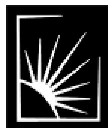
Student Medical Plan
2017 — 2018

The Case Western Reserve University is self-funded by Case Western Reserve University, with claims administration

Policy No: 474889

services provided by Chickering Claims Administrators, Inc. (CCA). Aetna Student Health℠ is the brand name for products and services provided by CCA and its applicable affiliated companies.



CASE WESTERN RESERVE
UNIVERSITY EST. 1826

PLAN INFORMATION

Sponsored By:
CASE WESTERN RESERVE UNIVERSITY
Cleveland, Ohio

Extending Eligibility To:
THE CLEVELAND INSTITUTE OF MUSIC, THE CLEVELAND INSTITUTE OF ART,

Administered By:
Aetna Student Health
P.O. Box 981106
El Paso, TX 79998
Toll Free: (877) 850-6038

TELEPHONE DIRECTORY

University Health Service
2145 Adelbert Road **(216) 368-2450**

University Counseling Services
Sears Bldg., Room 201 **(216) 368-5872**

Medical Plan Information **(216) 368-3049**
2145 Adelbert Road

WELCOME

Dear Student:

While you are at Case Western Reserve University, we want to ensure that the Student Medical Plan and Services are a positive experience for you. The university has contracted with Aetna Student Health in order to offer enhanced services that are easy to use, affordable and adaptable to your health care needs. One of the highlights of the Plan is an extensive nationwide health care network with access to doctors and specialists. The Student Medical Plan is offered as a supplement to the excellent care available to all Case Western Reserve students from the University Health Services and University Counseling Services.

The University also offers the Optional **Dependent** Medical Plan for those students who wish to purchase coverage for their **dependent** spouse, domestic partner and children. Our intent is to provide you with the opportunity to obtain effective medical coverage.

We appreciate your thoughts and suggestions. Questions or comments about either the Student Medical Plan or the Optional **Dependent** Plan can be directed to the University Health Service at **(216) 368-3049**.

Best Wishes,

The Student Medical Plan Committee

TABLE OF CONTENTS

STUDENT ELIGIBILITY 4

DEPENDENT ELIGIBILITY 4

STUDENT PERIODS OF COVERAGE AND COST 4

MEDICARE ELIGIBILITY NOTICE 4

DEPENDENT PERIODS OF COVERAGE AND COST 5

IMPORTANT DEFINITIONS 5

PREFERRED PROVIDER NETWORK INFORMATION 5

PRECERTIFICATION PROGRAM 6

DESCRIPTION OF BENEFITS STUDENT PLAN 7

Inpatient Hospitalization Benefits *8*
Outpatient Expense *9*
Preventive Care *11*
Treatment of Mental and Nervous Disorders *12*
Alcoholism and Drug Addiction Treatment *12*
Maternity Benefits *12*
Prescriptions coverage *13*
Additional Benefits *13*

DESCRIPTION OF BENEFITS DEPENDENT PLAN 16

Inpatient Hospitalization Benefits *16*
Outpatient Expense *17*
Preventive Care *19*
Treatment of Mental and Nervous Disorders *20*
Alcoholism and Drug Addiction Treatment *20*
Maternity Benefits *20*
Prescription Coverage *21*
Additional Benefits *21*

DENTAL COVERAGE 24

ONCALL TRAVEL ASSIST 24

COVERAGE TERMINATION 25

PERSONAL MEDICAL LEAVE 25

IDENTIFICATION CARD 26

CLAIM SUBMISSION 26

WAIVER OPTIONS 26

QUALIFYING EVENT 27

REFUND POLICY 27

APPEAL PROCESS/DENIAL OF BENEFITS 27

EXCLUSIONS 28

2017 - 2018* DEPENDENT ENROLLMENT FORM 31

2017 - 2018 DEPENDENT ENROLLMENT FORM 32

STUDENT ELIGIBILITY

1. Students of Case Western Reserve University registered for at least one credit hour.
2. Persons associated with special programs on the campus of Case Western Reserve University may be eligible for this student coverage.
3. Students of the Cleveland Institute of Art and the Cleveland Institute of Music registered for one or more credit hours.

NOT ELIGIBLE TO RECEIVE COVERAGE

1. Students cross-registered for classes at Case Western Reserve University or its affiliates.
2. Employees of Case Western Reserve University who are eligible for Benelect.
3. Students enrolled in virtual and online classes

DEPENDENT ELIGIBILITY

Covered students may also enroll their lawful spouse or domestic partner and dependent children up to the age of 26.

Newborn children may be enrolled onto the Plan within 30 days of birth **(ENROLLMENT IS NOT AUTOMATIC)**

If the plan covers dependent children, then any dependent unmarried child who will terminate coverage because he/she meets a limiting age under the policy, shall not terminate coverage if the child continues to incapable of self- sustaining employment by reason of mental retardation or physical handicap and primarily dependent upon the student for support and maintenance. Proof of such handicap and dependency may be required upon initial continuation and every two years thereafter.

STUDENT PERIODS OF COVERAGE AND COST

CASE WESTERN RESERVE UNIVERSITY SCHOOL OF MEDICINE, CASE WESTERN RESERVE UNIVERSITY SCHOOL OF DENTAL MEDICINE (MSD) STUDENTS, AND CLEVELAND CLINIC LERNER COLLEGE OF MEDICINE.

Fall Semester: July 1, 2017 (12:01 a.m.) to
January 15, 2018 (11:59 p.m.)

Spring Semester: January 16, 2017 (12:01 a.m.) to
June 30, 2018 (11:59 p.m.)

ALL STUDENTS EXCEPT THOSE LISTED ABOVE

Fall Semester: August 1, 2017 (12:01 a.m.) to
January 15, 2018 (11:59 p.m.)

Spring Semester: January 16, 2018 (12:01 a.m.) to
July 31, 2018 (11:59 p.m.)

If a student registers after September 8, 2017 for Fall Semester and after January 26, 2018 for Spring Semester, the Student Medical Plan will become effective on the date the student registers (not on the effective date listed above).

The fee for the 2017-2018 Student Medical Plan is **$ 1045.00** per semester. The fee for the Student Medical Plan is automatically billed each Fall and Spring semester to students registered for at least one credit hour. The fee will appear on the student's tuition bill each semester. Payment is due in accordance with the University's tuition schedule.
Students who waive the Plan see Waiver Options on page 28 will receive a credit of **$ 1045.00** on their account.

Medicare Eligibility Notice: If a covered person becomes eligible for **Medicare** after he or she is enrolled in the Policyholder's plan, such Medicare eligibility will not result in the termination of medical expense coverage and prescribed medicines expense coverage under the plan. As used within this provision, persons are "eligible for

Medicare" if they are entitled to benefits under Part A (receiving free Part A) or enrolled in Part B or Premium Part A.

DEPENDENT PERIODS OF COVERAGE AND COST

Medical coverage for spouse, domestic partner, and dependent child/ren may only be purchased if the student has purchased the Student Medical Plan coverage for students.

Coverage may be purchased on a per semester basis or on an annual basis. ENROLLMENT IS NOT AUTOMATIC. You must renew the coverage each semester or each year.

Students enrolled at Case Western Reserve University School of Medicine, Case Western Reserve University School of Dental Medicine (MSD) and Cleveland Clinic Lerner College of Medicine should refer to page 33 for coverage dates, enrollment and payment information.

All other students enrolled at Case Western Reserve University refer to page 32 for coverage dates, enrollment and payment information.

If coverage is desired, complete and return to University Health Service the enclosed enrollment form and appropriate premium, in the form of a check or money order, payable to Case Western Reserve University. **The completion of an Affidavit is necessary for the enrollment of a domestic partner. Forms are available at University Health Service.** Once paid, no portion of the premium for dependent coverage is refundable.

IMPORTANT DEFINITIONS

Injury:
Means bodily damages:

- Caused directly and independently of all other causes by an **Accident**; and,
- Which results in loss covered by the Plan.

