AvMed Empower Plans

Key Benefits for your Plan:	Empower MS300-IN21 Silver		
	In-Network Tier A	In-Network Tier B	Out-of-Network
CALENDAR YEAR DEDUCTIBLE (CYD)			
Individual/Family	$3,000 / $6,000	$3,000 / $6,000	$9,000 / $18,000
OUT-OF-POCKET MAX			
Individual/Family	$7,000 / $14,000	$7,000 / $14,000	$21,000 / $42,000
OFFICE SERVICES			
Primary Care Physician (PCP)	No charge for the first non-preventive visit; $25 copay / visit thereafter	$50 copay / visit	50% coinsurance after deductible
Specialist	$50 copay / visit	$100 copay / visit	50% coinsurance after deductible
Telehealth Virtual Visit	No charge	Not Covered	Not Covered
PREVENTIVE CARE			
Preventive Wellness Services (Adult, child and well baby care, mammograms, Pap smears, immunizations, etc.)	No charge	No charge	50% coinsurance after deductible
IMMEDIATE MEDICAL CARE**			
Retail Clinic	$35 copay / visit	$35 copay / visit	$35 copay / visit
Urgent Care at an independent facility	$100 copay / visit	$100 copay / visit	$100 copay / visit
Urgent Care at a hospital-owned or affiliated facility	$200 copay / visit	$200 copay / visit	$200 copay / visit
Emergency Room	$500 copay after deductible / visit	$500 copay after deductible / visit	$500 copay after deductible / visit
Ambulance (Ground)	$200 copay / one-way transport	$200 copay / one-way transport	$200 copay / one-way transport
OUTPATIENT SERVICES			
Outpatient Radiology			
Complex (CT/PET scans, MRIs, etc.) at an independent facility	$275 copay / visit	50% coinsurance after deductible	50% coinsurance after deductible
Complex (CT/PET scans, MRIs, etc.) at a hospital-owned or affiliated facility	$550 copay / visit	50% coinsurance after deductible	50% coinsurance after deductible
Other (X-ray, ultrasound, etc.) at an independent facility	$75 copay / visit	50% coinsurance after deductible	50% coinsurance after deductible
Other (X-ray, ultrasound, etc.) at a hospital-owned or affiliated facility	$150 copay / visit	50% coinsurance after deductible	50% coinsurance after deductible
Outpatient Routine Lab	$25 copay / visit for lab work at participating labs	$25 copay / visit for lab work at participating labs	50% coinsurance after deductible
Outpatient Surgery - facility	$750 copay after deductible / visit	50% coinsurance after deductible	50% coinsurance after deductible
Outpatient Surgery - physician services	No charge after deductible	50% coinsurance after deductible	50% coinsurance after deductible
HOSPITAL			
Inpatient	$750 copay per day for the first three days per admission after deductible	50% coinsurance after deductible	50% coinsurance after deductible
PRESCRIPTION DRUGS			
Rx (Retail) Copay Per Prescription: Preferred Generic / Generic / Preferred Brand / Non-Preferred Brand / Specialty / Non-Preferred Specialty	$20 / $40 / $80 / $100 / 40% coinsurance after deductible / 60% coinsurance after deductible	$20 / $40 / $80 / $100 / 40% coinsurance after deductible / 60% coinsurance after deductible	Not Covered
Rx (Mail Order, Up to 90-Day Supply): Preferred Generic / Generic / Preferred Brand / Non-Preferred Brand	$50 / $100 / $200 / $250	$50 / $100 / $200 / $250	Not Covered
PEDIATRIC DENTAL / VISION SERVICES			
Eye Exam*	No charge	No charge	50% coinsurance after deductible
Glasses*	No charge	No charge	50% coinsurance after deductible
Dental*	No charge for preventive care at Delta Dental Network providers	No charge for preventive care at Delta Dental Network providers	Preventive care may be subject to cost sharing if billed charges exceed allowed amount

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*Limitations may apply. Please refer to your contract.
**Coverage does not apply to facility fees (e.g. hospital room) or physician/surgeon fees.

