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

Embrace better health®

AvMed.org

20-14909 ENTRUST

IN-1816 (11/20)

2021

AvMed Entrust Plans

Individual and Family Benefits Highlights

Embrace better health®

AvMed Entrust Plans

Key benefits for your plan	AvMed Entrust Gold 125	AvMed Entrust Gold 125 Adult Dental + Vision	AvMed Entrust Silver 300	AvMed Entrust Silver 300 Adult Dental + Vision	AvMed Entrust Silver 350	AvMed Entrust Silver 350 Adult Dental + Vision	AvMed Entrust Silver 500
	Gold	Gold	Silver	Silver	Silver	Silver	Silver
	In-Network	In Network	In Network	In Network	In Network	In Network	In Network
CALENDAR YEAR DEDUCTIBLE (CYD)							
Individual/Family	$2,000 / $4,000	$2,000 / $4,000	$3,000 / $6,000	$3,000 / $6,000	$3,500 / $7,000	$3,500 / $7,000	$5,500 / $11,000
OUT-OF-POCKET MAX							
Individual/Family	$4,700 / $9,400	$7,000 / $14,000	$7,000 / $14,000	$7,000 / $14,000	$7,000 / $14,000	$7,000 / $14,000	$7,000 / $14,000
OFFICE SERVICES							
Primary Care Physician (PCP)	No charge for the first two non-preventive visits; $35 copay / visit thereafter	No charge for the first 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; $40 copay / visit thereafter	No charge for the first non-preventive visit; $30 copay / visit thereafter	No charge for the first non-preventive visit; $30 copay / visit thereafter	No charge for the first non-preventive visit; $45 copay / visit thereafter
Specialist	$70 copay / visit	$70 copay / visit	$80 copay / visit	$80 copay / visit	$60 copay / visit	$60 copay / visit	$90 copay / visit
Telehealth Virtual Visits	No charge	No charge	No charge	No charge	No charge	No charge	No charge
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	$45 copay / visit	$50 copay / visit	$50 copay / visit	$40 copay / visit	$40 copay / visit	$55 copay / visit
Urgent Care at an independent facility	$125 copay / visit at independent facilities; $250 copay / visit at hospital owned or affiliated facilities	$125 copay / visit at independent facilities; $250 copay / visit at hospital owned or affiliated facilities	$125 copay / visit at independent facilities; $250 copay / visit at hospital owned or affiliated facilities	$125 copay / visit at independent facilities; $250 copay / visit at hospital owned or affiliated facilities	$125 copay / visit at independent facilities; $250 copay / visit at hospital owned or affiliated facilities	$125 copay / visit at independent facilities; $250 copay / visit at hospital owned or affiliated facilities	$125 copay / visit at independent facilities; $250 copay / visit at hospital owned or affiliated facilities
Emergency Room	$500 copay after deductible / visit	$500 copay after deductible / visit	$500 copay after deductible / visit	$500 copay after deductible / visit	50% coinsurance after deductible	50% coinsurance after deductible	$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	$200 copay / one-way transport
OUTPATIENT SERVICES							
Outpatient Radiology							
Complex (CT/PET scans, MRIs, etc.) at an independent facility	$250 copay / visit at independent facilities; $500 copay / visit at hospital owned or affiliated facilities	$250 copay / visit at independent facilities; $500 copay / visit at hospital owned or affiliated facilities	$300 copay / visit at independent facilities; $600 copay / visit at hospital owned or affiliated facilities	$300 copay / visit at independent facilities; $600 copay / visit at hospital owned or affiliated facilities	50% coinsurance after deductible	50% coinsurance after deductible	$300 copay / visit at independent facilities; $600 copay / visit at hospital owned or affiliated facilities
Other (X-ray, ultrasound, etc.) at a hospital-owned or affiliated facility	$75 copay / visit at independent facilities; $150 copay / visit at hospital owned or affiliated facilities	$75 copay / visit at independent facilities; $150 copay / visit at hospital owned or affiliated facilities	$100 copay / visit at independent facilities; $200 copay / visit at hospital owned or affiliated facilities	$100 copay / visit at independent facilities; $200 copay / visit at hospital owned or affiliated facilities	50% coinsurance after deductible	50% coinsurance after deductible	$100 copay / visit at independent facilities; $200 copay / visit at hospital owned or affiliated facilities
Outpatient Routine Lab	$10 copay / visit for lab work at participating labs	$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	$30 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
Outpatient Surgery - facility	$650 copay after deductible / visit	$650 copay after deductible / visit	$725 copay after deductible / visit	$725 copay after deductible / visit	50% coinsurance after deductible	50% coinsurance after deductible	$750 copay after deductible / visit
Outpatient Surgery - physician services	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible	50% coinsurance after deductible	50% coinsurance after deductible	No charge after deductible
HOSPITAL							
Inpatient	$850 copay after deductible per admission	$850 copay after deductible per admission	$900 copay per day for the first two days per admission after deductible	$900 copay per day for the first two days per admission after deductible	50% coinsurance after deductible	50% coinsurance after deductible	$750 copay per day for the first two days per admission 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	$20/$40/$80/$100/ 40% coinsurance after deductible/60% coinsurance after deductible	$20/$40/$80/$100/ 40% coinsurance after deductible/60% coinsurance after deductible	$20/$45/$80/ 50% coinsurance after deductible/40% coinsurance after deductible/ 60% coinsurance after deductible	$20/$45/$80/ 50% coinsurance after deductible/40% coinsurance after deductible/60% coinsurance after deductible	$20/$40/$80/$100/ 40% coinsurance after deductible/60% coinsurance after deductible
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	$50 / $100 / $200 / $250	$50 / $100 / $200 / $250	$50 / $112.50 / $200 / 50% coinsurance after deductible	$50 / $112.50 / $200 / 50% coinsurance after deductible	$50 / $100 / $200 / $250
DENTAL / VISION SERVICES							
Pediatric Eye Exam and Pediatric Glasses*	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Dental*	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Adult Eye Exam/Adult Glasses*	Not Covered	No Charge/$150 allowance	Not Covered	No charge/$150 allowance	Not Covered	No charge/$150 allowance	Not Covered
Adult Dental*	Not Covered	No charge	Not Covered	No charge	Not Covered	No charge	Not Covered

