AvMed

www.avmed.org

Member Engagement Center: 800-882-8633

2018

A Health Maintenance Organization (standard option)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 8 for details. The plan is accredited. See page 13.

Serving: *South Florida*

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 14 for requirements.

IMPORTANT
- Rates: Back Cover
- Changes for 2018: Page 15
- Summary of benefits: Page 81

Enrollment code for this Plan:
ML4 Standard Option - Self Only
ML6 Standard Option - Self Plus One
ML5 Standard Option - Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

Important Notice from AvMed About
Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that AvMeds' prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213 (TTY: 800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 800-MEDICARE 800-633-4227, TTY: 877-486-2048.

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Introduction

This brochure describes the benefits of AvMed under our contract (CS 2876) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at (800)-882-8633 or through our website: www.avmed.org. The address for AvMed administrative offices is:

AvMed, Inc.
9400 South Dadeland Boulevard
Miami, FL 33156

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. If you are enrolled in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits. You do not have a right to benefits that were available before January 1, 2018, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2018, and changes are summarized on page 14. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

• Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means AvMed.

• We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.

• Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help compare plans.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud - Here are some things you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care provider, authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services that you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 800-882-8633 and explain the situation.
  - If we do not resolve the issue:

CALL **- THE HEALTH CARE FRAUD HOTLINE**
877-499-7295

OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26)
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

AvMed complies with all applicable Federal civil rights laws, to include both Title VII of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. Pursuant to Section 1557, AvMed does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own health care and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don’t assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:
  - "Exactly what will you be doing?"

- "About how long will it take?"
- "What will happen after surgery?"
- "How can I expect to feel during recovery?"

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up patient safety program.
- www.jointcommission.org/topics/patient safety.aspx. The Joint Commission helps health care organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a health care facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such a event occurs, neither you nor your FEHB plan will incur costs to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital-acquired conditions or for inpatient services needed to correct "Never Events", if you use AvMed preferred providers. This policy helps protect you from preventable medical errors and improve the quality of care you receive.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

  We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, and give you brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

  - When you may change your enrollment
  - How you can cover your family members
  - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
  - When your enrollment ends
  - When the next Open Season for enrollment begins

  We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

  Self Only coverage is for you alone. Self Plus One coverage is an enrollment that covers you and one eligible family member. Self and Family coverage is for you, your spouse, and your dependent children, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

  If you have a Self Only enrollment, you may change to a Self and Family or Self Plus One enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until you are married.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/ payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the FEHB Program if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll in Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;

- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to a Self Plus One or Self and Family, as appropriate, in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2018 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2017 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

  You will receive an additional 31 days of coverage, for no additional premium, when:

  - Your enrollment ends, unless you cancel your enrollment, or
  - You are a family member no longer eligible for coverage.

  Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

  You may be eligible for spouse equity coverage or assistance with enrolling in a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

  If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get information about your coverage choices. You can also visit OPM's website at http://www.opm.gov/healthcare-insurance/healthcare/plan-information/.

- **Temporary Continuation of Coverage (TCC)**

  If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, etc.

  You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

  Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

  Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHBP coverage.

- **Converting to individual coverage**

  If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must contact us in writing within 31 days after you are no longer eligible for coverage.

  Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 888-882-8633 or visit our website at www.avmed.org.

- **Health Insurance Marketplace** — If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this plan works

This Plan is a health maintenance organization (HMO). OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. AvMed holds the following accreditations: National Committee for Quality Assurance. To learn more about this plan's accreditations, please visit the following websites:

National Committee for Quality Assurance (www.ncqa.org)

We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

Questions regarding what protections apply and what protections do not apply to this Plan may be directed to us at 800-882-8633. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

General features of our Standard Option

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies).

Your rights and responsibilities

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB website (www.opm.gov/healthcare-insurance/) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- AvMed is an Individual Practice Association organization serving Floridians for nearly 50 years. Member's medical services are provided by a wide array of primary care doctors and specialists with whom AvMed contracts.
- As one of Florida's oldest and largest not-for-profit health plans, AvMed answers to our Members- not shareholders- and we reinvest profits to deliver on our mission, to "help our Members live healthier."
- The first and most important decision each member must make is the selection of a primary care doctor. It is the responsibility of your primary care doctor to obtain any necessary authorizations from the Plan before making arrangements for hospitalization.

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, AvMed at www.avmed.org. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 800-882-8633, or write to 9400 South Dadeland Blvd., Suite 200, Miami, Fl 33156. You may also contact us by fax at 305-671-4710 or visit our website at www.avmed.org.

By law, you have the right to access your personal health information (PHI). For more information regarding access to PHI, visit our website at www.avmed.org to obtain a Notice of our Privacy Practice. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area is:

South Florida: Dade, Broward and Palm Beach counties.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2018

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Changes to High Option only

- This option has been terminated for 2018.

Changes to Standard Option only

- Your share of the non-Postal and Postal premium will increase for Self Only, Self Plus One, and Self and Family. See page 82.
- Coverage for Medical Foods for children with inborn errors of metabolism up to age 24, or age 14 for Organic Acid Disorders (OAD) and Amino Acid Disorders (AAD) are now covered at 20% of the contracted rate after deductible. Limited at $2,500 per Calendar year and prescription is required. See page 56.
- Statin use for the Primary Prevention of Cardiovascular Disease for adults age 40 to 75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater are now covered under preventive care medication list at no charge. See page 57.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-882-8633 or write to us at 9400 South Dadeland Blvd., Suite 200, Miami, FL 33156. You may also request replacement cards through our website: www.avmed.org.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay your applicable cost-sharing (copayments, deductibles, and/or coinsurance) if you use our Open Access option. If you use your Open Access program you can receive covered services without a required referral from your primary care physician or by another provider in the network. Please see page 23 of your handbook for additional information.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

- **Primary care**

Your primary care physician can be a family practitioner, internist or pediatrician. Your primary care physician will provide most of your health care.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

If you are seeing a specialist when you enroll in our Plan, and your current specialist does not participate with us, you must receive treatment from a specialist who does.

Generally, we will not pay for you to see a specialist who does not participate with this Plan.

- If are seeing a specialist and you specialist leaves the Plan, call us, we will help you select a new one. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program
  - reduce our service area and you enroll in another FEHB plan

You may also be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond 90 days.

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800-882-8633. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center
- the day your benefits from your former plan run out
- the 92nd day after you become a member of this Plan, whichever happens first

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

Since your primary care physician arranges for inpatient hospitalizations, the pre-service claim approval process only applies to care shown under *Other services.*

You must get prior approval for certain services. You should remember that services provided or received without prior Plan authorization from AvMed when authorization is required, or services beyond the scope of practice authorized for a Health Professional under applicable state law, are not covered unless such services have otherwise been expressly authorized under the terms of this Contract or when required to treat an Emergency Medical Condition. Furthermore, if an inpatient admission is extended beyond the number of days initially approved, without prior Plan authorization for the continued stay, it may result in services not being covered. Before a service is performed, you should verify with your Health Professional that the service has received prior Plan authorization. If you are unable to secure verification from your Health Professional, you may also call 800-882-8633.

