



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.aetnastudenthealth.com> or by calling 1-888-834-4708. 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 1-888-834-4708 to request a copy.

Important Questions	Answers	Why This Matters:
<u>What is the overall deductible?</u>	For each <u>Plan</u> Year, Tier one Individual \$100/Family \$300 & <u>In-Network</u> : Individual \$500/Family \$1,500.	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.
<u>Are there services covered before you meet your deductible?</u>	Yes, The policy year deductible is waived for all of the following eligible health services: Preventive care and wellness, Pediatric Dental Care type A services, Pediatric Vision Care Services and Supplies, Physicians, Specialists and consults office visits, first postnatal visit, Well Newborn Nursery Care, Hospital emergency room, Urgent care, outpatient mental health and substance abuse office visits, Ambulance services, hearing aid exams, routine adult vision exams, Outpatient Prescription Drugs	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 without 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/
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	Tier one Individual \$2,000/Family \$6,000 & <u>In-Network</u> : Individual \$4,000/Family \$12,000	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
<u>What is not included in the out-of-pocket limit?</u>	Premiums, <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>precertification</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u>?	Yes. See www.aetna.com/docfind or call 1-888-834-4708 for a list of <u>in-network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	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	Tier one Provider (You will pay the least)	What You Will Pay In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not Covered	None
	<u>Specialist</u> visit	\$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not Covered	None
	<u>Preventive care /screening</u> /immunization	No charge	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	\$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not Covered	None
	Imaging (CT/PET scans, MRIs)	\$100 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	Not Covered	None

Common Medical Event	Services You May Need	Tier one Provider (You will pay the least)	What You Will Pay In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://www.aetna.com/individuals-families/pharmacy.html	Generic drugs	\$10 (retail) <u>Copay/prescription, deductible doesn't apply</u>	\$10 (retail) <u>Copay/prescription, deductible doesn't apply</u>	Not Covered	Covers 30 day supply (retail). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for FDA-approved women's contraceptives in-network.
	Preferred brand drugs	\$35 (retail) <u>Copay/prescription, deductible doesn't apply</u>	\$35 (retail) <u>Copay/prescription, deductible doesn't apply</u>	Not Covered	
	Non-preferred brand drugs	\$50 (retail) <u>Copay/prescription, deductible doesn't apply</u>	\$50 (retail) <u>Copay/prescription, deductible doesn't apply</u>	Not Covered	
	Specialty drugs	\$50 (retail) <u>Copay/prescription, deductible doesn't apply</u>	\$50 (retail) <u>Copay/prescription, deductible doesn't apply</u>	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 <u>copay/visit</u>	30% <u>coinsurance</u>	Not Covered	None
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	Not Covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay/visit, deductible doesn't apply</u>	\$100 <u>copay/visit, deductible doesn't apply</u>	\$100 <u>copay/visit, deductible doesn't apply</u>	No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	No charge	No charge	No charge	None
	<u>Urgent care</u>	\$50 <u>copay/visit, deductible doesn't apply</u>	\$50 <u>copay/visit, deductible doesn't apply</u>	\$50 <u>copay/visit, deductible doesn't apply</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 <u>copay/stay, after policy year deductible</u>	30% <u>coinsurance</u>	Not Covered	Penalty of \$500 for failure to obtain <u>precertification</u> for out-of-network care.
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	Not Covered	None

Common Medical Event	Services You May Need	Tier one Provider (You will pay the least)	What You Will Pay In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: \$25 <u>copay/visit, deductible</u> doesn't apply; Other outpatient services: No charge, <u>deductible</u> doesn't apply	Office Visit: \$25 <u>copay/visit, deductible</u> doesn't apply; Other outpatient services: No charge, <u>deductible</u> doesn't apply	Not Covered	None
	Inpatient services	\$250 <u>copay/stay, after policy year deductible</u>	No copay/stay, after policy year deductible	Not Covered	Penalty of \$500 for failure to obtain <u>precertification</u> for out-of-network care.
If you are pregnant	Office visits	No charge	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.) Penalty of \$500 for failure to obtain <u>precertification</u> for out-of-network care may apply.
	Childbirth/delivery professional services	No charge	30% <u>coinsurance</u>	Not Covered	
	Childbirth/delivery facility services	\$500 <u>copay/stay, after policy year deductible</u>	30% <u>coinsurance</u>	Not Covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	\$25 <u>copay/visit, deductible</u> doesn't apply	30% <u>coinsurance</u>	Not Covered	100 visits/ <u>plan year</u> .
	<u>Rehabilitation services</u>	\$25 <u>copay/visit, deductible</u> doesn't apply	\$40 <u>copay/visit, deductible</u> doesn't apply	Not Covered	Includes Physical, Occupational & Speech Therapy.
	<u>Habilitation services</u>	\$25 <u>copay/visit, deductible</u> doesn't apply	\$40 <u>copay/visit, deductible</u> doesn't apply	Not Covered	
	<u>Skilled nursing care</u>	\$500 <u>copay/stay, after policy year deductible</u>	30% <u>coinsurance</u>	Not Covered	Penalty of \$500 for failure to obtain <u>precertification</u> for out-of-network care.
	<u>Durable medical equipment</u>	No charge	\$25 copay/item, 30% <u>coinsurance</u>	Not Covered	
	<u>Hospice services</u>	No charge	30% <u>coinsurance</u>	Not Covered	Penalty of \$500 for failure to obtain <u>precertification</u> for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Not Covered	1 routine eye exam/ <u>plan year</u> up to age 19.
	Children's glasses	No charge	No charge	Not Covered	1 pair of glasses or lenses/ <u>plan year</u> .
	Children's dental check-up	Not Applicable	No charge	Not Covered	None

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
- Dental care (Adult)
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs - Except for required preventive services.

