The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. Please read the FEHB Plan brochure **(RI 73-899)** that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure**. Benefits may vary if you have other coverage, such as Medicare. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can get the FEHB Plan brochure at www.MedMutual.com/feds, and view the Glossary at www.MedMutual.com/feds . You can call **1-800-315-3144** to request a copy of either document.

Important Questions	Answers			Why This Matters:
	WellFlex Tier 1	**SuperMed Tier 2**	**Out-of-Network Tier 3**	
What is the overall **deductible?**	$ **500**/Self Only $ **1000**/Self Plus One $ **1000**/Self and Family	$ **1500**/Self Only $ **1500**/Self Plus One $**3000**/Self and Family	$ **4000**/Self Only $ **8000**/Self Plus One $ **8000**/Self and Family	Generally, you must pay all of the costs from providers up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your **deductible?**	**Yes.** Certain **preventive care** and all services with **copayments** are covered and paid by the **plan** before you meet your **deductible**.	**Yes.** Certain **preventive care** and all services with **copayments** are covered and paid by the **plan** before you meet your **deductible**.	**Yes.** Certain **preventive care** and all services with **copayments** are covered and paid by the **plan** before you meet your **deductible**	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost sharing** and before you meet your **deductible.** See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other **deductibles** for specific services**?**	No	No	No	You don't have to meet **deductibles** for specific services
What is the **out-of-pocket** limit for this **plan?**	$ **6,000**/Self Only $ **12,000**/Self Plus One $ **12,000**/Self and Family	**$ 8,500**/Self Only $ **17,000**/Self Plus One $ **17,000**/Self and Family	. $ **12,000**/Self Only $ **24,000**/Self Plus One $ **24,000**/Self and Family	The **out-of-pocket limit** or catastrophic maximum, is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met

What is not included in the **out-of-pocket limit?**	**Premiums**, balance-billed charges and health care this **plan** doesn't cover.	**Premiums**, balance-billed charges and health care this **plan** doesn't cover.	**Premiums**, balance-billed charges and health care this **plan** doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit.**
. Will you pay less if you use a **network provider**?	**Yes.** See **MedMutual.com/Feds** or call **1-800-315-3144** for a list of **network** providers.	**Yes.** See **MedMutual.com/Feds** or call **1-800-315-3144** for a list of network providers.	**Yes**. See. **MedMutual.com/Feds** or call **1-800-315-3144** for a list of network providers	This plan uses specific provider **networks for Tier 1** (Wellflex Network) and **Tier 2.** (SuperMed Network) You will pay less if you use a provider in the **plan's network.** You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the provider's charge and what your plan pays **(balance billing).** Be aware, your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	No	No	No	You can see the **specialist** you choose without a **referral**.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 WellFlex Network Provider (You will pay the least)	Tier 2 SuperMed Network Provider	Tier 3 Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay	35% **coinsurance**	50% **coinsurance**	None
	Specialist visit	$50 copay	35% **coinsurance**	50% **coinsurance**	None
	Preventive care/screening/ immunization	No charge	No charge	No charge	You may have to pay for services that aren't preventive. Ask your **provider** if the services you need are preventive. Then

For more information about limitations and exceptions, see the FEHB Plan brochure 73-899 at www.MedMutual.com/feds.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 WellFlex Network Provider (You will pay the least)	Tier 2 SuperMed Network Provider	Tier 3 Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
					check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% **coinsurance**	35% **coinsurance**	50% **coinsurance**	None
	Imaging (CT/PET scans, MRIs)	20% **coinsurance**	35% **coinsurance**	50% **coinsurance**	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].com	Tier 1 Generic drugs – retail	$5 copay	Does not apply	Does not apply	Covers up to a 30-day supply. Prescriptions must be filled at a Walgreens Advantage Network Pharmacy
	Tier 1 Generic drugs – mail order	$10 copay	Does not apply	Does not apply	Covers up to a 90-day supply
	Tier 2 Non-Preferred brand drugs - retail	40% up to $250 max per prescription or refill	Does not apply	Does not apply	Covers up to a 30-day supply. Prescriptions must be filled at a Walgreens Advantage Network Pharmacy
	Tier 2 Non-Preferred brand – mail order	40% up to $500 max per prescription or refill	Does not apply	Does not apply	Covers up to a 90-day supply
	Tier 3 – Preferred brand - retail	60% up to $350 max per prescription or refill	Does not apply	Does not apply	Covers up to a 30-day supply. Prescriptions must be filled at a Walgreen's Advantage Network Pharmacy

