinsurance after deductible
Ambulance (Ground)	$200 copay per one way ground transport	No charge	No charge	$200 copay per one way ground transport
OUTPATIENT SERVICES				
Outpatient Radiology				
Complex (CT/PET scans, MRIs, etc.)	25% coinsurance after deductible	No charge	No charge	25% coinsurance after deductible
Other (X-ray, ultrasound, etc.)	25% coinsurance after deductible	No charge	No charge	25% coinsurance after deductible
Outpatient Routine Lab	25% coinsurance after deductible	No charge	No charge	25% coinsurance after deductible
Outpatient Surgery - facility	25% coinsurance after deductible	No charge	No charge	25% coinsurance after deductible
Outpatient Surgery - physician services	25% coinsurance after deductible	No charge	No charge	25% coinsurance after deductible
HOSPITAL				
Inpatient	25% coinsurance after deductible	No charge	No charge	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]	$15 copay / $30 copay / $60 copay / $250 copay	No charge	No charge	$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]	$37.50 copay / $75 copay / $150 copay	No charge	No charge	$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 On-Exchange Individual & Family Plans - 2026

For agent use only

PLAN NAME	Entrust Silver 350 (2026)	Entrust Silver 350 Zero Cost Share (2026)	Entrust Silver 350 Limited Cost Share (2026)	
PLAN ID	AVIN_HS_165801_0126	AVIN_HS_165802_0126	AVIN_HS_165803_0126	
METAL TIER	Silver	Silver	Silver	
AvMed Confidential Proprietary / Internal Use Only	In-Network	IHCP	IHCP	Non-IHCP In-Network
DEDUCTIBLE: Individual/Family	$3,500 / $7,000	$0 / $0	$0 / $0	$3,500 / $7,000
OUT OF POCKET MAX: Individual/Family	$9,250 / $18,500	$0 / $0	$0 / $0	$9,250 / $18,500
OFFICE SERVICES				
Primary Care Physician (PCP)	$30 copay per visit	No charge	No charge	$30 copay per visit
Specialist	$60 copay per visit	No charge	No charge	$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	$40 copay per visit	No charge	No charge	$40 copay per visit
Urgent Care	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	No charge	No charge	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities
Emergency Room	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible
Ambulance (Ground)	$200 copay per one way ground transport	No charge	No charge	$200 copay per one way ground transport
OUTPATIENT SERVICES				
Outpatient Radiology				
Complex (CT/PET scans, MRIs, etc.)	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible
Other (X-ray, ultrasound, etc.)	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible
Outpatient Routine Lab	$30 copay per visit	No charge	No charge	$30 copay per visit
Outpatient Surgery - facility	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible
Outpatient Surgery - physician services	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible
HOSPITAL				
Inpatient	50% coinsurance after deductible	No charge	No charge	50% 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 / 50% coinsurance after deductible	No charge	No charge	$20 copay / $45 copay / $80 copay / 50% coinsurance after deductible / 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 / $112.50 copay / $200 copay / 50% coinsurance after deductible	No charge	No charge	$50 copay / $112.50 copay / $200 copay / 50% coinsurance 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 On-Exchange Individual & Family Plans - 2026