- **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

For certain services, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process preauthorization. Your physician must obtain authorization for the following services such as, but not limited to:

- Hospitalization
- Certain medications (including Sexual Dysfunction medication)
- Gender Reassignment surgery (Certain criteria applies, please see Page 39 for details)
- Growth hormone therapy (GHT)
- Most laboratory testing; and

- Other comprehensive diagnostic and treatment services

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call us at 800-882-8633 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay.

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 800-882-8633. You may also call OPM's Health Insurance 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 800-882-8633. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

Obstetrical care benefits are covered and include hospital care, anesthesia, diagnostic imaging and laboratory services for conditions related to pregnancy. The requesting obstetrical provider should obtain authorization by faxing a preauthorization request form to 800-552-8633.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-network facilities

If prior approval is not given for services provided by a non-network facility/provider, the Health plan shall have no liability or obligation whatsoever, on account of services or benefits sought or received by any member from any non-network physician, health professional, hospital or other health care facility, or other person, institution or organization.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Pre-certify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

2. Ask you or your provider for more information

   You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

   If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

  In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

  Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

  After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for covered care:

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: When you see your primary care physician, you pay a copayment of $25 per office visit, and when you go in the hospital, you pay $300 per day for the first three days per admission.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them.

The calendar year deductible is $500 per person under Standard Option. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $500 under Standard Option. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $1,000 under Standard Option. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $1,000 under the Standard Option.

Note: If you change plans during Open Season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible.
Example: In our Plan, you pay 20% of our allowance for durable medical equipment

Your catastrophic protection out-of-pocket maximum

After your out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance total $4,500 for Self Only, or $9,000 per person for Self Plus One and Self and Family enrollment under the Standard Option plan in any calendar year, you do not have to pay any more for covered services. ***The maximum annual limitation on cost sharing listed under Self Only of $4,500 under the Standard Option applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.***

Example Scenario: Your plan has a $4,500 Self Only maximum out-of-pocket limit and a $9,000 Self Plus One or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of $4,500 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket maximum of $9,000, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of $9,000 for the calendar year before their qualified medical expenses will begin to be covered in full.

However, copayments and coinsurance, if applicable for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services:

- Specialty drugs, out-of-pocket maximum of $2,500 per member per calendar year

- Prescription drug brand additional charges
- Services this plan doesn't cover
- Expenses for services and supplies that exceed the stated maximum dollar or day limit
- Expenses from utilizing out-of-network providers

Be sure to keep accurate records and receipts of your copayments and coinsurance to ensure the plan's calculation of your out-of-pocket maximum is reflected accurately.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Standard Option Benefits

See page 15 for how our benefits changed this year. Page 81 is a benefits summary. Make sure that you review the benefits that are available.

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Section 5. Standard Option Benefits Overview

This Plan offers a Standard Option. The benefit package is described in Section 5. Make sure that you review the benefits that are available.

The Standard Option Section 5 is divided into subsections. Please read "*Important things you should keep in mind"* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about Standard Option benefits, contact us at 800-882-8633 or on our website at www.avmed.org.

Option offers unique features.

- **Standard Option** The Standard Option has copayments, a calendar year deductible, and coinsurance.

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- The calendar year deductible is: $500 per person ($1,000 per Self Plus One enrollment, or $1,000 per Self and Family enrollment). The calendar year deductible applies to certain benefits in this Section. We added "(Calendar year deductible applies)" to show when the calendar year deductible does apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR CERTAIN SERVICES. Benefits are payable only when it is determined that the care is clinically appropriate to treat your condition and only when you receive the care as part of an approved treatment plan. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process. For more information, please refer to Section 3 of this brochure or contact our Member Engagement Center at 800-882-8633.**

Benefit Description	You Pay
Note: We state whether or not the calendar year deductible applies for each benefit listed in this Section.	
Diagnostic and treatment services	**Standard Option**
Professional services of physicians • In physician's office • Second surgical opinion Note: If the member chooses a non-Plan Physician for the second surgical opinion, the member will be responsible for 40% of the amount of reasonable and customary charges.	$25 per visit to your primary care physician $45 per visit to a participating specialist
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultation • Advance care planning • At home	Nothing

Diagnostic and treatment services - continued on next page

Benefit Description	You Pay
Diagnostic and treatment services (cont.)	**Standard Option**
Telehealth Services Note: AvMed's Telehealth Services provide anytime remote access to board-certified doctors from your home, your office, or on the go. Just 15 minutes after a simple sign-up, Members can speak with a doctor about non-emergency medical issues by phone or by secure video using a computer, tablet, or smartphone. It's healthcare that works for AvMed Members, wherever and whenever they need it.	Nothing
Lab, X-ray and other diagnostic tests	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology	$25 per visit to your primary care physician $45 per visit to a participating specialist
• X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG • CAT Scans/PET Scans/MRI NOTE: Prior authorization is required.	20% of the contracted rate (calendar year deductible applies)
Preventive care, adult	**Standard Option**
Annual physical examination Routine screenings, such as: • Total Blood Cholesterol • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy screening – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50	Nothing Nothing
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing
Well woman care based on current recommendations such as: • Cervical cancer screening (Pap smear) • Human Papillomavirus (HPV) testing • Chlamydia/Gonorrhea screening • Osteoporosis screening • Breast cancer screeing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You Pay
Preventive care, adult (cont.)	**Standard Option**
• Counseling for sexually transmitted infections • Counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence	Nothing
Routine mammogram - covered for women	Nothing
Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC) based on the Advisory Committee on Immunization Practices (ACIP) schedule.	Nothing
Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member cost-sharing (copayments, coinsurance, and deductible). Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online atwww.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ HHS:www.healthcare.gov/prevention-care-benefits/. CDC:www.cdc.gov/vaccines/schedules/index.html **Women's preventive services**:www.healthcare.gov/preventive-care-women/ For additional information: healthfinder.gov/myhealthfinder/default.aspx	
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*
Preventive care, children	**Standard Option**
• Well-child visits examinations, and immunizations as described in the Bright Future Guidelines provided by the American Academy of Pediatrics.	Nothing
Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member cost-sharing (copayments, coinsurance, and deductible).	

Preventive care, children - continued on next page

Benefit Description	You Pay
Preventive care, children (cont.)	**Standard Option**
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. HHS: www.healthcare.gov/prevention-care-benefits/. CDC: www.cdc.gov/vaccines/schedules/index.html For additional information: healthfinder.gov/myhealthfinder/default.aspx Note: For a complete list of the American Academy of Pediatrics Bright Future Guidelines, go to brightfutures.aap.org/Pages/default.aspx	
Maternity care	**Standard Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women after 24 weeks. • Postnatal care	Nothing
• Delivery	$300 per day for the first three days per hospital admission (Calendar year deductible applies)
Breastfeeding support, supplies and counseling for each birth	Nothing
Note: Here are some things to keep in mind: • You do not need to precertify your vaginal delivery; see page 19 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b).	

