


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/newschool> or by calling **1-800-878-1927**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$100 per Policy Year. Does not apply to Preferred Preventive, Preferred Pediatric Dental and Vision.	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?	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: \$2,500 / Family: \$5,000 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/newschool or call 1-800-878-1927	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?	No	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.

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- **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
		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	\$25 Copay per visit, 40% Coinsurance	---none---
	Specialist visit	10% Coinsurance	\$25 Copay per visit, 40% Coinsurance	---none---
	Other practitioner office visit	10% Coinsurance	40% Coinsurance	Coverage includes Chiropractic care.
	Preventive care/screening/immunization	No Charge	Preventative: \$25 Copay per visit, 30% Coinsurance Immunization: 30% Coinsurance	---none---
If you have a test	Diagnostic test (x-ray, blood work)	10% Coinsurance	40% Coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	40% 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/newschool	Generic drugs	\$25 Copay per prescription (retail)	\$25 Generic Copay, 30% Coinsurance per prescription (retail)	Covers up to a 30 day supply (retail)
	Preferred brand drugs	\$40 Copay per prescription (retail)	\$40 Copay, 30% Coinsurance per prescription (retail)	
	Non-preferred brand drugs	\$50 Copay per prescription (retail)	\$50 Copay, 30% Coinsurance per prescription (retail)	
	Specialty drugs	\$50 Copay per prescription (retail)	\$50 Copay, 30% Coinsurance per prescription (retail)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	40% Coinsurance	---none---
	Physician/surgeon fees	10% Coinsurance	40% Coinsurance	---none---
If you need immediate medical attention	Emergency room services	10% Coinsurance	10% Coinsurance	---none---
	Emergency medical transportation	10% Coinsurance	10% Coinsurance	---none---
	Urgent care	10% Coinsurance	\$25 Copay per visit, 40% Coinsurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	40% Coinsurance	If pre-certification is not obtained, a \$200 per admission penalty applies.
	Physician/surgeon fee	10% Coinsurance	40% Coinsurance	---none---

If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% Coinsurance	\$25 Copay per visit, 40% Coinsurance	Coverage for non-biological is limited to a maximum of 20 visits per Policy Year.
	Mental/Behavioral health inpatient services	10% Coinsurance	40% Coinsurance	Coverage for non-biological is limited to a maximum of 30 days per Policy Year. If pre-certification is not obtained, a \$200 per admission penalty applies.
	Substance use disorder outpatient services	10% Coinsurance	\$25 Copay per visit, 40% Coinsurance	---none---
	Substance use disorder inpatient services	10% Coinsurance	40% Coinsurance	If pre-certification is not obtained, a \$200 per admission penalty applies.
If you are pregnant	Prenatal and postnatal care	Prenatal: No Charge Diagnostic and Postnatal: 10% Coinsurance	Prenatal: \$25 Copay per visit, 30% Coinsurance Diagnostic: 40% Coinsurance Postnatal: \$25 Copay per visit, 40% Coinsurance	---none---
	Delivery and all inpatient services	10% Coinsurance	40% Coinsurance	If pre-certification is not obtained, a \$200 per admission penalty applies.
If you need help recovering or have other special health needs	Home health care	10% Coinsurance	40% Coinsurance	Coverage is limited to a maximum of 40 visits per Policy Year.
	Rehabilitation services	10% Coinsurance	40% Coinsurance	Includes Physical, Occupational & Speech Therapies.
	Habilitation services	10% Coinsurance	40% Coinsurance	Includes Physical, Occupational & Speech Therapies
	Skilled nursing care	10% Coinsurance	40% Coinsurance	If pre-certification is not obtained, a \$200 per admission penalty applies.
	Durable medical equipment	10% Coinsurance	40% Coinsurance	---none---
	Hospice service	No Charge	No Charge	If pre-certification is not obtained, a \$200 per admission penalty applies.
If your child needs dental or eye care	Eye exam	No Charge	30% Coinsurance	---none---
	Glasses	No Charge	30% Coinsurance	Coverage is limited to 1 pair of glasses (lenses and frames) per Policy Year.

	Dental check-up	No Charge	30% Coinsurance	Coverage is limited to 2 visits per Policy Year
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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.)		
<ul style="list-style-type: none">AcupunctureCosmetic surgeryDental care (adult)Glasses (adult)	<ul style="list-style-type: none">Infertility treatment (advanced reproductive technology services)Long term care	<ul style="list-style-type: none">Private-duty nursingRoutine eye care (adult)Routine foot careWeight 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.)		
<ul style="list-style-type: none">Bariatric surgeryChiropractic care	<ul style="list-style-type: none">Dental care (child)Glasses (child)Hearing aids	<ul style="list-style-type: none">Non-emergency care when traveling outside the U.S.Routine eye care (child)

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 **1-800-878-1927**. You may also contact your state insurance department at **1-518-474-6600**.

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 **1-800-878-1927**. You may also contact your state insurance department at **1-518-474-6600**.

Language Access Services:

Para obtener asistencia en Español, llame al **1-800-878-1927**.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-800-878-1927**.
如果需要中文的帮助，请拨打这个号码 **1-800-878-1927**.
Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' **1-800-878-1927**.

—————*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 \$6,550
- Patient pays \$990

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	\$100
Co-pays	\$20
Co-insurance	\$720
Limits or exclusions	\$150
Total	\$990

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

- Amount owed to providers: \$5,400
- Plan pays \$3,990
- Patient pays \$1,410

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	\$100
Co-pays	\$1,000
Co-insurance	\$230
Limits or exclusions	\$80
Total	\$1,410

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.