For agent use only

PLAN NAME	Entrust Silver 350 73% AV (2026)	Entrust Silver 350 87% AV (2026)	Entrust Silver 350 94% AV (2026)	Entrust Silver 550 (2026)
PLAN ID	AVIN_HS_165804_0126	AVIN_HS_165805_0126	AVIN_HS_165806_0126	AVIN_HS_166001_0126
METAL TIER	Silver	Silver	Silver	Silver
AvMed Confidential Proprietary / Internal Use Only	In-Network	In-Network	In-Network	In-Network
DEDUCTIBLE: Individual/Family	$3,000 / $6,000	$0 / $0	$0 / $0	$6,250 / $12,500
OUT OF POCKET MAX: Individual/Family	$8,000 / $16,000	$3,500 / $7,000	$1,650 / $3,300	$8,000 / $16,000
OFFICE SERVICES				
Primary Care Physician (PCP)	$15 copay per visit	$15 copay per visit	No charge	$55 copay per visit
Specialist	$30 copay per visit	$30 copay per visit	$10 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	$25 copay per visit	$25 copay per visit	No charge	$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	50% coinsurance after deductible	40% coinsurance	25% coinsurance	$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.)	50% coinsurance after deductible	40% coinsurance	25% coinsurance	$325 copay per visit at independent facilities; $650 copay per visit at hospital-owned or affiliated facilities
Other (X-ray, ultrasound, etc.)	50% coinsurance after deductible	40% coinsurance	25% coinsurance	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities
Outpatient Routine Lab	$30 copay per visit	$15 copay per visit	No charge	$35 copay per visit
Outpatient Surgery - facility	50% coinsurance after deductible	40% coinsurance	25% coinsurance	$500 copay per visit after deductible
Outpatient Surgery - physician services	50% coinsurance after deductible	40% coinsurance	25% coinsurance	No charge after deductible
HOSPITAL				
Inpatient	50% coinsurance after deductible	40% coinsurance	25% coinsurance	$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]	$20 copay / $45 copay / $80 copay / 50% coinsurance after deductible / 50% coinsurance after deductible	$15 copay / $30 copay / $40 copay / 50% coinsurance / 50% coinsurance	No charge / $5 copay / $20 copay / 50% coinsurance / 50% coinsurance	$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]	$50 copay / $112.50 copay / $200 copay / 50% coinsurance after deductible	$37.50 copay / $75 copay / $100 copay / 50% coinsurance	No charge / $12.50 copay / $50 copay / 50% coinsurance	$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.

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AvMed Entrust On-Exchange Individual & Family Plans - 2026

For agent use only

PLAN NAME	Entrust Silver 550 Zero Cost Share (2026)	Entrust Silver 550 Limited Cost Share (2026)		Entrust Silver 550 73% AV (2026)
PLAN ID	AVIN_HS_166002_0126	AVIN_HS_166003_0126		AVIN_HS_166004_0126
METAL TIER	Silver	Silver		Silver
AvMed Confidential Proprietary / Internal Use Only	IHCP	IHCP	Non-IHCP In-Network	In-Network
DEDUCTIBLE: Individual/Family	$0 / $0	$0 / $0	$6,250 / $12,500	$6,000 / $12,000
OUT OF POCKET MAX: Individual/Family	$0 / $0	$0 / $0	$8,000 / $16,000	$6,600 / $13,200
OFFICE SERVICES				
Primary Care Physician (PCP)	No charge	No charge	$55 copay per visit	$40 copay per visit
Specialist	No charge	No charge	$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	No charge	No charge	$65 copay per visit	$50 copay per visit
Urgent Care	No charge	No charge	$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	No charge	No charge	$500 copay per visit after deductible	No charge after deductible
Ambulance (Ground)	No charge	No charge	$200 copay per one way ground transport	$200 copay per one way ground transport
OUTPATIENT SERVICES				
Outpatient Radiology				
Complex (CT/PET scans, MRIs, etc.)	No charge	No charge	$325 copay per visit at independent facilities; $650 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
Other (X-ray, ultrasound, etc.)	No charge	No charge	$125 copay per visit at independent facilities; $250 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
Outpatient Routine Lab	No charge	No charge	$35 copay per visit	$30 copay per visit
Outpatient Surgery - facility	No charge	No charge	$500 copay per visit after deductible	No charge after deductible
Outpatient Surgery - physician services	No charge	No charge	No charge after deductible	No charge after deductible
HOSPITAL				
Inpatient	No charge	No charge	$500 copay per admission after deductible	No charge 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	No charge	$25 copay / $45 copay / $65 copay / $105 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]	No charge	No charge	$62.50 copay / $112.50 copay / $162.50 copay / $262.50 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.

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AvMed Entrust On-Exchange Individual & Family Plans - 2026