Maternity care - continued on next page

Benefit Description	You Pay
Maternity care (cont.)	**Standard Option**
Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.	
Family planning	**Standard Option**
Contraceptive counseling on an annual basis	Nothing
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Interauterine devices (IUDs) • Diaghragms *Note: We cover oral contraceptives under the prescription drug benefit.*	Nothing
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling*	*All charges*
Infertility services	**Standard Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: - Intravaginal insemination (IVI) • medically necessary hormone testing • semen analysis • sperm function testing • chromosomal analysis • medical imaging • surgical correction of genitourinary tract abnormalities NOTE: Infertility is defined as the inability of an individual to achieve conception after one year of unprotected intercourse; or the inability of an individual to achieve conception after six trials of artificial insemination over a one-year period. Infertility services require prior authorization.	$25 per visit to your primary care physician $45 per visit to a participating specialist
Not covered:	*All charges*

Infertility services - continued on next page

Benefit Description	You Pay
Infertility services (cont.)	**Standard Option**
• *Assisted reproductive technology (ART) procedures, such as:* *- In vitro fertilization (IVF)* *- Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer(ZIFT)* • *Artificial insemination (AI):* *- Intracervical insemination (ICI)* *- Intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Surgery for the enhancement of fertility* • *Cost of donor sperm* • *Cost of donor egg* • *Fertility drugs*	*All charges*
Allergy care	**Standard Option**
• Testing and treatment	$50 per course of testing
• Allergy injections	$25 per office visit
Allergy serum	Nothing
Not covered: *Provocative food testing and sublingual allergy desensitization*	*All charges*
Treatment therapies	**Standard Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 42. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit.	$25 per visit to your primary care physician $45 per visit to a participating specialist

Treatment therapies - continued on next page

Benefit Description	You Pay
Treatment therapies (cont.)	**Standard Option**
Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. *See Other services under You need prior Plan approval for certain services on page 16. Please refer to your provider directory for a list of authorized providers for this treatment or contact us at 888-882-8633.*	$25 per visit to your primary care physician $45 per visit to a participating specialist
Physical and occupational therapies	**Standard Option**
Short-term therapy for acute condition for which therapy applied for a consecutive two calendar month period (per condition) can be expected to result in significant improvements for the following: • Qualified physical therapists • Occupational therapists Note: We only cover therapy when a provider orders the care.	$45 per visit to a participating specialist
Cardiac Rehabilitation is covered for the following conditions: • Acute myocardial infarction • Percutaneous transluminal coronary angioplasty (PTCA) • Repair or replacement of heart valve(s) • Coronary artery bypass graft (CABG), or • Heart transplant Coverage is limited to 18 visits per year.	$25 per visit
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*
Speech therapy	**Standard Option**
(When medically necessary.) Short-term speech therapy for acute condition for which therapy applied for a consecutive two calendar month period (per condition) can be expected to result in significant improvement.	$25 per visit to your primary care physician $45 per visit to a participating specialist

Benefit Description	You Pay
Habilitative Services	**Standard Option**
• Coverage for Habilitative Services is covered the same as physical, occupational and speech therapy and includes services for Applied Behavior Analysis.	$25 per visit to primary care physician $45 per visit for physical, occupational and speech therapies
Hearing services (testing, treatment, and supplies)	**Standard Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	Nothing
• External hearing aids (limited to $3,000 per year) and testing to fit them • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, see *Section 5(a) Orthopedic and prosthetic devices.*	20% of the contracted rate (calendar year deductible applies)
Not covered: • *Hearing services that are not shown as covered*	*All charges*
Vision services (testing, treatment, and supplies)	**Standard Option**
• Annual eye refractions to determine the need for vision correction for children through age 17 • Diagnosis and treatment of diseases of the eye Note: See *Preventive care, children* for eye exams for children.	$25 per visit to your primary care physician $45 per visit to a participating specialist
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as cataracts).	$45 per pair
Not covered: • *All other vision testing (eye examinations and refractions)* • *Eyeglasses or contact lenses (including replacement of lenses provided during the same calendar year)* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*

Benefit Description	You Pay
Foot care	**Standard Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$25 per visit to your primary care physician $45 per visit to a participating specialist
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)* • *Podiatric shoe inserts or foot orthotics*	*All charges*
Orthopedic and prosthetic devices	**Standard Option**
• Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • External hearing aids and testing to fit them (External hearing aids limited to $3,000 per year) • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) for Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	20% of the contracted rate (calendar year deductible applies)
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Non orthopedic brace* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Penile implants* • *Prosthetic replacements provided less than 3 years after the last one we covered*	*All charges*

Benefit Description	You Pay
Durable medical equipment (DME)	**Standard Option**
We cover rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Standard wheelchairs • Crutches • Insulin pumps • Ostomy and catheter supplies Note: Coverage for orthotic appliances is limited to leg, arm, back, and neck custom-made braces when related to a surgical procedure or when used in an attempt to avoid surgery and are necessary to carry out normal activities of daily living, excluding sports activities. Coverage is limited to the first such item; repair and replacement is not covered. Note: Call us at 800-882-8633 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	20% of the contracted rate (calendar year deductible applies)
Not covered: • *Medical supplies such as corsets which do not require a prescription* • *Audible prescription reading devices* • *Speech generating devices* • *Motorized wheelchairs* • *Non-standard wheelchairs* • *All other orthotic appliances*	All charges
Home health services	**Standard Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	20% of the contracted rate (calendar year deductible applies)
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family*	*All charges*

Home health services - continued on next page

Benefit Description	You Pay
Home health services (cont.)	**Standard Option**
• *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges*
Chiropractic	**Standard Option**
• Manipulation of the spine and extremities *Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application*	$25 per visit to your primary care physician $45 per visit to a participating specialist
Alternative treatments	**Standard Option**
No benefit	*All charges*
Educational classes and programs	**Standard Option**
Coverage is provided for : Tobacco cessation programs, including individual/group/telephone counseling, and for over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for counseling for up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.
• Diabetes self-management	$25 per visit to your primary care physician $45 per visit to a participating specialist
• Childhood obesity education	Nothing

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The calendar year deductible is: $500 per person ($1,000 per Self Plus One enrollment, or $1,000 per Self and Family enrollment). The calendar year deductible applies to certain benefits in this Section. We added "(Calendar year deductible applies)" to show when the calendar year deductible does apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES**. Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefit Description	You Pay
Note: We state whether or not the calendar year deductible applies for each benefit listed in this Section.	
Surgical procedures	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery)* • Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Surgical treatment of morbid obesity (bariatric surgery) Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$25 per visit billed by your primary care physician $45 per visit billed by a participating specialist

