Aetna Student Health℠
Major Medical Outline of Coverage

Preferred Provider Organization (PPO)

University of Pennsylvania

Policy Year: 2025 – 2026
Policy Number: 724535
https://www.aetnastudenthealth.com
(800) 841-5374

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

Notice: This health insurance policy may not cover all your health care expenses. Read your member certificate carefully to determine which health care services are covered.

Wellness at the University of Pennsylvania

Wellness at Penn is dedicated to caring for students during their academic journey while creating a campus-wide community of care. Our team is committed to offering a wide range of opportunities to access support, clinical resources, education, and practical tools to meaningfully engage with one's health and wellbeing.

All full-time and dissertation-status students, and exchange students here for a semester or more, must carry comprehensive health insurance as a condition of student enrollment at the University of Pennsylvania. The Penn Student Insurance Plan (PSIP) through Aetna Student Health meets Penn's insurance requirements. For students in most graduate and professional programs, the cost of the health insurance plan is already incorporated into the cost-of-attendance budget used for purposes of financial aid and student loan eligibility. All students who enroll in PSIP will be charged the clinical fee in order to access Student Health and Counseling's services as your primary care provider.

Student Health and Counseling is the primary care and psychological care division of Wellness at Penn. Our state-of-the-art medical and counseling centers are designed to provide high-quality, compassionate care for undergraduate, graduate, and professional students during their academic journey.

For more information, call the Student Health and Counseling at (215) 746-WELL (9355) or visit our website at **https://wellness.upenn.edu.**

In the event of an emergency, call 911 or the Campus Police at (215) 573-3333 or **511** from campus phone.

Coverage Periods

Students: Coverage for all insured students enrolled in the Plan for the following Coverage Periods. Coverage will become effective at 12:01 AM (EST) on the Coverage Start Date indicated below and will terminate at 11:59 PM (EST) on the Coverage End Date indicated.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	08/01/2025	07/31/2026	08/31/2025
Spring	01/01/2026	07/31/2026	01/31/2026
Summer	05/01/2026	07/31/2026	05/31/2026

Eligible Dependents: Coverage for dependents eligible under the Plan for the following Coverage Periods. Coverage will, will become effective at 12:01 AM (EST) on the Coverage Start Date indicated below, and will terminate at 11:59 PM (EST) on the Coverage End Date indicated. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Master Policy.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment Deadline
Annual	08/01/2025	07/31/2026	08/31/2025
Spring	01/01/2026	07/31/2026	01/31/2026
Summer	05/01/2026	07/31/2026	05/31/2026

December Graduates: If you are a December Graduate and not are returning for another program in the spring term, your coverage will terminate at 11:59 p.m. (EST) on **January 31, 2026**. If you have enrolled dependents, their coverage will terminate in conjunction with your own.

Students on Leave of Absence, or who drop or withdraw from the University after the first 31 days of classes: Your coverage will terminate at 11:59 p.m. (EST) on **January 31, 2026,** unless you enroll in classes in the spring term by **January 31, 2026**. If you have enrolled dependents, their coverage will terminate in conjunction with your own. After enrollment, students may only add a spouse, child, or a domestic partner according to the Spouse/Domestic Partner and Newborn and Adopted Children Enrollment guidelines.

Termination and Refunds

Withdrawal from Classes – Other than Leave of Absence:

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

Rates

Rates Undergraduates, Graduate and Professional Students

	Annual	Spring Semester	Summer Semester
Student	$4,662	$2,708	$1,175
Spouse	$4,662	$2,708	$1,175
One Child	$4,662	$2,708	$1,175
Two or more children	$9,324	$5,416	$2,350

Student Coverage

Who is eligible?

You are eligible if you are a:

- Part-time student in degree or certification seeking programs
- Full-time student
- All students of the University who are registered and are actively participating in credit courses leading to a degree or a certificate are eligible to participate in the Penn Student Insurance Plan (PSIP). Students in online classes should check with their department.

NOTE: **English Language Program (ELP) students are not eligible for PSIP and should contact their Program Director for other options**.
You must actively attend classes for at least the first 31 days after the date your coverage becomes effective. You cannot meet this eligibility requirement if you take courses through:

- Home study
- Correspondence
- Television (TV)

Enrollment

Eligible students can enroll online at **https://studenthealth.bgenroll.com/home** then click on Enroll to complete application. **Your PennKey and Password authentication is required. For details, please go to http://www.upenn.edu/computing/pennkey/**.

Each school year, all full-time, dissertation and exchange students here for one semester or more must either enroll in PSIP or waive coverage with proof of comparable coverage by the stated deadline. Selections from previous years are not rolled forward or renewed. Students who do not enroll or waive participation in the Plan by the stated deadline will be subject to default enrollment in PSIP with student coverage only. Dependents are not default enrolled. Part-time students in degree or certification seeking programs are eligible to purchase this coverage as well; however, they are not default enrolled in the Plan. Students who wish PSIP coverage are required to actively enroll online to ensure continuation of insurance benefit without disruption and to guarantee coverage in the event that their student registration status changes. Eligible students can enroll online at **https://studenthealth.bgenroll.com** during the designated open enrollment period. Follow the links to the enrollment site). You must have your PennKey to access the system.

Late Enrollment

Coverage for late enrollees may be possible only under certain conditions. After the enrollment deadline, only those students who have involuntarily lost health insurance coverage through a "Qualifying Life Event" such as 1) removal from parent's health insurance coverage after achieving a landmark birthday that disqualifies them from a parent's health insurance plan or 2) losing private health insurance through loss of employment or divorce, may apply for late enrollment. A certificate of credible coverage stating the date of the involuntary loss of health coverage and a signed application must be submitted to the Student Health Insurance Office within 31 days of the qualifying life event. Please contact the Wellness at Penn Insurance Navigators at **(215) 746-WELL (9355)**, for details.