For agent use only

PLAN NAME	Entrust Silver 550 87% AV (2026)	Entrust Silver 550 94% AV (2026)	Entrust Silver Standard (2026)	Entrust Silver Standard Zero Cost Share (2026)
PLAN ID	AVIN_HS_166005_0126	AVIN_HS_166006_0126	AVIN_HS_165701_0126	AVIN_HS_165702_0126
METAL TIER	Silver	Silver	Silver	Silver
AvMed Confidential Proprietary / Internal Use Only	In-Network	In-Network	In-Network	IHCP
DEDUCTIBLE: Individual/Family	$1,850 / $3,700	$800 / $1,600	$6,000 / $12,000	$0 / $0
OUT OF POCKET MAX: Individual/Family	$2,000 / $4,000	$1,000 / $2,000	$8,900 / $17,800	$0 / $0
OFFICE SERVICES				
Primary Care Physician (PCP)	$40 copay per visit	$5 copay per visit	$40 copay per visit	No charge
Specialist	$80 copay per visit	$10 copay per visit	$80 copay per visit	No charge
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	$50 copay per visit	$15 copay per visit	$50 copay per visit	No charge
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	$60 copay per visit	No charge
Emergency Room	No charge after deductible	No charge after deductible	40% coinsurance after deductible	No charge
Ambulance (Ground)	$200 copay per one way ground transport	$200 copay per one way ground transport	$200 copay per one way ground transport	No charge
OUTPATIENT SERVICES				
Outpatient Radiology				
Complex (CT/PET scans, MRIs, etc.)	$300 copay per visit at independent facilities; $600 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	40% coinsurance after deductible	No charge
Other (X-ray, ultrasound, etc.)	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities	$25 copay per visit at independent facilities; $50 copay per visit at hospital-owned or affiliated facilities	40% coinsurance after deductible	No charge
Outpatient Routine Lab	$30 copay per visit	$5 copay per visit	40% coinsurance after deductible	No charge
Outpatient Surgery - facility	No charge after deductible	No charge after deductible	40% coinsurance after deductible	No charge
Outpatient Surgery - physician services	No charge after deductible	No charge after deductible	40% coinsurance after deductible	No charge
HOSPITAL				
Inpatient	No charge after deductible	No charge after deductible	40% coinsurance after deductible	No charge
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 / $40 copay / $80 copay / 50% coinsurance	No charge / $5 copay / $20 copay / $60 copay / 50% coinsurance	$20 copay / $40 copay / $80 copay after deductible / $350 copay after deductible	No charge
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 / $100 copay / $200 copay	No charge / $12.50 copay / $50 copay / $150 copay	$50 copay / $100 copay / $200 copay after deductible	No charge
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 On-Exchange Individual & Family Plans - 2026

For agent use only

PLAN NAME	Entrust Silver Standard Limited Cost Share (2026)		Entrust Silver Standard 73% AV (2026)	Entrust Silver Standard 87% AV (2026)	Entrust Silver Standard 94% AV (2026)
PLAN ID	AVIN_HS_165703_0126		AVIN_HS_165704_0126	AVIN_HS_165705_0126	AVIN_HS_165706_0126
METAL TIER	Silver		Silver	Silver	Silver
AvMed Confidential Proprietary / Internal Use Only	IHCP	Non-IHCP In-Network	In-Network	In-Network	In-Network
DEDUCTIBLE: Individual/Family	$0 / $0	$6,000 / $12,000	$3,000 / $6,000	$700 / $1,400	$0 / $0
OUT OF POCKET MAX: Individual/Family	$0 / $0	$8,900 / $17,800	$7,400 / $14,800	$3,300 / $6,600	$2,200 / $4,400
OFFICE SERVICES					
Primary Care Physician (PCP)	No charge	$40 copay per visit	$40 copay per visit	$20 copay per visit	No charge
Specialist	No charge	$80 copay per visit	$80 copay per visit	$40 copay per visit	$10 copay per visit
Telehealth Virtual Visits	No charge	No charge	No charge	No charge	No charge
PREVENTIVE CARE					
Preventive Wellness Services	No charge	No charge	No charge	No charge	No charge
IMMEDIATE MEDICAL CARE**					
Retail Clinic	No charge	$50 copay per visit	$40 copay per visit	$30 copay per visit	No charge
Urgent Care	No charge	$60 copay per visit	$60 copay per visit	$30 copay per visit	$5 copay per visit
Emergency Room	No charge	40% coinsurance after deductible	40% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance
Ambulance (Ground)	No charge	$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.)	No charge	40% coinsurance after deductible	40% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance
Other (X-ray, ultrasound, etc.)	No charge	40% coinsurance after deductible	40% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance
Outpatient Routine Lab	No charge	40% coinsurance after deductible	40% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance
Outpatient Surgery - facility	No charge	40% coinsurance after deductible	40% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance
Outpatient Surgery - physician services	No charge	40% coinsurance after deductible	40% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance
HOSPITAL					
Inpatient	No charge	40% coinsurance after deductible	40% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance
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	$20 copay / $40 copay / $80 copay after deductible / $350 copay after deductible	$20 copay / $40 copay / $80 copay after deductible / $350 copay after deductible	$10 copay / $20 copay / $60 copay after deductible / $250 copay after deductible	No charge / $15 copay / $50 copay / $150 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	$50 copay / $100 copay / $200 copay after deductible	$50 copay / $100 copay / $200 copay after deductible	$25 copay / $50 copay / $150 copay after deductible	No charge / $37.50 copay / $125 copay
DENTAL / VISION SERVICES*					
Pediatric Eye Exam	No charge	No charge	No charge	No charge	No charge
Pediatric Glasses	No charge	No charge	No charge	No charge	No charge
Pediatric Dental	No charge	No charge	No charge	No charge	No charge
Adult Eye Exam	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Glasses Allowance	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Dental	Not Covered	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 On-Exchange Individual & Family Plans - 2026

