
 **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 73-879 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.AetnaFeds.com, and view the Glossary at www.cciio.cms.gov. You can call 1-888-238-6240 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	Participating: Self \$1,000 / Self Plus One or Self & Family \$2,000	Generally you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay.
Are there services covered before you meet your <u>deductible</u>?	Yes. In-network preventive care is covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Participating: Self \$4,000 / Self Plus One or Self & Family \$6,850. Non-participating: Self \$5,000 / Self Plus One or Self & Family \$10,000.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
What is not included in the <u>out-of-pocket limit</u>?	Premiums, balance-billed charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.aetnafeds.com or call 1-888-238-6240 for a list of <u>network providers</u> .	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a provider in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> & you might receive a bill from a <u>provider</u> for the difference between the provider's charge & what your plan pays (balance billing).
Do you need a <u>referral</u> to see a <u>specialist</u>?	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	15% coinsurance	40% coinsurance	None
	<u>Specialist</u> visit	15% coinsurance	40% coinsurance	None
	<u>Preventive care/screening/immunization</u>	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	15% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	15% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.aetnafeds.com/pharmacy	Preferred generic drugs	Copay/prescription: \$10 (retail), \$20 (mail order)	40% coinsurance	Covers 30-day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives from preferred pharmacy. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics.
	Preferred brand drugs	Copay/prescription: \$35 (retail), \$70 (mail order)	40% coinsurance	
	Non-preferred generic/brand drugs	Copay/prescription: \$75 (retail), \$150 (mail order)	40% coinsurance	
	Value Formulary <u>Specialty drugs</u>	Preferred: 50% up to \$350 maximum, Non-Preferred: 50% up to \$700 maximum/prescription	Not covered	First prescription fill at a retail pharmacy or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	40% coinsurance	None
	Physician/surgeon fees	15% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	15% coinsurance	15% coinsurance	No coverage for non-emergency use.
	<u>Emergency medical</u>	15% coinsurance	15% coinsurance	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)	
	<u>transportation</u>			
	<u>Urgent care</u>	15% coinsurance	15% coinsurance	40% coinsurance for out-of-network non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
	Physician/surgeon fees	15% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 15% coinsurance	Office & other outpatient services: 40% coinsurance	None
	Inpatient services	15% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
If you are pregnant	Office visits	No charge for prenatal care & first postnatal visit	40% coinsurance	Subsequent postnatal visits 15% coinsurance for participating providers & 40% coinsurance for non-participating providers.
	Childbirth/delivery professional services	15% coinsurance	40% coinsurance	Cost sharing doesn't apply to certain preventive services. Maternity care may include tests & services described elsewhere in the SBC (i.e. ultrasound). Includes outpatient postnatal care. Pre-authorization required for out-of-network care may apply.
	Childbirth/delivery facility services	15% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	<u>Home health care</u>	15% coinsurance	40% coinsurance	1 visit/day up to 4 hours/visit, up to 60 visits per member/calendar year. Pre-authorization required for out-of-network care.
	<u>Rehabilitation services</u>	15% coinsurance	40% coinsurance	60 visits/calendar year for Physical & Occupational Therapy combined, 60 visits/calendar year for Speech Therapy.
	<u>Habilitation services</u>	15% coinsurance	40% coinsurance	
	<u>Skilled nursing care</u>	15% coinsurance	40% coinsurance	60 days/calendar year. Pre-authorization required for out-of-network care.
	<u>Durable medical equipment</u>	15% coinsurance	40% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.

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)	
	<u>Hospice services</u>	15% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge	40% coinsurance	1 routine eye exam/12 months.
	Children's glasses	Coverage is limited to available Medical Fund balance.	Coverage is limited to available Medical Fund balance.	None
	Children's dental check-up	No charge – Preventive care	Coverage is limited to available Dental Fund balance.	Coverage for other dental care is limited to available Dental Fund balance.

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.)

- Cosmetic surgery
- Long-term care
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Infertility treatment
- Private-duty nursing

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

- Chiropractic care – 20 visits/calendar year.
- Bariatric surgery
- Glasses (Child)
- Dental care (Adult & Child) - Coverage is limited to available Dental Fund balance.
- Acupuncture - Covered in lieu of anesthesia.
- Routine eye care (Adult) – 1 routine eye exam/12 months.
- Routine foot care – Coverage is limited to active treatment for a metabolic or peripheral vascular disease.
- Weight loss programs – Coverage is limited to dietary and nutritional counseling.

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 1-888-238-6240 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: 1-888-238-6240.

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 1-888-238-6240.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-238-6240.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-888-238-6240.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-238-6240.]

—————*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 \$1,000
- Specialist coinsurance 15%
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

This **EXAMPLE** event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests – may include non-routine services (*ultrasounds and blood work*)
Prescription drugs
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$30
Coinsurance	\$1,700
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,790

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

- The plan's overall deductible \$1,000
- Specialist coinsurance 15%
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$1,000
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,220

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

- The plan's overall deductible \$1,000
- Specialist coinsurance 15%
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$0
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,100