
 **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 73-128 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 1-800-537-9387 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	Participating: Self Only \$1,000 / Self Plus One or Self & Family \$3,000	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. Emergency care; plus in-network office visits, preventive care & prescription drugs are 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 Only \$5,000 / Self Plus One or Self & Family \$6,850	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.	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 1-800-537-9387 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> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and 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	\$30 copay/visit, deductible doesn't apply	Not covered	None
	<u>Specialist</u> visit	\$60 copay/visit, deductible doesn't apply	Not covered	None
	<u>Preventive care/screening/immunization</u>	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	<u>Diagnostic test</u> (x-ray, blood work)	25% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	25% 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 Value Formulary	Preferred generic drugs/Tier 1A & 1B	Copay/prescription, deductible doesn't apply: Tier 1A \$3; Tier 1B \$12 (retail); Tier 1A \$9, Tier 1B \$36 (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, deductible doesn't apply: \$50 (retail), \$150 (mail order)	Not covered	
	Non-preferred generic/brand drugs	Copay/ prescription, deductible doesn't apply: \$75 (retail), \$225 (mail order)	Not covered	
	<u>Specialty drugs</u>	20% coinsurance up to maximum/ prescription, deductible doesn't apply: \$200 (formulary),	Not covered	

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)	
		\$500 (non-formulary)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	Not covered	None
	Physician/surgeon fees	25% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	\$300 copay/visit, deductible doesn't apply	\$300 copay/visit, deductible doesn't apply	No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	25% coinsurance	25% coinsurance	None
	<u>Urgent care</u>	\$75 copay/visit, deductible doesn't apply	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	Not covered	None
	Physician/surgeon fees	25% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 25% coinsurance	Not covered	None
	Inpatient services	25% coinsurance	Not covered	None
If you are pregnant	Office visits	\$30 initial visit copay, deductible doesn't apply; no charge thereafter	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 professional services	25% coinsurance	Not covered	
	Childbirth/delivery facility services	25% coinsurance	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	25% coinsurance	Not covered	1 visit/day up to 4 hours/visit, up to 60 visits per member/calendar year.
	<u>Rehabilitation services</u>	25% coinsurance	Not covered	60 visits/calendar year for Physical &

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>Habilitation services</u>	25% coinsurance	Not covered	Occupational Therapy combined, 60 visits/calendar year for Speech Therapy. 60 days/calendar year.
	<u>Skilled nursing care</u>	25% coinsurance	Not covered	
	<u>Durable medical equipment</u>	50% coinsurance	Not covered	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	25% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	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	PPO Option: No charge	PPO Option: 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 excluded services.)

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

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

- Chiropractic care –60 visits/calendar year.
- Bariatric surgery
- Dental care (Adult & Child)
- Hearing aids
- Glasses (Child)
- 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 1-800-537-9384 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: 1-800-537-9387

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 1-800-537-9384.]

[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, kwijigo holne' 1-800-537-9384.]

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 <u>deductible</u>	\$1,000
■ <u>Specialist copay</u>	\$60
■ Hospital (facility) <u>coinsurance</u>	25%
■ <u>Other coinsurance</u>	25%

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	\$90
Coinsurance	\$2,800
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,950

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$1,000
■ <u>Specialist copay</u>	\$60
■ Hospital (facility) <u>coinsurance</u>	25%
■ <u>Other coinsurance</u>	25%

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	\$100
Copayments	\$1,600
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,720

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$1,000
■ <u>Specialist copay</u>	\$60
■ Hospital (facility) <u>coinsurance</u>	25%
■ <u>Other coinsurance</u>	25%

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	\$800
Copayments	\$400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,200