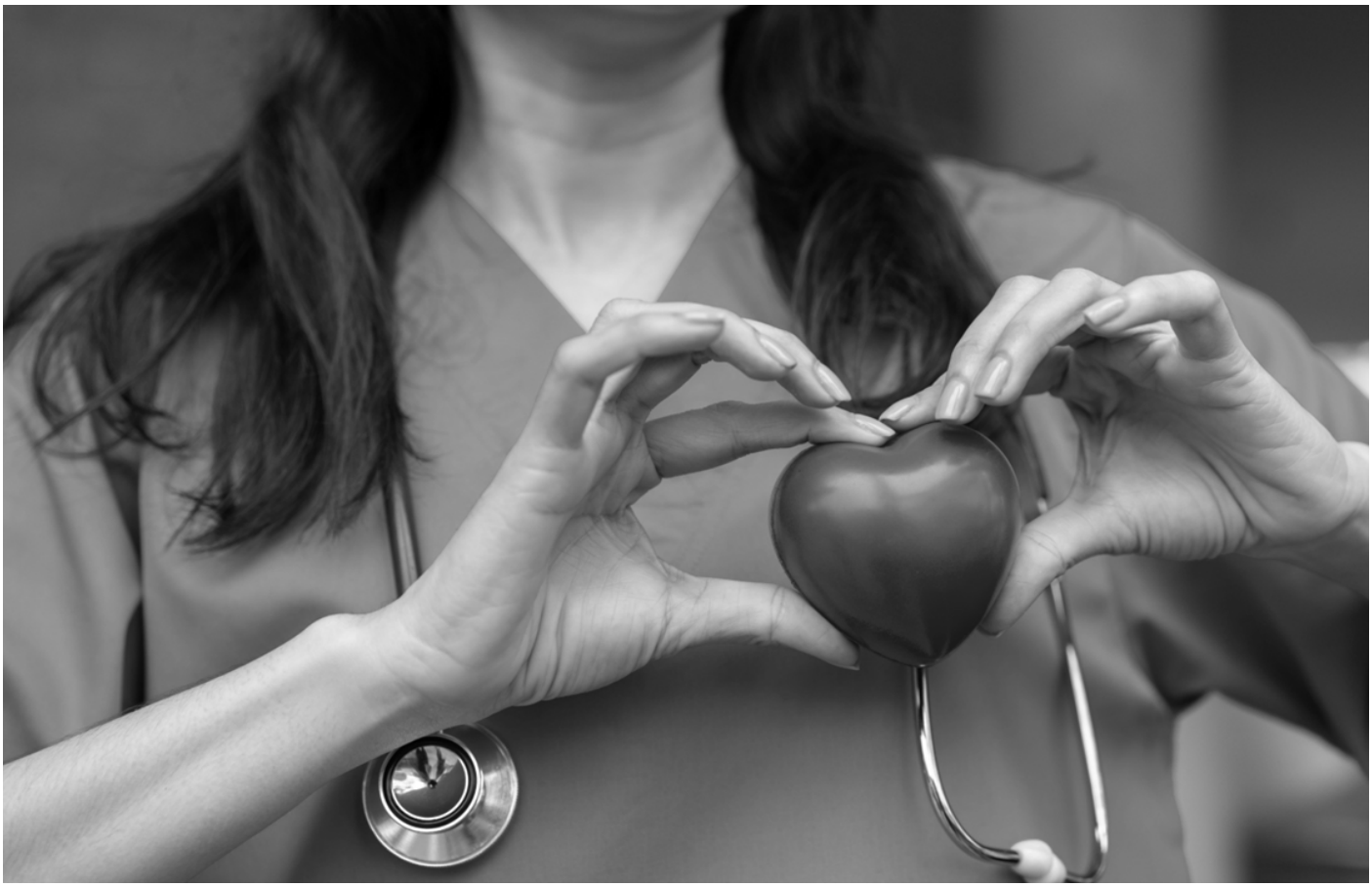
Aetna Student Health
Plan Design and Benefits Summary

Midwestern University – Downers Grove

Policy Year: 2025 - 2026
Policy Number: 724544
https://www.aetnastudenthealth.com
(800) 927-0783



This is a brief description of the Student Health Plan. The Plan is available for Midwestern University-Downers Grove students. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Certificate issued to you and may be viewed online at **https://www.aetnastudenthealth.com.** If there is a difference between this Plan Summary and the Certificate, the Certificate will control.

Midwestern University-Downers Grove Health Services

The Multispecialty Clinic's Family Medicine Clinic is Midwestern University's (MWU) health facility. Staffed with Doctors of Osteopathic Medicine, a Physician Assistant, a nurse and a medical assistant, it is open Monday - Friday and designated Saturdays for appointments during the fall, winter, spring and summer quarters.

For more information, or to schedule an appointment, call the Family Medicine Clinic at (630-743-4500, press option 3). You can also schedule an appointment online at https://online.midwestern.edu/student/patapptform.cgi In the event of an emergency, call 911.

Because the MWU Aetna Student Health plan is a preferred practitioner option (PPO), a Family Medicine Clinic referral is not required to see physicians outside of MWU's Family Medicine Clinic. If you are insured under the Student Health Insurance Plan, **out-of-pocket** medical expenses can be minimized by utilizing services provided in the Family Medicine Clinic. **Please note: Copays** and the **$500/$1000** annual **Deductible** for students will be waived for all **office visits** in MWU's Family Medicine Clinic, including routine office visits, sick visits, and physical examinations including pap testing for women. Lab testing performed during the visit is billed separately from the office visit. Required titers, immunizations, and annual tuberculosis screenings are covered with no co-pay or deductible when done in the Family Medicine Clinic.

Coverage Periods

Students: Coverage will become effective at 12:00 AM on the Coverage Start Date indicated below and will terminate at 11:59 PM on the Coverage End Date indicated.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	09/01/2025	08/31/2026	09/19/2025
CCOM MS1 & MS2 Early Arrival	08/12/2025	08/31/2026	08/22/2025
Fall	09/01/2025	11/30/2025	09/19/2025
Winter	12/01/2025	02/28/2026	12/12/2025
Spring	03/01/2026	05/31/2026	03/20/2026
Summer	06/01/2026	08/31/2026	06/19/2026

Rates

Population	Annual Rate 9/1/25 – 8/31/26	Quarterly Rate	Daily Rate
Premiere 500 Plan - Student	$4,742	$1,185.50	$12.99
Premiere 1000 Plan - Student	$3,708	$927	$10.16

Refund Policy

Any student withdrawing from Midwestern University after the quarterly waiver deadline will remain covered under the Policy for the full period for which premium has been paid. **No refund will be allowed.**

Exception: A **Covered Person** entering the armed forces of any country will not be covered under the Policy, as of the date of such entry. A pro rata refund of premium will be made for such person upon written request, received by Aetna within **90 days** of withdrawal from school.

Student Coverage

Eligibility

Enrollment in the Plan is required for all students, unless participation in the Plan is waived by the student and they certify that they are covered under a comparable plan for the entire Academic Year. Any student who had previously waived participation in the Plan may enroll after the deadline only if there has been a qualifying event (i.e. loss of prior insurance). The student must contact the Office of Student Services within **30 days** of the qualifying event and supply supporting documentation. Coverage will be dated to coincide with the date of the qualifying event and loss of coverage. If the coverage date is after the start of the current quarter the per diem rate will be charged for that quarter. If more than **30 days** have passed since the qualifying event, the student may not enroll in the Student Health Insurance Plan and will have to wait until the next annual open enrollment period to enroll. The student must find comparable coverage during this waiting period.

Students must actively attend classes for at least the first **31 days** after the date for which coverage is first purchased.

Home study, correspondence, Internet classes, and television (TV) courses do not fulfill the eligibility requirement that the student actively attend classes. If it is discovered that this eligibility requirement has not been met, our only obligation is to refund premium, less any claims paid.

Please Note: This is a STUDENT ONLY policy. Dependents are not allowed onto this plan.

Automatic Enrollment

Eligible students will be automatically enrolled in the premiere 1000 Plus plan unless the completed Waiver Form has been received and approved by the University. If you complete the Waiver Form after you are auto enrolled in the Premiere 1000 Plus Plan, and before the waiver deadline, you will be removed from the plan and your account will be credited. After the waiver deadline you will remain enrolled in the Premiere 1000 Plus Plan for the remainder of the quarter. You can complete the waiver and be removed from the plan effective with the start of the next quarter.

Please Note: All graduating students will automatically receive a one-month extension to their policy end date.

Medicare Eligibility Notice

You are not eligible to enroll in the student health plan if you have Medicare at the time of enrollment in this student plan. The plan does not provide coverage for people who have Medicare.

Termination and Refunds

Withdrawal from Classes – Leave of Absence

If you withdraw from classes under a school-approved leave of absence, your coverage will remain in force through the end of the period for which premium payment has been received. No premium will be refunded.

