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

Coverage Period: 08/20/2025-08/19/2026

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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 1-800-878-1927. 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 1 800-878-1927 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each Plan Year, In-Network: Individual $150. Out-of-Network: Individual $300.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Prescription drugs; plus in-network office visits & 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 $9,100 / Family $9,100. 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 www.aetna.com/docfind or call 1-800-878-1927 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	$20 copay/visit, deductible doesn't apply	30% coinsurance after $20 copay/visit	None
	Specialist visit	$20 copay/visit, deductible doesn't apply	30% coinsurance after $20 copay/visit	None
	Preventive care /screening /immunization	No charge	30% coinsurance	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)	15% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	15% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetna.com/pharmacy-insurance/individuals-families	Generic drugs	Copay/prescription, deductible doesn't apply: $15 (retail), $37.50 (mail order)	30% coinsurance, deductible doesn't apply (retail)	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	Copay/prescription, deductible doesn't apply: $40 (retail), $100 (mail order)	30% coinsurance, deductible doesn't apply (retail)	
	Non-preferred brand drugs	Copay/prescription, deductible doesn't apply: $50 (retail), $125 (mail order)	30% coinsurance, deductible doesn't apply (retail)	
	Specialty drugs	Applicable cost as noted above for generic or brand drugs	Applicable cost as noted above for generic or brand drugs	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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	40% coinsurance	None
	Physician/surgeon fees	15% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	15% coinsurance	15% coinsurance	Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use.
	Emergency medical transportation	15% coinsurance	15% coinsurance	Out-of-network emergency use paid the same as in-network.
	Urgent care	$50 copay/visit	30% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
	Physician/surgeon fees	15% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $20 copay/visit, deductible doesn't apply; other outpatient services: no charge	Office: 30% coinsurance after $20 copay/visit; other outpatient services: 30% coinsurance, deductible doesn't apply	None
	Inpatient services	15% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
If you are pregnant	Office visits	No charge	30% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Pre-authorization required for out-of-network care may apply.
	Childbirth/delivery professional services	15% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	15% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	15% coinsurance	40% coinsurance	40 visits/plan year.
	Rehabilitation services	15% coinsurance	40% coinsurance after $15 copay/visit	Includes Physical, Occupational & Speech Therapy.
	Habilitation services	15% coinsurance	40% coinsurance after $15 copay/visit	

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
	Skilled nursing care	15% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
	Durable medical equipment	15% coinsurance	40% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	0% coinsurance	0% coinsurance	Pre-authorization required for out-of-network care.
If your child needs dental or eye care	Children's eye exam	$20 copay/visit, deductible doesn't apply	30% coinsurance, deductible doesn't apply	1 routine eye exam/plan year up to age 19.
	Children's glasses	$40 copay/visit, deductible doesn't apply	30% coinsurance, deductible doesn't apply	1 pair of glasses or lenses/plan year.
	Children's dental check-up	$35 copay/visit, deductible doesn't apply	$35 copay/visit, deductible 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

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids - 1 hearing aid per ear/3 years.
- Infertility treatment - For more information & exceptions, see policy document using summary box link on page 1 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 1 800-878-1927.

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 1 800-878-1927.
- 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 plan's overall deductible	**$150**
Specialist copayment	**$20**
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	**$10,780**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$150
Copayments	$10
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,920**

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

The plan's overall deductible	**$150**
Specialist copayment	**$20**
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	**$4,280**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

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

The plan's overall deductible	**$150**
Specialist copayment	**$20**
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	**$2,300**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$150
Copayments	$50
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$500**

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.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide 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: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), 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).

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TTY: 711

Language Assistance:

To access language services at no cost to you, call 1-877-480-4161.

Albanian -	Për shërbime përkthimi falas për ju, telefononi 1-877-480-4161.
Amharic -	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-877-480-4161 ይደውሉ።
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء االتصال على الرقم 1-877-480-4161
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-877-480-4161 հեռախոսահամարով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-480-4161 tanpa dikenakan biaya.
Bantu-Kirundi -	Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-877-480-4161.
Bengali-Bangala -	আপনাকে বিনামূকযে ভাষা পবিকষিা পপকে হকয এই নম্বকি পেবযক ান েরুন: 1-877-480-4161
Bisayan-Visayan -	Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-877-480-4161.
Burmese -	သင့္အေနျဖင့္ အခေၾကးေငြ မေပးရပဲ ဘာသာစကားဝန္ေဆာင္မွဳမ်ား ရရွိႏုိင္ရန္ 1-877-480-4161 သို႔ ဖုန္းေခၚဆုိပါ။
Catalan -	Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-877-480-4161.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-877-480-4161.
Cherokee -	ᎶᎩᏍᏗ ᏚᏬᏂᎯᏍᏗ ᎤᏣᎾᏓᏛᏁᏗ Ꮭ ᎪᎱᏍᏗ ᏗᏣᎬᎶᎳᏁᏗ ᏑᎩ, ᏫᏅᎯᏏᎳᏛᏏ 1-877-480-4161.
Chinese -	如欲使用免費語言服務，請致電 1-877-480-4161.
Choctaw -	Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-877-480-4161.
Cushite -	Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-877-480-4161.
Dutch -	Voor gratis toegang tot taaldiensten, bell 1-877-480-4161.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-877-480-4161.
French Creole -	Pou jwenn sèvis lang gratis, rele 1-877-480-4161.
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-877-480-4161 an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-877-480-4161.
Gujarati -	તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેિાઓની પહોંર્ માટે, કોલ કરો1-877-480-4161.

