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 need immediate medical attention	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	$30 copay/visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	None
	Physician/surgeon fees	10% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: $20 copay/ visit	Not covered	None
	Inpatient services	10% coinsurance	Not covered	None
If you are pregnant	Office visits	No charge for prenatal care & first postnatal visit	Not covered	Subsequent postnatal visits $20 copay/visit for PCP; $30 copay/visit for specialist.
	Childbirth/delivery professional services	10% coinsurance	Not covered	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.
	Childbirth/delivery facility services	10% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	$20 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.
	Habilitation services	$30 copay/visit	Not covered	
	Skilled nursing care	10% coinsurance	Not covered	30 days/calendar year.
	Durable medical equipment	50% coinsurance	Not covered	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	$10 copay/visit	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	None
	Children's glasses	$100 allowance	Not covered	90% coinsurance after allowance up to age 18. Age and frequency schedules may

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

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-537-9387.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-537-9387.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-537-9387.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-537-9387.]

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.