**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 73-052 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 1-800-537-9384 to request a copy of either document.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network: Self $0 / Self Plus One or Self & Family $0 | See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | No. | You will have to meet the deductible before the plan pays for any services. |
| **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 $5,000 / Self Plus One or Self & Family $10,000. | The out-of-pocket limit is the most you could pay in a year for covered services. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billed charges & 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 www.aetnafeds.com or call 1-800-537-9384 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, and you might receive a bill from a provider for the difference between the provider's charge and 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 | $15 copay/visit | Not covered | None |
| | Specialist visit | $30 copay/visit | 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 copay/visit | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | $75 copay/visit | 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: $3 (retail), $6 (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 | Copay /prescription: $35 (retail), $70 (mail order) | Not covered | |
| | Non-preferred generic/brand drugs | 50% coinsurance up to maximum/prescription: $200 (retail), $400 (mail order) | Not covered | |
| | Specialty drugs | 50% coinsurance up to maximum/prescription: $350 (preferred), $700 (nom-preferred) | 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) | $150 copay/visit | Not covered | None |
| | Physician/surgeon fees | No charge | Not covered | None |





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

| 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 need immediate medical attention** | Emergency room care | $125 copay/visit | $125 copay/visit | No coverage for non-emergency use. |
| | Emergency medical transportation | Ground $100 copay/trip, Air/Sea ambulance $150 copay/trip | Ground $100 copay/trip, Air/Sea ambulance $150 copay/trip | None |
| | Urgent care | $50 copay/visit | Not covered | No coverage for non-urgent use. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $150 copay/day first 3 days per stay; no charge thereafter | Not covered | None |
| | Physician/surgeon fees | No charge | Not covered | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office & other outpatient services: $30 copay/visit | Not covered | None |
| | Inpatient services | $150 copay/day first 3 days per stay; no charge thereafter | Not covered | None |
| **If you are pregnant** | Office visits | No charge for prenatal care & first postnatal visit | Not covered | Subsequent postnatal visits $15 copay/visit for PCP; $30 copay/visit for specialist. |
| | Childbirth/delivery professional services | No charge | 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 facility services | $150 copay/day first 3 days per stay; no charge thereafter | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | $90 copay/visit | Not covered | 1 visit/day up to 4 hours/visit, up to 60 visits per member/calendar year. |
| | Rehabilitation services | $30 copay/visit | Not covered | 60 visits/calendar year for Physical & Occupational Therapy combined, 60 visits/calendar year for Speech Therapy. |





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

| 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) | |
| | Habilitation services | $30 copay/visit | 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 | $5 copay/visit | Not covered | None |
| **If your child needs dental or eye care** | Children's eye exam | $30 copay/visit | Not covered | 1 routine eye exam/12 months. |
| | Children's glasses | $100 allowance | Not covered | 90% coinsurance after allowance up to age 18. Age and frequency schedules may. |
| | Children's dental check-up | Basic Option: $5 copay/visit; PPO Option: No charge | Basic Option: Not covered; PPO Option: 50% coinsurance | $20 deductible for PPO Option. |

## 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
- 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.)**

- Acupuncture – 10 visits/calendar year for disease, injury, and chronic pain.
- Bariatric surgery
- Chiropractic care – 20 visits/calendar year.
- Dental care (Adult)
- Hearing aids – 1 hearing aid to $1,400 maximum per ear/36 months.
- 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 1-800-537-9384 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





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

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: 1-800-537-9384

**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 1-800-537-9384.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-537-9384.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-537-9384.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-537-9384.]

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




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 | $0 |
| Specialist copayment | $30 |
| Hospital (facility) copayment | $150 |
| Other copayment | $0 |

**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 | $0 |
| Copayments | $500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$560** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $30 |
| Hospital (facility) copayment | $150 |
| Other copayment | $0 |

**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 | $0 |
| Copayments | $900 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$920** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $30 |
| Hospital (facility) copayment | $150 |
| Other copayment | $0 |

**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 | $0 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$400** |





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