Sickness:
Means illness or disease for which treatment is received while the person is covered under this Plan.

Disability:
Means either a **Sickness** or **Injury**.

Plan Year:
Means fiscal year as described under period of coverage above.

PREFERRED PROVIDER NETWORK

The Student Medical Plan, subject to the outlined benefits, limits and exclusions, protects the student during the term for which the fee has been paid. The Plan reserves the right to coordinate benefits with any other medical coverage.

Participants of the Student Medical Plan are encouraged to access a national network of Preferred providers in the Aetna network. Participants may realize substantial savings by utilizing preferred providers.

A complete listing of Participating Providers is available through the internet by accessing www.aetnastudenthealth.com. Click on Find Your School and select Case Western Reserve University from the list. Additionally, information regarding Preferred Providers can be obtained by contacting Aetna Student Health at (877) 850-6038.

Failure to utilize a network provider, will result in a benefit reduction to 60% of covered charges.
In the case of a medical emergency as determined by the claims administrator, a participant who obtains health care from an out-of-network provider will be subject to the in-network limits and restrictions with respect to such care. When **hospital** or medical care is required because of a **Sickness** or **Injury** eligible for benefits under this Plan, the **reasonable and customary**

expense actually incurred will be paid, up to the specified limits for each **Sickness** or **Injury**.

PRE-CERTIFICATION PROGRAM

Your Plan requires pre-certification for certain services, such as inpatient stays, certain tests, procedures, outpatient surgery, therapies and equipment, and prescribed medications. Pre-certification simply means calling Aetna Student Health prior to treatment to get approval for coverage under your Plan for a medical procedure or service. For preferred care and designated care, the preferred care or designated care provider is responsible for obtaining pre-certification Since precertification is the preferred care or designated care provider's responsibility, there is no additional out-of-pocket cost to you as a result of a designated care provider's or a preferred care provider's failure to precertify services. For non-preferred care, you are responsible for obtaining pre-certification which can be initiated by you, a member of your family, a hospital staff member or the attending physician. The precertification process can be initiated by calling Aetna at the telephone number listed on your ID card.
If you do not secure pre-certification for the below listed inpatient and outpatient covered medical services and supplies obtained from a non-preferred provider, your medical expenses for these services and supplies will not be covered.

Pre-certification for the following inpatient and outpatient services or supplies is needed*:

- All inpatient maternity and newborn care, after the initial 48 hours for a vaginal delivery or 96 hours for a cesarean section;
- Ambulance (non-emergency transportation);
- Autologous chondrocyte implantation, Carticel®
- Bariatric surgery (bariatric surgery is not covered under the Policy unless specifically described in the Policy.);
- BRCA genetic testing;
- Cardiac rhythm implantable devices;
- Cochlear device and/or implantation;
- Dental implants and oral appliances;
- Dorsal column (lumbar) neurostimulators: trial or implantation;
- Drugs and Medical Injectables;
- Electric or motorized wheelchairs and scooters;
- Gender Reassignment (Sex Change) Surgery;
- Home health care related services (ie. private duty nursing),
- Hyperbaric oxygen therapy;
- Infertility treatment (Comprehensive and ART infertility treatment is not covered under the plan unless specifically described in the Policy.)
- Inpatient Confinements (surgical and non-surgical); hospital, skilled nursing facility, rehabilitation facility, residential treatment facility for mental disorders and substance abuse, hospice care;
- Inpatient mental disorders treatment;
- Inpatient substance abuse treatment;
- Kidney dialysis;
- Knee surgery;
- Limb Prosthetics;
- Out-of-network freestanding ambulatory surgical facility services when referred by a network provider;
- Oncotype DX;
- Orthognatic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint;
- Osseointegrated implant;
- Osteochondral allograft/knee;
- Outpatient back surgery not performed in a physician's office;
- Pediatric Congenital Heart Surgery;
- Pre-implantation genetic testing;

- Procedures that may be considered cosmetic. Cosmetic services and supplies are not covered under the plan unless specifically described in the Policy;
- Proton beam radiotherapy;
- Referral or use of out-of-network providers for non-emergency services, unless the covered person understands and consents to the use of an out-of-network provider under their out-of-network benefits when available in their plan;
- Spinal Procedures;
- Transplant Services;
- Uvulopalatopharyngoplasty, including laser-assisted procedures; and
- Ventricular assist devices.

*Your Plan may not include coverage for all of the services and supplies listed above. Please check your Master Policy for confirmation of which services and supplies are covered and which services and supplies are excluded under your Plan. If you cannot locate the benefit you are looking for in your Master Policy, contact Customer Service at the number listed on your ID card for further assistance.

Pre-certification DOES NOT guarantee the payment of benefits for your inpatient stays, certain tests, procedures, outpatient surgeries, therapies and equipment, and prescribed medications
Each claim is subject to medical policy review, in accordance with the exclusions and limitations contained in the Master Policy. The Master Policy also includes information regarding your eligibility criteria, notification guidelines, and benefit coverage.

Pre-certification of non-emergency admissions
Non-emergency admissions must be requested at least **fifteen (15) days** prior to the date they are scheduled to be admitted.

Pre-certification of emergency admissions
Emergency admissions must be requested within **twenty-four (24) hours** or as soon as reasonably possible after the admission.

Pre-certification of urgent admissions
Urgent admissions must be requested before you are scheduled to be admitted.

Pre-certification of outpatient non-emergency medical services
Outpatient non-emergency medical services must be requested within **fifteen (15) days** before the outpatient services, treatments, procedures, visits or supplies are provided or scheduled.

Pre-certification of prenatal care and delivery
Prenatal care medical services must be requested as soon as possible after the attending physician confirms pregnancy. Delivery medical services, which exceed the first 48 hours after delivery for a routine delivery and 96 hours for a cesarean delivery, must be requested within twenty-four (24) hours **of the birth or as soon thereafter as possible.**

Description of Benefits – Student Plan

Policy Year Maximum	**Unlimited**	
	Preferred Care	Non-Preferred Care
DEDUCTIBLE The policy year deductible is waived for preferred	**Preferred Care**	

care covered medical expenses that apply to Preventive Care Expense benefits. In addition to state and federal requirements for waiver of the Policy Year Deductible, this Plan will waive the Deductible for: Preferred Care and Non Preferred care Deductible-waived for Pediatric Vision Services, Preferred Care Deductible (only) is Waived for Pediatric Preventive Dental. Per visit or admission Deductibles do not apply towards satisfying the Policy Year Deductible.	Students: **$250** per Policy Year Family: **$750** per Policy Year **Non-Preferred Care** Students: **$400** Family: **$1,200** Per Policy Year	
COINSURANCE	Coinsurance is both the percentage of covered medical expenses that the plan pays, and the percentage of covered medical expenses that you pay. The percentage that the plan pays is referred to as "plan coinsurance" or the "payment percentage," and varies by the type of expense. Please refer to the Schedule of Benefits for specific information on coinsurance amounts.	
OUT OF POCKET MAXIMUMS	**Preferred Care**	**Non-Preferred Care**
Once the Individual or Family Out-of-Pocket Limit has been satisfied, Covered Medical Expenses will be payable at **100%** for the remainder of the Policy Year. The following expenses do not apply toward meeting the plan's out-of-pocket limits: • Non-covered medical expenses; and • Expenses that are not paid or precertification benefit reductions or penalties because a required precertification for the service(s) or supply was not obtained from Aetna.	Individual Out-of-Pocket: **$6,850** per Policy Year Family Out-of-Pocket: **$13,700** per Policy Year	Individual Out-of-Pocket: **$15,000** per Policy Year Family Out-of-Pocket: **$20,000** per Policy Year

