



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/en/school/232088/members.html> or by calling 1-877-626-2308. 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 1-877-626-2308 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	For each <u>Plan Year</u> , In- <u>Network</u> : Individual \$500. Out-of- <u>Network</u> : Individual \$1,000.	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. <u>Prescription drugs</u> ; plus in- <u>network</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 <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- <u>Network</u> : Individual \$7,500. Out-of- <u>Network</u> : Individual \$15,000.	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 <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 www.aetna.com/docfind or call 1-877-626-2308 for a list of in- <u>network</u> 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 provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u> after \$25 <u>copay</u> /visit	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	20% <u>coinsurance</u> after \$25 <u>copay</u> /visit	40% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	30% <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
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <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.aetnastudenthealth.com/en/school/232088/members/prescriptions.html	Generic drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$25 (retail)	30% <u>coinsurance</u> after <u>copay</u> /prescription, <u>deductible</u> doesn't apply: \$25 (retail)	Covers 30-day supply (retail). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> .
	Preferred brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$65 (retail)	30% <u>coinsurance</u> after <u>copay</u> /prescription, <u>deductible</u> doesn't apply: \$65 (retail)	
	Non-preferred brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$100 (retail)	30% <u>coinsurance</u> after <u>copay</u> /prescription, <u>deductible</u> doesn't apply: \$100 (retail)	
	<u>Specialty drugs</u>	20% <u>coinsurance</u> , <u>deductible</u> doesn't apply	20% <u>coinsurance</u> , <u>deductible</u> doesn't apply	None
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

* For more information about limitations and exceptions, see the plan or policy document at www.aetnastudenthealth.com.

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 \$200 <u>copay/visit</u>	20% <u>coinsurance</u> after \$200 <u>copay/visit</u>	Out-of-network emergency use paid the same as <u>in-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 <u>in-network</u> .
	<u>Urgent care</u>	20% <u>coinsurance</u> after \$25 <u>copay/visit</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> after \$200 <u>copay/stay</u>	40% <u>coinsurance</u>	Penalty of \$500 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: 20% <u>coinsurance</u> after \$25 <u>copay/visit</u> ; other outpatient services: 20% <u>coinsurance</u>	Office & other outpatient services: 40% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u> after \$200 <u>copay/stay</u>	40% <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	30% <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	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u> after \$200 <u>copay/stay</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Includes Physical & Occupational & Speech Therapy.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	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>	40% <u>coinsurance</u>	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>	40% <u>coinsurance</u>	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.

* For more information about limitations and exceptions, see the plan or policy document at www.aetnastudenthealth.com.

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 your child needs dental or eye care	Children's eye exam	No charge	30% <u>coinsurance</u>	1 routine eye exam/ <u>plan</u> year. Covered through the end of the month in which the covered person turns age 19.
	Children's glasses	No charge	30% <u>coinsurance</u>	1 pair of glasses or lenses/ <u>plan</u> year. Covered through the end of the month in which the covered person turns age 19.
	Children's dental check-up	No charge	30% <u>coinsurance</u>	Covered through the end of the month in which the covered person turns age 19.

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
- Routine eye care (Adult)
- 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
- Hearing aids – 1 hearing aid per ear/4 years
- Infertility treatment – Limited to the diagnosis & treatment of underlying medical condition.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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: Missouri Department of Commerce and Insurance, Harry S. Truman State Office Building, 573-751-4126, Insurance Consumer Hotline: 800-726-7390, <https://insurance.mo.gov/consumers/complaints/index.php>. For more information on your rights to continue coverage, contact the plan at 1-877-626-2308. 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 Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-877-626-2308 or Missouri Department of Commerce and Insurance, Harry S. Truman State Office Building, 573-751-4126, Insurance Consumer Hotline: 800-726-7390, <https://insurance.mo.gov/consumers/complaints/index.php>.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-626-2308.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-626-2308.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-626-2308.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-626-2308.

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 copayment \$25
- 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	\$9,930
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 \$500
- Specialist copayment \$25
- 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	\$3,580
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$1,400
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,020

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

- The plan's overall deductible \$500
- Specialist copayment \$25
- 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	\$1,790
In this example, Mia would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$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 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).

