



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 <u>deductible</u> ?	For each Plan Year, In-Network: Individual \$500 / Family \$1,500. Out-of-Network: Individual \$1,000 / Family \$3,000.	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. In-network 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	In-Network: Individual \$7,900 / Family \$15,800. Out-of-Network: Individual \$15,800 / Family \$31,600.	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 & penalties for failure to obtain <u>pre-authorization</u> 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 <u>network provider</u> ?	Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-877-480-4161 for a list of in-network providers.	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	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 <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$50 <b>copay</b> /visit, <b>deductible</b> doesn't apply	50% <b>coinsurance</b>	None
	<b>Specialist</b> visit	\$50 <b>copay</b> /visit, <b>deductible</b> doesn't apply	50% <b>coinsurance</b>	None
	<b>Preventive care</b> / <b>screening</b> /immunization	No charge	50% <b>coinsurance</b> , except no charge for immunizations up to age 6	You may have to pay for services that aren't preventive. Ask your <b>provider</b> if the services needed are preventive. Then check what your <b>plan</b> will pay for.
If you have a test	<b>Diagnostic test</b> (x-ray, blood work)	25% <b>coinsurance</b>	50% <b>coinsurance</b>	None
	Imaging (CT/PET scans, MRIs)	25% <b>coinsurance</b>	50% <b>coinsurance</b>	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)	
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="https://www.aetna.com/individuals-families/pharmacy.html">https://www.aetna.com/individuals-families/pharmacy.html</a>	Generic drugs	<u>Copay/prescription, deductible</u> doesn't apply: \$15 (retail), \$45 (mail order)	40% <u>coinsurance</u> after <u>copay/prescription, deductible</u> doesn't apply: \$15 (retail)	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in- <u>network</u> .
	Preferred brand drugs	<u>Copay/prescription, deductible</u> doesn't apply: \$50 (retail), \$135 (mail order)	40% <u>coinsurance</u> after <u>copay/prescription, deductible</u> doesn't apply: \$50 (retail)	
	Non-preferred brand drugs	<u>Copay/prescription, deductible</u> doesn't apply: \$65 (retail), \$180 (mail order)	40% <u>coinsurance</u> after <u>copay/prescription, deductible</u> doesn't apply: \$65 (retail)	
	<u>Specialty drugs</u>	<u>Copay/prescription, deductible</u> doesn't apply: \$150	40% <u>coinsurance</u> after <u>copay/prescription, deductible</u> doesn't apply: \$150	None
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	25% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	25% <u>coinsurance</u>	50% <u>coinsurance</u>	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	25% <u>coinsurance</u> after \$200 <u>copay/visit</u>	25% <u>coinsurance</u> after \$200 <u>copay/visit</u>	No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$50 <u>copay/visit</u> , <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	No coverage for non-urgent use.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	25% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	25% <u>coinsurance</u>	50% <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 mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply; other outpatient services: 25% <u>coinsurance</u>	Office & other outpatient services: 50% <u>coinsurance</u>	None
	Inpatient services	25% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you are pregnant	Office visits	No charge	50% <u>coinsurance</u>	<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>pre-authorization</u> for out-of-network care may apply.
	Childbirth/delivery professional services	25% <u>coinsurance</u> , <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	25% <u>coinsurance</u> , <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 60 visits/ <u>plan</u> year.
	<u>Rehabilitation services</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	Includes Physical, Occupational & Speech Therapy.
	<u>Habilitation services</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 25 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>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	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	50% <u>coinsurance</u>	1 routine eye exam/ <u>plan</u> year up to age 19.
	Children's glasses	No charge	50% <u>coinsurance</u>	1 pair of glasses or lenses/ <u>plan</u> year.
	Children's dental check-up	No charge	No charge	Limited to 2 visits every 12 months.

## 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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Chiropractic care – limited to 35 visits/plan year.
- Hearing aids - 1 hearing aid per ear/36 months.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Routine eye care (Adult)

## 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: Texas Department of Insurance, (800) 578-4677, <http://www.tdi.texas.gov/index.html>.