Key benefits for your plan	AvMed Entrust Silver 500 - Off Exchange	AvMed Entrust Silver 500 Adult Dental + Vision	AvMed Entrust Silver 550	AvMed Entrust Bronze 600	AvMed Entrust Bronze 650	AvMed Entrust Catastrophic 100
	Silver	Silver	Silver	Bronze	Bronze	Catastrophic
	In Network	In Network	In Network	In Network	In Network	In Network
CALENDAR YEAR DEDUCTIBLE (CYD)						
Individual/Family	$5,500 / $11,000	$5,500 / $11,000	$6,500 / $13,000	$6,500 / $13,000	$8,200 / $16,400	$8,550 / $17,100
OUT-OF-POCKET MAX						
Individual/Family	$7,000 / $14,000	$7,000 / $14,000	$7,000 / $14,000	$7,900 / $15,800	$8,200 / $16,400	$8,550 / $17,100
OFFICE SERVICES						
Primary Care Physician (PCP)	No charge for the first non-preventive visit; $45 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	No charge for the first three non-preventive visits; No charge after deductible thereafter
Specialist	$90 copay / visit	$90 copay / visit	$110 copay / visit	$140 copay / visit	No charge after deductible	No charge after deductible
Telehealth Virtual Visits	No charge	No charge	No charge	No charge	No charge after deductible	No charge 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
IMMEDIATE MEDICAL CARE**						
Retail Clinic	$55 copay / visit	$55 copay / visit	$65 copay / visit	$80 copay / visit	$85 copay / visit	No charge after deductible
Urgent Care at an independent facility	$125 copay / visit at independent facilities; $250 copay / visit at hospital owned or affiliated facilities	$125 copay / visit at independent facilities; $250 copay / visit at hospital owned or affiliated facilities	$125 copay / visit at independent facilities; $250 copay / visit at hospital owned or affiliated facilities	$125 copay / visit at independent facilities; $250 copay / visit at hospital owned or affiliated facilities	No charge after deductible	No charge after deductible
Emergency Room	$550 copay after deductible / visit	$550 copay after deductible / visit	$500 copay after deductible / visit	$500 copay after deductible / visit	No charge after deductible	No charge after deductible
Ambulance (Ground)	$200 copay / one-way transport	$200 copay / one-way transport	$200 copay / one-way transport	$200 copay / one-way transport	No charge after deductible	No charge after deductible
OUTPATIENT SERVICES						
Outpatient Radiology						
Complex (CT/PET scans, MRIs, etc.) at an independent facility	$300 copay / visit at independent facilities; $600 copay / visit at hospital owned or affiliated facilities	No charge after deductible	$325 copay / visit at independent facilities; $650 copay / visit at hospital owned or affiliated facilities	$250 copay after deductible / visit at independent facilities; $500 copay after deductible / visit at hospital owned or affiliated facilities	No charge after deductible	No charge after deductible
Other (X-ray, ultrasound, etc.) at a hospital-owned or affiliated facility	$100 copay / visit at independent facilities; $200 copay / visit at hospital owned or affiliated facilities	$200 copay / visit	$125 copay / visit at independent facilities; $250 copay / visit at hospital owned or affiliated facilities	$75 copay after deductible / visit at independent facilities; $150 copay after deductible / visit at hospital owned or affiliated facilities	No charge after deductible	No charge after deductible
Outpatient Routine Lab	$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	No charge after deductible
Outpatient Surgery - facility	$750 copay after deductible / visit	$750 copay after deductible / visit	$500 copay after deductible / visit	30% coinsurance after deductible	No charge after deductible	No charge after deductible
Outpatient Surgery - physician services	No charge after deductible	No charge after deductible	No charge after deductible	30% coinsurance after deductible	No charge after deductible	No charge after deductible
HOSPITAL						
Inpatient	$750 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	No charge 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	$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/$85/ 50% coinsurance after deductible/40% coinsurance after deductible/60% coinsurance after deductible	No charge after deductible
Rx (Mail Order, Up to 90-Day Supply): Preferred Generic / Generic / Preferred Brand / Non-Preferred Brand	$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 / $212.50 copay / No charge after deductible / No charge after deductible	No charge after deductible
DENTAL / VISION SERVICES						
Pediatric Eye Exam and Pediatric Glasses*	No charge	No charge	No charge	No charge	No charge	No charge after deductible
Pediatric Dental*	No charge	No charge	No charge	No charge	No charge	No charge after deductible
Adult Eye Exam/Adult Glasses*	Not Covered	No charge/$150 allowance	Not Covered	Not Covered	Not Covered	Not Covered
Adult Dental*	Not Covered	No charge	Not Covered	Not Covered	Not Covered	Not Covered

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 AvMed Entrust plans at AvMed.org. AvMed will not cover any services received outside of this Network.