



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:
<u>What is the overall deductible?</u>	For each Plan Year, In-Network: Individual \$300 / Family \$600. Out-of-Network: Individual \$600 / Family \$1,200.	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. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible expenses</u> paid by all family members meets the overall family <u>deductible</u> .
<u>Are there services covered before you meet your deductible?</u>	Yes. <u>Prescription drugs</u> ; plus <u>in-network 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/ .
<u>Are there other deductibles for specific services?</u>	Yes. \$100 for prescription drugs per policy year. There are no other specific deductibles.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	In-Network: Individual \$7,350 / Family \$10,000. Out-of-Network: Individual \$10,000 / Family \$20,000.	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.
<u>What is not included in the out-of-pocket limit?</u>	<u>Premiums</u> , <u>balance-billing</u> charges & health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<u>Will you pay less if you use a network provider?</u>	Yes. See www.aetna.com/docfind or call 1-866-381-1529 for a list of <u>in-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 charge</u> 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.
<u>Do you need a referral to see a 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	20% <u>coinsurance</u> after \$20 <u>copay/visit</u>	40% <u>coinsurance</u> after \$40 <u>copay/visit</u>	None
	<u>Specialist</u> visit	20% <u>coinsurance</u> after \$20 <u>copay/visit</u>	40% <u>coinsurance</u> after \$40 <u>copay/visit</u>	None
	<u>Preventive care /screening</u> /immunization	No charge	30% <u>coinsurance</u> except no charge for well child & immunizations up to age 19	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> after \$20 <u>copay/visit</u>	40% <u>coinsurance</u> after \$40 <u>copay/visit</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u> after \$20 <u>copay/visit</u>	40% <u>coinsurance</u> after \$40 <u>copay/visit</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://www.aetna.com/individuals-families/pharmacy.html	Generic drugs	<u>Copay/prescription</u> , after specific <u>deductible</u> : \$15 (retail)	30% <u>coinsurance</u> , after specific <u>deductible</u> (retail)	Covers 30-day supply (retail). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network.
	Preferred brand drugs	<u>Copay/prescription</u> , after specific <u>deductible</u> : \$40 (retail)	30% <u>coinsurance</u> , after specific <u>deductible</u> (retail)	
	Non-preferred brand drugs	<u>Copay/prescription</u> , after specific <u>deductible</u> : \$60 (retail)	30% <u>coinsurance</u> , after specific <u>deductible</u> (retail)	
	<u>Specialty drugs</u>	Applicable cost as noted above for generic or brand drugs	Applicable cost as noted above for generic or brand drugs	First prescription fill at a retail pharmacy or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Pharmacy Network.
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> after \$200 <u>copay/visit</u>	20% <u>coinsurance</u> after \$200 <u>copay/visit</u>	No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None

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>	20% <u>coinsurance</u> after \$20 <u>copay/visit</u>	40% <u>coinsurance</u> after \$40 <u>copay/visit</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Pre-authorization</u> required 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: 20% <u>coinsurance</u> ; other outpatient services: 0% <u>coinsurance</u>	Office: 40% <u>coinsurance</u> ; other outpatient services: 0% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Pre-authorization</u> required 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.) <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> deductible doesn't apply	50% <u>coinsurance</u> deductible doesn't apply	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>	<u>Pre-authorization</u> required 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>	<u>Pre-authorization</u> required for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge	30% <u>coinsurance</u> , <u>deductible</u> doesn't apply	1 routine eye exam/ <u>plan</u> year. Covered through end of month turning age 19.
	Children's glasses	No charge	30% <u>coinsurance</u> , <u>deductible</u> doesn't apply	1 pair of glasses or lenses/ <u>plan</u> year. Covered through end of month turning age 19.
	Children's dental check-up	No charge	30% <u>coinsurance</u>	Covered through end of month turning age 19.

Excluded Services & Other Covered Services:

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

• Acupuncture	• Long-term care	• Routine eye care (Adult)
• Cosmetic surgery	• Private-duty nursing	• Routine foot care
• Dental care (Adult)		• 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	• Hearing aids - 1 hearing aid per ear/24 months.	• Infertility treatment
• Chiropractic care		• 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, <http://www.dfs.ny.gov/consumer/fileacomplaint.htm>.