Surgical procedures - continued on next page

Benefit Description	You Pay
Surgical procedures (cont.)	**Standard Option**
Note: Morbid Obesity is a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. 1. Weight loss surgery may be an option for a select group of patients with clinically severe obesity or morbid obesity. When non-evasive methods of weight reduction have been exhausted, surgery will be considered for individuals with a Body Mass Index (BMI) of greater than or equal to 40 or a BMI of 35 or greater, with coexisting conditions. Individuals may qualify for surgery if they have been morbidly obese for a period of five (5) years or more. Morbid obesity is defined as having a BMI in excess of 40 or a BMI in excess of 35 with any of the following severe co-morbidities: coronary heart disease, diabetes mellitus, clinically significant obstructive sleep apnea, and medically refractory hypertension; 2. Member has completed growth (18 years of age or documentation of bone growth completion); 3. Recent psychiatric/psychological evaluation to rule out eating disorder(s) or psychological disturbance, such as Binge Eating Disorder, active drug abuse, active suicidal ideations/thoughts, borderline personality disorder, schizophrenia, terminal illness or uncontrolled depression, which may impede post-operative recovery and dietary restrictions; 4. Documentation (e.g., type, duration, amount of weight loss) of all prior weight control/loss programs including: food supplements, appetite suppressants, dietary regimens/treatments, and exercise programs; 5. Documentation of non-operative, physician supervised integrated weight reduction program consisting of dietary therapy, appropriate exercise, behavior modification and psychological support: Four (4) physician visits are required over a six (6) month period to document supervision; the program must maintain at least a six (6) month duration, within three (3) years of request for surgical intervention.	
• Voluntary sterilization (e.g., tubal ligation, Vasectomy)	Nothing
• Treatment of burns	$100 Copayment

Surgical procedures - continued on next page

Benefit Description	You Pay
Surgical procedures (cont.)	**Standard Option**
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot (see Foot care)*	*All charges*
Reconstructive surgery	**Standard Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect of the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see *Prosthetic devices*) • Gender reassignment surgery including mastectomy, gonadectomy (hysterectomy and oophorectomy in female-to-male and orchiectomy in male-to-female), and genital reconstruction (in female-to-male: vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, and placement of a testicular and erectile prosthesis; in male-to-female: penectomy, vaginoplasty, labiaplasty, and clitoroplasty).	$25 per visit billed by your primary care physician $45 per visit billed by a participating specialist

Reconstructive surgery - continued on next page

Benefit Description	You Pay
Reconstructive surgery (cont.)	**Standard Option**
Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Note: Gender reassignment surgery may be covered when ALL of the following criteria are met: 1. At least one (1) Referral Letter from a qualified Psychologist or Psychiatrist indicating: a. Results of the Member's psychosocial assessment and diagnoses; and b. Documentation and results of the type of evaluation and therapy or counseling to date; and c. Documentation that the World Professional Association for Transgender Health (WPATH) criteria for surgery have been met and the specific clinical rationale for supporting the Member's request for surgery; and 2. Documentation of persistent, well-documented Gender Dysphoria (DSM 5 criteria); and 3. Documentation of Member's capacity to make a fully informed decision and to consent for treatment; and 4. Member is 18 years of age or older; and 5. Documentation of at least 12 months of continuous hormone therapy as appropriate to the Member's gender goals (Note: that a trial of hormone therapy is not a pre-requisite to qualify for a mastectomy.); and 6. Important Note - For those Members requesting genital reconstruction: Two (2) Psychiatric Letters of Referral are needed along with documentation of at least 12 months of living in a gender role that is congruent with their gender identity (real life experience). Important Note: Coverage is limited to in-network AvMed participating providers only. Out of network benefits or exceptions do not apply to coverage of gender reassignment surgery.	

Reconstructive surgery - continued on next page

Benefit Description	You Pay
Reconstructive surgery (cont.)	**Standard Option**
Not covered: • *Feminizing procedures including Rhinoplasty, face-lifting, lip enhancement, facial bone reduction, blepharoplasty, breast augmentation, liposuction of the waist (body contouring), reduction of hyoid (chondroplasty), hair removal, voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing.* • *Masculinizing procedures including chin implants, nose implants, and lip reduction. In addition, the following procedures are not covered: Abdominoplasty, brow lift, calf implants, cheek/ malar implants, chin/nose implants, collagen injections, liposuction, mastopexy, and pectoral implants.*	*All charges*
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Procurement, cryopreservation or storage of embryo, sperm, oocytes for the preservation of fertility and the cryopreservation, storage, and thawing of reproductive tissue (i.e., ovaries, testicular tissue).*	*All charges*
Oral and maxillofacial surgery	**Standard Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. • TMJ (non-dental)	$25 per visit billed by your primary care physician $45 per visit billed by a participating specialist
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Impacted wisdom teeth*	*All charges*

Benefit Description	You Pay
Organ/tissue transplants	**Standard Option**
These **solid organ transplants** are covered. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants • Isolated Small intestine • Small intestine with the liver • Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney/Pancreas • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis Note: Subject to medical necessity and experimental/investigational review by the Plan. See *Other services* under *You need prior Plan approval for certain services* on page 16. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description and can safely tolerate the procedure.	$25 per visit billed by your primary care physician $45 per visit billed by a participating specialist
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	$25 per visit billed by your primary care physician $45 per visit billed by a participating specialist
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed)	$25 per visit billed by your primary care physician $45 per visit billed by a participating specialist

Organ/tissue transplants - continued on next page

Benefit Description	You Pay
Organ/tissue transplants (cont.)	**Standard Option**
- Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow Failure and Related Disorders (i.e. Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia/pediatric • Autologous transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer - Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors • Autogolous tandem transplants for recurrent germ cell tumors (including testicular cancer) Note: Treatment must be approved by the Plan's medical director in accordance with the Plan's protocols. AvMed will request the medical evidence we need to make our coverage determination.	$25 per visit billed by your primary care physician $45 per visit billed by a participating specialist

Organ/tissue transplants - continued on next page

Benefit Description	You Pay
Organ/tissue transplants (cont.)	**Standard Option**
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	$25 per visit billed by your primary care physician $45 per visit billed by a participating specialist

Organ/tissue transplants - continued on next page

Benefit Description	You Pay
Organ/tissue transplants (cont.)	**Standard Option**
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Autologous transplants for: - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Aggressive non-Hodgkin's lymphomas - Breast Cancer - Childhood rhabdomyosarcoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma)	$25 per visit billed by your primary care physician $45 per visit billed by a participating specialist
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	**Standard Option**
Professional services provided in – • Hospital (inpatient) • Outpatient surgery • Office	Nothing

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- The calendar year deductible is: $500 per person ($1,000 per Self Plus One enrollment, or $1,000 per Self and Family enrollment). The calendar year deductible applies to certain benefits in this Section. We added "(Calendar year deductible applies)" when it applies.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification or contact our Member Engagement Center at 800-882-8633.

