



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/usc> or by calling **1-877-626-2299**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	USC & Preferred: \$350, Non-Preferred Care: \$700. Waived for Preferred Routine Care. Refer to Full Plan Brochure for more information.	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 how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	Yes, \$50 Prescription Drug Deductible	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, USC & Preferred: \$3,500 Non-Preferred: \$7,000	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?	Copays, penalties, prescription drugs, 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?	Yes, \$750,000	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes <i>specific</i> coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. For a list of preferred providers , see http://www.aetnastudenthealth.com/usc or call 1-877-626-2299	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, Benefits will not be paid without a referral.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist .
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services .

Questions: Call **1-877-626-2299** or visit us at <http://www.aetnastudenthealth.com/usc>.

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If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.healthreformplanSBC.com.



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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 participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an			Limitations & Exceptions
		USC Designated Care	Preferred Provider	Non-Preferred Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% Coinsurance	20% Coinsurance	50% Coinsurance	---none---
	Specialist visit	10% Coinsurance	20% Coinsurance	50% Coinsurance	---none---
	Other practitioner office visit	10% Coinsurance	20% Coinsurance	50% Coinsurance	Includes Chiropractic
	Preventive care/screening/immunization	Chiropractic: \$15 Copay Acupuncture: 20% Coinsurance	Chiropractic: \$15 Copay Acupuncture: 20% Coinsurance	50% Coinsurance	Chiro - 26 visit max with Occupational & Physical Therapy, Acupuncture - \$500 maximum
If you have a test	Diagnostic test (x-ray, blood work)	10% Coinsurance	20% Coinsurance	50% Coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	20% Coinsurance	50% Coinsurance	---none---
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.aetnastudenthealth.com/usc	Generic drugs	N/A	After a \$50 Deductible, 10% Coinsurance/Minimum \$15 Copay (retail)		Covers up to a 30 day supply (retail)
	Preferred brand drugs		After a \$50 Deductible, 10% Coinsurance /Minimum \$25 Copay (retail)		
	Non-preferred brand drugs				
	Specialty drugs				

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Common Medical Event	Services You May Need	Your cost if you use an			Limitations & Exceptions
		USC Designated Care	Preferred Provider	Non-Preferred Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	20% Coinsurance	50% Coinsurance	---none---
	Physician/surgeon fees	10% Coinsurance	20% Coinsurance	50% Coinsurance	---none---
If you need immediate medical attention	Emergency room services	N/A	10% Coinsurance	10% Coinsurance	---none---
	Emergency medical transportation	10% Coinsurance	10% Coinsurance	10% Coinsurance	---none---
	Urgent care	10% Coinsurance	20% Coinsurance	50% Coinsurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	20% Coinsurance	50% Coinsurance	---none---
	Physician/surgeon fee	10% Coinsurance	20% Coinsurance	50% Coinsurance	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% Coinsurance	10% Coinsurance	50% Coinsurance	Coverage for Non-Biological Mental Health limited to 25 visits per Policy Year.
	Mental/Behavioral health inpatient services	10% Coinsurance	20% Coinsurance	50% Coinsurance	Coverage for Non-Biological Mental Health limited to 30 days per Policy Year.
	Substance use disorder outpatient services	10% Coinsurance	10% Coinsurance	50% Coinsurance	---none---
	Substance use disorder inpatient services	10% Coinsurance	20% Coinsurance	50% Coinsurance	Coverage is limited to a maximum of 30 days per Policy Year
If you are pregnant	Prenatal and postnatal care	Prenatal – No Charge, Postnatal and Diagnostic- 10% Coinsurance	Prenatal – No Charge, Postnatal and Diagnostic- 20% Coinsurance	50% Coinsurance	---none---
	Delivery and all inpatient services	10% Coinsurance	20% Coinsurance	50% Coinsurance	---none---

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Common Medical Event	Services You May Need	Your cost if you use an			Limitations & Exceptions
		USC Designated Care	Preferred Provider	Non-Preferred Provider	
If you need help recovering or have other special health needs	Home health care	10% Coinsurance	20% Coinsurance	50% Coinsurance	Coverage is limited to a maximum of 100 visits per Policy Year
	Rehabilitation services	\$15 Copay	\$15 Copay	50% Coinsurance	Includes physical, occupational, and speech
	Habilitation services	\$15 Copay	\$15 Copay	50% Coinsurance	Includes physical, occupational, and speech
	Skilled nursing care	20% Coinsurance	20% Coinsurance	50% Coinsurance	---none---
	Durable medical equipment	10% Coinsurance	20% Coinsurance	50% Coinsurance	---none---
	Hospice service	10% Coinsurance	20% Coinsurance	20% Coinsurance	Coverage is limited to a maximum of \$4,000 per lifetime, 15 visits available for Family Bereavement Counseling within 6 months
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Not Covered	---none---
	Glasses	Not Covered	Not Covered	Not Covered	---none---
	Dental check-up	Not Covered	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)
- Dental care (Child)
- Glasses
- Hearing aids
- Infertility treatment
- Long term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Child)
- Routine foot care
- Weight loss programs

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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.

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 **1-877-626-2299**. You may also contact your state insurance department at **1-800-927-4357**.

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 **1-877-626-2299**. You may also contact your state insurance department at **1-800-927-4357**.

Language Access Services:

Para obtener asistencia en Español, llame al **1-877-626-2299**.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-877-626-2299**.

如果需要中文的帮助, 请拨打这个号码 **1-877-626-2299**.

Dinek'ehgo shika at'ohwol ninisingo, kwüjigo holne' **1-877-626-2299**.

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

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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 \$5,640**
- **Patient pays \$1,900**

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	\$350
Co-pays	\$20
Co-insurance	\$1380
Limits or exclusions	\$150
Total	\$1,900

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

- **Amount owed to providers: \$5,400**
- **Plan pays \$3,530**
- **Patient pays \$1,870**

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	\$350
Co-pays	\$1000
Co-insurance	\$440
Limits or exclusions	\$80
Total	\$1,870

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.

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