For agent use only

PLAN NAME	Entrust Bronze 600 (2026)	Entrust Bronze 600 Zero Cost Share (2026)	Entrust Bronze 600 Limited Cost Share (2026)	
PLAN ID	AVIN_HB_164901_0126	AVIN_HB_164902_0126	AVIN_HB_164903_0126	
METAL TIER	Bronze	Bronze	Bronze	
AvMed Confidential Proprietary / Internal Use Only	In-Network	IHCP	IHCP	Non-IHCP In-Network
DEDUCTIBLE: Individual/Family	$6,500 / $13,000	$0 / $0	$0 / $0	$6,500 / $13,000
OUT OF POCKET MAX: Individual/Family	$9,500 / $19,000	$0 / $0	$0 / $0	$9,500 / $19,000
OFFICE SERVICES				
Primary Care Physician (PCP)	$70 copay per visit	No charge	No charge	$70 copay per visit
Specialist	$140 copay per visit	No charge	No charge	$140 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	No charge	No charge	$80 copay per visit
Urgent Care	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	No charge	No charge	$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	No charge	$500 copay per visit after deductible
Ambulance (Ground)	$200 copay per one way ground transport	No charge	No charge	$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	No charge	$250 copay per visit after deductible at independent facilities; $500 copay per visit after deductible 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	No charge	$75 copay per visit after deductible at independent facilities; $150 copay per visit after deductible at hospital-owned or affiliated facilities
Outpatient Routine Lab	$40 copay per visit	No charge	No charge	$40 copay per visit
Outpatient Surgery - facility	30% coinsurance after deductible	No charge	No charge	30% coinsurance after deductible
Outpatient Surgery - physician services	30% coinsurance after deductible	No charge	No charge	30% coinsurance after deductible
HOSPITAL				
Inpatient	$500 copay per admission after deductible	No charge	No charge	$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]	$25 copay / $45 copay / $85 copay after deductible / 50% coinsurance after deductible / 50% coinsurance after deductible	No charge	No charge	$25 copay / $45 copay / $85 copay after deductible / 50% coinsurance after deductible / 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]	$62.50 copay / $112.50 copay / $212.50 copay after deductible / 50% coinsurance after deductible	No charge	No charge	$62.50 copay / $112.50 copay / $212.50 copay after deductible / 50% coinsurance 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 On-Exchange Individual & Family Plans - 2026

For agent use only

PLAN NAME	Entrust Bronze 650 (2026)	Entrust Bronze 650 Zero Cost Share (2026)	Entrust Bronze 650 Limited Cost Share (2026)	
PLAN ID	AVIN_HB_165001_0126	AVIN_HB_165002_0126	AVIN_HB_165003_0126	
METAL TIER	Bronze	Bronze	Bronze	
AvMed Confidential Proprietary / Internal Use Only	In-Network	IHCP	IHCP	Non-IHCP In-Network
DEDUCTIBLE: Individual/Family	$10,150 / $20,300	$0 / $0	$0 / $0	$10,150 / $20,300
OUT OF POCKET MAX: Individual/Family	$10,150 / $20,300	$0 / $0	$0 / $0	$10,150 / $20,300
OFFICE SERVICES				
Primary Care Physician (PCP)	$75 copay per visit	No charge	No charge	$75 copay per visit
Specialist	No charge after deductible	No charge	No charge	No charge after deductible
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	$85 copay per visit	No charge	No charge	$85 copay per visit
Urgent Care	No charge after deductible	No charge	No charge	No charge after deductible
Emergency Room	No charge after deductible	No charge	No charge	No charge after deductible
Ambulance (Ground)	No charge after deductible	No charge	No charge	No charge after deductible
OUTPATIENT SERVICES				
Outpatient Radiology				
Complex (CT/PET scans, MRIs, etc.)	No charge after deductible	No charge	No charge	No charge after deductible
Other (X-ray, ultrasound, etc.)	No charge after deductible	No charge	No charge	No charge after deductible
Outpatient Routine Lab	$55 copay per visit	No charge	No charge	$55 copay per visit
Outpatient Surgery - facility	No charge after deductible	No charge	No charge	No charge after deductible
Outpatient Surgery - physician services	No charge after deductible	No charge	No charge	No charge after deductible
HOSPITAL				
Inpatient	No charge after deductible	No charge	No charge	No charge 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 / No charge after deductible / No charge after deductible / No charge after deductible	No charge	No charge	$25 copay / $45 copay / No charge after deductible / No charge after deductible / No charge 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 / No charge after deductible / No charge after deductible	No charge	No charge	$62.50 copay / $112.50 copay / No charge after deductible / No charge 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 On-Exchange Individual & Family Plans - 2026

