# Aetna Student Health: Nova Southeastern University

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period: Beginning on or after 6/1/2016**

**Coverage for:** Individual | **Plan Type:** PPO

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at http://www.aetnastudenthealth.com or by calling 1-855-821-9720.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | Designated Care: **$0**, Preferred Care: **$300**, Non-Preferred Care: **$600** per Policy Year. Does not apply to Preferred Preventive, Mammograms, Preferred Pediatric Dental or Pediatric Preventive Vision, Child Health Supervision Services, and Prescribed Medicine Expenses. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for your costs for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out-of-pocket limit on my expenses?** | Yes, for Preferred Care. Individual: **$5,250** per Policy Year. | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out-of-pocket limit?** | Non-Preferred Care, penalties, premiums, balance-billed charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. For a list of **preferred providers**, see http://www.aetnastudenthealth.com or call **1-855-821-9720**. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | Yes, services within 25 miles of health center for certain conditions. Refer to policy for details. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**. |

**Questions:** Call 1-855-821-9720 or visit us at http://www.aetnastudenthealth.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary at www.healthreformplanSBC.com or call 1-855-821-9720 to request a copy.

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your cost if you use a Preferred Provider | Your cost if you use a Non-Preferred Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $30 Copay per visit, 30% Coinsurance | 50% Coinsurance | ----------none---------- |
| | Specialist visit | $30 Copay per visit, 30% Coinsurance | 50% Coinsurance | ----------none---------- |
| | Other practitioner office visit | 30% Coinsurance | 50% Coinsurance | Refers to Chiropractic & Acupuncture. |
| | Preventive care/screening/immunization | 0% Coinsurance | 50% Coinsurance | ----------none---------- |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 30% Coinsurance | 50% Coinsurance | ----------none---------- |
| | Imaging (CT/PET scans, MRIs) | 30% Coinsurance | 50% Coinsurance | May require Precertification, refer to policy for details. |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at **www.aetna.com/Formulary** | Generic drugs | $15 Copay per prescription (retail) | $15 Copay, 50% Coinsurance per prescription (retail) | Covers up to a 30 day supply (retail). |
| | Preferred brand drugs | $45 Copay per prescription (retail) | $45 Copay, 50% Coinsurance per prescription (retail) | |
| | Non-preferred brand drugs | | | |
| | Specialty drugs | | | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% Coinsurance | 50% Coinsurance | May require Precertification, refer to policy for details. |
| | Physician/surgeon fees | 30% Coinsurance | 50% Coinsurance | ----------none---------- |

| Common Medical Event | Services You May Need | Your cost if you use a Preferred Provider | Your cost if you use a Non-Preferred Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need immediate medical attention** | Emergency room services | $300 Copay per visit, 30% Coinsurance | $300 Copay per visit , 30% Coinsurance | Copay waived if admitted. |
| | Emergency medical transportation | 30% Coinsurance | 30% Coinsurance | ----------none---------- |
| | Urgent care | $150 Copay per visit, 30% Coinsurance | $150 Copay per visit, 50% Coinsurance | ----------none---------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% Coinsurance | 50% Coinsurance | Precertification required. $500 benefit penalty for Non-Preferred Care which is not precertified. |
| | Physician/surgeon fee | 30% Coinsurance | 50% Coinsurance | ----------none---------- |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $30 Copay per visit, 30% Coinsurance | 50% Coinsurance | ----------none---------- |
| | Mental/Behavioral health inpatient services | 30% Coinsurance | 50% Coinsurance | Precertification required. $500 benefit penalty for Non-Preferred Care which is not precertified. |
| | Substance use disorder outpatient services | $30 Copay per visit, 30% Coinsurance | 50% Coinsurance | ----------none---------- |
| | Substance use disorder inpatient services | 30% Coinsurance | 50% Coinsurance | Precertification required. $500 benefit penalty for Non-Preferred Care which is not precertified. |
| **If you are pregnant** | Prenatal and postnatal care | **Prenatal & Postnatal:** No Charge **Diagnostic**: 30% Coinsurance | 50% Coinsurance | ----------none---------- |
| | Delivery and all inpatient services | 30% Coinsurance | 50% Coinsurance | Precertification required. $500 benefit penalty for Non-Preferred Care which is not precertified. |

| Common Medical Event | Services You May Need | Your cost if you use a Preferred Provider | Your cost if you use a Non-Preferred Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | 30% Coinsurance | 50% Coinsurance | ----------none---------- |
| | Rehabilitation services | 30% Coinsurance | 50% Coinsurance | Includes Physical, Occupational & Speech Therapies. |
| | Habilitation services | 30% Coinsurance | 50% Coinsurance | Includes Physical, Occupational & Speech Therapies. |
| | Skilled nursing care | 30% Coinsurance | 50% Coinsurance | Coverage is limited to 60 days per Policy Year. Precertification required. |
| | Durable medical equipment | 30% Coinsurance | 50% Coinsurance | ----------none---------- |
| | Hospice service | 30% Coinsurance | 50% Coinsurance | Precertification required. $500 benefit penalty for Non-Preferred Care which is not precertified. |
| **If your child needs dental or eye care** | Eye exam | Not Covered. | Not Covered. | ----------none---------- |
| | Glasses | Not Covered. | Not Covered. | ----------none---------- |
| | Dental check-up | Not Covered. | Not Covered. | ----------none---------- |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Hearing aids except for Cochlear implants
- Infertility treatment (Except for charges made by a physician to diagnose and surgically treat the underlying medical cause.)
- Long term care
- Private-duty nursing
- Weight loss programs

**Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (adult)
- Routine foot care

## Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at **1-855-821-9720**. You may also contact your state insurance department at **1-877-693-5236** (within FL). You may also contact your state insurance department at Office of Insurance Regulation, **(850)413-5914** (outside of FL), http://www.floir.com

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Aetna at **1-855-821-9720.** You may also contact your state insurance department at **1-877-693-5236** (within FL) or **(850) 413-3089** (outside of FL). You may also contact your state insurance department at Office of Insurance Regulation, (850)413-5914, http://www.floir.com

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-855-821-9712.**
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-855-821-9712.**
Chinese (中文): **如果需要中文的帮助**，请拨打这个号码 **1-855-821-9712.**
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-855-821-9712.**

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $4,920**
- **Patient pays $2,620**

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $ 900 |
| Anesthesia | $ 900 |
| Laboratory tests | $ 500 |
| Prescriptions | $ 200 |
| Radiology | $ 200 |
| Vaccines, other preventive | $ 40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $ 300 |
| Copays | $ 20 |
| Coinsurance | $2,100 |
| Limits or exclusions | $ 200 |
| **Total** | **$2,620** |

### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $3,520**
- **Patient pays $1,880**

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $ 700 |
| Education | $ 300 |
| Laboratory tests | $ 100 |
| Vaccines, other preventive | $ 100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $ 300 |
| Copays | $ 900 |
| Coinsurance | $ 600 |
| Limits or exclusions | $ 80 |
| **Total** | **$1,880** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.