

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services



Coverage Period: 08/15/2026-08/14/2027
Coverage for: Individual | Plan Type: PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <https://www.aetnastudenthealth.com/> or by calling 1-866-381-1529. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-866-381-1529 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	For each <u>Plan Year</u> , In- <u>Network</u> : Individual \$100. Out-of-Network: Individual \$100.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Prescription drugs</u> , <u>preventive care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	In- <u>Network</u> : Individual \$8,700. Out-of-Network: Individual \$17,400.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <u>Student Health Provider Search</u> or call 1-866-381-1529 for a list of in- <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	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 (You will pay the least)	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	15% <u>coinsurance</u>	35% <u>coinsurance</u>	None
	<u>Specialist</u> visit	15% <u>coinsurance</u>	35% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	0% <u>coinsurance</u>	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)	15% <u>coinsurance</u>	35% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	15% <u>coinsurance</u>	35% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at Prescription drug program Aetna Student Health	Generic drugs (including specialty drugs)	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$15 for 30 day supply (retail), \$45 for 31-90 day supply (retail & mail order)	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$15 for 30 day supply (retail), \$45 for 31-90 day supply (retail & mail order)	Covers 30 day supply (retail), 31-90 day supply (retail & participating mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in- <u>network</u> .
	Preferred brand drugs (including specialty drugs)	20% <u>coinsurance</u> , <u>deductible</u> doesn't apply	20% <u>coinsurance</u> , <u>deductible</u> doesn't apply	
	Non-preferred brand drugs (including special drugs)	20% <u>coinsurance</u> , <u>deductible</u> doesn't apply	20% <u>coinsurance</u> , <u>deductible</u> doesn't apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u>	35% <u>coinsurance</u>	None
	Physician/surgeon fees	15% <u>coinsurance</u>	35% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	Out-of-network emergency use paid the same as in- <u>network</u> . No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	Out-of-network emergency use paid the same as in- <u>network</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Urgent care</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% <u>coinsurance</u>	35% <u>coinsurance</u>	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	15% <u>coinsurance</u>	35% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office other outpatient services: 15% <u>coinsurance</u>	Office: 35% <u>coinsurance</u> . Other outpatient services: 15% <u>coinsurance</u>	None
	Inpatient services	15% <u>coinsurance</u>	35% <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	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
	Childbirth/delivery professional services	15% <u>coinsurance</u>	35% <u>coinsurance</u>	
	Childbirth/delivery facility services	15% <u>coinsurance</u>	35% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	40 visits per Plan Year
	<u>Rehabilitation services</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	Includes Physical, Occupational & Speech Therapy.
	<u>Habilitation services</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Skilled nursing care</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Durable medical equipment</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Hospice services</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	
If your child needs dental or eye care	Children's eye exam	No charge	20% <u>coinsurance</u> , <u>deductible</u> doesn't apply	1 routine eye exam/ <u>plan</u> year up to age 19.
	Children's glasses	No charge	20% <u>coinsurance</u> , <u>deductible</u> doesn't apply	1 pair of glasses or lenses/ <u>plan</u> year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	No charge	0% <u>coinsurance</u> , <u>deductible</u> doesn't apply	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing
- 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.)

- Acupuncture – 10 visits/plan year.
- Bariatric surgery
- Chiropractic care
- Hearing aids – 1 hearing aid/3 years.
- Infertility treatment – For more information & exceptions, see policy document provided by your plan sponsor or call the number on your ID card.
- Non-emergency care when traveling outside the U.S.

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: Department of Financial Services, Consumer Assistance Unit, 800-342-3736, https://www.dfs.ny.gov/consumers/health_insurance/home

- For more information on your rights to continue coverage, contact the plan at 1-877-480-4161.

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 1-877-480-4161.
- Department of Financial Services, Consumer Assistance Unit, 800-342-3736, https://www.dfs.ny.gov/consumers/health_insurance/home
- Additionally, a consumer assistance program can help you file your appeal. Contact Community Health Advocates, Community Service Society of New York, 633 Third Avenue 10th Floor, New York, NY 10017, 888-614-5400, <https://www.communityhealthadvocates.org/>, cha@cssny.org

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>	\$0
■ <u>Specialist</u> <u>coinsurance</u>	15%
■ Hospital (facility) <u>coinsurance</u>	15%
■ Other <u>coinsurance</u>	15%

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	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,700
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,870

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>	\$0
■ <u>Specialist</u> <u>coinsurance</u>	15%
■ Hospital (facility) <u>coinsurance</u>	15%
■ Other <u>coinsurance</u>	15%

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	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$900
<u>Coinsurance</u>	\$200
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,220

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> <u>coinsurance</u>	15%
■ Hospital (facility) <u>coinsurance</u>	15%
■ Other <u>coinsurance</u>	15%

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	\$2,800
In this example, Mia would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$400
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$510

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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