



 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](http://www.avmed.org), and view the Glossary at [www.cciio.cms.gov](http://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 <a href="#">deductible</a> ?	\$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 <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. In-Network <a href="#">preventive care</a> , office visits, certain <a href="#">prescription drugs</a> , <a href="#">urgent care</a> , <a href="#">emergency room</a> , outpatient <a href="#">rehabilitation</a> are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$4,500/Self Only \$9,000/Self Plus One \$9,000/Self and Family \$2,500/member for <a href="#">Specialty drugs</a>	The <a href="#">out-of-pocket limit</a> , 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 <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">prescription drug</a> brand additional charges, <a href="#">Specialty drugs</a> , and health care this <a href="#">plan</a> does not cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.avmed.org">www.avmed.org</a> or call 1-800-882-8633 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



 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)	
<b>If you visit a health care provider's office or clinic</b>	Primary Care visit to treat an injury or illness	\$25 <a href="#">copay</a> / visit	Not Covered	<a href="#">Deductible</a> does not apply.
	<a href="#">Specialist</a> visit	\$45 <a href="#">copay</a> / visit	Not Covered	<a href="#">Deductible</a> does not apply.
	<a href="#">Preventive care/screening</a> /immunization	Nothing	Not Covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	Not Covered	Charges for office visits may apply if services are performed in a Physician's office.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	Not Covered	Charges for office visits may apply if services are performed in a Physician's office.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.avmed.org">www.avmed.org</a>	Generic drugs	\$10 <a href="#">copay</a> / prescription (retail); \$30 <a href="#">copay</a> / 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 <a href="#">copay</a> / prescription (retail); \$120 <a href="#">copay</a> / prescription (mail order)	Not Covered	Certain drugs in all tiers require prior authorization. Brand additional charges may apply.
	Non-Preferred brand drugs	\$60 <a href="#">copay</a> / prescription (retail); \$180 <a href="#">copay</a> / prescription (mail order)	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.
	<a href="#">Specialty drugs</a>	30% <a href="#">coinsurance</a> (retail)	Not Covered Not Covered	<a href="#">Deductible</a> does not apply.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$300 <a href="#">copay</a> / visit	Not Covered	Prior authorization required.
	Physician/surgeon fees	Outpatient facility: Nothing; PCP office: \$25 <a href="#">copay</a> / visit; Specialist office: \$45 <a href="#">copay</a> / visit	Not Covered	Prior authorization required. <a href="#">Deductible</a> 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)	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$100 <a href="#">copay</a> / visit	\$100 <a href="#">copay</a> / 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. <a href="#">Deductible</a> does not apply.
	<a href="#">Emergency medical transportation</a>	Ground: Nothing; Air/Water: Nothing	Ground: Nothing; Air/Water: Nothing	Prior authorization required.
	<a href="#">Urgent care</a>	\$40 <a href="#">copay</a> / visit	\$60 <a href="#">copay</a> / visit	<a href="#">Deductible</a> does not apply.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Day 1 - 3: \$300 <a href="#">copay</a> / day per admission; Day 4 and after: Nothing	Not Covered	Prior authorization required.
	Physician/surgeon fees	Hospital facility: Nothing; PCP office: \$25 <a href="#">copay</a> / visit; Specialist office: \$45 <a href="#">copay</a> / visit	Not Covered	Prior authorization required. <a href="#">Deductible</a> does not apply.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	PCP office: \$25 <a href="#">copay</a> / visit; Specialist office: \$45 <a href="#">copay</a> / visit; Outpatient facility: \$300 <a href="#">copay</a> / visit; Test: 20% <a href="#">coinsurance</a>	Not Covered	Prior authorization may be required. <a href="#">Deductible</a> does not apply for PCP and Specialist visits.
	Inpatient services	Hospital stay: Day 1 - 3: \$300 <a href="#">copay</a> / day per admission; Day 4 and after: Nothing	Not Covered	Prior authorization may be required.
<b>If you are pregnant</b>	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 <a href="#">copay</a> / day per admission; Day 4 and after: Nothing	Not Covered	Prior authorization required.
	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Rehabilitation services</a>	PCP office: \$25 <a href="#">copay</a> / visit; Specialist office: \$45 <a href="#">copay</a> / visit	Not Covered	Short term physical, occupational, & speech therapies covered for a consecutive two calendar month period per condition. <a href="#">Deductible</a> does not apply.
	<a href="#">Habilitation services</a>	PCP office: \$25 <a href="#">copay</a> / visit; Specialist office: \$45 <a href="#">copay</a> / visit	Not Covered	Coverage for habilitative services is covered the same as physical, occupational and speech therapy. <a href="#">Deductible</a> does not apply.
	<a href="#">Skilled nursing care</a>	Nothing	Not Covered	Prior authorization required.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	Not Covered	None
	<a href="#">Hospice services</a>	Nothing	Not Covered	Physician certification required.
<b>If your child needs dental or eye care</b>	Children's eye exam	PCP office: \$25 <a href="#">copay</a> / visit; Specialist office: \$45 <a href="#">copay</a> / visit	Not Covered	<a href="#">Deductible</a> 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           | • Dental Care (Adult)                                | • Routine Eye Care (Adult) |
| • Child Dental Check Up | • Long-term Care                                     | • Weight Loss Programs     |
| • Child Glasses         | • Non-Emergency Care When Traveling Outside the U.S. |                            |
| • Cosmetic Surgery      | • 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 |
| • 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. 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:** 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:**

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$860</b>

**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:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,100
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,120</b>

**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:**

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$700</b>

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