Avalon Secure Medicare Supplement Reference Guide

This document only provides general information on your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company. This document does not give all the details of the Medicare coverage. Contact your local Social Security Office or consult Medicare and You for more details.

AV-204 (10/31/22)

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Thank you for choosing Avalon! We go the extra mile for you.

Avalon® Insurance Company (Avalon) aims to simplify, with easy and reliable insurance products for individuals. We offer simple, smart and practical insurance solutions in our Medicare Supplement Plans.

We hope this information will help make using your benefits easier by putting contact information and useful tips together in an easy-to-reference guide.

What your plan covers

Original Medicare pays for most of your hospital (Part A) and medical (Part B) expenses, but does not cover the full extent of your out-of-pocket costs. Medicare Supplement policies help with the remaining out-of-pocket costs that Original Medicare does not cover. Medicare Supplements are standardized policies, there are 10 plan types identified by specific letters, in most states.

Each standardized “letter” plan offers basic benefits that help cover the hospital (Part A) and medical (Part B) out-of-pocket costs. Some of the Medicare Supplement plan options cover additional benefits such as foreign travel coverage or coverage for Part B excess charges.

The chart below lists the current Avalon Secure Medicare Supplement plans we offer, and provides an overview of the benefits and out-of-pocket cost covered by the different plans (e.g., Plan A, B, N). To find which Avalon Secure Medicare Supplement plan that you are enrolled in please refer to your ID card (for additional information on your ID card please refer to page four of this guide).

Benefits	**Plans available to all applicants**				**Medicare first eligible before 2020 only**	
(Note: A ✓ means 100% of the benefit is paid.)	A	B	G	N	C	F
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓ copays apply*	✓	✓
Blood (first three pints)	✓	✓	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	✓	✓
Medicare Part B deductible					✓	✓
Medicare Part B excess charges			✓			✓
Foreign travel emergency (up to plan limits)			✓	✓	✓	✓

*Plan N requires a $20 copayment for office visits and $50 copayment for emergency room visits that do not result in an inpatient admission.

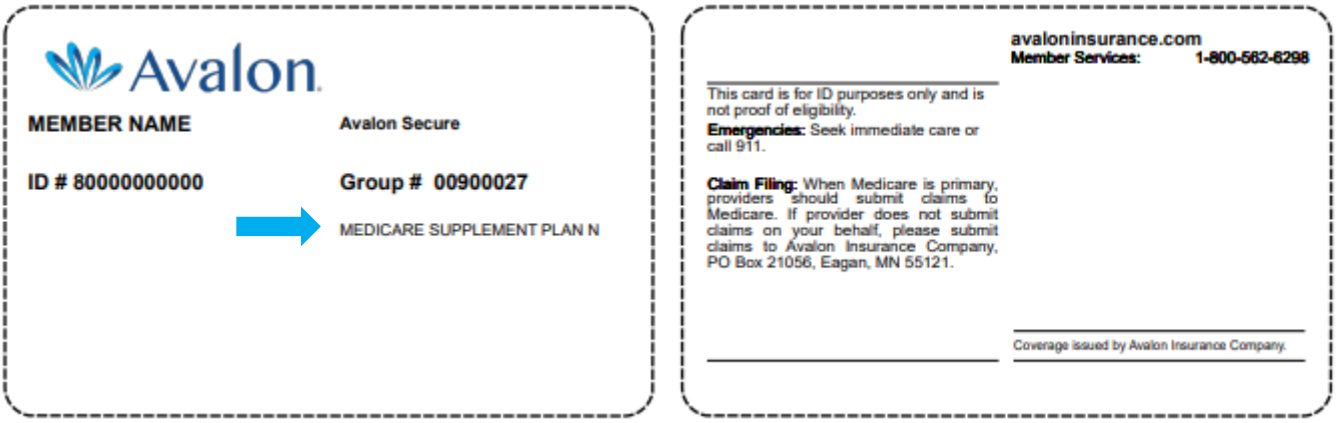
IMPORTANT NOTE: Plan C and Plan F are only available to individuals who were first eligible for Medicare Part A and B, prior to January 1, 2020. If you are currently enrolled in Plan C or Plan F you are able to remain enrolled in these plans.

The Medicare Part A deductible and coinsurance, skilled nursing facility coinsurance, and Part B deductible may increase on an annual basis. As a member of an Avalon Secure Plan, you will receive a notice of change

mailing in December that will provide you the updated out-of-pocket amounts that are covered for the following year.

ID card

A sample Medicare Supplement ID card is illustrated below. Your member ID number is listed beneath your name, and you can determine which plan you are on by referencing the bottom right corner of the card. If you have further questions about your plan, please reach out to Member Services.



Using your coverage

Medicare Supplement members must remain enrolled in Medicare Parts A and B. When you use medical services, you should bring your Original Medicare card in addition to your Avalon Secure Medicare Supplement ID card to your appointment. You should present both cards at the point of service, so your claims can be processed appropriately. When receiving Medicare approved services, Medicare pays as the primary insurance, and the Medicare Supplement functions as the secondary payer, assisting with the remaining out-of-pocket costs (depending on your plan) that Original Medicare does not cover.

