Student Medical Plan
2019 - 2020

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

Policy No: 474889

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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

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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.

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, 2019 (12:01 a.m.) to January 12, 2020 (11:59 p.m.)
Spring Semester:	January 13, 2020 (12:01 a.m.) to June 30, 2020 (11:59 p.m.)

ALL STUDENTS EXCEPT THOSE LISTED ABOVE

Fall Semester:	August 1, 2019 (12:01 a.m.) to January 12, 2020 (11:59 p.m.)
Spring Semester:	January 13, 2020 (12:01 a.m.) to July 31, 2020 (11:59 p.m.)

If a student registers after September 6, 2019 for Fall Semester and after January 24, 2020 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 2019-2020 Student Medical Plan is **$ 1,165.00** 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 44 will receive a credit of **$ 1,165.00** 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 50 for coverage dates, enrollment and payment information.

All other students enrolled at Case Western Reserve University refer to page 49 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.

NEWBORN INFANT AND ADOPTED CHILD COVERAGE

A child born to a **Covered person** shall be covered for Accident, Sickness, premature birth, and congenital defects, for **31 days** from the date of birth. Well Baby Care coverage will not be covered unless officially added to the plan. At the end of this **31 day** period, coverage will cease under the Case Western Reserve University Medical Plan. To extend coverage for a newborn past the **31 days**, the **covered student** must: 1) enroll the child within **31 days** of birth, and 2) pay the additional pro-rated premium, starting from the date of birth. Coverage is provided for a child legally placed for adoption with a **covered student** for **31 days** from the moment of placement provided the child lives in the household of the **covered student**, and is **dependent** upon the covered student for support. To extend coverage for an adopted child past the **31 days**, the **covered student** must 1) enroll the child within **31 days** of placement of such child, and 2) pay any additional premium, if necessary, starting from the date of placement.

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

You need pre-approval from us for some eligible medical services. Pre-approval is also called precertification.

Precertification for medical services and supplies

In-network care

Your in-network physician is responsible for obtaining any necessary precertification before you get the care. If your in-network physician doesn't get a required precertification, we won't pay the provider who gives you the care. You won't have to pay either if your in-network physician fails to ask us for precertification. If your in-network physician requests precertification and we refuse it, you can still get the care but the plan won't pay for it. You will find additional details on requirements in the Certificate of Coverage.

Out-of-network 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. If you do not precertify, your benefits may be reduced, or the plan may not pay any benefits. This does not apply to services and supplies deemed to be medically necessary. Refer to your schedule of benefits for this information. The list of services and supplies requiring precertification appears later in this section

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. This call must be made:

Non-emergency admissions:	You, your physician or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted.
An emergency admission:	You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
An urgent admission:	You, your physician or the facility will need to call before you are scheduled to be admitted. 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.
Outpatient non-emergency services requiring precertification:	You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.
Delivery:	You, your physician, or the facility must call within 48 hours of the birth or as soon thereafter as possible. No penalty will be applied for the first 48 hours after delivery for a routine delivery and 96 hours for a cesarean delivery.

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 30 days as long as you remain enrolled in the plan.

Once we authorize eligible medical services, we will not refuse to pay if your physician or PCP, in good faith, submitted complete, accurate, and all necessary information to us.

If you require an extension to the services that have been precertified, you, your physician, or the facility will need to call us at the number on your ID card as soon as reasonably possible, but no later than the final authorized day.

If precertification determines that the stay or outpatient services and supplies are not covered benefits, the notification will explain why and how you can appeal our decision. You or your provider may request a review of the precertification decision. See Article VI: Prior Authorization of Services in the Summary Plan Description and Plan Document.

What if you don't obtain the required precertification?
If you don't obtain the required precertification:
- Your benefits may be reduced, or the plan may not pay any benefits. This does not apply to services and supplies deemed to be medically necessary. See the schedule of benefits *Precertification penalty* section.
- You will be responsible for the unpaid balance of the bills.
- Any additional out-of-pocket expenses incurred will not count toward your deductibles or maximum out-of-pocket limits.

What types of services and supplies require precertification?

Precertification is required for the following types of services and supplies:

Inpatient services and supplies	Outpatient services and supplies
Stays in a hospice facility	Applied behavior analysis
Stays in a hospital	Certain prescription drugs and devices*
Stays in a rehabilitation facility	Complex imaging
Stays in a residential treatment facility for treatment of mental disorders and substance abuse	Cosmetic and reconstructive surgery
Stays in a skilled nursing facility	Intensive outpatient program (IOP) – mental disorder and substance abuse diagnoses
	Kidney dialysis
	Knee surgery
	Medical injectable drugs, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, botox, hepatitis C medications)*
	Outpatient back surgery not performed in a physician's office
	Outpatient detoxification
	Partial hospitalization treatment – mental disorder and substance abuse diagnoses
	Private duty nursing services
	Psychological testing/neuropsychological testing
	Sleep studies
	Transcranial magnetic stimulation (TMS)
	Wrist surgery

When you receive **precertification** for a chronic condition, we will honor this previous **precertification** for an approved drug from the date of approval to the lesser of either: a) 12 months or b) the last day of your eligibility under this policy.

For a current listing of the prescription drugs and medical injectable drugs that require precertification, contact Member Services by calling the toll-free number on your ID card in the How to contact us for help section or by logging onto the Aetna website at **www.aetnastudenthealth.com.*

Description of Benefits – Student 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 **www.aetnastudenthealth.com.** If any discrepancy exists between this Benefit Summary and the Certificate of Coverage, the Certificate will control.