Withdrawal from Classes – Other than Leave of Absence

If you withdraw from classes within 31 days after the policy effective date, you will be considered ineligible for coverage. Your coverage will be terminated retroactively, and any premium paid will be refunded.
If you withdraw from classes more than 31 days after the policy effective date, your coverage will remain in force through the end of the period for which premium payment has been received. No premium will be refunded.
If you withdraw from classes to enter the armed forces of any country, your coverage will end as of the date of such entry. We will refund your premium, on a pro-rata basis, if you submit a written request within 90 days from the date you withdraw.

In-network Provider Network

Aetna Student Health offers Aetna's broad network of In-network Providers. You can save money by seeing In-network Providers because Aetna has negotiated special rates with them, and because the Plan's benefits are better.

If you need care that is covered under the Plan but not available from an In-network Provider, contact Member Services for assistance at the toll-free number on the back of your ID card. In this situation, Aetna may issue a pre-approval for you to receive the care from an Out-of-network Provider. When a pre-approval is issued by Aetna, the benefit level is the same as for In-network Providers.

Precertification

You need pre-approval from us for some eligible health services. Pre-approval is also called precertification. Your in-network physician is responsible for obtaining any necessary precertification before you get the care. When you go to an out-of-network provider, it is your responsibility to obtain precertification from us for any services and supplies on the precertification list. For a current listing of the health services or prescription drugs that require precertification, contact Member Services or go to www.aetna.com.

Precertification call

Precertification should be secured within the timeframes specified below. To obtain precertification, call Member Services at the toll-free number on your ID card. You, your physician or the facility must call us within these timelines:

Non-emergency admissions	Call at least 14 days before the date you are scheduled to be admitted.
Emergency admission	Call within 48 hours or as soon as reasonably possible after you have been admitted.
Urgent admission	Call before you are scheduled to be admitted.
Outpatient non-emergency medical services	Call at least 14 days before the care is provided, or the treatment is scheduled

An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or an injury.

We will provide a written notification to you and your physician of the precertification decision, where required by state law. If your precertified services are approved, the approval is valid for 60 days as long as you remain enrolled in the plan.

Coordination of Benefits (COB)

Some people have health coverage under more than one health plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB). A complete description of the Coordination of Benefits provision is contained in the certificate issued to you.

Description of Benefits – 500 Plan

The Plan excludes coverage for certain services (referred to as exceptions in the certificate of coverage) and has limitations on the amounts it will pay. While this Plan Design and Benefit Summary document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. To look at the full Plan description, which is contained in the Certificate of Coverage issued to you, go to **https://www.aetnastudenthealth.com.** If any discrepancy exists between this Benefit Summary and the Certificate of Coverage, the Certificate will control.

This Plan will pay benefits in accordance with any applicable Illinois Insurance Law(s).

Policy year deductible	**In-network coverage**	**Out-of-network coverage**
You have to meet your policy year deductible before this plan pays for benefits.		
Student	$500 per policy year	$1,000 per policy year
PRESCRIBED MEDICINES		
Student	$500 per policy year	
Note: This is the amount you owe for in-network and out-of-network eligible health services each policy year before the plan begins to pay for eligible health services. After the amount you pay for eligible health services reaches the policy year deductible, this plan will begin to pay for eligible health services for the rest of the policy year.		

Policy year deductible waiver		
The policy year deductible is waived for all of the following eligible health services: • In-network care for Preventive care and wellness, Pediatric Dental benefits and Abortion • In-network care and out-of-network care for Pediatric Vision Benefits and Victims of sexual assault or abuse.		
Maximum out-of-pocket limits **Maximum out-of-pocket limit** per **policy year**		
Student	$6,350 per policy year	$12,700 per policy year

The coinsurance listed in the schedule of benefits below reflects the plan coinsurance percentage. This is the coinsurance amount that the plan pays. You are responsible for paying any remaining coinsurance.

Eligible health services	In-network coverage	Out-of-network coverage
Preventive care and wellness		
Routine physical exams	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit Policy year deductible applies
Covered persons through age 21 Maximum age and visit limits per policy year	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures//Health Resources and Services Administration guidelines for children and adolescents.	
Preventive care immunizations		
Performed in a facility or at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit Policy year deductible applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.	
The following is not covered under this benefit: • Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment or travel		
Routine gynecological exams (including Pap smears and cytology tests)		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit Policy year deductible applies
Preventive screening and counseling services		
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit Policy year deductible applies
Skin cancer behavioral counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit Policy year deductible applies
Falls prevention counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit Policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Routine cancer screenings performed at a physician's office, specialist's office or facility.		
Routine cancer screenings	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit Policy year deductible applies
Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration.	
Prenatal care services (Preventive care services only)	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	65% (of the recognized charge) per visit Policy year deductible applies
Lactation counseling services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	65% (of the recognized charge) per visit Policy year deductible applies
Breast pump supplies and accessories	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	65% (of the recognized charge) per visit Policy year deductible applies
Contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	65% (of the recognized charge) per visit Policy year deductible applies
Contraceptive prescription drugs and devices provided, administered, or removed, by a provider during an office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	65% (of the recognized charge) per visit Policy year deductible applies
Voluntary sterilization		
Inpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	65% (of the recognized charge) per visit Policy year deductible applies
Outpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	65% (of the recognized charge) per visit Policy year deductible applies
The following are not covered under this benefit: • Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care		

• Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA		
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Physicians and other health professionals		
Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist) includes telemedicine consultations)	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter Policy year deductible applies	$40 copayment then the plan pays 100% (of the balance of the recognized charge) per visit thereafter Policy year deductible applies
Allergy testing and treatment		
Allergy testing performed at a physician's or specialist's office	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter Policy year deductible applies	$40 copayment then the plan pays 100% (of the balance of the recognized charge) per visit thereafter Policy year deductible applies
Allergy injections treatment performed at a physician or specialist office	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter Policy year deductible applies	$40 copayment then the plan pays 100% (of the balance of the recognized charge) per visit thereafter Policy year deductible applies
Allergy sera and extracts administered via injection at a physician's or specialist's office	85% (of the negotiated charge) Policy year deductible applies	65% (of the recognized charge) Policy year deductible applies
Physician and specialist - surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	85% (of the negotiated charge) per admission Policy year deductible applies	65% (of the recognized charge) per admission Policy year deductible applies
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section) • Services of another physician for the administration of a local anesthetic		
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthetist and surgical assistant expenses)	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter Policy year deductible applies	$40 copayment then the plan pays 100% (of the balance of the recognized charge) per visit thereafter Policy year deductible applies
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic		

Eligible health services	In-network coverage	Out-of-network coverage
Alternatives to physician office visits		
Walk-in clinic visits (non-emergency visit)	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter Policy year deductible applies	$40 copayment then the plan pays 100% (of the balance of the recognized charge) per visit thereafter Policy year deductible applies
Hospital and other facility care		
Inpatient hospital (room and board) and other miscellaneous services and supplies) Includes birthing center facility charges	85% (of the negotiated charge) per admission Policy year deductible applies	65% (of the balance of the recognized charge) per admission Policy year deductible applies
The following are not eligible health services: • All services and supplies provided in: - Rest homes - Any place considered a person's main residence or providing mainly custodial or rest care - Health resorts - Spas - Schools or camps		
Preadmission testing	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
In-hospital non-surgical physician services	85% (of the negotiated charge) per admission Policy year deductible applies	65% (of the balance of the recognized charge) per admission Policy year deductible applies
Alternatives to hospital stays		
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center For physician charges, refer to the *Physician and specialist - outpatient surgical services* benefit	85% (of the negotiated charge) per visit Policy year deductible applies	65% (of the balance of the recognized charge) per visit Policy year deductible applies
The following are not covered under this benefit: • A stay in a hospital (See the *Hospital care – facility charges* benefit in this section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic		

<table>
<tr><th>Eligible health services</th><th>In-network coverage</th><th>Out-of-network coverage</th></tr>
<tr><td>Home health care</td><td>85% (of the negotiated charge) per visit
Policy year deductible applies</td><td>65% (of the balance of the recognized charge) per visit
Policy year deductible applies</td></tr>
<tr><td colspan="3">The following are not covered under this benefit:
Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
Transportation
Homemaker or housekeeper services
Food or home delivered services
Maintenance therapy</td></tr>
<tr><td>Hospice-Inpatient
(room and board and other miscellaneous services and supplies)</td><td>85% (of the negotiated charge) per admission
Policy year deductible applies</td><td>65% (of the balance of the recognized charge) per admission
Policy year deductible applies</td></tr>
<tr><td>Hospice-Outpatient</td><td>85% (of the negotiated charge) per visit
Policy year deductible applies</td><td>65% (of the balance of the recognized charge) per visit
Policy year deductible applies</td></tr>
<tr><td colspan="3">The following are not covered under this benefit:
Funeral arrangements
Pastoral counseling
Bereavement counseling
Financial or legal counseling which includes estate planning and the drafting of a will
Homemaker or caretaker services that are services which are not solely related to your care and may include:
Sitter or companion services for either you or other family members
Transportation
Maintenance of the house</td></tr>
<tr><td>Outpatient private duty nursing</td><td>85% (of the negotiated charge) per admission
Policy year deductible applies</td><td>65% (of the balance of the recognized charge) per admission
Policy year deductible applies</td></tr>
<tr><td>Skilled nursing facility-Inpatient
(room and board and miscellaneous inpatient care servic supplies)