For more information about limitations and exceptions, see the FEHB Plan brochure 73-899 at www.MedMutual.com/feds.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 WellFlex Network Provider (You will pay the least)	Tier 2 SuperMed Network Provider	Tier 3 Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
	Tier 3 – Preferred brand – mail order	60% up to $700 max per prescription or refill	Does not apply	Does not apply	Covers up to a 90-day supply
	Specialty drugs - (Covered through a contracted specialty pharmacy)	Retail Only 30% up to $500 max per prescription or refill	Does not apply	Does not apply	Covers up to a 30-day supply (Mail order not available for specialty medications)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% **coinsurance**	35% **coinsurance**	50% **coinsurance**	None
	Physician/surgeon fees	20% **coinsurance**	35% **coinsurance**	50% **coinsurance**	None
If you need immediate medical attention	Emergency room care	$200 per visit	$200 per visit	$200 per visit	None
	Emergency medical transportation	20% **coinsurance**	35% **coinsurance**	50% **coinsurance**	None
	Urgent care	$40 copay	35% **coinsurance**	50% **coinsurance**	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% **coinsurance**	35% **coinsurance**	50% **coinsurance**	**Coinsurance** applies to all services except Skilled Nursing Facility and Infertility Treatment
	Physician/surgeon fees	20% **coinsurance**	35% **coinsurance**	50% **coinsurance**	None

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 WellFlex Network Provider (You will pay the least)	Tier 2 SuperMed Network Provider	Tier 3 Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Benefits paid based on corresponding medical benefits	Benefits paid based on corresponding medical benefits	Benefits paid based on corresponding medical benefits	None
	Inpatient services	Benefits paid based on corresponding medical benefits	Benefits paid based on corresponding medical benefits	Benefits paid based on corresponding medical benefits	None
If you are pregnant	Office visits	No charge	No charge	No charge	**Cost sharing** does not apply to certain **preventative services.** Depending on the type of services, copay, **coinsurance** or **deductible** may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound)
	Childbirth/delivery professional services	No charge	No charge	No charge	None
	Childbirth/delivery facility services	No charge	No charge	No charge	None
If you need help recovering or have other special health needs	Home health care	20% **coinsurance**	35% **coinsurance**	50% **coinsurance**	(100 visits per benefit period)
	Rehabilitation services (Physical Therapy)	20% **coinsurance**	35% **coinsurance**	50% **coinsurance**	(60 visits per benefit period, combined with

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 WellFlex Network Provider (You will pay the least)	Tier 2 SuperMed Network Provider	Tier 3 Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
					Occupational Therapy)
	Habilitation services (Occupational Therapy)	20% **coinsurance**	35% **coinsurance**	50% **coinsurance**	(60 visits per benefit period, combined with Physical Therapy)
	Habilitation services (Speech Therapy)	20% **coinsurance**	35% **coinsurance**	50% **coinsurance**	(60 visits per benefit period)
	Skilled nursing care	20% **coinsurance**	35% **coinsurance**	50% **coinsurance**	(100 days per benefit period)
	Durable medical equipment	20% **coinsurance**	35% **coinsurance**	50% **coinsurance**	None
	Hospice services	No charge	No charge	No charge	None
If your child needs dental or eye care	Children's eye exam	No charge	No charge	No charge	None
	Children's glasses	Not Covered	Not Covered	Not Covered	Excluded Service
	Children's dental check-up	Not Covered	Not Covered	Not Covered	Excluded Service

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your FEHB Plan brochure for more information and a list of any other excluded services.)

- Acupuncture
- Children's Dental Check Up
- Children's Glasses
- Cosmetic Surgery
- Dental Care
- Hearing Aids (Adult)
- Long Term Care
- Non-emergency care when traveling outside the U.S
- Private Duty Nursing
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your FEHB Plan brochure.)

- Bariatric Surgery
- Infertility Treatment
- Chiropractic Care

Your Rights to Continue Coverage: You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at [contact number] or visit www.opm.gov.insure/health. Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or

For more information about limitations and exceptions, see the FEHB Plan brochure 73-899 at www.MedMutual.com/feds.

temporary continuation of coverage (TCC). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your FEHB Plan brochure. If you need assistance, you can contact: **Your Plan at 800-315-3144.**

Does this plan provide Minimum Essential Coverage? **Yes**

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

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** [insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	$500
■ Specialist *[cost sharing]*	20%
■ Hospital (facility) *[cost sharing]*	20%
■ Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$770**

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

■ The plan's overall deductible	$500
■ Specialist *[cost sharing]*	20%
■ Hospital (facility) *[cost sharing]*	20%
■ Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$300
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$900**

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

■ The plan's overall deductible	$500
■ Specialist *[cost sharing]*	20%
■ Hospital (facility) *[cost sharing]*	20%
■ Other *[cost sharing]*	20%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$300
300What isn't covered	
Limits or exclusions	1,000
The total Mia would pay is	**$1,000**

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

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