Individual Health Regional Offices:

4300 N.W. 89th Blvd.
Gainesville, FL 32606

13450 W. Sunrise Blvd.
Sunrise, FL 33323

9400 S. Dadeland Blvd.
Miami, FL 33156

AvMed's Agent Support Line:
1-800-461-2950

AvMed's Individual Health Sales Center:
1-877-513-9355 (TTY 711)
Monday–Friday from 9 am to 6 pm

AvMed

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AvMed.org

20-14909

IN-1312 (10/20)

2021

AvMed Empower Plans

Individual and Family
Benefits Highlights

AvMed

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AvMed Empower Plans

Key Benefits for your Plan:	Empower MG225-IN21 Gold		
	In-Network Tier A	In-Network Tier B	Out-of-Network
CALENDAR YEAR DEDUCTIBLE (CYD)			
Individual/Family	$1,400 / $2,800	$1,400 / $2,800	$4,200 / $8,400
OUT-OF-POCKET MAX (INCLUDES DEDUCTIBLE)			
Individual/Family	$5,400 / $10,800	$5,400 / $10,800	$16,200 / $32,400
OFFICE SERVICES			
Primary Care Physician (PCP)	No charge for the first two non-preventive visits; $20 copay / visit thereafter	$40 copay / visit	50% coinsurance after deductible
Specialist	$40 copay / visit	$80 copay / visit	50% coinsurance after deductible
Telehealth Virtual Visit	No charge	Not Covered	Not Covered
PREVENTIVE CARE			
Preventive Wellness Services (Adult, child and well baby care, mammograms, Pap smears, immunizations, etc.)	No charge	No charge	50% coinsurance after deductible
IMMEDIATE MEDICAL CARE**			
Retail Clinic	$30 copay / visit	$30 copay / visit	$30 copay / visit
Urgent Care at an independent facility	$70 copay / visit	$70 copay / visit	$70 copay / visit
Urgent Care at a hospital-owned or affiliated facility	$140 copay / visit	$140 copay / visit	$140 copay / visit
Emergency Room	$350 copay after deductible / visit	$350 copay after deductible / visit	$350 copay after deductible / visit
Ambulance (Ground)	$200 copay / one-way transport	$200 copay / one-way transport	$200 copay / one-way transport
OUTPATIENT SERVICES			
Outpatient Radiology			
Complex (CT/PET scans, MRIs, etc.) at an independent facility	$150 copay / visit	50% coinsurance after deductible	50% coinsurance after deductible
Complex (CT/PET scans, MRIs, etc.) at a hospital-owned or affiliated facility	$300 copay / visit	50% coinsurance after deductible	50% coinsurance after deductible
Other (X-ray, ultrasound, etc.) at an independent facility	$75 copay / visit	50% coinsurance after deductible	50% coinsurance after deductible
Other (X-ray, ultrasound, etc.) at a hospital-owned or affiliated facility	$150 copay / visit	50% coinsurance after deductible	50% coinsurance after deductible
Outpatient Routine Lab	$10 copay / visit for lab work at participating labs	$10 copay / visit for lab work at participating labs	50% coinsurance after deductible
Outpatient Surgery - facility	$650 copay after deductible / visit	50% coinsurance after deductible	50% coinsurance after deductible
Outpatient Surgery - physician services	No charge after deductible	50% coinsurance after deductible	50% coinsurance after deductible
HOSPITAL			
Inpatient	$700 copay per day for the first three days per admission after deductible	50% coinsurance after deductible	50% coinsurance after deductible
PRESCRIPTION DRUGS			
Rx (Retail) Copay Per Prescription: Preferred Generic / Generic / Preferred Brand / Non-Preferred Brand / Specialty / Non-Preferred Specialty	$15 / $30 / $60 / $120 / 40% coinsurance after deductible / 60% coinsurance after deductible	$15 / $30 / $60 / $120 / 40% coinsurance after deductible / 60% coinsurance after deductible	Not Covered
Rx (Mail Order, Up to 90-Day Supply): Preferred Generic / Generic Preferred Brand / Non-Preferred Brand	$37.50 / $75 / $150 / $300	$37.50 / $75 / $150 / $300	Not Covered
PEDIATRIC DENTAL/VISION SERVICES			
Eye Exam*	No charge	No charge	50% coinsurance after deductible
Glasses*	No charge	No charge	50% coinsurance after deductible
Dental*	No charge for preventive care at Delta Dental Network providers	No charge for preventive care at Delta Dental Network providers	Preventive care may be subject to cost sharing if billed charges exceed allowed amount

