Coverage Period: 01/01/2020 - 12/31/2020

aetna™ : **NORTHWESTERN UNIVERSITY POSTDOCTORAL FELLOW BENEFIT PROGRAM HMO - IL**

Coverage for: Individual + Family | **Plan Type:** HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://www.aetna.com/sbcsearch/getpolicydocs?u=081600-070020-771977 or by calling 1-888-982-3862. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: Individual $1,500 / Family $3,000.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See http://www.aetna.com/docfind or call 1-888-982-3862 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	Not covered	None
	Specialist visit	$25 copay/visit	Not covered	None
	Preventive care /screening /immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for laboratory; $25 copay/visit for x-ray	Not covered	None
	Imaging (CT/PET scans, MRIs)	$100 copay/visit	Not covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/advancedcontrolaetna	Preferred generic drugs	Copay/prescription: $10 for 30 day supply (retail), $20 for 31-90 day supply (retail & mail order)	Not covered	Covers 30 day supply (retail), 31-90 day supply (retail & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage.
	Preferred brand drugs	Copay/prescription: $30 for 30 day supply (retail), $60 for 31-90 day supply (retail & mail order)	Not covered	
	Non-preferred generic/brand drugs	Copay/prescription: $60 for 30 day supply (retail), $120 for 31-90 day supply (retail & mail order)	Not covered	
	Specialty drugs	Applicable cost as noted above for generic or brand drugs	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay/visit	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	No coverage for non-emergency use.
	Emergency medical transportation	No charge	No charge	Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	$35 copay/visit	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/stay	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $25 copay/visit; other outpatient services: no charge	Not covered	None
	Inpatient services	$500 copay/stay	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	$25 copay/pregnancy	Not covered	
	Childbirth/delivery facility services	$500 copay/stay	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	None
	Rehabilitation services	$25 copay/visit	Not covered	60 visits/calendar year for Physical, Occupational & Speech Therapy combined.
	Habilitation services	$25 copay/visit	Not covered	None
	Skilled nursing care	$500 copay/stay	Not covered	None
	Durable medical equipment	20% coinsurance	Not covered	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	$500 copay/stay for inpatient; no charge for outpatient	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 routine eye exam/24 months.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs - Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Hearing aids - 1 hearing aid per ear/36 months for children up to age 18.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition, artificial insemination, ovulation induction & advanced reproductive technology. Oocyte retrievals: 4/lifetime, if live birth 2 additional/lifetime.
- Routine eye care (Adult) - 1 routine eye exam/24 months.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Illinois Department of Insurance, Office of Consumer Health Insurance, 1-877-527-9431 toll free, 1-866-323-5321 (TDD), http://insurance.illinois.gov/.

- For more information on your rights to continue coverage, contact the plan at 1-888-982-3862.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-888-982-3862.
- Illinois Department of Insurance, Office of Consumer Health Insurance, 1-877-527-9431 toll free, 1-866-323-5321 (TDD), http://insurance.illinois.gov/.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa.

- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact Office of Consumer Health Insurance, Consumer Services Section, 122 South Michigan Avenue, 19th floor, Chicago, IL 60603, Or 320 W. Washington Street, Springfield, IL 62767-0001, 877-527-9431, 1-866-323-5321 (TDD), http://insurance.illinois.gov/

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*----------

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$25**
- **Hospital (facility) copayment** **$500**
- **Other copayment** **$0**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$660**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$25**
- **Hospital (facility) copayment** **$500**
- **Other copayment** **$0**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$25**
- **Hospital (facility) copayment** **$500**
- **Other copayment** **$0**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-888-982-3862.

The plan would be responsible for the other costs of these EXAMPLE covered services.

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Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not 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: 1-860-262-7705)

Email: CRCoordinator@aetna.com

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

TTY: 711

Language Assistance:

For language assistance in your language call 1-888-982-3862 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-888-982-3862 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني1-888-982-3862
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-982-3862 առանց գնով:
Bahasa-Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-888-982-3862 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-888-982-3862-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-982-3862 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-888-982-3862 sin gåstu.
Cherokee -	ᎾᏍᎩᎾ ᏕᏅᏂᏘᏍᏗ ᏗᏂᏍᏕᎵᏍᎩ ᎾᏍᎪ (ᏣᎳᎩ) ᏫᏓᎳᏫᎨᏍ 1-888-982-3862 ᎤᎾᎢ Ꮭ ᎪᎱᏍᏗ ᏧᎬᏩᎶᏗ ᏂᎨᏒᎾ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-888-982-3862，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-888-982-3862.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862.
French -	Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-982-3862 પર કૉલ કરો.