- For more information on your rights to continue coverage, contact the plan at 1-866-381-1529.
- State Consumer Assistance Program, if other than state insurance department contact Community Health Advocates, Community Service Society of New York, 633 Third Avenue, 10th Floor, New York, NY 10017, 1-888-614-5400, <http://www.communityhealthadvocates.org/>.

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 1-866-381-1529.
- Department of Financial Services, Consumer Assistance Unit, 800-342-3736, <http://www.dfs.ny.gov/consumer/fileacomplaint.htm>.
- 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, 1-888-614-5400, <http://www.communityhealthadvocates.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 overall deductible</u>	\$300
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other 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*)

Total Example Cost	\$12,800
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,360

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's overall deductible</u>	\$300
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other 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*)

Total Example Cost	\$7,400
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$1,300
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,820

Mia's Simple Fracture

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

■ The <u>plan's overall deductible</u>	\$300
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other 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*)

Total Example Cost	\$1,900
In this example, Mia would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$600

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 1-866-381-1529.

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, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779)
1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705)
Email: CRCoordinator@aetna.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.

Language Assistance:

For language assistance in your language call 1-866-381-1529 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-866-381-1529.
Amharic -	ለኢትዮጵያ አገልግሎት 1-866-381-1529 በነፃ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-866-381-1529
Armenian -	Լեզվի գուցաբերած աջակցության (հայերեն) զանգի 1-866-381-1529 առանց գնուվ:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-866-381-1529 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-866-381-1529 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামূলে 1-866-381-1529-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-866-381-1529 nga walay bayad.
Burmese -	ထွက်နှုန်းဝန်ဆောင်ရေး (မြန်မာဘာသာစကား) ဖြင့် ဘာသာစကားအကူအညီရပုံရန် 1-866-381-1529 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-866-381-1529.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-866-381-1529 sin gástu.
Cherokee -	Theta Salihi Ahači Jihohidzhoθy Ḧt̪t̪ (GWY) 0BW6'is 1-866-381-1529 O'θt̪ L AΓoči JEGP JL hPRθ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-866-381-1529，無需付費。
Choctaw -	(Chahta) anumpa ya_apela a chi l p̪aya hinla 1-866-381-1529.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-866-381-1529 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-866-381-1529.
French -	Pour une assistance linguistique en français appeler le 1-866-381-1529 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-866-381-1529 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-866-381-1529 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-866-381-1529 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-866-381-1529 પર કોલ કરો.

Hawaiian -	No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-866-381-1529. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi -	हन्दी में भाषा सहायता के लिए, 1-866-381-1529 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-866-381-1529.
Ibo -	Maka enyemaka asusụ na Igbo kpọọ 1-866-381-1529 na akwughị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-866-381-1529 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-866-381-1529.
Japanese -	日本語で援助をご希望の方は、1-866-381-1529まで無料でお電話ください。
Karen -	လာဝါမော်ကတိဂျီနီအရီ ကျို့ လို့ 1-866-381-1529 လာဝါဒီးတို့လို့လာ်စုံဘာ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-381-1529 번으로 전화해 주십시오.
Kru-Bassa -	Be'm'ké gbo-kpá-kpá dyé piidyi dé 'Bássó-wuɖuń wéé, qá 1-866-381-1529
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-866-381-1529 به خوراکی یمیوندی بکمن.
Laotian -	ທ້າທ່ານຕົວການຄວາມຊົວຍໍ້ໃນການແພພາສາລາວ, ກະລຸນາໄທ່ 1-866-381-1529 ໂດຍບໍ່ແສຍຄ່າໄທ.
Marathi -	कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-855-821-9720 वर फोन करा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-866-381-1529 ilo ejjelok wōnān.
Micronesian- Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-866-381-1529 ni sohte isais.
Mon-Khmer, Cambodian -	សមුළුප් සූයුගාසා ගාසාදුම් සුමුදු ස්තුජ්‍ය තොරා නෑ 1-866-381-1529 පිළායක්කි ගුව්වා ඇ
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-866-381-1529
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1- 866-381-1529 मा फोन गर्नुहोस्।
Nilotic-Dinka -	Tén kuɔɔny ë thok ë Thuɔɔjäŋ cɔl 1-866-381-1529 kecín aycöc.
Norwegian -	For språkassistanse på norsk, ring 1-866-381-1529 kostnadsfritt.
Punjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-866-381-1529 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-866-381-1529 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-866-381-1529 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-866-381-1529.