Inpatient Hospitalization Benefits	Preferred Care	Non-Preferred Care
Room and Board Expense	**80%** of the Negotiated Charge	**60%** of the Recognized Charge for a semi-private room
Intensive Care Room and Board Expense	**80%** of the Negotiated Charge	**60%** of the Recognized Charge for a semi-private room
Non-Surgical Physicians Expense	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Licensed Nurse Expense	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Miscellaneous Hospital Expense	**80%** of the Negotiated Charge	**60%** of the Recognized Charge

Includes but not limited to: operating room, laboratory tests/X rays, oxygen tent, drugs, medicines and dressings.		
Non-Surgical Physicians Expense Non-surgical services of the attending Physician, or a consulting Physician.	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Surgical Expenses	**Preferred Care**	**Non-Preferred Care**
Surgical Expense **(Inpatient and Outpatient)**	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Anesthesia Expense **(Inpatient and Outpatient)**	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Assistant Surgeon Expense (Inpatient and Outpatient)	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Outpatient Expense	**Preferred Care**	**Non-Preferred Care**
Hospital Outpatient Department Expense	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Walk-in Clinic Visit Expense	After a **$20** Copay per visit, **80%** of the Negotiated Charge	After a **$20** Deductible per visit, **60%** of the Recognized Charge
Ambulatory Surgical Expense	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Outpatient Expense (continued)	**Preferred Care**	**Non-Preferred Care**
Emergency Room Expense **Important Note**: Please note that Non-Preferred Care Providers do not have a contract with Aetna. The provider may not accept payment of your cost share (your deductible and 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. Please send Aetna the bill at the address listed on the back of your member ID card and Aetna will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.	After a **$100** Copay per visit (waived if admitted), **80%** of the Negotiated Charge	After a **$100** Deductible per visit (waived if admitted), **80%** of the Recognized Charge
Urgent Care Expense	After a **$30** Copay per visit, **80%** of the Negotiated Charge	After a **$30** Deductible per visit, **60%** of the Recognized Charge
Ambulance Expense	**80%** of the Negotiated	**80%** of the Recognized

	Charge	Charge
Physician's Office Visit Expense This benefit includes visits to specialists	After a **$20** Copay per visit, **80%** of the Negotiated Charge	After a **$20** Deductible per visit, **60%** of the Recognized Charge
Laboratory and X-ray Expense	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Consultant Expense	After a **$20** Copay per visit, **80%** of the Negotiated Charge	After a **$20** Deductible per visit, **60%** of the Recognized Charge
High Cost Procedures Expense Includes CT scans, MRIs, PET scans and Nuclear Cardiac Imaging Tests.	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Therapy Expense Includes Physical and Occupational Therapy	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Therapy Expense Includes Speech Therapy	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Therapy Expense Includes charges incurred by a covered person for the following types of therapy provided on an outpatient basis: Radiation therapy, Chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy, Dialysis, and Respiratory therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	
Cardiac Rehabilitation Services – Outpatient	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Pulmonary Rehabilitation Therapy	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Chiropractic Therapy Expense	After a **$20** Copay per visit, **80%** of the Negotiated Charge	After a **$20** Deductible per visit, **60%** of the Recognized Charge
Durable Medical and Surgical Equipment Expense	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Prosthetic Devices Expense	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Non-Prescription Enteral Formula Expense	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Second Surgical Opinion	After a **$20** Copay per visit, **80%** of the Negotiated Charge	After a **$20** Deductible per visit, **60%** of the Recognized Charge
Dental Injury Expense	**80%** of the Actual Charge	
Allergy Testing and Treatment Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	

Podiatric Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Diagnostic Testing For Learning Disabilities Expense Covered Medical Expenses include charges incurred by a covered student for diagnostic testing for: • attention deficit disorder; or • attention deficit hyperactive disorder Once a covered person has been diagnosed with one of these conditions, medical treatment will be payable as detailed under the outpatient Treatment of Mental and Nervous Disorders portion of this Plan.	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Preventive Care	**Preferred Care**	**Non-Preferred Care**
Pap Smear Screening Expense	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Mammogram Expense	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Immunizations Expense Includes travel immunizations and flu shots.	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Well Baby Care Expense	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Routine Physical Exam Expense Includes routine tests and related lab fees.	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Routine Screening for Sexually Transmitted Disease Expense	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Routine Colorectal Cancer Screening Expense	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Routine Prostate Cancer Screening	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Pediatric Vision Care Services and Supplies Supplies are limited to **1** Pair of glasses (lenses and frames) per Policy Year. Benefits are provided to covered persons through age **18**.	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge*
Pediatric Routine Dental Exam Expense Benefits are limited to **1** exam every **6** months. Benefits are provided to covered persons through age **18**.	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge

Pediatric Basic Dental Care Expense Benefits are provided to covered persons through age **18**.	**70%** of the Negotiated Charge*	**50%** of the Recognized Charge
Pediatric Major Dental Care Expense Benefits are provided to covered persons through age **18**.	**50%** of the Negotiated Charge*	**50%** of the Recognized Charge
Pediatric Orthodontia Expense Benefits are provided to covered persons through age **18**.	**50%** of the Negotiated Charge*	**50%** of the Recognized Charge
Treatment of Mental and Nervous Disorders	**Preferred Care**	**Non-Preferred Care**
Inpatient Expense	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Outpatient Expense	After a **$20** Copay per visit, **80%** of the Negotiated Charge	After a **$20** Deductible per visit, **60%** of the Recognized Charge
Alcoholism and Drug Addiction Treatment	**Preferred Care**	**Non-Preferred Care**
Inpatient Expense	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Outpatient Expense	After a **$20** Copay per visit, **80%** of the Negotiated Charge	After a **$20** Deductible per visit, **60%** of the Recognized Charge
Maternity Benefits	**Preferred Care**	**Non-Preferred Care**
Maternity Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Prenatal Care/Comprehensive Lactation Support and Counseling Services	**100%** of the Negotiated Charge*	After a **$20** Deductible per visit, **60%** of the Recognized Charge
Breast Feeding Durable Medical Equipment	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Well Newborn Nursery Care Expense	**80%** of the Negotiated Charge	**60%** of the Recognized Charge

Family Planning Expense

Unless specified below, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this Plan;
- Services and supplies incurred for an abortion;
- Services provided as a result of complications resulting from a voluntary sterilization
- Procedure and related follow-up care;
- Services which are for the treatment of an identified illness or injury;
- Services that are not given by a physician or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams;
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA;
- Male contraceptive methods, or devices;

• The reversal of voluntary sterilization procedures, including any related follow-up care		
Voluntary Sterilization Coverage for tubal ligation for voluntary sterilization.	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Voluntary Sterilization *Coverage for vasectomy for voluntary sterilization*	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Contraceptives **Important Note:** Brand-Name Prescription Drug or Devices for a Preferred Provider will be covered at **100%** of the Negotiated Charge, including waiver of per Policy Year Deductible if a Generic Prescription Drug or Device is not available in the same therapeutic drug class or the prescriber specifies Dispense as Written.	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Prescription Drug Coverage	**Preferred Care**	**Non-Preferred Care**
Prescribed Medicines Expense Prior Authorization may be required for certain Prescription Drugs and some medications may not be covered under this Plan. For assistance and a complete list of excluded medications, or drugs requiring prior authorization, please contact Aetna Pharmacy Management at **(888) RX-AETNA** (available 24 hours). Aetna Specialty Pharmacy provides specialty medications and support to members living with chronic conditions. The medications offered may be injected, infused or taken by mouth. For additional information please go to **www.AetnaSpecialtyRx.com** Oral Chemotherapy must be payable on the same basis as IV Chemotherapy.	**100%** of the Negotiated Charge following a **$15** Copay for each Generic Prescription Drug, a **$40** Copay for each Forumlary Brand Name Prescription Drug, or a **$70** Copay for each Non-Formulary Brand Name Prescription Drug. **80%** of the Negotiated Charge for each Specialty Drug.	**60%** of the Recognized Charge. You must pay out of pocket for Prescriptions at a Non-Preferred Pharmacy and then submit the receipt with a Prescription Claim Form for reimbursement.
Additional Benefits	**Preferred Care**	**Non-Preferred Care**
Diabetic Testing Supplies Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Outpatient Diabetic Self-management Education Program Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Hypodermic Needles Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Temporomandibular Joint Dysfunction Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Dermatological Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	

