Aetna Student Health
Plan Design and Benefits Summary
Preferred Provider Organization (PPO)

University of Maryland College Park

Policy Year: 2025–2026
Policy Number: 252649
https://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 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.

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.

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

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?

All Domestic Undergraduate students enrolled in six (6) or more credit hours and all International Undergraduate students, and "Graduate Students (Full Time Student) 48 units for the semester, 36 units for the 12-week terms are required to purchase this plan, unless proof of comparable coverage is provided.

All part-time Graduate student enrolled in one (1) or more credit hours are eligible to enroll in the UMD Student Health Insurance Plan or provide proof of other adequate health coverage.

Part-time students, non-degree seeking students, students enrolled in certificate programs, exclusively online programs, and/or programs at the Shady Grove campus are encouraged but not required to have health insurance, unless the student's immigration status requires insurance.

Home study, correspondence and online classes do not fulfill the eligibility requirements for active class attendance.

Eligible students who enroll in the Plan may also enroll their eligible dependents. Eligible dependents include the student's spouse and dependent children under age 26.

Dependent Coverage Eligibility

If your plan includes dependent coverage, you can enroll the following family members on your plan.

- Your legal spouse that resides with you
- Your domestic partner who meets the requirements under state law
- Your dependent children – your own or those of your spouse or domestic partner

- The children must be under 26 years of age, and they include:
  - Biological children
  - Stepchildren
  - Legally adopted children
  - A child legally placed with you for adoption (including a foster child)
  - A child for whom guardianship is granted by court or testamentary appointment, other than a temporary guardianship of less than 12 months
  - Children you are responsible for under a qualified medical support order or court-order (whether or not the child resides with you)
  - Grandchildren in your court-ordered custody

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).

	Fall 8/1/25-12/31/25	**Spring 1/1/26-7/31/26**	**Summer 6/1/26-7/31/26**
Student	$1,176	$1,630	$469
Student & Spouse	$2,352	$3,260	$938
Student & Child	$2,352	$3,260	$938
	Enrollment waivers must be submitted by: Fall 09/26/25 Spring 02/15/26		

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

You can add the following new dependents at any time during the year. These include any dependents described in the Who can be on your plan (who can be your dependent) section above.

Coverage begins on the date of the event for new dependents that join your plan for the following reasons:

- Birth
- Adoption or placement for adoption
- Marriage
- Domestic partnership
- Legal guardianship
- Court or administrative order
- Upon the death of a spouse, a dependent child previously covered by the spouse's plan

We must receive your completed enrollment information not more than 31 days after the event date.

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.

Adopted child, including an adopted grandchild - A child that you, or you and your spouse or domestic partner adopt, or that 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 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 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.

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. No premiums will be refunded.

Withdrawal from Classes – Other than Leave of Absence
If you withdraw from classes within 31 days after the policy effective date, 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 policy effective date, 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.

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 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:

Type of care	Timeframe
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 and within the timeframe specified 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 Maryland Insurance Law(s).

Policy year deductibles	Select care coverage	In-network coverage	Out-of-network coverage
You have to meet your policy year deductible before this plan pays for benefits.			
Student	None	$250 per policy year	$500 per policy year
Spouse	None	$250 per policy year	$500 per policy year
Each child	None	$250 per policy year	$500 per policy year
Family	None	$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: • 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	Select care coverage	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 select care and in-network maximum out-of-pocket limit and eligible health services applied to the select care and in-network maximum out-of-pocket limit will not be applied to satisfy the out-of-network maximum out-of-pocket limit.			

Description	Select care coverage	In-network coverage	Out-of-network coverage
Preventive care and wellness			
Routine physical exam performed at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit No policy year deductible applies
Routine physical exam limits for 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.		
Routine physical exam limits for 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	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (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.		
Your plan does not cover immunizations that are not considered preventive care, such as those required due to employment or travel.			
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 negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit No policy year deductible applies
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.		