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	$400 per policy year	$750 per policy year
Family	$1,200 per policy year	$2,250 per policy year
Policy year deductible waiver		
The policy year deductible is waived for all of the following eligible medical services: • In-network care for Preventive care and wellness • In-network care for Pediatric dental care • In-network care and out-of-network care for Pediatric vision care • In-network care and out-of-network care for Outpatient prescription drugs		
Maximum out-of-pocket limits **Maximum out-of-pocket limit per policy year**		
Student	$7,900 per policy year	$15,000 per policy year
Family	$15,800 per policy year	$20,000 per policy year
Precertification covered benefit penalty		
This only applies to out-of-network coverage: The certificate of coverage contains a complete description of the precertification program. You will find details on precertification requirements in the Article VI: Prior Authorization section. Failure to precertify your eligible medical services when required will result in the following benefit penalties: • The eligible medical services will not be covered. The additional percentage or dollar amount of the recognized charge which you may pay as a penalty for failure to obtain precertification is not a covered benefit, and will not be applied to the policy year deductible amount or the maximum out-of-pocket limit, if any.		

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 medical services	**In-network coverage**	**Out-of-network coverage**
Preventive care and wellness		
Routine physical exams		
Performed at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
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. For details, contact your physician or Member Services by logging onto your Aetna Navigator® secure website at **www.aetnastudenthealth.com** or calling the toll-free number on your ID card.	
Covered persons age 22 and over: Maximum visits	1 visit	

per policy year		
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	60% (of the recognized charge) per visit
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 For details, contact your physician or Member Services by logging onto your Aetna Navigator® secure website at **www.aetnastudenthealth.com** or calling the toll-free number on your ID card.	
Well woman preventive visits **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	60% (of the recognized charge) per visit
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	
Preventive screening and counseling services		
Obesity and/or healthy diet counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year (This maximum applies only to covered persons age 22 and older.)	26 visits (however, of these only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)]	
Misuse of alcohol and/or drugs counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year	5 visits	
Use of tobacco products counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year	8 visits	
Depression screening counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit

Maximum visits per policy year	1 visit	
Sexually transmitted infection counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year	2 visits	
Genetic risk counseling for breast and ovarian cancer counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
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	60% (of the recognized charge) per visit
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. For details, contact your physician or Member Services by logging onto your Aetna Navigator® secure website at **www.aetnastudenthealth.com** or calling the toll-free number on your ID card.	
Lung cancer screening maximums	1 screening every 12 months*	
***Important note:** Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.		
Prenatal care services (provided by a physician, an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)		
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
Important note: You should review the *Maternity care and Well newborn nursery care* sections. They will give you more information on coverage levels for maternity care under this plan.		
Comprehensive lactation support and counseling services		
Lactation counseling services - facility or office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits	
Important note: Any visits that exceed the lactation counseling services maximum are covered under the *Physicians and other health professionals* section.		
Breast pump supplies and accessories	100% (of the negotiated charge) per item	60% (of the recognized charge) per item

	No copayment or policy year deductible applies	
Maximums	An electric breast pump (non-hospital grade, cost is covered by your plan once every three years) or a manual breast pump (cost is covered by your plan once per pregnancy) If an electric breast pump was purchased within the previous three year period, the purchase of another electric breast pump will not be covered until a three year period has elapsed since the last purchase.	
Family planning services – female contraceptives		
Female 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
Contraceptives (prescription drugs and devices)		
Female contraceptive prescription drugs and devices provided, administered, or removed, by a physician during an office visit	100% (of the negotiated charge) per item No copayment or policy year deductible applies	60% (of the recognized charge) per item
Female voluntary sterilization		
Inpatient provider services	100% (of the negotiated charge) per admission No copayment or policy year deductible applies	60% (of the recognized charge) per admission
Outpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Eligible medical services	**In-network coverage**	**Out-of-network coverage**
Physicians and other health professionals		
Physician and specialist services (including nurse and physician assistant)		
Office hours visits (non-surgical and non-preventive care by a physician and specialist)	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	$30 copayment then the plan pays 60% (of the balance of the recognized charge) per visit thereafter
Telemedicine consultation by a physician or specialist	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	$30 copayment then the plan pays 60% (of the balance of the recognized charge) per visit thereafter
Allergy testing and treatment **(including nurse and physician assistant)**		
Allergy testing performed at a physician's or specialist's office	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Allergy injections treatment performed at a physician's, or specialist office	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	$30 copayment then the plan pays 60% (of the balance of the recognized charge) per visit thereafter
Allergy sera and extracts administered via injection at a physician's or specialist's office	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	$30 copayment then the plan pays 60% (of the balance of the recognized charge) per visit

		thereafter
Physician and specialist - inpatient 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)	60% (of the recognized charge)
Physician and specialist - outpatient surgical services		
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon	80% (of the negotiated charge)	60% (of the recognized charge)
In-hospital non-surgical physician services		
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Consultant services (non-surgical and non-preventive) (including nurse and physician assistant)		
Office hours visits (non-surgical and non-preventive care)	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	$30 copayment then the plan pays 60% (of the balance of the recognized charge) per visit thereafter
Telemedicine consultation by a consultant	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	$30 copayment then the plan pays 60% (of the balance of the recognized charge) per visit thereafter
Second surgical opinion	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
Alternatives to physician office visits		
Walk-in clinic visits(non-emergency visit)	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	$30 copayment then the plan pays 60% (of the balance of the recognized charge) per visit thereafter
Eligible medical services	**In-network coverage**	**Out-of-network coverage**
Hospital and other facility care		
Inpatient hospital *(room and board) and other miscellaneous services and supplies)* *Subject to semi-private room rate unless intensive care unit required* Room and board includes intensive care For physician charges, refer to the *Physician and specialist – inpatient surgical services* benefit	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
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
Alternatives to hospital stays		
Outpatient surgery (facility charges)		
Facility charges for surgery performed in the outpatient department of a hospital or surgery center	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

