



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 1-800-481-8814. 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 1-800-481-8814 to request a copy.

| Important Questions                                                 | Answers                                                                                                                                                               | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall deductible?</b>                              | For each Plan Year, In-Network: Individual \$350. Out-of-Network: Individual \$700.                                                                                   | 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.                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Are there services covered before you meet your deductible?</b>  | Yes. In-network <u>preventive care</u> is 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>                                              |
| <b>Are there other deductibles for specific services?</b>           | Yes. \$250 for <u>prescription drugs</u> . There are no other specific <u>deductibles</u> .                                                                           | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b> | In-Network: Individual \$5,000. Out-of-Network: Individual \$10,000.                                                                                                  | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                                                                     |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>      | <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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Will you pay less if you use a <u>network provider</u>?</b>      | Yes. See <u>Student Health Provider Search</u> or call 1-800-481-8814 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. |
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>    | No.                                                                                                                                                                   | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |



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<br>(You will pay the least)                                           | Out-of-Network Provider<br>(You will pay the most)                                                        |                                                                                                                                                                                                                                                                      |
| If you visit a health care <b>provider's</b> office or clinic                                                                                                                                         | Primary care visit to treat an injury or illness        | \$30 <u>copay</u> /visit                                                                  | 50% <u>coinsurance</u>                                                                                    | None                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                       | <u>Specialist</u> visit                                 | \$30 <u>copay</u> /visit                                                                  | 50% <u>coinsurance</u>                                                                                    | None                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                       | <u>Preventive care</u> / <u>screening</u> /immunization | No charge                                                                                 | 50% <u>coinsurance</u> , except <u>deductible</u> doesn't apply to child immunizations                    | 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>                                                                    | 50% <u>coinsurance</u>                                                                                    | None                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                       | Imaging (CT/PET scans, MRIs)                            | 20% <u>coinsurance</u>                                                                    | 50% <u>coinsurance</u>                                                                                    | None                                                                                                                                                                                                                                                                 |
| If you need drugs to treat your illness or condition<br><br>More information about <b>prescription drug coverage</b> is available at <a href="#">Prescription drug program   Aetna Student Health</a> | Generic drugs (including specialty drugs)               | <u>Copay</u> /prescription, after specific <u>deductible</u> : \$15 (retail & mail order) | 50% <u>coinsurance</u> after <u>copay</u> /prescription, after specific <u>deductible</u> : \$15 (retail) | Covers 30 day supply (retail), 31-90 day supply (retail & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> . |
|                                                                                                                                                                                                       | Preferred brand drugs (including specialty drugs)       | <u>Copay</u> /prescription, after specific <u>deductible</u> : \$45 (retail & mail order) | 50% <u>coinsurance</u> after <u>copay</u> /prescription, after specific <u>deductible</u> : \$45 (retail) |                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                       | Non-preferred brand drugs (including specialty drugs)   | <u>Copay</u> /prescription, after specific <u>deductible</u> : \$75 (retail & mail order) | 50% <u>coinsurance</u> after <u>copay</u> /prescription, after specific <u>deductible</u> : \$75 (retail) |                                                                                                                                                                                                                                                                      |
| 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>                                                                    | 20% <u>coinsurance</u>                                                                                    | No coverage for non-emergency use.                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                       | <u>Emergency medical transportation</u>                 | 20% <u>coinsurance</u>                                                                    | 20% <u>coinsurance</u>                                                                                    | None                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                       | <u>Urgent care</u>                                      | 0% <u>coinsurance</u> after \$40 <u>copay</u> /visit                                      | 50% <u>coinsurance</u>                                                                                    | No coverage for non-urgent use.                                                                                                                                                                                                                                      |

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                                                                   |                                                            | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                          |
|---------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------------------------|------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | In-Network Provider<br>(You will pay the least)                                     | Out-of-Network Provider<br>(You will pay the most)         |                                                                                                                                                                                                                                                                 |
| 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                                                                                                                                                                                                                                                            |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | Office: \$30 <u>copay</u> /visit; other outpatient services: 20% <u>coinsurance</u> | Office & other outpatient services: 50% <u>coinsurance</u> | None                                                                                                                                                                                                                                                            |
|                                                                           | Inpatient services                        | 20% <u>coinsurance</u>                                                              | 50% <u>coinsurance</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>                                     | Cost sharing 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>                                                              | 50% <u>coinsurance</u>                                     |                                                                                                                                                                                                                                                                 |
| 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>                                                              | 50% <u>coinsurance</u>                                     | Includes Physical, Occupational & Speech Therapy.                                                                                                                                                                                                               |
|                                                                           | <u>Habilitation services</u>              | 20% <u>coinsurance</u>                                                              | 50% <u>coinsurance</u>                                     |                                                                                                                                                                                                                                                                 |
|                                                                           | <u>Skilled nursing care</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.                                                                                                                                                                        |
|                                                                           | <u>Durable medical equipment</u>          | 20% <u>coinsurance</u>                                                              | 50% <u>coinsurance</u>                                     | Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.                                                                                                                                                      |
|                                                                           | <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.                                                                                                                                                                        |
| If your child needs dental or eye care                                    | Children's eye exam                       | No charge                                                                           | 50% <u>coinsurance</u>                                     | 1 routine eye exam/ <u>plan</u> year up to age 19.                                                                                                                                                                                                              |
|                                                                           | Children's glasses                        | No charge                                                                           | 50% <u>coinsurance</u>                                     | 1 pair of glasses or lenses/ <u>plan</u> year.                                                                                                                                                                                                                  |
|                                                                           | Children's dental check-up                | No charge                                                                           | 50% <u>coinsurance</u>                                     | 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.)**

