Aetna Student Health
Plan Design and Benefits Summary

Preferred Provider Organization (PPO)

University of Maryland, College Park

Policy Year: 2022-2023
Policy Number: 186135
www.aetnastudenthealth.com
(800) 878-1938

This is a brief description of the Student Health Plan. The plan is available for University of Maryland, College Park students and their eligible dependents. The plan is insured by Aetna Health and 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 **www.aetnastudenthealth.com**. If there is a difference between this Plan Summary and the Certificate, the Certificate will control.

UNIVERSITY OF MARYLAND UNIVERSITY HEALTH CENTER

The University Health Center is the University's on-campus health facility. Staffed by medical doctors, physician assistants, nurse practitioners and registered nurses. UMD's health center is open weekdays from 8:00 a.m. to 5:00 p. m. during the Fall and Spring semesters. A Physician and nurse practitioner are always on call and conduct clinics during the week. For more information, call the Health Services at 301-405-4325. In the event of an emergency, call 911 or the Campus Police at 301-405-3333.

When using the campus health center SHIP deductibles and copays are waived (excluding the 3rd or more massage therapy).

HOURS OF OPERATION

Monday..... 8:00am – 5:00pm
Tuesday..... 8:00am – 5:00pm
Wednesday..... 11:00am – 5:00pm
Thursday..... 8:00am – 5:00pm
Friday .....8:00am -5:00pm
Saturday..... 9:00am – 12:00pm
Sunday.....Closed

LIMITED SERVICES ARE AVAILABLE UNTIL FURTHER NOTICE:

TELEMEDICINE APPOINTMENTS

HEAL Line: (301) 405-4325 (Heal)
Appointments: (301) 304-8184
After-Hour Nurse Line: (301) 314-9386
Emergency? Call 911or an Urgent Care Center

Who is eligible?

You are eligible if you are a:

- Domestic Undergraduate student enrolled in six (6) or more credit hours
- International Undergraduate student
- Graduate student enrolled in one (1) or more credit hours
- Part-time student, non-degree seeking student, student enrolled in certificate programs, exclusively online programs, and/or programs at the Shady Grove campus

Dependent Coverage Eligibility

Covered students may also enroll their lawful spouse, domestic partner (same-sex, opposite sex), and dependent children up to the age of 26. (Dependents must be added at the time of student enrollment, dependents can only be added later if eligible for qualifying event).

Coverage Dates and Rates

Coverage for all insured students and eligible dependents will become effective at 12:01 AM on the Coverage Start Date indicated below and will terminate at 11:59 PM on the Coverage End Date indicated. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Certificate of Coverage.

The rates below include premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna).

	Annual 8/1/22-7/31/23	Fall 8/1/22-12/31/22	Spring 1/1/23-7/31/23	Summer 6/1/23-7/31/23
Student	$2,334	$978	$1,356	$390
Spouse	$2,334	$978	$1,356	$390
All Children	$2,334	$978	$1,356	$390
Enrollment waivers must be submitted by: 09/15/2022				

Enrollment

Undergraduate student accounts are charged for the premiums unless the online waiver is completed attesting that comparable coverage is in place. Those undergraduate students who wish to waive the Student Health Insurance must do so by completing the online Student Health Insurance Waiver at: **umdship.myahpcare.com**.

Voluntary Enrollment

To enroll the dependent(s) of a covered student, please complete the Enrollment Form by visiting **umdship.myahpcare.com**.

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

- A newborn child, including a grandchild in court ordered custody - Your newborn child is covered on your health plan from the moment of birth.
  - If coverage requires the payment of an additional premium for a dependent, to keep your newborn covered under your plan we must receive your completed enrollment information within the 31-day period.
  - 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.

- Upon the death of a spouse, a dependent child previously covered by the spouse's plan.

- An adopted child, including an adopted grandchild- 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 starting on the date of the adoption or the date the placement is complete, whichever is earlier.
  - If coverage requires the payment of an additional premium for a dependent, to keep your adopted child or child legally placed with you for adoption covered under your plan we must receive your completed enrollment information within the 31-day period.
  - 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.