For agent use only

PLAN NAME	Entrust Expanded Bronze Standard (2026)	Entrust Expanded Bronze Standard Zero Cost Share (2026)	Entrust Expanded Bronze Standard Limited Cost Share (2026)	
PLAN ID	AVIN_HB_164801_0126	AVIN_HB_164802_0126	AVIN_HB_164803_0126	
METAL TIER	Bronze	Bronze	Bronze	
AvMed Confidential Proprietary / Internal Use Only	In-Network	IHCP	IHCP	Non-IHCP In-Network
DEDUCTIBLE: Individual/Family	$7,500 / $15,000	$0 / $0	$0 / $0	$7,500 / $15,000
OUT OF POCKET MAX: Individual/Family	$10,000 / $20,000	$0 / $0	$0 / $0	$10,000 / $20,000
OFFICE SERVICES				
Primary Care Physician (PCP)	$50 copay per visit	No charge	No charge	$50 copay per visit
Specialist	$100 copay per visit	No charge	No charge	$100 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	$50 copay per visit	No charge	No charge	$50 copay per visit
Urgent Care	$75 copay per visit	No charge	No charge	$75 copay per visit
Emergency Room	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible
Ambulance (Ground)	$200 copay per one way ground transport	No charge	No charge	$200 copay per one way ground transport
OUTPATIENT SERVICES				
Outpatient Radiology				
Complex (CT/PET scans, MRIs, etc.)	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible
Other (X-ray, ultrasound, etc.)	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible
Outpatient Routine Lab	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible
Outpatient Surgery - facility	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible
Outpatient Surgery - physician services	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible
HOSPITAL				
Inpatient	50% coinsurance after deductible	No charge	No charge	50% 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 / $50 copay after deductible / $100 copay after deductible / $500 copay after deductible	No charge	No charge	$25 copay / $50 copay after deductible / $100 copay after deductible / $500 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]	$62.50 copay / $125 copay after deductible / $250 copay after deductible	No charge	No charge	$62.50 copay / $125 copay after deductible / $250 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 On-Exchange Individual & Family Plans - 2026

For agent use only

PLAN NAME	Entrust Platinum 25 Dental+Vision (2026)	Entrust Platinum 25 Dental+Vision Zero Cost Share (2026)	Entrust Platinum 25 Dental+Vision Limited Cost Share (2026)	
PLAN ID	AVIN_HP_165501_0126	AVIN_HP_165502_0126	AVIN_HP_165503_0126	
METAL TIER	Platinum	Platinum	Platinum	
AvMed Confidential Proprietary / Internal Use Only	In-Network	IHCP	IHCP	Non-IHCP In-Network
DEDUCTIBLE: Individual/Family	$0 / $0	$0 / $0	$0 / $0	$0 / $0
OUT OF POCKET MAX: Individual/Family	$5,500 / $11,000	$0 / $0	$0 / $0	$5,500 / $11,000
OFFICE SERVICES				
Primary Care Physician (PCP)	$10 copay per visit	No charge	No charge	$10 copay per visit
Specialist	$20 copay per visit	No charge	No charge	$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	$20 copay per visit	No charge	No charge	$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	No charge	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities
Emergency Room	$100 copay per visit	No charge	No charge	$100 copay per visit
Ambulance (Ground)	$200 copay per one way ground transport	No charge	No charge	$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	No charge	No charge	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities
Other (X-ray, ultrasound, etc.)	$10 copay per visit at independent facilities; $20 copay per visit at hospital-owned or affiliated facilities	No charge	No charge	$10 copay per visit at independent facilities; $20 copay per visit at hospital-owned or affiliated facilities
Outpatient Routine Lab	No charge	No charge	No charge	No charge
Outpatient Surgery - facility	$200 copay per visit	No charge	No charge	$200 copay per visit
Outpatient Surgery - physician services	No charge	No charge	No charge	No charge
HOSPITAL				
Inpatient	$350 copay per day for the first 3 days per admission	No charge	No charge	$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]	No charge / $5 copay / $20 copay / $60 copay / 50% coinsurance	No charge	No charge	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]	No charge / $12.50 copay / $50 copay / $150 copay	No charge	No charge	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	No charge	No charge	No charge	No charge
Adult Glasses Allowance	$150	$150	$150	$150
Adult Dental	No charge	No charge	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 On-Exchange Individual & Family Plans - 2026