Benefit Description	You Pay
Note: We state whether or not the calendar year deductible applies for each benefit listed in this Section.	
Inpatient hospital	**Standard Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$300 a day for the first three days per admission (calendar year deductible applies)
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, only if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	Nothing

Inpatient hospital - continued on next page

Benefit Description	You Pay
Inpatient hospital (cont.)	**Standard Option**
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care, except when medically necessary*	*All charges*
Outpatient hospital or ambulatory surgical center	**Standard Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia services Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$300 copay per visit (Calendar year deductible applies)
Extended care benefits/Skilled nursing care facility benefits	**Standard Option**
Extended care benefit: We provide a comprehensive range of benefits for up to 30 post-hospital days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. All necessary services are covered, including: • Bed, board and general nursing care; • Drugs biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor	Nothing
Not covered: Custodial care	*All charges*

Benefit Description	You Pay
Hospice care	**Standard Option**
We provide supportive and palliative care for a terminally ill member in the home or hospice facility. Services include: • Inpatient and outpatient care; • Family counseling These services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.	Nothing
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	**Standard Option**
Local professional ambulance service, including air ambulance, when medically appropriate and ordered or authorized by a Plan doctor.	Nothing

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $500 per person ($1,000 per Self Plus One enrollment, or $1,000 per Self and Family enrollment). The calendar year deductible applies to certain benefits in this Section. We added "(Calendar year deductible applies)" to show when the calendar year deductible does apply.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Emergencies within our service area

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency room. Be sure to tell the emergency room personnel that you are an AvMed member so they can notify AvMed. You or a family member must notify AvMed within 48 hours unless it was not reasonably possible to do so. It is your responsibility to make sure that AvMed has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following admission, unless it was not reasonably possible to notify AvMed within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan Hospital, you will be transferred when medically feasible with any ambulance charges covered in full. Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Emergencies outside our service area

If you need to be hospitalized, AvMed must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify AvMed within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Benefit Description	You Pay
Note: We state whether or not the calendar year deductible applies for each benefit listed in this Section.	
Emergency within our service area	**Standard Option**
• Emergency care at a participating doctor's office	$25 per visit to your primary care physician $45 per visit to your participating specialist
• Emergency care at a participating urgent care center	$40 per visit
• Emergency care at a non-participating urgent care center	$60 per visit
• Emergency care at a hospital emergency room Note: We waive the ER copay if you are admitted to the hospital.	$100 per visit
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	**Standard Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center	$60 per visit
• Emergency care at a hospital emergency room Note: We waive the ER copay if you are admitted to the hospital.	$100 per visit
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	**Standard Option**
Professional ambulance service when medically appropriate. Air ambulance, when medically necessary and preauthorized by Medical Director or Chief Medical Officer. Note: See 5(c) for non-emergency service.	Nothing

Section 5(e). Mental health and substance misuse disorder treatment

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $500 per person ($1,000 per Self Plus One enrollment, or $1,000 per Self and Family enrollment). The calendar year deductible applies to certain benefits in this Section. We added "(Calendar year deductible applies)" to show when the calendar year deductible does apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR CERTAIN SERVICES.** Benefits are payable only when it is determined that the care is clinically appropriate to treat your condition and only when you receive the care as part of an approved treatment plan. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process. To obtain preauthorization of an admission for mental/behavioral health conditions or substance abuse, call Magellan Healthcare, Inc. at 800-424-4810.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You Pay
Note: We state whether or not the calendar year deductible applies for each benefit listed in this Section.	
Professional services	**Standard Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance misuse disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	$25 per visit to your primary care physician $45 per visit to a participating specialist
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits)	$25 per visit to your primary care physician $45 per visit to a participating specialist

Professional services - continued on next page

Benefit Description	You Pay
Professional services (cont.)	**Standard Option**
• Diagnosis and treatment of alcoholism and drug misuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy • Applied Behavioral Analysis services	$25 per visit to your primary care physician $45 per visit to a participating specialist
Diagnostics	**Standard Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance misuse disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	$25 per visit to your primary care physician $45 per visit to a participating specialist 20% of the contracted rate (calendar year deductible applies)
Inpatient hospital or other covered facility	**Standard Option**
Inpatient services provided and billed by a hospital or other covered facility Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	$300 a day for the first three days per admission (Calendar year deductible applies)
Outpatient hospital or other covered facility	**Standard Option**
Outpatient services provided and billed by a hospital or other covered facility Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	$300 per visit (Calendar year deductible applies)

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the page 56.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- AvMed cannot accept return of unopened medications and the member cannot receive a refund. There is a Federal law that prevents a pharmacy from accepting returned, unused medications.
- The calendar year deductible is: $500 per person ($1,000 per Self Plus One enrollment, or $1,000 per Self and Family enrollment). The calendar year deductible applies to certain benefits in this Section. We added "(Calendar year deductible applies)" to show when the calendar year deductible does apply.
- **YOU MUST GET PREAUTHORIZATION FOR CERTAIN SERVICES.** Authorization may be required before some medications are dispensed. Authorization criteria are reviewed and approved by AvMed's Pharmacy and Therapeutics Committee. Approval must be obtained from AvMed by the prescribing physician. The list of medications requiring authorization is subject to periodic review and modification by AvMed. A copy of the list of medications requiring authorization and their authorization criteria are available from the Member Engagement Center 800-882-8633.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy or by mail for a maintenance medication. All Specialty medications must be filled by our plan Specialty pharmacy through the mail. Please see our website for a list of all AvMed contracted pharmacies or call the Member Engagement Center at 800-882-8633 for more information.
- **We use a Formulary.** The Formulary establishes four levels of copayment for medications and is updated monthly. A copy of the list is available from the Member Engagement Center at 800-882-8633. Levels of copayment are, in general, applied as follows:

Four-Tier Covered Therapeutic Classes

Tier 1 Lowest copay for Preferred Generic medications

Tier 2 Middle copay for Preferred Brand medications

Tier 3 Highest copay for Non-preferred Brand and Non-preferred Generic medications

Tier 4 Coinsurance for Specialty medications

Preferred Brand medications are determined by AvMed's Pharmacy and Therapeutics Committee and are evaluated based on clinical efficacy, relative safety and cost to the plan in comparison to similar medications within a therapeutic class. Pharmacy and Therapeutics Committee decisions are published in the Physician's Update which is distributed quarterly. Rarely, medications may be excluded in a regulated therapeutic class. These are medications that offer no clinical or financial advantage compared with other medications in that therapeutic class and are not covered. As new medications in a covered therapeutic class become available, they may be considered excluded until they have been reviewed by AvMed's Pharmacy and Therapeutics Committee.