Dependent Coverage

Eligibility

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

Enrollment

To enroll the dependent(s) of a covered student, please complete the Enrollment Form by visiting **https://www.aetnastudenthealth.com/upenn** and clicking on the "Enroll" link on the left hand side of the screen, or by calling customer service at **(800) 841-5374** and requesting that an Enrollment Form be sent in the mail. Please refer to the Coverage Periods section of this document for coverage dates and deadline dates. Dependent enrollment applications will not be accepted after the enrollment deadline, unless there is a significant life change that directly affects their insurance coverage. (An example of a significant life change would be loss of health coverage under another health plan). The completed Enrollment Form and premium must be sent to Aetna Student Health.

If, while you are covered by this plan, you have a covered dependent child who is called up for active duty (state National Guard or reserves) while he or she is a full-time student, Aetna Student Health will extend this child's coverage upon his or her return until you are no longer covered by this plan. This dependent coverage will be available at the first Fall or Spring enrollment period after the dependent child has 1) returned from duty and 2) returned to full time student status. The offered coverage for this dependent child will continue until A) you are no longer a student covered by this plan; or B) the dependent child is no longer a full-time student ***or*** a period of time equal to the duration of the child's military duty has passed.

Important note regarding coverage for a newborn infant or newly adopted child:

Newborn child

Your newborn child is covered on your health plan for the first 31 days from the moment of birth.

- To keep your newborn covered, you must notify us (or our agent) of the birth and pay any required premium contribution during that 31-day period.
- You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional premium contribution for the newborn.
- If you miss this deadline, your newborn will not have health benefits after the first 31 days.
- If your coverage ends during this 31-day period, then your newborn's coverage will end on the same date as your coverage. This applies even if the 31-day period has not ended.

Adopted child or a child legally placed with you for adoption

A child that you, or that you and your spouse or domestic partner adopts or is placed with you for adoption, is covered on your plan for the first 31 days after the adoption or the placement is complete.

- To keep your child covered, we must receive your completed enrollment information within 31 days after the adoption or placement for adoption.
- You must still enroll the child within 31 days of the adoption or placement for adoption even when coverage does not require payment of an additional premium contribution for the child.
- If you miss this deadline, your adopted child or child placed with you for adoption will not have health benefits after the first 31 days.
- If your coverage ends during this 31-day period, then coverage for your adopted child or child placed with you for adoption will end on the same date as your coverage. This applies even if the 31-day period has not ended.

Dependent coverage due to a court order

If you must provide coverage to a dependent because of a court order, your dependent is covered on your health plan for the first 31 days from the court order.

- To keep your dependent covered, we must receive your completed enrollment information within 31 days of the court order.
- You must still enroll the dependent within 31 days of the court order even when coverage does not require payment of an additional premium contribution for the dependent.
- If you miss this deadline, your dependent will not have health benefits after the first 31days.
- If your coverage ends during this 31-day period, then your dependent's coverage will end on the same date as your coverage. This applies even if the 31-day period has not ended.

If you need information or have general questions on dependent enrollment, call Member Services at **(800) 841-5374**.

Medicare Eligibility Notice

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

In-network Provider Network

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

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

Access our provider directory to find in-network providers for your plan at https://www.aetnastudenthealth.com.

Precertification

You need pre-approval from us for some eligible health services. Pre-approval is also called precertification. Your in-network physician is responsible for obtaining any necessary precertification before you get the care. When you go to an out-of-network provider, it is your responsibility to obtain precertification from us for any services and supplies on the precertification list. If you do not precertify when required, there is a **$500** penalty for each type of eligible health service that was not precertified. For a current listing of the health services or prescription drugs that require precertification, contact Member Services or go to **https://www.aetnastudenthealth.com**.

Precertification Call

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

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

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

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

Coordination of Benefits (COB)

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

Description of Benefits

The Plan excludes coverage for certain services and has limitations on the amounts it will pay. While this Plan Summary document will tell you about some of the important features of the Plan, other features that may be important to you are defined in the Certificate. To look at the full Plan description, which is contained in the Certificate issued to you, go to **https://www.aetnastudenthealth.com**.

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

	In-network coverage	Out-of-network coverage
Policy year deductibles		
You have to meet your policy year deductible before this plan pays for benefits.		
Student	$400 per policy year	$1,500 per policy year
Spouse	$400 per policy year	$1,500 per policy year
Each child	$400 per policy year	$1,500 per policy year
This is the amount you owe for in-network and out-of-network eligible health services each policy year before the plan begins to pay for eligible health services. This policy year deductible applies separately to you and each of your covered dependents. After the amount you pay for eligible health services reaches the policy year deductible, this plan will begin to pay for eligible health services for the rest of the policy year.		
Policy year deductible waiver		
The policy year deductible is waived for all of the following eligible health services: • In-network care for Preventive care and wellness • In-network care for Family planning services - female contraceptives • In-network care and out-of-network care for Cervical Cytologic Screenings • In-network care and out-of-network care for Immunization Services • In-network care and out-of-network care for Nutritional Supplement Services • In-network care and out-of-network care for Emergency Room Expense • In-network care and out-of-network care for Emergency ground, air, and water ambulance • In-network care and out-of-network care for Prescribed Medicines Expense • In-network care and out-of-network care for Adult Vision Care Exam Expense and Adult vision care services and supplies - Eyeglass frames, prescription lenses or prescription contact lenses • In-network care and out-of-network care for Diagnostic Testing For Learning Disabilities Expense • In-network care and out-of-network care for Treatment of Mental and Nervous Disorders Expense (inpatient and outpatient) • In-network care and out-of-network care for Alcoholism and Drug Addiction Treatment Expense (inpatient and outpatient) • In-network care for Pediatric Preventive Dental Services • In-network care and out-of-network care for Pediatric Vision Services • Newborn services for the first 31 days from birth		
Eligible health services applied to the out-of-network policy year deductibles will not be applied to satisfy the in-network policy year deductibles. Eligible health services applied to the in-network policy year deductibles will not be applied to satisfy the out-of-network policy year deductibles.		