For agent use only

PLAN NAME	Entrust Gold 125 Dental+Vision (2026)	Entrust Gold 125 Dental+Vision Zero Cost Share (2026)	Entrust Gold 125 Dental+Vision Limited Cost Share (2026)	
PLAN ID	AVIN_HG_165201_0126	AVIN_HG_165202_0126	AVIN_HG_165203_0126	
METAL TIER	Gold	Gold	Gold	
AvMed Confidential Proprietary / Internal Use Only	In-Network	IHCP	IHCP	Non-IHCP In-Network
DEDUCTIBLE: Individual/Family	$2,000 / $4,000	$0 / $0	$0 / $0	$2,000 / $4,000
OUT OF POCKET MAX: Individual/Family	$5,850 / $11,700	$0 / $0	$0 / $0	$5,850 / $11,700
OFFICE SERVICES				
Primary Care Physician (PCP)	$35 copay per visit	No charge	No charge	$35 copay per visit
Specialist	$70 copay per visit	No charge	No charge	$70 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	No charge	No charge	$45 copay per visit
Urgent Care	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	No charge	No charge	$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	No charge	$500 copay per visit after deductible
Ambulance (Ground)	$200 copay per one way ground transport	No charge	No charge	$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	No charge	No charge	$250 copay per visit at independent facilities; $500 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	No charge	No charge	$75 copay per visit at independent facilities; $150 copay per visit at hospital-owned or affiliated facilities
Outpatient Routine Lab	$10 copay per visit	No charge	No charge	$10 copay per visit
Outpatient Surgery - facility	$650 copay per visit after deductible	No charge	No charge	$650 copay per visit after deductible
Outpatient Surgery - physician services	No charge after deductible	No charge	No charge	No charge after deductible
HOSPITAL				
Inpatient	$850 copay per admission after deductible	No charge	No charge after deductible	$850 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	No charge	No charge	$15 copay / $30 copay / $60 copay / $120 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	No charge	No charge	$37.50 copay / $75 copay / $150 copay / $300 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	No charge
Adult Glasses Allowance	$150	$150	$150	$150
Adult Dental	No charge	No charge	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 On-Exchange Individual & Family Plans - 2026