- A child under guardianship - A child for whom guardianship is granted by court or testamentary appointment, other than a temporary guardianship of less than 12 months, is covered from the date of appointment.
  - To keep your child covered, we must receive your completed enrollment information within the 31-day period.
  - If you miss this deadline, your child under guardianship will not have health benefits after the first 31 days.
  - If your coverage ends during this 31-day period, then coverage for your child under guardianship will end on the same date as your coverage. This applies even if the 31-day period has not ended.

- A stepchild - You may put a child of your spouse or domestic partner on your plan.
  - You must complete your enrollment information and send it to us within 31 days after the date of your marriage or your Declaration of Domestic Partnership with your stepchild's parent.
  - Ask the policyholder when benefits for your stepchild will begin. It is either on the date of your marriage or the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.
  - To keep your stepchild covered, we must receive your completed enrollment information within 31 days after the date of your marriage or your Declaration of Domestic Partnership.
  - You must still enroll the stepchild within 31 days after the date of your marriage or your Declaration of Domestic Partnership even when coverage does not require payment of an additional premium contribution for the stepchild.
  - If you miss this deadline, your stepchild will not have health benefits after the first 31 days.
  - If your coverage ends during this 31-day period, then your stepchild's coverage 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 31 days.
  - 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 1-800-878-1938.

Medicare Eligibility Notice

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

Termination and Refunds

Withdrawal from Classes – Leave of Absence

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

Withdrawal from Classes – Other than Leave of Absence

If you withdraw from classes other than under a school-approved leave of absence within 31 days after the policy effective date, you will be considered ineligible for coverage, your coverage will be terminated retroactively and any premiums collected will be refunded. If the withdrawal is more than 31 days after the policy effective date, your coverage will remain in force through the end of the period for which payment has been received and no premiums will be refunded. If you withdraw from classes to enter the armed forces of any country, coverage will terminate as of the effective date of such entry and a pro rata refund of premiums will be made if you submit a written request within 90 days of withdrawal from classes.

In-network Provider Network

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

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

Precertification

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

Precertification Call

Precertification should be secured within the timeframes specified below. To obtain precertification, call Member Services at the toll-free number on your ID card. This call must be made:

Non-emergency admissions:	You, your physician or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted.
An emergency admission:	You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
An urgent admission:	You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or an injury.
Outpatient non-emergency services requiring precertification:	You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

We will provide a written notification to you and your physician of the precertification decision, where required by state law. If your precertified services are approved, the approval is valid for 30 days as long as you remain enrolled in the plan.

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 **www.aetnastudenthealth.com**.

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

Policy year deductibles	**In-network coverage**	**Out-of-network coverage**
You have to meet your policy year deductible before this plan pays for benefits.		
Student	$250 per policy year	$500 per policy year
Spouse	$250 per policy year	$500 per policy year
Each child	$250 per policy year	$500 per policy year
Family	$500 per policy year	$600 per 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* • Any service identified as "no policy year deductible applies" in the schedule of benefits		
Individual deductible This is the amount you incur 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 incur 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.		
Family deductible This is the amount you and your covered dependents incur for in-network and out-of-network eligible health services each policy year before the plan begins to pay for eligible health services. After the amount you and your covered dependents incur for eligible health services reaches this family policy year deductible, this plan will begin to pay for eligible health services incur for the rest of the policy year. To satisfy this family policy year deductible limit for the rest of the policy year, the following must happen: • The combined eligible health services costs that you and each of your covered dependents incur towards the individual policy year deductibles must reach this family policy year deductible limit in a policy year. When this occurs in a policy year, the individual policy year deductibles for you and your covered dependents will be considered to be met for the rest of the policy year.		
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	$3,500 per policy year
Spouse	$1,500 per policy year	$3,500 per policy year
Each child	$1,500 per policy year	$3,500 per policy year
Family	$3,000 per policy year	$5,000 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.		