- **These are the dispensing limitations.** Your Prescription Medication coverage may require Prior Authorization, including the Progressive Medication Program, for certain covered medications. The Progressive Medication Program encourages the use of therapeutically-equivalent lower-cost medications by requiring certain medications to be utilized to treat a medical condition prior to approving another medication for that condition. This includes the first-line use of preferred medications that are proven to be safe and effective for a given condition and can provide the same health benefit as more expensive non-preferred medications at a lower cost.
  - Your Retail prescription medication coverage includes up to a 30-day supply of a medication for the listed Co-payment. Your prescription may be refilled via retail or mail order after 75% of your previous fill has been used and subject to a maximum of 13 refills per year. You also have the opportunity to obtain a 90-day supply of medications used for chronic conditions including, but not limited to asthma, cardiovascular disease, and diabetes from the retail pharmacy for the applicable co-payment per 30-day supply. To ensure you tolerate a new medication and limit waste, you must fill a new medication for a 30-day supply first before you can fill a 90-day supply at Retail.
  - Your Mail-order prescription medication coverage includes up to a 90-day supply of a routine maintenance medication. If the amount of medication is less than a 90-day supply, you will still be charged the listed mail order Co-payment.
  - Your Specialty medication coverage extends to many high cost self-injectable and oral medications approved by the FDA. These medications must be prescribed by a physician and dispensed by a participating specialty pharmacy. Specialty Medications are limited to a 30-day supply and Prior Authorization is often required.
- **Why use Generic drugs?** Generic drugs provide a lower cost alternative to name brand drugs. Generic drugs contain the same active ingredients as name brand drugs. They undergo a strict review process by the U.S. Food and Drug Administration to determine they meet the same standards of quality and strength as name brand drugs.
- **A generic equivalent will be dispensed if it is available,** unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- **When you do have to file a claim.** If you need a prescription before you receive your Membership card, you can fill the prescription at a participating pharmacy and submit the receipt and a copy of the prescription to AvMed for reimbursement. Claims for reimbursement are subject to all definitions, limitations and exclusions in this brochure and AvMed's authorization criteria, when applicable. The applicable copayment amount will be subtracted from the reimbursement. Please indicate your AvMed Member ID Number on the receipt. See Section 7 for specific information.

Benefit Description	You Pay
Note: We state whether or not the calendar year deductible applies for each benefit listed in this Section.	
Covered medications and supplies	**Standard Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin • Diabetic supplies limited to: - Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (Prior authorization required). Coverage is limited; contact AvMed for dose limits. You pay the corresponding drug copayment up to the dosage limit and all charges above that. • Growth hormone medication Note: Growth hormone therapy is covered under the medical benefit. Note: We only cover growth hormone medication when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. *See Other services under You need prior Plan approval for certain services on page 16. Please refer to your provider directory for a list of authorized providers for this treatment or contact us at 888-882-8633.* Your Specialty medication prescription coverage includes the quantity sufficient to treat the acute phase of an illness or established by the manufacturers packaging guidelines but not more than a 30 day supply per coinsurance or actual cost, whichever is less. Note: We have an out-of-pocket maximum of $2,500 per member per calendar year on the Specialty medication benefit.	Retail Drugs $10 Generic Drugs (Tier 1) $40 Preferred Brand Name Drugs (Tier 2) $60 Non-Preferred Brand Name and Generic Drugs (Tier 3) 30% coinsurance Specialty Medication (Tier 4) Mail Order Drugs $30 Generic Drugs (Tier 1) $120 Preferred Brand Name Drugs (Tier 2) $180 Non-Preferred Brand Name and Generic Drugs (Tier 3) Note: If there is no generic equivalent available, you will still have to pay the brand name copay.

Covered medications and supplies - continued on next page

Benefit Description	You Pay
Covered medications and supplies (cont.)	**Standard Option**
Note: Mail service is a benefit option for maintenance medications needed for chronic or long-term health conditions. It's best to get an initial prescription filled at your retail pharmacy. Ask your physician for an additional prescription for up to a 90-day supply of your medication to be ordered through mail service. Pay the following copayment (as well as the cost difference if you or your physician choose a name Brand drug when there is an FDA-approved Generic).	Retail Drugs $10 Generic Drugs (Tier 1) $40 Preferred Brand Name Drugs (Tier 2) $60 Non-Preferred Brand Name and Generic Drugs (Tier 3) 30% coinsurance Specialty Medication (Tier 4) Mail Order Drugs $30 Generic Drugs (Tier 1) $120 Preferred Brand Name Drugs (Tier 2) $180 Non-Preferred Brand Name and Generic Drugs (Tier 3) Note: If there is no generic equivalent available, you will still have to pay the brand name copay.
• Medical foods for children with inborn errors of metabolism up to age 24, or age 14 for Organic Acid Disorders (OAD) and Amino Acid Disorders (AAD). Note: Medical foods are foods that are specifically formulated and intended for the dietary management of a disease that has distinctive nutritional needs that cannot be met by normal diet alone. Prescription is required. Note: Limited to $2,500 per calendar year.	20% of the contracted rate (calendar year deductible applies)
Vitamin D for adults 65 and older Women's contraceptive drugs and devices Note: Over-the-counter contraceptive drugs and devices approved by the FDA require a written prescription by an approved provider.	Nothing
Here are some things to keep in mind about our prescription drug program: • When you have a prescription filled, a Generic equivalent to a name Brand drug will be dispensed. If you or your physician choose a name Brand drug when there is a FDA-approved Generic equivalent to that name Brand drug, you have to pay the difference in cost between the name Brand drug and the Generic drug plus the applicable Brand copayment. For name Brand drugs that do not have an FDA-approved Generic equivalent you will pay the applicable Brand copayment.	

Benefit Description	You Pay
Preventive care medications	**Standard Option**
The following drugs and supplements are covered, even if over-the-counter, if prescribed by a health care professional and filled at a network pharmacy. • Aspirin (81 mg) for men 45-79 and women age 55-79 and women of childbearing age. • Folic acid supplements for women of childbearing age 400 & 800 mcg • Liquid iron supplements for child age 0-1 year • Vitamin D supplements (prescription strength) (400 & 1000 units) for members 65 or older • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 • Statin use for the Primary Prevention of Cardiovascular Disease for adults aged 40 to 75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater. Note: To receive this benefit a prescription from a doctor must be presented to pharmacy. *Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit and we require a written prescription by an approved provider. (See page 36.)*	Nothing
Not covered: • *Drugs and supplies for cosmetic purposes.* • *Drugs to enhance athletic performance.* • *Fertility drugs.* • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies.* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them.* • *Nonprescription medicines or medicines for which there is a nonprescription alternative.* • *Medical supplies, including therapeutic devices, dressings, antiseptics, appliances, and support garments.* • *Compounded prescriptions, except pediatric preparations.* • *Prescription and non-prescription appetite suppressants and products for the purpose of weight loss.*	All charges

