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, https://www.aetna.com/sbcsearch/getpolicydocs?u=070500-010020-011866 or by calling 1-888-802-3862. 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 1-888-802-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: Individual $6,800 / Family $13,600. Out-of-network: Individual $13,600 / Family $27,200.	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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain office visits, preventive care and urgent care in-network.	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?	Yes. For prescription drug expenses - In-network: Individual $550 / Family $1,100. Does not apply to in-network for preferred generic drugs. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-network: Individual $7,350 / Family $14,700. Out-of-network: Individual $14,700 / Family $29,400.	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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain pre-authorization for services, and 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.aetna.com/docfind or call 1-888-802-3862 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.

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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$60 copay/visit, deductible does not apply	50% coinsurance	None
	Specialist visit	$95 copay/visit	50% coinsurance	None
	Preventive care /screening /immunization	No charge	50% coinsurance	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)	Lab: $75 copay/visit, deductible does not apply; X-ray: 50% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	50% coinsurance	50% coinsurance	Applies to services received in office or in outpatient setting. Precertification required for out-of-network care or a $400 per occurrence penalty applies. However, penalty will not exceed the cost of the benefit.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at client.formularynavigator.com/Search.aspx?siteCode=4195839145	Preferred/non-preferred generic drugs (Tier 1)	$30 copay (retail), $60 copay (mail order), deductible does not apply	Not covered	Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order prescription). Applicable cost share plus difference (brand minus generic cost) applies for brand when generic available. No charge for preferred generic FDA-approved women's contraceptives in-network. Precertification and step therapy for certain prescription drugs may be required.
	Preferred brand drugs (Tier 2)	$100 copay (retail), $200 copay (mail order)	Not covered	
	Non-preferred brand drugs (Tier 3)	$150 copay (retail), $300 copay (mail order)	Not covered	
	Specialty drugs (Tier 4)	50% coinsurance up to a $500 maximum for up to a 30 day supply	Not covered	All specialty prescription drug fills on initial fill must be filled at a network specialty pharmacy except for urgent situations. Your plan may include access to CVS retail pharmacies for certain specialty drugs.

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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	50% coinsurance	Precertification required for out-of-network care or a $400 per occurrence penalty applies. However, penalty will not exceed the cost of the benefit.
	Physician/surgeon fees	50% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	50% coinsurance	50% coinsurance	No coverage for non-emergency care.
	Emergency medical transportation	50% coinsurance	50% coinsurance	Precertification is required for certain services.
	Urgent care	$100 copay/visit, deductible does not apply	$100 copay/visit, deductible does not apply	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance	50% coinsurance	Precertification required for out-of-network care or a $400 per occurrence penalty applies. However, penalty will not exceed the cost of the benefit. Precertification is not required in an emergency.
	Physician/surgeon fees	50% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits and all other outpatient services: $95 copay/visit, deductible does not apply	Office visits and all other outpatient services: 50% coinsurance	Precertification is required for certain services.
	Inpatient services	50% coinsurance	50% coinsurance	Precertification required for out-of-network care or a $400 per occurrence penalty applies. However, penalty will not exceed the cost of the benefit. Precertification is not required in an emergency.
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply to preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	50% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	50% coinsurance	50% coinsurance	

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)	
If you need help recovering or have other special health needs	Home health care	50% coinsurance	50% coinsurance	Coverage is limited to 100 visits/year. Precertification required for out-of-network care or a $400 per occurrence penalty applies. However, penalty will not exceed the cost of the benefit.
	Rehabilitation services	50% coinsurance	50% coinsurance	None
	Habilitation services	50% coinsurance	50% coinsurance	None
	Skilled nursing care	50% coinsurance	50% coinsurance	Coverage is limited to 100 days/benefit period. Precertification required for out-of-network care or a $400 per occurrence penalty applies. However, penalty will not exceed the cost of the benefit.
	Durable medical equipment	50% coinsurance	50% coinsurance	Coverage is limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	50% coinsurance	50% coinsurance	Precertification required for out-of-network care or a $400 per occurrence penalty applies. However, penalty will not exceed the cost of the benefit.
If your child needs dental or eye care	Children's eye exam	$60 copay/visit, deductible does not apply	Not covered	Coverage is limited up to age 19.
	Children's glasses	No charge	Not covered	Coverage is limited to 1 pair of glasses (lenses and frames) or a one-year supply of contact lenses.
	Children's dental check-up	0% coinsurance	30% coinsurance	Coverage is limited to 2 prophylaxis (cleanings) and 2 flouride applications a year.

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)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Acupuncture	• Chiropractic care - Coverage is limited to 20 visits.
• Bariatric surgery	• Infertility treatment - Benefit limitations may apply.

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: California Department of Insurance, Consumer Communications Bureau Health Unit, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-HELP (4357), 1-800-482-4833 TDD, http://www.insurance.ca.gov.

- For more information on your rights to continue coverage, contact the plan at 1-888-802-3862.
- If your group health coverage is subject to ERISA, 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.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

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:

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 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:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-888-802-3862.
- California Department of Insurance, Consumer Communications Bureau Health Unit, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-HELP (4357), 1-800-482-4833 TDD, http://www.insurance.ca.gov.
- If your group health coverage is subject to ERISA, 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 the California Department of Insurance at the contact information provided above

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 Minimum Value Standard? **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** **$6,800**
- **Specialist copayment** **$95**
- **Hospital (facility) coinsurance** **50%**
- **Other coinsurance** **50%**

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	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles*	$6,800
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,360**

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

- **The plan's overall deductible** **$6,800**
- **Specialist copayment** **$95**
- **Hospital (facility) coinsurance** **50%**
- **Other coinsurance** **50%**

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**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	$1,200
Copayments	$2,700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,920**

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

- **The plan's overall deductible** **$6,800**
- **Specialist copayment** **$95**
- **Hospital (facility) coinsurance** **50%**
- **Other coinsurance** **50%**

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**
In this example, Mia would pay:	
Cost Sharing	
Deductibles*	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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: 1-888-802-3862.