Eligible health services	In-network coverage	Out-of-network coverage
Routine physical exams		
Performed at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit
Maximum age and visit limits per policy year through age 21	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.	
Covered persons age 22 and over: Maximum visits per policy year	1 visit	
Preventive care immunizations		
Performed in a facility or at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention	
Routine gynecological exams (including Pap smears and cytology tests)		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	

Eligible health services	In-network coverage	Out-of-network coverage
Preventive screening and counseling services		
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, Depression Screening, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit
Routine cancer screenings Breast cancer screening is not subject to deductible	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit
Maximum:	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration.	
Prenatal care services (Preventive care services only)	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit
Lactation support and counseling services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit
Maximums	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	
Breast pump supplies and accessories	100% (of the negotiated charge) per item No copayment or policy year deductible applies	100% (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	100% (of the recognized charge) per visit
Maximums	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	

Eligible health services	In-network coverage	Out-of-network coverage
Family planning services – female contraceptives (continued)		
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	100% (of the recognized charge) per item
Female Voluntary sterilization - Inpatient & Outpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	100% (of the recognized charge)
Physicians and other health professionals		
Physician & specialist including Consultants Office visits (includes Telehealth consultation)	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	80% (of the recognized charge) per visit No policy year deductible applies
Allergy testing and treatment (including allergy serum)		
Allergy testing & Allergy injections treatment, including Allergy sera and extracts administered via injection, 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
Physician and specialist surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon	80% (of the negotiated charge)	60% (of the recognized charge)
Anesthetist	80% (of the negotiated charge)	60% (of the recognized charge)
Surgical assistant	80% (of the negotiated charge)	60% (of the recognized charge)
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Anesthetist	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Surgical assistant	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Alternatives to physician office visits		
Walk-in clinic visits (non-emergency visit)	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	80% (of the recognized charge) per visit No policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Hospital and other facility care		
Inpatient hospital (room and board) and other miscellaneous services and supplies) Includes birthing center facility charges	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Anesthesia and related facility charges for dental procedure Coverage is subject to certain conditions. See the benefit description in the certificate of coverage for details.	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Alternatives to hospital stays		
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	80% (of the negotiated charge)	60% (of the recognized charge)
Home Health Care	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Hospice - Inpatient facility	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Hospice - Outpatient	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Outpatient private duty nursing	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Skilled nursing facility - Inpatient facility	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Emergency services and urgent care		
Hospital 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 a hospital emergency room	Not covered	Not covered

Important note:

- As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment/coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on the back of your ID card or call Member Services for an address at 1-800-878-1938 and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill.
- A separate hospital emergency room copayment/coinsurance will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/coinsurance will be waived and your inpatient copayment/coinsurance will apply.

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Eligible health services	In-network coverage	Out-of-network coverage
Emergency services and urgent care (continued)		
Hospital emergency room - Important note (continued): • Covered benefits that are applied to the hospital emergency room copayment/coinsurance cannot be applied to any other copayment/coinsurance under the plan. Likewise, a copayment/coinsurance that applies to other covered benefits under the plan cannot be applied to the hospital emergency room copayment/coinsurance. • Separate copayment/coinsurance amounts may apply for certain services given to you in the hospital emergency room that are not part of the hospital emergency room benefit. These copayment/coinsurance amounts may be different from the hospital emergency room copayment/coinsurance. They are based on the specific service given to you. • Services given to you in the hospital emergency room that are not part of the hospital emergency room benefit may be subject to copayment/coinsurance amounts.		
Urgent care	$50copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$50 copayment then the plan pays 100% (of the balance of the recognized charge) per visit No policy year deductible applies
Non-urgent use of an urgent care provider	Not covered	Not covered
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	50% (of the recognized charge) per visit
Type C services	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Orthodontic services	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Dental emergency services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
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
Diabetes test strips	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
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

Eligible health services	In-network coverage	Out-of-network coverage
Specific conditions (continued)		
Impacted wisdom teeth - For persons beyond the age as covered under the *Pediatric dental care* provision	80% (of the negotiated charge)	60% (of the recognized charge)
Accidental injury to sound natural teeth	80% (of the negotiated charge)	60% (of the recognized charge)
Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
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
Obesity (Bariatric) Surgery and services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
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
Postpartum home visits See the certificate of coverage for visit limits	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the recognized charge) per visit No policy year deductible applies
The following are not covered under this benefit: • Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries		
Well newborn nursery care in a hospital or birthing center	80% (of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies
Family planning services – other		
Voluntary sterilization for males - surgical services	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
Abortion - Inpatient	80% (of the negotiated charge)	60% (of the recognized charge)
Abortion - Outpatient	80% (of the negotiated charge)	60% (of the recognized charge)
Gender affirming treatment		
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Autism spectrum disorder		
Autism spectrum disorder treatment and Applied behavior analysis	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Eligible health services	In-network coverage	Out-of-network coverage
Behavioral Health **Mental health & Substance Abuse related disorders Treatment**		
Inpatient hospital	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Outpatient office visits (includes telehealth consultations)	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	80% (of the recognized charge) per visit No policy year deductible applies
Other outpatient treatment (includes skilled behavioral health services in the home, Partial hospitalization and Intensive Outpatient Program)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