Description	Select care coverage	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 services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, 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 negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit No policy year deductible applies
Maximums	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Reasonable medical management techniques will be used to determine the frequency, method, treatment, or setting for an item or service.		
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 negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit No policy year deductible applies
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 in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your physician or Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.		
Routine prostate cancer screenings			
Routine prostate cancer screenings performed at a physician's office, specialist's office or facility	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit No policy year deductible applies
Maximums	Review the *Routine prostate cancer screenings* section of your certificate of coverage for limitations.		
Prenatal care services (Preventive care services only)	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit No policy year deductible applies

Description	Select care coverage	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	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit No policy year deductible applies
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 negotiated charge) per item No copayment or policy year deductible applies	80% (of the recognized charge) per item No policy year deductible applies
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 negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit No policy year deductible applies
Maximums	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.		
Female contraceptive prescription drugs and devices provided, administered, or removed, by a provider during an office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit No policy year deductible applies
Female voluntary sterilization			
Inpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	100% (of the negotiated charge) No copayment or policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
Outpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit No policy year deductible applies
Physicians and other health professionals			
Physician & specialist including Consultants Office visits (Includes Telehealth consultation)	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	$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

Description	Select care coverage	In-network coverage	Out-of-network coverage
Important note: You will have 0 cost share (no deductible, copayment or coinsurance) for diagnostic breast exams when it is used to evaluate a breast abnormality seen or suspected from a prior screening examination or by other means of prior examination, or when it is a supplemental breast examination where no abnormality is seen or suspected from a prior examination and there is a personal or family history of breast cancer or additional factors that may increase your risk of breast cancer.			
Allergy testing and treatment (including allergy serum)			
Physician and specialist services (non-surgical and non-preventive) - allergy testing and 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	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	Not available	80% (of the negotiated charge)	60% (of the recognized charge)
Anesthetist	Not available	80% (of the negotiated charge)	60% (of the recognized charge)
Surgical assistant	Not available	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	100% (of the negotiated charge) per visit No policy year deductible applies	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Anesthetist	100% (of the negotiated charge) per visit No policy year deductible applies	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Surgical assistant	100% (of the negotiated charge) per visit No policy year deductible applies	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)	100% (of the negotiated charge) per visit No policy year deductible applies	$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

Description	Select care coverage	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	Not available	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Surprise bill important note: Balance billing protections for non-emergency services performed by non-participating providers at participating facilities, including ancillary services and services for unseen urgent medical needs. We cover items and services furnished by a non-participating provider with respect to a covered visit at a participating facility in the following manner, except when the non-participating provider has satisfied the notice and consent criteria of 45 C.F.R. §149.420 (c) through (i): • The copayment amount, coinsurance percentage and/or other cost-sharing requirement for such items and services furnished by a non-participating provider with respect to a visit in a participating facility is the same as the copayment amount, coinsurance percentage and/or other cost-sharing requirement listed in the contract for the items and services when provided by a participating provider. • Any cost-sharing requirements for the items and services will be calculated based on the recognized amount; • Any cost-sharing payments made with respect to the items and services will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum; • We will make payment for the items and services directly to the non-participating provider or non-participating emergency facility. The payment amount will be equal to the amount by which the out-of-network rate exceeds the cost-sharing amount for the services; and • You will not be liable for an amount that exceeds your cost-sharing requirement. The above bulleted provisions are not applicable when the non-participating provider has satisfied the notice and consent criteria of 45 C.F.R. §149.420 (c) through (i), including providing notice to you of the estimated charges for the items and services and that the provider is a non-participating provider, and obtaining consent form you to be treated and balanced billed by the non-participating provider. The notice and consent criteria of 45 C.F.R. §149.420 (c) through (i) do not apply to non-participating providers with respect to: • Covered services rendered by an on-call physician or a hospital-based physician who has obtained assignment of benefits from you. • Ancillary services • Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the non-participating provider satisfied the notice and consent criteria; and such items and services furnished by non-participating providers will always be subject to the bullets listed in the first paragraph.			
In-hospital non-surgical physician services	Not available	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Preadmission testing	Not available	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

