



ARTCENTER COLLEGE OF DESIGN:
Open Choice® PPO

Coverage for: Individual + Family | Plan Type: PPO



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 1-855-236-2138 . 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 1-855-236-2138 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. Out-of-Network: 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. <u>Prescription drugs</u> ; plus in- <u>network 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 \$7,350 / Family \$14,700. Out-of-Network: Individual NONE / Family NONE.	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 out-of-pocket limit?	<u>Premiums</u> , <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> .
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-855-236-2138 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 charge</u> 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	20% <u>coinsurance</u> after \$25 <u>copay</u> /visit	50% <u>coinsurance</u> after \$50 <u>copay</u> /visit	None
	<u>Specialist</u> visit	20% <u>coinsurance</u> after \$25 <u>copay</u> /visit	50% <u>coinsurance</u> after \$50 <u>copay</u> /visit	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	50% <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>	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.aetna.com/individuals-families/pharmacy.html	Generic drugs	<u>Copay/prescription, deductible doesn't apply: \$10 (retail)</u>	<u>Copay/prescription, deductible doesn't apply: \$10 (retail)</u>	Covers 30 day supply (retail). \$250 maximum copay for each 30 day supply. 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 doesn't apply: \$40 (retail)</u>	<u>Copay/prescription, deductible doesn't apply: \$40 (retail)</u>	
	Non-preferred brand drugs	40% <u>coinsurance, deductible doesn't apply (retail)</u>	40% <u>coinsurance, deductible doesn't apply (retail)</u>	
	<u>Specialty drugs</u>	Applicable cost as noted above for generic or brand drugs	Applicable cost as noted above for generic or brand drugs	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <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 immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u> after \$150 <u>copay/visit</u>	20% <u>coinsurance</u> after \$150 <u>copay/visit</u>	No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	20% <u>coinsurance</u> after \$25 <u>copay/visit</u>	50% <u>coinsurance</u> after \$50 <u>copay/visit</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$200 for failure to obtain <u>precertification</u> for out-of-network care.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<u>Deductible</u> doesn't apply: Office: 20% <u>coinsurance</u> after \$25 <u>copay/visit</u> ; other outpatient services: 20% <u>coinsurance</u>	<u>Deductible</u> doesn't apply: Office: 50% <u>coinsurance</u> after \$50 <u>copay/visit</u> ; other outpatient services: 50% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$200 for failure to obtain <u>precertification</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 \$200 for failure to obtain <u>precertification</u> for out-of-network care may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	

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 help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Rehabilitation services</u>	20% <u>coinsurance</u> after \$25 <u>copay</u> /visit	50% <u>coinsurance</u> after \$50 <u>copay</u> /visit	Includes Physical, Occupational & Speech Therapy.
	<u>Habilitation services</u>	20% <u>coinsurance</u> after \$25 <u>copay</u> /visit	50% <u>coinsurance</u> after \$50 <u>copay</u> /visit	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$200 for failure to obtain <u>precertification</u> for out-of-network care.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$200 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	50% <u>coinsurance</u> , <u>deductible</u> doesn't apply	1 routine eye exam/ <u>plan</u> year up to age 19.
	Children's glasses	No charge	50% <u>coinsurance</u> , <u>deductible</u> doesn't apply	1 pair of glasses or lenses/ <u>plan</u> year.
	Children's dental check-up	No charge	50% <u>coinsurance</u>	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 | • Hearing aids | • Routine foot care |
| • Dental care (Adult) | • Long-term care | • Weight loss programs - Except for required preventive services. |
| | • Private-duty nursing | |

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 1-855-236-2138 .

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 1-855-236-2138 .
- 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 plan's overall deductible \$500
- 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:	
<u>Cost Sharing</u>	
Deductibles	\$500
Copayments	\$10
Coinsurance	\$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 \$500
- Specialist coinsurance 20%
- 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>	
Deductibles	\$500
Copayments	\$900
Coinsurance	\$100
<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 \$500
- 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:	
<u>Cost Sharing</u>	
Deductibles	\$500
Copayments	\$10
Coinsurance	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,010

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 1-855-236-2138 .

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.

- Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-855-236-2138 . Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - **हन्दि में भाषा सहायता के लएि, 1-855-236-2138 पर मुफ्त कॉल करें।**
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-855-236-2138 .
- Ibo - **Maka enyemaka asụsụ na Igbo kpọọ 1-855-236-2138 na akwughị ugwo ọ bụla**
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-855-236-2138 nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-855-236-2138 .
- Japanese - **日本語で援助をご希望の方は、1-855-236-2138 まで無料でお電話ください。**
- Karen - လာဝတီမတၢတၢ်ကတိၤကိၣ်အိၣ်ကိၣ် ကိၣ်ကိၣ် 1-855-236-2138 လာဝတီအိၣ်ဒီးတၢ်လာဝတီၤကတိၤကိၣ်
- Korean - **한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-855-236-2138 번으로 전화해 주십시오.**
- Kru-Bassa - **Ḃe m'ké gbo-kpá-kpá dyé pídyi dé Ḃaśwó-wuḂuḂũn wěě, dǎ** 1-855-236-2138
- Kurdish - **برای راهنمایی به زبان فارسی با شماره 1-855-236-2138 به خۆرای یه یۆمندی بکهن.**
- Laotian - **ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-855-236-2138 ໂດຍບໍ່ເສຍຄ່າໂທ.**
- Marathi - **कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-855-236-2138 वर फोन करा.**
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-855-236-2138 ilo ejjelok wōnān.
- Micronesian-Pohnpeyan - **Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-855-236-2138 ni sohte isais.**
- Mon-Khmer, Cambodian - **សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-855-236-2138 ដោយឥតគិតថ្លៃ។**
- Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-855-236-2138
- Nepali - **(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1- 855-236-2138 मा फोन गर्नुहोस् ।**
- Nilotic-Dinka - **Tèn kuwoony ë thok ë Thuonjān col 1-855-236-2138 kec'in ayöc.**
- Norwegian - **For språkassistanse på norsk, ring 1-855-236-2138 kostnadsfritt.**
- Panjabi - **ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-855-236-2138 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।**
- Pennsylvania Dutch - **Fer Hefle in Deitsch, ruf: 1-855-236-2138 aa. Es Aaruf koschtet nix.**
- Persian - **برای راهنمایی به زبان فارسی با شماره 1-855-236-2138 بدون هیچ هزینه ای تماس بگیرید. انگلیسی**
- Polish - **Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-855-236-2138 .**

- Portuguese - Para obter assistência linguística em português ligue para o 1-855-236-2138 gratuitamente.
- Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-855-236-2138
- Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-855-236-2138 .
- Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-855-236-2138 e aunoa ma se totogi.
- Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-855-236-2138 .
- Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-855-236-2138 .
- Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-855-236-2138 . Njodi woo fawaaki on.
- Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-855-236-2138 bila malipo.
- Syriac - ܠܟܘܢ ܠܗܘܠܐܢܘܬܐ ܕܠܘܓܗܐ ܕܟܝܘܘܬܝܝܐ ܕܗܘܐܠܐ ܦܘܠܐܪ ܢܘܕܕܝܐ ܕܘܘܢܘܡܪܘܘܢ ܕܠܟܘܢ ܕܘܘܢܘܡܪܘܘܢ ܕܠܟܘܢ ܕܘܘܢܘܡܪܘܘܢ ܕܠܟܘܢ ܕܘܘܢܘܡܪܘܘܢ 1-855-236-2138 ܕܠܟܘܢ .
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-855-236-2138 nang walang bayad.
- Telugu - భాషలో సాయం కోరకు ఎలాంటి ఖర్చు లేకుండా 1-855-236-2138 కు కాల్ చేయండి. (తెలుగు)
- Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-855-236-2138 ฟรีไม่มีค่าใช้จ่าย
- Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-855-236-2138 'o 'ikai hā ʻōtōngi.
- Trukese - Ren ánninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-855-236-2138 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedi 1-855-236-2138 .
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-855-236-2138 .
- Urdu - بلا قیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے 1-855-236-2138 پر بات کریں۔
- Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-855-236-2138 .
- Yiddish - פאר שפראך הילף אין אידיש רופט 1-855-236-2138 פון אפצאל.
- Yoruba - Fún irànጔwọ nípa èdè (Yorùbá) pe 1-855-236-2138 láí san owó kankan rárá.