Subject to semi-private room rate unless intensive care unit is required

Room and board includes intensive care</td><td>$75 copayment then the plan pays 85% (of the balance of the negotiated charge) per admission
Policy year deductible applies</td><td>$150 copayment then the plan pays 65% (of the balance of the recognized charge) per admission
Policy year deductible applies</td></tr>
</table>

Eligible health services	In-network coverage	Out-of-network coverage
Emergency room	$200 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit Policy year deductible applies	Paid the same as in-network coverage
Emergency services resulting from a criminal sexual assault or abuse	100% (of the negotiated charge) per visit	Paid the same as in-network coverage
The following are not covered under this benefit: Non-emergency services in a hospital emergency room or an independent freestanding emergency department		
Important note: • As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment/coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on the back of your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill. • A separate emergency room copayment/coinsurance will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/coinsurance will be waived and your inpatient copayment/coinsurance will apply. • Covered benefits that are applied to the emergency room copayment/coinsurance cannot be applied to any other copayment/coinsurance under the plan. Likewise, a copayment/coinsurance that applies to other covered benefits under the plan cannot be applied to the emergency room copayment/coinsurance. • Separate copayment/coinsurance amounts may apply for certain services given to you in the emergency room that are not part of the emergency room benefit. These copayment/coinsurance amounts may be different from the emergency room copayment/coinsurance. They are based on the specific service given to you. • Services given to you in the emergency room that are not part of the emergency room benefit may be subject to copayment/coinsurance amounts.		
Urgent medical care	$50 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter Policy year deductible applies	$75 copayment then the plan pays 100% (of the balance of the recognized charge) per visit thereafter Policy year deductible applies
Pediatric dental care (Limited to covered persons through the end of the month in which the person turns age 19)		
Type A services	100% (of the negotiated charge) per visit No copayment or deductible applies	70% (of the recognized charge) per visit Policy year deductible applies
Type B services	70% (of the negotiated charge) per visit No copayment or deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Type C services	50% (of the negotiated charge) per visit No copayment or deductible applies	50% (of the recognized charge) per visit Policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Orthodontic services	50% (of the negotiated charge) per visit No copayment or deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Dental emergency services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received.

The following are not covered under this benefit:

- Any instruction for diet, plaque control and oral hygiene
- Cosmetic services and supplies including:
  - Plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance
  - Augmentation and vestibuloplasty, and other substances to protect, clean, whiten, bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons, except to the extent coverage is specifically provided in the *Eligible health services and exclusions* section
  - Facings on molar crowns and pontics will always be considered cosmetic
- Crown, inlays, onlays, and veneers unless:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants and braces (that are determined not to be medically necessary), mouth guards, and other devices to protect, replace or reposition teeth
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - For splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint dysfunction disorder (TMJ) and craniomandibular joint dysfunction disorder (CMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Eligible health services and exclusions – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another eligible health service
- Orthodontic treatment except as covered above and in the *Pediatric dental care* section of the schedule of benefits
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Routine dental exams and other preventive services and supplies, except as specifically provided in the *Pediatric dental care* section of the schedule of benefits
- Services and supplies:
  - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
  - Provided for your personal comfort or convenience or the convenience of another person, including a provider
  - Provided in connection with treatment or care that is not covered under your policy
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a dentist or dental provider that is legally qualified to furnish dental services or supplies

Eligible health services	In-network coverage	Out-of-network coverage
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Podiatric (foot care) treatment Physician and specialist non-routine foot care treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Services and supplies for: - The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies - Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet		
Impacted wisdom teeth		
Impacted wisdom teeth	85% (of the negotiated charge) Policy year deductible applies	85% (of the recognized charge) Policy year deductible applies
Accidental injury to sound natural teeth	85% (of the negotiated charge) Policy year deductible applies	85% (of the recognized charge) Policy year deductible applies
The following are not covered under this benefit: • The care, filling, removal or replacement of teeth and treatment of diseases of the teeth • Dental services related to the gums • Apicoectomy (dental root resection) • Orthodontics • Root canal treatment • Soft tissue impactions • Bony impacted teeth • Alveolectomy • Augmentation and vestibuloplasty treatment of periodontal disease • False teeth • Prosthetic restoration of dental implants • Dental implants		
Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: Dental implants		
Clinical trials		
Routine patient costs	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

The following are not eligible health services: • Services and supplies related to data collection and record-keeping needed only for the clinical trial • Services and supplies provided by the trial sponsor for free • The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with our policies)		
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Dermatological treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: Cosmetic treatment and procedures		
Obesity Surgery and services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered services: • Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, except as described in the certificate. This is regardless of whether there are other related conditions. This includes: - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications - Hypnosis or other forms of therapy - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement		
Maternity care		
Maternity care (includes delivery and postpartum care services in a hospital or birthing center)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries		
Well newborn nursery care in a hospital or birthing center	85% (of the negotiated charge) No Policy year deductible applies	65% (of the recognized charge) No Policy year deductible applies
Abortion		
Inpatient physician or specialist surgical services	100% (of the negotiated charge) No policy year deductible applies	65% (of the recognized charge)
Outpatient physician or specialist surgical services	100% (of the negotiated charge) No policy year deductible applies	65% (of the recognized charge)
Travel and lodging reimbursement	100% No Policy year deductible applies	
Limit per policy year	$3,000	

The following are not covered travel and lodging expenses under this rider:

- Expenses for more than one travel companion
- Gasoline/fuel costs
- Car rentals
- Meals, groceries, hotel room service, alcohol/tobacco products
- Personal care/convenience items, (e.g. shampoo, clothing, deodorant)
- Entertainment/souvenir expenses
- Telephone calls
- Taxes
- Tips, gratuities
- Childcare expenses
- Lost wages

Abortion drugs (abortifacients)
Covered services include prescription drugs used for elective termination of pregnancy, including those prescribed or ordered for off label use.

Eligible health services	In-network coverage	Out-of-network coverage
Gender affirming treatment		
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Autism spectrum disorder		
Autism spectrum disorder treatment, diagnosis and testing. Includes Applied behavior analysis and Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	Benefits will be the same as those stated under each covered service category in this Schedule of benefits	Benefits will be the same as those stated under each covered service category in this Schedule of benefits
Mental Health & Substance related disorders treatment		
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	85% (of the negotiated charge) per admission Policy year deductible applies	65% (of the recognized charge) per admission Policy year deductible applies
Outpatient mental health disorders treatment office visits to a physician or behavioral health provider (includes telemedicine consultations)	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter Policy year deductible applies	$40 copayment then the plan pays 100% (of the balance of the recognized charge) per visit thereafter Policy year deductible applies
Outpatient office visits (includes telemedicine consultations)	85% (of the negotiated charge) Policy year deductible applies	65% (of the recognized charge) Policy year deductible applies

Eligible health services	In-network coverage (IOE facility)	Out-of-network coverage (Includes providers who are otherwise part of Aetna's network but are non-IOE providers)
Transplant services		
Inpatient and outpatient transplant facility services	Covered according to the type of benefit and the place where the service is received.	
Inpatient and outpatient transplant physician and specialist services	Covered according to the type of benefit and the place where the service is received.	
Transplant services-travel and lodging	Covered	Covered
Lifetime maximum payable for travel and lodging expenses for any one transplant, including tandem transplants	$10,000	$10,000
Maximum payable for Lodging Expenses per **IOE** patient	$50 per night	$50 per night
Maximum payable for Lodging Expenses per companion	$50 per night	$50 per night
The following are not covered under this benefit: • Services and supplies furnished to a donor when the recipient is not a covered person • Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness • Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness		
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Treatment of basic infertility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Limited infertility services Inpatient and outpatient care	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Advanced reproductive technology (ART) services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
For treatment that includes an oocyte retrieval, maximum number of oocyte retrievals	4, however if a live birth follows a completed oocyte retrieval, 2 additional oocyte retrievals will be covered.	
The following are not covered under the infertility services benefit: • Cryopreservation (freezing) of eggs, embryos, or sperm. However, subsequent non-experimental or investigational procedures that use the cryopreserved eggs, embryos or sperm are covered. • Travel costs within 100 miles of your home or travel cost not required by Aetna. • Non-medical costs of an egg or sperm donor • Experimental or investigational treatment as determined by the American Society for Reproductive Medicine • Infertility medication. See the Eligible health services and exclusions-Outpatient prescription drugs section for information on coverage of infertility prescription drugs.		