NOTE: If Original Medicare does not cover a hospital or medical service then your Medicare Supplement plan will not cover that service either.

Provider network

One of the advantages of having a Medicare Supplement is that members can receive treatment from any medical provider* for medically necessary Medicare covered services. Some providers do not accept Medicare, and although members can still see these providers, they may be liable to pay a Part B excess charge. Part B excess charges occur when a provider does not accept Medicare assignment. In this instance, the nonparticipating provider may charge up to 115% of the Medicare rate. Some Medicare Supplement policies, such as Plan F and G, cover the member for any potential Part B excess charges as well.

***NOTE:** If a provider opts out of Medicare or is not an eligible Medicare provider then Original Medicare nor the Avalon Secure Medicare Supplement plan will pay for these services.

Preventive services

Avalon encourages members to take control of their health with preventive medical care. These benefits are designed to prevent or diagnose common health conditions before they can become serious. There is typically no coinsurance, copayment, or deductible for members eligible for preventive screenings when they see a Medicare provider. To verify your cost share for preventive services please check with your healthcare provider beforehand. Preventive screenings are used for people with no symptoms of the disease and who have not been previously diagnosed. Additional cost-sharing may apply if your doctor provides other services at the same time as your preventive screening.

Remote visits

Original Medicare covers a variety of remote medical services through mediums such as telehealth, virtual check-ins, and e-visits. You can schedule an appointment with your provider or health professional by phone or online when in-office access is unavailable or you are unable to get to the office.

Telehealth includes certain medical or health services that are provided by a doctor or other health care provider who’s located elsewhere using audio and video communication technology, like your phone or a computer.

You can get certain Medicare covered telehealth services without being in a rural health care setting, including:

- Monthly End-Stage Renal Disease (ESRD) visits for home dialysis.
- Services for diagnosis, evaluation, or treatment of symptoms of an acute stroke wherever you are, including in a mobile stroke unit.
- Services to treat a substance use disorder or a co-occurring mental health disorder (sometimes called a "dual disorder") in your home.

Things to know:

- You can get Medicare telehealth services at renal dialysis facilities and at home.
- You can get Medicare telehealth services for certain emergency department visits at home.
- You can get certain physical and occupational therapy services at home.
- Medicare covers some services delivered via audio only devices.

Virtual check-ins allow you to talk to your doctor or certain other practitioners, like nurse practitioners or physician assistants, using audio and video communication technology, like your phone or a computer without going to the doctor’s office.

Your doctor or other practitioner can respond to you using:

- Phone.
- Audio/visit.
- Secure text messages.
- Email.
- Use of a patient portal.

Things to know:

- You must talk to your doctor or other practitioner to start these types of visits.
- The communication must not be related to a medical visit within the past seven days and must not lead to the medical visit within the next 24 hours (or the soonest appointment available).
- You must verbally consent to the virtual check-in, and your consent must be documented in your medical record. Your doctor may obtain a single consent for a year's worth of these services.

E-visits allow you to talk to your doctor using an online patient portal without going to the doctor's office.

Practitioners who may furnish these services include:

- Doctors.
- Nurse practitioners.
- Physician assistants.
- Licensed clinical social workers, in specific circumstances.
- Clinical psychologists, in specific circumstances.
- Physical therapists.
- Occupational therapists.
- Speech language pathologists.

Things to know:

- You must talk to your doctor or other practitioner to start these types of visits.

Check with your healthcare provider(s) to see if they offer telehealth services. Regular cost-shares and deductibles may apply, as applicable for a face-to-face office visit.

Original Medicare is the primary insurer for these services, if you have additional questions about what is covered please contact **800.MEDICARE**. If a provider is able to bill for the remote medical services the provider will bill Medicare as the primary insurer and the Medicare Supplement plan will pick up the 20% coinsurance once the Part B deductible is met, if applicable for your plan.

What your policy does not cover

Long term care

Generally, Medicare Supplement policies do not cover long term care (like nonskilled care you get in a nursing home), assisted living, custodial (personal care), adult day care, or private duty nursing.

Dental and Vision

Medicare Supplement policies do not include routine dental services like teeth cleanings or coverage for comprehensive services like fillings or simple extractions. These plans only cover dental services that are considered medically necessary under Part B medical benefits.

Similarly, routine vision services for the purposes of gauging the quality of one's vision are not Medicare covered services. Medicare covers medically necessary vision procedures, addressing medical conditions and diseases of the eyes such as cataracts and glaucoma.

Prescription drug coverage

Although some Medicare Supplement policies sold in the past covered prescription drugs, Medicare Supplement policies sold after January 1, 2006, aren't allowed to include prescription drug coverage. Medicare requires all Medicare beneficiaries to have credible prescription drug coverage, and individuals may be penalized if they have a lapse in drug coverage spanning 63 days or longer. Part D prescription drug coverage can be purchased during certain times of the year such as the Annual Enrollment Period or during a Special Enrollment Period, however a late enrollment penalty may apply if an individual did not have creditable prescription drug coverage.