For physician charges, refer to the *Physician and specialist - outpatient surgical services* benefit		
Home health care		
Outpatient	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Outpatient private duty nursing	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Hospice care		
Inpatient facility *(room and board and other miscellaneous services and supplies)*	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Outpatient	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Skilled nursing facility		
Inpatient facility *(room and board and miscellaneous inpatient care services and supplies)* Subject to semi-private room rate unless intensive care unit is required Room and board includes intensive care	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Eligible medical services	**In-network coverage**	**Out-of-network coverage**
Emergency services and urgent care		
Emergency services		
Hospital emergency room *Includes complex imaging services, lab work and radiological services performed during a hospital emergency room visit, and any surgery which results from the hospital emergency room visit	$250 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit	Paid the same as in-network coverage
Non-emergency care in a hospital emergency room	Not covered	Not covered

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 hospital 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 hospital 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 hospital emergency room copayment/coinsurance.
- Separate copayment/coinsurance amounts may apply for certain services given to you in the hospital emergency room that are not part of the hospital emergency room benefit. These copayment/coinsurance amounts may be different from the hospital emergency room copayment/coinsurance. They are based on the specific service given to you.
- Services given to you in the hospital emergency room that are not part of the hospital emergency room benefit may be subject to

copayment/coinsurance amounts that are different from the hospital emergency room copayment/coinsurance amounts.		
Urgent care		
Urgent medical care provided by an urgent care provider Does not include complex imaging services, lab work and radiological services performed during an urgent medical care visit	$30 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter	$30 copayment then the plan pays 60% (of the balance of the recognized charge) per visit thereafter
Non-urgent use of urgent care provider Examples of non-urgent care are: • Routine or preventive care (this includes immunizations) • Follow-up care • Physical therapy • Elective treatment • Any diagnostic lab work and radiological services which are not related to the treatment of the urgent condition.	Not covered	Not covered
Eligible medical services	**In-network coverage**	**Out-of-network coverage**
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
Type B services	70% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit
Type C services	50% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit
Orthodontic services	50% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit
Dental emergency treatment Coverage for dental emergencies includes only the dental care needed to reduce pain and stabilize the condition.	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
Eligible medical services	**In-network coverage**	**Out-of-network coverage**
Specific conditions		
Birthing center (facility charges)		
Inpatient (room and board and other miscellaneous services and supplies)	Paid at the same cost-sharing as hospital care	Paid at the same cost-sharing as hospital care
Diabetic services and supplies (including equipment and training)		

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
Accidental dental injury		
Accidental injury to sound natural teeth	80% (of the negotiated charge)	80% (of the recognized charge)
Anesthesia and related facility charges for a dental procedure		
Anesthesia and related facility charges for a dental procedure *Coverage is subject to certain conditions. See the benefit description in the certificate of coverage for details.*	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
Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment		
TMJ and 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
Dermatological treatment		
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
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
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
Note: *The per admission copayment amount and/or policy year deductible for newborns will be waived for nursery charges for the duration of the newborn's initial routine facility stay. The nursery charges waiver will not apply for non-routine facility stays.*		
Pregnancy complications		
Inpatient *(room and board and other miscellaneous services and supplies)* *Subject to semi-private room rate unless intensive care unit required* Room and board includes intensive 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
Family planning services – other		
Voluntary sterilization for males *Inpatient physician or specialist surgical services*	80% (of the negotiated charge)	60% (of the recognized charge)
Voluntary sterilization for males Outpatient physician or specialist surgical services	80% (of the negotiated charge)	60% (of the recognized charge)
Abortion Inpatient physician or specialist surgical services	80% (of the negotiated charge)	60% (of the recognized charge)
Abortion Outpatient physician or specialist surgical services	80% (of the negotiated charge)	60% (of the recognized charge)

Gender reassignment (sex change) 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
Important Note: Just log into your Aetna Navigator® secure website at **www.aetnastudenthealth.com** for detailed information about this covered benefit, including eligibility requirements in Aetna's clinical policy bulletin #0615. You can also call *Member Services* at the toll-free number on the back of your ID card.		
Autism spectrum disorder		
Autism spectrum disorder treatment (includes physician and specialist office visits, diagnosis and 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
Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	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
Applied behavior analysis*	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
***Important note**: Applied behavior analysis requires precertification by Aetna. Your in-network provider is responsible for obtaining precertification. You are responsible for obtaining precertification when you use an out-of-network provider.		
Mental health treatment (Includes coverage for biologically and non-biologically based mental illness)		
Mental health treatment – inpatient		
Inpatient hospital mental disorders treatment *(room and board and other miscellaneous hospital services and supplies)* Inpatient residential treatment facility mental disorders treatment (room and board and other miscellaneous residential treatment facility services and supplies) Subject to semi-private room rate unless intensive care unit is required Mental disorder room and board intensive care	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Mental health treatment - outpatient		
Outpatient mental disorders treatment office visits to a physician or behavioral health provider (includes telemedicine cognitive behavioral therapy consultations)	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	$30 copayment then the plan pays 60% (of the balance of the recognized charge) per visit thereafter
Other outpatient mental disorders treatment (includes skilled behavioral health services in the home) Partial hospitalization treatment (at least 4 hours, but less than 24 hours per day of clinical treatment) Intensive Outpatient Program (at least 2 hours per day and at least 6 hours per week of clinical treatment)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