Maximum out-of-pocket limits		
	In-network coverage	**Out-of-network coverage**
Student	$1,500 per policy year	$4,000 per policy year
Spouse	$1,500 per policy year	$4,000 per policy year
Each child	$1,500 per policy year	$4,000 per policy year
Family	$3,000 per policy year	$8,000 per policy year
Eligible health services applied to the out-of-network maximum out-of-pocket limit will not be applied to satisfy the in-network maximum out-of-pocket limit and eligible health services applied to the in-network maximum out-of-pocket limit will not be applied to satisfy the out-of-network maximum out-of-pocket limit.		

Referral penalty

You must get a referral from school health services for off-campus care.

If you do not get a referral, then we will pay covered benefits at the out-of-network coverage cost sharing.

Exceptions:

- Treatment for an emergency medical condition.
- Obstetric and gynecological treatment.
- Pediatric care.
- The covered student is more than 25 miles away from the school health services.
- The school health services is closed.
- Annual Eye Exam and Adult vision care services and supplies
- Injury to sound natural teeth or the extraction of impacted wisdom teeth
- Mental Health and Substance Abuse
- Women's Health and Voluntary Termination of Pregnancy
- Students on Leave of Absence
- Preventive/Routine Services (services considered preventive according to Health Care Reform and/or services rendered not to diagnose or treat an Accident or Sickness
- Outpatient lab services

Your **covered dependents** do not use the **school health services** for care, so they don’t need to get **referrals**.

Eligible health services	In-network coverage	Out-of-network coverage
Routine physical exams		
Routine physical exams	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (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 in to your Aetna website at https://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		
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	70% (of the recognized charge) per visit No policy year deductible applies
Preventive care immunization 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 in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
The following is not covered under this benefit: • Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment.		
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	70% (of the recognized charge) per visit
Well woman routine gynecological exam maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	
Maximum visits per policy year	1 visit	

Eligible health services	In-network coverage	Out-of-network coverage
Preventive screening and counseling services In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		
Preventive screening and counseling office visits for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, and Tobacco Products	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Obesity and/or healthy diet counseling - Maximum visits	Age 0-22: unlimited visits. Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	
Misuse of alcohol and/or drugs counseling - Maximum visits per policy year	5 visits	
Use of tobacco products counseling - Maximum visits per policy year	8 visits	
Preventive screening and counseling office visits for Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Sexually transmitted infection counseling - Maximum visits per policy year	2 visits	
Genetic risk counseling for breast and ovarian cancer limitations	Not subject to any age or frequency limitations	
Routine cancer screenings	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Routine cancer screening maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF • Comprehensive guidelines supported by the Health Resources and Services Administration For details, contact your physician or Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Lung cancer screening maximums	1 screening every 12 months	
Prenatal care services (Preventive care services only)	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Preventive screening and counseling services (continued) In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		
Lactation counseling services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits	
Breast pump supplies and accessories	100% (of the negotiated charge) per item No copayment or policy year deductible applies	70% (of the recognized charge) per item
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	70% (of the recognized charge) per visit
Contraceptive counseling services maximum visits per policy year either in a group or individual setting	2 visits	
Female contraceptive prescription drugs and devices provided, administered, or removed, by a provider during an office visit	100% (of the negotiated charge) per item No copayment or policy year deductible applies	70% (of the recognized charge) per item
Female Voluntary sterilization - Inpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	70% (of the recognized charge)
Female Voluntary sterilization - Outpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	70% (of the recognized charge)
The following are not covered under this benefit: • Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care • Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA • Male contraceptive methods, sterilization procedures or devices, except for male condoms prescribed by a provider		

Eligible health services	In-network coverage	Out-of-network coverage
Physicians and other health professionals		
Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist) Includes telemedicine consultations	$35 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	70% (of the recognized charge) per visit
Allergy testing and treatment		
Allergy testing performed at a physician's or specialist's office	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
Allergy injections treatment performed at a physician's or specialist's office	$35 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	70% (of the recognized charge) per visit
Allergy sera and extracts administered via injection at a physician's or specialist's office	$35 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	70% (of the recognized charge) per visit
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Physician and specialist surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon	$100 copayment then the plan pays 100% (of the balance of the negotiated charge)	70% (of the recognized charge)
Anesthetist Expense	100% (of the negotiated charge)	70% (of the recognized charge)
Assistant Surgeon Expense	100% (of the negotiated charge)	70% (of the recognized charge)
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section) • Services of another physician for the administration of a local anesthetic		
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon	$100 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	70% (of the recognized charge) per visit
Anesthetist Expense	100% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Assistant Surgeon Expense	100% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic		
Alternatives to physician office visits		
Walk-in clinic visits (non-emergency visit)	$35 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	70% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Hospital and other facility care		
Inpatient hospital (room & board, including intensive care and other miscellaneous services and supplies) Includes birthing center facility charges	$100 copayment then the plan pays 100% (of the balance of the negotiated charge) per admission	$100 copayment then the plan pays 70% (of the balance of the recognized charge) per admission
The following are not eligible health services: • All services and supplies provided in: - Rest homes - Any place considered a person's main residence or providing mainly custodial or rest care - Health resorts - Spas - Schools or camps		
In-hospital non-surgical physician services	100% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
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) performed in the outpatient department of a hospital or surgery center	$100 copayment then the plan pays 100% (of the balance of the negotiated charge)	70% (of the recognized charge)
The following are not covered under this benefit: • A stay in a hospital (See the *Hospital care – facility charges* benefit in this section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic		
Home Health Care	100% (of the negotiated charge) per visit	100% (of the recognized charge) per visit
Home health care maximum visits per policy year	60 visits	
The following are not covered under this benefit: • Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work, or recreational activities) • Transportation • Homemaker or housekeeper services • Food or home delivered services • Maintenance therapy		

