

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

Coverage Period: 08/07/2025-09/30/2026



MIDWESTERN UNIVERSITY - DOWNERS GROVE, IL:
Open Choice® - \$500 Deductible

Aetna Life Insurance Company

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 1-800-927-0783. 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 1-800-927-0783 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each Plan Year, In-Network: Individual \$500. Out-of-Network: Individual \$1,000.	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?	Yes. \$500 for prescription drugs. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-Network: Individual \$6,350. Out-of-Network: Individual \$12,700.	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.	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 1-800-927-0783 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		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network 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 <u>copay</u> /visit	\$40 <u>copay</u> /visit	None
	<u>Specialist</u> visit	\$25 <u>copay</u> /visit	\$40 <u>copay</u> /visit	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	0% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	15% <u>coinsurance</u>	35% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	15% <u>coinsurance</u>	35% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.aetnastudenthealth.com/	Preferred Generic drugs	<u>Copay</u> /prescription, after specific <u>deductible</u> : \$10 (retail & mail order)	30% <u>coinsurance</u> after <u>copay</u> /prescription, after specific <u>deductible</u> : \$10 (retail)	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in- <u>network</u> .
	Preferred brand drugs	<u>Copay</u> /prescription, after specific <u>deductible</u> : \$45 (retail & mail order)	30% <u>coinsurance</u> after <u>copay</u> /prescription, after specific <u>deductible</u> : \$45 (retail)	
	Non-preferred Generic & Brand drugs	<u>Copay</u> /prescription, after specific <u>deductible</u> : \$70 (retail & mail order)	30% <u>coinsurance</u> after <u>copay</u> /prescription, after specific <u>deductible</u> : \$70 (retail)	
	<u>Specialty drugs</u>	<u>Copay</u> /prescription, after specific <u>deductible</u> : 30% (retail & mail order)	<u>Copay</u> /prescription, after specific <u>deductible</u> : 30% (retail & mail order)	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u>	35% <u>coinsurance</u>	None
	Physician/surgeon fees	15% <u>coinsurance</u>	35% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay/visit</u>	\$200 <u>copay/visit</u>	No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	\$150 <u>copay/trip</u>	\$150 <u>copay/trip</u>	Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	\$50 <u>copay/visit</u>	\$75 <u>copay/visit</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% <u>coinsurance</u>	35% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
	Physician/surgeon fees	15% <u>coinsurance</u>	35% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$25 <u>copay/visit</u> ; other outpatient services: 15% <u>coinsurance</u>	Office: \$40 <u>copay/visit</u> ; other outpatient services: 35% <u>coinsurance</u>	None
	Inpatient services	15% <u>coinsurance</u>	35% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
If you are pregnant	Office visits	No charge	35% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . 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	15% <u>coinsurance</u>	35% <u>coinsurance</u>	
	Childbirth/delivery facility services	15% <u>coinsurance</u>	35% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	None
	<u>Rehabilitation services</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	Includes Physical, Occupational & Speech Therapy.
	<u>Habilitation services</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
	<u>Skilled nursing care</u>	15% <u>coinsurance</u> after \$75 <u>copay/stay</u>	35% <u>coinsurance</u> after \$150 <u>copay/stay</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Durable medical equipment</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
	<u>Hospice services</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information	Common Medical Event
If your child needs dental or eye care	Children's eye exam	No charge	30% <u>coinsurance, deductible</u> doesn't apply	None
	Children's glasses	No charge	30% <u>coinsurance, deductible</u> doesn't apply	1 pair of glasses or lenses/ <u>plan</u> year.
	Children's dental check-up	No charge	30% <u>coinsurance</u>	None

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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- 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.)

- Abortion
- Chiropractic care
- Hearing aids - 1 hearing aid per ear/24 months.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition, artificial insemination & ovulation induction. Advanced reproductive technology: 4 oocyte retrievals, if live birth 2 additional retrievals.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing - Limited to in-network providers.

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: Illinois Department of Insurance, Office of Consumer Health Insurance, 1-877-527-9431 toll free, 1-217-782-4515, 1-866-323-5321 (TDD), <https://idoihelpcenter.illinois.gov/s/>.

