AvMed Embrace better health® **Federal Employees - Standard Option HMO**

Coverage for: Self Only, Self Plus One, or Self and Family | **Plan Type:** HMO

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 RI 73-815 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, and view the Glossary at www.cciio.cms.gov. You can call 1-800-882-8633 to request a copy of either document.

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. 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. In-Network preventive care, office visits, certain prescription drugs, urgent care, emergency room, outpatient rehabilitation are covered before you meet your deductible.	This plan covers some items and services even 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, 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 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 health care this plan does not 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 1-800-882-8633 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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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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 (You will pay the least)	Out-of-Network (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	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	Diagnostic test (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.
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. 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. Out-of-pocket maximum of $2,500 per member per calendar year for Specialty drugs. Deductible does not apply.
	Preferred brand drugs	$40 copay/ prescription (retail); $120 copay/ prescription (mail order)	Not Covered	
	Non-Preferred brand drugs	$60 copay/ prescription (retail); $180 copay/ prescription (mail order)	Not Covered	
	Specialty drugs	30% coinsurance (retail)	Not CoveredNot Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300 copay/ visit	Not Covered	Prior authorization required.
	Physician/surgeon fees	Outpatient facility: Nothing; PCP office: $25 copay/ visit; Specialist office: $45 copay/ visit	Not Covered	Prior authorization required. Deductible does not apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need immediate medical attention	Emergency room care	$100 copay/ visit	$100 copay/ visit	AvMed must be notified within 24-hours of inpatient admission following emergency services, or as soon as reasonably possible. Charges are waived if admitted. Deductible does not apply.
	Emergency medical transportation	Ground: Nothing; Air/Water: Nothing	Ground: Nothing; Air/Water: Nothing	Prior authorization required.
	Urgent care	$40 copay/ visit	$60 copay/ visit	Deductible does not apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	Day 1 - 3: $300 copay/ day per admission; Day 4 and after: Nothing	Not Covered	Prior authorization required.
	Physician/surgeon fees	Hospital facility: Nothing; PCP office: $25 copay/ visit; Specialist office: $45 copay/ visit	Not Covered	Prior authorization required. Deductible does not apply.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	PCP office: $25 copay/ visit; Specialist office: $45 copay/ visit; Outpatient facility: $300 copay/ visit; Test: 20% coinsurance	Not Covered	Prior authorization may be required. Deductible does not apply for PCP and Specialist visits.
	Inpatient services	Hospital stay: Day 1 - 3: $300 copay/ day per admission; Day 4 and after: Nothing	Not Covered	Prior authorization may be required.
If you are pregnant	Office visits	Nothing	Not Covered	None
	Childbirth/delivery professional services	Nothing	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth/delivery facility services	Hospital stay: Day 1 - 3: $300 copay/ day per admission; Day 4 and after: Nothing	Not Covered	Prior authorization required.
	Home health care	20% coinsurance	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need help recovering or have other special health needs	Rehabilitation services	PCP office: $25 copay/ visit; Specialist office: $45 copay/ visit	Not Covered	Short term physical, occupational, & speech therapies covered for a consecutive two calendar month period per condition. Deductible does not apply.
	Habilitation services	PCP office: $25 copay/ visit; Specialist office: $45 copay/ visit	Not Covered	Coverage for habilitative services is covered the same as physical, occupational and speech therapy. Deductible does not apply.
	Skilled nursing care	Nothing	Not Covered	Prior authorization required.
	Durable medical equipment	20% coinsurance	Not Covered	None
	Hospice services	Nothing	Not Covered	Physician certification required.
If your child needs dental or eye care	Children's eye exam	PCP office: $25 copay/ visit; Specialist office: $45 copay/ visit	Not Covered	Deductible 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
- Child Dental Check Up
- Child Glasses
- Cosmetic Surgery
- Dental Care (Adult)
- 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 document.)

- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Infertility Treatment
- Routine Foot Care

Your Rights to Continue Coverage: There are agencies that can 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. 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 or call 1-800-318-2596.

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 on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact AvMed's Member Engagement Center at 1-800-882-8633.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, certain Medicare, Medicaid coverage, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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.

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** **$500**
- **Specialist copayment** **$45**
- **Hospital (facility) copayment** **$300**
- **Other copayment** **$25**

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*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$860**

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$45**
- **Hospital (facility) copayment** **$300**
- **Other copayment** **$25**

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*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,120**

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$45**
- **Hospital (facility) copayment** **$300**
- **Other copayment** **$25**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$700**

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