Eligible health services	In-network coverage	Out-of-network coverage
Alternatives to hospital stays (continued)		
Hospice - Inpatient	100% (of the negotiated charge) per admission	70% (of the recognized charge) per admission
Hospice - Outpatient	100% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Respite care-maximum number of days	7 days per 30-day period	
The following are not covered under this benefit: • Funeral arrangements • Pastoral counseling • Bereavement counseling • Financial or legal counseling which includes estate planning and the drafting of a will • Homemaker or caretaker services that are services which are not solely related to your care and may include: - Sitter or companion services for either you or other family members - Transportation - Maintenance of the house		
Skilled nursing facility - Inpatient	$100 copayment then the plan pays 100% (of the balance of the negotiated charge) per admission	$100 copayment then the plan pays 70% (of the balance of the recognized charge) per admission
Emergency services and urgent care		
Emergency room	$100 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	Paid the same as in-network coverage
Non-emergency care in an emergency room	Not covered	Not covered

Emergency services important note:

- Out-of-network providers do not have a contract with us. The provider may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by the 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 your ID card or call Member Services for an address at 1-800-841-5374 and we will resolve any payment issue with the provider. Make sure the member ID is on the bill.
- A separate emergency room copayment 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 will be waived and your inpatient copayment will apply.
- Covered benefits that are applied to the emergency room copayment cannot be applied to any other copayment under the plan. Likewise, a copayment that applies to other covered benefits under the plan cannot be applied to the emergency room copayment.
- Separate copayment amounts may apply for certain services given to you in the emergency room that are not part of the emergency room benefit. These copayment amounts may be different from the emergency room copayment. They are based on the specific service given to you.
- Services given to you in the emergency room that are not part of the emergency room benefit may be subject to copayment amounts that are different from the emergency room copayment amounts.

Eligible health services	In-network coverage	Out-of-network coverage
Emergency services and urgent care (continued)		
The following are not covered under this benefit: • Non-emergency services in a hospital emergency room or and independent freestanding emergency medical department.		
Urgent care	$35 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	70% (of the recognized charge) per visit
Non-urgent use of an urgent care provider	Not covered	Not covered
The following is not covered under this benefit: • Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)		
Eligible health services	**Contracting dental provider coverage**	**Non-contracting dental provider 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	80% (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	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
Pediatric dental care exclusions These dental exclusions are in addition to the exclusions that apply to health coverage. The following are not covered under this benefit: • Any instruction for diet, plaque control and oral hygiene ***(continued on next page)***		

Eligible health services	In-network coverage	Out-of-network coverage

Pediatric dental care exclusions (continued)

These dental exclusions are in addition to the exclusions that apply to health coverage.

The following are not covered under this benefit:

- Cosmetic services and supplies including:
  - Plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance
  - Augmentation and vestibuloplasty, and other substances to protect, clean, whiten, bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons, except to the extent coverage is specifically provided in the *Eligible health services and exclusions* section
  - Facings on molar crowns and pontics will always be considered cosmetic
- Crown, inlays, onlays, and veneers unless:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants and braces (that are determined not to be medically necessary), mouth guards, and other devices to protect, replace or reposition teeth
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of:
  - Splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint dysfunction disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Eligible health services and exclusions – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another eligible health service
- Orthodontic treatment except as covered above and in the *Pediatric dental care* section of the schedule of benefits
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication, or analgesia (nitrous oxide)
- Replacement of a device or appliance that is lost, missing, or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Routine dental exams and other preventive services and supplies, except as specifically provided in the *Pediatric dental care* section of the schedule of benefits
- Services and supplies:
  - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
  - Provided for your personal comfort or convenience or the convenience of another person, including a provider
  - Provided in connection with treatment or care that is not covered under your policy
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a dental provider

