**Key Benefits for your Plan: Small Group Achieve MS 100**

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| --- | --- | --- |
| Benefit | AvMed Network Provider | Out-of-network Provider |
| Coinsurance | 0% | 25% |
| Out of Pocket Max (Includes Deductible) | $7,500 individual/$15,600 family. Pediatric Dental is limited to $350 per child, or $700 for 2 or more children. | $20,400 individual/$40,800 family. Pediatric Dental is limited to $350 per child, or $700 for 2 or more children. |
| Inpatient Hospital Cost Share | $750 copay/day for the first 3 days per admission, after deductible | 50% Coinsurance after deductible |
| Deductible | $3,500 individual/$7,500 family Doesnt apply to preventive care | $7,500 individual/$15,000 family Doesnt apply to preventive care |
| ER Cost Share | $600 copay/ visit | Same as AvMed Network |
| Urgent Care Cost Share | $125 copay/ visit at urgent care facilities; $35 copay/ visit at retail clinics | 50% coinsurance after deductible at urgent care facilities or retail clinics |
| Imaging Tests (CT / PET scans / MRIs) Cost Share | $350 copay/ visit at independent facilities; $1,000 copay/ visit after deductible at all other facilities | 50% Coinsurance after deductible |
| PCP Cost Share | No charge for first non-preventive visit; $35 copay/ visit thereafter | 50% Coinsurance after deductible |
| Specialist Cost Share (No Referral Needed) | $75 copay/ visit | 50% Coinsurance after deductible |
| Other Deductible | $65 per child for Pediatric Dental. Doesn’t apply to overall deductible. There are no other specific deductibles. | Not Applicable |
| Outpatient Surgery Cost Share | $1500 copay/ visit at independent facilities; $1000 copay/ visit after deductible at all other facilities | 50% Coinsurance after deductible |
| Drug Cost Share | Generic - $25 copay (retail)/ $62.50 copay (mail order) Preferred Brand - $55 copay (retail)/ $137.50 copay (mail order) Non-Preferred Brand - $95 copay (retail)/ $237.50 copay (mail order) Specialty - 50% coinsurance after deductible (retail only) | Not Covered |

**Census**

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| --- | --- | --- | --- | --- |
| Employee Name | Employee Number | Date of Birth | # of Dependents | Family Rate |
| Mark Levingston | A001 | 11/9/1986 |  | $419.16 |
| Fred Therou | A002 | 3/4/1989 |  | $396.49 |
| Harry Davidson | A003 | 5/4/1978 |  | $452.83 |
| Bruce Campbell | A004 | 5/4/1983 |  | $432.98 |
| David ORourke | A005 | 7/21/1985 |  | $424.48 |
| John Fields | A006 | 11/9/1989 |  | $396.49 |
| Kevin Moore | A007 | 12/11/1989 |  | $385.15 |
| Bryan Friedson | A008 | 10/15/1985 |  | $424.48 |
| David Parker | A009 | 5/4/1983 |  | $432.98 |
| Henry Blake | A010 | 11/9/1986 |  | $419.16 |
| Kevin Wayne | A015 | 5/23/1990 |  | $385.15 |
| Luke Stevenson | A016 | 6/7/1990 |  | $385.15 |
| Jesus Lugo | A011 | 11/5/1982 |  | $435.82 |
| Benjamin Rodstein | A012 | 11/5/1982 |  | $435.82 |
| John Smith | A013 | 11/11/1986 |  | $419.16 |
| Dwayne Jonson | A014 | 5/4/1978 |  | $452.83 |

Rating Method : Member Level Rating

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| --- |
| Monthly Premium Rate : $10499.32 |

Pediatric dental coverage is a required Essential Health Benefit under the Affordable Care Act. AvMed has entered into an alliance with Delta Dental Insurance Company to provide the required coverage under the Delta Dental PPOSM Pediatric Basic Plan. Pediatric dental benefits are included in your monthly premium and cannot be waived or omitted from your policy.

For specific plan details, please refer to the Summary of Benefits and Coverage (SBC) of each plan design at www.avmed.org. For questions, please contact your independent agent or AvMed at 1-800-835-6131.