- |                       |                     |                                                                   |
|-----------------------|---------------------|-------------------------------------------------------------------|
| • Bariatric surgery   | • Long-term care    | • Weight loss programs - Except for required preventive services. |
| • Cosmetic surgery    | • Routine foot care |                                                                   |
| • Dental care (Adult) |                     |                                                                   |

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- |                                                                                                |                                                                                                                                               |                                                           |
|------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| • Acupuncture                                                                                  | • Infertility treatment – Limited to the diagnosis & treatment of underlying medical condition, artificial insemination& ovulation induction. | • Non-emergency care when traveling outside the U.S.      |
| • Chiropractic care                                                                            | Advanced reproductive technology: 4 cycles/lifetime.                                                                                          | • Private-duty nursing - Limited to in-network providers. |
| • Hearing aids - 1 hearing aid to \$1,000 maximum per ear/24 months for children up to age 16. |                                                                                                                                               |                                                           |

**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: Office of Managed Care, Consumer Protection Services, NJ Department of Banking and Insurance, Toll-free phone: 1-888-393-1062, In-State Only, or Consumer Hotline: 1-800-446-7467, [https://www.state.nj.us/dobi/division\\_insurance/managedcare/mcfaqs.htm](https://www.state.nj.us/dobi/division_insurance/managedcare/mcfaqs.htm).

- For more information on your rights to continue coverage, contact the plan at 1-800-481-8814.

**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 on how 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 1-800-481-8814.
- Office of Managed Care, Consumer Protection Services, NJ Department of Banking and Insurance, Toll-free phone: 1-888-393-1062, In-State Only, or Consumer Hotline: 1-800-446-7467, [https://www.state.nj.us/dobi/division\\_insurance/managedcare/mcfaqs.htm](https://www.state.nj.us/dobi/division_insurance/managedcare/mcfaqs.htm).
- Additionally, a consumer assistance program can help you file your appeal. Contact The Office of the Insurance Ombudsman, NJ Department of Banking and Insurance, 20 West State Street, PO Box 472, Trenton, NJ 08625-0472, 1-800-446-7467, Fax: 609-292-2431, <http://www.state.nj.us/dobi/consumer.htm>, [ombudsman@dobi.state.nj.us](mailto:ombudsman@dobi.state.nj.us)

**Does this plan provide Minimum Essential Coverage? Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**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 <u>plan's</u> overall <u>deductible</u> | \$350 |
| ■ <u>Specialist copayment</u>                 | \$30  |
| ■ Hospital (facility) <u>coinsurance</u>      | 20%   |
| ■ Other <u>coinsurance</u>                    | 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*)

|                                        |                 |
|----------------------------------------|-----------------|
| <b>Total Example Cost</b>              | <b>\$12,700</b> |
| <b>In this example, Peg would pay:</b> |                 |
| <u>Cost Sharing</u>                    |                 |
| <u>Deductibles</u>                     | \$350           |
| <u>Copayments</u>                      | \$100           |
| <u>Coinsurance</u>                     | \$2,400         |
| <u>What isn't covered</u>              |                 |
| Limits or exclusions                   | \$60            |
| <b>The total Peg would pay is</b>      | <b>\$2,910</b>  |

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

|                                               |       |
|-----------------------------------------------|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$350 |
| ■ <u>Specialist copayment</u>                 | \$30  |
| ■ Hospital (facility) <u>coinsurance</u>      | 20%   |
| ■ Other <u>coinsurance</u>                    | 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*)

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | <b>\$5,600</b> |
| <b>In this example, Joe would pay:</b> |                |
| <u>Cost Sharing</u>                    |                |
| <u>Deductibles</u>                     | \$350          |
| <u>Copayments</u>                      | \$1,800        |
| <u>Coinsurance</u>                     | \$10           |
| <u>What isn't covered</u>              |                |
| Limits or exclusions                   | \$20           |
| <b>The total Joe would pay is</b>      | <b>\$2,180</b> |

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

|                                               |       |
|-----------------------------------------------|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$350 |
| ■ <u>Specialist copayment</u>                 | \$30  |
| ■ Hospital (facility) <u>coinsurance</u>      | 20%   |
| ■ Other <u>coinsurance</u>                    | 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*)

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | <b>\$2,800</b> |
| <b>In this example, Mia would pay:</b> |                |
| <u>Cost Sharing</u>                    |                |
| <u>Deductibles</u>                     | \$350          |
| <u>Copayments</u>                      | \$100          |
| <u>Coinsurance</u>                     | \$200          |
| <u>What isn't covered</u>              |                |
| Limits or exclusions                   | \$0            |
| <b>The total Mia would pay is</b>      | <b>\$650</b>   |

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 866-393-0002.

### 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.

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