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TTY: 711

Language Assistance:

To access language services at no cost to you, call 1-877-626-2308.

- Albanian - Për shërbime përkthimi falas për ju, telefononi 1-877-626-2308.
- Amharic - የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-877-626-2308 ይደውሉ።
- Arabic - للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-877-626-2308
- Armenian - Անվճար լեզվալիան ծառայություններից օգտվելու համար զանգահարեք 1-877-626-2308 հեռախոսահամարով:
- Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-626-2308 tanpa dikenakan biaya.
- Bantu-Kirundi - Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-877-626-2308.
- Bengali-Bangala - আপনাকে বিনামূল্যে ভাষা পবিকষি পপকে হকয এই নম্বকি পেবযক ান েরন: 1-877-626-2308
- Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-877-626-2308.
- Burmese - သငှ်အေနှုဖှ်အေဗှ်ကေးငှ် မေပးရဲပဲ ဘာသာစကားဝန်ဆေးမ်း ရှိှ်ငှ် 1-877-626-2308 သို့ ဖှ်ေးခေငှ်ပိ။
- Catalan - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-877-626-2308.
- Chamorro - Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-877-626-2308.
- Cherokee - Ⴀႃႆႃ Ⴁႃႆႃႆႃ Ⴁႃႆႃႆႃ Ⴁႃႆႃ Ⴁႃႆႃႆႃ Ⴁႃႆႃ Ⴁႃႆႃႆႃႆႃ 1-877-626-2308.
- Chinese - 如欲使用免費語言服務，請致電 1-877-626-2308.
- Choctaw - Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-877-626-2308.
- Cushite - Tajaajiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-877-626-2308.
- Dutch - Voor gratis toegang tot taaldiensten, bell 1-877-626-2308.
- French - Afin d'accéder aux services langagiers sans frais, composez le 1-877-626-2308.
- French Creole - Pou jwenn sèvis lang gratis, rele 1-877-626-2308.
- German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-877-626-2308 an.
- Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-877-626-2308.
- Gujarati - તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેવાઓની પહોંર માટે, કોલ કરો1-877-626-2308.

- Punjabi - ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-877-626-2308 'ਤੇ ਫੋਨ ਕਰੋ।
- Romanian - Pentru a accesa gratuit serviciile de limbă, apălați 1-877-626-2308.
- Russian - Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-877-626-2308.
- Samoan - Mo le mauaina o auaunaga tau gagana e aunoa ma se tologi, vala'au le 1-877-626-2308.
- Serbo-Croatian - Za besplatne prevodilačke usluge pozovite 1-877-626-2308.
- Spanish - Para acceder a los servicios de idiomas sin costo, llame al 1-877-626-2308.
- Sudanic-Fulfude - Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-877-626-2308.
- Swahili - Kupata huduma za lugha bila malipo kwako, piga 1-877-626-2308.
- Syriac - ܟܝ ܫܒܩܐ, ܟܝ ܟܠ ܝܠܟܝܢܐ ܟܝ ܢܝܒܝܢܐ ܟܝ ܩܝܠܩܝܬܐ ܟܝ ܩܝܠܩܝܬܐ, ܟܝ ܩܝܠܩܝܬܐ: 1-877-626-2308
- Tagalog - Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-877-626-2308.
- Telugu - మీరు భాష సేవలను ఉచితంగా అందుకునందుకు, 1-877-626-2308 కు కాల్ చేయండి.
- Thai - หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-877-626-2308.
- Tongan - Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-877-626-2308.
- Trukese - Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-877-626-2308.
- Turkish - Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-877-626-2308 numarayı arayın.
- Ukrainian - Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-877-626-2308.
- Urdu - بالقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-888-982-3862 پر بات کریں۔
- Vietnamese - Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-877-626-2308.
- Yiddish - צו צוטריט שפראך באדינונגען אין קיין פרייז צו איר, רופן 1-877-626-2308
- Yoruba - Lati wọnú awọn isẹ èdè l'ọfẹ fun ọ, pe 1-877-626-2308.