



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 1-866-654-2338. 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 1-866-654-2338 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-Network: Individual \$5,000. | 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. |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. <u>Prescription drugs</u> ; plus in- <u>network</u> office visits & <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 \$7,350. | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. |
| 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 1-866-654-2338 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</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> ? | Yes. | You must get a <u>referral</u> from school health services for off-campus care. Exception , referral not required for Physical Therapy. |

The West Virginia University Student Health Insurance Plan is underwritten by Aetna Life Insurance Company (Aetna). Aetna Student Health (SM) is the brand name used for products and services provided by Aetna Life Insurance Company and its applicable affiliated companies.



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 <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | 20% <u>coinsurance</u> after \$25 <u>copay/visit</u> , <u>deductible</u> doesn't apply | 50% <u>coinsurance</u> after \$70 <u>copay/visit</u> | None |
| | <u>Specialist</u> visit | 20% <u>coinsurance</u> after \$25 <u>copay/visit</u> , <u>deductible</u> doesn't apply | 50% <u>coinsurance</u> after \$70 <u>copay/visit</u> | None |
| | <u>Preventive care</u> / <u>screening</u> /immunization | No charge | 50% <u>coinsurance</u> , except no charge for child immunizations up to age 19 | 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> after \$25 <u>copay/visit</u> , <u>deductible</u> doesn't apply | 50% <u>coinsurance</u> after \$70 <u>copay/visit</u> | None |
| | Imaging (CT/PET scans, MRIs) | 20% <u>coinsurance</u> after \$25 <u>copay/visit</u> , <u>deductible</u> doesn't apply | 50% <u>coinsurance</u> after \$70 <u>copay/visit</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 drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.aetna.com/individuals-families/pharmacy.html | Preferred generic drugs | <u>Copay/prescription, deductible</u> doesn't apply: \$15 (retail), \$30 (mail order) | <u>Copay/prescription, deductible</u> doesn't apply: \$15 (retail) mail order not covered | Covers 30 day supply retail. Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network. |
| | Preferred brand drugs | <u>Copay/prescription, deductible</u> doesn't apply: \$40 (retail) \$80 (mail order) | <u>Copay/prescription, deductible</u> doesn't apply: \$40 (retail) mail order not covered | |
| | Non-preferred generic/brand drugs | <u>Copay/prescription, deductible</u> doesn't apply: \$75 (retail) \$150 (mail order) | <u>Copay/prescription, deductible</u> doesn't apply: \$75 (retail) mail order not covered | |
| | <u>Specialty drugs</u> | <u>Copay/prescription, deductible</u> doesn't apply: \$100 (retail) | Not covered | |
| 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 |
| If you need immediate medical attention | <u>Emergency room care</u> | 20% <u>coinsurance</u> after \$300 <u>copay/visit</u> | 20% <u>coinsurance</u> after \$300 <u>copay/visit</u> | No coverage for non-emergency use. |
| | <u>Emergency medical transportation</u> | No charge | No charge | None |
| | <u>Urgent care</u> | 20% <u>coinsurance</u> after \$50 <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 \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care. |
| | 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 mental health, behavioral health, or substance abuse services | Outpatient services | Office & other outpatient services: 20% <u>coinsurance</u> | Office & other outpatient services: 50% <u>coinsurance</u> | None |
| | Inpatient services | 20% <u>coinsurance</u> after \$300 <u>copay/visit</u> | 50% <u>coinsurance</u> after \$300 <u>copay/visit</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 | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | |
| | Childbirth/delivery facility services | 20% <u>coinsurance</u> , <u>deductible</u> doesn't apply | 50% <u>coinsurance</u> , <u>deductible</u> doesn't apply | |
| 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/visit</u> , <u>deductible</u> doesn't apply | 20% <u>coinsurance</u> after \$25 <u>copay/visit</u> | |
| | <u>Habilitation services</u> | 20% <u>coinsurance</u> after \$25 <u>copay/visit</u> , <u>deductible</u> doesn't apply | 20% <u>coinsurance</u> after \$25 <u>copay/visit</u> | Includes Physical, Occupational & Speech Therapy. |
| | <u>Skilled nursing care</u> | 20% <u>coinsurance</u> after \$300 <u>copay/visit</u> | 50% <u>coinsurance</u> after \$300 <u>copay/visit</u> | |
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | |
| | <u>Hospice services</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | |
| | | | | Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care. |
| | | | | Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse. |
| | | | | Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care. |

| 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 | 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> , <u>deductible</u> doesn't apply | 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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- 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.)

- Bariatric surgery
- Chiropractic care
- Hearing aids - 1 hearing aid per ear/24 months
- 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 up to age 19.

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: West Virginia Offices of the Insurance Commissioner, ATTN: Consumer Service Division, (304) 558-3386, 1-888-879-9842, (TDD) (304) 558-1296, (TDD) 1-800-435-7381, <http://www.wvinsurance.gov/ConsumerServices/ConsumerServices.aspx>.

- For more information on your rights to continue coverage, contact the plan at 1-866-654-2338.

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 1-866-654-2338.
- West Virginia Offices of the Insurance Commissioner, ATTN: Consumer Service Division, (304) 558-3386, 1-888-879-9842, (TDD) (304) 558-1296, (TDD) 1-800-435-7381, <http://www.wvinsurance.gov/ConsumerServices/ConsumerServices.aspx>.

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 \$500
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 30%

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 | \$500 |
| Copayments | \$40 |
| Coinsurance | \$2,400 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$3,000 |

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 30%

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 | \$0 |
| Copayments | \$1,400 |
| Coinsurance | \$200 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,620 |

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 30%

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 | \$500 |
| Copayments | \$0 |
| Coinsurance | \$300 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$800 |

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 1-866-654-2338.

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 1-866-654-2338. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - हनिदी में भाषा सहायता के लिए, 1-866-654-2338 पर मुफ्त कॉल करें।
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-866-654-2338.
- Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-866-654-2338 na akwughị ugwo ọ bụla
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-866-654-2338 nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-866-654-2338.
- Japanese - 日本語で援助をご希望の方は、1-866-654-2338 まで無料でお電話ください。
- Karen - လာဝတ်မတၢ်တၢ်ကတိၤကိၣ်အိၣ်ကိၣ် ကိၣ် ကိၣ်: 1-866-654-2338 လာဝတ်အိၣ်ဒီးတၢ်လာဝတ်တၢ်တၢ်တၢ်
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-654-2338 번으로 전화해 주십시오.
- Kru-Bassa - Ɓe m'ké gbo-kpá-kpá dyé pídyi dé Ɓáwó-wuḍuŋ wɛɛ, dǎ 1-866-654-2338
- Kurdish - برابری را هه‌نمایی به زبانی فارسی با شماره 1-866-654-2338 به خۆرای یه‌یۆمندی بکهن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-866-654-2338 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-866-654-2338 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-866-654-2338 ilo ejjelok wōnān.
- Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-866-654-2338 ni sohte isais.
- Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទេពកាន់លេខ 1-866-654-2338 ដោយឥតគិតថ្លៃ។
- Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-866-654-2338
- Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1- 866-654-2338 मा फोन गर्नुहोस् ।
- Nilotic-Dinka - Tën kuwoony ë thok ë Thuonjäng col 1-866-654-2338 kec'in ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-866-654-2338 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-866-654-2338 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Hefte in Deitsch, ruf: 1-866-654-2338 aa. Es Aaruf koschtet nix.
- Persian - برای راهنمایی به زبان فارسی با شماره 1-866-654-2338 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
- Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-866-654-2338.

