aetna : RICE UNIVERSITY : Aetna Select℠

Coverage for: Individual + Family | **Plan Type:** EPO

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, **www.HealthReformPlanSBC.com** or by calling **1-800-905-7670**. 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 1-800-905-7670 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each Plan Year, Network: Individual $0 / Family $0.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
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?	Network: Individual $3,000 / Family $6,000.	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?	Premiums, balance-billing charges & 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 1-800-905-7670 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?	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
		Network Provider (You will pay the least)	Non-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	$30 copay/visit	Not covered	None
	Specialist visit	$40 copay/visit	Not covered	None
	Preventive care / screening / immunization	No charge	Not covered	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)	No charge for laboratory; $40 copay/visit for x-ray	Not covered	None
	Imaging (CT/PET scans, MRIs)	$40 copay/visit	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition **Prescription drug coverage** is administered by Express Scripts, Inc. More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	Copay/prescription: $10 (retail), $25 (mail order)	Not covered	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written. Maintenance drugs - after two retail fills, members are required to fill a 90-day supply through mail order or retail pharmacy.
	Preferred brand drugs	Copay/prescription: $40 (retail), $100 (mail order)	Not covered	
	Non-preferred brand drugs	Copay/prescription: $60 (retail), $150 (mail order)	Not covered	
	Specialty drugs	25% coinsurance up to a $150 maximum/ prescription	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$175 copay/visit	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	$200 copay/visit	$200 copay/visit	No coverage for non-emergency use.
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$50 copay/visit	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copay/stay	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: $40 copay/visit	Not covered	None
	Inpatient services	$300 copay/stay	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge	Not covered	Cost sharing doesn't apply to certain preventive services. Maternity care may include tests & services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	$35 copay/pregnancy	Not covered	
	Childbirth/delivery facility services	$300 copay/stay	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	None
	Rehabilitation services	$40 copay/visit	Not covered	None
	Habilitation services	Not covered	Not covered	Not covered.
	Skilled nursing care	$300 copay/stay	Not covered	None
	Durable medical equipment	No charge	Not covered	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	$300 copay/stay for inpatient; no charge for outpatient	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 routine eye exam/12 months.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

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 & Child)
- Glasses (Child)
- Habilitation services
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Chiropractic care - 20 visits/plan year.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Routine eye care (Adult) - 1 routine eye exam/12 months.

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:

- For more information on your rights to continue coverage, contact the plan at 1-800-905-7670.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

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 1-800-905-7670.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

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 Standard? **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	**$0**
Specialist copayment	**$40**
Hospital (facility) copayment	**$300**
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	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$560**

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	**$40**
Hospital (facility) copayment	**$300**
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	**$40**
Hospital (facility) copayment	**$300**
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	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

Note: If your **plan** has a wellness program and you choose to participate, you may be able to reduce your costs.

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 1-800-905-7670.

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 on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

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

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com.

California HMO/HNO Members: Civil Rights Coordinator, PO Box 24030 Fresno CA, 93779, 1-800-648-7817, TTY 711, Fax 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, 1-800-537-7697 (TDD).

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

TTY: 711

Language Assistance:

For language assistance in your language call 1-800-905-7670 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-800-905-7670.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-800-905-7670 በነጻ ይደውሉ
Arabic -	1-800-905-7670 للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-905-7670 առանց գնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-905-7670 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-905-7670 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-800-905-7670-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-905-7670 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-905-7670 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-800-905-7670.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-800-905-7670 sin gåstu.
Cherokee -	ᎾᏍᎩᎾ ᏕᏡᏂᎯᏍᏗ ᏗᏂᏍᎦᏢᏍᎩ ᎾᏋᎢ (ᏣᎳᎩ) ᏫᏏᎳᎻᎥᏕ 1-800-905-7670 ᏅᎾᎢ Ꮭ ᎠᎱᏍᏗ ᏧᎬᏩᏢᏗ ᏂᎨᏒᎾ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-800-905-7670，無需付費。
Choctaw -	(Chahta) anumpa ya̱ apela a chi I̱ pa̱ya hinla 1-800-905-7670.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-905-7670 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-905-7670.
French -	Pour une assistance linguistique en français appeler le 1-800-905-7670 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-905-7670 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-905-7670 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-905-7670 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-800-905-7670 પર કૉલ કરો.

Hawaiian -	No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-800-905-7670. Kāki ʻole ʻia kēia kōkua nei.
Hindi -	हन्दिी में भाषा सहायता के लएि, 1-800-905-7670 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-905-7670.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-800-905-7670 na akwụghị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-905-7670 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-905-7670.
Japanese -	日本語で援助をご希望の方は、1-800-905-7670 まで無料でお電話ください。
Karen -	လၢတၫ်မၤစၢၤတၫ်ကတိၤကျိဉ်အဂီၤ် ကျိဉ် ကိး 1-800-905-7670 လၢတအိဉ်ဒီးတၫ်လၢာ်ဘျုာ်လၢာ်စ့ၤဘဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-905-7670번으로 전화해 주십시오.
Kru-Bassa -	Ɓɛ́m`ké gbo-kpá-kpá dyé piɗyi ɖé Ɓaɓɔɔ̀-wuɖuǔn wɛ̃ɛ, ɖá 1-800-905-7670
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-800-905-7670 به خۆرایی پەیوەندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-800-905-7670 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	तीलभाषा (मराठी) सहाय्यासाठी 1-800-905-7670 क्रमांकावरकोणत्याहीखर्चाशवियकॉलकरा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-905-7670 ilo ejjelok wōnān.
Micronesian-Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-905-7670 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-800-905-7670 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-905-7670
Nepali -	(नेपाली) मा नःिशुल्क भाषा सहायता पाउनका लागि 1-800-905-7670 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-800-905-7670 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-800-905-7670 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-905-7670 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-800-905-7670 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-800-905-7670 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-905-7670.

Portuguese -	Para obter assistência linguística em português ligue para o 1-800-905-7670 gratuitamente.
Romanian -	Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-800-905-7670
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-905-7670.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-905-7670 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-905-7670.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-800-905-7670.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-800-905-7670. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-905-7670 bila malipo.
Syriac -	ܠܗܝܢܘܢ ܕܡܡܠܠܝܢ ܣܘܪܝܬ ܐܝܬ ܠܗ ܗܘܦܩܐ ܕܥܘܕܪܢܐ ܒܠܫܢܐ ܕܝܠܗܘܢ ܐܬܘ ܠܘܬܢ ܐܝܟ ܡܢܝܢܐ 1-800-905-7670 ܡܓܢܐ.
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-905-7670 nang walang bayad.
Telugu -	భాషతో సహాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-800-905-7670 కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-905-7670 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-800-905-7670 ‘o ‘ikai hā tōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-905-7670 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-905-7670.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-905-7670.
Urdu -	اردو میں مفت لسانی معاونت کیلئے 1-800-905-7670 پر کال کریں
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-905-7670.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-800-905-7670 פריי פון אפצאל.
Yoruba -	Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-800-905-7670 lái san owó kankan rárá.