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 https://www.aetnastudenthealth.com/en/school/686156/members.html or by calling 1-800-897-7042

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your costs for services this plan covers.
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..
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?	For Preferred Care, Individual: $6,350/Family: $12,700 per policy year	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?	Non-Preferred Care, Penalties, Premiums, balance-billing 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.
Does this plan us a network of providers?	Yes. For a listing of participating providers, see https://www.aetnastudenthealth.com/schools/rochester or call 1-800-897-7042	If you use an in-network doctor or other health care provider, this plan will pay some or all of the cost of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the tern 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 you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive service.
- **Coinsurance** is your share of the cost of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plans allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200.
- 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 copayments and coinsurance amounts.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred 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	$25 copay/office visit	$25 copay, 30% coinsurance	None
	Specialist visit	$25 copay/office visit, 30% coinsurance without referral	$25 copay 30% coinsurance	None
	Preventive care/screening/ immunization	No charge	**Preventive**: 30% coinsurance **Immunizations**: 20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance 30% coinsurance without referral	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance 30% coinsurance without referral	30% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetna.com/individuals-families/find-a-medication.html	Generic drugs	$10 copay/prescription (retail),	$10 copay/prescription (retail),	Covers up to a 90-day supply (retail) at one copy per 30 day supply.
	Preferred brand drugs	$30 copay/prescription (retail).	$30 copay/prescription (retail).	
	Non-preferred brand drugs	$60 copay/prescription (retail).	$60 copay/prescription (retail).	
	Specialty drugs	$60 copay/prescription (retail).	$60 copay/prescription (retail).	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	20% coinsurance	May require pre-authorization or referral, refer to policy for details.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
	Physician/surgeon fees	0% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance $100 copay/visit	0% coinsurance $100 copay/visit	Copay waived if admitted. Non-Preferred emergency room care cost-share same as Preferred. No coverage for non-emergency care.
	Emergency medical transportation	0% coinsurance	0% coinsurance	Non-Preferred cost-share same as Preferred.
	Urgent care	0% coinsurance $25 copay/visit	0% coinsurance $25 copay/visit	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	30% coinsurance	May require pre-authorization or referral, refer to policy for details.
	Physician/surgeon fees	0% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/office visit,	$25 copay/office visit 30% coinsurance	None
	Inpatient services	0% coinsurance	30% coinsurance	May require pre-authorization or referral, refer to policy for details.
If you are pregnant	Office visits	No Charge	20% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	20% coinsurance	Pre-authorization required for all inpatient maternity & newborn care, after the initial 48 hours for vaginal delivery or 96 hours for a cesarean section.
If you need help recovering or have other special health needs	Home health care	0% coinsurance	$10 copay/visit 30% coinsurance	None
	Rehabilitation services	$10 copay/visit 0% coinsurance	$10 copay/visit 30% coinsurance	Refers to Physical, Occupational & Speech Therapies.
	Habilitation services	$10 copay/visit 0% coinsurance	$10 copay/visit 30% coinsurance	
	Skilled nursing care	0% coinsurance	30% coinsurance	Pre-authorization required

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
	Durable medical equipment	0% coinsurance	30% coinsurance	None.
	Hospice services	0% coinsurance	30% coinsurance	Pre-authorization required
If your child needs dental or eye care	Children's eye exam	No Charge	30% coinsurance	One exam per 12-Month Period
	Children's glasses	No Charge	30% coinsurance	Coverage limited to one pair of glasses/year (lenses & Frames) per policy year.
	Children's dental check-up	No Charge	0% coinsurance	Coverage is limited to 1 exam every 6 months.

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 (Except when used in lieu of other anesthesia
- 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.)

- Bariatric surgery
- Chiropractic
- Hearing aids
- Infertility treatment – except for Advanced Reproductive Technology
- 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:

- For more information on your rights to continue coverage, contact the plan at 1-800-897-7042
- You may also contact your state insurance department.
- .Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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 at **1-800-897-7042.** You may also contact your state insurance department at, Community Health Advocates, 633 Third Avenue, 10th Floor, New York, NY 10017, (888) 614-5400 or email cha@cssny.org

Does this plan provide Minimum Essential Coverage? Yes.
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 plan meet Minimum Value Standards? Yes.
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 **1-800-897-7042.**
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-800-897-7042**
[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码1-800-897-7042**
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-800-897-7042.**

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.

Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$160**

Managing type 2 Diabetes

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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	$0
Copayments	$990
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,045**

Mia's Simple Fracture

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$10**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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	$0
Copayments	$415
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$415**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.