



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**. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-88-AVMED (1-800-882-8633) or visit www.avmed.org. 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 view the Glossary at www.cciio.cms.gov or call 1-800-88-AVMED (1-800-882-8633) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$500 / Self-only \$1,000 / Self plus one \$1,000 / Self and family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan 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 deductible , only the Plan allowance for the service/supply counts towards the deductible . If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive care , office visits, certain lab tests, prescription drugs , urgent and emergent care , and certain recovery services e.g., habilitation and rehabilitation services , are covered before you meet your deductible .	This plan covers some items and services if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$4,500 / Self-only \$9,000 / Self plus one \$9,000 / Self and family \$2,500 / member for Specialty drugs.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , prescription drug brand additional charges, Specialty drugs, and services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.avmed.org or call 1-800-88-AVMED (1-800-882-8633) for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
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
		an In-Network Provider (You will pay the least)	an Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copay/ visit	Not Covered	Deductible does not apply.
	Specialist visit	\$45 copay/ visit	Not Covered	Deductible does not apply.
	Preventive care/screening/immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	Not Covered	Charges for office visits may apply if services are performed in a Physician's office.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	Not Covered	Charges for office visits may apply if services are performed in a Physician's office.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.avmed.org	Generic drugs	\$10 copay/ prescription (retail); \$30 copay/ prescription (mail order)	Not Covered	Retail charge applies per 30-day supply. Generic & brand drugs: covers up to a 90-day supply at retail pharmacies and a 31-90 day supply via mail order.
	Preferred brand drugs	\$40 copay/ prescription (retail); \$120 copay/ prescription (mail order)	Not Covered	Certain drugs in all tiers require prior authorization.
	Non-preferred brand drugs	\$60 copay/ prescription (retail); \$180 copay/ prescription (mail order)	Not Covered	Brand additional charges may apply.
	Specialty drugs	30% coinsurance/ prescription (retail)	Not Covered	Specialty drugs available in 30-day supply only; not available via mail order. Out-of-pocket maximum of \$2,500 per member per calendar year for Specialty drugs. Deductible does not apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an In-Network Provider (You will pay the least)	an Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$300 copay/ visit after deductible	Not Covered	Prior authorization required.
	Physician/surgeon fees	No charge at hospital-owned or affiliated facilities; \$25 copay/ visit at PCP; \$45 copay/ visit at Specialist	Not Covered	Prior authorization required.
If you need immediate medical attention	Emergency room care	\$100 copay/ visit	\$100 copay/ visit	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>Deductible</u> does not apply.
	Emergency medical transportation	No charge one way ground transport	No charge one way ground transport	No charge for air and water transportation. Prior authorization required.
	Urgent care	Participating provider: \$40 copay/ visit; Non-participating provider:\$60 copay/ visit	\$60 copay/ visit	<u>Deductible</u> does not apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$300 copay/ day for the first 3 days per admission after deductible	Not Covered	Prior authorization required.
	Physician/surgeon fees	No charge at hospital-owned or affiliated facilities; \$25 copay/ visit at PCP; \$45 copay/ visit at Specialist	Not Covered	Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an In-Network Provider (You will pay the least)	an Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 copay/ visit PCP office; \$45 copay/ visit Specialist; 20% coinsurance after deductible per test; \$300 copay/ visit after deductible at outpatient hospital-owned or affiliated facilities	Not Covered	<u>Deductible</u> does not apply for PCP and Specialist visits. Prior authorization may be required.
	Inpatient services	Hospital stay: \$300 copay/ day for the first 3 days per admission after deductible; Residential stay: No Charge	Not Covered	Prior authorization may be required.
If you are pregnant	Office visits	Routine OB & midwife: No Charge	Not Covered	-----None-----
	Childbirth/delivery professional services	No Charge	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth/delivery facility services	Hospital stay: \$300 copay/ day for the first 3 days per admission after deductible; Birthing center: same as routine OB	Not Covered	Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an In-Network Provider (You will pay the least)	an Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	Not Covered	-----None-----
	Rehabilitation services	\$25 copay/ visit at PCP; \$45 copay/ visit at Specialist	Not Covered	Short term physical, occupational, and speech therapies covered for a consecutive two calendar month period per condition. <u>Deductible</u> does not apply.
	Habilitation services	\$25 copay/ visit at PCP; \$45 copay/ visit at Specialist	Not Covered	Coverage for Habilitative services is covered the same as physical, occupational, and speech therapy. <u>Deductible</u> does not apply.
	Skilled nursing care	No Charge	Not Covered	Prior authorization required.
	Durable medical equipment	20% coinsurance after deductible	Not Covered	-----None-----
	Hospice services	No Charge	Not Covered	Physician certification required.
If your child needs dental or eye care	Children's eye exam	\$25 copay/ exam at PCP; \$45 copay/ exam at Specialist	Not Covered	<u>Deductible</u> does not apply.
	Children's glasses	Not Covered	Not Covered	-----None-----
	Children's dental check-up	Not Covered	Not Covered	-----None-----

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
• Acupuncture	• Long-Term Care	• Routine Eye Care (Adult)
• Cosmetic Surgery	• Non-Emergency Care When Traveling Outside the U.S.	• Weight Loss Programs
• Dental Care (Adult)	• Private-Duty Nursing	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery	• Hearing Aids	• Routine Foot Care -when under active treatment for a metabolic or peripheral vascular disease
• Chiropractic Care	• Infertility Treatment	

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Florida Office of Insurance Regulation at 1-877-693-5236 or www.floir.com/consumers, the U.S. Department of Labor, Employee Benefits Security Administration, at 1-866-444-3272 or www.dol.gov/ebsa/contactEBSA/consumerassistance.html, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 or call 1-800-318-2596. For more information on your rights to continue coverage, 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.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your **plan** for a denial of a **claim**. This complaint is called a **grievance** or **appeal**. For more information about your rights, look at the explanation of benefits you will receive for that medical **claim**. Your **plan** documents also provide complete information to submit a **claim**, **appeal**, or a **grievance** for any reason to your **plan**. For more information about your rights, this notice, or assistance, 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 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 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.

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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$500	■ The plan's overall deductible	\$500	■ The plan's overall deductible	\$500
■ Specialist copayment	\$45	■ Specialist copayment	\$45	■ Specialist copayment	\$45
■ Hospital (facility) copayment	\$300	■ Hospital (facility) copayment	\$300	■ Hospital (facility) copayment	\$300
■ Other coinsurance	20%	■ Other coinsurance	20%	■ Other coinsurance	20%
<p>This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/delivery professional services Childbirth/delivery facility services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p>	
Total Example Cost	\$12,700	Total Example Cost	\$7,400	Total Example Cost	\$1,900
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$500	Deductibles	\$500	Deductibles	\$70
Copayments	\$390	Copayments	\$1,120	Copayments	\$530
Coinsurance	\$210	Coinsurance	\$370	Coinsurance	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$0	Limits or exclusions	\$0	Limits or exclusions	\$0
The total Peg would pay is	\$1,100	The total Joe would pay is	\$1,990	The total Mia would pay is	\$600

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.