



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=081500-110020-022386> 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 <u>deductible</u>?	In- <u>Network</u> : Individual \$2,500 / Family \$5,000.	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> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Certain office visits, <u>preventive care</u> and <u>urgent care</u> in- <u>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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. For <u>prescription drug</u> expenses - In- <u>network</u> : Individual \$300 / Family \$600. Does not apply to in- <u>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.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	In- <u>Network</u> : Individual \$8,750 / Family \$17,500.	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.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See http://www.aetna.com/docfind or call 1-866-529-2517 for a list of in- <u>network providers</u> .	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 provider</u> , 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 provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	Yes.	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	\$55 <u>copay</u> /visit, <u>deductible</u> does not apply	Not covered	None
	<u>Specialist</u> visit	\$90 <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 aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Lab: \$55 <u>copay</u> /visit, <u>deductible</u> does not apply; X-ray: \$90 <u>copay</u> /visit, <u>deductible</u> does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$300 <u>copay</u> /visit	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://aet.na/casg24	Preferred/non-preferred generic drugs (Tier 1)	\$19 <u>copay</u> / prescription (retail), \$38 <u>copay</u> / prescription (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> . Maintenance drugs-after two retail fills, you are required to fill a 90-day supply at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy.
	Preferred brand drugs (Tier 2)	\$85 <u>copay</u> / prescription (retail), \$170 <u>copay</u> / prescription (mail order)	Not covered	
	Non-preferred brand drugs (Tier 3)	\$110 <u>copay</u> / prescription (retail), \$220 <u>copay</u> / prescription (mail order) , <u>deductible</u> does not apply	Not covered	
	Preferred/non-preferred <u>specialty drugs</u> (Tier 4)	30% <u>coinsurance</u> up to a \$250 maximum/ prescription for up to a 30 day supply	Not covered	All specialty <u>prescription drug</u> fills on initial fill must be filled at a <u>network</u> specialty pharmacy except for urgent situations. Your <u>plan</u> may include access to CVS retail pharmacies for certain <u>specialty drugs</u> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	35% <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)	
	Physician/surgeon fees	35% <u>coinsurance</u> , <u>deductible</u> does not apply	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	35% <u>coinsurance</u>	35% <u>coinsurance</u>	No coverage for non-emergency care.
	<u>Emergency medical transportation</u>	35% <u>coinsurance</u>	35% <u>coinsurance</u>	Precertification is required for certain services.
	<u>Urgent care</u>	\$55 <u>copay/visit</u> , <u>deductible</u> does not apply	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	35% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	35% <u>coinsurance</u> , <u>deductible</u> does not apply	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient office visits: \$55 <u>copay/visit</u> , <u>deductible</u> does not apply; All other outpatient services: No charge	Not covered	None
	Inpatient services	35% <u>coinsurance</u>	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	35% <u>coinsurance</u> , <u>deductible</u> does not apply	Not covered	
	Childbirth/delivery facility services	35% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	\$45 <u>copay/visit</u> , <u>deductible</u> does not apply	Not covered	Coverage is limited to 100 visits per year.
	<u>Rehabilitation services</u>	\$55 <u>copay/visit</u> , <u>deductible</u> does not apply	Not covered	None
	<u>Habilitation services</u>	\$55 <u>copay/visit</u> , <u>deductible</u> does not apply	Not covered	None
	<u>Skilled nursing care</u>	35% <u>coinsurance</u>	Not covered	Coverage is limited to 100 days per benefit period.
	<u>Durable medical equipment</u>	35% <u>coinsurance</u> , <u>deductible</u> does not apply	Not covered	None
	<u>Hospice services</u>	No charge	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 your child needs dental or eye care	Children's eye exam	No charge	Not covered	Coverage is limited to 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 up to age 19.
	Children's dental check-up	No charge	Not covered	Coverage is limited to 2 prophylaxis (cleanings) and 2 fluoride applications a year up to age 19.

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.)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) • Hearing aids • Long-term care 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine eye care (Adult) 	<ul style="list-style-type: none"> • 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.)	
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery 	<ul style="list-style-type: none"> • 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, 1-888-466-2219 (toll-free), 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.
- For more information on your rights to continue coverage, contact the [plan](#) at 1-866-529-2517.
- 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 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 1-866-529-2517. 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.
- California Department of Managed Health Care, 1-888-466-2219 (toll-free), 1-877-688-9891 (TDD), <http://www.dmhc.ca.gov>.
- 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 California Consumer Assistance Program, Operated by the California Department of Managed Health Care, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, 1-888-466-2219 (toll-free), 1-877-688-9891 (TDD), Fax: 916-255-5241, <http://www.dmhc.ca.gov>, helpline@dmhc.ca.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 **\$2,500**
- Specialist copayment **\$90**
- Hospital (facility) coinsurance **35%**
- Other coinsurance **35%**

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:	
<i>Cost Sharing</i>	
Deductibles*	\$2,500
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$2,600
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,560

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

- The plan's overall deductible **\$2,500**
- Specialist copayment **\$90**
- Hospital (facility) coinsurance **35%**
- Other coinsurance **35%**

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Diabetic supplies (*glucose meter*)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles*	\$300
<u>Copayments</u>	\$2,200
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,520

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

- The plan's overall deductible **\$2,500**
- Specialist copayment **\$90**
- Hospital (facility) coinsurance **35%**
- Other coinsurance **35%**

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	\$2,800
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles*	\$1,900
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,300

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.