Substance abuse related disorders treatment-inpatient		
Inpatient hospital substance abuse detoxification *(room and board and other miscellaneous hospital services and supplies)* *Inpatient hospital substance abuse rehabilitation* *(room and board and other miscellaneous hospital services and supplies)* *Inpatient residential treatment facility substance abuse* (room and board and other miscellaneous residential treatment facility services and supplies) Subject to semi-private room rate unless intensive care unit is required Substance abuse room and board intensive care	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Substance abuse related disorders treatment-outpatient: detoxification and rehabilitation		
Outpatient substance abuse office visits to a physician or behavioral health provider (includes telemedicine cognitive behavioral therapy consultations)	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	$30 copayment then the plan pays 60% (of the balance of the recognized charge) per visit thereafter
Other outpatient substance abuse services (includes skilled behavioral health services in the home) Partial hospitalization treatment (at least 4 hours, but less than 24 hours per day of clinical treatment) Intensive Outpatient Program (at least 2 hours per day and at least 6 hours per week of clinical treatment)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Reconstructive surgery and supplies		
Reconstructive surgery and supplies (includes reconstructive breast surgery)	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

Eligible medical 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 - live donor health services	Covered according to the type of benefit and the place where the service is		

(facility and non-facility) Inpatient (room and board and other miscellaneous services and supplies) and outpatient	received		
Live donor health services -physician and specialist services (including office visits)	Covered according to the type of benefit and the place where the service is received		
Transplant services-travel and lodging	100% of the actual charge	100% of the actual charge	100% of the actual charge
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
Transplant services – unrelated donor search services			
Maximum Benefit for unrelated donor search services	$30,000 per transplant	$30,000 per transplant	$30,000 per transplant
Eligible medical services	**In-network coverage**		**Out-of-network coverage**
Treatment of infertility			
Basic infertility services Inpatient and outpatient care - 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
Specific therapies and tests			
Outpatient diagnostic testing			
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit		60% (of the recognized charge) per visit
Diagnostic lab work and radiological services performed in a physician's office, the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit		60% (of the recognized charge) per visit
Chemotherapy			
Chemotherapy	80% (of the negotiated charge) per visit		60% (of the recognized charge) per visit
Outpatient infusion therapy			
Outpatient infusion therapy performed in a covered person's home, physician's office, outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit		60% (of the recognized charge) per visit
Outpatient radiation therapy			
Outpatient radiation therapy	80% (of the negotiated charge) per visit		60% (of the recognized charge) per visit
Outpatient respiratory therapy			
Respiratory therapy	80% (of the negotiated charge) per visit		60% (of the recognized charge) per visit
Transfusion or kidney dialysis of blood			
Transfusion or kidney dialysis of blood	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

Short-term cardiac and pulmonary rehabilitation services		
Cardiac rehabilitation	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Pulmonary rehabilitation	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Short-term rehabilitation and habilitation therapy services		
Outpatient physical, occupational, speech, cognitive and inhalation therapies Combined for short-term rehabilitation services and habilitation therapy services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Day rehabilitation services (physical medicine and rehabilitation)		
Day rehabilitation services (physical medicine and rehabilitation)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Manipulation therapy services (includes osteopathic/chiropractic manipulation therapy)		
Manipulation therapy	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	$30 copayment then the plan pays 60% (of the balance of the recognized charge) per visit thereafter
Diagnostic testing for learning disabilities		
Diagnostic testing for learning disabilities	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
Specialty prescription drugs (Purchased and injected or infused by your provider in an outpatient setting)		
Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting	Covered according to the type of benefit or the place where the service is received	Covered according to the type of benefit or the place where the service is received
Eligible medical services	**In-network coverage**	**Out-of-network coverage**
Other services and supplies		
Acupuncture in lieu of anesthesia	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
Emergency ground, air, and water ambulance	80% (of the negotiated charge) per trip	Paid the same as in-network coverage
Clinical trial therapies	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
Clinical trial (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
Durable medical and surgical equipment	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Enteral formulas and nutritional supplements	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Prosthetic devices		
Cranial prosthetics *(Medical wigs)*	80% (of the negotiated charge) per item	60% (of the recognized charge) per item

Surgical bras following mastectomy	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Surgical bras following mastectomy Maximum per policy year	4	4
All other prosthetic devices	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Orthotic devices	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Cochlear implants	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
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
Vision care		
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	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit No policy year deductible applies
Maximum visits per policy year	1 visit	
Pediatric comprehensive low vision evaluations		
Performed by a legally qualified ophthalmologist or optometrist	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	One comprehensive low vision evaluation every policy year	
Pediatric vision care services and supplies		
Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit No policy year deductible applies
Maximum number of eyeglass frames per policy year Maximum number of prescription lenses per policy year	One set of eyeglass frames One pair of prescription lenses	
Maximum number of prescription contact lenses per policy year (includes non-conventional prescription contact lenses and aphakic lenses prescribed after cataract surgery)	Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set	
Office visit for fitting of contact lenses	100% (of the negotiated charge) per	60% (of the recognized charge) per

	visit No policy year deductible applies	visit No policy year deductible applies
Optical devices Maximum number of optical devices per policy year: One optical device	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

*__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.

