



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=080900-090020-092239> 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:
<b>What is the overall <u>deductible</u>?</b>	In- <u>Network</u> : Individual \$2,500 / Family \$5,000. Out-of- <u>Network</u> : Individual \$5,000 / Family \$10,000.	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> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	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.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	In- <u>Network</u> : Individual \$8,600 / Family \$17,200. Out-of- <u>Network</u> : Individual \$17,200 / Family \$34,400.	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 <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>pre-authorization</u> for services, 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> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.aetna.com/docfind">http://www.aetna.com/docfind</a> or call 1-888-802-3862 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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$55 <u>copay</u> /visit, <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$90 <u>copay</u> /visit, <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
	<u>Preventive care /screening /immunization</u>	No charge	50% <u>coinsurance</u>	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.
<b>If you have a test</b>	<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	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	35% <u>coinsurance</u>	50% <u>coinsurance</u>	Precertification required for out-of-network care or a \$400 per occurrence penalty applies. However, penalty will not exceed the cost of the benefit.
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://aet.na/casg23">http://aet.na/casg23</a>	Preferred/non-preferred generic drugs (Tier 1)	\$20 <u>copay</u> / prescription (retail), \$40 <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 in- <u>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)	\$75 <u>copay</u> / prescription (retail), \$150 <u>copay</u> / prescription (mail order)	Not covered	
	Non-preferred brand drugs (Tier 3)	\$105 <u>copay</u> / prescription (retail), \$210 <u>copay</u> / prescription (mail order)	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	

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)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	35% <u>coinsurance</u>	50% <u>coinsurance</u>	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	35% <u>coinsurance</u> , <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
<b>If you need immediate medical attention</b>	<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	50% <u>coinsurance</u>	No coverage for non-urgent use.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	35% <u>coinsurance</u>	50% <u>coinsurance</u>	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	35% <u>coinsurance</u>	50% <u>coinsurance</u>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Outpatient office visits: \$55 <u>copay/visit</u> , <u>deductible</u> does not apply; All other outpatient services: No charge	Office visits and all other outpatient services: 50% <u>coinsurance</u>	None
	Inpatient services	35% <u>coinsurance</u>	50% <u>coinsurance</u>	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.
<b>If you are pregnant</b>	Office visits	No charge	50% <u>coinsurance</u>	<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>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	35% <u>coinsurance</u>	50% <u>coinsurance</u>	

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)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	35% <u>coinsurance</u> , <u>deductible</u> does not apply	50% <u>coinsurance</u>	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.
	<u>Rehabilitation services</u>	\$55 <u>copay</u> /visit, <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
	<u>Habilitation services</u>	\$55 <u>copay</u> /visit, <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	35% <u>coinsurance</u>	50% <u>coinsurance</u>	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.
	<u>Durable medical equipment</u>	35% <u>coinsurance</u> , <u>deductible</u> does not apply	50% <u>coinsurance</u>	Coverage is limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	No charge	50% <u>coinsurance</u>	Precertification required for out-of-network care or a \$400 per occurrence penalty applies. However, penalty will not exceed the cost of the benefit.
<b>If your child needs dental or eye care</b>	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	30% <u>coinsurance</u>	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.)

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

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- |               |  |  |
|---------------|--|--|
| • Acupuncture | • Bariatric surgery - Coverage is limited to in-network providers. | • 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, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-HELP (4357), 1-800-482-4833 (TTY), <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](http://www.dol.gov/ebsa/healthreform).
- For more information on your rights to continue coverage, contact the plan at 1-888-802-3862.
- 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 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](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 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 1-888-802-3862. 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).
- California Department of Insurance, Consumer Communications Bureau Health, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-HELP (4357), 1-800-482-4833 (TTY), <http://www.insurance.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](http://www.cciio.cms.gov).
- Additionally, a consumer assistance program can help you file your appeal. Contact California Department of Insurance, Consumer Communications Bureau, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-Help (4357), 1-800-482-4833(TTY), [www.insurance.ca.gov](http://www.insurance.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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
<b>In this example, Peg would pay:</b>	
<u>Cost Sharing</u>	
Deductibles*	\$2,500
Copayments	\$400
Coinsurance	\$2,600
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,560</b>

**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
- Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
<b>In this example, Joe would pay:</b>	
<u>Cost Sharing</u>	
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>\$2,420</b>

**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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Mia would pay:</b>	
<u>Cost Sharing</u>	
Deductibles*	\$1,900
Copayments	\$400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,300</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: 1-888-802-3862.

\*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 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](http://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 and its affiliates (Aetna).**







- Persian - برای راهنمایی به زبان فارسی با شماره 1-888-802-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
- Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-802-3862.
- Portuguese - Para obter assistência linguística em português ligue para o 1-888-802-3862 gratuitamente.
- Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-888-802-3862
- Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-802-3862.
- Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-802-3862 e aunoa ma se totogi.
- Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-802-3862.
- Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-888-802-3862.
- Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-888-802-3862 Njodi woo fawaaki on.
- Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-802-3862 bila malipo.
- Syriac - ܠܗܘܢܐ ܕܡܘܨܝܘܢܐ ܕܡܘܨܝܘܢܐ ܕܡܘܨܝܘܢܐ ܕܡܘܨܝܘܢܐ ܕܡܘܨܝܘܢܐ 1-888-802-3862 ܡܘܨܝܘܢܐ .
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-802-3862 nang walang bayad.
- Telugu - భృషణీ సాయం కిరకు ఎలంటి ఖరీచు లకుండా 1-888-802-3862 కు శ్రీ చేయండి. (తెలుగు)
- Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-802-3862 ฟรีไม่มีค่าใช้จ่าย
- Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-802-3862 'o 'ikai hā tōtōngi.
- Trukese - Ren ánnisinisn chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-888-802-3862 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedi 1-888-802-3862.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-802-3862.
- Urdu - بلا قیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-888-802-3862 پر بات کریں
- Vietnamese - Đê' được hõ trợ ngôn ngữ bằng (ngôn ngữ), hãỵ goị miễn phi' đêh sô' 1-888-802-3862.
- Yiddish - פאר שפראך הילף אין אידיש רופט 1-888-802-3862 פון אפצאל.
- Yoruba - Fún iranlọwọ nípa èdè (Yorùbá) pẹ 1-888-802-3862 láí san owó kankan rárá.