AvMed Individual & Family Plans

Affordable health plans that help you protect what matters most.

Questions or Ready to Enroll?

800-390-9355

AvMed.org/Shop

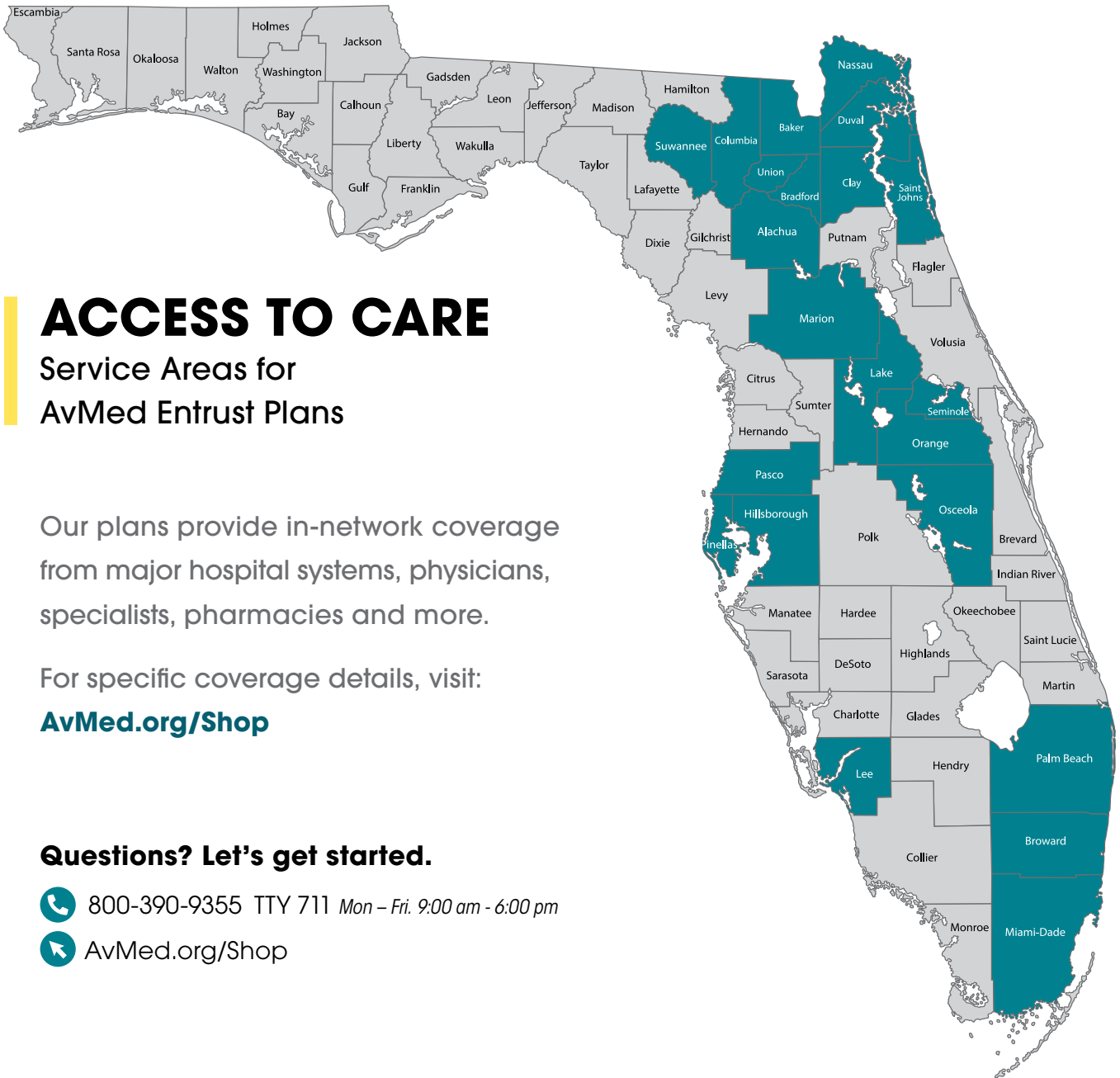
LOCAL SERVICE FOR OVER 55 YEARS

We're here for you in-person, over the phone or online.

Established for over five decades, providing dedicated service to our Florida communities.

AvMed | 3470 NW 82nd Ave. | Doral, FL 33122

TABLE OF CONTENTS



ACCESS TO CARE

Service Areas for AvMed Entrust Plans

Our plans provide in-network coverage from major hospital systems, physicians, specialists, pharmacies and more.