Eligible medical services	**In-network coverage**	**Out-of-network coverage**
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: • Certain 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%. Also, you may qualify for a medical exception. If your provider documents a medical exception and submits the exception to us, certain FDA-approved brand-name or non-formulary contraceptives may also be covered as preventive care. We will defer to the provider's determination. The 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 a in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.		
Preferred Generic prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30-day supply filled at a retail pharmacy	$15 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$15 copayment per supply then the plan pays 60% (of the recognized charge) No policy year deductible applies

More than a 30- day supply but less than a 91-day supply filled at a mail order pharmacy	$30 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	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	$50 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$50 copayment per supply then the plan pays 60% (of the recognized charge) No policy year deductible applies
More than a 30- day supply but less than a 91-day supply filled at a mail order pharmacy	$100 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	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	$100 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$100 copayment per supply then the plan pays 60% (of the recognized charge) No policy year deductible applies
More than a 30- day supply but less than a 91-day supply filled at a mail order pharmacy	$200 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	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	$100 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$100 copayment per supply then the plan pays 60% (of the recognized charge) No policy year deductible applies
More than a 30- day supply but less than a 91-day supply filled at a mail order pharmacy	$200 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	Not Covered
Orally administered anti-cancer prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30-day supply filled at a retail pharmacy	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
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

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. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna Navigator® secure website at **www.aetnastudenthealth.com** or calling the toll-free number on the back of your ID card.	
Risk reducing breast cancer prescription drugs		
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. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna Navigator® secure website at **www.aetnastudenthealth.com** or calling the toll-free number on the back of your ID card.	
Tobacco cessation prescription and over-the-counter drugs *(preventive care)*		
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
Maximums:	Coverage is permitted for two 90-day treatment regimens only. 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. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna Navigator® secure website at **www.aetnastudenthealth.com** or calling the toll-free number on the back of your ID card.	

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 – Dependent 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 **www.aetnastudenthealth.com.** If any discrepancy exists between this Benefit Summary and the Certificate of Coverage, the Certificate will control.

Policy year deductible	**In-network coverage**	**Out-of-network coverage**
You have to meet your policy year deductible before this plan pays for benefits.		
Spouse	$400 per policy year	$750 per policy year
Each child	$400 per policy year	$750 per policy year
Family	$1,200 per policy year	$2,250 per policy year
Policy year deductible waiver		
The policy year deductible is waived for all of the following eligible medical services: • In-network care for Preventive care and wellness • In-network care for Pediatric dental care • In-network care and out-of-network care for Pediatric vision care • In-network care and out-of-network care for Outpatient prescription drugs		
Maximum out-of-pocket limits **Maximum out-of-pocket limit per policy year**		
Spouse	$7,900 per policy year	$15,000 per policy year
Each child	$7,900 per policy year	$15,000 per policy year
Family	$15,800 per policy year	$20,000 per policy year
Precertification covered benefit penalty		
This only applies to out-of-network coverage: The certificate of coverage contains a complete description of the precertification program. You will find details on precertification requirements in the *Article VI: Prior Authorization* section. Failure to precertify your eligible medical services when required will result in the following benefit penalties: • The eligible medical services will not be covered. The additional percentage or dollar amount of the recognized charge which you may pay as a penalty for failure to obtain precertification is not a covered benefit, and will not be applied to the policy year deductible amount or the maximum out-of-pocket limit, if any.		

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 medical services	**In-network coverage**	**Out-of-network coverage**
Preventive care and wellness		
Routine physical exams		
Performed at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
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. For details, contact your physician or Member Services by logging onto your Aetna Navigator® secure website at **www.aetnastudenthealth.com** or	

	calling the toll-free number on your ID card.	
Covered persons age 22 and over: Maximum visits per policy year	1 visit	
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	60% (of the recognized charge) per visit
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 For details, contact your physician or Member Services by logging onto your Aetna Navigator® secure website at **www.aetnastudenthealth.com** or calling the toll-free number on your ID card.	
Well woman preventive visits **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	60% (of the recognized charge) per visit
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	
Preventive screening and counseling services		
Obesity and/or healthy diet counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year (This maximum applies only to covered persons age 22 and older.)	26 visits (however, of these only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)]	
Misuse of alcohol and/or drugs counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year	5 visits	
Use of tobacco products counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year	8 visits	
Depression screening counseling office visits	100% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

	No copayment or policy year deductible applies	
Maximum visits per policy year	1 visit	
Sexually transmitted infection counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year	2 visits	
Genetic risk counseling for breast and ovarian cancer counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
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	60% (of the recognized charge) per visit
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. For details, contact your physician or Member Services by logging onto your Aetna Navigator® secure website at **www.aetnastudenthealth.com** or calling the toll-free number on your ID card.	
Lung cancer screening maximums	1 screening every 12 months*	
***Important note:** Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.		
Prenatal care services (provided by a physician, an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)		
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
Important note: You should review the *Maternity care and Well newborn nursery care* sections. They will give you more information on coverage levels for maternity care under this plan.		
Comprehensive lactation support and counseling services		
Lactation counseling services - facility or office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits	
Important note: Any visits that exceed the lactation counseling services maximum are covered under the *Physicians and other health professionals* section.		
Breast pump supplies and accessories	100% (of the negotiated charge) per	60% (of the recognized charge) per