For agent use only

PLAN NAME	Entrust Silver 350 Dental+Vision (2026)	Entrust Silver 350 Dental+Vision Zero Cost Share (2026)	Entrust Silver 350 Dental+Vision Limited Cost Share (2026)	
PLAN ID	AVIN_HS_165901_0126	AVIN_HS_165902_0126	AVIN_HS_165903_0126	
METAL TIER	Silver	Silver	Silver	
AvMed Confidential Proprietary / Internal Use Only	In-Network	IHCP	IHCP	Non-IHCP In-Network
DEDUCTIBLE: Individual/Family	$3,500 / $7,000	$0 / $0	$0 / $0	$3,500 / $7,000
OUT OF POCKET MAX: Individual/Family	$9,250 / $18,500	$0 / $0	$0 / $0	$9,250 / $18,500
OFFICE SERVICES				
Primary Care Physician (PCP)	$30 copay per visit	No charge	No charge	$30 copay per visit
Specialist	$60 copay per visit	No charge	No charge	$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	$40 copay per visit	No charge	No charge	$40 copay per visit
Urgent Care	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities	No charge	No charge	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities
Emergency Room	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible
Ambulance (Ground)	$200 copay per one way ground transport	No charge	No charge	$200 copay per one way ground transport
OUTPATIENT SERVICES				
Outpatient Radiology				
Complex (CT/PET scans, MRIs, etc.)	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible
Other (X-ray, ultrasound, etc.)	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible
Outpatient Routine Lab	$30 copay per visit	No charge	No charge	$30 copay per visit
Outpatient Surgery - facility	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible
Outpatient Surgery - physician services	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible
HOSPITAL				
Inpatient	50% coinsurance after deductible	No charge	No charge	50% 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 / 50% coinsurance after deductible	No charge	No charge	$20 copay / $45 copay / $80 copay / 50% coinsurance after deductible / 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 / $112.50 copay / $200 copay / 50% coinsurance after deductible	No charge	No charge	$50 copay / $112.50 copay / $200 copay / 50% coinsurance 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	No charge	No charge	No charge	No charge
Adult Glasses Allowance	$150	$150	$150	$150
Adult Dental	No charge	No charge	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 On-Exchange Individual & Family Plans - 2026

For agent use only

PLAN NAME	Entrust Silver 350 Dental+Vision 73% AV (2026)	Entrust Silver 350 Dental+Vision 87% AV (2026)	Entrust Silver 350 Dental+Vision 94% AV (2026)	Entrust Silver 550 Dental+Vision (2026)
PLAN ID	AVIN_HS_165904_0126	AVIN_HS_165905_0126	AVIN_HS_165906_0126	AVIN_HS_166101_0126
METAL TIER	Silver	Silver	Silver	Silver
AvMed Confidential Proprietary / Internal Use Only	In-Network	In-Network	In-Network	In-Network
DEDUCTIBLE: Individual/Family	$3,000 / $6,000	$0 / $0	$0 / $0	$6,250 / $12,500
OUT OF POCKET MAX: Individual/Family	$8,000 / $16,000	$3,500 / $7,000	$1,650 / $3,300	$8,000 / $16,000
OFFICE SERVICES				
Primary Care Physician (PCP)	$15 copay per visit	$15 copay per visit	No charge	$55 copay per visit
Specialist	$30 copay per visit	$30 copay per visit	$10 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	$25 copay per visit	$25 copay per visit	No charge	$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	50% coinsurance after deductible	40% coinsurance	25% coinsurance	$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.)	50% coinsurance after deductible	40% coinsurance	25% coinsurance	$325 copay per visit at independent facilities; $650 copay per visit at hospital-owned or affiliated facilities
Other (X-ray, ultrasound, etc.)	50% coinsurance after deductible	40% coinsurance	25% coinsurance	$125 copay per visit at independent facilities; $250 copay per visit at hospital-owned or affiliated facilities
Outpatient Routine Lab	$30 copay per visit	$15 copay per visit	No charge	$35 copay per visit
Outpatient Surgery - facility	50% coinsurance after deductible	40% coinsurance	25% coinsurance	$500 copay per visit after deductible
Outpatient Surgery - physician services	50% coinsurance after deductible	40% coinsurance	25% coinsurance	No charge after deductible
HOSPITAL				
Inpatient	50% coinsurance after deductible	40% coinsurance	25% coinsurance	$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]	$20 copay / $45 copay / $80 copay / 50% coinsurance after deductible / 50% coinsurance after deductible	$15 copay / $30 copay / $40 copay / 50% coinsurance / 50% coinsurance	No charge / $5 copay / $20 copay / 50% coinsurance / 50% coinsurance	$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]	$50 copay / $112.50 copay / $200 copay / 50% coinsurance after deductible	$37.50 copay / $75 copay / $100 copay / 50% coinsurance	No charge / $12.50 copay / $50 copay / 50% coinsurance	$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	No charge	No charge	No charge	No charge
Adult Glasses Allowance	$150	$150	$150	$150
Adult Dental	No charge	No charge	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 On-Exchange Individual & Family Plans - 2026