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	Covered

Eligible health services	In-network coverage	Out-of-network coverage
Treatment of infertility		
Basic 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
Comprehensive infertility services and in vitro 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
Maximum	Outpatient in-vitro services up to 3 attempts	
Specific therapies and tests		
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	80% (of the negotiated charge)	60% (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	80% (of the negotiated charge)	60% (of the recognized charge)

Eligible health services	In-network coverage	Out-of-network coverage
Specific therapies and tests (continued)		
Outpatient Chemotherapy, Radiation, Infusion & Respiratory Therapy	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy) Combined for short-term rehabilitation services and habilitation therapy services There is no age limit except for certain habilitative services. See the Habilitation therapy services section in the certificate of coverage for details.	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	80% (of the recognized charge) per visit No policy year deductible applies
Chiropractic services	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	80% (of the recognized charge) per visit No policy year deductible applies
Acupuncture	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	80% (of the recognized charge) per visit No policy year deductible applies
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
Other services and supplies		
Emergency ground ambulance & Emergency air or water ambulance	80% (of the negotiated charge) per trip	Paid the same as in-network coverage
Non-emergency ambulance	80% (of the negotiated charge) per trip	80% (of the recognized charge) per trip
Durable medical and surgical equipment	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Enteral formulas and nutritional supplements	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Prosthetic Devices & Orthotics Includes Cranial prosthetics *(Medical wigs)*	80% (of the negotiated charge) per item	60% (of the recognized charge) per item

Eligible health services	In-network coverage	Out-of-network coverage
Hearing aids and exams		
Hearing exam	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	80% (of the recognized charge) per visit No policy year deductible applies
Hearing exam maximum	1 hearing exams 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		
Hearing Aids	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Hearing aids maximum per ear	One hearing aid per hearing impaired ear every policy year	
Pediatric vision care Limited to covered persons through the end of the month in which the person turns age 19.		
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
Maximum visits per policy year Low vision Maximum Fitting of contact Maximum	1 visit One comprehensive low vision evaluation every 5 years and 4 follow-up visits in any 5-year period 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
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 12-month supply Extended wear disposable: up to 12-month supply Non-disposable lenses: one set	
Low vision prescribed optical devices	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Maximum number of optical devices per policy year	One optical device	
***Important note**: Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.		

Outpatient prescription drugs

Copayment/coinsurance waiver for risk reducing breast cancer drugs

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

Outpatient prescription drug copayment waiver for tobacco cessation prescription and over-the-counter drugs

Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, see the *How to contact us for help* section.

Outpatient prescription drug 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 therapeutically equivalent 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.

We cover a 12-month supply of prescription contraceptives for a single dispensing.

Eligible health services	In-network coverage	Out-of-network coverage
Preferred generic prescription 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
Preferred brand-name prescription drugs		
For each fill up to a 30-day supply filled at a retail pharmacy	$40 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$40 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient prescription drugs (continued)		
Non-preferred generic prescription drugs		
For each fill up to a 30-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	$60 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies
Non-preferred brand-name prescription drugs		
For each fill up to a 30-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	$60 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies
Specialty drugs		
For each fill up to a 30-day supply filled at a specialty pharmacy or retail pharmacy	$60 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$60 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies
Prescription drugs to treat diabetes, HIV, or AIDS		
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	Paid according to the type of drug per the schedule of benefits
Important note: The copayment or coinsurance for a covered prescription drug to treat diabetes, HIV, or AIDS will not exceed $150 for a 30-day supply.		
Orally administered anti-cancer prescription drugs For each fill up to a 90-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 fill up to a 90-day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	100% (of the recognized charge) per prescription or refill No policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient prescription drugs (continued)		
Risk reducing breast cancer prescription drugs filled at a retail pharmacy For each fill up to a 90-day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	100% (of the recognized charge) per prescription or refill No policy year deductible applies
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.	
Tobacco cessation prescription drugs and OTC drugs filled at a retail pharmacy For each fill up to a 90-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.	