Description	Select care coverage	In-network coverage	Out-of-network coverage
Hospital and other facility care (continued)			
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.	Not available	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% (of the negotiated charge) No policy year deductible applies	80% (of the negotiated charge)	60% (of the recognized charge)
Home health care	Not available	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Hospice-Inpatient facility	Not available	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Hospice-Outpatient	Not available	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Outpatient private duty nursing	Not available	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Skilled nursing facility-Inpatient facility	Not available	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Patient-centered medical homes			
Patient-centered medical homes	Not available	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
Case management program			
Case management program	Not available	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Emergency services and urgent care			
Hospital emergency room	100% (of the negotiated charge) per visit No policy year deductible applies	$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	Not covered

Description	Select care coverage	In-network coverage	Out-of-network coverage
Emergency services and urgent care (continued)			
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. • Covered benefits that are applied to the hospital emergency room copayment/coinsurance cannot be applied to any other copayment/coinsurance under the plan. Likewise, a copayment/coinsurance that applies to other covered benefits under the plan cannot be applied to the hospital emergency room copayment/coinsurance. • Separate copayment/coinsurance amounts may apply for certain services given to you in the hospital emergency room that are not part of the hospital emergency room benefit. These copayment/coinsurance amounts may be different from the hospital emergency room copayment/coinsurance. They are based on the specific service given to you. • Services given to you in the hospital emergency room that are not part of the hospital emergency room benefit may be subject to copayment/coinsurance amounts that are different from the hospital emergency room copayment/coinsurance amounts.			
Surprise bill important note: Balance billing protections for emergency services: • The copayment amount, coinsurance percentage and/or other cost-sharing requirement for emergency services provided by a non-participating provider or non-participating emergency facility is the same as the copayment amount, coinsurance percentage and/or other cost-sharing requirement listed in the contract for emergency services provided by a participating provider or participating emergency facility. • Any cost-sharing payments made with respect to emergency services provided by a non-participating provider or non-participating emergency facility will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum; • If emergency services provided by a non-participating provider or non-participating emergency facility, any cost-sharing requirement will be calculated on the recognized amount; • If emergency services provided by a non-participating provider or non-participating emergency facility, we will make payment for the covered emergency services directly to the non-participating provider or non-participating emergency facility. The payment amount will be equal to the amount by which the out-of-network rate exceeds the cost-sharing amount for the services; and • You will not be liable for an amount that exceeds your cost-sharing requirement.			
Urgent care	100% (of the negotiated charge) per visit No policy year deductible applies	$50 copayment 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	Not covered

Description	Select care coverage	In-network coverage	Out-of-network coverage
Pediatric dental care Limited to covered persons through the end of the month in which the person turns age 19			
Type A services	Not available	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit
Type B services	Not available	70% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Type C services	Not available	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Orthodontic services	Not available	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Dental emergency services	Not available	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, supplies and treatment (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	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 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	Not available	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
Impacted wisdom teeth - For persons beyond the age as covered under the *Pediatric dental care* provision	100% (of the negotiated charge) No policy year deductible applies	80% (of the negotiated charge)	80% (of the recognized charge)
Accidental injury to sound natural teeth	100% (of the negotiated charge) No policy year deductible applies	80% (of the negotiated charge)	80% (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	Covered according to the type of benefit and the place where the service is received

Description	Select care coverage	In-network coverage	Out-of-network coverage
Specific conditions (continued)			
Clinical trial (routine patient costs)	Not available	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	Covered according to the type of benefit and the place where the service is received
Obesity (bariatric) surgery and services	Not available	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)	Not available	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	Not available	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the recognized charge) per visit No policy year deductible applies
Well newborn nursery care in a hospital or birthing center	Not available	80% (of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) per visit No policy year deductible applies
Important note: If applicable, the per admission copayment and/or policy year deductible amounts for newborns will be waived for nursery charges for the duration of the newborn's initial routine facility stay. The nursery charges waiver will not apply for non-routine facility stays.			
Voluntary sterilization for males-Inpatient physician or specialist surgical services	Not available	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
Voluntary sterilization for males-Outpatient physician or specialist surgical services	Not available	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies