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AvMed Empower Plans

Key Benefits for your Plan:	Empower MS400-IN21			Empower MS500-IN21		
	Silver			Silver		
	In-Network Tier A	In-Network Tier B	Out-of-Network	In-Network Tier A	In-Network Tier B	Out-of-Network
CALENDAR YEAR DEDUCTIBLE (CYD)						
Individual/Family	$4,500 / $9,000	$4,500 / $9,000	$13,500 / $27,000	$5,500 / $11,000	$5,500 / $11,000	$16,500 / $33,000
OUT-OF-POCKET MAX						
Individual/Family	$7,000 / $14,000	$7,000 / $14,000	$21,000 / $42,000	$7,000 / $14,000	$7,000 / $14,000	$21,000 / $42,000
OFFICE SERVICES						
Primary Care Physician (PCP)	No charge for the first non-preventive visit; $30 copay / visit thereafter	$60 copay / visit	50% coinsurance after deductible	No charge for the first non-preventive visit; $30 copay / visit thereafter	$60 copay / visit	50% coinsurance after deductible
Specialist	$60 copay / visit	$120 copay / visit	50% coinsurance after deductible	$60 copay / visit	$120 copay / visit	50% coinsurance after deductible
Telehealth Virtual Visit	No charge	Not Covered	Not Covered	No charge	Not Covered	Not Covered
PREVENTIVE CARE						
Preventive Wellness Services (Adult, child and well baby care, mammograms, Pap smears, immunizations, etc.)	No charge	No charge	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible
IMMEDIATE MEDICAL CARE**						
Retail Clinic	$40 copay / visit	$40 copay / visit	$40 copay / visit	$40 copay / visit	$40 copay / visit	$40 copay / visit
Urgent Care at an independent facility	$100 copay / visit	$100 copay / visit	$100 copay / visit	$110 copay / visit	$110 copay / visit	$110 copay / visit
Urgent Care at a hospital-owned or affiliated facility	$200 copay / visit	$200 copay / visit	$200 copay / visit	$220 copay / visit	$220 copay / visit	$220 copay / visit
Emergency Room	$500 copay after deductible / visit	$500 copay after deductible / visit	$500 copay after deductible / visit	$550 copay after deductible / visit	$550 copay after deductible / visit	$550 copay after deductible / visit
Ambulance (Ground)	$200 copay / one-way transport	$200 copay / one-way transport	$200 copay / one-way transport	$200 copay / one-way transport	$200 copay / one-way transport	$200 copay / one-way transport
OUTPATIENT SERVICES						
Outpatient Radiology						
Complex (CT/PET scans, MRIs, etc.) at an independent facility	$275 copay / visit	50% coinsurance after deductible	50% coinsurance after deductible	$300 copay / visit	50% coinsurance after deductible	50% coinsurance after deductible
Complex (CT/PET scans, MRIs, etc.) at a hospital-owned or affiliated facility	$550 copay / visit	50% coinsurance after deductible	50% coinsurance after deductible	$600 copay / visit	50% coinsurance after deductible	50% coinsurance after deductible
Other (X-ray, ultrasound, etc.) at an independent facility	$75 copay / visit	50% coinsurance after deductible	50% coinsurance after deductible	$100 copay / visit	50% coinsurance after deductible	50% coinsurance after deductible
Other (X-ray, ultrasound, etc.) at a hospital-owned or affiliated facility	$150 copay / visit	50% coinsurance after deductible	50% coinsurance after deductible	$200 copay / visit	50% coinsurance after deductible	50% coinsurance after deductible
Outpatient Routine Lab	$30 copay / visit for lab work at participating labs	$30 copay / visit for lab work at participating labs	50% coinsurance after deductible	$30 copay / visit for lab work at participating labs	$30 copay / visit for lab work at participating labs	50% coinsurance after deductible
Outpatient Surgery - facility	$750 copay after deductible / visit	50% coinsurance after deductible	50% coinsurance after deductible	$750 copay after deductible / visit	50% coinsurance after deductible	50% coinsurance after deductible
Outpatient Surgery - physician services	No charge after deductible	50% coinsurance after deductible	50% coinsurance after deductible	No charge after deductible	50% coinsurance after deductible	50% coinsurance after deductible
HOSPITAL						
Inpatient	$800 copay per day for the first three days per admission after deductible	50% coinsurance after deductible	50% coinsurance after deductible	$950 copay after deductible per admission	50% coinsurance after deductible	50% coinsurance after deductible
PRESCRIPTION DRUGS						
Rx (Retail) Copay Per Prescription: Preferred Generic / Generic / Preferred Brand / Non-Preferred Brand / Specialty / Non-Preferred Specialty	$20 / $40 / $80 / $100 / 40% coinsurance after deductible / 60% coinsurance after deductible	$20 / $40 / $80 / $100 / 40% coinsurance after deductible / 60% coinsurance after deductible	Not Covered	$20 / $40 / $80 / $100 / 40% coinsurance after deductible / 60% coinsurance after deductible	$20 / $40 / $80 / $100 / 40% coinsurance after deductible / 60% coinsurance after deductible	Not Covered
Rx (Mail Order, Up to 90-Day Supply): Preferred Generic / Generic / Preferred Brand / Non-Preferred Brand	$50 / $100 / $200 / $250	$50 / $100 / $200 / $250	Not Covered	$50 / $100 / $200 / $250	$50 / $100 / $200 / $250	Not Covered
PEDIATRIC DENTAL / VISION SERVICES						
Eye Exam*	No charge	No charge	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible
Glasses*	No charge	No charge	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible
Dental*	No charge for preventive care at Delta Dental Network providers	No charge for preventive care at Delta Dental Network providers	Preventive care may be subject to cost sharing if billed charges exceed allowed amount	No charge for preventive care at Delta Dental Network providers	No charge for preventive care at Delta Dental Network providers	Preventive care may be subject to cost sharing if billed charges exceed allowed amount

