



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=082900-080020-002525> or by calling 1-866-551-6664. 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 1-866-551-6664 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	For each Calendar Year, In- <u>Network</u> Designated: Individual \$500 / Family \$1,000.	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. Emergency care; plus in- <u>network</u> office visits, <u>prescription drugs</u> & <u>preventive care</u> are covered before you meet your <u>deductible</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 drugs</u> - Individual \$150 / Family \$450. Doesn't apply to Tier 1A & 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>?	For each Calendar Year, In- <u>Network</u> Designated: Individual \$6,000 / Family \$12,000.	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> , <u>balance-billing</u> charges & 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 1-866-551-6664 for a list of in- <u>network</u> designated <u>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 Designated 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	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	None
	<u>Specialist</u> visit	\$60 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	None
	<u>Preventive care</u> / <u>screening</u> /immunization	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)	No charge for laboratory; \$60 <u>copay</u> /visit for x-ray, <u>deductible</u> doesn't apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$200 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.aetnapharmacy.com/advancedcontrolaetnaca	Generic drugs (includes Tier 1A - Value Drugs)	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: Tier 1A \$3 for 30 day supply, \$6 for 60 day supply, \$9 for 90 day supply (retail); \$6 for 31-90 day supply (mail order); Generic \$15 for 30 day supply, \$30 for 60 day supply, \$45 for 90 day supply (retail); \$30 for 31-90 day supply (mail order)	Not covered	Covers 30 day supply (retail), 31-90 day supply (retail & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your <u>formulary</u> for prescriptions requiring precertification or step therapy for coverage. <u>Copay</u> /prescription for preferred insulin, <u>deductible</u> doesn't apply: \$25 for each 30 day supply. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written.
	Preferred brand drugs	<u>Copay</u> /prescription, after specific <u>deductible</u> : \$35 for 30 day supply, \$70 for 60 day supply, \$105 for 90 day supply (retail); \$70 for 31-90 day supply (mail	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Designated Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		order)		
	Non-preferred brand drugs	<u>Copay</u> /prescription, after specific <u>deductible</u> : \$60 for 30 day supply, \$120 for 60 day supply, \$180 for 90 day supply (retail); \$120 for 31-90 day supply (mail order)	Not covered	
	<u>Specialty drugs</u>	30% <u>coinsurance</u> , after specific <u>deductible</u>	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$350 <u>copay</u> /visit	Not covered	None
	Physician/surgeon fees	0% <u>coinsurance</u>	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$350 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$350 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	No charge	No charge	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	\$75 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$600 <u>copay</u> /day first 3 days per stay; 0% <u>coinsurance</u> thereafter	Not covered	None
	Physician/surgeon fees	0% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$60 <u>copay</u> /visit, <u>deductible</u> doesn't apply; other outpatient services: no charge	Not covered	Other outpatient services: partial <u>hospitalization</u> , intensive programs, behavioral health treatment for pervasive developmental disorder/autism, home health care, electroconvulsive therapy, day treatment, medical treatment for withdrawal symptoms & outpatient monitoring of injectable therapy.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Designated Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Inpatient services	\$600 <u>copay</u> /day first 3 days per stay; 0% <u>coinsurance</u> thereafter	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	\$30 <u>copay</u> /pregnancy, <u>deductible</u> doesn't apply	Not covered	
	Childbirth/delivery facility services	\$600 <u>copay</u> /day first 3 days per stay; 0% <u>coinsurance</u> thereafter	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	Not covered	120 visits/calendar year.
	<u>Rehabilitation services</u>	\$60 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	None
	<u>Habilitation services</u>	No charge	Not covered	None
	<u>Skilled nursing care</u>	\$600 <u>copay</u> /day first 3 days per stay; 0% <u>coinsurance</u> thereafter	Not covered	100 days/calendar year.
	<u>Durable medical equipment</u>	50% <u>coinsurance</u> , <u>deductible</u> doesn't apply	Not covered	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	\$600 <u>copay</u> /day first 3 days per stay; 0% <u>coinsurance</u> thereafter for inpatient; 0% <u>coinsurance</u> for outpatient	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 routine eye exam/12 months.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

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

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

- Acupuncture - 20 visits/calendar year for disease, injury & chronic pain.
- Bariatric surgery
- Chiropractic care - 20 visits/calendar year.
- Infertility treatment - For more information & exceptions, see policy document using summary box link on page 1 or call the number on your ID card.
- Routine eye care (Adult) - 1 routine eye exam/12 months.

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.dmhca.ca.gov>.