Hawaiian -	No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki ʻole ʻia kēia kōkua nei.
Hindi -	हिन्दी में भाषा सहायता के लिए, 1-888-982-3862 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-888-982-3862 na akwụghị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862.
Japanese -	日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。
Karen -	လၢတၢ်မၤစၢၤတၢ်ကတိၤကျိာ်အဂီၤ် ကျိာ် ကိး 1-888-982-3862 လၢတအိာ်ဒီးတၢ်လၢာ်ဘူာ်လၢာ်စုၤဘာ
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862 번으로 전화해 주십시오.
Kru-Bassa -	Ɓɛ́m`ké gbo-kpá-kpá dyé piɗyi ɖé Ɓaǎɔɔ̀-wuɖuǔn wɛ̃ɛ, ɖá 1-888-982-3862
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 به خۆرایی پەیوەندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ **1-888-982-3862** ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	तीलभाषा(मराठी)सहाय्यासाठी 1-888-982-3862 क्रमांकावरकोणत्याहीखर्चाशवियकॉलकरा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān.
Micronesian - Pohnpeyan	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-982-3862
Nepali -	(नेपाली) मा नःशुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-888-982-3862 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.

Persian -	برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.
Portuguese -	Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.
Romanian -	Pentru asistenţă lingvistică în românește telefonaţi la numărul gratuit 1-888-982-3862
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-982-3862.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-982-3862 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-982-3862.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-888-982-3862 Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-982-3862 bila malipo.
Syriac -	[illegible] 1-888-982-3862 [illegible].
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.
Telugu -	భాషతో సహాయం కొరకు ఎలాంటి ఖర్చు లేకుండా **1-888-982-3862** కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau ʻoku fiema'u hā tokoni ʻi he lea faka-Tonga telefoni 1-888-982-3862 ʻo ʻikai hā tōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-982-3862.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862.
Urdu -	ا ریرک ل گتف م رپ 1-888-982-3862 یعل یکتنو اعمین للل ریی م و در
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-888-982-3862.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-888-982-3862 פריי פון אפצאל.
Yoruba -	Fún ìrànlọ́wọ́ nípa èdè (Yorùbá) pe 1-888-982-3862 lái san owó kankan rárá.

NORTHWESTERN UNIVERSITY POSTDOCTORAL FELLOW BENEFIT PROGRAM

Supplemental Information **Coverage for:** Individual + Family | **Plan Type:** HMO

How is the overall deductible or out-of-pocket limit met?	Individual **deductible** and **out-of-pocket limit** payments apply to the family **deductible** and **out-of-pocket limit**.	The family **deductible** and family **out-of-pocket limit** are cumulative for all family members. The family **deductible** and **out-of-pocket limit** can be met by a combination of family members; however no single individual within the family will be subject to more than the individual **deductible** or **out-of-pocket limit** amount.

How your out-of-network care is reimbursed:

Your **plan** does not cover care you get outside of our **network**. Generally, we will not pay anything for that care. But your **plan** will pay for **emergency services** you receive from health care **providers** not in our **network**. Your cost sharing – **deductibles**, **coinsurance**, **copayments** – will be the same as if you got the care in-network. You are not responsible for paying anything else. If you get a bill for anything more, contact us.

Other important information about your plan:

This **plan** does not cover all health care expenses and includes exclusions and limitations. Members should refer to their **plan** documents to determine which health care services are covered and to what extent.

Additional information regarding your **plan** is available in the Disclosure Document on www.aetna.com.

