



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 \$300. Out-of- <u>Network</u> : Individual \$300. | 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> & emergency care; 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 deductibles 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 & Out-of- <u>Network</u> : Individual \$5,000 / Family \$10,000. | 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 1-877-480-4161 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> after \$25 <u>copay</u> /visit | None |
| | <u>Specialist</u> visit | 20% <u>coinsurance</u> after \$25 <u>copay</u> /visit | 40% <u>coinsurance</u> after \$25 <u>copay</u> /visit | None |
| | <u>Preventive care</u> / <u>screening</u> /immunization | No charge | 0% <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.aetna.com/individuals-families/pharmacy.html | Generic drugs | <u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$20 (retail), \$50 (mail order) | 20% <u>coinsurance</u> /prescription, <u>deductible</u> doesn't apply | 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</u> /prescription, <u>deductible</u> doesn't apply: \$40 (retail), \$100 (mail order) | 30% <u>coinsurance</u> /prescription, <u>deductible</u> doesn't apply | |
| | Non-preferred brand drugs | <u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$80 (retail), \$200 (mail order) | 30% <u>coinsurance</u> /prescription, <u>deductible</u> doesn't apply | |
| | <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> | 40% <u>coinsurance</u> | None |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |

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| | | 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> | \$200 <u>copay/visit</u> , <u>deductible</u> doesn't apply | \$200 <u>copay/visit</u> , <u>deductible</u> doesn't apply | No coverage for non-emergency use. |
| | <u>Emergency medical transportation</u> | \$200 <u>copay/visit</u> , <u>deductible</u> doesn't apply | \$200 <u>copay/visit</u> , <u>deductible</u> doesn't apply | None |
| | <u>Urgent care</u> | 20% <u>coinsurance</u> after \$25 <u>copay/visit</u> | 40% <u>coinsurance</u> , after \$25 <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> | 40% <u>coinsurance</u> | None |
| | 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: 40% <u>coinsurance</u> after \$25 <u>copay/visit</u> ; & other outpatient services: 40% <u>coinsurance</u> | None |
| | Inpatient services | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |
| If you are pregnant | Office visits | No charge | 0% <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.) |
| | Childbirth/delivery professional services | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | |
| | Childbirth/delivery facility services | 20% <u>coinsurance</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> | 130 visits/ <u>plan</u> year. |
| | <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> | None |
| | <u>Skilled nursing care</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |
| | <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> | None |
| If your child needs dental or eye care | Children's eye exam | No charge | 0% <u>coinsurance</u> | 1 routine eye exam/ <u>plan</u> year up to age 19 |
| | Children's glasses | No charge | 0% <u>coinsurance</u> | 1 pair of glasses or lenses/ <u>plan</u> year. |
| | Children's dental check-up | No charge | 0% <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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- 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.)

- Acupuncture
- Chiropractic care – 35 visits/plan year.
- Hearing aids - 1 hearing aid per ear/3 years.
- 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: Washington State Office of the Insurance Commissioner, Consumer Protection Division, 800-562-6900, <http://www.insurance.wa.gov> or contact the plan at 1-877-480-4161. 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 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 or Washington State Office of the Insurance Commissioner, Consumer Protection Division, 800-562-6900, <http://www.insurance.wa.gov>.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-480-4161.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-480-4161.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-480-4161.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-480-4161.

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 \$100
- Specialist coinsurance 15%
- 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 | \$12,800 |
| In this example, Peg would pay: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$100 |
| Copayments | \$40 |
| Coinsurance | \$2,500 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$2,700 |

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

- The plan's overall deductible \$100
- Specialist coinsurance 15%
- 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 | \$7,400 |
| In this example, Joe would pay: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$100 |
| Copayments | \$1,500 |
| Coinsurance | \$200 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,820 |

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

- The plan's overall deductible \$100
- Specialist coinsurance 15%
- 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 | \$1,900 |
| In this example, Mia would pay: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$100 |
| Copayments | \$200 |
| Coinsurance | \$200 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$500 |

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 and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity. We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation or gender identity. We:

- Provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language assistance services to people whose primary language is not English, which may include:
 - Qualified interpreters
 - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call us at 1-888-982-3862 (TTY: 711).

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity you can file a grievance with:

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: 860-262-7705)
CRCoordinator@aetna.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with:

- The U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:
 - U.S. Department of Health and Human Services
 - 200 Independence Avenue, SW Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

- The Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at <https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx>

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