• Infertility medication not injected by your provider, including but not limited to menotropins, hCG, and GnRH agonists. See the Coverage and exclusions-Prescription drugs – outpatient section for information on coverage of infertility prescription drugs • All non-medical charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father. • Infertility treatment when a successful pregnancy could have been obtained through less costly treatment.		
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Specific therapies and tests		
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility No additional expense, such as a copayment or deductible amount, will be imposed for mammograms	85% (of the negotiated charge) Policy year deductible applies	65% (of the recognized charge) Policy year deductible applies
Diagnostic lab work performed in a physician's office, the outpatient department of a hospital or other facility	85% (of the negotiated charge) Policy year deductible applies	65% (of the recognized charge) Policy year deductible applies
Diagnostic radiological services performed in a physician's office, the outpatient department of a hospital or other facility No additional expense, such as a copayment or deductible amount, will be imposed for mammograms	85% (of the negotiated charge) Policy year deductible applies	65% (of the recognized charge) Policy year deductible applies
Outpatient Chemotherapy, Radiation & Respiratory Therapy	85% (of the negotiated charge) Policy year deductible applies	65% (of the recognized charge) Policy year deductible applies
Outpatient infusion therapy	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan • Enteral nutrition • Blood transfusions and blood products • Dialysis		

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy)	85% (of the negotiated charge) Policy year deductible applies	65% (of the recognized charge) Policy year deductible applies
Chiropractic services	85% (of the negotiated charge) per visit Policy year deductible applies	65% (of the recognized charge) per visit Policy year deductible applies
Emergency ground, air, and water ambulance	$150 copayment then the plan pays 100% (of the balance of the negotiated charge) per trip thereafter Policy year deductible applies	Paid the same as in-network coverage
The following are not covered under this benefit: • Ambulance services for routine transportation to receive outpatient or inpatient care		
Durable medical and surgical equipment	85% (of the negotiated charge) per items Policy year deductible applies	65% (of the recognized charge) per items Policy year deductible applies
The following are not covered under this benefit: • Whirlpools • Portable whirlpool pumps • Sauna baths • Massage devices • Over bed tables • Elevators • Communication aids • Vision aids • Telephone alert systems • Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician		
Nutritional support	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition. except as described above		
Prosthetic and customized orthotic Devices & Orthotics Includes Cranial prosthetics *(Medical wigs)*	85% (of the negotiated charge) per items Policy year deductible applies	65% (of the recognized charge) per items Policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
All other prosthetic devices	85% (of the negotiated charge) per items Policy year deductible applies	65% (of the recognized charge) per items Policy year deductible applies
If you receive a prosthetic device as part of another eligible health service, it will not be covered under this benefit.		
Hearing aids		
Hearing aids	85% (of the negotiated charge) per items Policy year deductible applies	65% (of the recognized charge) per items Policy year deductible applies
Hearing aids maximum per ear	One hearing aid per ear every 12 months	
The following are not eligible health services: – Replacement of a hearing aid that is lost, stolen or broken – Batteries or cords – A hearing aid that does not meet the specifications prescribed for correction of hearing loss – Any hearing aid prescribed by someone other than a hearing care professional		
Hearing exams	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter Policy year deductible applies	$40 copayment then the plan pays 100% (of the balance of the recognized charge) per visit thereafter Policy year deductible applies
The following are not covered under this benefit: • Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay		
Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)		
Pediatric routine vision exams (including refraction)-Performed by a legally qualified ophthalmologist or optometrist Includes comprehensive low vision evaluations Includes visit for fitting of contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	70% (of the recognized charge) per visit No policy year deductible applies
Low vision Maximum	One comprehensive low vision evaluation every policy year	
Pediatric vision care services & supplies-Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	70% (of the recognized charge) per visit No policy year deductible applies
Maximum number Per year: Eyeglass frames Prescription lenses Contact lenses (includes non-	 One set of eyeglass frames One pair of prescription lenses Daily disposables: up to 3 month supply	

conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery)	Extended wear disposable: up to 6 month supply Non-disposable lenses: one set	
Optical devices	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum number of optical devices per policy year	One optical device	

Important note: Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies.

As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.

Outpatient prescription drugs

Policy year deductible and copayment/coinsurance waiver for risk reducing breast cancer

The policy year deductible and the per prescription copayment/coinsurance will not apply to risk reducing breast cancer prescription drugs when obtained at a retail in-network, pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.

Policy year deductible and copayment/coinsurance waiver for tobacco cessation prescription and over-the-counter drugs

The policy year deductible and the per prescription copayment/coinsurance will not apply to the first two 90-day treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at a retail in-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%.

Your policy year deductible and any prescription copayment/coinsurance will apply after those two regimens per policy year have been exhausted.

Policy year deductible and copayment/coinsurance waiver for contraceptives

The policy year deductible and the per prescription copayment/coinsurance will not apply to female contraceptive methods when obtained at an in-network pharmacy.

This means that such contraceptive methods are paid at 100% for:

- All over-the-counter (OTC) and generic contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%.
- If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drug or device for that method paid at 100%.

The policy year deductible prescription drug policy year deductible and the per prescription copayment/coinsurance continue to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at an in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.

Outpatient prescription drugs		
Outpatient prescription drug policy year deductibles **A separate policy year deductible applies to prescription drugs**		
You have to meet your prescription drug policy year deductible below before this plan pays for outpatient prescription drug benefits.		
Student	$500 per policy year	
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Preferred Generic prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	$10 copayment per supply then the plan pays 100% (of the negotiated charge)	$10 copayment per supply then the plan pays 70% (of the recognized charge)
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	$25 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	Not covered
Preferred brand-name prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	$45 copayment per supply then the plan pays 100% (of the negotiated charge)	$45 copayment per supply then the plan pays 70% (of the recognized charge)
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	$112.50 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	Not covered
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Non-preferred generic prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	$70 copayment per supply then the plan pays 100% (of the negotiated charge)	$70 copayment per supply then the plan pays 70% (of the recognized charge)
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	$175copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	Not Covered
Non-preferred brand-name prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	$70 copayment per supply then the plan pays 100% (of the negotiated charge)	$70 copayment per supply then the plan pays 70% (of the recognized charge)
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	$175 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	Not Covered

Eligible health services	In-network coverage	Out-of-network coverage
Specialty Drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	Copayment per supply of 30% (of the negotiated charge)	Not Covered
Diabetic Insulin		
30 day supply at retail pharmacy	Paid according to the type of drug per the schedule of benefits above	Paid according to the type of drug per the schedule of benefits above
90 supply at mail order pharmacy	Paid according to the type of drug per the schedule of benefits above	Paid according to the type of drug per the schedule of benefits above
Important note:		
Diabetic supplies, drugs, and insulin important note: Your cost share will not exceed $35 per 30 day supply of a covered prescription insulin drug. No deductible applies for diabetic supplies and insulin.		
Anti-cancer drugs taken by mouth- For each fill up to a 30 day supply	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
Infertility Drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above
Contraceptives (birth control)		
For each fill up to a 12 month supply of generic and OTC drugs and devices filled at a retail or mail order pharmacy	100% (of the negotiated charge) No policy year deductible applies	[100% (of the recognized charge)] [No policy year deductible applies]
For each fill up to a 12 month supply of brand name prescription drugs and devices filled at a retail or mail order pharmacy	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above
Contraceptive prescription drugs We may cover the dispensing of up to a 12 month supply worth of contraception at one time. The copayment per supply is 1-12 times the 30 day copayment per supply		

Eligible health services	In-network coverage	Out-of-network coverage
Preventive care drugs and supplements		
Preventive care drugs and supplements filled at a retail pharmacy For each 30 day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Risk reducing breast cancer prescription drugs filled at a pharmacy For each 30 day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.	
Tobacco cessation prescription and over-the-counter drugs		
Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy For each 30 day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Generic prescription drug substitution		
If you or your prescriber requests a covered brand-name prescription drug when a covered generic prescription drug equivalent is available, you will be responsible for the cost difference between the generic prescription drug and the brand-name prescription drug, plus the cost sharing that applies to the brand-name prescription drug. The cost difference is not applied towards your outpatient prescription drug deductible.		

