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, http://www.aetnastudenthealth.com or by calling 1-877-381-3544. 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 1-877-381-3544 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1: None. Tier 2: Individual: $300/ Family: $600. Tier 3: Individual: $600/ Family: $1,200 per Policy Year.	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.
Are there services covered before you meet your deductible?	Yes. In-Network preventive care including Pediatric Dental & Vision, O/P Mental & Substance, In-Network & Out-of-Network Prescribed Medicines and any service that applies copay.	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 https://www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Select Care (SLU Care): Individual: $2,150/ Family: $4,300 per Policy Year. In-network: Individual: $5,000/ Family: $10,000 per Policy Year. Out-of-network: Unlimited.	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.
What is not included in the out-of-pocket limit?	Penalties, Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-877-375-7905 for a list of network providers.	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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		Tier 1 Your Cost if You Use a Select Care Provider (SLU *Care*)	Tier 2 Your Cost if You Use a In-Network Provider (Aetna)	Tier 3 Your Cost if You Use an Out-of-Network Provider (Aetna)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	$40 copay/visit, deductible doesn't apply	30% coinsurance	None
	Specialist visit	0% coinsurance	$40 copay/visit, deductible doesn't apply	30% coinsurance	None
	Preventive care/screening/ immunization	No charge	No charge	30% coinsurance, except deductible doesn't apply to immunizations up to age 5	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	20% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	30% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/premierplus	Generic drugs (including specialty drugs)	Not Covered	$15 copay/supply (retail) /$30 copay/supply (mail order)	$15 copay/supply (retail) /$30 copay/supply (mail order)	Covers up to a 30 day supply (retail). Mail order covers up to a 90 day supply at 2 times the initial 30 day copay per supply.
	Preferred brand drugs (including specialty drugs)	Not Covered	$45 copay/supply (retail) /$90 copay/supply (mail order)	$45 copay/supply (retail) /$90 copay/supply (mail order)	
	Non-preferred brand drugs (including specialty drugs)	Not Covered	$75 copay/supply (retail) /$150 copay/supply (mail order)	$75 copay/supply (retail) /$150 copay/supply (mail order)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 copay/visit, deductible doesn't apply	$200 copay/visit, deductible doesn't apply	30% coinsurance	Pre-certification required, $500 penalty applies for Out-of-Network care which is not pre-certified. However, penalty will not exceed the cost of the benefit.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Your Cost if You Use a Select Care Provider (SLU *Care*)	Tier 2 Your Cost if You Use a In-Network Provider (Aetna)	Tier 3 Your Cost if You Use an Out-of-Network Provider (Aetna)	
	Physician/surgeon fees	$50 copay/visit	$200 copay/visit	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$150 copay/visit, deductible doesn't apply	$150 copay/visit, deductible doesn't apply	$150 copay/visit, deductible doesn't apply	Copay waived if admitted. Out-of-network emergency room care cost-share same as In-Network. No coverage for non-emergency care.
	Emergency medical transportation	0% coinsurance	0% coinsurance	0% coinsurance	Out-of-Network cost-share same as In-Network.
	Urgent care	Not Covered	$40 copay/visit, deductible doesn't apply	$75 copay/visit, deductible doesn't apply	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	$565 copay/per admission, deductible doesn't apply	30% coinsurance	Pre-certification required, $500 penalty applies for Out-of-Network care which is not pre-certified. However, penalty will not exceed the cost of the benefit.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Your Cost if You Use a Select Care Provider (SLU *Care*)	Tier 2 Your Cost if You Use a In-Network Provider (Aetna)	Tier 3 Your Cost if You Use an Out-of-Network Provider (Aetna)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: no charge	Office: $40 copay/visit, deductible doesn't apply; other outpatient services: 0%	Office & other outpatient services: 30% coinsurance	Penalty of $500 for failure to obtain pre-authorization for out-of-network care for ntensive outpatient program, outpatient detoxification, and partial hospitalization treatment.
	Inpatient services	0% coinsurance	$565 copay/per admission, deductible doesn't apply	30% coinsurance	Pre-certification required, $500 penalty applies for Out-of-Network care which is not pre-certified. However, penalty will not exceed the cost of the benefit.
If you are pregnant	Office visits	No Charge	No Charge	30% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	$565 copay/per admission, deductible doesn't apply	30% coinsurance	During the initial 48 or 96 hours; no pre-certification is required for the mother or her newly born child. A $500 penalty for Out-of-Network Care which is not pre-certified applies after 48/96 hours. However, penalty will not exceed the cost of the benefit.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Your Cost if You Use a Select Care Provider (SLU *Care*)	Tier 2 Your Cost if You Use a In-Network Provider (Aetna)	Tier 3 Your Cost if You Use an Out-of-Network Provider (Aetna)	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	0% coinsurance	30% coinsurance	Benefit limited to a maximum of 100 Visits per Policy Year.
	Rehabilitation services	0% coinsurance	$40 copay/visit, deductible doesn't apply	30% coinsurance	Refers to Physical, Occupational, Speech & Cognitive therapies. Benefit limited to 30 Visits per type per Policy Year.
	Habilitation services	0% coinsurance	$40 copay/visit, deductible doesn't apply	30% coinsurance	
	Skilled nursing care	0% coinsurance	0% coinsurance	30% coinsurance	Pre-certification required, $500 penalty applies for Out-of-Network Care which is not pre-certified. However, penalty will not exceed the cost of the benefit. Benefit limited to 150 days per Policy Year.
	Durable medical equipment	20% coinsurance	20% coinsurance	30% coinsurance	None.
	Hospice services	0% coinsurance	0% coinsurance	30% coinsurance	Pre-certification required, $500 penalty applies for Out-of-Network care which is not pre-certified. However, penalty will not exceed the cost of the benefit.
If your child needs dental or eye care	Children's eye exam	No Charge, Deductible does not apply	No Charge, Deductible does not apply	30% coinsurance	Covered through the end of the month in which the covered person turns 19. Limited to 1 exam per Policy Year.
	Children's glasses	No Charge, deductible does not apply	No Charge, deductible does not apply	30% coinsurance	Covered through the end of the month in which the covered person turns 19. Limited to 1 pair of glasses per Policy Year.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Your Cost if You Use a Select Care Provider (SLU *Care*)	Tier 2 Your Cost if You Use a In-Network Provider (Aetna)	Tier 3 Your Cost if You Use an Out-of-Network Provider (Aetna)	
	Children's dental check-up	No Charge, deductible does not apply	No Charge, deductible does not apply	30% coinsurance	Covered through the end of the month in which the covered person turns 19. Limited to 2 visits every 12 months.