Elective Abortion Expense	**80%** of the Negotiated Charge	**80%** of the Recognized Charge
Acupuncture In Lieu Of Anesthesia Expense	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Hospice Expense	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Home Health Care Expense	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Skilled Nursing Facility Expense	**80%** of the Negotiated Charge for the semi-private room rate	**60%** of the Recognized Charge for the semi-private room rate
Rehabilitation Facility Expense	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Cochlear Implant Expense	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Foot Orthotics & Orthopedic Shoes Expense Includes Medically Necessary foot orthotics and orthopedic shoes for covered persons with diabetes.	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Private Duty Nursing Expense Includes home nursing services provided through home health care. Limit applies to Private duty nursing in home setting.	**80%** of the Negotiated Charge	**60%** of the Recognized Charge for a semi-private room
Transfusion or Dialysis of Blood Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Human Organ Transplants Includes medically necessary human organ and tissue transplant services. When a human organ or tissue transplant is provided from a living donor to a covered person, both the recipient and the donor may receive the benefits of the health Plan.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Human Organ Transplant - Transportation and Lodging	**100%** of the Actual Charge	
Human Organ and Tissue Transplant Services - Unrelated donor search	Payable in accordance with the type of expense incurred and the place where service is provided.	
Nutritional Counseling Expense	After a **$20** Copay per visit, **80%** of the Negotiated Charge	After a **$20** Deductible per visit, **60%** of the Recognized Charge
Non-Routine Dental Services Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	

Limited to facility charges for Outpatient Services for the removal of teeth or for other dental processes only if the patient's medical condition or the dental procedure requires a Hospital setting to ensure the safety of the patient; 2) Dental xrays, supplies, & appliances and all associated expenses, including hospitalization and anesthesia are limited to services/treatments for: transplant preparation; initiation of immunosuppresives; or direct treatment of acute traumatic injury, cancer, or cleft palate.		
Vision Correction after Surgery or Accident Includes prescription glasses or contact lenses when required as a result of surgery or for the treatment of accidental injury.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Mastectomy And Reconstructive Surgery Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Reconstructive Surgery	Payable in accordance with the type of expense incurred and the place where service is provided.	
Transgender Related Expense Covered Medical Expenses include charges incurred by a covered person for medically necessary surgery, mental health, prescription drugs and other related services that are Covered Medical Expenses under this plan. Surgical transgender services are limited to **$50,000** per Policy Year.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Biofeedback Expense	**80%** of the Negotiated Charge	**60%** of the Recognized Charge

Annual Deductible does not apply to these services

Description of Benefits – Dependent Plan

POLICY YEAR MAXIMUM	Unlimited	
	Preferred Care	Non-Preferred Care
DEDUCTIBLE The policy year deductible is waived for preferred care covered medical expenses that apply to Preventive Care Expense benefits. In addition to state and federal requirements for waiver of the Policy Year Deductible, this Plan will waive the Deductible for: Preferred Care and Non Preferred care Deductible-waived for Pediatric Vision Services, Preferred Care Deductible (only) is Waived for Pediatric Preventive Dental. Per visit or admission Deductibles do not apply towards satisfying the Policy Year Deductible.	Family: **$750** per Policy Year	Family: **$1,200** per Policy Year
COINSURANCE	Coinsurance is both the percentage of covered medical expenses that the plan pays, and the percentage of covered medical expenses that you pay. The percentage that the plan pays is referred to as "plan coinsurance" or the "payment percentage," and varies by the type of expense. Please refer to the Schedule of Benefits for specific information on coinsurance amounts.	
OUT-OF-POCKET MAXIMUMS	**Preferred Care**	**Non-Preferred Care**
Once the Family Out-of-Pocket Limit has been satisfied, Covered Medical Expenses will be payable at **100%** for the remainder of the Policy Year. The following expenses do not apply toward meeting the plan's out-of-pocket limits: • Non-covered medical expenses; and • Expenses that are not paid or precertification benefit reductions or penalties because a required precertification for the service(s) or supply was not obtained from Aetna.	Family Out-of-Pocket: **$13,700** per Policy Year	Family Out-of-Pocket: **$20,000** per Policy Year

INPATIENT HOSPITALIZATION BENEFITS	Preferred Care	Non-Preferred Care
Room and Board Expense	**70%** of the Negotiated Charge	**60%** of the Recognized Charge for a semi-private room
Intensive Care Room and Board Expense	**70%** of the Negotiated Charge	**60%** of the Recognized Charge for a semi-private room

Non-Surgical Physicians Expense Non-surgical services of the attending Physician, or a consulting Physician.	**70%** of the Negotiated Charge	**60%** of the Recognized Charge
Licensed Nurse Expense	**70%** of the Negotiated Charge	**60%** of the Recognized Charge
Miscellaneous Hospital Expense Includes but not limited to: operating room, laboratory tests/X rays, oxygen tent, drugs, medicines and dressings.	**70%** of the Negotiated Charge	**60%** of the Recognized Charge
SURGICAL EXPENSES	**Preferred Care**	**Non-Preferred Care**
Surgical Expense **(Inpatient and Outpatient)**	**70%** of the Negotiated Charge	**60%** of the Recognized Charge
Anesthesia Expense **(Inpatient and Outpatient)**	**70%** of the Negotiated Charge	**60%** of the Recognized Charge
Assistant Surgeon Expense (Inpatient and Outpatient)	**70%** of the Negotiated Charge	**60%** of the Recognized Charge
OUTPATIENT EXPENSE	**Preferred Care**	**Non-Preferred Care**
Hospital Outpatient Department Expense	**70%** of the Negotiated Charge	**60%** of the Recognized Charge
Walk-in Clinic Visit Expense	After a **$20** Copay per visit, **70%** of the Negotiated Charge	After a **$20** Deductible per visit, **60%** of the Recognized Charge
Ambulatory Surgical Expense	**70%** of the Negotiated Charge	**60%** of the Recognized Charge

OUTPATIENT EXPENSE (continued)	**Preferred Care**	**Non-Preferred Care**
Emergency Room Expense **Important Note**: Please note that Non-Preferred Care Providers do not have a contract with Aetna. The provider may not accept payment of your cost share (your deductible and 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. Please send Aetna the bill at the address listed on the back of your member ID card and Aetna will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.	After a **$100** Copay per visit (waived if admitted), **70%** of the Negotiated Charge	After a **$100** Deductible per visit (waived if admitted), **70%** of the Recognized Charge

Urgent Care Expense	After a **$30** Copay per visit, **70%** of the Negotiated Charge	After a **$30** Deductible per visit, **60%** of the Recognized Charge
Ambulance Expense	**70%** of the Negotiated Charge	**70%** of the Recognized Charge
Physician's Office Visit Expense This benefit includes visits to specialists	After a **$20** Copay per visit, **70%** of the Negotiated Charge	After a **$20** Deductible per visit, **60%** of the Recognized Charge
Laboratory and X-ray Expense	**70%** of the Negotiated Charge	**60%** of the Recognized Charge
Consultant Expense	After a **$20** Copay per visit, **70%** of the Negotiated Charge	After a **$20** Deductible per visit, **60%** of the Recognized Charge
High Cost Procedures Expense Includes CT scans, MRIs, PET scans and Nuclear Cardiac Imaging Tests.	**70%** of the Negotiated Charge	**60%** of the Recognized Charge
Therapy Expense Includes Physical and Occupational Therapy	**70%** of the Negotiated Charge	**60%** of the Recognized Charge
Therapy Expense Includes Speech Therapy	**70%** of the Negotiated Charge	**60%** of the Recognized Charge
Therapy Expense Includes charges incurred by a covered person for the following types of therapy provided on an outpatient basis: Radiation therapy, Chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy, Dialysis, and Respiratory therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	

