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

Coverage Period: 08/15/2025-08/14/2026

aetna : THE JUILLIARD SCHOOL: Open Choice®

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 1-888-272-4950. 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 1-888-272-4950 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each Plan Year, Preferred: Individual $50. In-Network: Individual: $50. Out-of-Network: Individual $100.	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. prescription drugs; plus in-network 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?	Preferred: Individual $7,150. In-Network: Individual $7,150. Out-of-Network: Individual $10,000.	The out–of–pocket limit is the most you could pay in a year for covered services.
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 1-888-272-4950 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 Preferred Provider (You will pay the least)	Participating Provider (You will pay the least)	Non-Participating 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	No charge	20% coinsurance after $20 copay/visit	40% coinsurance after $20 copay/visit	None
	Specialist visit	No charge	20% coinsurance after $20 copay/visit	40% coinsurance after $20 copay/visit	None
	Preventive care /screening / immunization	No charge	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)	No charge	20% coinsurance after $20 copay/visit	40% coinsurance after $20 copay/visit	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance after $20 copay/visit	40% coinsurance after $20 copay/visit	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.aetna.com/individuals-families/pharmacy.html	Preferred Generic drugs	Not Applicable	Copay/prescription, deductible doesn't apply: $20 (retail)/ $50 (mail order)	Copay/prescription, deductible doesn't apply: $20 (retail)	Covers 30 day supply (retail), 31-90 day supply (mail order prescription). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network.
	Preferred Brand drugs	Not Applicable	Copay/prescription, deductible doesn't apply: $45 (retail)/ $112.50 (mail order)	Copay/prescription, deductible doesn't apply: $45 (retail)	
	Non-preferred Generic & Brand drugs	Not Applicable	Copay/prescription, deductible doesn't apply: $70 (retail)/ $175 (mail order)	Copay/prescription, deductible doesn't apply: $70 (retail)	
	Specialty drugs	Not Applicable	Applicable cost as noted above for generic or brand drugs	Applicable cost as noted above for generic or brand drugs	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	No charge	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance after $150 copay/visit	20 coinsurance after $150 copay/visit	20% coinsurance after $150 copay/visit	No coverage for non-emergency use.
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	20% coinsurance	20% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: No charge	Office: 20% coinsurance after $20 copay/visit; other outpatient services: 0% coinsurance deductible doesn't apply	Office: 40% coinsurance after $20 copay/visit; other outpatient services: 30% coinsurance	None
	Inpatient services	20% coinsurance	20% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
If you are pregnant	Office visits	No charge	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	20% coinsurance	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay Preferred Provider (You will pay the least)	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	40% coinsurance	None
	Rehabilitation services	No charge	20% coinsurance after $20 copay/visit	40% coinsurance after $20 copay/visit	Includes Physical, Occupational & Speech Therapy.
	Habilitation services	No charge	20% coinsurance after $20 copay/visit	40% coinsurance after $20 copay/visit	
	Skilled nursing care	20% coinsurance	20% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
	Durable medical equipment	20% coinsurance, deductible doesn't apply	20% coinsurance	40% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	20% coinsurance	20% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
If your child needs dental or eye care	Children's eye exam	20% coinsurance	20% coinsurance	20% coinsurance	1 routine eye exam/plan year. Covered through the end of the month in which the covered person turns 19.
	Children's glasses	20% coinsurance	20% coinsurance	20% coinsurance	1 pair of glasses or lenses/plan year. Covered through the end of the month in which the covered person turns 19.
	Children's dental check-up	20% coinsurance	20% coinsurance	20% coinsurance	Covered through the end of the month in which the covered person turns 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
- 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.)		
• Bariatric surgery • Chiropractic care	• Hearing aids - single purchase once every three (3) years • Infertility treatment – Limited to the diagnosis & treatment of underlying medical condition, artificial insemination, ovulation induction & oral & injectable fertility drugs.	• 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 1-888-272-4950.