Description	Select care coverage	In-network coverage	Out-of-network coverage
Abortion care			
Abortion - Inpatient physician or specialist surgical services	Not available	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
Abortion - Outpatient physician or specialist surgical services	Not available	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
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	Covered according to the type of benefit and the place where the service is received
Gender affirming additional services			
Reduction thyroid chondroplasty (tracheal shave)	Not available	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	Not available	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	Not available	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	Not available	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	Not available	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	Not available	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	Not available	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

Description	Select care coverage	In-network coverage	Out-of-network coverage
Gender affirming additional services (continued)			
Facial bone reduction or augmentation	Not available	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	Not available	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	Not available	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	Not available	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
Rhytidectomy (face lift, facial liposuction, neck tightening)	Not available	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 modification surgery, laryngoplasty	Not available	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	Not available	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
Behavioral Health - Mental health and substance related disorders treatment			
Inpatient hospital	Not available	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Outpatient office visits (includes telehealth consultations)	100% (of the negotiated charge) per visit No policy year deductible applies	$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)	100% (of the negotiated charge) per visit No policy year deductible applies	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

Description	Select care coverage	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	Not available	Covered according to the type of benefit and the place where the service is received	
Inpatient and outpatient transplant physician and specialist services	Not available	Covered according to the type of benefit and the place where the service is received	
Transplant services-travel and lodging	Not available	Covered	
Description	**Select care coverage**	**In-network coverage**	**Out-of-network coverage**
Infertility services			
Treatment of basic infertility	Not available	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			
Inpatient and outpatient care	Not available	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	100% (of the negotiated charge) No policy year deductible applies	80% (of the negotiated charge)	60% (of the recognized charge)
Diagnostic lab work performed in a physician's office, the outpatient department of a hospital or other facility	100% (of the negotiated charge) No policy year deductible applies	80% (of the negotiated charge)	60% (of the recognized charge)
Diagnostic radiological services performed in a physician's office, the outpatient department of a hospital or other facility	100% (of the negotiated charge) No policy year deductible applies	80% (of the negotiated charge)	60% (of the recognized charge)

<table>
<tr><th>Description</th><th>Select care coverage</th><th>In-network coverage</th><th>Out-of-network coverage</th></tr>
<tr><td colspan="4">Specific therapies and tests (continued)</td></tr>
<tr><td colspan="4">Surprise bill important note:
Balance billing protections for non-emergency services performed by non-participating providers at participating facilities, including ancillary services and services for unseen urgent medical needs.
We cover items and services furnished by a non-participating provider with respect to a covered visit at a participating facility in the following manner, except when the non-participating provider has satisfied the notice and consent criteria of 45 C.F.R. §149.420 (c) through (i):
• The copayment amount, coinsurance percentage and/or other cost-sharing requirement for such items and services furnished by a non-participating provider with respect to a visit in a participating facility is the same as the copayment amount, coinsurance percentage and/or other cost-sharing requirement listed in the contract for the items and services when provided by a participating provider.
• Any cost-sharing requirements for the items and services will be calculated based on the recognized amount;
• Any cost-sharing payments made with respect to the items and services will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum;
• We will make payment for the items and services directly to the non-participating provider or non-participating emergency facility. The payment amount will be equal to the amount by which the out-of-network rate exceeds the cost-sharing amount for the services; and
• You will not be liable for an amount that exceeds your cost-sharing requirement.