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-802-3862.

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 discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides 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 1-888-802-3862.

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: PO Box 24030 Fresno, CA 93779)

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705)

Email: 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).

TTY: 711

Language Assistance:

For language assistance in your language call 1-888-802-3862 at no cost.

Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-802-3862
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-802-3862 առանց գնով:
Chinese -	欲取得繁體中文語言協助，請撥打 1-888-802-3862，無需付費。
Hindi -	हिन्दी में भाषा सहायता के लिए, 1-888-802-3862 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-802-3862.
Japanese -	日本語で援助をご希望の方は、1-888-802-3862 まで無料でお電話ください。
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-802-3862 번으로 전화해 주십시오.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-802-3862 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-802-3862
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-802-3862 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Persian -	برای راهنمایی به زبان فارسی با شماره 1-888-802-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-802-3862.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-888-802-3862.
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-802-3862 nang walang bayad.
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-802-3862 ฟรีไม่มีค่าใช้จ่าย
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy goị miễn phí đến số 1-888-802-3862.

Supplemental Information **Coverage for:** Employee + Family | **Plan Type:** POS

How is the overall deductible or out-of-pocket limit met?	Individual **deductible** and **out-of-pocket limit** payments apply to the family **deductible** and **out-of-pocket limit**.	The family **deductible** and family **out-of-pocket limit** are cumulative for all family members. The family **deductible** and **out-of-pocket limit** can be met by a combination of family members; however no single individual within the family will be subject to more than the individual **deductible** or **out-of-pocket limit** amount.

How your out-of-network care is reimbursed:

We cover the cost of services based on whether doctors are "in-network" or "out-of-network." We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

You may choose a **provider** (doctor or hospital) in our **network**. You may choose to visit an out-of-network **provider**. If you choose a doctor who is out-of-network, your Aetna health **plan** may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "**allowed**" **amount**.

Professional Services: 100% of Medicare	Facility Services: 100% of Medicare

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your Aetna **plan** "recognizes." Your doctor may bill you for the dollar amount that your **plan** doesn't "recognize." You must also pay any **copayments**, **coinsurance** and **deductibles** under your **plan**. No dollar amount above the "recognized charge" counts toward your **deductible** or **out-of-pocket limit**. To learn more about how we pay out-of-network benefits, visit www.aetna.com. Type "how Aetna pays" in the search box.

You can avoid these extra costs by getting your care from Aetna's **network** of health care **providers**. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna Navigator® member site.

This applies when you *choose* to get care out-of-network. When you have no choice (for example: emergency room visit after a car accident or for other **emergency services**), we will pay the bill as if you got care in-network. You pay cost sharing and **deductibles** for your in-network level of benefits. Contact Aetna if your health care **provider** asks you to pay more. You are not responsible for any outstanding **balance billed** by your **providers** for **emergency services** beyond your cost sharing and **deductibles**.

Other important information about your plan:

This **plan** does not cover all health care expenses and includes exclusions and limitations. Members should refer to their **plan** documents to determine which

health care services are covered and to what extent.

Additional information regarding your **plan** is available in the Disclosure Document on www.aetna.com.

Information includes:

- "Knowing what is covered" which describes how we review a request for coverage for a service or supply
- "**Prescription drug** benefit" which describes procedures we use to manage **prescription drug** benefits. These procedures include how to obtain a list of covered drugs and the exception policy for receiving coverage of a drug that is not on a closed formulary

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and **health insurance plans** contain exclusions and limitations. Not all health services are covered.

See **plan** documents for a complete description of benefits, exclusions, limitations and conditions of coverage. **Plan** features and availability may vary by location and are subject to change. You may be responsible for the health care **provider's** full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the **plan**. **Providers** are independent contractors and are not agents of Aetna. **Provider** participation may change without notice. We do not provide care or guarantee access to health services.

The following is a partial list of services and supplies that are generally not covered. However, your **plan** documents may contain exceptions to this list based on state mandates or the **plan** design or rider(s) purchased by you or your employer.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your **plan** documents
- Donor egg retrieval
- Experimental and investigational procedures, except for coverage for **medically necessary** routine patient care costs for members participating in a cancer clinical trial with respect to the treatment of cancer or other life-threatening disease or condition
- Home births
- Immunizations for travel or work except where **medically necessary** or indicated
- Implantable drugs and certain injectable drugs including injectable infertility drugs
- Long-term rehabilitation therapy
- Non-**medically necessary** services or supplies
- Orthotics except diabetic orthotics
- Outpatient **prescription drugs** (except for treatment of diabetes), unless covered by a prescription **plan** rider and over-the-counter medications (except as provided in a hospital) and supplies
- Radial keratotomy or related procedures
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling or **prescription drugs**
- Therapy or rehabilitation other than those listed as covered

Supplemental Information

Coverage for: Employee + Family | **Plan Type:** POS

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

We consider your personal information to be private. We have policies and procedures in place to protect your personal information from unlawful use and disclosure. For a summary of our policy, go to www.aetna.com. You'll find the Privacy Notices link at the bottom of the page.

Plan features and availability may vary by location and group size.