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 - 82 visits/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: Missouri Division of Insurance, 301 W. High St., Room 350, Jefferson City, MO 065101, (573) 751-4126, http://insurance.mo.gov/consumers. For more information on your rights to continue coverage, contact the plan at 1-877-375-7905. 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 1-877-381-3544.
- Missouri Division of Insurance, (573) 751-4126, http://insurance.mo.gov/consumers.
- Additionally, a consumer assistance program can help you file your appeal. Contact Missouri Division of Insurance 301 W. High St., Room 350, Jefferson City, MO 065101, (573) 751- 4126, https://insurance.mo.gov/consumers/.

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 1-877-381-3544.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-381-3544.
Chinese (中文):如果需要中文的帮助，请拨打这个号码1-877-381-3544.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-381-3544.

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	$0
■ Specialist copayment	$0
■ Hospital (facility) copayment	$0
■ Other copayment	$0

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:

Cost Sharing	
Deductibles	$0
Copayments	$40
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$100**

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

■ The plan's overall deductible	$0
■ Specialist copayment	$0
■ Hospital (facility) copayment	$0
■ Other copayment	$0

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:

Cost Sharing	
Deductibles	$0
Copayments	$1,500
Coinsurance	$0
What isn't covered	
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	$0
■ Specialist copayment	$0
■ Hospital (facility) copayment	$0
■ Other copayment	$0

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:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

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: 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).

TTY: 711

To access language services at no cost to you, call 1-877-381-3544.
Para acceder a los servicios de idiomas sin costo, llame al 1-877-381-3544. (Spanish)
如欲使用免費語言服務，請致電1-877-381-3544.(Chinese)
Afin d'accéder aux services langagiers sans frais, composez le 1-877-381-3544. (French)
Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-877-381-3544. (Tagalog)
Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-877-381-3544. an. (German)
للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-877-381-3544. (Arabic)
Pou jwenn sèvis lang gratis, rele 1-877-381-3544. (French Creole-Haitian)
Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-877-381-3544. (Italian)
言語サービスを無料でご利用いただくには、1-877-381-3544. までお電話ください。(Japanese)
무료 언어 서비스를 이용하려면 1-877-381-3544. 번으로 전화해 주십시오. (Korean)
برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-877-381-3544 تماس بگیرید. (Persian-Farsi)
Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-877-381-3544. (Polish)
Para acessar os serviços de idiomas sem custo para você, ligue para 1-877-381-3544. (Portuguese)
Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-877-381-3544 (Russian)
Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-877-381-3544. Vietnamese)