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 1-888-272-4950.
- 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	**$50**
Specialist coinsurance	**$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	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$50
Copayments	$100
Coinsurance	$1,890
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,100**

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

The plan's overall deductible	**$50**
Specialist coinsurance	**$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	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$50
Copayments	$1,800
Coinsurance	$10
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,880**

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

The plan's overall deductible	**$50**
Specialist coinsurance	**$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	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$50
Copayments	$300
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$410**

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).

TTY: 711

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Language Assistance:

For language assistance in your language call 1-877-480-4161 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-877-480-4161.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-877-480-4161 በነጻ ይደውሉ
Arabic -	1-877-480-4161 للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-877-480-4161 առանց գնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-480-4161 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-877-480-4161 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-877-480-4161-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-877-480-4161 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-877-480-4161 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-877-480-4161.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-877-480-4161 sin gåstu.
Cherokee -	ᎾᏍᎩᎾ ᏕᏬᏂᎯᏍᏗ ᏗᏂᏍᏕᎵᏍᎩ ᎾᎿᎢ (ᏣᎳᎩ) ᏫᏏᎳᏮᎥᏕ 1-877-480-4161 ᏅᎾᎢ Ꮭ ᎪᏁᏍᏗ ᏧᎬᎶᎵᏗ ᏂᎲᏒᎾ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-877-480-4161，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-877-480-4161.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-877-480-4161 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-877-480-4161.
French -	Pour une assistance linguistique en français appeler le 1-877-480-4161 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-877-480-4161 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-877-480-4161 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-877-480-4161 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-877-480-4161 પર કોલ કરો.

Hawaiian -	No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-877-480-4161. Kāki ʻole ʻia kēia kōkua nei.
Hindi -	हिन्दी में भाषा सहायता के लिए, 1-877-480-4161 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-877-480-4161.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-877-480-4161 na akwụghị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-480-4161 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-877-480-4161.
Japanese -	日本語で援助をご希望の方は、1-877-480-4161 まで無料でお電話ください。
Karen -	လာတၢ်မၤစၢၤတၢ်ကတိၤကျိာ်အဂီၢ် ကျိာ် ကိး 1-877-480-4161 လာတအိဉ်ဒီးတၢ်လၢာ်ဘျာ်လၢာ်စုၤဟဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-480-4161 번으로 전화해 주십시오.
Kru-Bassa -	Bɛ´m`ké gbo-kpá-kpá dyé pídyi ɖé Bǎsɔ́ɔ̀-wùɖùǔn wɛ̃ɛ, ɖá 1-877-480-4161
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-877-480-4161 به خۆرایی پەیوەندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-877-480-4161 ໂດຍບໍ່ເສຍຄ່າໃຫ.
Marathi -	कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-855-821-9720 वर फोन करा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-877-480-4161 ilo ejjelok wōnān.
Micronesian-Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-877-480-4161 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-877-480-4161 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-877-480-4161
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1- 877-480-4161 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-877-480-4161 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-877-480-4161 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-877-480-4161 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-877-480-4161 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-877-480-4161 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-877-480-4161.

Portuguese -	Para obter assistência linguística em português ligue para o 1-877-480-4161 gratuitamente.
Romanian -	Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-877-480-4161
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-877-480-4161.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-877-480-4161 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-877-480-4161.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-877-480-4161.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-877-480-4161. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-877-480-4161 bila malipo.
Syriac -	[illegible] 1-877-480-4161 [illegible].
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-877-480-4161 nang walang bayad.
Telugu -	భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-877-480-4161 కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-877-480-4161 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-877-480-4161 ‘o ‘ikai hā ōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-877-480-4161 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-877-480-4161.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-877-480-4161.
Urdu -	بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-877-481-4161 پر بات کریں۔
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-877-480-4161.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-877-480-4161 פריי פון אפצאל.
Yoruba -	Fún ìrànlọ́wọ́ nípa èdè (Yorùbá) pe 1-877-480-4161 lái san owó kankan rárá.

8-8577 lái san owó kankan rárá.