OUTPATIENT EXPENSE (continued)	**Preferred Care**	**Non-Preferred Care**
Cardiac Rehabilitation Services – Outpatient	**70%** of the Negotiated Charge	**60%** of the Recognized Charge
Pulmonary Rehabilitation Therapy	**70%** of the Negotiated Charge	**60%** of the Recognized Charge
Chiropractic Therapy Expense	After a **$20** Copay per visit, **70%** of the Negotiated Charge	After a **$20** Deductible per visit, **60%** of the Recognized Charge
Durable Medical and Surgical Equipment Expense	**70%** of the Negotiated Charge	**60%** of the Recognized Charge
Prosthetic Devices Expense	**70%** of the Negotiated Charge	**60%** of the Recognized Charge
Non-Prescription Enteral Formula Expense	**70%** of the Negotiated Charge	**60%** of the Recognized Charge

Second Surgical Opinion	After a **$20** Copay per visit, **70%** of the Negotiated Charge	After a **$20** Deductible per visit, **60%** of the Recognized Charge
Dental Injury Expense	**70%** of the Actual Charge	
Allergy Testing and Treatment Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Podiatric Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Diagnostic Testing For Learning Disabilities Expense Covered Medical Expenses include charges incurred by a covered student for diagnostic testing for: • attention deficit disorder; or • attention deficit hyperactive disorder Once a covered person has been diagnosed with one of these conditions, medical treatment will be payable as detailed under the outpatient Treatment of Mental and Nervous Disorders portion of this Plan.	**70%** of the Negotiated Charge	**60%** of the Recognized Charge
PREVENTIVE CARE	**Preferred Care**	**Non-Preferred Care**
Pap Smear Screening Expense	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Mammogram Expense	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Immunizations Expense Includes travel immunizations and flu shots.	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Well Baby Care Expense	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
PREVENTIVE CARE (continued)	**Preferred Care**	**Non-Preferred Care**
Routine Physical Exam Expense Includes routine tests and related lab fees.	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Routine Screening for Sexually Transmitted Disease Expense	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Routine Colorectal Cancer Screening Expense	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Routine Prostate Cancer Screening	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Pediatric Vision Care Services and Supplies Supplies are limited to **1** Pair of glasses (lenses and frames) per Policy Year. Benefits are provided to covered persons through age **18**.	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge*

Pediatric Routine Dental Exam Expense Benefits are limited to **1** exam every **6** months. Benefits are provided to covered persons through age **18**.	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge
Pediatric Basic Dental Care Expense Benefits are provided to covered persons through age **18**.	**70%** of the Negotiated Charge*	**50%** of the Recognized Charge
Pediatric Major Dental Care Expense Benefits are provided to covered persons through age **18**.	**50%** of the Negotiated Charge*	**50%** of the Recognized Charge
Pediatric Orthodontia Expense Benefits are provided to covered persons through age **18**.	**50%** of the Negotiated Charge*	**50%** of the Recognized Charge
TREATMENT OF MENTAL AND NERVOUS DISORDERS	**Preferred Care**	**Non-Preferred Care**
Inpatient Expense	**70%** of the Negotiated Charge	**60%** of the Recognized Charge
Outpatient Expense	After a **$20** Copay per visit, **70%** of the Negotiated Charge	After a **$20** Deductible per visit, **60%** of the Recognized Charge
ALCOHOLISM AND DRUG ADDICTION TREATMENT	**Preferred Care**	**Non-Preferred Care**
Inpatient Expense	**70%** of the Negotiated Charge	**60%** of the Recognized Charge
Outpatient Expense	After a **$20** Copay per visit, **70%** of the Negotiated Charge	After a **$20** Deductible per visit, **60%** of the Recognized Charge

MATERNITY BENEFITS	Preferred Care	Non-Preferred Care
Maternity Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Prenatal Care/Comprehensive Lactation Support and Counseling Services	**100%** of the Negotiated Charge*	After a **$20** Deductible per visit, **60%** of the Recognized Charge
Breast Feeding Durable Medical Equipment	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Well Newborn Nursery Care Expense	**70%** of the Negotiated Charge	**60%** of the Recognized Charge

Family Planning Expense

Unless specified below, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this Plan;
- Services and supplies incurred for an abortion;

- Services provided as a result of complications resulting from a voluntary sterilization
- Procedure and related follow-up care;
- Services which are for the treatment of an identified illness or injury;
- Services that are not given by a physician or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams;
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA;
- Male contraceptive methods, or devices;
- The reversal of voluntary sterilization procedures, including any related follow-up care

Voluntary Sterilization Coverage for tubal ligation for voluntary sterilization.	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Voluntary Sterilization Coverage for vasectomy for voluntary sterilization	**70%** of the Negotiated Charge	**60%** of the Recognized Charge
Contraceptives **Important Note:** Brand-Name Prescription Drug or Devices for a Preferred Provider will be covered at **100%** of the Negotiated Charge, including waiver of per Policy Year Deductible if a Generic Prescription Drug or Device is not available in the same therapeutic drug class or the prescriber specifies Dispense as Written.	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge

PRESCRIPTION DRUG COVERAGE	Preferred Care	Non-Preferred Care
Prescribed Medicines Expense Prior Authorization may be required for certain Prescription Drugs and some medications may not be covered under this Plan. For assistance and a complete list of excluded medications, or drugs requiring prior authorization, please contact Aetna Pharmacy Management at **(888) RX-AETNA** (available 24 hours). Aetna Specialty Pharmacy provides specialty medications and support to members living with chronic conditions. The medications offered may be injected, infused or taken by mouth. For additional information please go to **www.AetnaSpecialtyRx.com** Oral Chemotherapy must be payable on the same basis as IV Chemotherapy.	**100%** of the Negotiated Charge following a **$15** Copay for each Generic Prescription Drug, a **$40** Copay for each Forumlary Brand Name Prescription Drug, or a **$70** Copay for each Non-Formulary Brand Name Prescription Drug. **80%** of the Negotiated Charge for each Specialty Drug.	**60%** of the Recognized Charge. You must pay out of pocket for Prescriptions at a Non-Preferred Pharmacy and then submit the receipt with a Prescription Claim Form for reimbursement.
ADDITIONAL BENEFITS	**Preferred Care**	**Non-Preferred Care**
Diabetic Testing Supplies Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Outpatient Diabetic Self-management Education Program Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	

Hypodermic Needles Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Temporomandibular Joint Dysfunction Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Dermatological Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Elective Abortion Expense	**70%** of the Negotiated Charge	**60%** of the Recognized Charge
Acupuncture In Lieu Of Anesthesia Expense	**70%** of the Negotiated Charge	**60%** of the Recognized Charge
Hospice Expense	**70%** of the Negotiated Charge	**60%** of the Recognized Charge
Home Health Care Expense	**70%** of the Negotiated Charge	**60%** of the Recognized Charge
Skilled Nursing Facility Expense	**70%** of the Negotiated Charge for the semi-private room rate	**60%** of the Recognized Charge for the semi-private room rate
Rehabilitation Facility Expense	**70%** of the Negotiated Charge	**60%** of the Recognized Charge

ADDITIONAL BENEFITS (continued)	**Preferred Care**	**Non-Preferred Care**
Cochlear Implant Expense	**70%** of the Negotiated Charge	**60%** of the Recognized Charge
Foot Orthotics & Orthopedic Shoes Expense Includes Medically Necessary foot orthotics and orthopedic shoes for covered persons with diabetes.	**70%** of the Negotiated Charge	**60%** of the Recognized Charge
Private Duty Nursing Expense Includes home nursing services provided through home health care. Limit applies to Private duty nursing in home setting.	**70%** of the Negotiated Charge	**60%** of the Recognized Charge for a semi-private room
Transfusion or Dialysis of Blood Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Human Organ Transplants Includes medically necessary human organ and tissue transplant services. When a human organ or tissue transplant is provided from a living donor to a covered person, both the recipient and the donor may receive the benefits of the health Plan.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Human Organ Transplant - Transportation and Lodging	**100%** of the Actual Charge	