Outpatient prescription drug exclusions

The following are not eligible health services:

- Any services related to providing, injecting or application of a drug
- Compounded prescriptions containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products and appliances unless listed as an eligible health service
- Dietary supplements including medical foods
- Drugs or medications:
  - Administered or entirely consumed at the time and place they are prescribed or provided
  - Which do not require a prescription by law, even if a prescription is written, unless we have approved a medical exception
  - That are therapeutically the same or an alternative to a covered prescription drug, unless we approve a medical exception
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while inpatient at a healthcare facility
  - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
  - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as an eligible health service
  - That are indicated or used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, non-prescription appetite suppressants or other medications except as described in the certificate
  - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature, unless there is evidence that the covered person meets one or more clinical criteria detailed in our precertification and clinical policies
- Duplicative drug therapy; for example, two antihistamines for the same condition
- Genetic care including:
  - Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes unless listed as an eligible health service
- Immunizations related to travel or work
- Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate
- Implantable drugs and associated devices except as specifically stated in the schedule of benefits or the certificate

- Injectables including:
  - Any charges for the administration or injection of prescription drugs
  - Needles and syringes except for those used for insulin administration
  - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting with the exception of Depo Provera and other injectable drugs for contraception
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- Prescription drugs:
  - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or prescription drugs for the treatment of a dental condition
  - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's drug guide
  - That are used for the purpose of improving visual acuity or field of vision
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the person identified on the ID card
- Prescription drugs indicated for the purpose of weight loss.
- Replacement of lost or stolen prescriptions
- Test agents except diabetic test agents
- Tobacco cessation drugs, unless recommended by the USPSTF
- We reserve the right to exclude:
  - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's drug guide
  - Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's drug guide

A covered person, a covered person's designee or a covered person's prescriber may seek an expedited medical exception process to obtain coverage for non-covered drugs in exigent circumstances. An "exigent circumstance" exists when a covered person is suffering from a health condition that may seriously jeopardize a covered person's life, health, or ability to regain maximum function or when a covered person is undergoing a current course of treatment using a non-formulary drug. The request for an expedited review of an exigent circumstance may be submitted by contacting Aetna's *Pre-certification Department* at **1-855-240-0535**, faxing the request to **1-877-269-9916**, or submitting the request in writing to:

CVS Health
ATTN: Aetna PA
1300 E Campbell Road
Richardson, TX 75081

Description of Benefits – 1000 Plan

The Plan excludes coverage for certain services (referred to as exceptions in the certificate of coverage) and has limitations on the amounts it will pay. While this Plan Design and Benefit Summary document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. To look at the full Plan description, which is contained in the Certificate of Coverage issued to you, go to **https://www.aetnastudenthealth.com.** If any discrepancy exists between this Benefit Summary and the Certificate of Coverage, the Certificate will control.

This Plan will pay benefits in accordance with any applicable Illinois Insurance Law(s).

Policy year deductible	**In-network coverage**	**Out-of-network coverage**
You have to meet your policy year deductible before this plan pays for benefits.		
Student	$1,000 per policy year	$2,000 per policy year
PRESCRIBED MEDICINES		
Student	$500 per policy year	
Note: This is the amount you owe for in-network and out-of-network eligible health services each policy year before the plan begins to pay for eligible health services. After the amount you pay for eligible health services reaches the policy year deductible, this plan will begin to pay for eligible health services for the rest of the policy year.		

Policy year deductible waiver		
The policy year deductible is waived for all of the following eligible health services: • In-network care for Preventive care and wellness, Pediatric Dental benefits and Abortion • In-network care and out-of-network care for Pediatric Vision Benefits and Victims of sexual assault or abuse.		
Maximum out-of-pocket limits **Maximum out-of-pocket limit** per **policy year**		
Student	$6,350 per policy year	$12,700 per policy year

The coinsurance listed in the schedule of benefits below reflects the plan coinsurance percentage. This is the coinsurance amount that the plan pays. You are responsible for paying any remaining coinsurance.

Eligible health services	In-network coverage	Out-of-network coverage
Preventive care and wellness		
Routine physical exams	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit Policy year deductible applies
Covered persons through age 21 Maximum age and visit limits per policy year	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures//Health Resources and Services Administration guidelines for children and adolescents.	
Preventive care immunizations		
Performed in a facility or at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit Policy year deductible applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.	
The following is not covered under this benefit: • Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment or travel		
Routine gynecological exams (including Pap smears and cytology tests)		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit Policy year deductible applies
Preventive screening and counseling services		
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, Screening, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit Policy year deductible applies
Skin cancer behavioral counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit Policy year deductible applies
Falls prevention counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit Policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Routine cancer screenings performed at a physician's office, specialist's office or facility.		
Routine cancer screenings	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit Policy year deductible applies
Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration.	
Prenatal care services (Preventive care services only)	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Lactation counseling services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Breast pump supplies and accessories	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Contraceptive prescription drugs and devices provided, administered, or removed, by a provider during an office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Voluntary sterilization		
Inpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Outpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
The following are not covered under this benefit: • Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care		

• Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA		
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Physicians and other health professionals		
Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist) includes telemedicine consultations)	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Allergy testing and treatment		
Allergy testing performed at a physician's or specialist's office	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Allergy injections treatment performed at a physician or specialist office	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Allergy sera and extracts administered via injection at a physician's or specialist's office	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Physician and specialist - surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge) per admission Policy year deductible applies	60% (of the recognized charge) per admission Policy year deductible applies
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section) • Services of another physician for the administration of a local anesthetic		
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge) per admission Policy year deductible applies	60% (of the recognized charge) per admission Policy year deductible applies
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic		

Eligible health services	In-network coverage	Out-of-network coverage
Alternatives to physician office visits		
Walk-in clinic visits (non-emergency visit)	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter Policy year deductible applies	$40 copayment then the plan pays 100% (of the balance of the recognized charge) per visit thereafter Policy year deductible applies
Hospital and other facility care		
Inpatient hospital (room and board) and other miscellaneous services and supplies) Includes birthing center facility charges	80% (of the negotiated charge) per admission Policy year deductible applies	60% (of the balance of the recognized charge) per admission Policy year deductible applies
The following are not eligible health services: • All services and supplies provided in: - Rest homes - Any place considered a person's main residence or providing mainly custodial or rest care - Health resorts - Spas - Schools or camps		
Preadmission testing	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
In-hospital non-surgical physician services	80% (of the negotiated charge) per admission Policy year deductible applies	60% (of the balance of the recognized charge) per admission Policy year deductible applies
Alternatives to hospital stays		
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center For physician charges, refer to the *Physician and specialist - outpatient surgical services* benefit	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
The following are not covered under this benefit: • A stay in a hospital (See the *Hospital care – facility charges* benefit in this section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic		

Eligible health services	In-network coverage	Out-of-network coverage
Home health care	85% (of the negotiated charge) per visit Policy year deductible applies	65% (of the balance of the recognized charge) per visit Policy year deductible applies
The following are not covered under this benefit: • Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities) • Transportation • Homemaker or housekeeper services • Food or home delivered services • Maintenance therapy		
Hospice-Inpatient (room and board and other miscellaneous services and supplies)	80% (of the negotiated charge) per admission Policy year deductible applies	60% (of the recognized charge) per admission Policy year deductible applies
Hospice-Outpatient	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
The following are not covered under this benefit: • Funeral arrangements • Pastoral counseling • Bereavement counseling • Financial or legal counseling which includes estate planning and the drafting of a will • Homemaker or caretaker services that are services which are not solely related to your care and may include: - Sitter or companion services for either you or other family members - Transportation - Maintenance of the house		
Outpatient private duty nursing	80% (of the negotiated charge) per admission Policy year deductible applies	60% (of the recognized charge) per admission Policy year deductible applies
Skilled nursing facility-Inpatient (room and board and miscellaneous inpatient care servic supplies) Subject to semi-private room rate unless intensive care unit is required	$100 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission Policy year deductible applies	$200 copayment then the plan pays 60% (of the balance of the recognized charge) per admission Policy year deductible applies
Emergency room	80% of the negotiated charge) per visit Policy year deductible applies	Paid the same as in-network coverage
Emergency services resulting from a criminal sexual assault or abuse	100% (of the negotiated charge) per visit	Paid the same as in-network coverage

Important note:

- As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment/coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on the back of your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill.
- A separate emergency room copayment/coinsurance will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/coinsurance will be waived and your inpatient copayment/coinsurance will apply.
- Covered benefits that are applied to the emergency room copayment/coinsurance cannot be applied to any other copayment/coinsurance under the plan. Likewise, a copayment/coinsurance that applies to other covered benefits under the plan cannot be applied to the emergency room copayment/coinsurance.
- Separate copayment/coinsurance amounts may apply for certain services given to you in the emergency room that are not part of the emergency room benefit. These copayment/coinsurance amounts may be different from the emergency room copayment/coinsurance. They are based on the specific service given to you.
- Services given to you in the emergency room that are not part of the emergency room benefit may be subject to copayment/coinsurance amounts that are different from the emergency room copayment/coinsurance amounts.