- For more information on your rights to continue coverage, contact the plan at 1-800-927-0783.

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 1-800-927-0783.
- Illinois Department of Insurance, Office of Consumer Health Insurance, 1-877-527-9431 toll free, 1-217-782-4515, 1-866-323-5321 (TDD), <https://idoihelpcenter.illinois.gov/s/>.
- Additionally, a consumer assistance program can help you file your appeal. Contact Illinois Department of Insurance, Office of Consumer Health Insurance, Consumer Services Section, 320 West Washington Street, Springfield, IL 62767, 1-877-527-9431 toll free, 1-217-782-4515, 1-866-323-5321 (TDD), <https://idoihelpcenter.illinois.gov/s/>, DOI.Complaints@Illinois.gov

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 \$500
- Specialist copayment \$25
- 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:	
<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$50
Coinsurance	\$1,800
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,410

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

- The plan's overall deductible \$500
- Specialist copayment \$25
- 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:	
<i>Cost Sharing</i>	
Deductibles	\$550
Copayments	\$1,400
Coinsurance	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,980

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

- The plan's overall deductible \$500
- Specialist copayment \$25
- 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:	
<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$300
Coinsurance	\$30
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$830

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).

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- Hawaiian - No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona 1-877-480-4161. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए,1-877-480-4161 पर कॉल करें।
- Hmong - Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-877-480-4161.
- Igbo - Iji nwetaòhèrè na orụ gasị asụsụ n'efu, kpọọ 1-877-480-4161
- Ilocano - Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-877-480-4161.
- Indonesian - Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-877-480-4161.
- Italian - Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-877-480-4161.
- Japanese - 言語サービスを無料でご利用いただくには、1-877-480-4161 までお電話ください。
- Karen - လၢတၢ်ကမၤန့ၢ်ကိၣ်အတၢ်မၤစၢအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပူၤလၢကတၢ်ဟ့ၣ်အိၣ်အဂီၢ်ဘၣ်န့ၣ် ကိး 1-877-480-4161 တက့ၢ်.
- Korean - 무료 언어 서비스를 이용하려면 1-877-480-4161 번으로 전화해 주십시오.
- Kru-Bassa - M̈ d̈yi wuḍu-dù kà kò d̈ò b̈ě d̈yi m̈oú n̈ ní Pídyi ní, n̈ii, d̈á n̈òbà n̈ià ke: 1-877-480-4161
- Kurdish - 1-877-480-4161 بۆ دهسپێر اگه‌شتن به خزمه‌تگوزاری زمان به‌بێ تێچوون بۆ تو، په‌یو‌مندی بکه به ژماره‌ی
- Laotian - ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໃບຫາເບີ1-877-480-4161
- Marathi - कोणत्याही शक्ुकालशवाय भाषा सेवा प्राप्त करण्यासाठी,, 1-877-480-4161 वर फोन करा.
- Marshallese - Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-877-480-4161.
- Micronesian- Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-877-480-4161.
- Pohnpeyan - ເຂົ້າເມັດຮຽນດາສເສກກຢູ່ກາສາໄຂ່ລຸດຄັ້ງໄຮ້ສຸມຮັບເລກສູ່ກ ສູບເມັດຮຽນສັ່ງເອົາຄ່າສ່ເລຂ 1-877- 480-4161
- Mon-Khmer, Cambodian - 1-877-480-4161 1-877-480-4161 1-877-480-4161
- Navajo - T’áá ni nizaad k’ehjí bee níká a’doowoł doo bą́ąh ílínígóó kojí’ hólne’ 1-877-480-4161.
- Nepali - निःशुल्क भाषा सेवा प्राप्त गर्न 1-877-480-4161 मा टेलिफोन गर्नुहोस् ।
- Nilotic-Dinka - Të kɔɔr yin wɛɛř de thokic ke cïn wëu kɔr keek tɛnɔŋ yin. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 1-877-480-4161.
- Norwegian - For tilgang til kostnadsfri språktjenester, ring 1-877-480-4161.
- Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-877-480-4161.
- Persian - برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-877-480-4161 تماس بگیرید .
- Polish - Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-877-480-4161.
- Portuguese - Para acessar os serviços de idiomas sem custo para você, ligue para 1-877-480-4161.