- For more information on your rights to continue coverage, contact the plan at 1-877-480-4161.
- State Consumer Assistance Program, if other than state insurance department contact Texas Department of Insurance, 333 Guadalupe, Austin, TX 78701, (800) 578-4677, <http://www.tdi.texas.gov/index.html>.
- 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](http://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:

- Texas Department of Insurance, (800) 578-4677, <http://www.tdi.texas.gov/index.html>.
- Additionally, a consumer assistance program can help you file your appeal. Contact Texas Department of Insurance, 333 Guadalupe, Austin, TX 78701, (800) 578-4677, <http://www.tdi.texas.gov/index.html>.

## 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 <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist</u> <u>copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	25%
■ Other <u>coinsurance</u>	25%

**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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
<b>In this example, Peg would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$100
Coinsurance	\$3,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,660</b>

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

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist</u> <u>copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	25%
■ Other <u>coinsurance</u>	25%

**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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
<b>In this example, Joe would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$1,900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,020</b>

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

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist</u> <u>copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	25%
■ Other <u>coinsurance</u>	25%

**This EXAMPLE event includes services like:**  
Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$100
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$900</b>

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 1-877-480-4161.

### 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](mailto: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.**



**Language Assistance:**

Albanian -	Për asistencë në gjuhën shqipe telefononifalas në 1-877-480-4161.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-877-480-4161 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-877-480-4161
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) գանգի 1-877-480-4161 առանց գումար:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-480-4161 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-877-480-4161 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-877-480-4161-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-877-480-4161 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-877-480-4161 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-877-480-4161.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-877-480-4161 singåstu.
Cherokee -	ᏅᎠᏂᏚᏐ ᏍᏓᏃᏗᏙᏗᏔᏗᏞᏗᏙ ᏅᎠᏂᏚᏐ ᏧᏪᏄᏗᏙ (GWY) ᏕᏊᏊᏗᏙᏗᏙ 1-877-480-4161 ᏕᏂᏒᏗᏙ ᏕᏂᏒᏗᏙ ᏧᏪᏄᏗᏙ ᏧᏪᏄᏗᏙ.
Chinese -	欲取得繁體中文語言協助，請撥打1-877-480-4161，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi l paya hinla 1-877-480-4161.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-877-480-4161 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-877-480-4161.
French -	Pour une assistance linguistique en français appeler le 1-877-480-4161 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-877-480-4161 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-877-480-4161 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-877-480-4161 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-877-480-4161 પર કોલ કરો.

Hawaiian -	No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-877-480-4161. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi -	हन्दि में भाषा सहायता के लएि, 1-877-480-4161 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-877-480-4161.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-877-480-4161 na akwughị ugwo o bula
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-480-4161 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-877-480-4161.
Japanese -	日本語で援助をご希望の方は、1-877-480-4161 まで無料でお電話ください。
Karen -	လၢတၢ်မၤစၢၤတၢ်ကတိၤကိၣ်အံၤကိၣ် ဂီၣ် ဂီၣ်: 1-877-480-4161 လၢတၢ်အိၣ်ဒီးတၢ်လၢၢ်ဘျၣ်လၢၢ်စၢၤဘျၣ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-480-4161 번으로 전화해 주십시오.
Kru-Bassa -	Ḑe'm'ké gbo-kpá-kpá dyé pídyi dé Ḑaśwó-wuḍuŋn wěɛ, d́á 1-877-480-4161
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-877-480-4161 به خورایی یه یومندی بکهن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-877-480-4161 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	तीलभाषा (मराठी) सहाय्यासाठी 1-877-480-4161 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-877-480-4161 ilo ejjelok wōnān.
Micronesian - Pohnpeyan - Mon-Khmer, Cambodian -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-877-480-4161 ni sohte isais. សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទទេៅកាន់លេខ 1-877-480-4161 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjíkoji' t'áá jíík'e hólne' 1-877-480-4161
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1- 877-480-4161 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuwoɲy ë thok ë Thuonjäŋ col 1-877-480-4161 kec'in ayöc.
Norwegian -	For språkassistanse på norsk, ring 1-877-480-4161 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-877-480-4161 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Hefle in Deitsch, ruf: 1-877-480-4161 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-877-480-4161 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-877-480-4161.

[illegible]