**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-73-017) 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 medmutual.com/feds, and view the Glossary at MedMutual.com/SBC. You can call 1-800-315-3144 to request a copy of either document.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$ 750**/Self Only<br>**$ 1,500**/ Self Plus One<br>**$ 1,500**/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**. | This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost sharing** and before you meet your **deductible**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No | You don't have to meet **deductibles** for specific services. |
| **What is the out-of-pocket limit for this plan?** | **$6,500**/single,**$13,000**/family HMO Network | The **out-of-pocket limit** 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. | 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. | This **plan** uses a provider **network**. You will pay less if you use a provider in the plan's **network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services. |
| **Do you need a referral to see a specialist?** | No | You can see the **specialist** you choose without a **referral**. |

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 |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | 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 | $30 copay/visit at PCP office; 20% coinsurance for PCP Home | Not Covered | None |
| | Specialist visit | $60 copay/visit at Specialist office; 20% coinsurance for Specialist home | Not Covered | None |
| | Preventive care/screening/ immunization | No charge | Not Covered | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | Not Covered | None |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www. MedMutual.com /Feds | Tier 1 Generic drugs – retail | $10 copay | Not Covered | Covers up to a 30-day supply. |
| | Tier 1 Generic drugs – mail order | $20 copay | Not Covered | Covers up to a 90-day supply. |
| | Tier 2 Preferred brand drugs – retail | 40% up to $125 max per prescription or refill | Not Covered | Covers up to a 30-day supply. |
| | Tier 2 Preferred brand drugs – mail order | 40% up to $250 max per prescription or refill | Not Covered | Covers up to a 90-day supply |
| | Tier 3 Non-preferred brand drugs – retail | 60% up to $250 max per prescription or refill | Not Covered | Covers up to a 30-day supply |
| | Tier 3 Non-preferred brand drugs – mail order | 60% up to $500 max per prescription or refill | Not Covered | Covers up to a 90-day supply |
| | Tier 4 Specialty drugs (Covered through a contracted specialty pharmacy) | 30% up to $500 max per prescription or refill | Not Covered | 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 | Not Covered | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most, plus you may be balance billed) | |
| | Physician/surgeon fees | 20% coinsurance | Not Covered | None |
| **If you need immediate medical attention** | Emergency room care | $250 copay/visit | | None |
| | Emergency medical transportation | 20% coinsurance | | None |
| | Urgent care | $45 copay/visit | Not Covered | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | Not Covered | (copay applies to all services except Skilled Nursing Facility and Infertility Treatment) |
| | Physician/surgeon fees | 20% coinsurance | Not Covered | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | First 3 visits no charge, thereafter, Benefits paid based on corresponding medical benefits | Not Covered | None |
| | Inpatient services | 20% coinsurance | Not Covered | None |
| **If you are pregnant** | Office visits | No charge | Not Covered | 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 | Not Covered | None |
| | Childbirth/delivery facility services | No charge | Not Covered | None |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | Not Covered | |
| | Rehabilitation services (Physical Therapy) | 20% coinsurance | Not Covered | (60 visits per benefit period, combined with Occupational Therapy) |
| | Habilitation services (Occupational Therapy) | 20% coinsurance | Not Covered | (60 visits per benefit period, combined with Physical Therapy) |
| | Habilitation services (Speech) | $30 copay/visit | Not Covered | (60 visits per benefit period) |
| | Skilled nursing care | 20% coinsurance | Not Covered | (100 days per benefit period) |
| | Durable medical equipment | 30% coinsurance | Not Covered | None |
| | Hospice services | No charge | Not Covered | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most, plus you may be balance billed) | |
| **If your child needs dental or eye care** | Children's eye exam | No charge | Not Covered | None |
| | Children's glasses | Not Covered | | Excluded Service |
| | Children's dental check-up | Not Covered | | Excluded Service |

## Excluded Services & Other Covered Services:

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

- Acupuncture
- Children's dental check-up
- Children's glasses
- Chiropractic Care
- Cosmetic Surgery
- Dental Care
- Hearing Aids (Adult)
- Long-Term Care
- Non-emergency care when traveling outside the U.S
- Private-Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

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

- Bariatric Surgery
- Infertility Treatment

**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 1-800-315-3144 or visit www.opm.gov.insure/health. Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or receive temporary continuation of coverage (TCC). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** 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 plan's FEHB brochure. If you need assistance, you can contact: Your plan at 800-315-3144.

**Does this plan provide Minimum Essential Coverage? Yes.**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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 1-800-686-7100.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-686-7100.
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-800-686-7100.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-686-7100.

*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** | **$750** |
| **Specialist copay** | **$60** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **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** | **$12,800** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $750 |
| Copayments | $30 |
| Coinsurance | $500 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,340** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$750** |
| **Specialist copay** | **$60** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **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** | **$7,400** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $100 |
| Copayments | $1000 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$1,160** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$750** |
| **Specialist copay** | **$60** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **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** | **$1,900** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $750 |
| Copayments | $500 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,350** |

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