For specific coverage details, visit:
AvMed.org/Shop

Questions? Let's get started.

800-390-9355 TTY 711 *Mon – Fri. 9:00 am - 6:00 pm*

AvMed.org/Shop

AVMED INDIVIDUAL & FAMILY HEALTH PLANS

This Buyer's Guide provides health plan basics to help you determine which plan best fits your health, budget and lifestyle needs.

Finding the right health coverage is more important now than ever. AvMed Individual and Family Plans provide the right amount of coverage at an affordable price. And with several options to choose from, it's easy to find the plan that fits you.

We're here to help.
Talk to a licensed benefits consultant, or view plans and get a quote.

OUR QUALITY STARS RATING

AvMed's Entrust plan (subsidy-eligible) has received 3 stars out of 5 stars from The Centers for Medicare & Medicaid Services (CMS). The number of stars shows how well a plan performs based on a 5-star rating system. This rating is based on factors that include member surveys, data from doctors and hospitals, and how long members have stayed with their health plan.

Global Rating:

Plan Efficiency, Affordability, and Management:

Clinical Quality Management:

CMS scores qualified health plans (QHPs) offered through the Exchanges using the Quality Rating System (QRS) based on third-party validated clinical measure data and QHP Enrollee Survey responses. CMS calculates ratings yearly on a 5-star scale. Ratings may change from year to year. The "Enrollee Experience" rating is non-reportable due to insufficient data to calculate a score or rating according to the QRS rating methodology.

THE AVMED HEALTH PLAN DIFFERENCE

AvMed is one of Florida's oldest and largest not-for-profit health plans headquartered in Miami, Florida with over 55 years of experience focused on providing quality cost-effective plans and excellent Member services.

Access to Care: AvMed members are connected to a network of over 24,000 providers.

Exceptional Customer Service: Our representatives' proximity and local knowledge enable us to go above and beyond to assist our members.

Tools for Well-Being: Our WELLfluent Living® Program gives Members access to classes, resources, nutrition guidance and more so they can lead a happy and healthy life.

VALUE-ADDED BENEFITS & SERVICES

Our plans include benefits to help control and manage your health and lower costs. We are committed to our mission: to improve health every day — so we're always innovating to add value to the products and services we provide.

Cost Saving Tools

AvMed Cost Calculator allows you to see the total costs of a procedure or service before you schedule an appointment.

Rx Savings Solutions is a free, confidential medication service linked to your plan that helps you find the best deals on your prescriptions.

AvMed SmartShopper™ is a powerful tool that rewards eligible members with cash back when they choose the best care at the best price.

Wellness Tools

At AvMed we truly believe people are happiest when they're living a balanced and active life. We call it WELLfluent Living® and it includes tools to help you reach your goals.

That's why as an AvMed member, you get access to programs on exercise, nutrition and other wellbeing resources like discount programs, mental health tools and more!

ENROLLMENT PERIODS & EFFECTIVE DATES

The Open Enrollment Period (OEP) for Individual & Family Health Plans is:

Nov. 1 through **Jan. 15**

Plan effective date depends on when you enroll:

- If you enroll by December 15, your effective date is January 1.
- If you enroll December 16 – January 15, your effective date is February 1.

Special Enrollment Period (SEP)

SEP is a time outside of the annual OEP when an individual can enroll in a health insurance plan. An individual must experience a qualifying life event and provide proof of eligibility in order to qualify. You have 60 days from the qualifying life event to enroll in a health plan. You don't need a qualifying life event during OEP.

What is a Qualifying Life Event?

- Moving to a new area where your current health plan does not provide coverage
- Turning 26 and aging off your parents' health plan
- Losing your health insurance coverage for reasons other than non-payment of premiums or fraud
- Getting married or divorced and needing to add dependents
- Having a substantial change in income, which may qualify you for a subsidy or tax credit with a Marketplace plan

YOUR OPEN ENROLLMENT CHECKLIST

- [ ] **Are you eligible for health insurance through your employer or government programs like Medicaid or Medicare?** If not, an individual health insurance plan may be the best choice.
- [ ] **Are you losing your Medicaid eligibility?** We can help transition you to an affordable health plan packed with comprehensive benefits.
- [ ] **Are you turning 26?** If so, your parents may no longer be able to cover you on their insurance policy. We can help you choose the plan that's right for you.
- [ ] **Understand** how deductibles, copays and coinsurance work.
- [ ] **Gather information on your household income.** You may qualify for a subsidy or cost-sharing reduction to help lower your healthcare costs.
- [ ] **Set your budget.** Monthly premiums and out-of-pocket expenses are all important considerations when selecting a health plan that best fits your needs.