Eligible health services	In-network coverage	Out-of-network coverage
Specific conditions		
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Podiatric (foot care) treatment - Physician and specialist non-routine foot care treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Services and supplies for: - The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies - Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet		
Impacted wisdom teeth	90% (of the negotiated charge)	90% (of the recognized charge)
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Specific conditions (continued)		
Accidental injury to sound natural teeth	90% (of the negotiated charge)	90% (of the recognized charge)
The following are not covered under this benefit: • The care, filling, removal or replacement of teeth and treatment of diseases of the teeth • Dental services related to the gums • Apicoectomy (dental root resection) • Orthodontics • Root canal treatment • Soft tissue impactions • Bony impacted teeth • Alveolectomy • Augmentation and vestibuloplasty treatment of periodontal disease • False teeth • Prosthetic restoration of dental implants • Dental implants		
Blood and body fluid exposure	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 health services	In-network coverage	Out-of-network coverage
Clinical trials		
Routine patient costs	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not eligible health services: • Services and supplies related to data collection and record-keeping needed only for the clinical trial • Services and supplies provided by the trial sponsor for free • The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with our policies		
Dermatological treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Cosmetic treatment and procedures		
Maternity care (includes delivery and postpartum care services in a hospital or birthing center)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries		
Well newborn nursery care in a hospital or birthing center	100% (of the negotiated charge) No policy year deductible applies	70% (of the recognized charge) No policy year deductible applies
Family planning services – other		
Voluntary sterilization for males - Inpatient physician or specialist surgical services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Voluntary sterilization for males - Outpatient physician or specialist surgical services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Reversal of voluntary sterilization procedures, including related follow-up care • Services provided as a result of complications resulting from a male voluntary sterilization procedure and related follow-up care		
Gender affirming treatment		
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Eligible health services	In-network coverage	Out-of-network coverage
Gender affirming additional services		
Reduction thyroid chondroplasty (tracheal shave)	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
Electrolysis, laser hair removal	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
Nipple reconstruction	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
Voice and communication therapy, voice lessons	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
Chest binders	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
Blepharoplasty	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
Brow lift	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
Cheek implants	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
Chin implants	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
Facial bone reduction or augmentation	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
Forehead lift	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
Hair transplantation	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
Lip enhancement or reduction	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
Rhinoplasty or nose implants	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 health services	In-network coverage	Out-of-network coverage
Gender affirming additional services (continued)		
Rhytidectomy (face lift, facial liposuction, neck tightening)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not eligible health services under this benefit: • Any treatment, surgery, service or supply that is not in the list above of eligible health services		
Autism spectrum disorder		
Autism spectrum disorder treatment, diagnosis and testing. Includes Applied behavior analysis and Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	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
Mental Health & Substance related disorders		
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	$100 copayment then the plan pays 100% (of the balance of the negotiated charge) per admission No policy year deductible applies	70% (of the recognized charge) per admission No policy year deductible applies
Outpatient office visits (includes telemedicine consultations)	$10 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	70% (of the recognized charge) per visit No policy year deductible applies
Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)	100% (of the negotiated charge) per visit No policy year deductible applies	70% (of the recognized charge) per visit No policy year deductible applies

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

Eligible health services	In-network coverage	Out-of-network coverage
Infertility services		
Treatment of basic infertility	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Limited infertility services - Inpatient and outpatient care	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Advanced reproductive technology (ART) services - Inpatient and outpatient care	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Infertility services exclusions

The following are not covered under the infertility services benefit:

- Infertility medication. See the *Eligible health services and exclusions-Outpatient prescription drugs* section for information on coverage of infertility prescription drugs.
- Cryopreservation (freezing) and storage of eggs, embryos, sperm, or reproductive tissue.
- Thawing of cryopreserved (frozen) eggs, sperm, or reproductive tissue.
- The donor's care in a donor egg cycle. This includes, but is not limited to, screening fees, lab test fees and charges associated with donor care as part of donor egg retrievals or transfers.
- A gestational carrier's care, including transfer of the embryo to the carrier. A gestational carrier is a woman who has a fertilized egg from another woman placed in her uterus and who carries the resulting pregnancy on behalf of another person.
- Infertility medication not injected by your provider, including but not limited to menotropins, hCG, and GnRH agonists. See the *Eligible health services and exclusions-Outpatient prescription drugs* section for information on coverage of infertility prescription drugs.
- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor eggs or donor sperm.
- Obtaining sperm from a person not covered under this plan.
- Infertility treatment when a successful pregnancy could have been obtained through less costly treatment.
- Infertility treatment when either partner has had voluntary sterilization surgery, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- Infertility treatment when infertility is due to a natural physiologic process such as age-related ovarian insufficiency (e.g., perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period or other abnormal testing results as outlined in Aetna's infertility clinical policy.
- Treatment for dependent children.

Eligible health services	In-network coverage	Out-of-network coverage
Specific therapies and tests		
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	$50 copayment then the plan pays 100% (of the balance of the negotiated charge)	70% (of the recognized charge)
Diagnostic lab work and radiological services performed in a physician's office, the outpatient department of a hospital or other facility	$35 copayment then the plan pays 100% (of the balance of the negotiated charge)	70% (of the recognized charge)
Outpatient Chemotherapy, Radiation & Respiratory Therapy	100% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Outpatient infusion therapy performed in a covered person's home, physician's office, outpatient department of a hospital or other facility	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan • Enteral nutrition • Blood transfusions and blood products • Dialysis		
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy) Combined for short-term rehabilitation services and habilitation therapy services	$35 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	70% (of the recognized charge) per visit
Chiropractic services	$35 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	70% (of the recognized charge) per visit
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
Ambulance Service		
Emergency ground, air, and water ambulance	$100 copayment then the plan pays 100% (of the balance of the negotiated charge) per trip No policy year deductible applies	Paid the same as in-network coverage
The following are not covered under this benefit: • Ambulance services for routine transportation to receive outpatient or inpatient services		