Eligible health services	**In-network coverage**	**Out-of-network coverage**
Urgent medical care	80% (of the negotiated charge) per visit thereafter Policy year deductible applies	60% (of the recognized charge) per visit thereafter Policy year deductible applies
Pediatric dental care (Limited to covered persons through the end of the month in which the person turns age 19)		
Type A services	100% (of the negotiated charge) per visit No copayment or deductible applies	70% (of the recognized charge) per visit Policy year deductible applies
Type B services	70% (of the negotiated charge) per visit No copayment or deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Type C services	50% (of the negotiated charge) per visit No copayment or deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Orthodontic services	50% (of the negotiated charge) per visit No copayment or deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Dental emergency services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received.

The following are not covered under this benefit:

- Any instruction for diet, plaque control and oral hygiene
- Cosmetic services and supplies including:
  - Plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance
  - Augmentation and vestibuloplasty, and other substances to protect, clean, whiten, bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons, except to the extent coverage is specifically provided in the *Eligible health services and exclusions* section
  - Facings on molar crowns and pontics will always be considered cosmetic
- Crown, inlays, onlays, and veneers unless:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants and braces (that are determined not to be medically necessary), mouth guards, and other devices to protect, replace or reposition teeth
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - For splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint dysfunction disorder (TMJ) and craniomandibular joint dysfunction disorder (CMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Eligible health services and exclusions – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another eligible health service
- Orthodontic treatment except as covered above and in the *Pediatric dental care* section of the schedule of benefits
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Routine dental exams and other preventive services and supplies, except as specifically provided in the *Pediatric dental care* section of the schedule of benefits
- Services and supplies:
  - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
  - Provided for your personal comfort or convenience or the convenience of another person, including a provider
  - Provided in connection with treatment or care that is not covered under your policy
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a dentist or dental provider that is legally qualified to furnish dental services or supplies

Eligible health services	In-network coverage	Out-of-network coverage
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Podiatric (foot care) treatment Physician and specialist non-routine foot care treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Services and supplies for: - The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies - Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet		
Impacted wisdom teeth		
Impacted wisdom teeth	80% (of the negotiated charge) Policy year deductible applies	80% (of the recognized charge) Policy year deductible applies
Accidental injury to sound natural teeth	80% (of the negotiated charge) Policy year deductible applies	80% (of the recognized charge) Policy year deductible applies
The following are not covered under this benefit: • The care, filling, removal or replacement of teeth and treatment of diseases of the teeth • Dental services related to the gums • Apicoectomy (dental root resection) • Orthodontics • Root canal treatment • Soft tissue impactions • Bony impacted teeth • Alveolectomy • Augmentation and vestibuloplasty treatment of periodontal disease • False teeth • Prosthetic restoration of dental implants • Dental implants		
Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: Dental implants		
Clinical trials		
Routine patient costs	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

The following are not eligible health services: • Services and supplies related to data collection and record-keeping needed only for the clinical trial • Services and supplies provided by the trial sponsor for free • The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with our policies)		
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Dermatological treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: Cosmetic treatment and procedures		
Obesity Surgery and services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered services: • Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, except as described in the certificate. This is regardless of whether there are other related conditions. This includes: - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications - Hypnosis or other forms of therapy - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement		
Maternity care		
Maternity care (includes delivery and postpartum care services in a hospital or birthing center)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries		
Well newborn nursery care in a hospital or birthing center	80% (of the negotiated charge) No Policy year deductible applies	60% (of the recognized charge) No Policy year deductible applies
Abortion		
Inpatient physician or specialist surgical service	100% (of the negotiated charge) No policy year deductible applies	60% (of the recognized charge)
Outpatient physician or specialist surgical service	100% (of the negotiated charge) No policy year deductible applies	60% (of the recognized charge)
Travel and lodging reimbursement	100% No Policy year deductible applies	

Limit per policy year	$3,000

The following are not covered travel and lodging expenses under this rider:

- Expenses for more than one travel companion
- Gasoline/fuel costs
- Car rentals
- Meals, groceries, hotel room service, alcohol/tobacco products
- Personal care/convenience items, (e.g. shampoo, clothing, deodorant)
- Entertainment/souvenir expenses
- Telephone calls
- Taxes
- Tips, gratuities
- Childcare expenses
- Lost wages

Abortion drugs (abortifacients)
Covered services include prescription drugs used for elective termination of pregnancy, including those prescribed or ordered for off label use.

Eligible health services	In-network coverage	Out-of-network coverage
Gender affirming treatment		
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Autism spectrum disorder		
Autism spectrum disorder treatment, diagnosis and testing. Includes Applied behavior analysis and Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	Benefits will be the same as those stated under each covered service category in this Schedule of benefits	Benefits will be the same as those stated under each covered service category in this Schedule of benefits
Mental Health & Substance related disorders treatment		
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	$100 copayment plus 80% (of the balance of the negotiated charge) per admission Policy year deductible applies	$200 copayment plus 60% (of the balance of the recognized charge) per admission Policy year deductible applies
Outpatient office visits (includes telemedicine consultations)	80% (of the negotiated charge) Policy year deductible applies	60% (of the recognized charge) Policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Other outpatient health disorders treatment (includes skilled behavioral health services in the home) and (includes Partial hospitalization and Intensive Outpatient Program)	80% (of the negotiated charge) Policy year deductible applies	60% (of the recognized charge) Policy year deductible applies

Eligible health services	In-network coverage (IOE facility)	In-network coverage (Non-IOE facility)	Out-of-network coverage
Transplant services			
Inpatient and outpatient transplant facility services	Covered according to the type of benefit and the place where the service is received.		
Inpatient and outpatient transplant physician and specialist services	Covered according to the type of benefit and the place where the service is received.		
Transplant services-travel and lodging	Covered	Covered	Covered
Lifetime maximum payable for travel and lodging expenses for any one transplant, including tandem transplants	$10,000	$10,000	$10,000
Maximum payable for Lodging Expenses per **IOE** patient	$50 per night	$50 per night	$50 per night
Maximum payable for Lodging Expenses per companion	$50 per night	$50 per night	$50 per night
The following are not covered under this benefit: • Services and supplies furnished to a donor when the recipient is not a covered person • Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness • Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness			

Eligible health services	In-network coverage	Out-of-network coverage
Treatment of basic infertility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Limited infertility services Inpatient and outpatient care	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Advanced reproductive technology (ART) services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
For treatment that includes an oocyte retrieval, maximum number of oocyte retrievals	4, however if a live birth follows a completed oocyte retrieval, 2 additional oocyte retrievals will be covered.	
The following are not covered under the infertility services benefit:		

• Cryopreservation (freezing) of eggs, embryos, or sperm. However, subsequent non-experimental or investigational procedures that use the cryopreserved eggs, embryos or sperm are covered.
• Travel costs within 100 miles of your home or travel cost not required by Aetna.
• Non-medical costs of an egg or sperm donor
• Experimental or investigational treatment as determined by the American Society for Reproductive Medicine
• Infertility medication. See the Eligible health services and exclusions-Outpatient prescription drugs section for information on coverage of infertility prescription drugs.
• Infertility medication not injected by your provider, including but not limited to menotropins, hCG, and GnRH agonists. See the Coverage and exclusions-Prescription drugs – outpatient section for information on coverage of infertility prescription drugs
• All non-medical charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
• Infertility treatment when a successful pregnancy could have been obtained through less costly treatment.

Eligible health services	In-network coverage	Out-of-network coverage
Specific therapies and tests		
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility No additional expense, such as a copayment or deductible amount, will be imposed for mammograms	80% (of the negotiated charge) Policy year deductible applies	60% (of the recognized charge) Policy year deductible applies
Diagnostic lab work performed in a physician's office, the outpatient department of a hospital or other facility	80% (of the negotiated charge) Policy year deductible applies	60% (of the recognized charge) Policy year deductible applies
Diagnostic radiological services performed in a physician's office, the outpatient department of a hospital or other facility No additional expense, such as a copayment or deductible amount, will be imposed for mammograms	80% (of the negotiated charge) Policy year deductible applies	60% (of the recognized charge) Policy year deductible applies
Outpatient Chemotherapy, Radiation & Respiratory Therapy	80% (of the negotiated charge) Policy year deductible applies	60% (of the recognized charge) Policy year deductible applies
Outpatient infusion therapy	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit:		

- Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan
- Enteral nutrition
- Blood transfusions and blood products
- Dialysis

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy)	80% (of the negotiated charge) Policy year deductible applies	60% (of the recognized charge) Policy year deductible applies
Chiropractic services	80% (of the negotiated charge) Policy year deductible applies	60% (of the recognized charge) Policy year deductible applies
Emergency ground, air, and water ambulance	80% (of the negotiated charge) per trip Policy year deductible applies	Paid the same as in-network coverage
The following are not covered under this benefit: • Ambulance services for routine transportation to receive outpatient or inpatient care		
Durable medical and surgical equipment	80% (of the negotiated charge) per items Policy year deductible applies	60% (of the recognized charge) per items Policy year deductible applies
The following are not covered under this benefit: • Whirlpools • Portable whirlpool pumps • Sauna baths • Massage devices • Over bed tables • Elevators • Communication aids • Vision aids • Telephone alert systems • Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician		
Nutritional support	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition. except as described above		

