Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2022 - 12/31/2022

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Open Choice® - Aetna CDHP with Open Choice PPO

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. For more information about your coverage, or to get a copy of the complete terms of coverage, go to https://www.aetna.com/sbcsearch/getpolicydocs?u=082900-090020-032124 or by calling 1-800-370-4526. 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 view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-370-4526 to request a copy.

Important Questions | Answers | Why This Matters:
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What is the overall deductible? | In-Network: EE Only $1,400; EE+ Family $2,800. Out-of-Network: EE Only $2,500; EE+ Family $5,000. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the 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. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.

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: EE Only $3,425; EE+ Family $6,850. Out-of-Network: EE Only $6,450; EE+ Family $12,900. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.

What is not included in the out-of-pocket limit? | Premiums, balance-billing charges, health care this plan doesn’t cover & penalties for failure to obtain pre-authorization for services. | 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 http://www.aetna.com/docfind or call 1-800-370-4526 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). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

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.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>15% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>15% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>15% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>15% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>Copay/prescription: $10 (retail), $20 (mail order)</td>
<td>20% coinsurance after copay/prescription: $10 (retail)</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Copay/prescription: $30 (retail), $60 (mail order)</td>
<td>20% coinsurance after copay/prescription: $30 (retail)</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Copay/prescription: $60 (retail), $120 (mail order)</td>
<td>20% coinsurance after copay/prescription: $60 (retail)</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Applicable cost as noted above for generic or brand drugs</td>
<td>Applicable cost as noted above for generic or brand drugs</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>15% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>15% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>---------------------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>15% coinsurance</td>
<td>15% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>15% coinsurance</td>
<td>15% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>15% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>15% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>15% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office &amp; other outpatient services: 15% coinsurance</td>
<td>Office: 25% coinsurance; other outpatient services: 25% coinsurance for first 40 visits; 40% coinsurance thereafter</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>15% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>15% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>15% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>In-Network Provider (You will pay the least)</td>
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</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>---------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Home health care</td>
<td>15% coinsurance</td>
<td>40% coinsurance</td>
<td>60 visits/calendar year. Penalty of $400 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>15% coinsurance</td>
<td>40% coinsurance</td>
<td>60 visits/calendar year for Physical, Occupational &amp; Speech Therapy combined.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>15% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>15% coinsurance</td>
<td>40% coinsurance</td>
<td>60 days/calendar year. Penalty of $400 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>15% coinsurance</td>
<td>40% coinsurance</td>
<td>Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.</td>
</tr>
<tr>
<td>Hospice services</td>
<td>15% coinsurance</td>
<td>40% coinsurance</td>
<td>Penalty of $400 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
</tbody>
</table>

### If your child needs dental or eye care
- **Children's eye exam**: No charge, 40% coinsurance, 1 routine eye exam/12 months.
- **Children's glasses**: No charge, No charge, $100 maximum/24 months.
- **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 policy or plan document for more information and a list of any other excluded services.)
- Cosmetic surgery
- Dental care (Adult & Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs - Except for required preventive services.

#### Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)
- Acupuncture - 10 visits/calendar year for disease, injury & chronic pain.
- Bariatric surgery - Limited to in-network providers.
- Chiropractic care - 20 visits/calendar year.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Routine eye care (Adult) - 1 routine eye exam/12 months.

### Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: The...
Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526. You may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact Office of Health Care Ombudsman, One Judiciary Square, 441 4th Street, NW, 250 North Washington, DC 20001, Phone: (202) 724-7491, TTY: 711, https://healthcareombudsman.dc.gov/, healthcareombudsman@dc.gov

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 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.

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 deductible**: $1,400
- **Specialist coinsurance**: 15%
- **Hospital (facility) coinsurance**: 15%
- **Other coinsurance**: 15%

This EXAMPLE event includes services like:

- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

**Total Example Cost**: $12,700

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,400</td>
</tr>
<tr>
<td>Copayments</td>
<td>$10</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,500</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $60

**The total Peg would pay is**: $2,970

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

- **The plan’s overall deductible**: $1,400
- **Specialist coinsurance**: 15%
- **Hospital (facility) coinsurance**: 15%
- **Other coinsurance**: 15%

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)
- Rehabilitation services (physical therapy)
- Durable medical equipment (crutches)

**Total Example Cost**: $5,600

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,400</td>
</tr>
<tr>
<td>Copayments</td>
<td>$700</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$80</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $20

**The total Joe would pay is**: $2,200

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

- **The plan’s overall deductible**: $1,400
- **Specialist coinsurance**: 15%
- **Hospital (facility) coinsurance**: 15%
- **Other coinsurance**: 15%

This EXAMPLE event includes services like:

- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Rehabilitation services (physical therapy)

**Total Example Cost**: $2,800

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,400</td>
</tr>
<tr>
<td>Copayments</td>
<td>$10</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$200</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $0

**The total Mia would pay is**: $1,610

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Note: These numbers assume the patient does not participate in the plan’s wellness program. If you participate in the plan’s wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-370-4526.