Eligible health services	In-network coverage	Out-of-network coverage
Other services		
Durable medical and surgical equipment	90% (of the negotiated charge) per item	60% (of the recognized charge) per item
The following are not covered under this benefit: • Whirlpools • Portable whirlpool pumps • Sauna baths • Massage devices • Over bed tables • Elevators • Communication aids • Vision aids • Telephone alert systems • Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician		
Nutritional support	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition		
Prosthetic Devices	90% (of the negotiated charge) per item	60% (of the recognized charge) per item
The following are not covered under this benefit: • Services covered under any other benefit • Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace • Trusses, corsets, and other support items • Repair and replacement due to loss, misuse, abuse or theft • Communication aids • Cochlear implants		
Hearing aids and exams		
Hearing exam	$35 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	70% (of the recognized charge) per visit
Hearing exam maximum	1 hearing exam every **policy year**	
The following are not covered under this benefit: • Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay		

Eligible health services	In-network coverage	Out-of-network coverage
Hearing aids and exams (continued)		
Hearing aids	90% (of the negotiated charge) per item	60% (of the recognized charge) per item
Hearing aids maximum per ear	One hearing aid per ear every policy year	
The following are not covered under this benefit: • A replacement of: - A hearing aid that is lost, stolen or broken - A hearing aid installed within the prior 12-month period • Replacement parts or repairs for a hearing aid • Batteries or cords • Cochlear implants • A hearing aid that does not meet the specifications prescribed for correction of hearing loss • Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist		
Pediatric vision care Limited to covered persons through the end of the month in which the person turns age 19.		
Pediatric routine vision exams (including refraction) performed by a legally qualified ophthalmologist or optometrist (includes comprehensive low vision evaluations)	100% (of the negotiated charge) per visit No policy year deductible applies	80% (of the recognized charge) per visit No policy year deductible applies
Maximum visits per policy year Low vision Maximum Fitting of contact Maximum	1 visit One comprehensive low vision evaluation every policy year 1 visit	
Pediatric vision care services & supplies-Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per item No policy year deductible applies	80% (of the recognized charge) per item No policy year deductible applies
Maximum number Per year: Eyeglass frames Prescription lenses Contact lenses (includes non-conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery)	One set of eyeglass frames One pair of prescription lenses Daily disposables: up to 3-month supply Extended wear disposable: up to 6-month supply Non-disposable lenses: one set	
Optical devices	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Maximum number of optical devices per policy year	One optical device	
***Important note**: Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.		
The following are not covered under this benefit: • Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes		

Eligible health services	In-network coverage	Out-of-network coverage
Adult vision care - Limited to covered persons age 19 over		
Adult routine vision exams (including refraction) performed by a legally qualified ophthalmologist or therapeutic optometrist, or any other providers acting within the scope of their license	90% (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	
Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per item No policy year deductible applies	100% (of the recognized charge) per visit No policy year deductible applies
Maximum per policy year eyeglass frames, prescription lenses or prescription contact lenses	$125	

***Important note**:
Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies. Coverage does not include the office visit for the fitting of prescription contact lenses.

The following are not covered under this benefit:
Adult vision care
- Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses
- Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes

Adult vision care services and supplies
- Special supplies such as non-prescription sunglasses
- Special vision procedures, such as orthoptics or vision therapy
- Eye exams during your stay in a hospital or other facility for health care
- Eye exams for contact lenses or their fitting
- Replacement of lenses or frames that are lost or stolen or broken
- Acuity tests
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures
- Services to treat errors of refraction

Outpatient prescription drugs		
Copayment/coinsurance waiver for risk reducing breast cancer drugs		
The outpatient prescription drug copayment/coinsurance will not apply to risk reducing breast cancer prescription drugs filled at a retail or mail order in-network pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.		
Copayment waiver for tobacco cessation prescription and over-the-counter drugs		
The outpatient prescription drug copayment 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 outpatient prescription drug copayment will apply after those two regimens per policy year have been exhausted.		
Copayment waiver for contraceptives		
The outpatient prescription drug copayment 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%. The outpatient prescription drug copayment will continue to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at an in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.		
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Preferred generic prescription drugs (including specialty drugs)		
For each fill up to a 30-day supply filled at a retail pharmacy	$20 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$20 copayment per supply then the plan pays 100% (of the balance 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 retail pharmacy	$60 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
More than a 30-day supply but less than a 91-day supply filled at a mail order pharmacy	$60 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient prescription drugs (continued)		
Preferred brand-name prescription drugs (including specialty drugs)		
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 balance of the negotiated charge) No policy year deductible applies	$50 copayment per supply then the plan pays 100% (of the balance 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 retail pharmacy	$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
More than a 30-day supply but less than a 91-day supply filled at a mail order pharmacy	$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
Non-preferred generic prescription drugs (including specialty drugs)		
For each fill up to a 30-day supply filled at a retail pharmacy	$20 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$20 copayment per supply then the plan pays 100% (of the balance 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 retail pharmacy	$60 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
More than a 30-day supply but less than a 91-day supply filled at a mail order pharmacy	$60 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
Non-preferred brand-name prescription drugs (including specialty drugs)		
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 balance of the negotiated charge) No policy year deductible applies	$50 copayment per supply then the plan pays 100% (of the balance 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 retail pharmacy	$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient prescription drugs (continued)		
Non-Preferred brand-name prescription drugs (including specialty drugs) (continued)		
More than a 30-day supply but less than a 91-day supply filled at a mail order pharmacy	$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
Diabetic supplies, drugs and insulin		
For each fill up to a 30-day supply filled at a retail pharmacy	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above
More than a 30-day supply but less than a 91-day supply filled at a mail order pharmacy	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above
Diabetic insulin important note: Your cost share will not exceed $25 per 30-day supply of a covered preferred prescription insulin drug filled at an in-network pharmacy. No policy year deductible applies for preferred insulin.		
Orally administered anti-cancer prescription drugs 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 filled at a retail pharmacy For each 30–day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Risk reducing breast cancer prescription drugs filled at a pharmacy For each 30–day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.	