Human Organ and Tissue Transplant Services - Unrelated donor search	**100%** of the Actual Charge	
Nutritional Counseling Expense	After a **$20** Copay per visit, **70%** of the Negotiated Charge	After a **$20** Deductible per visit, **60%** of the Recognized Charge
Non-Routine Dental Services Expense Limited to facility charges for Outpatient Services for the removal of teeth or for other dental processes only if the patient's medical condition or the dental procedure requires a Hospital setting to ensure the safety of the patient; 2) Dental xrays, supplies, & appliances and all associated expenses, including hospitalization and anesthesia are limited to services/treatments for: transplant preparation; initiation of immunosuppresives; or direct treatment of acute traumatic injury, cancer, or cleft palate.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Vision Correction after Surgery or Accident Includes prescription glasses or contact lenses when required as a result of surgery or for the treatment of accidental injury.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Mastectomy And Reconstructive Surgery Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Reconstructive Surgery	Payable in accordance with the type of expense incurred and the place where service is provided.	
ADDITIONAL BENEFITS (continued)	**Preferred Care**	**Non-Preferred Care**
Transgender Related Expense Covered Medical Expenses include charges incurred by a covered person for medically necessary surgery, mental health, prescription drugs and other related services that are Covered Medical Expenses under this plan. Surgical transgender services are limited to **$50,000** per Policy Year.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Biofeedback Expense	**70%** of the Negotiated Charge	**60%** of the Recognized Charge

***Annual Deductible does not apply to these services**

DENTAL COVERAGE

Coverage is provided per the benefits outlined in the Plan for **injury** to sound, natural teeth. Participants are eligible for the following services only when obtained from the Case Western Reserve University School of Dental Medicine.

- Two oral exams and evaluations, including one dental and medical history per Plan Year, at **100%** coverage.
- Two oral cleanings per Plan Year at **100%** coverage.
- Periodic Bite Wing X-rays per Plan Year at **100%** coverage.
- Up to a **40%** discount on certain dental services offered at the Case Western Reserve University School of Dental Medicine.

Services are provided at the Case Western Reserve University School of Dental Medicine by both Pre-Doctoral and Doctoral Students.

Appointments are necessary and may be made by calling the Case Western Reserve University Dental Clinic at **216.368.3200**.

Please Note: The Case Western Reserve University School of Dental Medicine closes periodically throughout the year. Oral cleanings are not provided when the clinic is closed. Emergency care is limited at this time but can be accessed by calling **216. 368.3200** or dental.case.edu

On Call International 24/7 Emergency Travel Assistance Services (Students only)

These services are provided by On Call International and designed to protect Case Western Reserve University students and/or eligible dependents when traveling more than 100 miles from home, anywhere in the world. Medical Repatriation and Return of Mortal Remains services are also available at the participant's campus location.

If you experience a medical emergency while traveling more than 100 miles from your home or campus, you have access to a comprehensive group of emergency assistance services provided by On Call International. Eligible participants have immediate access to doctors, hospitals, pharmacies and other services when faced with an emergency while traveling. The On Call International Operations Center can be reached 24 hours a day, 365 days a year to provide services including: medical consultation and evaluation, medical referrals, foreign **hospital** admission guarantee, **prescription** assistance, lost luggage assistance, legal and interpreter assistance, and travel information such as Visa and passport requirements, travel advisories, etc.

Medical Evacuation and Return of Mortal Remains Services (Students only)
In the event that a participant becomes injured and adequate medical facilities are not available locally, On Call International will use whatever mode of transport, equipment and personnel necessary to evacuate you to the nearest facility capable of providing required care. In the event of death of a participant, On Call International will render every possible assistance in return of mortal remains including locating a sending funeral home, preparing the deceased for transport, procuring required documentation, providing necessary shipping container as well as paying for transport.

Accidental Death and Dismemberment Benefit (Students only)

This insurance coverage provides **Accidental** Death and Dismemberment coverage underwritten by United States Fire Insurance Company. Benefits are payable for the **Accidental** Death and Dismemberment of the eligible insured (Exclusions and limitations may apply.)

To file a claim for **Accidental** Death and Dismemberment, please contact Aetna Student Health at **(877) 850-6038** for the appropriate claim forms.

Please note: Any third party expenses incurred are the responsibility of the Participant. An On Call International ID card will be supplied to you once you enroll in the Aetna Student Health Insurance Plan. Please remember to carry your On Call card and call toll-free within the U.S. at **(866) 525-1956** or outside the U.S. call collect (dial U.S. access code) plus **(603) 328-1956** in the event of an emergency when you are traveling. With one phone call, you will be connected to a global network of over 600,000 pre-qualified medical providers. On Call Operations Centers have worldwide assistance capabilities and are known throughout the world as a premier Emergency Assistance Services provider.

NOTE: On Call International pays for all Assistance Services it provides. All Assistance Services must be arranged and provided by On Call. On Call does not reimburse for services not provided by On Call.
The On Call International program meets and exceeds the requirements of USIA for International Students & Scholars.

Emergency Travel Assistance Services are administered by On Call International.

For questions about:
On Call International 24/7 Emergency Travel Assistance Services

Please contact:
On Call International at **(866) 525-1956** (within U.S.). If outside the U.S., call collect by dialing the U.S. access code plus **(603) 328-1956**. Please also **visit www.aetnastudenthealth.com** and visit your school-specific site for further information.

These services, programs or benefits are offered by vendors who are independent contractors and not employees or agents of Aetna.

COVERAGE TERMINATION

Coverage terminates at 11:59 p.m. local time at the address of the University on the earliest of the dates indicated below:

- The end of the Period of Coverage;
- The date on which the Student Medical Plan terminates;
- The date a student withdraws from school to enter military service; in this case a prorated refund will be available upon request;
- The first day of any term for which a student waives coverage;
- The end of the period for which the required payments have been received, if future payments cease.

If Case Western Reserve University terminates and does not replace this Student Medical Plan, students then receiving or entitled to receive benefits for a covered **Sickness** or **Injury** will continue to be covered for that Disability for up to 52 weeks following the date of termination or in accordance with the time period stated under the Student Medical Plan, whichever is less.

Benefits payable during this period will not be more than the amounts provided under the Plan at the time the Disability began.

PLEASE NOTE: Any subsequent change in the limits provided under this Plan will not affect the benefits payable for a Disability for which benefits have been extended under this provision.

PERSONAL MEDICAL LEAVE

Coverage may be continued without interruption for one additional semester for a student who leaves the University due to a **personal medical condition** provided the student was registered and enrolled in the Student Medical Plan during the semester in which the student left.

In order to continue medical coverage under the Student Medical Plan, the Student Medical Plan department (located at the University Health Service) must be notified of the leave prior to the semester in which the leave is to take effect.

Students must provide the following:

1. A letter from the Dean or Advisor of the School in which the student is enrolled approving the requested medical

leave.

2. A letter from the student's medical provider or counselor/therapist confirming the medical necessity for the requested medical leave.
3. Payment (in cash or check) of the Student Medical Plan fee prior to the beginning of the semester in which the leave is to take effect.

This extension does not apply to students who are leaving the University for reasons other than a personal medical condition.

PLEASE NOTE: When a student is on a leave of absence, the student is not eligible to use the services offered by the Case Western Reserve University Health Service or the Case Western Reserve University Counseling Services. When a student is on a personal medical leave of absence, payment of the Student Medical Plan fee allows coverage under the Student Medical Plan only, subject to the exclusions and limitations of the Plan, as outlined in this brochure.

