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/emory or by calling 1-877-261-8403.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Core Network: **$150**/Preferred: **$300**/ Non-Preferred: **$450** per policy year. Does not apply to Prescribed Medicines Expenses, Preferred Preventive, Preferred Preventive 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 Designated and Preferred. Individual: **$6,850** per Policy Year. For Non-Preferred, Individual: **$6,850** 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/emory or call **1-877-261-8403.**	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. Refer to policy for more detail.	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 5. See your policy or plan document for additional information about **excluded services**.

- **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 a non-preferred **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-preferred 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 Core Network Provider	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	$25 Copay per visit 10% Coinsurance	$35 Copay per visit 20% Coinsurance	$40 Copay per visit 40% Coinsurance	----------none----------
	Specialist visit	$25 Copay per visit 10% Coinsurance	$35 Copay per visit 20% Coinsurance	$40 Copay per visit 40% Coinsurance	----------none----------
	Other practitioner office visit	$25 Copay per visit 10% Coinsurance	$25 Copay per visit 20% Coinsurance	$40 Copay per visit 40% Coinsurance	Includes Chiropractic.
	Preventive care/screening/ immunization	**Preventative**: 0% Coinsurance **Immunization**: 0% Coinsurance	**Preventative**: 0% Coinsurance **Immunization**: 0% Coinsurance	**Preventative**: 30% Coinsurance **Immunization**: 30% Coinsurance	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	**LAB**:10% Coinsurance **XRAY**: $25 Copay, 10% Coinsurance	**LAB**:20% Coinsurance **XRAY**: $25 Copay, 20% Coinsurance	**LAB**: 40% Coinsurance **XRAY**: $25 Copay, 40% Coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	20% Coinsurance	40% Coinsurance	May require Precertification, refer to policy for details.

Common Medical Event	Services You May Need	Your Cost If You Use a Core Network Provider	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetna.com/Formulary	Generic drugs	$15 Copay per prescription (retail)	$15 Copay per prescription (retail)	$15 Copay per prescription (retail)	Covers up to a 30 day supply (retail).
	Preferred brand drugs	$30 Copay per prescription (retail)	$30 Copay per prescription (retail)	$30 Copay per prescription (retail)	
	Non-preferred brand drugs	$30 Copay per prescription (retail)	$30 Copay per prescription (retail)	$30 Copay per prescription (retail)	
	Specialty drugs	$30 Copay per prescription (retail)	$30 Copay per prescription (retail)	$30 Copay per prescription (retail)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 Copay per surgery, 10% Coinsurance	20% Coinsurance	40% Coinsurance	May require Precertification, refer to policy for details.
	Physician/surgeon fees	$100 Copay per surgery, 10% Coinsurance	20% Coinsurance	40% Coinsurance	----------none----------
If you need immediate medical attention	Emergency room services	$75 Copay (waived if admitted) per visit, 10% Coinsurance	$75 Copay (waived if admitted) per visit, 20% Coinsurance	$75 Copay (waived if admitted) per visit, 20% Coinsurance	----------none----------
	Emergency medical transportation	10% Coinsurance	20% Coinsurance	20% Coinsurance	----------none----------
	Urgent care	10% Coinsurance	20% Coinsurance	40% Coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	20% Coinsurance	40% Coinsurance	Pre-certification required. $500 penalty for Non-Preferred Care which is not pre-certified.
	Physician/surgeon fee	10% Coinsurance	20% Coinsurance	40% Coinsurance	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use a Core Network Provider	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 Copay per visit 10% Coinsurance	$10 Copay per visit 20% Coinsurance	$10 Copay per visit 20% Coinsurance	----------none----------
	Mental/Behavioral health inpatient services	10% Coinsurance	20% Coinsurance	40% Coinsurance	Pre-certification required. $500 penalty for Non-Preferred Care which is not pre-certified.
	Substance use disorder outpatient services	10% Coinsurance	20% Coinsurance	40% Coinsurance	----------none----------
	Substance use disorder inpatient services	10% Coinsurance	20% Coinsurance	40% Coinsurance	Pre-certification required. $500 penalty for Non-Preferred Care which is not pre-certified.
If you are pregnant	Prenatal and postnatal care	**Prenatal -** 0% Coinsurance **Postnatal -** $25 Copay per visit, 10% Coinsurance. **Diagnostic - LAB**: 10% Coinsurance. **XRAY**: $25 Copay per visit, 10% Coinsurance	**Prenatal -** 0% Coinsurance **Postnatal -** $35 Copay per visit, 10% Coinsurance. **Diagnostic - LAB**: 20% Coinsurance. **XRAY**: $25 Copay per visit, 20% Coinsurance	**Prenatal -** 30% Coinsurance **Postnatal -** $35 Copay per visit, 40% Coinsurance **Diagnostic - LAB**: 40% Coinsurance. **XRAY**: $25 Copay per visit, 40% Coinsurance.	----------none----------
	Delivery and all inpatient services	10% Coinsurance	20% Coinsurance	40% Coinsurance	Precertification required for all inpatient maternity & newborn care, after the initial 48 hours for a vaginal delivery or 96 hours for a cesarean section. $500 penalty for Non-Preferred Care which is not precertified.