	item No copayment or policy year deductible applies	item
Maximums	An electric breast pump (non-hospital grade, cost is covered by your plan once every three years) or a manual breast pump (cost is covered by your plan once per pregnancy) If an electric breast pump was purchased within the previous three year period, the purchase of another electric breast pump will not be covered until a three year period has elapsed since the last purchase.	
Family planning services – female contraceptives		
Female 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
Contraceptives (prescription drugs and devices)		
Female contraceptive prescription drugs and devices provided, administered, or removed, by a physician during an office visit	100% (of the negotiated charge) per item No copayment or policy year deductible applies	60% (of the recognized charge) per item
Female voluntary sterilization		
Inpatient provider services	100% (of the negotiated charge) per admission No copayment or policy year deductible applies	60% (of the recognized charge) per admission
Outpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Eligible medical services	**In-network coverage**	**Out-of-network coverage**
Physicians and other health professionals		
Physician and specialist services (including nurse and physician assistant)		
Office hours visits *(non-surgical and non-preventive care by a physician and specialist)*	$20 copayment then the plan pays 70% (of the balance of the negotiated charge) per visit thereafter	$20 copayment then the plan pays 60% (of the balance of the recognized charge) per visit thereafter
Telemedicine consultation by a physician or specialist	$20 copayment then the plan pays 70% (of the balance of the negotiated charge) per visit thereafter	$20 copayment then the plan pays 60% (of the balance of the recognized charge) per visit thereafter
Allergy testing and treatment **(including nurse and physician assistant)**		
Allergy testing performed at a physician's or specialist's office	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Allergy injections treatment performed at a physician's, or specialist office	$20 copayment then the plan pays 70% (of the balance of the negotiated charge) per visit thereafter	$20 copayment then the plan pays 60% (of the balance of the recognized charge) per visit thereafter

Allergy sera and extracts administered via injection at a physician's or specialist's office	$20 copayment then the plan pays 70% (of the balance of the negotiated charge) per visit thereafter	$20 copayment then the plan pays 60% (of the balance of the recognized charge) per visit thereafter
Physician and specialist - inpatient surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	70% (of the negotiated charge)	60% (of the recognized charge)
Physician and specialist - outpatient surgical services		
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon	70% (of the negotiated charge)	60% (of the recognized charge)
In-hospital non-surgical physician services		
In-hospital non-surgical physician services	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Consultant services (non-surgical and non-preventive) (including nurse and physician assistant)		
Office hours visits (non-surgical and non-preventive care)	$20 copayment then the plan pays 70% (of the balance of the negotiated charge) per visit thereafter	$20 copayment then the plan pays 60% (of the balance of the recognized charge) per visit thereafter
Telemedicine consultation by a consultant	$20 copayment then the plan pays 70% (of the balance of the negotiated charge) per visit thereafter	$20 copayment then the plan pays 60% (of the balance of the recognized charge) per visit thereafter
Second surgical opinion	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
Alternatives to physician office visits		
Walk-in clinic visits(non-emergency visit)	$20 copayment then the plan pays 70% (of the balance of the negotiated charge) per visit thereafter	$20 copayment then the plan pays 60% (of the balance of the recognized charge) per visit thereafter
Eligible medical services	**In-network coverage**	**Out-of-network coverage**
Hospital and other facility care		
Inpatient hospital *(room and board) and other miscellaneous services and supplies)* *Subject to semi-private room rate unless intensive care unit required* Room and board includes intensive care For physician charges, refer to the *Physician and specialist – inpatient surgical services* benefit	70% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
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
Alternatives to hospital stays		
Outpatient surgery (facility charges)		

Facility charges for surgery performed in the outpatient department of a hospital or surgery center For physician charges, refer to the *Physician and specialist - outpatient surgical services* benefit	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Home health care		
Outpatient	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Outpatient private duty nursing	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Hospice care		
Inpatient facility *(room and board and other miscellaneous services and supplies)*	70% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Outpatient	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Skilled nursing facility		
Inpatient facility *(room and board and miscellaneous inpatient care services and supplies)* Subject to semi-private room rate unless intensive care unit is required Room and board includes intensive care	70% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Eligible medical services	**In-network coverage**	**Out-of-network coverage**
Emergency services and urgent care		
Emergency services		
Hospital emergency room *Includes complex imaging services, lab work and radiological services performed during a hospital emergency room visit, and any surgery which results from the hospital emergency room visit	$250 copayment then the plan pays 70% (of the balance of the negotiated charge) per visit	Paid the same as in-network coverage
Non-emergency care in a hospital emergency room	Not covered	Not covered

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 hospital 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 hospital 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 hospital emergency room copayment/coinsurance.
- Separate copayment/coinsurance amounts may apply for certain services given to you in the hospital emergency room that are not

part of the hospital emergency room benefit. These copayment/coinsurance amounts may be different from the hospital emergency room copayment/coinsurance. They are based on the specific service given to you. • Services given to you in the hospital emergency room that are not part of the hospital emergency room benefit may be subject to copayment/coinsurance amounts that are different from the hospital emergency room copayment/coinsurance amounts.		
Urgent care		
Urgent medical care provided by an urgent care provider Does not include complex imaging services, lab work and radiological services performed during an urgent medical care visit	$30 copayment then the plan pays 70% (of the balance of the negotiated charge) per visit thereafter	$30 copayment then the plan pays 60% (of the balance of the recognized charge) per visit thereafter
Non-urgent use of urgent care provider Examples of non-urgent care are: • Routine or preventive care (this includes immunizations) • Follow-up care • Physical therapy • Elective treatment • Any diagnostic lab work and radiological services which are not related to the treatment of the urgent condition.	Not covered	Not covered
Eligible medical services	**In-network coverage**	**Out-of-network coverage**
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
Type B services	70% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit
Type C services	50% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit
Orthodontic services	50% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit
Dental emergency treatment Coverage for dental emergencies includes only the dental care needed to reduce pain and stabilize the condition.	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
Eligible medical services	**In-network coverage**	**Out-of-network coverage**
Specific conditions		
Birthing center (facility charges)		

