Healthier living
Financial well-being
Intelligent solutions
Quality health plans & benefits

Aetna Student Health
Plan Design and Benefits Summary

Preferred Provider Organization (PPO)

Virginia Tech

Policy Year: 2020 - 2021
Policy Number: 474968
www.aetnastudenthealth.com
(866) 577-7027

This is a brief description of the Student Health Plan. The Plan is available for Virginia Tech students and their eligible dependents. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Certificate of Coverage and may be viewed online at **www.aetnastudenthealth.com.** If there is a difference between this Benefit Summary and the Certificate of Coverage, the Certificate will control.

Virginia Tech Health Services

The Schiffert Health Center is the University's on-campus health facility. Staffed by physicians, nurse practitioners and registered nurses, it 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 on call at all times, and conduct clinics during the week.

For more information, call the Health Services at **(540) 231-6444**. In the event of an emergency, call **911**.

Coverage Periods

Students/Eligible Dependents: Coverage will become effective at 12:00 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.

Coverage Period	Coverage Start Date	Coverage End Date	Open Enrollment Deadline
Annual	08/01/2020	07/31/2021	09/09/2020
Spring /Summer	01/01/2021	07/31/2021	01/31/2021

Rates

	Annual	Spring Semester
Student	$3,173	$1,843
Spouse/Domestic Partner	$3,173	$1,843
Child	$3,173	$1,843
2+ Children	$6,346	$3,686

Refund Policy

If you withdraw from school within the first **31 days** of a coverage period, you will not be covered under the policy and the full premium will be refunded, less any claims paid. After **31 days**, you will be covered for the full period that you have paid the premium for, and no refund will be allowed. (This refund policy will not apply if you withdraw due to a covered Accident or Sickness.)

Exception: No premium refunds will be made except for situations where a Covered Person enters the armed forces of any country and will not be covered under the policy as of the date of such entry. In this case, a pro-rata refund of premium will be made for any such person and any covered dependents upon written request received by Aetna Student Health within **90 days** of withdrawal from school.

Coverage

Eligibility

Students must be enrolled as **full-time** students at the university on the first day that coverage will be effective. Students in Cooperative Education and serving approved internships off-campus or performing credited research hours are considered to be full-time students of the university. However, if the student takes fewer than full-time hours but is enrolled in the maximum number of hours allowed toward graduation (i.e. working on a dissertation), the student may obtain a statement to this effect in writing on the department's letterhead and with the signature of the department head. This confirmation may be attached to the application for insurance. The student shall then be considered as full-time and shall be eligible to enroll in the university's insurance plans.

- Undergraduate Eligibility: 12 or more credit hours
- Graduate Eligibility: 9 or more credit hours
- International Students & Veterinary Medicine DVM Students are required to maintain health insurance either through the school sponsored plan or a comparable plan.
- Eligible Graduate Assistants wishing to use the health care subsidy must in enroll in the Virginia Tech sponsored plan.
- Graduate students who are defending their thesis are eligible to remain on the insurance program if previously insured through the end of the month in which they defend. Documentation from the department head must be provided to the Student Medical Insurance office.
- Visiting Scholars are required to maintain health insurance either though the schools sponsored plan or a comparable plan during their stay at Virginia Tech.
- Language and Culture Institute VT Advantage students.

Students must actively attend classes for at least the first **31 days**, after the date when coverage becomes effective.

Home study, correspondence, Internet classes, and television (**TV**) courses, do not fulfill the eligibility requirement that the student actively attend classes. If it is discovered that this eligibility requirement has not been met, our only obligation is to refund premium, less any claims paid.

Enrollment: To enroll online, log on to **www.aetnastudenthealth.com,** search for your school, click on Enroll and follow the steps. Enrollment will not be accepted after the enrollment deadline unless there is a significant life change that directly affects their insurance coverage. (An example of a significant life change would be loss of health coverage under another health plan.) The completed Enrollment and premium must be sent to Aetna Student Health.

ID Cards: To print an ID card, log on to **www.aetnastudenthealth.com**, search for your school, click on Get your ID card and follow the steps. Please note that the ID card will be available within 7-10 business days after enrollment is completed.

Please note: Visiting Scholars and Language and Culture Institute students must enroll through the Virginia Tech Student Medical Insurance office.

Waiver Process/Procedure

International Students & Veterinary Medicine DVM Students are required to maintain health insurance either through the school sponsored plan or a comparable plan.

