



Coverage for: Individual + Family | Plan Type: POS



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/sbsearch/getpolicydocs?u=372769-102255-748002> or by calling 1-888-982-3862. 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 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each Plan Year, In-Network: Individual \$3,400 / Family \$6,800. Out-of-Network: Individual \$5,000 / Family \$10,000.	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 <u>deductible</u> 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. In-network preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	In-Network: Individual \$3,500 / Family \$7,000. Out-of-Network: 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 plan, 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 out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	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 network provider?	Yes. See www.aetna.com/docfind or call 1-888-982-3862 for a list of In-Network providers.	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>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 plan 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 referral to see a specialist?	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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	40% <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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Imaging</u> (CT/PET scans, MRIs)	30% <u>coinsurance</u>	40% <u>coinsurance</u>	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/advancedcontrols	Generic drugs	<u>Copay/prescription</u> : \$10 (retail), \$20 (mail order)	40% <u>coinsurance</u> (retail)	Covers 30 day supply (retail), 31-90 day supply (mail order). \$250 maximum <u>copay</u> for each 30 day supply. Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> . Review your <u>formulary</u> for prescriptions requiring precertification or step therapy for coverage. <u>Copay/prescription</u> 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. Maintenance drugs- after two retail fills, you are required to fill a 90-day supply at a participating mail service pharmacy or at selected participating retail providers.
	Preferred brand drugs	<u>Copay/prescription</u> : \$20 (retail), \$40 (mail order)	40% <u>coinsurance</u> (retail)	
	Non-preferred brand drugs	<u>Copay/prescription</u> : \$40 (retail), \$80 (mail order)	40% <u>coinsurance</u> (retail)	
	<u>Specialty drugs</u>	<u>Copay/prescription</u> : 20%	Not covered	All prescriptions must be filled through the Aetna Specialty Pharmacy <u>Network</u> . \$200 maximum <u>copay</u> for each 30 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	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>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 20% <u>coinsurance</u>	Office & other outpatient services: 40% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Office visits	No charge	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive</u> services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
If you are pregnant	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	120 visits/ <u>plan</u> year out-of-network combined with private-duty nursing. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Home health care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	60 days/ <u>plan</u> year. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Habilitation services</u>	0% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Durable medical equipment</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	1 routine eye exam/24 months.
If your child needs	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Children's eye exam	No charge	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)	
dental or eye care	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.)

• Bariatric surgery	• Glasses (Child)	• Non-emergency care when traveling outside the U.S.
• Cosmetic surgery	• Hearing aids	• Routine foot care
• Dental care (Adult & Child)	• Long-term care	• 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/ <u>plan</u> year for disease, injury & chronic pain.	• 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/24 months for in- <u>network</u> only.
• Chiropractic care - 20 visits/ <u>plan</u> year for out-of- <u>network</u> .	• Private-duty nursing - Included as part of <u>home health care</u> .	

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 Services Division, 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 more information on your rights to continue coverage, contact the plan at 1-888-982-3862.
- 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 <http://www.dol.gov/ebsa/healthreform>
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

• 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 number at 1-888-982-3862. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>
- California Department of Insurance, Consumer Services Division, 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.
- Additionally, a consumer assistance program can help you file your appeal. Contact California Department of Insurance, Consumer Services Division, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-Help (4357), 1-800-482-4833 (TTY), 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 \$3,400
- Specialist coinsurance 20%
- 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	\$12,700
In this example, Peg would pay:	
Cost Sharing	
Deductibles	\$3,400
Copayments	\$0
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,560

Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$3,400
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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:	
Cost Sharing	
Deductibles	\$2,300
Copayments	\$300
Coinsurance	\$0
What isn't covered	
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 \$3,400
- Specialist coinsurance 20%
- 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	\$2,800
In this example, Mia would pay:	
Cost Sharing	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

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.

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:
 - Qualified sign language interpreters
 - 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:
 - Qualified sign language interpreters
 - 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").

TTY: 711

English -
To access language services at no cost to you, call 1-888-982-3862.

Amharic - የቋንቋ አገልግሎቶችን ያላካፍያ ለመግኘት፣ በ 1-888-982-3862 ይደውሉ፡፡

Arabic - للحصول على الخدمات اللغوية دون أى تكلفة، الرجاء الاتصال على الرقم 1-888-982-3862

Armenian -
Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-888-982-3862 հեռախոսահամարով:

Carolinian
ngere aukke ghut alili is reel kapasa | Falawasch au fafaingi tilifon ve 1-888-982-3862.

Chamorro - Para un hago' i setbision lengguahi ni dibåtde para hāgu, āgang 1-888-982-3862.

Chinese Traditional -
如欲使用免費語言服務，
請致電 1-888-982-3862.

Cushitic-Oromo -
Tajaaiiloota afaanii garuu bilisaa ati argaachuuf, bilbili 1-888-982-3862.

French - Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862.

French Creole (Haitian) - Pou jwenn sèvis lang gratis, rele 1-888-982-3862.

German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an.

Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-888-982-3862.

Gujarati -
તમારેકોઇ જાતના ખરચવના ભાષાની સેવના ઓની પહોર માટે, કોલ કરો 1-888-982-3862.

Hindi -
आपके लिए बनी ककसी कीमत केभाषा उपयोग करनेकेलिए, 1-888-982-3862 पर कॉल करें।

Hmong -
Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-888-982-3862.

Italian - Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-982-3862.

Japanese -
言語サービスを無料でご利用いただくには、1-888-982-3862 までお電話ください。

Karen - လာဘ်ကမ္းနီကိုအတိုင်းမစားတတ်ဖူးတော့မလောင်လှဘဲအိပ်နေတာကို နားထောင်ရပါမယ်။ အသက် ၁၈ နှစ်၊ အမြင့် ၅ ပေ ၆ လောက်ရှိပြီး အလေးချိန် ၁၂၀ ပေါ့နုပါတယ်။ အင်္ကျီအောက်မှာ ကျွန်းပုံအင်္ကျီဝတ်ထားပြီး မီးခိုးဆူနေတဲ့ အင်္ကျီအောက်မှာ အင်္ကျီအောက်အင်္ကျီဝတ်ထားပါတယ်။

Korean -
마르코 언어 서비스 센터
이웃을 사랑하며 1-888-982-3862
포인트 샌프란시스코
전국 해안

Laotian - ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໄດ້ຍ່ອຍສຳຕັ້ງທ່ານ, ໃຫ້ໂທຫາເບີ 1-888-982-3862.

Mon-Khmer, 1-888-982-3862

Navajo -
T'áá ni nizaad k'éhji bee níká a'doował doo bąąh ílínígóó kojí' hólné' 1-888-982-3862

Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-888-982-3862.

Persian-Farsi -

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-888-982-3862 تماس بگیرید.

Polish -

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonić 1-888-982-3862.

Portuguese -

Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-982-3862.

Puniabi -

ਤੁਹਾਡੇ ਲਈ ਬਨਿ ਕਸਿ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-888-982-3862 'ਤੇ ਫੋਨ ਕਰੋ।

Russian -

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-982-3862.

Samoan -

Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-888-982-3862.

Serbo-Croatian -

Za besplatne prevodilačke usluge pozovite 1-888-982-3862.

Spanish -

Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862.

Syriac-Assyrian -

1-888-982-3862

Tagalog -

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-982-3862.

Thai -

หากท่านต้องการเข้าถึงบริการทางด้านภาษาโดยไม่ค่าใช้จ่าย โปรดโทร 1-888-982-3862.

Ukrainian -

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