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 1-877-261-8403. 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 1-877-261-8403 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Core Network: $200 per Policy Year / Preferred Care: $500 per Policy Year / Non-Preferred Care: $750 per Policy Year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preferred preventive care, Child Wellness Services from birth to age 5, Prescribed Medicine Expense, Preferred Care Pediatric Preventive Dental, Pediatric Vision Services, Prescribed Medicines and certain primary care services, are covered before you meet the deductible.	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?	For Designated and Preferred Care Combined: Individual: $7,000/ Family: $14,000 per Policy Year. Non-Preferred Care Individual: Unlimited/ Family: 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 1-877-261-8403 for a list of network providers.	You pay the least if you use a provider in the Core network. You pay more if you use a provider in the Preferred Care 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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
		Core Network Provider (You will pay the least)	Preferred Provider (You will pay less)	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	10% coinsurance, after $25 copay/visit	20% coinsurance, after $35 copay/visit	40% coinsurance, after $40 copay/visit	None
	Specialist visit	10% coinsurance, after $25 copay/visit	20% coinsurance, after $35 copay/visit	40% coinsurance, after $40 copay/visit	None
	Preventive care/screening/ immunization	No charge	No charge	30% coinsurance	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.
If you have a test	Diagnostic test (x-ray, blood work)	LAB: 10% coinsurance XRAY: 10% coinsurance, after $25 copay/visit	LAB: 20% coinsurance XRAY: 20% coinsurance, after $35 copay/visit	LAB: 40% coinsurance XRAY: 40% coinsurance, after $40 copay/visit	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetna.com/individuals-families/find-a-medication.html	Generic drugs	$15 copay/supply (retail), Deductible does not apply.	$15 copay/supply (retail), Deductible does not apply.	$15 copay/supply (retail), Deductible does not apply.	Covers up to a 90 day supply (retail) and mail order.
	Preferred brand drugs	$35 copay/supply (retail), Deductible does not apply	$35 copay/supply (retail), Deductible does not apply.	$35 copay/supply (retail), Deductible does not apply.	
	Non-preferred brand drugs	$65 copay/supply (retail), Deductible does not apply.	$65 copay/supply (retail), Deductible does not apply.	$65 copay/supply (retail), Deductible does not apply.	
	Specialty drugs	$150 copay/supply (retail), Deductible does not apply.	$150 copay/supply (retail), Deductible does not apply.	$150 copay/supply (retail), Deductible does not apply.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	40% coinsurance	Pre-certification required, $500 penalty applies for Non-Preferred Care which is not pre-certified.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Core Network Provider (You will pay the least)	Preferred Provider (You will pay less)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	10% coinsurance, after $100 copay/surgery	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance, after $150 copay/visit	10% coinsurance, after $150 copay/visit	10% coinsurance, after $150 copay/visit	Copay waived if admitted. Preferred and Non-Preferred emergency room care cost-share same as Select Care (Emory Core). No coverage for non-emergency care.
	Emergency medical transportation	10% coinsurance	20% coinsurance	20% coinsurance	Pre-certification required for emergency transportation by airplane, $500 penalty applies for Non-Preferred Care which is not pre-certified.
	Urgent care	10% coinsurance after $25 copay/visit	20% coinsurance after $25 copay/visit	40% coinsurance after $25 copay/visit	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	40% coinsurance	Pre-certification required, $500 penalty applies for Non-Preferred Care which is not pre-certified; benefit includes inpatient Rehabilitation Services
	Physician/surgeon fees	10% coinsurance	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance, after $10 copay/visit; All other outpatient services 10% coinsurance	20% coinsurance, after $10 copay/visit; All other outpatient services 20% coinsurance	20% coinsurance, after $10 copay/visit; All other outpatient services 40% coinsurance	
	Inpatient services	10% coinsurance	20% coinsurance	40% coinsurance	Pre-certification required; $500 penalty applies for Non-Preferred Care which is not pre-certified.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Core Network Provider (You will pay the least)	Core Network Provider (You will pay the least)	Core Network Provider (You will pay the least)	
If you are pregnant	Office visits	Prenatal: No Charge Postnatal: 10% coinsurance, after $25 copay/visit Diagnostic LAB: 10% coinsurance Diagnostic XRAY: 10% coinsurance, after $25 copay/visit	Prenatal: No Charge Postnatal: 20% coinsurance, after $35 copay/visit Diagnostic LAB: 20% coinsurance Diagnostic XRAY: 20% coinsurance, after $35 copay/visit	Prenatal: 30% coinsurance Postnatal: 40% coinsurance, after $40 copay/visit Diagnostic LAB: 40% coinsurance Diagnostic XRAY: 40% coinsurance, after $40 copay/visit	Cost sharing does not apply for 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	10% coinsurance	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	40% 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 Non-Preferred Care which is not pre-certified applies after 48/96 hours.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	40% coinsurance	Benefit limited to a maximum of 120 Visits per Policy Year. Pre-certification required for home health care (i.e., private duty nursing); $500 penalty applies for Non-Preferred Care which is not pre-certified.
	Rehabilitation services	10% coinsurance, after $35 copay/visit	20% coinsurance, after $35 copay/visit	40% coinsurance, after $40 copay/visit	Refers to Physical, Occupational & Speech Therapies.
	Habilitation services	10% coinsurance, after $35 copay/visit	20% coinsurance, after $35 copay/visit	40% coinsurance, after $40 copay/visit	
	Skilled nursing care	10% coinsurance	20% coinsurance	40% coinsurance	Pre-certification required, $500 penalty applies for Non-Preferred Care which is not pre-certified.
	Durable medical equipment	10% coinsurance	20% coinsurance	40% coinsurance	None.