Preventive care medications - continued on next page

Benefit Description	You Pay
Preventive care medications (cont.)	**Standard Option**
• *Medications for non-business related travel, including transdermal scopolamine, i.e. motion sickness patches.* • *Replacement prescription products resulting from a lost, stolen, expired, broken, or destroyed prescription orders for refill.* • *Medications that require preauthorization and for which preauthorization is denied or not obtained by a physician.* • *Medications for dental purposes, including fluoride medications, antibiotics and pain medications for dental care.*	All charges

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- Plan dentists must provide or arrange your care.
- T**he calendar year deductible is: $500 per individual ($1,000 per Self Plus One enrollment, or $1,000 per Self and Family enrollment). The calendar year deductible applies to certain benefits in this Section. We added "(Calendar year Deductible applies)" when it applies.**
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay
Accidental injury benefit	**Standard Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	Nothing
Dental benefits	**Standard Option**
We have no other dental benefits.	All charges

Section 5(h). Wellness and Other Special Features

Flexible benefits Option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call 888-866-5432 and talk with a registered nurse who will discuss treatment options and answer your health questions.
Centers of Excellence for transplant/heart/surgery, etc.	Consult the Member Engagement Center, at 800-882-8633 to obtain a complete list of centers.
Disease Management	As part of our Healthy Living Programs, AvMed provides Disease Management for the following conditions: • COPD (Chronic Obstructive Pulmonary Disease) • CAD (Coronary Artery Disease) • Heart failure • Diabetes • Asthma You may call us at 855-812-8633 if you wish to learn more about our Disease Management programs.
Wellness Program	AvMed has a comprehensive and engaging Wellness Program that will assist you to embrace better health. The program provides you with online tools that include a Personal Health Assessment (PHA), a personal Scorecard detailing your health status, e-courses, health centers and a printable library with additional self-management tools to enhance your healthy living. The Wellness Program can help you with: • Changing health risks, with and without a chronic illness • Weight management (nutrition and exercise) • Tobacco cessation

	• Stress management • Pre-diabetes • Metabolic syndrome • Sleep In addition, through our partnerships we provide you with: • Weight Watchers discounts and reimbursements • The ChooseHealthy Program: where you can get up to 25% off services from more than 33,000 contracted chiropractors, acupuncturists, massage therapists and registered dieticians. You can also shop from an online catalog of discounted health and wellness products, all with free shipping. Log onto our website at www.avmed.org to access the Wellness Program. Click on **Health and Wellness**, and find all these resources and more under **Tools for a Healthier You**.
AvMed Member Engagement Center	Every AvMed member has a friend in our Member Engagement Center, we are open Monday - Friday from 8 a.m. to 8 p.m. and on Saturdays from 9 a.m. to 1 p.m.. Representatives are here for you to answer questions regarding benefits, claims, changing physicians – anything involving your AvMed membership. Next to health care coverage itself, every satisfaction survey tells us this is every member's most valued service. Contact them at members@avmed.org or call 800-882-8633.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 800-882-8633 or visit their website at www.avmed.org.

AvMed Value Added Services:

Massage Therapy, Yoga, Acupuncture & etc.	AvMed's partnership with Healthways WholeHealth, the nation's leading alternative health management company, brings to you up to 30% off non-traditional services in your area. To locate a practitioner, go to www.avmed.org, click on **Health and Wellness**, and find the **WholeHealth Network** link under **Tools for a Healthier You.**
Weight Watchers	Monthly discounts and full reimbursement for up to one year of Weight Watchers fees once you reach your goal weight. For the form to register, go to www.avmed.org, click on **Health and Wellness**, and find the Weight Watchers **It pays to lose** link under **Tools for a Healthier You**.
Tobacco Cessation	AvMed offers a variety of smoking cessation resources and tools. You can go to www.avmed.org, click on Health and Wellness, and find the **Want to quit smoking? AvMed can help** link under **Embrace Better Health**. In addition, under **Tools for a Healthier You**, click on **Wellness portal powered by Healthyroads**, for additional resources under **Tools** like how to overcome symptoms and cravings.
Vitamins and Health and Beauty Magazines	Great pricing on vitamin packages and health and beauty magazines available to AvMed members through our partner, Healthways WholeHealth Inc. Go to www.avmed.org, click on **Health and Wellness**, and find the **WholeHealth Network** link under **Tools for a Healthier You**. Scroll to the bottom of the main page to view these discounts!
AvMed's Nurse On Call	24-hour telephone line where you can speak confidentially with a registered nurse about any health concern. 888-866-5432.
Expanded vision care	Discounts on vision services are available to AvMed members. Services include: Eye exams, Eyeglasses, Contact lenses, Designer glasses, sunglasses, etc. To find a provider in your area, call the AvMed Member Engagement Center any hour of any day at 800-882-8633 or e-mail us at members@avmed.org.
Individual Plans	AvMed has medically underwritten individual coverage plans available in Miami-Dade, Broward and Palm Beach Counties, Florida. For more information call 800-390-9355 or visit our website at www.avmed.org/individual.

Medicare prepaid plan enrollment – This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated in Section 9, annuitants and former spouses with FEHB coverage and Medicare Part A and Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later re-enroll in the FEHB program. Most Federal annuitants have Medicare Part A. Before you join the Plan, ask whether the Plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on changing your FEHB enrollment and changing to Medicare prepaid plan. Contact us at 800-535-9355 for information on the Medicare prepaid plan and the cost of that enrollment.

If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB Plan, call 800-535-9355 for information on the benefits available under the Medicare HMO.

Section 6. General exclusions – services, drugs and supplies we don't cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3** ***When you need prior Plan approval for certain services.***

We do not cover the following:

- Care by non-plan providers except for emergencies (see *Emergency services/accidents*)
- Services, drugs, or supplies you receive while you are not enrolled in this Plan
- Services, drugs, or supplies not medically necessary
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants)
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program
- Services, drugs, or supplies you receive without charge while in active military service
- Services or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider.

If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 800-882-8633, or at our website at www.avmed.org.

When you must file a claim – such as for services you received outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the physician or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to: 9400 South Dadeland Blvd., Suite 200, Miami, FL 33156, 800-882-8633, www.avmed.org

Prescription drugs

Submit your claims to: 9400 South Dadeland Blvd., Suite 200, Miami, FL 33156, 800-882-8633, www.avmed.org

Other supplies or services

Submit your claims to: 9400 South Dadeland Blvd., Suite 200, Miami, FL 33156, 800-882-8633, www.avmed.org

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The disputed claims process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit http://www.avmed.org/fehbclaims/.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, drugs, or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing 9400 South Dadeland Blvd., Suite 200, Miami, FL 33156 or calling 800-882-8633.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: AvMed Member Relations, P.O. Box 749, Gainesville, FL 32602-0749; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or

c) Ask you or your provider for more information

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 800-882-8633. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at 202-606-0737 between 8 a.m. and 5 p. m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.avmed.org.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

- **TRICARE and CHAMPVA**

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

When others are responsible for injuries

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone at 877-888-3337 (TTY 877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this plan.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan does not cover these costs.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

- **What is Medicare?**

Medicare is a health insurance program for:

- People 65 years of age or older

- Some people with disabilities under 65 years of age
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure.
- For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 800-772-1213 (TTY: 800-325-0778).

