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 deductible?	In-Network: Self $1,000 / Self Plus One or Self & Family $2,000.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network preventive care is covered 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.
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?	In-Network: Self $6,500 / Self Plus One or Self & Family $13,000.	The out-of-pocket limit is the most you could pay in a year for covered services. In-network and out-of-network out-of-pocket limits do not cross apply and will need to be met separately before this plan begins to pay.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges & health care this plan doesn't.	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 www.aetnafeds.com or call 1-888-238-6240 for a list of in-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 & you might receive a bill from a provider for the difference between the provider's charge & what your plan pays (balance billing).
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
		In-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% coinsurance	Not covered	None
	Specialist visit	30% coinsurance	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 needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnafeds.com/pharmacy.php	Preferred generic drugs	Copay/prescription: $10 (retail), $30 (mail order)	Not covered	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% coinsurance	Not covered	
	Non-preferred brand drugs	Not covered	Not covered	
	Specialty drugs	$10 copay/prescription (preferred generic), 50% coinsurance (preferred brand)	Not covered	All prescriptions must be filled through the Aetna Specialty Pharmacy Network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	None
	Physician/surgeon fees	30% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	No coverage for non-emergency use.
	Emergency medical transportation	30% coinsurance	30% coinsurance	None
	Urgent care	30% coinsurance	Not covered	No coverage for non-urgent use.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	None
	Physician/surgeon fees	30% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 30% coinsurance	Not covered	None
	Inpatient services	30% coinsurance	Not covered	None
If you are pregnant	Office visits	No charge for prenatal care & first postnatal visit	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Includes outpatient postnatal care.
	Childbirth/delivery professional services	30% coinsurance	Not covered	
	Childbirth/delivery facility services	30% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	1 visit/day up to 4 hours/visit, up to 60 visits per member/calendar year.
	Rehabilitation services	30% coinsurance	Not covered	60 visits/calendar year for Physical & Occupational Therapy combined, 60 visits/calendar year for Speech Therapy.
	Habilitation services	30% coinsurance	Not covered	None
	Skilled nursing care	30% coinsurance	Not covered	60 days/calendar year.
	Durable medical equipment	30% coinsurance	Not covered	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	30% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	30% coinsurance	Not covered	1 routine eye exam/12 months.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered.	Not covered.

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
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Non-preferred brand drugs
- 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.)

- Acupuncture - 10 visits/calendar year for disease, injury, and chronic pain.
- Bariatric surgery
- Chiropractic care – 20 visits/calendar year.
- Infertility treatment
- Routine eye care (Adult) – 1 routine eye exam/12 months.
- Routine foot care – Limited to active treatment for a metabolic or peripheral vascular disease.
- Weight loss programs – 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/healthcare-insurance/healthcare/**.** 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

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 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, kwiijigo holne' 1-888-238-6240.]

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

Proprietary

For more information about limitations and exceptions, see the FEHB Plan brochure at www.AetnaFeds.com.

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	**30%**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$10
Coinsurance	$2,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,770**

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	**30%**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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	$1,000
Copayments	$300
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,020**

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

The plan's overall deductible	**$1,000**
Specialist coinsurance	**30%**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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	$1,000
Copayments	$10
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

Proprietary

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