Key Benefits for your Plan:	Empower HSAQ MS350-IN21			Empower MB600-IN21			Empower MB650-IN21		
	Silver			Bronze			Bronze		
	In-Network Tier A	In-Network Tier B	Out-of-Network	In-Network Tier A	In-Network Tier B	Out-of-Network	In-Network Tier A	In-Network Tier B	Out-of-Network
CALENDAR YEAR DEDUCTIBLE (CYD)									
Individual/Family	$3,500 / $7,000	$3,500 / $7,000	$10,500 / $21,000	$7,900 / $15,800	$7,900 / $15,800	$23,700 / $47,400	$8,200 / $16,400	$8,200 / $16,400	$24,600 / $49,200
OUT-OF-POCKET MAX									
Individual/Family	$6,000 / $12,000	$6,000 / $12,000	$18,000 / $36,000	$8,200 / $16,400	$8,200 / $16,400	$24,600 / $49,200	$8,200 / $16,400	$8,200 / $16,400	$24,600 / $49,200
OFFICE SERVICES									
Primary Care Physician (PCP)	20% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	$50 copay / visit	$100 copay / visit	50% coinsurance after deductible	$75 copay / visit	$150 copay / visit	No charge after deductible
Specialist	20% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	$100 copay / visit	$200 copay / visit	50% coinsurance after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Telehealth Virtual Visit	20% coinsurance after deductible	Not Covered	Not Covered	No charge	Not Covered	Not Covered	No charge	Not Covered	Not Covered
PREVENTIVE CARE									
Preventive Wellness Services (Adult, child and well baby care, mammograms, Pap smears, immunizations, etc.)	No charge	No charge	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible	No charge	No charge	No charge after deductible
IMMEDIATE MEDICAL CARE**									
Retail Clinic	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	$60 copay / visit	$60 copay / visit	$60 copay / visit	$85 copay / visit	$85 copay / visit	$85 copay / visit
Urgent Care at an independent facility	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	$60 copay / visit	$60 copay / visit	$60 copay / visit	No charge after deductible	No charge after deductible	No charge after deductible
Urgent Care at a hospital-owned or affiliated facility	20% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible	$120 copay / visit	$120 copay / visit	$120 copay / visit	No charge after deductible	No charge after deductible	No charge after deductible
Emergency Room	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	$300 copay after deductible / visit	$300 copay after deductible / visit	$300 copay after deductible / visit	No charge after deductible	No charge after deductible	No charge after deductible
Ambulance (Ground)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	$200 copay / one-way transport	$200 copay / one-way transport	$200 copay / one-way transport	No charge after deductible	No charge after deductible	No charge after deductible
OUTPATIENT SERVICES									
Outpatient Radiology									
Complex (CT/PET scans, MRIs, etc.) at an independent facility	20% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	$250 copay after deductible / visit	50% coinsurance after deductible	50% coinsurance after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Complex (CT/PET scans, MRIs, etc.) at a hospital-owned or affiliated facility	20% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	$300 copay after deductible / visit	50% coinsurance after deductible	50% coinsurance after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Other (X-ray, ultrasound, etc.) at an independent facility	20% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	$65 copay after deductible / visit	50% coinsurance after deductible	50% coinsurance