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

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 Out-of-network level of benefits.

General exceptions and exclusions

The plan does not cover:

- Services that are not medically necessary.
- Services performed or prescribed under the direction of a person who is not a health professional.
- Services that are beyond the scope of practice of the health professional performing the service.
- Services to the extent they are covered by any government unit, except for veterans in Veterans' Administration or armed forces facilities for services received for which the recipient is liable.

- Services for which you are not legally, or as a customary practice, required to pay in the absence of a health benefit plan.
- The purchase, examination, or fitting of eyeglasses or contact lenses, except for aphakic lenses and soft or rigid gas permeable lenses or sclera shells intended for use in the treatment of an illness or injury. This does not apply to the covered benefits for pediatric vision care.
- Personal care services and domiciliary care services.
- Services rendered by a health professional who is your spouse, mother, father, daughter, son, brother, or sister.
- Experimental or investigational procedures.
- Practitioner, hospital, or clinical services related to radial keratotomy, myopic keratomileusis, and surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.
- Ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures.
- Services to reverse a voluntary sterilization procedure.
- Services for sterilization or reverse sterilization for a dependent minor. This does not apply to FDA approved sterilization procedures for women with reproductive capacity.
- Medical or surgical treatment or regimen for reducing or controlling weight, unless otherwise specified in the covered benefit.
- Services incurred before the effective date of coverage for a member.
- Services incurred after a member's termination of coverage, including any extension of benefits.
- Surgery or related services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies.
- Services for injuries or illnesses related to your job to the extent that you are required to be covered by a worker's compensation law.
- Services rendered from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.
- Personal hygiene and convenience items, including, but not limited to, air conditioners, humidifiers, or physical fitness equipment.
- Charges for telephone consultations, failure to keep a scheduled visit, or completion of any form.
- Inpatient admissions primarily for diagnostic studies, unless authorized by Aetna.

- The purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers, unless otherwise specified in covered benefits.

- Except for covered ambulance services and transplant travel and lodging benefits specified under covered benefits, travel, whether or not recommended by a health professional.

- Except for emergency services, services received while you are outside the United States.

- Immunizations related to foreign travel.

- With the exception of covered pediatric dental benefits, dental work or treatment, which includes hospital or health professional care in connection with:
  - The operation or treatment for the fitting or wearing of dentures
  - Orthodontic care or malocclusion
  - Operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for removal of tumors and cysts or treatment of injury to natural teeth due to an accident if the treatment is received within 6 months of the accident
  - Dental implants

- Accidents occurring while and as a result of chewing. This does not apply to covered pediatric dental benefits.

- Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless otherwise included as covered benefits or these services are determined to be medically necessary.

- Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports, or exams for their prescription or fitting, unless these services are determined to be medically necessary.

- Inpatient admissions primarily for physical therapy, unless authorized by Aetna.

- Treatment of sexual dysfunction not related to organic illness.

- Services that duplicate benefits provided under federal, state, or local laws, regulations, or programs.

- Nonhuman organs and their implantation.

- Non-replacement fees for blood and blood products.

- Lifestyle improvements, including nutrition counseling, or physical fitness programs, unless included as a covered benefit.

- Wigs or cranial prosthesis, except hair prostheses for covered persons whose hair loss results from chemotherapy or radiation treatment for cancer.

- Weekend admission charges, except for emergencies and maternity, unless authorized by Aetna.

- Outpatient orthomolecular therapy, including nutrients, vitamins, and food supplements, unless included as a covered benefit.

- Temporomandibular joint syndrome (TMJ) treatment and treatment for craniomandibular pain syndrome (CPS), except for surgical services for TMJ and CPS, if medically necessary and if there is a clearly demonstrable radiographic evidence of joint abnormality due to illness or injury.

- Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.

- Services for conditions that state or local laws, regulations, ordinances, or similar provisions require to be provided in a public institution.

- Services for, or related to, the removal of an organ from a covered person for purposes of transplantation into another person, unless the:
  - Transplant recipient is covered under the plan and is undergoing a covered transplant
  - Services are not payable by another carrier.

- Physical examinations required for obtaining or continuing employment, insurance, or government licensing.

- Nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.

- Private hospital room, unless authorized by Aetna.

- Private duty nursing, unless authorized by Aetna.

- Family planning services - other
  - Reversal of voluntary sterilization procedures, including related follow-up care
  - Family planning services received while confined as an inpatient in a hospital or other facility
  - Services and supplies provided as a result of complications resulting from a male voluntary sterilization procedure and related follow-up care

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

- Mental health and substance use treatment
  Mental health and substance use services for the following categories (or equivalent terms as listed in the most recent version of the International classification of diseases (ICD)):
  - Services by pastoral or marital counselors
  - Therapy for sexual problems
  - Treatment of learning disabilities and intellectual disabilities
  - Travel time to a member's home to conduct therapy
  - Marriage counseling
  - Services that are not medically necessary

- Outpatient prescription drugs
  - Any services related to the dispensing, injection or application of a drug
  - Biological liquids and fluids
  - Brand-name prescription drugs and devices when a generic prescription drug equivalent, biosimilar prescription drug or generic prescription drug alternative is available, unless otherwise covered by medical exception
  - Cosmetic drugs medications or preparations used for cosmetic purposes
  - Except for the bulk chemicals expressly designated as exempt from regulation by the U.S. Food and Drug Administration (FDA), compound prescriptions containing bulk chemicals that have not been approved by the FDA
  - Devices, products and appliances that do not have a National Drug Code (NDC)
  - Services and supplies provided as a result of complications resulting from voluntary sterilization procedure and related follow-up care
  - Drugs or medications:
    - Administered or entirely consumed at the time and place it is prescribed or dispensed
    - Which do not, by federal or state law, require a prescription order (i.e. over-the-counter (OTC) drugs), even if a prescription is written, except where stated in the *Eligible health services under your plan – Outpatient prescription drugs* section
    - That includes the same active ingredient or a modified version of an active ingredient as a covered prescription drug, unless a medical exception is approved
    - That is therapeutically equivalent or a therapeutic alternative to a covered prescription drug unless a medical exception is approved
    - That is therapeutically equivalent or a therapeutic alternative to an over-the-counter (OTC) product unless a medical exception is approved
    - Provided by, or while you are an inpatient in, any healthcare facility, or for any drugs provided on an outpatient basis in any such institution to the extent benefits are payable for it
  - That include vitamins and minerals
  - For which the cost is recoverable under any federal, state, or government agency or any medication for which there is no charge made to the recipient
  - That are used for the treatment of 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
  - Not approved by the FDA or not proven to be safe and effective
  - Immunizations related to travel or work
  - Implantable drugs and associated devices except where stated in the *Eligible health services under your plan – Preventive care and wellness* and *Outpatient prescription drugs* sections
  - Infertility: Injectable prescription drugs used primarily for the treatment of infertility except where stated in the *Eligible health services under your plan – Treatment of infertility* section
  - Injectables
    - Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by us
    - Needles and syringes, except where stated in the *Eligible health services under your plan – Diabetic equipment, supplies and education* section.
    - Specialty prescription drugs, unless dispensed through the in-network specialty pharmacy, or specifically described as covered in the *Eligible health services under your plan* section of this certificate of coverage.
  - Prescription drugs
    - Filled prior to the effective date or after the end date of coverage under this plan
    - Dispensed by a mail order pharmacy that includes prescription drugs that cannot be shipped by mail due to state or federal laws or regulations, or when the plan considers shipment through the

mail to be unsafe.
    - That include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and is no clinically superior to that drug as determined by the plan unless a medical exception is approved
    - That are not covered or related to a non-covered service
    - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not medically necessary, or otherwise improper and drugs obtained for use by anyone other than the covered person identified on the ID card
  - Prophylactic drugs for travel
  - Refills
    - Refills dispensed more than one year from the date the latest prescription order was written, or as otherwise permitted by applicable law of the area in which the drug is dispensed
  - Replacement of lost or stolen prescriptions
  - Tobacco use
    - 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). See the *Eligible health services under the plan – Outpatient prescription drugs* section.
  - Test agents except diabetic test agents
  - Experimental or investigational drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies (experimental or investigational) or covered under clinical trials (routine patient costs).

