



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=072800-110020-071639> 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:
<b>What is the overall deductible?</b>	<u>In-network</u> : Employee <b>\$250</b> / Family <b>\$500</b> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Certain office visits, <u>preventive care</u> and <u>urgent care in-network</u> .	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. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	Yes. For <u>prescription drug</u> expenses - <u>In-network</u> : Employee <b>\$250</b> / Family <b>\$500</b> . Does not apply to <u>in-network</u> for preferred generic drugs. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
<b>What is the out-of-pocket limit for this plan?</b>	<u>In-network</u> : Employee <b>\$6,000</b> / Family <b>\$12,000</b> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> and health care this <u>plan</u> does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-866-529-2517 for a list of <u>in-network</u> providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network</u> provider, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network</u> provider might use an <u>out-of-network</u> provider for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a referral to see a specialist?</b>	Yes. A written <u>referral</u> is required for most <u>specialist</u> visits.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



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	\$20 <u>copay</u> /visit, <u>deductible</u> does not apply	Not covered	None
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit, <u>deductible</u> does not apply	Not covered	None
	<u>Preventive care/screening/ immunization</u>	No charge	Not covered	You may have to pay for services that are not <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Lab: \$20 <u>copay</u> /visit, <u>deductible</u> does not apply; X-ray: \$40 <u>copay</u> /visit, <u>deductible</u> does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$250 <u>copay</u> /visit, <u>deductible</u> does not apply	Not covered	None

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)	
<p><b>If you need drugs to treat your illness or condition.</b></p> <p>More information about <b>prescription drug coverage</b> is available at <a href="http://www.aetna.com/individuals-families/find-a-medication/2017-value-small-group-plans.html?plan-year=2017&amp;plan-name=value-small-group-plans#california">www.aetna.com/individuals-families/find-a-medication/2017-value-small-group-plans.html?plan-year=2017&amp;plan-name=value-small-group-plans#california</a></p> <p>Value Small Group Plans</p>	Preferred generic drugs	\$25 <u>copay</u> (retail), \$50 <u>copay</u> (mail order), <u>deductible</u> 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 <u>in-network</u> . Precertification and step therapy for certain <u>prescription drugs</u> is required.
	Preferred brand drugs	\$50 <u>copay</u> (retail), \$100 <u>copay</u> (mail order)	Not covered	
	Non-preferred generic/brand drugs	\$100 <u>copay</u> (retail), \$200 <u>copay</u> (mail order)	Not covered	
	Preferred/non-preferred <u>specialty drugs</u>	30% <u>coinsurance</u> up to a \$250 maximum for up to a 30 day supply	Not covered	
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	\$600 <u>copay</u> /visit for hospital facility; \$400 <u>copay</u> /visit for free standing facility	Not covered	None
	Physician/surgeon fees	0% <u>coinsurance</u>	Not covered	None
<p><b>If you need immediate medical attention</b></p>	<u>Emergency room care</u>	\$300 <u>copay</u> /visit	\$300 <u>copay</u> /visit	<u>Copay</u> waived if admitted. No coverage for non-emergency care.
	<u>Emergency medical transportation</u>	\$150 <u>copay</u> /trip	\$150 <u>copay</u> /trip	Precertification is required for certain services.
	<u>Urgent care</u>	\$50 <u>copay</u> /visit, <u>deductible</u> does not apply	\$50 <u>copay</u> /visit, <u>deductible</u> does not apply	No coverage for non-urgent use.
<p><b>If you have a hospital stay</b></p>	Facility fee (e.g., hospital room)	\$500 <u>copay</u> /day, days 1-3	Not covered	None
	Physician/surgeon fees	0% <u>coinsurance</u>	Not covered	None

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 mental health, behavioral health, or substance abuse services	Outpatient services	Office visits and all other outpatient services: \$40 <u>copay/visit</u> , <u>deductible</u> does not apply	Not covered	None
	Inpatient services	\$500 <u>copay/day</u> , days 1-3	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	\$500 <u>copay/day</u> , days 1-3	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	\$20 <u>copay/visit</u>	Not covered	Coverage is limited to 100 visits per year.
	<u>Rehabilitation services</u>	\$40 <u>copay/visit</u> , <u>deductible</u> does not apply	Not covered	None
	<u>Habilitation services</u>	\$40 <u>copay/visit</u> , <u>deductible</u> does not apply	Not covered	None
	<u>Skilled nursing care</u>	\$500 <u>copay/day</u> , days 1-3	Not covered	Coverage is limited to 100 days per benefit period.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	Excludes vehicle modifications, home modifications & exercise equipment.
	<u>Hospice services</u>	Inpatient: \$500 <u>copay/day</u> , days 1-3; Outpatient: 0% <u>coinsurance</u>	Not covered	None
If your child needs dental or eye care	Children's eye exam	\$20 <u>copay/visit</u> , <u>deductible</u> does not apply	Not covered	Coverage is limited to age 0-19.
	Children's glasses	No charge	Not covered	Coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses per calendar year age 0-19.

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)	
	Children's dental check-up	No charge	Not covered	Coverage is limited to 2 prophylaxis (cleanings) and 2 fluoride 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 Managed Health Care, (888) 466-2219, 1-877-688-9891 TDD, <http://www.dmhc.ca.gov>.

- For more information on your rights to continue coverage, contact the plan at 1-866-529-2517.
- 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](http://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](http://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 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](http://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:

- California Department of Managed Health Care, (888) 466-2219, 1-877-688-9891 TDD, <http://www.dmhc.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](http://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](http://www.cciio.cms.gov).
- Additionally, a consumer assistance program can help you file your **appeal**. Contact California Department of Managed Health Care, California Help Center, 980 9th Street, Suite #500, Sacramento, CA 95814, (888) 466-2219, <http://www.healthhelp.ca.gov>, [helpline@dmhc.ca.gov](mailto:helpline@dmhc.ca.gov). A list of states with Consumer Assistance Programs is available at: [www.dol.gov/ebsa/healthreform](http://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** \$250
- **Specialist copayment** \$40
- **Hospital (facility) copayment** \$500
- **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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$300
Copayments	\$1,200
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,506</b>

**Managing Joe's type 2 Diabetes**

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

- The **plan's overall deductible** \$250
- **Specialist copayment** \$40
- **Hospital (facility) copayment** \$500
- **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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$300
Copayments	\$2,100
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,348</b>

**Mia's Simple Fracture**

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

- The **plan's overall deductible** \$250
- **Specialist copayment** \$40
- **Hospital (facility) copayment** \$500
- **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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$300
Copayments	\$700
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$900</b>

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

## 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 24030 Fresno, CA 93779, 1-800-648-7817, TTY 711, Fax 860-262-7705, [CRCoordinator@aetna.com](mailto: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>.

**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 1-866-529-2517 at no cost.

- Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-866-529-2517
- Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-866-529-2517 առանց գումարի:
- 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។
- Punjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਮਦਦ ਲਈ, 1-866-529-2517 'ਤੇ ਮੁਫਤ 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 - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-866-529-2517.