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) - 1 routine eye exam/plan year.

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>.

- For more information on your rights to continue coverage, contact the plan at 1-888-834-4708.

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:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-888-834-4708.
- 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> .
- 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

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 <u>plan's overall deductible</u>	\$450
■ <u>Specialist coinsurance</u>	10%
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	10%

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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$450
<u>Copayments</u>	\$40
<u>Coinsurance</u>	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,750

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's overall deductible</u>	\$450
■ <u>Specialist coinsurance</u>	10%
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	10%

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	\$5,600
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$450
<u>Copayments</u>	\$1,000
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,570

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's overall deductible</u>	\$450
■ <u>Specialist coinsurance</u>	10%
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	10%

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
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$450
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$600

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 1-888-834-4708.

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 the number on your ID card.

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 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779)
1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705)
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.

TTY: 711

Language Assistance:

For language assistance in your language call 1-888-834-4708 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-888-834-4708.
Amharic -	አማርኛ አገልግሎት 1-888-834-4708 በነጋድ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-834-4708
Armenian -	Լեզվի գուցաբերած աջակցության (հայերեն) զանգի 1-888-834-4708 առանց զնուպ:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-834-4708 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-888-834-4708 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামূলে 1-888-834-4708 -তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-834-4708 nga walay bayad.
Burmese -	ထွက်နှုန်းစရာမလိုဘဲ (မြန်မာဘာသာဝက္ခာ) ဖြင့် ဘာသာဝက္ခာအကူအညီရယူရန် 1-888-834-4708 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-888-834-4708.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-888-834-4708 sin gåstu.
Cherokee -	Theta Wyethi Ahači Jihoháči Ródy Theta (GWY) O'BWÓ'IS 1-888-834-4708 O'Theta L' AΓούλι JEGP JL hPRTheta.
Chinese -	欲取得繁體中文語言協助，請撥打 1-888-834-4708，無需付費。
Choctaw -	(Chahta) anumpa ya_apela a chi I p_aya hinla 1-888-834-4708.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-834-4708 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-834-4708.
French -	Pour une assistance linguistique en français appeler le 1-888-834-4708 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-834-4708 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-834-4708 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-834-4708 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-834-4708 પર કોલ કરો.

Hawaiian -	No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-888-834-4708 . Kāki ‘ole ‘ia kēia kōkua nei.
Hindi -	हन्दी में भाषा सहायता के लिए, 1-888-834-4708 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-834-4708 .
Ibo -	Maka enyemaka asusụ na Igbo kpọọ 1-888-834-4708 na akwughị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-834-4708 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-834-4708 .
Japanese -	日本語で援助をご希望の方は、1-888-834-4708まで無料でお電話ください。
Karen -	လာတ်မြတ်တို့ကတိုင်အရှင် လိုင် လီ: 1-888-834-4708 လာတ်အိုးတို့လာတ်စွား၏
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-834-4708 번으로 전화해 주십시오.
Kru-Bassa -	Be'm'ké gbo-kpá-kpá dyé piáyi dé Bašoó-wuquùn wéé, dá 1-888-834-4708
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-888-834-4708 به خوراکی پیمودنی بگم.
Laotian -	ຖ້າທ່ານຕົ້ນອງການຄວາມຊັ້ນເຫຼືອໃນການແປພາສາລາວ, ລະລຸນາໄທທາ 1-888-834-4708 ໄດຍບໍ່ເສຍຄ່າໄທ.
Marathi -	कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-888-834-4708 वर फोन करा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-834-4708 ilo ejjelok wōnān.
Micronesian- Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-834-4708 ni sohte isais.
Mon-Khmer, Cambodian -	សមුජබ්ධියායා ກාසිංහ් ສුජ්දාස් ຖුංචා ຕාක්නෑ 1-888-834-4708 ຜ්‍රායකක්ක් ස්ථානීය
Navajo -	T'áá shi shizaad k'ehjí bee shíká a doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-834-4708
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1- 888-834-4708 मा फोन गर्नुहोस्।
Nilotic-Dinka -	Tēn kuɔɔny ë thok ë Thuɔɔnjān̄ cōl 1-888-834-4708 kecīn ayc̄c.
Norwegian -	For språkassistanse på norsk, ring 1-888-834-4708 kostnadsfritt.
Punjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-834-4708 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-888-834-4708 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-888-834-4708 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-834-4708 .