The above bulleted provisions are not applicable when the non-participating provider has satisfied the notice and consent criteria of 45 C.F.R. §149.420 (c) through (i), including providing notice to you of the estimated charges for the items and services and that the provider is a non-participating provider, and obtaining consent form you to be treated and balanced billed by the non-participating provider. The notice and consent criteria of 45 C.F.R. §149.420 (c) through (i) do not apply to non-participating providers with respect to:
• Covered services rendered by an on-call physician or a hospital-based physician who has obtained assignment of benefits from you.
• Ancillary services
• Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the non-participating provider satisfied the notice and consent criteria; and such items and services furnished by non-participating providers will always be subject to the bullets listed in the first paragraph.</td></tr>
<tr><td colspan="4">Important note:
Your cost share for diagnostic imaging using mammography, ultrasound imaging, or magnetic resonance imaging will be the same as mammograms performed for routine cancer screenings as described in the Preventive Care section when it is used to evaluate a breast abnormality seen or suspected from a prior screening examination or by other means of prior examination, or when it is a supplemental examination where no abnormality is seen or suspected from a prior examination and there is a personal or family history of breast cancer or additional factors that may increase your risk of breast cancer.

Cost share will be no more than the cost share for breast cancer screening and diagnosis for diagnostic ultrasound, magnetic resonance imaging, computed tomography and image-guided biopsy for recommended follow-up diagnostic imaging to assist in the diagnosis of lung cancer when recommended by the U.S. Preventative Services Task Force.</td></tr>
<tr><td>Outpatient Chemotherapy, Radiation, Infusion & Respiratory Therapy</td><td>Not available</td><td>80% (of the negotiated charge)</td><td>60% (of the recognized charge)</td></tr>
</table>

Description	Select care coverage	In-network coverage	Out-of-network coverage
Specific therapies and tests (continued)			
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy) Combined for 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.	100% (of the negotiated charge) per visit No policy year deductible applies	$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
Maximum visits per policy year	Unlimited		
Chiropractic services	100% (of the negotiated charge) per visit No policy year deductible applies	$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	Covered according to the type of benefit or the place where the service is received
Other services			
Acupuncture	Not available	$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
The following is not covered under this benefit: • Acupressure			

Description	Select care coverage	In-network coverage	Out-of-network coverage
Other services (continued)			
Emergency ground ambulance	100% (of the negotiated charge) per trip No policy year deductible applies	$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
Emergency air or water ambulance	100% (of the negotiated charge) per trip No policy year deductible applies	$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
Non-emergency ambulance	100% (of the negotiated charge) per trip No policy year deductible applies	80% (of the negotiated charge) per trip	60% (of the recognized charge) per trip
Surprise bill important note: Balance billing for non-participating providers-air ambulance services: When services are received from a non-participating provider of an air ambulance services: • The copayment amount, coinsurance percentage and/or other cost-sharing requirement for the air ambulance service is the same as the copayment amount, coinsurance percentage and/or other cost-sharing requirement listed in the contract for air ambulance services when provided by a participating provider of ambulance services. • Any cost-sharing requirement will be calculated based on the lesser of the qualifying payment amount or the billed amount for the services; • Any cost-sharing payments made with respect to the air ambulance service will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum; • We will make payment for the air ambulance services directly to the non-participating provider of ambulance services. The payment amount will be equal to the amount by which the out-of-network rate exceeds the cost-sharing amount for air ambulance services; and • You will not be liable for an amount that exceeds your cost-sharing requirement.			
Durable medical and surgical equipment	100% (of the negotiated charge) per item No policy year deductible applies	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Professional nutritional counseling and medical nutrition 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	Covered according to the type of benefit and the place where the service is received

Description	Select care coverage	In-network coverage	Out-of-network coverage
Other services (continued)			
Enteral formulas and nutritional supplements	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	Covered according to the type of benefit and the place where the service is received
Prosthetic Devices & Orthotics (Includes Cranial prosthetics *(Medical wigs))*	100% (of the negotiated charge) per item No policy year deductible applies	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Hearing aids and exams			
Hearing exam	Not available	$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
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			
Hearing aids	100% (of the negotiated charge) per item No policy year deductible applies	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 36-month consecutive period		
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 and dilation) performed by a legally qualified ophthalmologist or optometrist	Not available	100% (of the negotiated charge) per visit No policy year deductible applies	80% (of the recognized charge) per visit
Maximum visits per policy year Fitting of contact Maximum	1 visit 1 visit		