IDENTIFICATION CARD

Each student participating in the Student Medical Plan will need to go onto aetnastudenthealth.com website and choose Case Western Reserve University from the list to obtain an ID Card. You do not need an ID card to be eligible to receive benefits. Once you have obtained your ID card, present it to the provider or pharmacy to facilitate prompt payment of your claims.

Note: Please be advised you will receive a unique Aetna member ID number on your membership card.

CLAIM SUBMISSION

Please send all itemized medical bills as soon as possible after treatment is rendered to Aetna Student Health. Your name, identification number and Case Western Reserve University should be written clearly and attached to your medical bills. All information should be mailed to:

Aetna Student Health
P.O. Box 981106
El Paso, TX 79998
(877) 850-6038

Customer Service Representatives are available 8:30 a.m. to 5:30 p.m. Monday through Friday, for any questions.

- Bills must be submitted within 15 months from the date of treatment.
- Payment for **Covered Medical Expenses** will be made directly to the **hospital** or **Physician** concerned unless bill receipts and proof of payment are submitted.
- If itemized medical bills are available at the time the claim form is submitted, attach them to the claim form.
- Subsequent medical bills should be mailed promptly to the above address.

In all cases, expenses must be filed within 15 months of treatment to be considered for payment under this Plan.

WAIVER OPTIONS

Eligible students will be automatically enrolled in this Plan, unless a waiver is submitted by the waiver deadline dates. Under certain conditions, the $ 1045.00 Student Medical Plan fee may be waived.

All registered students are required to have medical insurance that is comparable to the Case Western Reserve University Student Medical Plan. Insurance coverage must meet the following criteria in order to be deemed comparable.

1. Students who have insurance comparable to the Student Medical Plan may waive the coverage. Comparable coverage means:
   a. Insurance coverage is provided by a company licensed to do business in the United States, with a U.S. claims payment office and telephone number.
   b. Coverage is currently active and the student agrees to maintain health coverage throughout the entire policy year.

c. Offers unlimited coverage per accident or illness.
d. Offers inpatient and outpatient medical care in Northeast Ohio or where enrolled in CWRU classes. (emergency only coverage does not satisfy this requirement).
e. Covers inpatient mental health and alcohol abuse care within Northeast Ohio or where enrolled in CWRU classes (emergency only coverage does not satisfy this requirement).
f. Provides coverage for prescription drugs.
g. Provides coverage for pre-existing conditions.
h. Provides at least $25,000 coverage for Repatriation (repatriation provides transportation to the student's home country in the event of death). International students only.
i. Provides Emergency Medical Evacuation coverage in the amount of at least $50,000 (medical evacuation is emergency transportation to the nearest, most qualified treatment facility). International students only.

2. **It is each student's responsibility to ensure that the alternate coverage is adequate.** Before submitting a waiver, please note that many commercial insurance plans do not cover a student after a certain age.

3. **A waiver request is valid for two semesters when the fee is waived in fall semester**. Students who elect to waive the Medical Plan will automatically have the fee waived for the fall and spring semesters. The waiver must be received no later than September 8, 2017. The waiver deadline for students starting in spring semester is January 26, 2018.

4. Case Western Reserve students can waive the Student Medical plan on the Student Information System (SIS) located at **http://www.case.edu/sis.**

5 Students from CIA and CIM should submit a waiver form to their individual school.

6 All waivers are subject to audit by Case Western Reserve University & Aetna Student Health. Any student's plan Found to not meet the requirements will be enrolled in the Student Medical Plan.

QUALIFYING EVENT

Students who waive the Plan for a given semester are eligible to apply for coverage during that semester if they experience a qualifying event. A qualifying event is defined as:

- Reaching the age limit of another health insurance plan;
- Loss of health insurance through a marriage or divorce;
- Involuntary loss of coverage from another health insurance plan.

Contact the Student Medical Plan for further details at **(216) 368-3049**. Students must apply for coverage with the Case Western Reserve University Student Medical Plan within 31 days of loss of coverage from their current medical insurance.

REFUND POLICY

After the deadline for submitting a request waiver (see the preceding section), no portion of the fee is refundable, with one limited exception. If a student withdraws from school to enter military service, a prorated refund will be available upon request.

APPEAL PROCESS/DENIAL OF BENEFITS

If the participant believes a claim was improperly settled, please complete the following process:

1. Within 60 days of receipt of the claim, the participant may request, in writing, that the plan administrator conduct a review of the processed claim. The plan administrator will review the processed claim and inform the participant (within 30 days) whether or not an error was made.

2. If the participant is not satisfied with the above review, a written request for a second review may be submitted to the plan administrator within 60 days of the first review. The request should state, in clear and concise terms the reason for disagreement with the way the claim was processed. When the written request is received, the claim will be reviewed again and the results of this review furnished in writing to the participant within 60 days in most cases, but no longer than 120 days.

All requests for review of denied claims should include a copy of the initial denial letter and any other pertinent information. Send all information to:

Aetna Student Health
P.O. Box 981106
El Paso, TX 79998
(877) 850-6038

EXCLUSIONS

This Plan does not cover nor provide benefits for:

1. Services rendered after termination of participation in the Plan.

2. Services or supplies which constitute personal comfort or beautification items, television or telephone use, or in connection with custodial care, education, or training, or expenses actually incurred by other persons except as specifically addressed under Covered Medical Expenses.

3. Services needed due to war or any act of war, whether declared or undeclared.

4. Expense incurred as a result of commission of a felony.

5. Expense incurred by a covered person, not a United States citizen, for services performed within the covered person’s home country, if the covered person’s home country has a socialized medicine program.

6. Expense incurred for any services rendered by a member of the **covered person**'s immediate family or a person who lives in the **covered person**'s home.

7. Services rendered for treatment of any Sickness or Injury for which benefits are available under workers' compensation employer liability law or services for any occupational Sickness or Injury. Occupational Sickness or Injury includes those as a result of any work for wage or profit.

8. Charges for completion of claim forms.

9. Education classes, including charges for natural childbirth instruction.

10. Services performed for cosmetic or reconstructive Surgery or complications of cosmetic or reconstructive Surgery procedures unless: 1. the condition is necessary as the result of an accident of Sickness. 2. Scar revision due to an accident or Sickness. 3. Correction of congenital defects which interferes with bodily function, 4. The services are performed during the period a Participant is participating under the plan, and 5. The services are for reconstruction of the breast on which a mastectomy was performed, Surgery and reconstruction of the other breast to achieve symmetry in appearance and necessary prosthesis or physical complications at any stage of mastectomy, including lymphedemas. These procedures shall be performed in a manner determined in consultation with the patient and the patient's attending physician.

11. Charges which are payable by any third party due to legal liability including, but not limited to, professional liability insurance, motor vehicle liability insurance, individual liability insurance, and any other source from which medical benefits would be paid if this Plan did not exist, whether or not legal

action is taken on behalf of the Participant.

12. Charges to the extent of coverage required by, or available through, any federal, state, municipal or other governmental body or agency, except as otherwise states in the Plan and except for medical assistance under a state plan for medical assistance covered under Title XIX of the Social Security Act ("Medicaid")

13. Experimental/Investigative drugs, chemical, services or procedures, except where covered in the Policy.

14. Expense incurred when the person or individual is acting beyond the scope of his/her/its legal authority.

15. Music Therapy, vision therapy or remedial reading therapy.

16. Expense for personal hygiene and convenience items, such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if such items are prescribed by a physician.

17. Charges and services related to a newborn who is not a participating Dependent.

18. Dental expenses except as specifically addressed under Covered Medical Expenses.

19. Reversal of sterilization for Participating Student, Spouse, Domestic Partner or Dependent.

20. Services or supplies rendered or furnished in a Military or Veterans Administration Hospital, unless rendered in connection with Disability which is not in any way related to the Participants military service.

21. With respect to diagnostic testing: 1. Tests performed more frequently than is necessary according to the diagnosis and accepted medical practice 2. Genetic testing unless family history necessitates. 3. Premarital examinations. 4. Duplicate testing by different Physicians unless Second Opinions are authorized herein, 5. Test associated with routine visits except those covered under the Wellness benefit provision.

