## 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/](https://www.aetnastudenthealth.com/) or by calling 1-877-375-7905. 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/](https://www.healthcare.gov/sbc-glossary/) or call 1-877-375-7905 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>For each Plan Year, In-Network: Individual $400. Out-of-Network: Individual $800.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Prescription drugs; plus in-network preventive care are covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don't have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>In-Network: Individual $7,500 / Family $15,000. Out-of-Network: Individual NONE / Family NONE.</td>
<td>The out–of–pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out–of–pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, health care this plan doesn't cover &amp; penalties for failure to obtain pre-authorization for services.</td>
<td>Even though you pay these expenses, they don't count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="https://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-877-375-7905 for a list of in-network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Out-of-Network Provider</td>
<td>20% coinsurance after $20 copay/visit</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>In-Network Provider</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Copay/prescription, deductible doesn't apply: $15 (retail), $30 (mail order)</td>
<td>Covers 30-day supply (retail), 31-90 day supply (retail &amp; mail order). Includes contraceptive drugs &amp; devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women’s contraceptives in-network.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Copay/prescription, deductible doesn't apply: $40 (retail), $80 (mail order)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Copay/prescription, deductible doesn't apply: $65 (retail), $130 (mail order)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Copay/prescription, deductible doesn't apply: $100</td>
<td>None</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>20% coinsurance after $100 copay/visit</td>
<td>20% coinsurance after $100 copay/visit</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance after $200 copay/stay</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office: 20% coinsurance after $20 copay/visit; other outpatient services: 20% coinsurance</td>
<td>Office &amp; other outpatient services: 50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance after $200 copay/stay</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance after $200 copay/stay</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance after $200 copay/stay</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
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<td>------------------------------------------</td>
<td>----------------------------</td>
<td>-------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>No charge</td>
<td>30% coinsurance, deductible doesn't apply</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>No charge</td>
<td>30% coinsurance, deductible doesn't apply</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>No charge</td>
<td>30% coinsurance</td>
</tr>
</tbody>
</table>

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/plan year.
- 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, 573-751-4126, https://insurance.mo.gov/consumers/complaints/index.php.

- For more information on your rights to continue coverage, contact the plan at 1-877-375-7905.

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 1-877-375-7905.

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 plan's overall deductible: $400
- 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:** $12,800

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$400</td>
</tr>
<tr>
<td>Copayments</td>
<td>$40</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,400</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions: $60

The total Peg would pay is **$2,900**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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

- The plan's overall deductible: $400
- 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:** $7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$400</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,400</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$200</td>
</tr>
</tbody>
</table>

**What isn't covered**
- 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: $400
- 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:** $1,900

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$400</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$300</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions: $0

The total Mia would pay is **$700**

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 1-877-375-7905.

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.
TTY: 711

Language Assistance:

For language assistance in your language call 1-877-375-7905 at no cost.
Hawaiian -

Hindi -
हिन्दी में भाषा सहायता के लिए, 1-877-375-7905 पर मुफ्त कॉल करें।

Hmong -
Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-877-375-7905.

Ibo -
Maka enyemaka asusu na Igbo kpọ 1-877-375-7905 na akwughị ụgwọ ọ bula

Ilocano -
Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-375-7905 nga awan ti bayadanyo.

Italian -
Per ricevere assistenza linguistica in italiano, puo' chiamare gratuitamente 1-877-375-7905.

Japanese -
日本語で援助をご希望の方は、1-877-375-7905 まで無料でお電話ください。

Karen -
คำขอความช่วยเหลือทางภาษาในภาษาอื่นๆ เวลาติดต่อ 1-877-375-7905.

Korean -
한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-375-7905 번으로 전화해 주십시오.

Kru-Bassa -
Bè’m ké gbo-kpá-kpá dyé pidyi dje Baso-wuquün wëe, dë 1-877-375-7905

Kurdish -

Laotian -

Marathi -

Marshallese -

Micronesian-Pohnpeyan -

Mon-Khmer, Cambodian -

Navajo -
T'áá shi shizaad k'ehjí bee shiká a'doowol nínízingo Diné k'ehjí koji' t'áá jiik'e hólne' 1-877-375-7905

Nepali -
(नेपाली) मा नि:शुल्क भाषा सहायता पाउनका लागि 1-877-375-7905 मा फोन गर्नुहोस्।

Nilotic-Dinka -

Norwegian -
For språkassistanse på norsk, ring 1-877-375-7905 kostnadsfritt.

Panjabi -

Pennsylvania Dutch -

Persian -

Polish -
Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-877-375-7905.
Portuguese - Para obter assistência linguística em português ligue para o 1-877-375-7905 gratuitamente.

Romanian - Pentru asistență lingvistică în română, telefonați la numărul gratuit 1-877-375-7905.

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-877-375-7905.

Samoan - Mo fesoasoani tau gagana le Gagana Samoa vala’au le 1-877-375-7905 e aunoa ma se totoni.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-877-375-7905.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-877-375-7905.

Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular nodde e oo numero doo 1-877-375-7905. Njodi woo fawaakii on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-877-375-7905 bila malipo.

Syriac - 1-877-375-7905

Tagalog - Para sa tulong sa wika na Tagalog, tawagan ang 1-877-375-7905 nang walang bayad.

Telugu - Ren áninnisin chikú ren (Kapasen Chuuk) kopwe kékkééri 1-877-375-7905 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-877-375-7905.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-877-375-7905.

Urdu - ارکارکرد کیونم رہی 1-877-375-7905 و اعلیٰ مین رہی م و در

Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-877-375-7905.

Yiddish - 1-877-375-7905

Yoruba - Fún irànlòwọ nípa èdè (Yòrùbá) pe 1-877-375-7905 lái san owó kankan rárá.