Inpatient (room and board and other miscellaneous services and supplies)	Paid at the same cost-sharing as hospital care	Paid at the same cost-sharing as hospital care
Diabetic services and supplies (including equipment and training)		
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
Accidental dental injury		
Accidental injury to sound natural teeth	70% (of the negotiated charge)	70% (of the recognized charge)
Anesthesia and related facility charges for a dental procedure		
Anesthesia and related facility charges for a dental procedure *Coverage is subject to certain conditions. See the benefit description in the certificate of coverage for details.*	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
Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment		
TMJ and 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
Dermatological treatment		
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
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
Well newborn nursery care in a hospital or birthing center	70% (of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies
Note: *The per admission copayment amount and/or policy year deductible for newborns will be waived for nursery charges for the duration of the newborn's initial routine facility stay. The nursery charges waiver will not apply for non-routine facility stays.*		
Pregnancy complications		
Inpatient *(room and board and other miscellaneous services and supplies)* *Subject to semi-private room rate unless intensive care unit required* Room and board includes intensive 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
Family planning services – other		
Voluntary sterilization for males *Inpatient physician or specialist surgical services*	70% (of the negotiated charge)	60% (of the recognized charge)
Voluntary sterilization for males Outpatient physician or specialist surgical services	70% (of the negotiated charge)	60% (of the recognized charge)

Abortion Inpatient physician or specialist surgical services	70% (of the negotiated charge)	60% (of the recognized charge)
Abortion Outpatient physician or specialist surgical services	70% (of the negotiated charge)	60% (of the recognized charge)
Gender reassignment (sex change) 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
Important Note: Just log into your Aetna Navigator® secure website at **www.aetnastudenthealth.com** for detailed information about this covered benefit, including eligibility requirements in Aetna's clinical policy bulletin #0615. You can also call *Member Services* at the toll-free number on the back of your ID card.		
Autism spectrum disorder		
Autism spectrum disorder treatment (includes physician and specialist office visits, diagnosis and 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
Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	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
Applied behavior analysis*	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
***Important note**: Applied behavior analysis requires precertification by Aetna. Your in-network provider is responsible for obtaining precertification. You are responsible for obtaining precertification when you use an out-of-network provider.		
Mental health treatment (Includes coverage for biologically and non-biologically based mental illness)		
Mental health treatment – inpatient		
Inpatient hospital mental disorders treatment *(room and board and other miscellaneous hospital services and supplies)* Inpatient residential treatment facility mental disorders treatment (room and board and other miscellaneous residential treatment facility services and supplies) Subject to semi-private room rate unless intensive care unit is required Mental disorder room and board intensive care	70% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Mental health treatment - outpatient		
Outpatient mental disorders treatment office visits to a physician or behavioral health provider (includes telemedicine cognitive behavioral therapy consultations)	$20 copayment then the plan pays 70% (of the balance of the negotiated charge) per visit thereafter	$20 copayment then the plan pays 60% (of the balance of the recognized charge) per visit thereafter
Other outpatient mental disorders treatment (includes skilled behavioral health services in the home) Partial hospitalization treatment (at least 4 hours, but less than 24 hours per day of clinical	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

treatment) Intensive Outpatient Program (at least 2 hours per day and at least 6 hours per week of clinical treatment)		
Substance abuse related disorders treatment-inpatient		
Inpatient hospital substance abuse detoxification *(room and board and other miscellaneous hospital services and supplies)* *Inpatient hospital substance abuse rehabilitation* *(room and board and other miscellaneous hospital services and supplies)* *Inpatient residential treatment facility substance abuse* (room and board and other miscellaneous residential treatment facility services and supplies) Subject to semi-private room rate unless intensive care unit is required Substance abuse room and board intensive care	70% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Substance abuse related disorders treatment-outpatient: detoxification and rehabilitation		
Outpatient substance abuse office visits to a physician or behavioral health provider (includes telemedicine cognitive behavioral therapy consultations)	$20 copayment then the plan pays 70% (of the balance of the negotiated charge) per visit thereafter	$20 copayment then the plan pays 60% (of the balance of the recognized charge) per visit thereafter
Other outpatient substance abuse services (includes skilled behavioral health services in the home) Partial hospitalization treatment (at least 4 hours, but less than 24 hours per day of clinical treatment) Intensive Outpatient Program (at least 2 hours per day and at least 6 hours per week of clinical treatment)	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Reconstructive surgery and supplies		
Reconstructive surgery and supplies (includes reconstructive breast surgery)	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

Eligible medical 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 - live donor health services (facility and non-facility) Inpatient (room and board and other miscellaneous services and supplies) and outpatient	Covered according to the type of benefit and the place where the service is received		
Live donor health services -physician and specialist services (including office visits)	Covered according to the type of benefit and the place where the service is received		
Transplant services-travel and lodging	100% of the actual charge	100% of the actual charge	100% of the actual charge
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
Transplant services – unrelated donor search services			
Maximum Benefit for unrelated donor search services	$30,000 per transplant	$30,000 per transplant	$30,000 per transplant
Eligible medical services	**In-network coverage**	**Out-of-network coverage**	
Treatment of infertility			
Basic infertility services Inpatient and outpatient care - 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	
Specific therapies and tests			
Outpatient diagnostic testing			
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	
Diagnostic lab work and radiological services performed in a physician's office, the outpatient department of a hospital or other facility	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	
Chemotherapy			
Chemotherapy	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	
Outpatient infusion therapy			
Outpatient infusion therapy performed in a covered person's home, physician's office, outpatient department of a hospital or other facility	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	
Outpatient radiation therapy			
Outpatient radiation therapy	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	
Outpatient respiratory therapy			