SUBSIDY ELIGIBILITY GUIDELINES

Advanced Premium Tax Credit (APTC)

Individuals may apply for APTC to lower their monthly insurance payment (called the "premium") when they enroll in a plan through the Marketplace. The tax credit is based on the individual's income estimate and household information on their Marketplace application. Individuals can buy health insurance through other sources, but the only way to get a tax credit is through the Marketplace.

Federal Poverty Guidelines

A measure of income, federal poverty guidelines are issued every year by the Department of Health and Human Services. Federal poverty levels are used to determine member eligibility for certain programs and benefits, including savings on the Exchange, and Medicaid and CHIP coverage.

Persons in family/household	Poverty guideline
1	$15,650
2	$21,150
3	$26,650
4	$32,150
5	$37,650
6	$43,150
7	$48,650
8	$54,150

The 2025 federal poverty guidelines for the 48 contiguous states and the District of Columbia are in effect as of January 2025.

For families/households with more than eight persons, add $5,500 for each additional person. Source: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

COMPARE AVMED PLANS

Each plan type provides various options with pricing that adjusts based on the benefits, allowing you to choose the exact level of coverage that suits your needs.

2026 plans	Entrust Subsidy Eligible	Engage Copay-Based	Empower Broad Network	Entrust Plus NEW!
$0 Cost Preventive Visits	X	X	X	X
No Referral Needed for Specialist Appointments			X	X
Virtual Visits	X	X	X	X
Wellness Programs	X	X	X	X
Prescription Coverage	X	X	X	X
HSA Eligible	X	X	X	X
Adult Dental and Vision Coverage	X			X
Minimum Deductible	$0 (Individual) $0 (Family)	$2,000 (Individual) $4,000 (Family)	$1,400 (Individual) $2,800 (Family)	$0 (Individual) $0 (Family)
Lowest Out-of-Pocket Limit	$1,000 (Individual) $2,000 (Family)	$4,700 (Individual) $9.400 (Family)	$5,400 (Individual) $10,800 (Family)	$9,000 (Individual) $18,000 (Family)
Estimated In-Network Copay: Primary vs. Specialist	$0 / $10 and up	$35 / $70 and up	$20 / $40 and up	$20 / $40 and up

For additional plan details, visit AvMed.org/shop.

Things to Consider

The Health Insurance Marketplace classifies plans by metallic tiers: Gold, Silver and Bronze. Each of the AvMed plans above (Entrust, Engage and Empower) are available with different tier options.

If you don't anticipate needing a lot of healthcare services, you may want to consider a bronze or silver plan with lower monthly premium; however, if you or a family member have an unexpected serious injury or illness, an AvMed Gold or Platinum tier plan offers richer benefits and would cover more out-of-pocket costs.

FREQUENTLY ASKED QUESTIONS

How do I know which health insurance carrier is right for me?

Many factors, such as price, network and benefits are important when choosing an insurance carrier. Identify what's important to you and choose the carrier that best meets your lifestyle and benefit preferences.

Can I buy individual insurance with a pre-existing condition?

Yes. Insurers must offer insurance plans to individuals with pre-existing conditions at no additional cost. This is called guaranteed availability under the Affordable Care Act.

What is the advantage of using generic prescription drugs?

Generic drugs are a more affordable version of a standard prescription drug. Most health plans offer discounts to members for using generics. Remember to discuss generic drug options with your primary care physician.

Do all health plans include additional benefits?

AvMed plans offer Members additional discounts, value-added services and other wellness and prevention programs that are not part of a health plan benefits package, but are available at no additional cost. Talk to an AvMed advisor if you have questions about additional benefits. These can help you save money and reduce your medical costs by helping you stay healthier.

How can I learn about healthcare terms and their impact on me?

There are numerous terms associated with health insurance. Understanding them and how they may affect you and the coverage you choose is important. To learn more about health insurance terms and what they mean, visit healthcare.gov/glossary.

UNDERSTANDING HEALTHCARE TERMS

Numerous words and terms are associated with health insurance. It is important to have a basic understanding of their meaning and how these terms may affect you and the coverage you choose.