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 California and Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, ancestry, religion, sex, marital status, age, gender, gender identity, sexual orientation 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 the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on race, color, national origin, ancestry, religion, sex, marital status, age, gender, gender identity, sexual orientation or disability, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator, Non-HMO,
P.O. Box 14462, Lexington, KY 40512,
1-800-648-7817, TTY: 711, Fax: 859-425-3379,
CRCoordinator@aetna.com.

Civil Rights Coordinator, HMO,
P.O. Box 24030, Fresno, CA 93779,
1-800-648-7817, TTY: 711, Fax: 860-262-7705,
CRCoordinator@aetna.com.

You can also file a complaint with the California Department of Insurance at www.insurance.ca.gov, or at: Consumer Services Division, 300 Spring Street South Tower, Los Angeles CA 90013, or at 1-800-927-HELP (4357), TDD: 1-800-482-4TDD (4833).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights if there is a concern of discrimination based on the federal protected classes which include race, color, national origin, age, disability, or sex. You can 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 companies, including Aetna Life Insurance Company, Aetna Health of California Inc., and their affiliates (Aetna).

TTY: 711

Language Assistance:

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

- Albanian - Për shërbime përkthimi falas për ju, telefononi 1-866-529-2517.
- Amharic - የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-866-529-2517 ይደውሉ።
- Arabic - مقررا لى ع لاصتالاء اجرلا ،ةفلكت يى نود ةيوغللال تامدخال لى ع لوصحلل 1-866-529-2517
- Armenian - Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-866-529-2517 հեռախոսահամարով:
- Bahasa-Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-866-529-2517 tanpa dikenakan biaya.
- Bantu-Kirundi - Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-866-529-2517.
- Bengali-Bangala - আপনাকে বিনামূল্যে ভাষা পবকিসাি পপকে হকয এই নম্বকি পবেযক ান ব্লেন: 1-866-529-2517।
- Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-866-529-2517.
- Burmese - သင့်အနေဖြင့် အခကြေးငွေ မပေးရပဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန် 1-866-529-2517 သို့ ဖုန်းခေါ်ဆိုပါ။
- Catalan - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-866-529-2517.
- Chamorro - Para un hago' i setbision lenggua'hi ni dibåtde para hãgu, ågang 1-866-529-2517.
- Cherokee - ႠႩႪႩ ႩႪႩႩႪႩ ႩႪႩႩႪႩ ႩႪႩႩႪႩ ႩႪႩႩႪႩ ႩႪႩႩႪႩ ႩႪႩႩႪႩ ႩႪႩႩႪႩ 1-866-529-2517.
- Chinese - 如欲使用免費語言服務，請致電 1-866-529-2517。
- Choctaw - Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-866-529-2517.
- Cushite - Tajaajiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-866-529-2517.
- Dutch - Voor gratis toegang tot taaldiensten, bell 1-866-529-2517.
- French - Afin d'accéder aux services langagiers sans frais, composez le 1-866-529-2517.
- French Creole - Pou jwenn sèvis lang gratis, rele 1-866-529-2517.
- German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-866-529-2517 an.
- Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-866-529-2517.

- Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-866-529-2517.
- Persian - دیری گب سامت 1-866-529-2517 مر امش اب ،ن انگیار روط هب نابز تامدخ هب یسرتسد یارب
- Polish - Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonić 1-866-529-2517.
- Portuguese - Para acessar os serviços de idiomas sem custo para você, ligue para 1-866-529-2517.
- Punjabi - ਤੁਹਾਡੇ ਲਈ ਬਨਿੰ ਬਸਿੰ ਮਿਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਰਿਨ ਲਈ, 1-866-529-2517 'ਤੇ ਫੋਨ ਰਿੰ।
- Romanian - Pentru a accesa gratuit serviciile de limbă, apălați 1-866-529-2517.
- Russian - Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-866-529-2517.
- Samoan - Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-866-529-2517.
- Serbo-Croatian - Za besplatne prevodilačke usluge pozovite 1-866-529-2517.
- Spanish - Para acceder a los servicios de idiomas sin costo, llame al 1-866-529-2517.
- Sudanic-Fulfulde - Heeba a nastá jangirde djey wolde wola chede bo apelou lamba 1-866-529-2517.
- Swahili - Kupata huduma za lugha bila malipo kwako, piga 1-866-529-2517.
- Syriac - 1-866-529-2517 .
- Tagalog - Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-866-529-2517.
- Telugu - మరొక భాష నవలను ఉచితంగా అందుకునందుకు, 1-866-529-2517 కు కల్ చీయండి.
- Thai - หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-866-529-2517.
- Tongan - Kapau 'oku ke fiema'u ta'etötōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-866-529-2517.
- Trukese - Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-866-529-2517.
- Turkish - Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-866-529-2517 numarayı arayın.
- Ukrainian - Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-866-529-2517.
- Urdu - سیری ک تاب رپ 1-866-529-2517 سے رک لصاح تامدخ مقل عتم سے نابز تم قلاب۔
- Vietnamese - Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-866-529-2517.
- Yiddish - 1-866-529-2517 צו צוטריט קארפּש באַדינונגען אין קיין פּרייז צו איר, רופן
- Yoruba - Lati wonú awon isẹ èdè l'ofẹ fun o, pe 1-866-529-2517.