	Hospice services	10% coinsurance	20% coinsurance	40% coinsurance	Pre-certification required, $500 penalty applies for Non-Preferred Care which is not pre-certified.
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	30% coinsurance, Deductible does not apply	Covered through the end of the month in which the covered person turns 19. Benefits are limited to 1 visit per policy year.
	Children's glasses	No Charge	No Charge	30% coinsurance, Deductible does not apply	Covered through the end of the month in which the covered person turns 19.
	Children's dental check-up	No Charge	No Charge	0% coinsurance, Deductible does not apply	Covered through the end of the month in which the covered person turns 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 (except when used in lieu of anesthesia)
- Cosmetic Surgery
- Dental Care (Adult) - except accidental injury.
- 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.)

- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Infertility Treatment
- Non-emergency care when traveling outside the U.S
- Private Duty Nursing, limited to home health services only

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: Georgia Office of Insurance and Safety Fire Commissioner, Customer Services Division, (800) 656-2298, http://www.oci.ga.gov/consumerservice/home.aspx.

For more information on your rights to continue coverage, contact the plan at 1-877-261-8403.

Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html.

State consumer assistance program, if other than state insurance department: Georgia Office of Insurance and Safety Fire Commissioner, Customer Services Division, 2 Martin Luther King, Jr. Drive, West Tower, Suite 716, Atlanta, GA 30334, (800) 656-2298, http://www.oci.ga.gov/consumerservice/home.aspx.

Office of Personnel Management Multi State Plan Program: https://www.opm.gov/healthcare-insurance/multi-state-plan-program/externalreview/.

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 1-877-261-8403.
- Georgia Office of Insurance and Safety Fire Commissioner, Customer Services Division, (800) 656-2298, http://www.oci.ga.gov/consumerservice/home.aspx.
- Additionally, a consumer assistance program can help you file your appeal. Contact Georgia Office of Insurance and Safety Fire Commissioner, Customer Services Division, 2 Martin Luther King, Jr. Drive, West Tower, Suite 716, Atlanta, GA 30334, (800) 656-2298, http://www.oci.ga.gov/consumerservice/home.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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-261-8403.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-261-8403.
Chinese (中文):如果需要中文的帮助，请拨打这个号码1-877-261-8403.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-261-8403.

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**	**$150**
■ **Specialist copayment/coinsurance**	**$25/10%**
■ **Hospital (facility) coinsurance**	**10%**
■ **Other coinsurance**	**10%**

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	$150
Copayments	$100
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,510**

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

■ **The plan's overall deductible**	**$150**
■ **Specialist copayment/coinsurance**	**$25/10%**
■ **Hospital (facility) coinsurance**	**10%**
■ **Other coinsurance**	**10%**

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	$150
Copayments	$400
Coinsurance	$700
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,270**

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

■ **The plan's overall deductible**	**$150**
■ **Specialist copayment/coinsurance**	**$25/10%**
■ **Hospital (facility) coinsurance**	**10%**
■ **Other coinsurance**	**10%**

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	$150
Copayments	$100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$450**

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 1-877-261-8403.

Para acceder a los servicios de idiomas sin costo, llame al 1-877-261-8403. (Spanish)

如欲使用免費語言服務，請致電1-877-261-8403.(Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1-877-261-8403. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-877-261-8403. (Tagalog)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-877-261-8403. an. (German)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-877-261-8403. (Arabic)

Pou jwenn sèvis lang gratis, rele 1-877-261-8403. (French Creole-Haitian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-877-261-8403. (Italian)

言語サービスを無料でご利用いただくには、1-877-261-8403. までお電話ください。(Japanese)

무료 언어 서비스를 이용하려면 1-877-261-8403. 번으로 전화해 주십시오. (Korean)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-877-261-8403 تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-877-261-8403. (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-877-261-8403. (Portuguese)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-877-261-8403 (Russian)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-877-261-8403. Vietnamese)