Information includes:

- "Knowing what is covered" which describes how we review a request for coverage for a service or supply
- "**Prescription drug** benefit" which describes procedures we use to manage **prescription drug** benefits. These procedures include how to obtain a list of covered drugs and the exception policy for receiving coverage of a drug that is not on a closed formulary

Health benefits and **health insurance plans** are offered and/or underwritten by Aetna Health Inc., Aetna Health of California Inc., Aetna Health Insurance Company of New York, Aetna Health Insurance Company and/or Aetna Life Insurance Company (Aetna). In Florida, by Aetna Health Inc. and/or Aetna Life Insurance Company. In Maryland, by Aetna Health Inc., 151 Farmington Avenue, Hartford, CT 06156. Each insurer has sole financial responsibility for its own products. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and **health insurance plans** contain exclusions and limitations. Not all health services are covered.

See **plan** documents for a complete description of benefits, exclusions, limitations and conditions of coverage. **Plan** features and availability may vary by location and are subject to change. You may be responsible for the health care **provider's** full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the **plan**. **Providers** are independent contractors and are not agents of Aetna. **Provider** participation may change without notice. We do not provide care or guarantee access to health services.

NORTHWESTERN UNIVERSITY POSTDOCTORAL FELLOW BENEFIT PROGRAM

Supplemental Information

Coverage for: Individual + Family | **Plan Type:** HMO

The following is a partial list of services and supplies that are generally not covered. However, your **plan** documents may contain exceptions to this list based on state mandates or the **plan** design or rider(s) purchased by you or your employer.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your **plan** documents
- Donor egg retrieval
- Experimental and investigational procedures, except for coverage for **medically necessary** routine patient care costs for members participating in a cancer clinical trial with respect to the treatment of cancer or other life-threatening disease or condition
- Home births
- Immunizations for travel or work except where **medically necessary** or indicated
- Implantable drugs and certain injectable drugs including injectable infertility drugs
- Long-term rehabilitation therapy
- Non-**medically necessary** services or supplies
- Orthotics except diabetic orthotics
- Outpatient **prescription drugs** (except for treatment of diabetes), unless covered by a prescription **plan** rider and over-the-counter medications (except as provided in a hospital) and supplies
- Radial keratotomy or related procedures
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling or **prescription drugs**
- Therapy or rehabilitation other than those listed as covered

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

We consider your personal information to be private. We have policies and procedures in place to protect your personal information from unlawful use and disclosure. For a summary of our policy, go to www.aetna.com. You'll find the Privacy Notices link at the bottom of the page.

Plan features and availability may vary by location and group size.

Colorado Supplement to the Summary of Benefits and Coverage Form

INSURANCE COMPANY NAME	Aetna Health Inc.
NAME OF PLAN	HMO - IL
1. Type of Policy	Large Employer Group Policy
2. Type of Plan	Health maintenance organization (HMO)
3. Areas of Colorado Where Plan is Available	Plan is available only in the following areas: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Elbert, Fremont, Jefferson, Larimer, Mesa, Pueblo, Teller, Weld.

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Note: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits and Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

	Description
4. Annual Deductible Type	EMBEDDED DEDUCTIBLE INDIVIDUAL: The amount that each member of the family must meet prior to claims being paid. Claims will not be paid for any other individual until their individual deductible or the family deductible has been met. FAMILY: The maximum amount that the family will pay for the year. The family deductible can be met by 2 or more individuals.
5. Out-of-Pocket Type	EMBEDDED OUT-OF-POCKET INDIVIDUAL: The amount that each member of the family must meet prior to claims being paid at 100%. Claims will not be paid at 100% for any other individual until their individual out-of-pocket or the family out-of-pocket has been met. FAMILY: The maximum amount that the family will pay for the year. The family out-of-pocket can be met by 2 or more individuals.
6. What is included in the In-Network Out-of-Pocket Maximum?	Deductible, copayments, coinsurance
7. Is pediatric dental coverage included in this plan?	No, the plan does not include pediatric dental.
8. What cancer screenings are covered?	Prostate Cancer Screening, Cervical Cancer Screening, Breast Cancer Screening, Colorectal Cancer Screening – age and frequency schedules may apply.

USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
9. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, refer to your certificate of coverage for details.
10. Does the plan have a binding arbitration clause?	No	

Questions: Call 1-888-982-3862, TDD 1-800-628-3323 (hearing impaired only) or visit www.Aetna.com.

