



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 1-877-480-4161. 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 1-877-480-4161 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each <u>Plan Year</u> , In- <u>Network</u> : Individual \$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.
Are there services covered before you meet your deductible?	Yes. 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 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- <u>Network</u> : Individual \$8,750.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	<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 network provider?	Yes. See www.aetna.com/docfind or call 1-877-480-4161 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.
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	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	None
	<u>Specialist</u> visit	\$30 <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)	20% <u>coinsurance</u>	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	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.aetna.com/pharmacy-insurance/individuals-families	Generic drugs	\$20 (retail), \$40 (mail order) <u>Copay</u> /prescription, <u>deductible</u> doesn't apply	Not covered	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> .
	Preferred brand drugs	\$40 (retail), \$80 (mail order) <u>Copay</u> /prescription, <u>deductible</u> doesn't apply	Not covered	
	Non-preferred brand drugs	\$65 (retail), \$130 (mail order) <u>Copay</u> /prescription, <u>deductible</u> doesn't apply	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)	
	<u>Specialty drugs</u>	Applicable cost as noted above for generic or brand drugs	Not covered	First prescription fill at a retail pharmacy or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Pharmacy <u>Network</u> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u> after \$150 <u>copay/visit</u>	Not covered	None
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u> after \$350 <u>copay/visit</u>	20% <u>coinsurance</u> after \$350 <u>copay/visit</u>	Out-of-network 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-network emergency use paid the same as in- <u>network</u> .
	<u>Urgent care</u>	\$30 <u>copay/visit</u> , <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)	20% <u>coinsurance</u> after \$150 <u>copay/admission</u>	Not covered	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$20 <u>copay/visit</u> , <u>deductible</u> doesn't apply; other outpatient services: 20% <u>coinsurance</u>	Not covered	None
	Inpatient services	20% <u>coinsurance</u> after \$150 <u>copay/admission</u>	Not covered	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
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
	Childbirth/delivery professional 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)	
	Childbirth/delivery facility services	20% <u>coinsurance</u> after \$150 <u>copay/admission</u>	Not covered	services described elsewhere in the SBC (i.e., ultrasound). Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	Not covered	100 visits/ <u>plan</u> year.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	Not covered	Includes Physical, Occupational & Speech Therapy combined.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	Not covered	
	<u>Skilled nursing care</u>	\$250 <u>copay/admission</u>	Not covered	100 days/ <u>plan</u> year. Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	20% <u>coinsurance</u>	Not covered	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 routine eye exam/ <u>plan</u> year up to age 19.
	Children's glasses	No charge	Not covered	1 pair of glasses or lenses/ <u>plan</u> year.
	Children's dental check-up	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.)

- | | | |
|---|--|---|
| <ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) • Hearing aids | <ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing | <ul style="list-style-type: none"> • Routine eye care (Adult) • Routine foot care • Weight loss programs - Except for required <u>preventive services</u>. |
|---|--|---|

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.

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: Idaho Department of Insurance, (800) 721-3272, (208) 334-4319, <http://www.doi.idaho.gov>.

- For more information on your rights to continue coverage, contact the [plan](#) at 1-877-480-4161.

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 1-877-480-4161.
- Idaho Department of Insurance, (800) 721-3272, (208) 334-4319, <http://www.doi.idaho.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 \$0
- Specialist copayment \$30
- 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:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,770

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

- The plan's overall deductible \$0
- Specialist copayment \$30
- 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	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,400
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,520

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

- The plan's overall deductible \$0
- Specialist copayment \$30
- 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:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$70
<u>Coinsurance</u>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$970

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

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 unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide 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: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), 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 companies, including Aetna Life Insurance Company and its affiliates (Aetna).

TTY: 711

Language Assistance:

To access language services at no cost to you, call 1-877-480-4161.