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

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Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-370-4526.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.
TTY: 711

Language Assistance:

For language assistance in your language call 1-800-370-4526 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526.
Amharic - ኢንጅነን ከጆች ከ 1-800-370-4526 ያስቃል抚
Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-370-4526.
Armenian - ինչպիս է անցեք բարձր աշխատավարժական համակարգերի (համար համախմբ) 1-800-370-4526 հաշվից գնիք.
Bahasa-Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-800-370-4526 ku busa
Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-800-370-4526-তে কল করুন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.
Burmese - 1-800-370-4526
Catalan - Per rebre assistència en (català), truqui al número gratuit 1-800-370-4526.
Chamorro - Para ayuda gi fino` (Chamoru), ágang 1-800-370-4526 sin gástu.
Cherokee - ᎨᏣᎳᎩ ᎤᏬᏂᎯᏍᏗ ᏗᏂᏍᏤᏍᎩ ᎨᎾᏝ (ᏣᎳᎩ) ᎨᏬᎧᏗᏽᏏ 1-800-370-4526 ᎨᏤᏏ ʃ Ages ʃEG.PA h:TᏗ.
Chinese - 欲取得繁體中文語言協助，請撥打 1-800-370-4526，無需付費。
Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-800-370-4526.
Cushite - Gargaarsa afaan Oromiffa hiikuu argachuu fakkokkos biibila 1-800-370-4526 irratti biisaan biibila.
Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526.
French - Pour une assistance linguistique en français appelez le 1-800-370-4526 sans frais.
French Creole - Pou jwenn asistans nan lang Kreyól Ayisyen, rele nimewo 1-800-370-4526 gratis.
German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.
Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση.
Gujarati - ગુજરાતીમાં ભાષાના સહાય મેટી કોઇ પણ પરસ્પર વચ્ચે 1-800-370-4526 પર કોટ્સ કરો.
Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki ‘ole ‘ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-800-370-4526 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526.

Ibo - Maka enyemaka asusu na Igbo kpọọ 1-800-370-4526 na akwụkwọ ọ bụla

Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.

Japanese - 日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。

Karen - 幇堵拑細.co 幇堵拑細.co 1-800-370-4526 幇堵拑細.coATUS

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해 주십시오.

Kurdish - 1-800-370-4526

Laotian - ເຖົ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ,

Marathi - कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-800-370-4526 वर फोन करा.

Marshallese - Ñan bök jipaŋ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wônân.

Micronesian - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.

Mon-Khmer, Cambodian - ពិសេសនូវការបង្កើតភាសាខ្មែរ ក្នុងការសម្រាប់ការជួយ 1-800-370-4526 ផ្លាស់ប្ដូរភាសាផ្លូវសារ

Navajo - T'áá shi shizaad k'ehji bee shiká a'doowol ninizingo Diné k'ehji kojí t'áá jiík'e hólné' 1-800-370-4526

Nepali - (लेपाली) मा निष्कृतक भाषा सहायता पाउनका लागाउँ 1-800-370-4526 मा फोन गर्नुहोस्।

Nilotic-Dinka - Tên kucony ê thok ê Thuonjâŋ col 1-800-370-4526 kecîn ayoç.

Norwegian - For språkkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਦੌਰਾਨ ਮੰਜ਼ਿਤਾ ਉਪਲੱਬਧ, 1-800-370-4526 ਇੱਕ ਭਾਰਤੀ ਵਾਲੇ ਵੀਅੰਟੀ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.
Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.

Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.

Предоставьте лигвистическую помощь по русскому языку, позвоните по бесплатному номеру 1-800-370-4526.

Получить помощь по-украински, позвоните по номеру 1-800-370-4526.

Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526.

Para el niñez, llame sin cargo al 1-800-370-4526.

Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.

Предоставить поддержку на английском языке, позвоните по номеру 1-800-370-4526.

Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.

Предоставить поддержку на русском языке, позвоните по номеру 1-800-370-4526.

Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.