Eligible health services	In-network coverage	Out-of-network coverage
Prosthetic and customized orthotic Devices & Orthotics Includes Cranial prosthetics *(Medical wigs)*	80% (of the negotiated charge) per items Policy year deductible applies	60% (of the recognized charge) per items Policy year deductible applies
All other prosthetic devices	80% (of the negotiated charge) per items Policy year deductible applies	60% (of the recognized charge) per items Policy year deductible applies
If you receive a prosthetic device as part of another eligible health service, it will not be covered under this benefit.		
Hearing aids		
Hearing aids	80% (of the negotiated charge) per visit thereafter Policy year deductible applies	60% (of the recognized charge) per visit thereafter Policy year deductible applies
Hearing aids maximum per ear	One hearing aid per ear every 12 month consecutive period every policy year	
The following are not eligible health services: – Replacement of a hearing aid that is lost, stolen or broken – Batteries or cords – A hearing aid that does not meet the specifications prescribed for correction of hearing loss – Any hearing aid prescribed by someone other than a hearing care professional		
Hearing exams	80% (of the negotiated charge) per visit thereafter Policy year deductible applies	60% (of the recognized charge) per visit thereafter Policy year deductible applies
The following are not covered under this benefit: • Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay		
Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)		
Pediatric routine vision exams (including refraction)-Performed by a legally qualified ophthalmologist or optometrist Includes comprehensive low vision evaluations Includes visit for fitting of contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	70% (of the recognized charge) per visit No policy year deductible applies
Low vision Maximum	One comprehensive low vision evaluation every policy year	
Pediatric vision care services & supplies-Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	70% (of the recognized charge) per visit No policy year deductible applies

Maximum number Per year: Eyeglass frames Prescription lenses Contact lenses (includes non-conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery)	One set of eyeglass frames One pair of prescription lenses Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set	
Optical devices	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum number of optical devices per policy year	One optical device	

Important note: Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies.

As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.

Outpatient prescription drugs

Policy year deductible and copayment/coinsurance waiver for risk reducing breast cancer

The policy year deductible and the per prescription copayment/coinsurance will not apply to risk reducing breast cancer prescription drugs when obtained at a retail in-network, pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.

Policy year deductible and copayment/coinsurance waiver for tobacco cessation prescription and over-the-counter drugs

The policy year deductible and the per prescription copayment/coinsurance will not apply to the first two 90-day treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at a retail in-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%.

Your policy year deductible and any prescription copayment/coinsurance will apply after those two regimens per policy year have been exhausted.

Policy year deductible and copayment/coinsurance waiver for contraceptives

The policy year deductible and the per prescription copayment/coinsurance will not apply to female contraceptive methods when obtained at an in-network pharmacy.

This means that such contraceptive methods are paid at 100% for:

- All over-the-counter (OTC) and generic contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%.
- If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drug or device for that method paid at 100%.

The policy year deductible prescription drug policy year deductible and the per prescription copayment/coinsurance continue to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at an in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.

Outpatient prescription drugs		
Outpatient prescription drug policy year deductibles **A separate policy year deductible applies to prescription drugs**		
You have to meet your prescription drug policy year deductible below before this plan pays for outpatient prescription drug benefits.		
Student	$500 per policy year	
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Preferred Generic prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	$10 copayment per supply then the plan pays 100% (of the negotiated charge)	$10 copayment per supply then the plan pays 70% (of the recognized charge)
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	$25 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	Not covered
Preferred brand-name prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	$45 copayment per supply then the plan pays 100% (of the negotiated charge)	$45 copayment per supply then the plan pays 70% (of the recognized charge)
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	$112.50 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	Not covered
Non-preferred generic prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	$70 copayment per supply then the plan pays 100% (of the negotiated charge)	$70 copayment per supply then the plan pays 70% (of the recognized charge)
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	$175copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	Not Covered

Eligible health services	In-network coverage	Out-of-network coverage
Non-preferred brand-name prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	$70 copayment per supply then the plan pays 100% (of the negotiated charge)	$70 copayment per supply then the plan pays 70% (of the recognized charge)
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	$175 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	Not Covered
Specialty Drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	Copayment per supply of 30% (of the negotiated charge)	Not Covered
Diabetic Insulin		
30 supply at retail pharmacy	Paid according to the type of drug per the schedule of benefits above	Paid according to the type of drug per the schedule of benefits above
90 supply at mail order pharmacy	Paid according to the type of drug per the schedule of benefits above	Paid according to the type of drug per the schedule of benefits above
Diabetic supplies, drugs, and insulin important note: Your cost share will not exceed $35 per 30 day supply of a covered prescription insulin drug. No deductible applies for diabetic supplies and insulin.		
Anti-cancer drugs taken by mouth- For each fill up to a 30 day supply	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
Infertility Drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above
Contraceptives (birth control)		
For each fill up to a 12 month supply of generic and OTC drugs and devices filled at a retail or mail order pharmacy	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
For each fill up to a 12 month supply of brand name prescription drugs and devices filled at a retail or mail order pharmacy	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above

Contraceptive prescription drugs We may cover the dispensing of up to a 12 month supply worth of contraception at one time. The copayment per supply is 1-12 times the 30 day copayment per supply		
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Preventive care drugs and supplements		
Preventive care drugs and supplements filled at a retail pharmacy For each 30 day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Risk reducing breast cancer prescription drugs filled at a pharmacy For each 30 day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.	
Tobacco cessation prescription and over-the-counter drugs		
Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy For each 30 day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Generic prescription drug substitution		
If you or your prescriber requests a covered brand-name prescription drug when a covered generic prescription drug equivalent is available, you will be responsible for the cost difference between the generic prescription drug and the brand-name prescription drug, plus the cost sharing that applies to the brand-name prescription drug. The cost difference is not applied towards your outpatient prescription drug deductible.		

Outpatient prescription drug exclusions

The following are not eligible health services:

- Any services related to providing, injecting or application of a drug
- Compounded prescriptions containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products and appliances unless listed as an eligible health service
- Dietary supplements including medical foods
- Drugs or medications:
  - Administered or entirely consumed at the time and place they are prescribed or provided
  - Which do not require a prescription by law, even if a prescription is written, unless we have approved a medical exception
  - That are therapeutically the same or an alternative to a covered prescription drug, unless we approve a medical exception
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while inpatient at a healthcare facility
  - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
  - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as an eligible health service
  - That are indicated or used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, non-prescription appetite suppressants or other medications except as described in the certificate
  - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature, unless there is evidence that the covered person meets one or more clinical criteria detailed in our precertification and clinical policies
- Duplicative drug therapy; for example, two antihistamines for the same condition
- Genetic care including:
  - Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes unless listed as an eligible health service
- Immunizations related to travel or work
- Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate
- Implantable drugs and associated devices except as specifically stated in the schedule of benefits or the certificate
- Injectables including:
  - Any charges for the administration or injection of prescription drugs
  - Needles and syringes except for those used for insulin administration
  - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting with the exception of Depo Provera and other injectable drugs for contraception
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- Prescription drugs:

  - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or prescription drugs for the treatment of a dental condition
  - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's drug guide
  - That are used for the purpose of improving visual acuity or field of vision
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the person identified on the ID card
- Prescription drugs indicated for the purpose of weight loss.
- Replacement of lost or stolen prescriptions
- Test agents except diabetic test agents
- Tobacco cessation drugs, unless recommended by the USPSTF
- We reserve the right to exclude:
  - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's drug guide
  - Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's drug guide

A covered person, a covered person's designee or a covered person's prescriber may seek an expedited medical exception process to obtain coverage for non-covered drugs in exigent circumstances. An "exigent circumstance" exists when a covered person is suffering from a health condition that may seriously jeopardize a covered person's life, health, or ability to regain maximum function or when a covered person is undergoing a current course of treatment using a non-formulary drug. The request for an expedited review of an exigent circumstance may be submitted by contacting Aetna's *Pre-certification Department* at **1-855-240-0535**, faxing the request to **1-877-269-9916**, or submitting the request in writing to:

CVS Health
ATTN: Aetna PA
1300 E Campbell Road
Richardson, TX 75081

General Exclusions

Behavioral health treatment

- Services for the following based on categories, conditions, diagnoses or equivalent terms as listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association:
  - School and/or education service including special education, remedial education, wilderness treatment programs, or any such related or similar programs
  - Services provided in conjunction with school, vocation, work or recreational activities
  - Transportation

Blood and blood products

- Blood, blood products, and related services that are supplied to your provider free of charge

Cosmetic services and plastic surgery

- Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body except where described in the *Eligible health services - Reconstructive surgery and supplies* section, except where described in the *Eligible health services and exclusions* section.