Respiratory therapy	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Transfusion or kidney dialysis of blood		
Transfusion or kidney dialysis of blood	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
Short-term cardiac and pulmonary rehabilitation services		
Cardiac rehabilitation	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Pulmonary rehabilitation	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Short-term rehabilitation and habilitation therapy services		
Outpatient physical, occupational, speech, cognitive and inhalation therapies Combined for short-term rehabilitation services and habilitation therapy services	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Day rehabilitation services (physical medicine and rehabilitation)		
Day rehabilitation services (physical medicine and rehabilitation)	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Manipulation therapy services (includes osteopathic/chiropractic manipulation therapy)		
Manipulation therapy	$20 copayment then the plan pays 70% (of the balance of the negotiated charge) per visit thereafter	$20 copayment then the plan pays 60% (of the balance of the recognized charge) per visit thereafter
Diagnostic testing for learning disabilities		
Diagnostic testing for learning disabilities	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
Specialty prescription drugs (Purchased and injected or infused by your provider in an outpatient setting)		
Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting	Covered according to the type of benefit or the place where the service is received	Covered according to the type of benefit or the place where the service is received
Eligible medical services	**In-network coverage**	**Out-of-network coverage**
Other services and supplies		
Acupuncture in lieu of anesthesia	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
Emergency ground, air, and water ambulance	70% (of the negotiated charge) per trip	Paid the same as in-network coverage
Clinical trial therapies	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
Clinical trial (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

Durable medical and surgical equipment	70% (of the negotiated charge) per item	60% (of the recognized charge) per item
Enteral formulas and nutritional supplements	70% (of the negotiated charge) per item	60% (of the recognized charge) per item
Prosthetic devices		
Cranial prosthetics *(Medical wigs)*	70% (of the negotiated charge) per item	60% (of the recognized charge) per item
Surgical bras following mastectomy	70% (of the negotiated charge) per item	60% (of the recognized charge) per item
Surgical bras following mastectomy Maximum per policy year	4	4
All other prosthetic devices	70% (of the negotiated charge) per item	60% (of the recognized charge) per item
Orthotic devices	70% (of the negotiated charge) per item	60% (of the recognized charge) per item
Cochlear implants	70% (of the negotiated charge) per item	60% (of the recognized charge) per item
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
Vision care		
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	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit No policy year deductible applies
Maximum visits per policy year	1 visit	
Pediatric comprehensive low vision evaluations		
Performed by a legally qualified ophthalmologist or optometrist	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	One comprehensive low vision evaluation every policy year	
Pediatric vision care services and supplies		
Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit No policy year deductible applies

Maximum number of eyeglass frames per policy year Maximum number of prescription lenses per policy year	One set of eyeglass frames One pair of prescription lenses	
Maximum number of prescription contact lenses per policy year (includes non-conventional prescription contact lenses and aphakic lenses prescribed after cataract surgery)	Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set	
Office visit for fitting of contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit No policy year deductible applies
Optical devices Maximum number of optical devices per policy year: One optical device	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

*__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.

Eligible medical services	**In-network coverage**	**Out-of-network coverage**

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:

- Certain 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%.

Also, you may qualify for a medical exception. If your provider documents a medical exception and submits the exception to us, certain FDA-approved brand-name or non-formulary contraceptives may also be covered as preventive care. We will defer to the provider's determination.

The 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 a in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.		
Preferred Generic prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30-day supply filled at a retail pharmacy	$15 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$15 copayment per supply then the plan pays 60% (of the recognized charge) No policy year deductible applies
More than a 30- day supply but less than a 91-day supply filled at a mail order pharmacy	$30 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	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	$50 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$50 copayment per supply then the plan pays 60% (of the recognized charge) No policy year deductible applies
More than a 30- day supply but less than a 91-day supply filled at a mail order pharmacy	$100 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	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	$ 100 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$100 copayment per supply then the plan pays 60% (of the recognized charge) No policy year deductible applies
More than a 30- day supply but less than a 91-day supply filled at a mail order pharmacy	$200 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	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	$100 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$100 copayment per supply then the plan pays 60% (of the recognized charge) No policy year deductible applies
More than a 30- day supply but less than a 91-day supply filled at a mail order pharmacy	$200 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	Not Covered
Orally administered anti-cancer prescription drugs		

Per prescription copayment/coinsurance		
For each fill up to a 30-day supply filled at a retail pharmacy	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
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
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. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna Navigator® secure website at **www.aetnastudenthealth.com** or calling the toll-free number on the back of your ID card.	
Risk reducing breast cancer prescription drugs		
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. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna Navigator® secure website at **www.aetnastudenthealth.com** or calling the toll-free number on the back of your ID card.	
Tobacco cessation prescription and over-the-counter drugs ***(preventive care)***		
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
Maximums:	Coverage is permitted for two 90-day treatment regimens only. 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. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna Navigator® secure website at **www.aetnastudenthealth.com** or calling the toll-free number on the back of your ID card.	

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

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 **216.368.8730**.

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. 368.8730** 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. Payment 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.

Coordination of Benefits (COB)

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one plan. Plan is defined below. The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans does not exceed 100% of the total allowable expense

For more information about the Coordination of Benefits provision, including determining which plan is primary and which is secondary, you may call the Member Services telephone number shown on your ID card.

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 $ 1,165.00 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 6, 2019. The waiver deadline for students starting in spring semester is January 24, 2020.

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.

The Case Western Reserve University Student Health Insurance Plan is self-funded by Case Western Reserve University, with claim administration services provided 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**.

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

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted

above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), **CRCoordinator@aetna.com**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

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).