For agent use only

PLAN NAME	Entrust Silver 550 Dental+Vision Zero Cost Share (2026)	Entrust Silver 550 Dental+Vision Limited Cost Share (2026)		Entrust Silver 550 Dental+Vision 73% AV (2026)
PLAN ID	AVIN_HS_166102_0126	AVIN_HS_166103_0126		AVIN_HS_166104_0126
METAL TIER	Silver	Silver		Silver
AvMed Confidential Proprietary / Internal Use Only	IHCP	IHCP	Non-IHCP In-Network	In-Network
DEDUCTIBLE: Individual/Family	$0 / $0	$0 / $0	$6,250 / $12,500	$6,000 / $12,000
OUT OF POCKET MAX: Individual/Family	$0 / $0	$0 / $0	$8,000 / $16,000	$6,600 / $13,200
OFFICE SERVICES				
Primary Care Physician (PCP)	No charge	No charge	$55 copay per visit	$40 copay per visit
Specialist	No charge	No charge	$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	No charge	No charge	$65 copay per visit	$50 copay per visit
Urgent Care	No charge	No charge	$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	No charge	No charge	$500 copay per visit after deductible	No charge after deductible
Ambulance (Ground)	No charge	No charge	$200 copay per one way ground transport	$200 copay per one way ground transport
OUTPATIENT SERVICES				
Outpatient Radiology				
Complex (CT/PET scans, MRIs, etc.)	No charge	No charge	$325 copay per visit at independent facilities; $650 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
Other (X-ray, ultrasound, etc.)	No charge	No charge	$125 copay per visit at independent facilities; $250 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
Outpatient Routine Lab	No charge	No charge	$35 copay per visit	$30 copay per visit
Outpatient Surgery - facility	No charge	No charge	$500 copay per visit after deductible	No charge after deductible
Outpatient Surgery - physician services	No charge	No charge	No charge after deductible	No charge after deductible
HOSPITAL				
Inpatient	No charge	No charge	$500 copay per admission after deductible	No charge 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	No charge	$25 copay / $45 copay / $65 copay / $105 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]	No charge	No charge	$62.50 copay / $112.50 copay / $162.50 copay / $262.50 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	No charge	No charge	No charge	No charge
Adult Glasses Allowance	$150	$150	$150	$150
Adult Dental	No charge	No charge	No charge	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 On-Exchange Individual & Family Plans - 2026

For agent use only

PLAN NAME	Entrust Silver 550 Dental+Vision 87% AV (2026)	Entrust Silver 550 Dental+Vision 94% AV (2026)
PLAN ID	AVIN_HS_166105_0126	AVIN_HS_166106_0126
METAL TIER	Silver	Silver
AvMed Confidential Proprietary / Internal Use Only	In-Network	In-Network
DEDUCTIBLE: Individual/Family	$1,850 / $3,700	$800 / $1,600
OUT OF POCKET MAX: Individual/Family	$2,000 / $4,000	$1,000 / $2,000
OFFICE SERVICES		
Primary Care Physician (PCP)	$40 copay per visit	$5 copay per visit
Specialist	$80 copay per visit	$10 copay per visit
Telehealth Virtual Visits	No charge	No charge
PREVENTIVE CARE		
Preventive Wellness Services	No charge	No charge
IMMEDIATE MEDICAL CARE**		
Retail Clinic	$50 copay per visit	$15 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
Emergency Room	No charge after deductible	No charge after deductible
Ambulance (Ground)	$200 copay per one way ground transport	$200 copay per one way ground transport
OUTPATIENT SERVICES		
Outpatient Radiology		
Complex (CT/PET scans, MRIs, etc.)	$300 copay per visit at independent facilities; $600 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
Other (X-ray, ultrasound, etc.)	$100 copay per visit at independent facilities; $200 copay per visit at hospital-owned or affiliated facilities	$25 copay per visit at independent facilities; $50 copay per visit at hospital-owned or affiliated facilities
Outpatient Routine Lab	$30 copay per visit	$5 copay per visit
Outpatient Surgery - facility	No charge after deductible	No charge after deductible
Outpatient Surgery - physician services	No charge after deductible	No charge after deductible
HOSPITAL		
Inpatient	No charge after deductible	No charge 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 / $40 copay / $80 copay / 50% coinsurance	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]	$37.50 copay / $75 copay / $100 copay / $200 copay	No charge / $12.50 copay / $50 copay / $150 copay
DENTAL / VISION SERVICES*		
Pediatric Eye Exam	No charge	No charge
Pediatric Glasses	No charge	No charge
Pediatric Dental	No charge	No charge
Adult Eye Exam	No charge	No charge
Adult Glasses Allowance	$150	$150
Adult Dental	No charge	No charge

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