aetna : **CA Bronze Providence MC 6500 Copay (01/17)**

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

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 at **https://www.aetna.com/sbcsearch/getpolicydocs?u=070900-110020-001647** or by calling **1-866-529-2517**. 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 1-866-529-2517 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall **deductible**?	In-network: Employee **$6,500** / Family **$13,000**. Out-of-network: Employee **$13,000** / Family **$26,000**.	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 **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**?	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 annual **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: Employee **$500** / Family **$1,000**. 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: Employee **$7,150** / Family **$14,300**. Out-of-network: Employee **$14,300** / Family **$28,600**.	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-billed charges, penalties for failure to obtain pre-authorization for services, and health care this plan does not 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 1-866-529-2517 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	$40 copay/visit, deductible does not apply	50% coinsurance	None
	Specialist visit	$75 copay/visit	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	50% coinsurance	You may have to pay for services that are not preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab: $40 copay/visit, deductible does not apply; X-ray: $150 copay/visit	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$500 copay/visit	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.

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 drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.aetna.com/individuals-families/find-a-medication/2017-value-small-group-plans.html?plan-year=2017&plan-name=value-small-group-plans#california Value Small Group Plans	Preferred generic drugs	$35 copay (retail), $70 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 is required.
	Preferred brand drugs	$100 copay (retail), $200 copay (mail order)	Not covered	
	Non-preferred generic/brand drugs	$150 copay (retail), $300 copay (mail order)	Not covered	
	Preferred/non-preferred specialty drugs	30% coinsurance up to a $500 maximum for up to a 30 day supply	Not covered	Aetna Specialty CareRx℠ – First Prescription must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy®. Subsequent fills must be through Aetna Specialty Pharmacy®. Your plan may include access to CVS retail pharmacies for certain specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$750 copay/visit for hospital facility; $500 copay/visit for free standing facility	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	0% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$500 copay/visit	$500 copay/visit	Copay waived if admitted. No coverage for non-emergency care.
	Emergency medical transportation	$200 copay/trip	$200 copay/trip	Precertification is required for certain services.
	Urgent care	$50 copay/visit, deductible does not apply	$50 copay/visit, deductible does not apply	No coverage for non-urgent use.

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 a hospital stay	Facility fee (e.g., hospital room)	$750 copay/day, days 1-5	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	0% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits and all other outpatient services: $75 copay/visit, deductible does not apply	Office visits and all other outpatient services: 50% coinsurance	None
	Inpatient services	$750 copay/day, days 1-5	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 certain 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	0% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	$750 copay/day, days 1-5	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	$40 copay/visit	50% coinsurance	Coverage is limited to 100 visits per 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	$75 copay/visit	50% coinsurance	None
	Habilitation services	$75 copay/visit	50% coinsurance	None
	Skilled nursing care	$750 copay/day, days 1-5	50% coinsurance	Coverage is limited to 100 days per 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.

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)	
	Durable medical equipment	20% coinsurance	50% coinsurance	Excludes vehicle modifications, home modifications & exercise equipment.
	Hospice services	Inpatient: $750 copay/day, days 1-5; Outpatient: $40 copay/visit	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	$40 copay/visit, deductible does not apply	Not covered	Coverage is limited to age 0-19.
	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	No charge	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) - except accidental injury.
- 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 - 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
- Bariatric surgery
- Chiropractic care - Coverage is limited to 20 visits.
- 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**.

- 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 options to continue coverage are 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 us by calling the toll free number on your Medical ID Card.

- 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. A list of states with Consumer Assistance Programs is available at: **www.dol.gov/ebsa/healthreform** and **http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/**.

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 page.*----------

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	**$6,500**
Specialist copayment	**$75**
Hospital (facility) copayment	**$750**
Other coinsurance	**0%**

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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$6,500
Copays	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,210**

Managing Joe's type 2 Diabetes

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

The plan's overall deductible	**$6,500**
Specialist copayment	**$75**
Hospital (facility) copayment	**$750**
Other coinsurance	**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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$1,100
Copays	$2,800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,946**

Mia's Simple Fracture

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

The plan's overall deductible	**$6,500**
Specialist copayment	**$75**
Hospital (facility) copayment	**$750**
Other coinsurance	**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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,900
Copays	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,925**

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: 1-866-529-2517.

*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.

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Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-866-529-2517.

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 on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

TTY: 711

Language Assistance:

For language assistance in your language call 1-866-529-2517 at no cost.

Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-866-529-2517
Armenian -	Լեզվիցուցաբերածաջակցության (հայերեն) զանգի 1-866-529-2517 առանցգնով:
Chinese -	欲取得繁體中文語言協助，請撥打 1-866-529-2517，無需付費。
Hindi -	हिन्दी में भाषा सहायता के लिए, 1-866-529-2517 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-866-529-2517.
Japanese -	日本語で援助をご希望の方は、1-866-529-2517 まで無料でお電話ください。
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-529-2517번으로 전화해 주십시오.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-866-529-2517 ដោយឥតគិតថ្លៃ។
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-866-529-2517 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Persian -	برای راهنمایی به زبان فارسی با شماره 1-866-529-2517 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-866-529-2517.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-866-529-2517.
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-866-529-2517 nang walang bayad.
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-866-529-2517 ฟรีไม่มีค่าใช้จ่าย
Vietnamese -	Đê ̉được hô ̃trơ ̣ngôn ngư ̃bằng (ngôn ngư ̃), hãy goị miễn phi ́đến sô ́1-866-529-2517.