Hawaiian -	No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona 1-877-480-4161. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi -	आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए,1-877-480-4161 पर कॉल करें।
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-877-480-4161.
Igbo -	Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-877-480-4161
Ilocano -	Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-877-480-4161.
Indonesian -	Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-877-480-4161.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-877-480-4161.
Japanese -	言語サービスを無料でご利用いただくには、1-877-480-4161 までお電話ください。
Karen -	လၢတၢ်ကမၤနှၢ်ကျိာ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖာ်လၢတအိာ်ဒီးအပှၤလၢကဘာ်ဟ့ာ်အီၤအဂိၢ်ဘာ်နှာ် ကိး 1-877-480-4161 တက့ၢ်.
Korean -	무료 언어 서비스를 이용하려면 1-877-480-4161 번으로 전화해 주십시오.
Kru-Bassa -	M̀ dyi wuɖu-dù kà kò ɖò ɓě dyi mɔú ń nì Pídyi ní, nìí, ɖá nɔ̀ɓà nìà kɛ: 1-877-480-4161
Kurdish -	بۆ دەستپێڕاگەیشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی 1-877-480-4161
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ1-877-480-4161
Marathi -	कोणत्याही शल्ुकालशवाय भाषा सेवा प्राप्त करण्यासाठी,, 1-877-480-4161 वर फोन करा.
Marshallese -	Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-877-480-4161.
Micronesian-Pohnpeyan -	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-877-480-4161.
Mon-Khmer, Cambodian -	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-877- 480-4161។
Navajo -	T’áá ni nizaad k’ehjí bee níká a’doowoł doo bą́ą́h ílínígóó kojį’ hólne’ 1-877-480-4161.
Nepali -	निःशुल्क भाषा सेवा प्राप्त गर्न 1-877-480-4161 मा टेलिफोन गर्नुहोस् ।
Nilotic-Dinka -	Të kɔɔr yïn wɛëï de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 1-877-480-4161.
Norwegian -	For tilgang til kostnadsfri språktjenester, ring 1-877-480-4161.
Pennsylvania Dutch -	Um Schprooch Services zu griege mitaus Koscht, ruff 1-877-480-4161.
Persian -	برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-877-480-4161 تماس بگیرید.
Polish -	Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-877-480-4161.
Portuguese -	Para acessar os serviços de idiomas sem custo para você, ligue para 1-877-480-4161.

Punjabi -	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-877-480-4161 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Romanian -	Pentru a accesa gratuit serviciile de limbă, apelați 1-877-480-4161.
Russian -	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-877-480-4161.
Samoan -	Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, valaʾau le 1-877-480-4161.
Serbo-Croatian -	Za besplatne prevodilačke usluge pozovite 1-877-480-4161.
Spanish -	Para acceder a los servicios de idiomas sin costo, llame al 1-877-480-4161.
Sudanic-Fulfude -	Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-877-480-4161.
Swahili -	Kupata huduma za lugha bila malipo kwako, piga 1-877-480-4161.
Syriac -	ܠܬܘܟ ،ܒܫܒܩ ܕܝܠܟ ܒܠܫ ܕܝܠ ܒܝ ܕܝܠ ܕܫܘܬܦ ܕܝܠ ܕܫܘܬܦ ܕܝܠ ܕܝܠ ܕܝܠ ܕܝܠ ܕܝܠ ܕܝܠ ܕܝܠ ܕܝܠ ܕܝܠ ܕܝܠ ܕ 1-877-480-4161
Tagalog -	Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-877-480-4161.
Telugu -	మీరు భాష సేవలను ఉచితంగా అందుకునందుకు, 1-877-480-4161 కు కాల్ చేయండి.
Thai -	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-877-480-4161.
Tongan -	Kapau ‘oku ke fiema’u ta’etōtōngi ‘a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-877-480-4161.
Trukese -	Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-877-480-4161.
Turkish -	Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-877-480-4161 numarayı arayın.
Ukrainian -	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-877-480-4161.
Urdu -	بالقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-888-982-3862 پر بات کریں۔
Vietnamese -	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-877-480-4161.
Yiddish -	צו צוטריט שפּראַך באַדינונגען אין קיין פּרייַז צו איר, רופן 1-877-480-4161
Yoruba -	Lati wọnú awọn isẹ èdè l’ọfẹ fun ọ, pe 1-877-480-4161.