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage.

It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payer, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 800-882-8633 or see our website at www.avmed.org.

We do not waive any costs if the Original Medicare Plan is your primary payer.

Please review the following table - it illustrates your cost share if you are enrolled in Medicare Part B. Medicare will be primary for all Medicare eligible services. Members must use providers who accept Medicare's assignment.

Benefit Description	Member Cost without Medicare	Member Cost with Medicare Part B
Deductible	$500 individual / $1,000 family	$500 individual / $1,000 family
Out of Pocket Maximum	$4,500 self only / $9,000 family	$4,500 self only / $9,000 family
Primary Care Physician	$25	$25
Specialist	$45	$45
Inpatient Hospital	$300 a day for the first three days per admission	$300 a day for the first three days per admission
Outpatient Hospital	$300 copay per visit	$300 copay per visit
Rx	Tier 1 -$10 Tier 2 -$40 Tier 3 -$60 Tier 4 -Specialty (30 day supply) 30% coinsurance - OOP Maximum of $2,500	Tier 1 -$10 Tier 2 -$40 Tier 3 -$60 Tier 4 -Specialty (30 day supply) 30% coinsurance - OOP Maximum of $2,500
Rx–Mail Order (90 day supply)	3x retail copay	3x retail copay

You can find more information about how our plan coordinates with Medicare in the "Medicare & You" publication at http://www.medicare.gov/publications/pubs/pdf/10050.pdf.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (800-633-4227) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Medicare Advantage plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments for your FEHB coverage.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers).

However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical Trials Cost Categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan does not cover these costs.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 21.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 21.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

Services and supplies that are furnished mainly to train or assist in the activities of daily living, such as bathing, feeding, dressing, walking and taking oral medicines. "Custodial Care" also means services and supplies that can be safely and adequately provided by persons other than licensed health care professionals, such as dressing changes and catheter care or that of ambulatory patients customarily provide for themselves, such as ostomy care, measuring and recording urine and blood sugar levels, and administering insulin. Custodial care that lasts 90 days or more is sometimes know as Long Term Care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 21.

Experimental or investigational service

The Plan's experimental/investigational determination process is based on authoritative information from medical literature, medical consensus bodies, FDA approval, clinical trials, and health care professionals with specialty expertise in the subject.

Group health coverage

The form of health insurance covering groups of persons under a master group health insurance policy issued to any one group.

Health Care Professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Medical necessity The use of any appropriate medical treatment, service, equipment and/or supply as provided by a hospital, skilled nursing facility, physician or other provider which is necessary for the diagnosis, care and/or treatment of a Member's illness or injury.

Plan allowance Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows:

- Network Providers - we negotiate rates with doctors and other health care providers to help save you money. We refer to these providers as "Network Providers". These negotiated rates are our Plan allowance for network providers. We calculate a member's coinsurance using these negotiated rates. The member is not responsible for amounts that are billed by network providers that are greater than our Plan allowance.

Post-service claims Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims Those claims (1) that require precertification or prior approval and (2) where failure to obtain precertification or prior approval results in a reduction of benefits.

Reimbursement A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Subrogation A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

Urgent care claims A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 800-882-8633. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We Us and We refer to AvMed.

You You refers to the enrollee and each covered family member.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no Government contribution.

Important information about Four Federal programs that complement the FEHB program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

Fourth, the **Federal Employees' Group Life Insurance Program (FEGLI)** can help protect your family from burdensome funeral costs and the unexpected loss of your income.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,600. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

  FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to out-of-pocket dental and vision care expenses for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible non-medical day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an **HCFSA** or **LEX HCFSA** and/or **DCFSA**, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 877-FSAFEDS, 877-372-3337 (TTY, 1-866-353-8058), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time.

The Federal Employees Dental and Vision Insurance Program –*FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.**

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and X-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 12-month waiting period. **Most FEDVIP dental plans cover adult orthodontia but may be limited. Review your FEDVIP dental plan's brochure for information on this benefit.**

Vision Insurance

All vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/dental and www.opm.gov/vision. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 877-888-3337 (TTY: 877- 889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection	The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. Long term care can be received in your home, in a nursing home, in an assisted living facility or in adult day care. You must apply, answer health questions, and be approved for enrollment. Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Your qualified relatives can apply even if you do not. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. To request an Information Kit and application, call 800-LTC-FEDS (800-582-3337), (TTY: 800-843-3557), or visit www.ltcfeds.com.

The Federal Employees' Group Life Insurance Program - FEGLI

Peace of Mind for You and Your Family	The Federal Employees' Group Life Insurance Program (FEGLI) can help protect your family from burdensome funeral costs and the unexpected loss of your income. You can get life insurance coverage starting at one year's salary to more than six times your salary and many options in between. You can also get coverage on the lives of your spouse and unmarried dependent children under 22. You can continue your coverage into retirement if you meet certain requirements. For more information, visit www.opm.gov/life.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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Summary of benefits for the Standard Option of AvMed - 2018

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- Below, an asterisk (*) means the item is subject to the $500 per individual ($1,000 Self Plus One, or $1,000 Self and Family) calendar year deductible.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $25 primary care; $45 specialist	26
Services provided by a hospital:		
• Inpatient	$300 * per day for the first three days of admission up to a $900 maximum	46
• Outpatient	$300 * per visit	47
Emergency benefits:		
• In-area	$100 per visit (copayment waived if admitted)	50
• Out-of-area	$100 per visit (copayment waived if admitted)	50
Mental health and substance abuse treatment:	Regular cost sharing	51
Prescription drugs:		
• Retail pharmacy	Generic $10, Preferred Brand $40, Non-Preferred Brand $60, Specialty medications 30% coinsurance	55
• Mail order	Generic $30, Preferred Brand $120, Non-Preferred Brand $180, No 4th Tier	55
Dental care:	No benefit.	59
Vision care: Refractions, including lens prescriptions, limited to children through age 17.	$45 per visit to a participating specialist	33
Special features: Flexible benefit option, 24-hour nurse line, Disease Management, Centers of Excellence	Special features described in Section 5(h).	60
Protection against catastrophic costs (out-of-pocket maximum)**:** We have an out-of-pocket maximum of $2,500 per member per calendar year on the injectable drug benefit.	Nothing after $4,500/Self only, $9,000 Self Plus One, or $9,000 Self and Family enrollment per year Some costs do not count toward this protection	21

2018 Rate Information

For 2018 FEHB plan premium information, please see:

https://www.opm.gov/healthcare-insurance/tribal-employers/benefits-premiums/ or contact your tribal employer's Human Resources department.