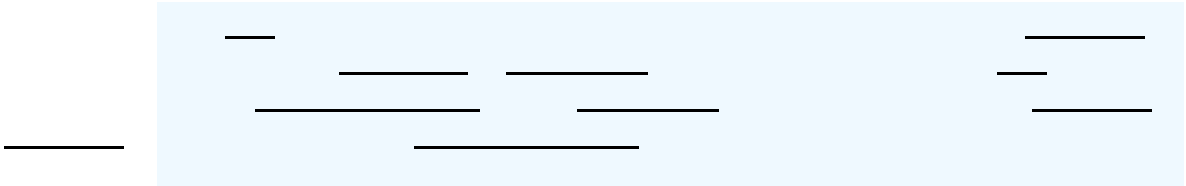




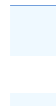
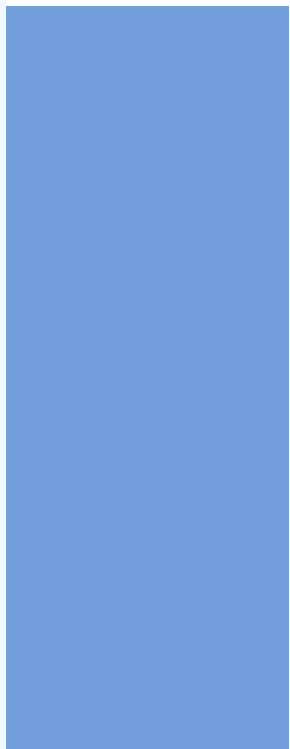
Coverage for Individual+Family | PlanType:PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you will share the cost for covered health care services. NOTE: Information about the cost of (the plan premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, <https://www.aetnastudenthealth.com/en/school/867936/members/8773813544>. For general definitions of common terms, such as amount, balance billing, insurance, pay, Wd6(bal)1 (gt EMC /P <</MCID 344 >>5 <</MCID 344 >>BDC 0.002 TID 344 >>5 <</17wM f\* 3



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







Excluded Services & Other Covered Services:

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

- x Acupuncture x
- x Bariatric surgery
- x Cosmetic surgery



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Hawaiian

No ka walaau ana me ka lawelawe ʻĀlelo e kahea aku i kēhelu kelepona 1-877-

Punjabi

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