Court-ordered services and supplies

- Court-ordered testing or care unless medically necessary. This exclusion does not apply to court-ordered FDA-approved prescription drugs for the treatment of substance use disorders and any associated counseling or wraparound services.

Custodial care

Services and supplies meant to help you with activities of daily living or other personal needs.
Services and supplies meant to help you with activities of daily living or other personal needs.
Examples of these are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter including emptying or changing containers and clamping tubing
- Watching or protecting you
- Respite care except in connection with hospice care, adult or child day care, or convalescent care
- Institutional care, including room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom , eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- For behavioral health (mental health treatment and substance use disorder treatment):
  - Services provided when you have reached the greatest level of function expected with the current level of care, for a specific diagnosis
  - Services given mainly to:
    - Maintain, not improve, a level of function

- Provide a place free from conditions that could make your physical or mental state worse

Dental care for adults

- Dental services for adults including services related to:
  - The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
  - Dental services related to the gums
  - Apicoectomy (dental root resection)
  - Orthodontics
  - Root canal treatment
  - Soft tissue impactions
  - Alveolectomy
  - Augmentation and vestibuloplasty treatment of periodontal disease
  - False teeth
  - Prosthetic restoration of dental implants
  - Dental implants except when part of an approved treatment plan for an eligible health service described in the *Eligible health services and exclusions – Reconstructive surgery and supplies* section.

This exception does not include treatment of accidental injuries to sound natural teeth and treatment for diseases of the teeth, removal of bony impacted teeth, bone fractures, removal of tumors, and odontogenic cysts. This exclusion also does not include tooth extraction surgery in preparation for radiation treatment of neoplastic jaw or throat diseases

Educational services

Examples of these are:

- Any service or supply for education, training or retraining services or testing.
  This includes:
  - Special education
  - Remedial education
  - Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
  - Job training
  - Job hardening programs
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting. However, covered services for autism spectrum disorders or habilitative services for children will not be denied solely because of the location where clinically appropriate services of this type are provided.

Examinations

Any health or dental examinations needed:

- Because a third party requires the exam. Examples include examinations to get or keep a job and examinations required under a labor agreement or other contract
- To buy insurance or to get or keep a license
- To travel
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity

Experimental or investigational

- Experimental or investigational drugs, devices, treatments or procedures unless otherwise covered under clinical trials. Note that this exclusion will not impact your ability to obtain an external review of denial of coverage for a service or supply denied by us as experimental or investigational.

Gene-based, cellular and other innovative therapies (GCIT)

Growth/Height care

- A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth
- Surgical procedures, devices and growth hormones to stimulate growth

Illegal Occupation

Services and supplies that you receive as a result of an injury due to your commission of a felony to which the contributing cause was the engagement of an illegal occupation.

The company shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

Jaw joint disorder

- Surgical treatment of jaw joint disorders
- Non-surgical treatment of jaw joint disorders
- Jaw joint disorders treatment performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutics services related to jaw joint disorders including associated myofascial pain

This exclusion does not apply to covered benefits for treatment of TMJ and CMJ as described in the *Eligible health services under your plan –Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment* section.

Maintenance care

- Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services.

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device, except for compression sleeves to prevent or reduce lymphedema. Examples of these include:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Home test kits not related to diabetic testing
  - Splints
  - Neck braces
  - Compresses
  - Other devices not intended for reuse by another patient

Non-U.S. citizen

- Services and supplies received by a covered person (who is not a United States citizen) within the covered person’s home country but only if the home country has a socialized medicine program

Other primary payer

- Payment for a portion of the charge that Medicare or another party is responsible for as the primary payer

Personal care, comfort or convenience items

- Any service or supply primarily for your convenience and personal comfort or that of a third party

Routine exams and preventive services and supplies

- Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *Eligible health services under your plan* section

School health services

- Services and supplies normally provided by the policyholder's:
  - School health services
  - Infirmary
  - Hospital
  - Pharmacy

- Services and supplies provided by health professionals who the policyholder:
  - Employs
  - Is affiliated with
  - Has an agreement or arrangement with
  - Otherwise designates

Services not permitted by law

- Some laws restrict the range of health care services a provider may perform under certain circumstances or in a particular state. When this happens, the services are not covered by the plan.

Services provided by a family member

- Services provided by a spouse, civil union partner, domestic partner, parent, child, stepchild, brother, sister, in-law or any household member

Sexual dysfunction and enhancement

- Any treatment, prescription drug, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

This exclusion does not include surgery and prosthetic devices for erectile dysfunction resulting from:

- Natural causes
- Trauma
- Infection
- Congenital disease or defects

Strength and performance

- Services, devices and supplies such as drugs or preparations designed primarily to enhance your strength, physical condition, endurance or physical performance

Therapies and tests

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used for physical therapy treatment
- Sensory or hearing and sound integration therapy

Tobacco cessation

- Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:
  - Counseling, except as specifically provided in the *Eligible health services under your plan – Preventive care and wellness* section
  - Hypnosis and other therapies
  - Medications, except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section
  - Nicotine patches
  - Gum

Treatment in a federal, state, or governmental entity

- Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, unless coverage is required by applicable laws

Voluntary sterilization

Reversal of voluntary sterilization procedures, including related follow-up care

Wilderness treatment programs

See *Educational services* in this section

Work related illness or injuries

- Coverage available to you under worker's compensation or a similar program under local, state or federal law for any illness or injury related to employment or self-employment.

Important Note:

A source of coverage or reimbursement is considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered "non-occupational" regardless of cause.

Midwestern University Downers Grove Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student Health℠ is the brand name for products and services provided by Aetna Life Insurance Company and its applicable affiliated companies (Aetna).

Sanctioned Countries

If coverage provided by this policy violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a written Office of Foreign Asset Control (OFAC) license. For more information, visit http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-877-480-4161.

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.

Discrimination is Against the Law

Aetna Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with 45 CFR § 92.101(a)(2)). Aetna Inc. does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Aetna Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
    - Qualified interpreters
    - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 1-877-480-4161 (TTY: 711) or the number on the back of your ID card.

If you believe that Aetna Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator

Attn: 1557 Coordinator
CVS Pharmacy, Inc.
1 CVS Drive, MC 2332,
Woonsocket, RI 02895

Phone: 1-800-648-7817, TTY: 711
Email: CRCoordinator@aetna.com

You can file a grievance in person, by mail, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
This notice is available at Aetna Inc.'s website: https://www.aetnastudenthealth.com

Please note, Aetna covers health services in compliance with applicable federal and state laws. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations, and conditions of coverage.

Language accessibility statement

TTY: **711**

English	**To access language services at no cost to you, call the number on your ID card.**
Amharic	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎት ላይ ያለውን ቁጥር ይደውሉ::
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Armenian	Ձեր նախընտրած լեզվով ավվճար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հէրախոսահամարով հէրախոսահամարով
Carolinian (Kapasal Falawasch)	Ngir mëna am sarwis lakk yi te doo fay, woo nimero bi am ci sa kàrt.
Chamorro	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang i numiru gi iyo-mu kard aidentifikasion.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Cushitic-Oromo	Tajaajiiloota afaanii gatii bilisaa ati argaachuuf, lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Greek	Για πρόσβαση στις υπηρεσίες γλώσσας χωρίς χρέωση, καλέστε τον αριθμό στην κάρτα ασφάλισής σας.
Gujarati	તમારે કોઇ પણ જાતના ખર્ચ વિના ભાષા સેવાઓ મેળવવા માટે, તમારા આઇડી કાર્ડ પર રહેલ નંબર પર કૉલ કરવો.
Hindi	बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	**無料の言語サービスは、IDカードにある番号にお電話ください。**
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Laotian	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈໍາຕົວຂອງທ່ານ.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T’11 ni nizaad k’ehj7 bee n7k1 a’doowo[doo b33h 7l7n7g00 naaltsoos bee atah n7l98go nanitin7g77 bee n44ho’d0lzin7g77 b44sh bee hane’7 bik1’7g77 1aj8’ h0lne’.
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.
Persian-Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ‘ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Samoan	Mō le mauaina o 'au'aunaga tau gagana e aunoa ma se totogi, vala'au le numera i luga o lau pepa ID.
Serbo-Croatian	Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici.
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Syriac-Assyrian	ܒܝܢ ܡܫܩܠܐ ܬܠܘܢ ܥܠ ܡܠܦܢܘܬܐ ܕܡܫܪܘܬܐ ܒܠܫܢܐ ܡܓܢܢܐܝܬ، ܩܪܝܬܘܢ ܠܡܢܝܢܐ ܥܠ ܦܬܩܐ ܕܡܫܘܕܥܢܘܬܐ ܕܝܠܟܘܢ.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.

Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน
Ukrainian	Щоб безкоштовнj отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікайній картці.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).