Individual Health Regional Offices:

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

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20-14909

IN-1368 (10/20)

2021

AvMed Engage Plans

Individual and Family
Benefits Highlights

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AvMed Engage Plans

Key benefits for your plan	Engage LG125-IN21 Gold In Network	Engage LS300-IN21 Silver In Network	Engage LS500-IN21 Silver In Network	Engage LS550-IN21 Silver In Network	Engage LB600-IN21 Bronze In Network	Engage LB650-IN21 Bronze In Network	Engage HSAQ LS350-IN21 Silver In Network
CALENDAR YEAR DEDUCTIBLE (CYD)							
Individual/Family	$2,000 / $4,000	$3,000 / $6,000	$5,500 / $11,000	$6,500 / $13,000	$6,500 / $13,000	$8,200 / $16,400	$3,500 / $7,000
OUT-OF-POCKET MAX							
Individual/Family	$4,700 / $9,400	$7,000 / $14,000	$7,000 / $14,000	$7,000 / $14,000	$7,900 / $15,800	$8,200 / $16,400	$6,000 / $12,000
OFFICE SERVICES							
Primary Care Physician (PCP)	No charge for the first two non-preventive visits; $35 copay / visit thereafter	No charge for the first non-preventive visit; $40 copay / visit thereafter	No charge for the first non-preventive visit; $45 copay / visit thereafter	No charge for the first non-preventive visit; $55 copay / visit thereafter	$70 copay / visit	$75 copay / visit	20% coinsurance after deductible
Specialist	$70 copay / visit	$80 copay / visit	$90 copay / visit	$110 copay / visit	$140 copay / visit	No charge after deductible	20% coinsurance after deductible
Telehealth Virtual Visits	No charge	No charge	No charge	No charge	No charge	No charge	20% coinsurance after deductible
PREVENTIVE CARE							
Preventive Wellness Services (Adult, child and well baby care, mammograms, Pap smears, immunizations, etc.)	No charge	No charge	No charge	No charge	No charge	No charge	No charge
IMMEDIATE MEDICAL CARE**							
Retail Clinic	$45 copay / visit	$50 copay / visit	$55 copay / visit	$65 copay / visit	$80 copay / visit	$85 copay / visit	20% coinsurance after deductible
Urgent Care at an independent facility	$125 copay / visit	$125 copay / visit	$125 copay / visit	$125 copay / visit	$125 copay / visit	No charge after deductible	20% coinsurance after deductible
Urgent Care at a hospital-owned or affiliated facility	$250 copay / visit	$250 copay / visit	$250 copay / visit	$250 copay / visit	$250 copay / visit	No charge after deductible	20% coinsurance after deductible
Emergency Room	$500 copay after deductible / visit	$500 copay after deductible / visit	$550 copay after deductible / visit	$500 copay after deductible / visit	$500 copay after deductible / visit	No charge after deductible	20% coinsurance after deductible
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	No charge after deductible	20% coinsurance after deductible
OUTPATIENT SERVICES							
Outpatient Radiology							
Complex (CT/PET scans, MRIs, etc.) at an independent facility	$250 copay / visit	$300 copay / visit	$300 copay / visit	$325 copay / visit	$250 copay after deductible / visit	No charge after deductible	20% coinsurance after deductible
Complex (CT/PET scans, MRIs, etc.) at a hospital-owned or affiliated facility	$500 copay / visit	$600 copay / visit	$600 copay / visit	$650 copay / visit	$500 copay after deductible / visit	No charge after deductible	20% coinsurance after deductible
Other (X-ray, ultrasound, etc.) at an independent facility	$75 copay / visit	$100 copay / visit	$100 copay / visit	$125 copay / visit	$75 copay after deductible / visit	No charge after deductible	20% coinsurance after deductible
Other (X-ray, ultrasound, etc.) at a hospital-owned or affiliated facility	$150 copay / visit	$200 copay / visit	$200 copay / visit	$250 copay / visit	$150 copay after deductible / visit	No charge after deductible	20% coinsurance after deductible
Outpatient Routine Lab	$10 copay / visit for lab work at participating labs	$30 copay / visit for lab work at participating labs	$30 copay / visit for lab work at participating labs	$35 copay / visit for lab work at participating labs	$40 copay / visit for lab work at participating labs	No charge after deductible	20% coinsurance after deductible
Outpatient Surgery - facility	$650 copay after deductible / visit	$725 copay after deductible / visit	$750 copay after deductible / visit	$500 copay after deductible / visit	30% coinsurance after deductible	No charge after deductible	20% coinsurance after deductible
Outpatient Surgery - physician services	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible	30% coinsurance after deductible	No charge after deductible	20% coinsurance after deductible
HOSPITAL							
Inpatient	$850 copay after deductible per admission	$900 copay per day for the first two days per admission after deductible	$750 copay per day for the first two days per admission after deductible	$500 copay after deductible per admission	$500 copay after deductible per admission	No charge after deductible	20% 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	$20 / $40 / $80 / $100 / 40% coinsurance after deductible / 60% coinsurance after deductible	$20 / $40 / $80 / $100 / 40% coinsurance after deductible / 60% coinsurance after deductible	$25 / $45 / $65 / $105 / 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	$25 / $45 / No charge after deductible / No charge after deductible / No charge after deductible / No charge after deductible	20% coinsurance after deductible
Rx (Mail Order, Up to 90-Day Supply): Preferred Generic / Generic / Preferred Brand / Non-Preferred Brand	$37.50 / $75 / $150 / $300	$50 / $100 / $200 / $250	$50 / $100 / $200 / $250	$62.50 / $112.50 / $162.50 / $262.50	$62.50 / $112.50 / $212.50 copay after deductible / 50% coinsurance after deductible	$62.50 / $112.50 / No charge after deductible / No charge after deductible	20% coinsurance after deductible
PEDIATRIC DENTAL / VISION SERVICES							
Eye Exam*	No charge	No charge	No charge	No charge	No charge	No charge	20% coinsurance after deductible
Glasses*	No charge	No charge	No charge	No charge	No charge	No charge	20% coinsurance after deductible
Dental*	No charge for preventive care at Delta Dental Network providers	No charge for preventive care at Delta Dental Network providers	No charge for preventive care at Delta Dental Network providers	No charge for preventive care at Delta Dental Network providers	No charge for preventive care at Delta Dental Network providers	No charge for preventive care at Delta Dental Network providers	No charge for preventive care at Delta Dental Network providers

This schedule is not a contract. It is a brief summary of benefits. For more information on benefits, exclusions and limitations, refer to the Detailed Schedule of Benefits (DSoB), the Individual and Family Medical and Hospital Service Contract, or contact your AvMed Sales/Service representative.
*Limitations may apply. Please refer to your contract. **Coverage does not apply to facility fees (e.g. hospital room) or physician/surgeon fees.

For a complete listing of the doctors and hospitals that make up our Partner Network, refer to the directory for Engage plans at AvMed.org. AvMed will not cover any services received outside of this Network.