22. With respect to consultations, 1. Telephone only consultations. 2. Consultations for indelible or unnecessary procedures. 3. Services rendered by practitioners other than Physicians.

23. With respect to Infertility: 1. Invitro or invivio fertilization, artificial insemination, or any other impregnation procedure. 2. Fertility drugs. 3. Any treatment other than that which treats a medical condition. 4. Diagnostic tests unless necessary to diagnose a medical condition. 5. Fertility supplies, treatment and counseling.

24. With respect to Hospital services, 1. Room and Board Charges made by a facility other than a Hospital or Extended Care Facility. 2. Admission for observation, rest, physical therapy, or testing. 3. Weekend admissions except for Medical Emergencies. 4. Charges for any period of confinement prior to the day before scheduled Surgery unless a documented hazardous medical condition exists. 5. Charges deemed not Medically Necessary by the Utilization Review Service and/or Claims Administrator.

25. Expense for transplant expenses, unless otherwise provided on the Policy.

26. Expense incurred for eye refractions, vision therapy, radial keratotomy, eyeglasses, contact lenses (except when required after cataract surgery), or other vision or hearing aids, or prescriptions or examinations except as required for repair caused by a covered injury, unless otherwise provided in this Policy.

27. Penile implants and/or any related expenses unless having organic origin.

28. Expense for services or supplies provided for the treatment of obesity and/or weight control, unless specifically provided for in the policy.

29. Expense incurred for alternative, holistic medicine, and/or therapy, including but not limited to, yoga and

hypnotherapy.

30. Expense incurred for acupuncture, unless services are rendered for anesthetic purposes.

31. Medical care claims filed more than fifteen (15) months from the date of service.

32. Care and treatment that is deemed not Medically Necessary.

33 For removal of excess skin unless Medically Necessary.

34. Expense incurred as a result of injury due to participation in a riot. "Participation in a riot" means taking part in a riot in any way, including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense, so long as they are not taken against persons who are trying to restore law and order.

35. Expense incurred for **elective treatment** or elective surgery except as specifically provided elsewhere in this Policy and performed while this Policy is in effect.

36. Expense for treatment of covered students who specialize in the mental health care field, and who receive treatment as a part of their training in that field.

37. For all NCAA Sanctioned Intercollegiate Sports Injuries, the Plan is primary for the first $90,000of eligible expense per injury and secondary to coverage provided under the NCAA catastrophic policy.

CASE WESTERN RESERVE UNIVERSITY EST. 1826

Date ______________

2017-2018 DEPENDENT ENROLLMENT FORM

Deadline for Fall Semester enrollment is September 8, 2017. Deadline for Spring/Summer Semesters enrollment is January 26, 2018. Deadline for Summer only enrollment is June 16, 2018.

Contact University Health Service for the Payment Plan Option.

Student's ID # ____________________

Student's Name ____
(Please Print) (First) (Middle) (Last)

Address ____
(Street) (City) (State) (Zip Code)

I have purchased Case Western Reserve University Student Medical Plan; I wish to enroll the following members of my family in the Dependent Medical Plan sponsored by Case Western Reserve University.
Eligible dependents of the covered student shall include the spouse or domestic partner and dependent child/ren under the age of 26 years. Newborns must be enrolled within 31 days of birth. Enrollment is not automatic.

	Annual Cost 8/1/17-7/31/18	Fall 2017 8/1/17-1/15/18	Spring & Summer 2018 1/16/18-7/31/18	Summer 2018 Only* 06/4/18-7/31/18
Spouse/Domestic Partner Only	$3,876	$1,614	$2,262	$800
Spouse or Domestic Partner/Child/ren	$7,163	$2,987	$4,176	$1,484
Child/ren Only	$3,286	$1,367	$1,919	$682

NOTE: Return this enrollment form and automatic payment plan form or appropriate check, money order (made payable to Case Western Reserve University) to University Health Service, 2145 Adelbert Rd., Cleveland, OH 44106-4901. Coverage becomes effective August 1, 2017 or the date the payment is received, whichever is later. Deadline for enrollment is September 8, 2017 for Fall Semester, January 26, 2018 or Spring/Summer Semesters and June 16, 2018 for Summer Semester only. If a student registers after September 8, 2017 for fall semester and after January 26, 2018 for spring semester, the Student Medical Plan will become effective on the date the student registers (not on the effective date listed above).

Medical coverage for spouse/domestic partner and dependent child/ren may not be purchased unless medical coverage for Student is purchased. Students purchasing dependent coverage for Fall Semester only must submit another enrollment form to renew coverage for Spring/Summer Semesters. In order to maintain continuous coverage payment must be received prior to January 26, 2018. *Only students registered for classes for Summer Semester 2018 who were not registered for classes Spring Semester 2018 are eligible to enroll their dependents in the Summer Semester 2018.

Place Dependent Name(s) Below

1. ________________________________ Birth Date ______________ M/F ______
   Spouse/Domestic Partner (circle one)
2. ________________________________ Birth Date ______________ M/F ______
   Child
3. ________________________________ Birth Date ______________ M/F ______
   Child
4. ________________________________ Birth Date ______________ M/F ______
   Child

Completion of an Affidavit is necessary for the enrollment of a Domestic Partner. Enrollment forms are available at University Health Service.

CASE WESTERN RESERVE UNIVERSITY EST. 1826

Date ______________

2017 -2018 DEPENDENT ENROLLMENT FORM

(For Students of Case Western Reserve University School of Medicine, the Cleveland Clinic Lerner College of Medicine, and Case Western Reserve University School of Dental Medicine - MSD Program)

Deadline for Fall Semester enrollment is September 8, 2017 Deadline for Spring/Summer Semesters enrollment is January 26, 2018.

Contact University Health Service for the Payment Plan Option.

Student's ID # ____________________

Student's Name ____
(Please Print) (First) (Middle) (Last)

Address ____
(Street) (City) (State) (Zip Code)

I have purchased Case Western Reserve University Student Medical Plan; I wish to enroll the following members of my family in the Dependent Medical Plan sponsored by Case Western Reserve University.
Eligible dependents of the covered student shall include the spouse or domestic partner and dependent child/ren under the age of 26 years. Newborns must be enrolled within 31 days of birth. Enrollment is not automatic.

	Annual Cost 7/1/17-6/30/18	**Fall 2017 7/1/17-1/15/18**	**Spring & Summer 2018 1/16/18-6/30/18**
Spouse/Domestic Partner Only	$3,876	$2,262	$1,614
Spouse or Domestic Partner/Child/ren	$7,163	$4,176	$2,987
Child/ren Only	$3,286	$1,919	$1,367

NOTE: Return this enrollment form and automatic payment plan form or appropriate check, money order (made payable to Case Western Reserve University) to University Health Service, 2145 Adelbert Rd., Cleveland, OH 44106-4901.

Coverage becomes effective July 1, 2017 or the date the payment is received, whichever is later. Deadline for enrollment is September 8, 2017 for Fall Semester, January 26, 2018 for Spring/Summer Semesters.

Medical coverage for spouse/domestic partner and dependent child/ren may not be purchased unless medical coverage for Student is purchased. Students purchasing dependent coverage for Fall Semester only must submit another enrollment form to renew coverage for Spring/Summer Semesters. In order to maintain continuous coverage payment must be received prior to January 26, 2018.

Place Dependent Name(s) Below

1. ________________________ Birth Date ____________ M/F ____
   Spouse/Domestic Partner (circle one)
2. ________________________ Birth Date ____________ M/F ____
   Child
3. ________________________ Birth Date ____________ M/F ____
   Child
4. ________________________ Birth Date ____________ M/F ____
   Child

Completion of an Affidavit is necessary for the enrollment of a Domestic Partner. Enrollment forms are available at University Health Service.