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient prescription drugs (continued)		
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.	
Contraceptives (birth control) Brand-name prescription drugs and devices are covered at 100% at an in-network pharmacy when a generic is not available		
For each fill up to a 12-month supply of generic and OTC drugs and devices filled at a retail pharmacy or mail order pharmacy	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
For each fill up to a 12-month supply of brand-name prescription drugs and devices filled at a retail pharmacy or mail order pharmacy	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above
Outpatient prescription drugs important note: If a provider prescribes a covered brand-name prescription drug when a generic prescription drug equivalent is available and specifies “Dispense As Written” (DAW), you will pay the cost share for the brand-name drug. If a provider does not specify DAW and you request a covered brand-name prescription drug, you will be responsible for the cost share that applies to the brand-name drug plus the cost difference between the generic drug and the brand-name drug. The cost difference related to a prescription not specified as DAW does not apply toward your policy year deductible or maximum out-of-pocket limit.		

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient prescription drug exclusions		
The following are not eligible health services: • Allergy sera and extracts given by injection • Any services related to providing, injecting or application of a drug • Compounded prescriptions containing bulk chemicals not approved by the FDA including compounded bioidentical hormones • Cosmetic drugs including medication and preparations used for cosmetic purposes • Devices, products, and appliances unless listed as an eligible health service • Dietary supplements including medical foods • Drugs or medications: - Administered or entirely consumed at the time and place they are prescribed or provided - Which do not require a prescription by law, even if a prescription is written, unless we have approved a medical exception - That are therapeutically the same or an alternative to a covered prescription drug, unless we approve a medical exception - Not approved by the FDA or not proven safe or effective - Provided under your medical plan while inpatient at a healthcare facility - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF) ***(continued on next page)***		

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient prescription drug exclusions (continued) The following are not eligible health services: • Drugs or medications: - That are used to treat sexual dysfunction, enhance sexual performance, or increase sexual desire, including drugs, implants, devices, or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as an eligible health service - That are indicated or used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, non-prescription appetite suppressants or other medications except as described in the certificate. - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature, unless there is evidence that the covered person meets one or more clinical criteria detailed in our precertification and clinical policies • Duplicative drug therapy; for example, two antihistamines for the same condition • Genetic care including: - Any treatment, device, drug, service, or supply to alter the body's genes, genetic makeup or the expression of the body's genes unless listed as an eligible health service • Immunizations related to work • Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate • Implantable drugs and associated devices except as specifically stated in the schedule of benefits or the certificate • Injectables including: - Any charges for the administration or injection of prescription drugs - Needles and syringes except for those used for insulin administration - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting with the exception of Depo Provera and other injectable drugs for contraception • Off-label drug use except for indications recognized through peer-reviewed medical literature • Prescription drugs: - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or prescription drugs for the treatment of a dental condition - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's drug guide - That are used for the purpose of improving visual acuity or field of vision - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the person identified on the ID card • Replacement of lost or stolen prescriptions • Test agents except diabetic test agents • Tobacco cessation drugs, unless recommended by the USPSTF • We reserve the right to exclude: - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's drug guide - Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's drug guide		

A covered person, a covered person's designee or a covered person's prescriber may seek an expedited medical exception process to obtain coverage for non-covered drugs in exigent circumstances. An "exigent circumstance" exists when a covered person is suffering from a health condition that may seriously jeopardize a covered person's

life, health, or ability to regain maximum function or when a covered person is undergoing a current course of treatment using a non-formulary drug. The request for an expedited review of an exigent circumstance may be submitted by contacting Aetna's *Pre-certification Department* at **1-855-240-0535**, faxing the request to **1-877-269-9916**, or submitting the request in writing to:

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

Travel and Lodging Reimbursement

We will reimburse you for travel and lodging expenses when you need to travel at least 100 miles to access eligible health services because a law or regulation where you are located prohibits those eligible health services. The following are covered travel and lodging expenses:

- U.S. domestic travel expenses for the covered person and the covered person's travel companion in the 48 contiguous states (coach class air, bus, train or shuttle fares, taxi or ride share fares for local travel)
- Mileage costs, not to exceed amounts permitted by Internal Revenue Service guidelines
- Parking and tolls
- Lodging costs of up to $50 per night per covered person or $100 per night, total for the covered person and the covered person's travel companion, not to exceed amounts permitted by Internal Revenue Service guidelines

You must submit a travel and lodging claim form to be reimbursed. You will need to confirm travel was necessary because no provider within 100 miles of where you are located was available to provide the eligible health services when you submit your travel and lodging claim form.

Call the toll-free number on your ID card to:

- Obtain a travel and lodging claim form
- Get assistance in locating a provider
- Get information about these eligible health services including specific eligibility requirements and limitations

We will reimburse your covered travel and lodging expenses as described in the schedule of benefits below.

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

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

This rider is subject to the requirements described in your medical plan schedule of benefits unless otherwise noted below.

Description	Amount
Travel and lodging reimbursement	100%, no policy year deductible applies
Limit per policy year	$3,000

Out of Country Claims

Out of Country claims should be submitted with appropriate medical service and payment information from the provider of service. Covered services received outside the United States will be considered at the In-network level of benefits.

