



 The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** Please read the FEHB Plan brochure ([insert brochure number]) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure RI 73-815.** Benefits may vary if you have other coverage, such as Medicare. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can get the FEHB Plan brochure RI 73-815 at [www.avmed.org](http://www.avmed.org), and view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov). You can call 1-800-88-AVMED (1-800-882-8633) to request a copy of either document.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	\$1,500/Self Only \$3,000/Self Plus One \$3,000/Self and Family	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. Copayments and coinsurance amounts do not count toward your deductible, which generally starts over January 1. When a covered service/supply is subject to a deductible, only the Plan allowance for the service/supply counts toward the deductible. If you have other family members on the <u>plan</u> , the overall family <u>deductible</u> must be met before this plan begins to pay.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. <u>Preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	Yes. \$4,000/Self Only \$6,750/Self Plus One \$6,750/Self and Family	The <u>out-of-pocket limit</u> , or catastrophic maximum, is the most you could pay during the year for your share of the cost of covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.



What is not included in the <u>out-of-pocket limit</u> ?	Premiums, <u>prescription drug</u> brand additional charges, Specialty drugs, and health care this <u>plan</u> does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.avmed.org">www.avmed.org</a> or call 1-800-88-AVMED (1-800-882-8633) for a list of <u>network providers</u> .	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a provider in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	Not Covered	Additional charges may apply for non-preventive services performed in the Physician's office.
	<u>Specialist</u> visit	20% coinsurance	Not Covered	Additional charges may apply for non-preventive services performed in the Physician's office.
	<u>Preventive care/screening/immunization</u>	Nothing	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if services needed are preventive. Then check what your plan will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% coinsurance	Not Covered	Charges for office visits may apply if services are performed in a Physician's office.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not Covered	Charges for office visits may apply if services are performed in a Physician's office.

For more information about limitations and exceptions, see the FEHB Plan brochure RI 73-815 at [www.avmed.org](http://www.avmed.org).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="http://www.avmed.org">prescription drug coverage</a> is available at <a href="http://www.avmed.org">www.avmed.org</a>	Generic drugs	\$10/prescription (retail); \$30/prescription (mail order)	Not Covered	Retail charge applies per 30-day supply.
	Preferred brand name drugs	\$30/prescription (retail); \$90/prescription (mail order)	Not Covered	Generic & brand drugs: covers up to a 90-day supply at retail pharmacies and a 31-90 day supply via mail order.
	Non-preferred brand name drugs and generics	\$50/prescription (retail); \$150/prescription (mail order)	Not Covered	
	<u>Specialty drugs</u>	\$75/prescription (retail)	Not Covered	Certain drugs in all tiers require prior authorization.  Brand additional charges may apply.  Specialty drugs available in 30-day supply only; not available via mail order.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not Covered	Prior authorization required.
	Physician/surgeon fees	20% coinsurance	Not Covered	Prior authorization required.
<b>If you need immediate medical attention</b>	Emergency room care	20% coinsurance	20% coinsurance	AvMed must be notified within 48-hours of inpatient admission following emergency services, or as soon as reasonably possible. Charges are waived if admitted.
	<u>Emergency medical transportation</u>	20% coinsurance	20% coinsurance	20% coinsurance after deductible for air and water transportation.
	<u>Urgent care</u>	20% coinsurance	20% coinsurance	-----None-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% coinsurance	Not Covered	Prior authorization required.
	Physician/surgeon fees	20% coinsurance	Not Covered	Prior authorization required.

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		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	Not Covered	Prior authorization may be required.
	Inpatient services	20% coinsurance	Not Covered	Prior authorization may be required.
If you are pregnant	Office visits	Routine OB: 20% coinsurance	Not Covered	-----None-----
	Childbirth/delivery professional services	20% coinsurance	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound.)
	Childbirth/delivery facility services	Hospital stay: 20% coinsurance; Birthing center: same as routine OB	Not Covered	Prior authorization required.
If you need help recovering or have other special health needs	<u>Home health care</u>	20% coinsurance	Not Covered	-----None-----
	<u>Rehabilitation services</u>	20% coinsurance	Not Covered	Short term physical, occupational, & speech therapies covered for a consecutive two calendar month period per condition.
	<u>Habilitation services</u>	20% coinsurance	Not Covered	Coverage for habilitative services is covered the same as physical, occupational and speech therapy.
	<u>Skilled nursing care</u>	20% coinsurance	Not Covered	Prior authorization required.
	<u>Durable medical equipment</u>	20% coinsurance	Not Covered	-----None-----
	<u>Hospice services</u>	20% coinsurance	Not Covered	Physician certification required.
If your child needs dental or eye care	Children's eye exam	20% coinsurance	Not Covered	-----None-----
	Children's glasses	Not Covered	Not Covered	-----None-----
	Children's dental check-up	Not Covered	Not Covered	-----None-----

For more information about limitations and exceptions, see the FEHB Plan brochure RI 73-815 at [www.avmed.org](http://www.avmed.org).

## Excluded Services & Other Covered Services:

### Services Your Plan Generally Does NOT Cover (Check your plan's FEHB brochure for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss programs

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan's FEHB brochure.)

- Bariatric surgery
- Chiropractic care
- Habilitation services
- Hearing aids
- Infertility treatment
- Routine foot care when under active treatment for a metabolic or peripheral vascular disease, such as diabetes

**Your Rights to Continue Coverage:** You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 1-800-882-8633 or visit [www.opm.gov/insure/health](http://www.opm.gov/insure/health). Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or receive temporary continuation of coverage (TCC). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your plan's FEHB brochure. If you need assistance, you can contact AvMed's Member Engagement Center at 1-800-882-8633.

**Does this plan provide Minimum Essential Coverage?** Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards?** Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

## Language Access Services:

Para obtener asistencia en Español, llame al 1-800-882-8633.

----- *To see examples of how this plan might cover costs for a sample medical situation, see the next section.* -----

For more information about limitations and exceptions, see the FEHB Plan brochure RI 73-815 at [www.avmed.org](http://www.avmed.org).

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$1,500
- Specialist [*cost sharing*] 20%
- Hospital (facility) [*cost sharing*] 20%
- Other [*cost sharing*] 20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,100
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1,100</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$1,500
- Specialist [*cost sharing*] 20%
- Hospital (facility) [*cost sharing*] 20%
- Other [*cost sharing*] 20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$490
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,990</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$1,500
- Specialist [*cost sharing*] 20%
- Hospital (facility) [*cost sharing*] 20%
- Other [*cost sharing*] 20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$600
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$600</b>

The plan would be responsible for the other costs of these EXAMPLE covered services.