Term	Definition
Authorization: The process by which a covered service is approved by a health plan's medical care management department.	When your doctor requests a procedure or diagnostic testing, medication, etc., many plans require prior authorization. This is approval given by your insurance company for this aspect of your medical care. If this approval is not received, you will be responsible for all costs associated with your unauthorized treatment as if you had no insurance.
Coinsurance: Shared cost of covered services paid by the plan and the member. Depending on the service, a coinsurance amount may apply before you meet your deductible, or after you meet your deductible, if applicable.	Anytime you use your health plan, you're using your benefits. For example, if you get a procedure that costs $5,000 and your coverage is 20% after a $1,500 deductible, you'll pay the $1,500 first (if you haven't already met your deductible), then 20% of the remaining balance of $3,500, or $700.
Copayment (or copay): A fixed amount, paid at the time services are rendered, that a member of a health plan pays when seeing a participating provider for services.	A fixed amount, like $25, that you'll spend each time you visit the doctor or fill a prescription at the time of your visit.
Deductible: The dollar amount that a covered person is responsible to pay before benefits are payable under a health plan for covered services.	The part you pay before your coverage begins. Usually, the higher your deductible, the lower your monthly premium or payment.
Dependent: A family member who can be covered by your health plan. A dependent could be a spouse or unmarried child (natural, step or adopted).	Adding dependents to your plan may increase the cost of your premium.
Enrollee: An individual who is enrolled in a benefit plan. Enrollees are also referred to as members.	You or your family who is signed up for a health plan.
Explanation of Benefits (EOB): A printed explanation sent to health plan members that describes the benefits received and services for which a healthcare provider has requested payment.	This is not a bill but an itemized statement that shows what action your health plan has taken on your claims. An EOB is for your information and files.
Family Deductible: A deductible which is met by the combined expenses of all covered family members.	A sum the covered family must pay towards the cost of treatment before the benefits of the program go into effect.

UNDERSTANDING HEALTHCARE TERMS
(CONTINUED)

Term	Definition
Health Savings Account (HSA): A type of savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses.	By using untaxed dollars in an HSA to pay for deductibles, copayments, coinsurance, and some other expenses, you may be able to lower your out-of-pocket health care costs. HSA funds generally may not be used to pay premiums.
In-Network: The use of providers who participate with the health plan's network. Many plans require members to use a participating (in-network) provider to receive benefits or the highest level of benefits.	Doctors, hospitals and other healthcare providers and facilities who have agreed to provide services at a reduced rate. If you do not use an in-network provider, you will pay more.
Member: Each individual enrolled and eligible for services in the health plan.	Each member is given an ID number on the health plan.
Member Engagement (member services): Health plan employees who are trained to help members understand and use the benefits in a member's specific plan.	AvMed's representatives available to answer your questions, offer assistance and give you the information you need to get the best value for your money.
Out-of-Pocket Maximum: The maximum amount that a health plan member will have to pay for covered expenses under the plan each year.	The higher the out-of-pocket maximum, the lower your premium or monthly payment.
Out-of-Network: The use of non-network providers.	Those providers who are not contracted with the health plan are considered out of network. You will pay more to use them.
Participating Provider: Any physician, hospital, pharmacy or laboratory or healthcare providers and facilities under contract with the health plan to provide services to members at a specified cost.	These are the individual physicians, hospitals and other healthcare providers who are part of the health plan's network.
Preventive Care: Preventive health screenings help fight communicable diseases and diagnose cancer in the earliest, most treatable stages. Your health plan may pay for all or some of these services so it is smart to take advantage of them.	Preventive health screenings help fight communicable diseases and diagnose cancer in the earliest, most treatable stages. Your health plan may pay for all or some of these services so it is smart to take advantage of them.
Service Area: Coverage area or the geographic locations that a health plan serves.	A service area is defined by its boundaries. Ensure that the plan and the carrier you select have a broad network where you live and work so you are not driving an hour to see a doctor.
Summary of Benefits: A document that outlines the benefits an individual may receive.	These summaries explain how your plan covers a medical occurrence. It is helpful to review and understand these documents to maximize your health coverage.

AvMed

A Sentara Health Plan

AVMED INDIVIDUAL & FAMILY PLANS

Questions or ready to enroll?

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SCAN TO SHOP PLANS

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.

AvMed complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, sexual orientation, gender, gender identity, disability, or age, in its programs and activities, including in admission or access to, or treatment or employment in, its programs and activities. The following person has been designated to handle inquiries regarding AvMed's nondiscrimination policies: AvMed 1557 Coordinator/Compliance, P.O. Box 66189, Virginia Beach, VA 23466 by phone 757-552-7485 (TTY 711), or by email to SHPNDN@sentara.com.

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