after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Other (X-ray, ultrasound, etc.) at a hospital-owned or affiliated facility	20% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	$130 copay after deductible / visit	50% coinsurance after deductible	50% coinsurance after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Outpatient Routine Lab	20% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible	$40 copay / visit for lab work at participating labs	$40 copay / visit for lab work at participating labs	50% coinsurance after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Outpatient Surgery - facility	20% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Outpatient Surgery - physician services	20% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	No charge after deductible	No charge after deductible	No charge after deductible
HOSPITAL									
Inpatient	20% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	$300 copay after deductible per admission	50% coinsurance after deductible	50% coinsurance after deductible	No charge after deductible	No charge after deductible	No charge after deductible
PRESCRIPTION DRUGS									
Rx (Retail) Copay Per Prescription: Preferred Generic / Generic / Preferred Brand / Non-Preferred Brand / Specialty / Non-Preferred Specialty	20% coinsurance after deductible	20% coinsurance after deductible	Not Covered	$25 / $45 / $85 copay after deductible / 50% coinsurance after deductible / 40% coinsurance after deductible / 60% coinsurance after deductible	$25 / $45 / $85 copay after deductible / 50% coinsurance after deductible / 40% coinsurance after deductible / 60% coinsurance after deductible	Not Covered	$25 / $45 / No charge after deductible / No charge after deductible / No charge after deductible / No charge after deductible	$25 / $45 / No charge after deductible / No charge after deductible / No charge after deductible / No charge after deductible	Not Covered
Rx (Mail Order, Up to 90-Day Supply): Preferred Generic / Generic / Preferred Brand / Non-Preferred Brand	20% coinsurance after deductible	20% coinsurance after deductible	Not Covered	$62.50 / $112.50 / $212.50 copay after deductible / 50% coinsurance after deductible	$62.50 / $112.50 / $212.50 copay after deductible / 50% coinsurance after deductible	Not Covered	$62.50 / $112.50 / No charge after deductible / No charge after deductible	$62.50 / $112.50 / No charge after deductible / No charge after deductible	Not Covered
PEDIATRIC DENTAL / VISION SERVICES									
Eye Exam*	20% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible	No charge	No charge	No charge after deductible
Glasses*	20% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible	No charge	No charge	50% coinsurance after deductible	No charge	No charge	No charge after deductible
Dental*	No charge for preventive care at Delta Dental Network providers	No charge for preventive care at Delta Dental Network providers	Preventive care may be subject to cost sharing if billed charges exceed allowed amount	No charge for preventive care at Delta Dental Network providers	No charge for preventive care at Delta Dental Network providers	Preventive care may be subject to cost sharing if billed charges exceed allowed amount	No charge for preventive care at Delta Dental Network providers	No charge for preventive care at Delta Dental Network providers	Preventive care may be subject to cost sharing if billed charges exceed allowed amount

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