General Exclusions

Acupuncture

- Acupuncture
- Acupressure

Behavioral health treatment

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

Blood and blood products

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

Cosmetic services and plastic surgery

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

Court-ordered testing

- Court-ordered testing or care unless medically necessary

Custodial care

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

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying/changing containers and clamping tubing)

- Watching or protecting you
- Respite care except in connection with hospice care, adult (or child) day care, or convalescent care
- Institutional care. This includes room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training
- For behavioral health (mental health treatment and substance related disorders treatment):
  - Services provided when you have reached the greatest level of function expected with the current level of care, for a specific diagnosis
  - Services given mainly to:
    o Maintain, not improve, a level of function
    o Provide a place free from conditions that could make your physical or mental state worse

Dental care for adults

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

This exception does not include removal of bony impacted teeth, bone fractures, removal of tumors, and odontogenic cysts.

Educational services

Examples of these services are:

- Any service or supply for education, training or retraining services or testing. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
  - Job training
  - Job hardening programs
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

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

Experimental, investigational, or unproven
- Experimental, investigational or unproven drugs, devices, treatments or procedures unless otherwise covered under clinical trials

Gene-based, cellular and other innovative therapies

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

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

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

Medical supplies – outpatient disposable
- Any outpatient disposable supply or device. Examples of these are:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Home test kits not related to diabetic testing
  - Splints
  - Neck braces
  - Compresses
- Other devices not intended for reuse by another patient

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

Obesity surgery and services
• Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity except as described in the *Eligible health services and exclusions* section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
- Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery
- Surgical procedures, medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including morbid obesity
- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
- Hypnosis, or other forms of therapy
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Outpatient prescription or non-prescription drugs and medicines
• Specialty prescription drugs except as stated in the *Eligible health services and exclusions section*

Personal care, comfort or convenience items
• Any service or supply primarily for your convenience and personal comfort or that of a third party

Private duty nursing

Routine exams and preventive services and supplies
• Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *Eligible health services and exclusions* section.

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

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

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

Sports
- Any services or supplies given by providers as a result from play or practice of collegiate or intercollegiate sports, not including intercollegiate club sports and intramurals.

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

Students in mental health field
- Any services and supplies provided to a covered student who is specializing in the mental health care field and who receives treatment from a provider as part of their training in that field

Telemedicine
- Services given when you are not present at the same time as the provider
- Services including:
  - Telemedicine kiosks
  - Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke)

Therapies and tests
- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used as a physical therapy treatment
- Sensory or hearing and integration therapy

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

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

Wilderness treatment programs
See *Educational services* within this section

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

Disclosure: If your request for a service was denied, you may have the right to file a request for independent external review of an Adverse Benefit Determination or a Final Adverse Benefit Determination. This independent external review would be done at no cost to you.

What is an Adverse Benefit Determination?

An Adverse Benefit Determination may be any of the following:

(1) A decision by Aetna or someone on behalf of Aetna to deny a service or payment for a service. This decision is based on a review of the information provided and that the request does not meet Aetna's requirements for:
- medical necessity
- appropriateness
- the type of health care setting
- the level of care
- effectiveness of the service, or
- the service is considered to be experimental or investigational.

(2) Aetna's determination that the service is not covered by this policy.

(3) A cancellation of coverage determination by Aetna.

What is a Final Adverse Benefit Determination

A Final Adverse Benefit Determination happens when Aetna's decision to deny your initial request is partially or fully upheld by Aetna's internal appeal process.

What other rights do I have?

You also have the right to a review of whether we have complied with the surprise billing and cost-sharing protections under the No Surprises Act.

For example, if you receive a covered health care service at an in-network facility, you should not receive a bill for other than your in-network cost-sharing.

For more information, you can visit the Pennsylvania Insurance Department's website dedicated to this topic: www.insurance.pa.gov/nosurprises.

How do I ask for an independent external review?

For more information on the independent external review process, you can visit the Pennsylvania Insurance Department's website at: www.insurance.pa.gov/externalreview.

To submit a request for either standard or expedited independent external review, please submit a copy of your adverse benefit determination or final adverse benefit determination notice and a completed independent external review request form to:

Mail:	Pennsylvania Insurance Department Attn: Bureau of Health Coverage Access, Administration, and Appeals 1311 Strawberry Square Harrisburg, PA 17120	
Fax:	717-231-7960	
Email:	RA-IN-ExternalReview@pa.gov	
Phone:	Consumer Services	1-877-881-6388

What happens next?

Once the Insurance Department receives your request, your eligibility for independent external review will be confirmed with Insurer.

If your adverse benefit determination or final adverse benefit determination is eligible for independent external review, the Insurance Department will assign an Independent Review Organization, provide you with notice of the assignment, and provide information on how you may submit information to support your position. The Independent Review Organization will issue a decision to uphold, partially uphold, or overturn Insurer's decision based on the information provided by you and Insurer.

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

Sanctioned Countries

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

For more information, visit **http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx**.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-841-5374.

Smartphone or Tablet

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

Discrimination is Against the Law

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

Aetna Inc.:

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

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

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

Civil Rights Coordinator

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

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

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

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

U.S. Department of Health and Human Services

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

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

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

Language accessibility statement

TTY: **711**

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

Syriac-Assyrian	ܠܡܐܢ ܕܬܬܩܒܠ ܫܘܬܦ̈ܐ ܒܠܫܢ̈ܐ ܕܠܐ ܡܬܚܝܒ ܐܢ ܬܬܨܠ ܥܠ ܡܣܦܪ ܕܒܛܐ ܒܬܥܪܝܬ ܗܘ ܕܟ̈ ܒܟܪܛܝܣ ܕܗܘ.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน
Ukrainian	Щоб безкоштовнj отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікайній картці.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.

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