
 **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 73-828 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 \$1,600/ Self Plus One or Self & Family \$3,200. Non-Participating: Self \$2,600/ Self Plus One or Self & Family \$5,200.	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. In- <u>Network</u> and Out-of- <u>Network</u> <u>deductibles</u> do not cross apply and will need to be met separately before this plan begins to pay.
Are there services covered before you meet your <u>deductible</u>?	Yes. In- <u>network</u> preventive care is covered before you meet your <u>deductible</u> .	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 <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Participating: Self \$6,000 / Self Plus One or Self & Family \$7,900. Non-participating: Self \$7,000/ Self Plus One or Self & Family \$14,000.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. In-network and out-of-network <u>out-of-pocket limits</u> do not cross apply and will need to be met separately before this <u>plan</u> begins to pay.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this plan doesn't cover & penalties for failure to obtain <u>pre-authorization</u> 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 <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's 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 <u>provider's</u> charge & what your <u>plan</u> pays (<u>balance billing</u>).
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	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	<u>Copay/prescription</u> : \$10 (retail), \$20 (mail order)	40% <u>coinsurance</u>	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	50% <u>coinsurance</u> up to maximum/ <u>prescription</u> : \$200 (retail), \$400 (mail order)	40% <u>coinsurance</u>	
	Non-preferred generic/brand drugs	50% <u>coinsurance</u> up to maximum/ <u>prescription</u> : \$300 (retail), \$600 (mail order)	40% <u>coinsurance</u>	
	Value Plus Formulary	<u>Specialty drugs</u>	50% <u>coinsurance</u> up to maximum/ <u>prescription</u> : \$350 (preferred), \$700 (non-preferred)	Not covered
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	Emergency room care	10% <u>coinsurance</u>	10% <u>coinsurance</u>	No coverage for non-emergency use.
	<u>Emergency medical</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	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>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u> for out-of-network non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 10% <u>coinsurance</u>	Office & other outpatient services: 40% <u>coinsurance</u>	None
	Inpatient services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.
If you are pregnant	Office visits	No charge for prenatal care & first postnatal visit	40% <u>coinsurance</u>	Subsequent postnatal visits 10% <u>coinsurance</u> for participating providers and 40% <u>coinsurance</u> for non-participating providers.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Cost sharing</u> 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. <u>Pre-authorization</u> required for out-of-network care may apply.
	Childbirth/delivery facility services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	1 visit/day up to 4 hours/visit, up to 60 visits per member/calendar year. <u>Pre-authorization</u> required for out-of-network care.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	60 visits/calendar year for Physical & Occupational Therapy combined, 60 visits/calendar year for Speech Therapy.
	<u>Habilitation services</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	60 days/calendar year. <u>Pre-authorization</u> required for out-of-network care.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	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>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge	40% <u>coinsurance</u>	1 routine eye exam/12 months.
	Children's glasses	\$100 allowance	\$100 allowance	90% <u>coinsurance</u> after allowance up to age 18. Age and frequency schedules may apply.
	Children's dental check-up	No charge	Not covered	None

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 <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Chiropractic care • Cosmetic surgery • Hearing aids 	<ul style="list-style-type: none"> • Infertility treatment • Long-term care 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S • 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.)		
<ul style="list-style-type: none"> • Acupuncture - Covered in lieu of anesthesia. • Bariatric surgery • Dental care (Adult & Child) 	<ul style="list-style-type: none"> • Dental care (Adult & Child) • Glasses (Child) • Routine eye care (Adult) –1 routine eye exam/12 months. 	<ul style="list-style-type: none"> • 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.*—————