Description	Select care coverage	In-network coverage	Out-of-network coverage
Pediatric vision care (continued) Limited to covered persons through the end of the month in which the person turns age 19			
Low vision services- Performed by a legally qualified ophthalmologist or optometrist	Not available	100% (of the negotiated charge) per visit No policy year deductible applies	80% (of the recognized charge) per visit
Maximum	One comprehensive low vision evaluation every 5 years and 4 follow-up visits in any 5-year period		
Pediatric vision care services & supplies - Eyeglass frames, prescription lenses or prescription contact lenses	Not available	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	Not available	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.			

Travel and Lodging Reimbursement

Rider effective date: 8/1/2025

This rider is added to the *Eligible health services and exclusions* section of your certificate of coverage. This rider is subject to all other requirements described in your certificate, including general exclusions and defined terms.

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). Expenses for two travel companions will be reimbursed when two parents travel with a minor child.
- 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.

Contact us 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

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

- Expenses for more than one travel companion unless two parents are traveling with a minor child
- 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

Description	Amount
Travel and lodging reimbursement	100%. No policy year deductible applies
Limit per policy year	$2,000

Outpatient prescription drugs			
Copayment waiver for risk reducing breast cancer drugs			
The outpatient prescription drug copayment 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			
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.			
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.			
Preferred generic prescription drugs (including specialty 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	$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 mail order pharmacy	100% (of the negotiated charge) No policy year deductible applies	$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

Description	Select care coverage	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	100% (of the negotiated charge) No policy year deductible applies	$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
More than a 30-day supply but less than a 91-day supply filled at a mail order pharmacy	100% (of the negotiated charge) No policy year deductible applies	$100 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$100 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies
Non-preferred generic prescription drugs (including specialty 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	$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
More than a 30-day supply but less than a 91-day supply filled at a mail order pharmacy	100% (of the negotiated charge) No policy year deductible applies	$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$150 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 (including specialty 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	$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
More than a 30-day supply but less than a 91-day supply filled at a mail order pharmacy	100% (of the negotiated charge) No policy year deductible applies	$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$150 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies

Description	Select care coverage	In-network coverage	Out-of-network coverage
Outpatient prescription drugs (continued)			
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	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	Paid according to the type of drug per the schedule of benefits, above
Diabetic supplies, drugs, and insulin important note: Your cost share will not exceed $25 per 30-day supply of a covered prescription insulin drug filled at an in-network pharmacy. No policy year deductible applies for diabetic supplies and insulin.			
Important note: • Your plan covers maintenance drugs up to a 90-day supply. See your certificate for details. The cost share is 3 times the 30-day amount, and • The copayment or coinsurance for a covered specialty prescription drug filled at an in-network pharmacy will not exceed $150 for each 30-day supply.			
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, above	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
90-day supply at 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	Paid according to the type of drug per the schedule of benefits, above
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.			
Anti-cancer drugs taken by mouth			
For each fill up to a 30-day supply	100% (of the negotiated charge) No policy year deductible applies	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
Contraceptives (birth control)			
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 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	Paid according to the type of drug per the schedule of benefits, above

Description	Select care coverage	In-network coverage	Out-of-network coverage
Outpatient prescription drugs (continued)			
Preventive care drugs and supplements			
Preventive care drugs and supplements filled at a retail pharmacy For each fill up to a 30–day supply	100% (of the negotiated charge) No policy year deductible applies	100% (of the negotiated charge) No policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Preventive care drugs and supplements maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.		
Risk reducing breast cancer prescription drugs filled at a pharmacy For each fill up to a 30-day supply	100% (of the negotiated charge) No policy year deductible applies	100% (of the negotiated charge) No policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Risk reducing breast cancer prescription drugs maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For details on the guidelines and the current list of covered risk reducing breast cancer prescription drugs, contact Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.		
Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy For each fill up to a 30-day supply	100% (of the negotiated charge) No policy year deductible applies	100% (of the negotiated charge) No policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Tobacco cessation prescription drugs and OTC drugs maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.		
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.			