Common Medical Event	Services You May Need	Your Cost If You Use a Core Network Provider	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	10% Coinsurance	20% Coinsurance	40% Coinsurance	Coverage is limited to a maximum of 120 visits per Policy Year.
	Rehabilitation services	$35 Copay per visit, 10% Coinsurance	$35 Copay per visit, 20% Coinsurance	$35 Copay per visit, 40% Coinsurance	Includes physical, occupational, and speech.
	Habilitation services	$35 Copay per visit, 10% Coinsurance	$35 Copay per visit, 20% Coinsurance	$35 Copay per visit, 40% Coinsurance	Includes physical, occupational, and speech.
	Skilled nursing care	10% Coinsurance	20% Coinsurance	40% Coinsurance	Pre-certification required. $500 penalty for Non-Preferred Care which is not pre-certified.
	Durable medical equipment	10% Coinsurance	20% Coinsurance	40% Coinsurance	----------none----------
	Hospice service	10% Coinsurance	20% Coinsurance	40% Coinsurance	----------none----------
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.)

- Acupuncture (Except when used in lieu of other anesthesia)
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Long term care
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care
- 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.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment
- 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 **1-877-261-8403**. You may also contact your state insurance department at **1-404-656-2056**. You may also contact your state insurance department at Office of Insurance and Safety Fire Commissioner, **1-404-656-2070**, **http://www.oci.ga.gov**.

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 **1-877-261-8403.** You may also contact your state insurance department at **1-404-656-2056**. You may also contact your state insurance department at Office of Insurance and Safety Fire Commissioner, **1-404-656-2070, http://www.oci.ga.gov**.

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 **1-877-261-8403.**
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-877-261-8403.**
Chinese (中文): 如果需要中文的帮助，请拨打这个号码**1-877-261-8403.**
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-877-261-8403.**

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 $5,540**
- **Patient pays $2,000**

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	$ 100
Coinsurance	$ 1,400
Limits or exclusions	$ 200
Total	**$ 2,000**

Managing Type 2 Diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $3,820**
- **Patient pays $1,580**

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	$ 1,000
Coinsurance	$ 200
Limits or exclusions	$ 80
Total	**$ 1,580**

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.

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides 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 877-480-4161.

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: PO 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

For language assistance in your language call 877-480-4161 at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al 877-480-4161. (Spanish)

欲取得繁體中文語言協助，請撥打877-480-4161，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le 877-480-4161sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang 877-480-4161nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 877-480-4161 an. (German)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 877-480-4161. (Arabic)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 877-480-4161 gratis. (French Creole)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 877-480-4161. (Italian)

日本語で援助をご希望の方は、877-480-4161 まで無料でお電話ください。(Japanese)

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 877-480-4161 번으로 전화해 주십시오. (Korean)

برای راهنمایی به زبان فارسی با شماره 877-480-4161 بدون هیچ هزینه ای تماس بگیرید. انگلیسی (Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 877-480-4161. (Polish)

Para obter assistência linguística em português ligue para o 877-480-4161 gratuitamente. (Portuguese)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 877-480-4161. (Russian)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 877-480-4161. (Vietnamese)