If you are not satisfied with the resolution of your complaint or grievance, contact: Colorado Division of Insurance
Consumer Services, Life and Health Section
1560 Broadway, Suite 850, Denver, CO 80202
Call 303-894-7490 (in state, toll free: 800-930-3745)
Email: dora_insurance@state.co.us

Colorado Network Access Plan Disclosure:
Aetna maintains and makes available to interested parties upon request a managed care network access plan on its business premises. The managed care network access plan demonstrates the managed care network contains an adequate number of accessible acute care hospitals, primary care providers, and specialists available to provide covered health care services. Among other things, the access plan describes Aetna's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of plan enrollees.

This document is available in other languages. Do you need this in another language? Call us.
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-888-982-3862.

Si necesita asistencia lingüistica en español, llámenos al número que figura en su tarjeta de identificación (ID) médica.
Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-888-982-3862.

NOTICE OF CERTAIN MANDATORY BENEFITS — Texas

In compliance with State of Texas laws, we are pleased to provide you with the following notice about your health care coverage.

If any person covered by this plan has questions concerning the below information, please contact us. Our phone number and mailing address are on your member ID card.

Need inpatient care for a mastectomy or lymph node dissection?

Minimum inpatient stay: If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:

(a) 48 hours following a mastectomy, and

(b) 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the covered person receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not (a) deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours; (b) provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours; (c) reduce or limit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a covered person to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

Do you have questions about your coverage and/or benefits for reconstructive surgery after mastectomy?

Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including:

(a) all stages of the reconstruction of the breast on which mastectomy has been performed;

(b) surgery and reconstruction of the other breast to achieve a symmetrical appearance; and

(c) prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the covered person and the attending physician.

Prohibitions: We may not (a) offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or (c) reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits shown above.

Do you need an exam for detection of prostate cancer?

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

(a) a physical examination for the detection of prostate cancer; and

(b) a prostate-specific antigen test for each covered male who is

(1) at least 50 years of age; or

(2) at least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

Are you planning to have a baby?

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

(a) 48 hours following an uncomplicated vaginal delivery, and

(b) 96 hours following an uncomplicated delivery by cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to (a) give birth in a hospital or other health care facility or (b) remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse or other appropriate licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

Since we provide in-home post-delivery care, we are not required to provide the minimum number of hours outlined above unless (a) the mother's or child's physician determines the inpatient care is medically necessary or (b) the mother requests the inpatient stay.

Prohibitions: We may not (a) modify the terms of this coverage based on any covered person requesting less than the minimum coverage required; (b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements below the usual and customary rate; or (e) penalize a physician for recommending inpatient care for the mother and/or the newborn child.

Did you know you have coverage for tests to detect colorectal cancer?

Benefits are provided for each person enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer. These benefits provide for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include the covered person's choice of:

(a) a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years, or

(b) a colonoscopy performed every 10 years.

Did you know you have coverage for tests to detect the human papillomavirus (HPV), ovarian cancer and cervical cancer?

Coverage is provided for each woman enrolled in the plan who is 18 years of age or older for expenses incurred for an annual medically recognized diagnostic examination for the early detection of ovarian and cervical cancer. Coverage required under this section includes a CA 125 blood test and, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the FDA, alone or in combination with a test approved by the FDA for the detection of the human papillomavirus.

Did you know your plan may cover acquired brain injury services?

Your health benefit plan coverage for an acquired brain injury includes the following services when they are medically necessary:

- Cognitive rehabilitation therapy
- Cognitive communication therapy
- Neurocognitive therapy and rehabilitation
- Neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing and treatment
- Neurofeedback therapy and remediation
- Post-acute transition services and community reintegration services, including outpatient day treatment services or other post-acute-care treatment services
- Reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date, at which time the cognitive rehabilitation services would be a covered benefit.

The fact that an acquired brain injury does not result in hospitalization or acute-care treatment does not affect the right of the insured or the enrollee to receive the preceding treatments or services commensurate with their condition.

Post-acute-care treatment or services may be obtained in any facility where those services may legally be provided, including acute or post-acute rehabilitation hospitals and assisted living facilities regulated under the Health and Safety Code.

You may obtain additional information from the Texas Department of Insurance regarding your rights by contacting them. Their website is **tdi.texas.gov**. Their toll-free telephone number is **1-800-252-3439**. Their address is 333 Guadalupe Street, Austin, TX 78701.

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