Outpatient prescription drug exclusions

The following are not eligible health services:

- Any services related to providing, injecting or application of a drug, except where stated in the *Eligible health services – Family planning services – female contraceptives* section
- Except for the bulk chemicals expressly designated as exempt from regulation by the U.S. Food and Drug Administration (FDA), 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
- 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 except where stated in the *Eligible health services – Clinical trial therapies (experimental or investigational) and routine patient costs* section and the *Medical necessity and precertification requirements – Step therapy* section
  - Provided under your medical plan while inpatient at a 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 unless recommended by the United States Preventive Services Task Force (USPSTF)
  - 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
- Immunizations related to travel or work
- Implantable drugs and associated devices except as specifically stated in the schedule of benefits or the certificate
- Infertility:
- Prescription drugs used primarily for the treatment of infertility except where stated in the *Eligible health services – Treatment of infertility* section
- 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
  - Specialty prescription drugs, unless dispensed through the specialty pharmacy, or specifically described as covered in the *Eligible health services* section of this certificate of coverage.
- Off-label drug use except for indications recognized for treatment in any of the standard reference compendia or through peer-reviewed medical literature
- Prescription drugs:
  - 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

(continued on next page)

Outpatient prescription drug exclusions (continued)
The following are not eligible health services:
- Replacement of lost or stolen prescriptions
- Test agents except diabetic test agents
- Tobacco cessation drugs, including nicotine patches and gum, unless recommended by the USPSTF. See the *Eligible health services under the plan – Outpatient prescription drugs* section
- Except where stated in the *Eligible health services – Medical exceptions* section, 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

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 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 with the exception of telehealth services, 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 for medically necessary hair prostheses when prescribed by the attending oncologist for covered persons whose hair loss results from chemotherapy or radiation treatment for cancer or by a provider for a condition other than the treatment of cancer and the prosthesis is appropriate or efficient.

- 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.

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:
- 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

Dental care for adults

- Dental services for adults including services related to:
  - The care, filling, removal or replacement of teeth and treatment of injuries to or 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

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

Family planning services

- 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 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. See the *Eligible health services– Habilitation therapy service*s section.

Vision care for adults

- Routine vision exam provided by an ophthalmologist or optometrist, including refraction and glaucoma testing
- Vision care services and supplies

Wilderness treatment programs

- Whether or not the program is part of a **r**esidential treatment facility or otherwise licensed institution

Work related illness or injuries

- Coverage available to you under worker's compensation or under a similar program under local, state or federal law for any illness or injury related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered "non-occupational" regardless of cause.

The University of Maryland College Park Student Health Insurance Plan is underwritten by Aetna Life Insurance Company (Aetna). 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 1-877-480-4161.

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 1-877-480-4161.

If you have questions about our nondiscrimination policy or have a discrimination-related concern that you would like to discuss, please call us at 1-877-480-4161.

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.

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 કૉલ 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。**
Karen	လၢတၢကမ့ၢကိုၢတၢမၤစၢၤအတၢဖံးတၢမၤတဖၣ လၢတအိၣ်ဒီးအပ့ၢ လၢနကဘၣ်ဟ့ၣ်အီၤအဂ့ၢ်ကီးဘၣ်လီၤတံၢ်စိနီၣ်ဂံၢ် လၢအအိၣ်လၢနခိၣ်ကီၤ ဗ (ၡိ) အလိၤ်ဘၣ်တက့ၢ်ၡိ
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Laotian	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T'áá ni nizaad k'ehjí bee níká a'doowoł doo bąąh ílínígóó naaltsoos bee atah nílįįgo nanitinígíí bee nééhó'dólzinígíí béésh bee hane'í biká'ígíí áajį' hólne'.
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	[illegible]
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.