We reserve the right to include only one manufacturer's product on the preferred drug guide when the same or similar drug (that is, a drug with the same active ingredient), supply or equipment is made by two or more different manufacturers.

- We reserve the right to include only one dosage or form of a prescription drug on the preferred drug guide when the same drug (that is, a drug with the same active ingredient) is available in different dosages or forms from the same or different manufacturers. The product in the dosage or form that is listed on our preferred drug guide will be subject to the applicable copayment. Please refer to the *Medical exceptions* section for details.

- Pediatric dental care

  With the exception of covered pediatric dental benefits, in addition to the exclusions that apply to health coverage:
  - 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 other substances to protect, clean, whiten bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons
    - 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, or
    - The tooth is an abutment to a covered partial denture or fixed bridge; or
    - They are specifically covered under the pediatric dental care benefits
  - Dental implants and braces (that are determined not to be medically necessary) and other devices to protect, replace or reposition teeth

- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - For splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment or orthognathic surgery
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another eligible health service
- Orthodontic treatment
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Routine dental exams and other preventive services and supplies
- 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
  - Rendered before the effective date or after the termination of coverage
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a dental provider

- Work related: Any illness or injury related to employment or self-employment including any injuries that arise out of (or in the course of) any work for pay or profit even if you have waived your right to payment from that source. Exceptions include:
  - When there is no other source of coverage or reimbursement available to you for the services or supplies.
  - You submit proof that you are not covered for a particular illness or injury under a worker's compensation or similar law. The illness or injury will be considered "non-occupational" regardless of cause.

  Other sources of coverage or reimbursement may include:
  - Your employer
  - Workers' compensation
  - Occupational illness
  - Similar program under local, state or federal law.

- Dental care for adults unless specifically covered under the plan
  This exclusion does not apply to removal of bony impacted teeth, bone fractures, removal of tumors, and odontogenic cysts.

- Pediatric vision care
  - Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes
  - Services and materials not meeting accepted standards of optometric practice
  - Services and materials resulting from the member's failure to comply with professionally prescribed

treatment
  - Charges associated with copies of records and charts
  - Visual therapy
  - Special lens designs or coatings other than those specified under covered benefits
  - Replacement of lost or stolen eyewear
  - Non-prescription (Plano) lenses
  - Two pairs of eyeglasses in lieu of bifocals
  - Insurance of contact lenses

- Vision care services and supplies for adults unless specifically covered under the *Your plan does not cover vision care services and supplies, except as described in the Eligible health services under your plan – Other services section.*
  - Special supplies such as non-prescription sunglasses
  - Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes
  - 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
  - Eyeglasses or duplicate or spare eyeglasses or lenses or frames
  - 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

- Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)

Gene-based, cellular and other innovative therapies (GCIT)
The following are not eligible health services unless you receive prior written approval from us:

- All associated services when GCIT services are not covered. Examples include infusion, laboratory, radiology, anesthesia, and nursing services.

Please refer to the *Medical necessity and precertification requirements* section.

- Payment of any claim, bill or other demand or request for payment for health care services determined to be furnished as a result of a referral prohibited by Section 1-302 of the Health Occupations Article.

- Limitations
  - In the event there are 2 or more alternative medical services which in the sole judgment of Aetna are equivalent in quality of care, Aetna reserves the right to provide coverage only for the least costly medical service, as determined by Aetna, provided that Aetna pre-authorizes the medical service or treatment.
  - Determinations regarding eligibility for benefits, coverage for services, benefit denials and all other terms of this certificate of coverage are at the sole discretion of Aetna, subject to the terms of this certificate of coverage.

The University of Maryland, College Park Student Health Insurance Plan is underwritten by Aetna Health and Life Insurance Company (Aetna). Aetna Student Health[SM] is the brand name for products and services provided by Aetna Health and 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 1-800-878-1938.