- For more information on your rights to continue coverage, contact the plan at 1-866-551-6664.
- 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 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 1-866-551-6664. 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.dmhca.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.dmhca.ca.gov>, helpline@dmhca.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 **\$500**
- Specialist copayment **\$60**
- Hospital (facility) copayment **\$600**
- 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*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
Deductibles*	\$500
Copayments	\$1,400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,960

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

- The plan's overall deductible **\$500**
- Specialist copayment **\$60**
- Hospital (facility) copayment **\$600**
- Other coinsurance **0%**

This EXAMPLE event includes services like:
Primary care provider 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:	
<u>Cost Sharing</u>	
Deductibles	\$0
Copayments	\$900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$920

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

- The plan's overall deductible **\$500**
- Specialist copayment **\$60**
- Hospital (facility) copayment **\$600**
- 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	\$2,800
In this example, Mia would pay:	
<u>Cost Sharing</u>	
Deductibles	\$0
Copayments	\$700
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$700

*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 1-866-551-6664.

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.

Discrimination is Against the Law

Aetna complies with applicable California and Federal civil rights laws and does not discriminate on the basis of race, color, national origin, ethnic group, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, medical condition, genetic information, or sex (consistent with 45 CFR § 92.101(a)(2) and California 2 CCR § 14025). Aetna does not exclude people or treat them less favorably because of race, color, national origin, ethnic group, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, medical condition, genetic information, or disability.

Aetna:

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

If you need reasonable medications, appropriate auxiliary aids and services, or language assistance services, call 1-800-872-3862 (TTY: 711) or the number on the back of your ID card.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ethnic group, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, medical condition, genetic information, or disability, by action or inaction, you can file a grievance with:

Civil Rights Coordinator

Attn: 1557 Coordinator

CVS Pharmacy, Inc.

1 CVS Drive, MC 2332, (HMO customers: P.O. Box 14032 Lexington, KY 40512-4032)

Woonsocket, RI 02895

Phone: 1-800-648-7817, TTY: 711

Email: CRCoordinator@aetna.com

You can file a grievance in person, by mail, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

Please visit <https://www.aetna.com/individuals-families/member-rights-resources/complaints-grievances-appeals.html#california> for information about how to file a complaint or grievance with the California Department of Insurance or California Department of Managed Health Care (for HMO enrollees).

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, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>. This notice is available at Aetna's website: <https://www.aetna.com/>

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group of companies offering and administering health and dental plans and other products such as life, disability, and long-term care insurance. In California, this includes Aetna's wholly-owned subsidiaries Aetna Life Insurance Company, Aetna Health of California Inc., Aetna Better Health of California Inc., Aetna Dental of California Inc., and Health and Human Resource Center Inc., and its other affiliates licensed in California. Aetna's ultimate parent is CVS Health Corporation ("CVS Health").

English	To access language services at no cost to you, call 1-866-551-6664.
Amharic	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-866-551-6664 ይደውሉ፡፡.
Arabic	للحصول على خدمات لغوية دون تكلفة، الرجاء الاتصال على الرقم 1-866-551-6664
Armenian	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-866-551-6664 հեռախոսահամարով:
Carolinian (Kapasal Falawasch)	ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-551-6664.
Chamorro	Para un hago' i setbision lengguahi ni dibatde para hagu, a'gang 1-866-551-6664.
Chinese Traditional	如欲使用免費語言服務，請致電 1-866-551-6664.
Cushitic-Oromo	Tajaajiloota afaanii garuu bilisaa ati argaachuuf, bilbili 1-866-551-6664.
French	Afin d'accéder aux services langagiers sans frais, composez le 1-866-551-6664.
French Creole (Haitian)	Pou jwenn sèvis lang gratis, rele 1-866-551-6664.
German	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-866-551-6664 an.
Greek	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-866-551-6664.
Gujarati	તમારે કોઇ જાતના ખર્ચ વગર ભાષાની સેવિસોની પહોંચ માટે, કોલ કરો 1-866-551-6664.
Hindi	आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, 1-866-551-6664 पर कॉल करें।.
Hmong	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-866-551-6664.
Italian	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-866-551-6664.
Japanese	言語サービスを無料でご利用いただくには、1-866-551-6664 までお電話ください。
Karen	လၢတၢ်ကမၤန့ၣ် ကံၣ်စၢ အတၢ်မၤစၢၤ အတၢ်ဖဲးတၢ်မၤတဖၣ်လၢ တအံၤဒီးအပၤလၢကတၢ်ဟ့ၣ်အၤအဂီၢ်ဘၣ်န့ၣ် ကံး 1-866-551-6664 တကါၢ်.
Korean	무료 언어 서비스를 이용하려면 1-866-551-6664 번으로 전화해 주십시오.
Laotian	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ສະຄຳຄ່າທຳນາ, ໃຫ້ໃບຫາບ 1-866-551-6664.
Mon-Khmer Cambodian	ដើម្បីទទួលបានសេវាភាសាដោយឥតគិតថ្លៃ ម្ចាស់ទូរស័ព្ទត្រូវតែទូរស័ព្ទលេខ 1-866-551-6664 ។
Navajo	T'áá ni nizaad k'ehjí bee níká a'doowol doo bą́ą́h ílínígóó kojí' hólne' 1-866-551-6664.
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff 1-866-551-6664.

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