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

Coverage Period: 08/18/2026-08/17/2027

aetna

STEVENS INSTITUTE OF TECHNOLOGY:
Open Choice®

Coverage for: Individual + Family | 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 1-800-481-8814. 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:
What is the overall deductible?	For each Plan Year, $0.	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. In-network office visits, prescription drugs & preventive care are covered before you meet your 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?	In-Network: Individual $10,600/ Family $21,200. Out-of-Network: Individual None/ Family None.	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 & penalties for failure to obtain pre-authorization for services.	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 Student Health Provider Search or call 1-800-481-8814 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	15% coinsurance	25% coinsurance	None
	Specialist visit	15% coinsurance	25% coinsurance	None
	Preventive care /screening /immunization	No charge	No charge	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)	5% coinsurance	25% coinsurance	None
	Imaging (CT/PET scans, MRIs)	15% coinsurance	25% coinsurance	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)	Copay/prescription, deductible doesn't apply: $15 (retail), $37.50 (mail order)	Copay/prescription, deductible doesn't apply: $15 (retail), $37.50 (mail order)	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.
	Preferred brand drugs (including specialty drugs)	Copay/prescription, deductible doesn't apply: 20% (retail and mail order)	Copay/prescription, deductible doesn't apply: 20% (retail and mail order)	
	Non-preferred brand drugs (including specialty drugs)	Copay/prescription, deductible doesn't apply: 20% (retail and mail order)	Copay/prescription, deductible doesn't apply: 20% (retail and mail order)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	25% coinsurance	None
	Physician/surgeon fees	15% coinsurance	25% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	15% coinsurance	15% coinsurance	No coverage for non-emergency use.
	Emergency medical transportation	15% coinsurance	15% coinsurance	None
	Urgent care	15% coinsurance	25% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	25% coinsurance	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	15% coinsurance	25% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 15% coinsurance	Office & other outpatient services: 25% coinsurance	None
	Inpatient services	15% coinsurance	25% coinsurance	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits	No charge	No charge	
	Childbirth/delivery professional services	15% coinsurance	25% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of $500 for failure to obtain pre-authorization for out-of-network care may apply.
	Childbirth/delivery facility services	15% coinsurance	25% coinsurance	
If you need help recovering or have	Home health care	15% coinsurance	25% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
other special health needs	Rehabilitation services	15% coinsurance	25% coinsurance	Includes Physical, Occupational & Speech Therapy.
	Habilitation services	15% coinsurance	25% coinsurance	
	Skilled nursing care	15% coinsurance	25% coinsurance	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
	Durable medical equipment	15% coinsurance	25% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	15% coinsurance	25% coinsurance	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge	25% coinsurance	1 routine eye exam/plan year up to age 19.
	Children's glasses	No charge	25% coinsurance	1 pair of glasses or lenses/plan year.
	Children's dental check-up	No charge	25% coinsurance	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.)

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery • Chiropractic care • Hearing aids - 1 hearing aid/24 months	• Infertility treatment – Limited to the diagnosis & treatment of underlying medical condition, artificial insemination& ovulation induction. Advanced reproductive technology: 4 cycles/lifetime.	• Non-emergency care when traveling outside the U.S. • Private-duty nursing - Limited to in-network providers.

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.

- 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.
- 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

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 plan's overall deductible	$0
Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	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:	
Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$520
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$680**

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 coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	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:	
Cost Sharing	
Deductibles	$0
Copayments	$1,800
Coinsurance	$760
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,580**

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

The plan's overall deductible	$0
Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	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:	
Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$540
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$640**

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.

TTY: **711**

English	To access language services at no cost to you, call the number on your ID card.
Amharic	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎት ላይ ያለውን ቁጥር ይደውሉ።
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Armenian	Ձեր նախընտրած լեզվով ավվձար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հէրախոսահամարով հէրախոսահամարով
Carolinian (Kapasal Falawasch)	Ngir mëna am sarwis lakk yi te doo fay, woo nimero bi am ci sa kàrt.
Chamorro	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang i numiru gi iyo-mu kard aidentifikasion.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Cushitic-Oromo	Tajaajiiloota afaanii gatii bilisaa ati argaachuuf, lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Greek	Για πρόσβαση στις υπηρεσίες γλώσσας χωρίς χρέωση, καλέστε τον αριθμό στην κάρτα ασφάλισής σας.
Gujarati	તમારે કોઇ પણ જાતના ખર્ચ વિના ભાષા સેવાઓ મેળવવા માટે, તમારા આઇડી કાર્ડ પર રહેલ નંબર પર કૉલ કરવો.
Hindi	बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Karen	လၫ်တၢ်ကမ္ၢၤကျိာတၢ်မၤစၫၤအတၢ်ဖံးတၢ်မၤတဖၣ လၫ်တအိာဒီးအပှၤလၫ်နကဘာဘဉ်အီၤအဂိၢ်ကီးဘာလိတဲစိနိၣ်ဂံၤလၫ်အအိာလၫ်နခိၣ်ဂီၤ ၀ (၍) အလိၢ်ဉတက့ၢ်၍
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Laotian	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T’áá ni nizaad k’ehjí bee níká a’doowoł doo bą́ą́h ílínígóó naaltsoos bee atah nílı̨́go nanitinígíí bee néého’dólzinígíí béésh bee hane’í biká’ígíí áajı̨’ hólne’.
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.
Persian-Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Samoan	Mō le mauaina o 'au'aunaga tau gagana e aunoa ma se totogi, vala'au le numera i luga o lau pepa ID.
Serbo-Croatian	Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici.
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Syriac-Assyrian	ܠܡܛܥܢ ܐܝܬ ܠܟ ܒܠܝܫ ܒܬܪ ܠܡܫܡܫ ܕܝܠܟ ܒܫܘܠ ܐܝܬ ܠܟ ܒܛܝܟ ܕܗܘ ܐܝܬ ܠܟ ܒܟܪܛܝܣ ܕܐܝܕܢܛܝܛܝ ܕܝܠܟ.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน
Ukrainian	Щоб безкоштовнj отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікайній картці.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.