- Albanian - Për shërbime përkthimi falas për ju, telefononi 1-877-480-4161.
- Amharic - የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-877-480-4161 ይደውሉ።
- Arabic - للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-877-480-4161
- Armenian - Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-877-480-4161 հեռախոսահամարով:
- Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-480-4161 tanpa dikenakan biaya.
- Bantu-Kirundi - Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-877-480-4161.
- Bengali-Bangala - আপনাকে বিনামূল্যে ভাষা পবিকষিা পপকে হকয এই নম্বকি পেবযক ান েরন: 1-877-480-4161
- Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-877-480-4161.
- Burmese - သငှ်အေ့ဖှ်အေ့ဖှ်ကေးဝေးငြ် မေးရပဲ ဘာသာစကားဝန်ဆောင်မေး ရရှိပိုင်ရန် 1-877-480-4161 သို့၎ ဖုန်းေးခေ့ဆှ်ပါ။
- Catalan - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-877-480-4161.
- Chamorro - Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-877-480-4161.
- Cherokee - ႠႃႆႠ ႠႃႆႠ ႠႃႆႠ ႠႃႆႠ ႠႃႆႠ ႠႃႆႠ ႠႃႆႠ ႠႃႆႠ ႠႃႆႠ ႠႃႆႠ 1-877-480-4161.
- Chinese - 如欲使用免費語言服務，請致電 1-877-480-4161.
- Choctaw - Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-877-480-4161.
- Cushite - Tajaajiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-877-480-4161.
- Dutch - Voor gratis toegang tot taaldiensten, bell 1-877-480-4161.
- French - Afin d'accéder aux services langagiers sans frais, composez le 1-877-480-4161.
- French Creole - Pou jwenn sèvis lang gratis, rele 1-877-480-4161.
- German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-877-480-4161 an.
- Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-877-480-4161.
- Gujarati - તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેવાઓની પહોર માટે, કોલ કરો1-877-480-4161.

- Hawaiian - No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i kēia helu kelepona 1-877-480-4161. Kāki 'ole 'ia kēia kōkua nei.
- Hindi - आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए, 1-877-480-4161 पर कॉल करें।
- Hmong - Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-877-480-4161.
- Igbo - Iji nwetaòhèrè na orụ gasị asụsụ n'efu, kpọọ 1-877-480-4161
- Ilocano - Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-877-480-4161.
- Indonesian - Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-877-480-4161.
- Italian - Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-877-480-4161.
- Japanese - 言語サービスを無料でご利用いただくには、1-877-480-4161 までお電話ください。
- Karen - လၢတၢ်ကမၤန့ၢ်ကိၣ်အတၢ်မၤစၢၤအတၢ်ဖဲၤတၢ်မၤတဖၣ်လၢတၢ်အိၣ်ဒီးအပူၤလၢကဘၣ်ဟ့ၣ်အိၣ်အဂီၢ်ဘၣ်န့ၣ် ကိး 1-877-480-4161 တက့ၢ်.
- Korean - 무료 언어 서비스를 이용하려면 1-877-480-4161 번으로 전화해 주십시오.
- Kru-Bassa - M̈ dyi wuḍu-dù kà kò dò bë dyi m̈ou ní nì Pídyi ní, níí, dá nòbà nià ke: 1-877-480-4161
- Kurdish - 1-877-480-4161 بۆ دەسپێرێتگه‌شتن به خزمه‌تگوزاری زمان به‌ی تێچوون بۆ تۆ، په‌یوه‌ندی بکه به ژماره‌ی
- Laotian - ເພື່ອຂ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໃບຫາເບີ1-877-480-4161
- Marathi - कोणत्याही शक्ुकालशवाय भाषा सेवा प्राप्त करण्यासाठी,, 1-877-480-4161 वर फोन करा.
- Marshallese - Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-877-480-4161.
- Micronesian - Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-877-480-4161.
- Pohnpeyan - 1-877-480-4161 ເຂົ້າໄປສູ່ເວັບໄຊຂອງພວກຂ້າເພື່ອສອບຖາມກ່ຽວກັບບໍລິການພາສາຂ້າ ຫຼື ສອບຖາມກ່ຽວກັບບໍລິການອື່ນໆຂ້າ ຈົ່ງ ໂທຫາເບີ 1-877-480-4161
- Mon-Khmer, Cambodian - 1-855-821-9720 ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ
- Navajo - T'áá ni nizaad k'ehjí bee níká a'doowoł doo báąh ílínígóó kojí' hólne' 1-877-480-4161.
- Nepali - निःशुल्क भाषा सेवा प्राप्त गर्न 1-877-480-4161 मा टेलिफोन गर्नुहोस् ।
- Nilotic-Dinka - Të koor yin wεĕř de thokic ke cĭn wĕu kɔr keek tĕnɔŋ yĭn. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 1-877-480-4161.
- Norwegian - For tilgang til kostnadsfri språktjenester, ring 1-877-480-4161.
- Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-877-480-4161.
- Persian - برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-877-480-4161 تماس بگیرید .
- Polish - Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-877-480-4161.
- Portuguese - Para acessar os serviços de idiomas sem custo para você, ligue para 1-877-480-4161.

