



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=080300-100020-251975> 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: Individual \$2,250 / Family \$4,500. | 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, urgent care and outpatient hospital services 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 \$300 / Family \$600. 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 \$7,800 / Family \$15,600. | 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 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 http://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? | Yes. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. |



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 | \$50 <u>copay</u> /visit, <u>deductible</u> does not apply | Not covered | None |
| | <u>Specialist</u> visit | \$85 <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: \$40 <u>copay</u> /visit, <u>deductible</u> does not apply; X-ray: \$85 <u>copay</u> /visit, <u>deductible</u> does not apply | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | \$300 <u>copay</u> /visit, <u>deductible</u> does not apply | Not covered | None |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://client.formularynavigator.com/Search.aspx?siteCode=4391485344 | Preferred/non-preferred generic drugs (Tier 1) | \$17 <u>copay</u> / prescription (retail), \$34 <u>copay</u> / prescription (mail order) | 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> . Precertification and step therapy for certain <u>prescription drugs</u> is required. |
| | Preferred brand drugs (Tier 2) | \$65 <u>copay</u> / prescription (retail), \$130 <u>copay</u> / prescription (mail order) | Not covered | |
| | Non-preferred brand drugs (Tier 3) | \$90 <u>copay</u> / prescription (retail), \$180 <u>copay</u> / prescription (mail order) | Not covered | |
| | Preferred/non-preferred <u>specialty drugs</u> (Tier 4) | 20% <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) | 20% <u>coinsurance</u> , <u>deductible</u> does not apply | Not covered | None |
| | Physician/surgeon fees | 20% <u>coinsurance</u> , <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) | |
| If you need immediate medical attention | <u>Emergency room care</u> | \$400 <u>copay</u> /visit | \$400 <u>copay</u> /visit | <u>Copay</u> waived if admitted. No coverage for non-emergency care. |
| | <u>Emergency medical transportation</u> | \$250 <u>copay</u> /trip | \$250 <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 | Not covered | No coverage for non-urgent use. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% <u>coinsurance</u> | Not covered | None |
| | Physician/surgeon fees | 20% <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: \$50 <u>copay</u> /visit, <u>deductible</u> does not apply; All other outpatient services: No charge | Not covered | None |
| | Inpatient services | 20% <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> . 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 | 20% <u>coinsurance</u> | Not covered | |
| | Childbirth/delivery facility services | 20% <u>coinsurance</u> | 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) | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | \$45 <u>copay</u> /visit, <u>deductible</u> does not apply | Not covered | Coverage is limited to 100 visits per year. |
| | <u>Rehabilitation services</u> | \$50 <u>copay</u> /visit, <u>deductible</u> does not apply | Not covered | None |
| | <u>Habilitation services</u> | \$50 <u>copay</u> /visit, <u>deductible</u> does not apply | Not covered | None |
| | <u>Skilled nursing care</u> | 20% <u>coinsurance</u> | Not covered | Coverage is limited to 100 days per benefit period. |
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> , <u>deductible</u> does not apply | Not covered | 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 | Not covered | None |
| 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.)

- | | | |
|-----------------------|--|----------------------------|
| • 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 | • 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 (TTY), <http://www.HealthHelp.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 <https://www.dol.gov/agencies/ebsa>.
- 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 1-866-529-2517.
- California Department of Managed Health Care, 888-466-2219, 1-877-688-9891 (TTY), <http://www.HealthHelp.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 <https://www.dol.gov/agencies/ebsa>.
- 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, 888-466-2219, 877-688-9891 (TTY), Fax: 916-255-5241, <http://www.healthhelp.ca.gov>, helpline@dmhc.ca.gov

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 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 **\$2,250**
- Specialist copayment **\$85**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

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: | |
| <i>Cost Sharing</i> | |
| Deductibles* | \$2,300 |
| Copayments | \$300 |
| Coinsurance | \$1,800 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$4,460 |

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

- The plan's overall deductible **\$2,250**
- Specialist copayment **\$85**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

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: | |
| <i>Cost Sharing</i> | |
| Deductibles* | \$300 |
| Copayments | \$2,300 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$2,620 |

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

- The plan's overall deductible **\$2,250**
- Specialist copayment **\$85**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

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: | |
| <i>Cost Sharing</i> | |
| Deductibles* | \$1,300 |
| Copayments | \$300 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,600 |

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 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 1-866-529-2517.

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 24030, Fresno, CA 93779

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

Fax: 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).

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.

- Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-866-529-2517. Kāki ‘ole ‘ia kēia kōkua nei.
- 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.
- Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-866-529-2517 na akwughị ugwo ọ bụla
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-866-529-2517 nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 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。
- Karen - လာတိုမာစာတိုကတိကိတ်အင်္ဂါ ကို နိတ် နိတ် 1-866-529-2517 လာတိုအိတ်ဒီးတိုလာတိုဘူတ်လာတိုစာဘူ
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-529-2517 번으로 전화해 주십시오.
- Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pídyi dé Bašwó`wuḍuñ wεε, dá 1-866-529-2517
- Kurdish - برائى راهنمایی به زبان فارسى با شماره 1-866-529-2517 به خۆرایى پهیوهندى بکهن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-866-529-2517 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - तीलभाषा(मराठी)सहाय्यासाठी 1-866-529-2517 क्रमांकावरकोणत्याहीखर्चाशवियकॉलकरा.
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-866-529-2517 ilo ejjelok wōnān.
- Micronesian - Pohnpeyan Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-866-529-2517 ni sohte isais.
- Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទទៅកាន់លេខ 1-866-529-2517 ដោយឥតគិតថ្លៃ។
- Navajo - T'áá shi shizaad k'ehjí bee shiká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-866-529-2517
- Nepali - (नेपाली) मा नःशुल्क भाषा सहायता पाउनका लागि 1-866-529-2517 मा फोन गर्नुहोस् ।
- Nilotic-Dinka - Tën kuwoony ë thok ë Thuonjäŋ col 1-866-529-2517 kecïn ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-866-529-2517 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵੱਲੋਂ ਭਾਸ਼ਾਈ ਮਦਦ ਲਈ, 1-866-529-2517 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Hilfe in Deutsch, ruf: 1-866-529-2517 aa. Es Aaruf koschtet nix.