Smartphone or Tablet

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

Non-Discrimination

Aetna is committed to being an inclusive health care company. Aetna does not discriminate on the basis of ancestry, race, ethnicity, color, religion, sex/gender (including pregnancy), national origin, sexual orientation, gender identity or expression, physical or mental disability, medical condition, age, veteran status, military status, marital status, genetic information, citizenship status, unemployment status, political affiliation, or on any other basis or characteristic prohibited by applicable federal, state or local law.

Aetna provides free aids and services to people with disabilities and free language services to people whose primary language is not English.

These aids and services include:

- Qualified language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Qualified interpreters
- Information written in other languages

If you need these services, contact the number on your ID card. Not an Aetna member? Call us at 1-800-878-1938.

If you have questions about our nondiscrimination policy or have a discrimination-related concern that you would like to discuss, please call us at 1-800-878-1938.

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

Interpreter services are available for free.

Attention: If you speak English, language assistance service, free of charge, are available to you. Call **1-800-878-1938** (TTY: **711**).

Español/Spanish

Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-878-1938** (TTY: **711**).

አማርኛ**/Amharic**

ልብ ይበሉ: አማርኛ ቋንቋ የሚናገሩ ከሆነ፥ የትርጉም ድጋፍ ሰጪ ድርጅቶች፣ ያለምንም ክፍያ እርስዎን ለማገልገል ተዘጋጅተዋል። የሚከተለው ቁጥር ላይ ይደውሉ **1-800-878-1938** (መስማት ለተሳናቸው: **711**).

العربية**/Arabic**

ملحوظة: إذا كنت تتحدث اللغة العربية فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-878-1938** (رقم الهاتف النصي: **711**).

Bàsɔ̀ɔ̀ Wùdù/Bassa

Dè dɛ nìà kɛ dyeˈdɛˈ gbo: ɔ juˇ keˈ m̀ dyi Bàsɔ̀ɔ̀-wùdù-po-nyɔ̀ juˇ niˇ, nìiˇ à wudu kà kò dɔ̀ po-poɔ̀ ɓɛ́ m̀ gbo kpaˈa. Ðaˈ **1-800-878-1938** (TTY: **711**).

中文/Chinese

注意：如果您说中文，我们可为您提供免费的语言协助服务。请致电 **1-800-878-1938** (TTY: **711**)。

فارسی**/Farsi**

توجه: اگر به زبان فارسی صحبت می کنید، خدمات زبانی رایگان به شما ارایه میگردد، با شماره **1-800-878-1938** (TTY: **711**) تماس بگیرید.

Français/French

Attention : Si vous parlez français, vous pouvez disposer d’une assistance gratuite dans votre langue en composant le **1-800-878-1938** (TTY: **711**).

ગુજરાતી**/Gujarati**

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો ભાષાકીય સહાયતા સેવા તમને નિ:શુલ્ક ઉપલબ્ધ છે. કૉલ કરો **1-800-878-1938** (TTY: **711**).

Kreyòl Ayisyen/Haitian Creole

Atansyon: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-878-1938** (TTY: **711**).

Igbo

Nrụbama: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-878-1938** (TTY: **711**).

한국어/Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스가 무료로 제공됩니다. **1-800-878-1938** (TTY: **711**)번으로 전화해 주십시오.

Português/Portuguese

Atenção: a ajuda está disponível em português por meio do número **1-800-878-1938** (TTY: **711**).
Estes serviços são oferecidos gratuitamente.

Русский/Russian

Внимание: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Звоните по телефону **1-800-878-1938** (TTY: **711**).

Tagalog

Paunawa: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-878-1938** (TTY: **711**).

اردو/Urdu

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت دستیاب ہیں ۔ **1-800-878-1938** (TTY: **711**) پر کال کریں.

Tiếng Việt/Vietnamese

Lưu ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số **1-800-878-1938** (TTY: **711**).

Yorùbá/Yoruba

Àkíyèsí: Bí o bá nsọ èdè Yorùbá, ìrànlọ́wọ́ lórí èdè, lófẹ̀ẹ́, wà fún ọ. Pe **1-800-878-1938** (TTY: **711**).

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