To meet the criteria of a comparable insurance plan, coverage must meet or exceed all of the following:

1. The policy must offer adequate provider care within a 50-mile radius of the campus of enrollment. Coverage for emergency only care does not satisfy this requirement. (Adequate means Preferred Care coverage for non-emergency care.)
2. The policy must have a deductible of **$500** per accident or illness or less.
3. The policy must provide major medical benefits of at least **$500,000** per accident or illness.
4. The policy must provide a minimum benefit of **$25,000** for repatriation of remains and **$50,000** medical evacuation to the home country. (Repatriation provides transportation to your home country in the event of death.)
5. Medical expenses for pregnancy, childbirth and complications of pregnancy must be treated as any other illness under the policy.
6. The policy must provide Prescription Medication coverage (after co-pays) with a minimum of **$500,000** per insured per policy year.
7. Coverage must be valid from either August 01, 2020, or the first day of enrollment at Virginia Tech, until July 31, 2021 or, if graduating, the last day of the month of the student's graduation.
8. The policy must cover Outpatient and Inpatient Mental Health Care as any other illness.
9. The policy **must not** have limits or internal dollar caps on coverage, including services, treatment or surgery.
10. The policy **must not** have a pre-existing condition waiting period.

Waiver submissions will be audited by Virginia Tech, and/or their contractors or representatives. You may be required to provide, upon request, any coverage documents and/or other records demonstrating that you meet the school's requirements for waiving the student health insurance plan.

All International and Veterinary Medicine DVM Students records will be blocked and students will be unable to register for classes until the university-sponsored insurance or alternate approved insurance is purchased. There are no exemptions from this requirement. Waivers must be remitted by the deadlines listed below.

Waiver Deadline Dates

1. Students enrolling for the Fall Semester- 09/09/2020
2. Students enrolling for the Spring Semester- 01/31/2021

In order to avoid having a block placed on a student's account the student must enroll in the Student Medical Insurance Program or provide details of their current comparable coverage to the Student Medical Insurance Office before the deadline.

Dependent Coverage

Eligibility

Covered students may also enroll their lawful spouse or domestic partner (same-sex, opposite sex) and any dependent children up to the age of **26**. ***Verification of Dependent status may be required.***

If a child is covered based on being a full-time student and he/she can't attend school because of a medical condition, the plan must allow the child to stay on the plan, if certified by a physician as medically necessary, until the earlier of 12 months or when coverage would otherwise terminate for the dependent.

Enrollment

To enroll the dependent(s) of a covered student, please complete the Enrollment by visiting **www.aetnastudenthealth.com**, selecting the school name, and clicking on Enroll. Please refer to the Coverage Periods section of this document for coverage dates and deadline dates. Dependent enrollment will not be accepted after the enrollment deadline unless there is a significant life change that directly affects their insurance coverage. (An example of a significant life change would be loss of health coverage under another health plan.) The completed Enrollment and premium must be sent to Aetna Student Health.

Newborn Infant and Adopted Child Coverage

A child born to a Covered Person shall be covered for Accident, Sickness, and congenital defects including cleft lip/cleft palate or ectodermal dysplasia, for **60 days** from the date of birth. At the end of this **60-day** period, coverage will cease under the **Virginia Tech** Student Health Insurance Plan. To extend coverage for a newborn past the **60 days**, the Covered Student must: 1) enroll the child within **60 days** of birth, and 2) pay the additional premium, starting from the date of birth.

Coverage is provided for a child legally placed for adoption with a Covered Student for **60 days** from the moment of placement provided the child lives in the household of the Covered Student, and is dependent upon the Covered Student for support. To extend coverage for an adopted child past the **60 days**, the Covered Student must 1) enroll the child within **60 days** of placement of such child, and 2) pay any additional premium, if necessary, starting from the date of placement.

For information or general questions on dependent enrollment, contact Student Medical Insurance at **(540) 231-6226**

Medicare Eligibility Notice

You are <u>not</u> eligible for health coverage under this student policy if you have Medicare at the time of enrollment in this student plan.

If you obtain Medicare after you enrolled in this student plan, your health coverage under this plan will not end.

As used here, “have Medicare” means that you are entitled to benefits under Part A (receiving free Part A) or enrolled in Part B or Premium Part A.

Preferred Provider Network

Aetna Student Health offers Aetna's broad network of Preferred Providers. You can save money by seeing Preferred Providers because Aetna has negotiated special rates with them, and because the Plan's benefits are better. Cost sharing for Preferred Care may differ depending on whether a referral is obtained, care is received outside of a 20 mile radius from the school campus, and/or when school health services is closed. Please see the specific plan and benefit cost sharing in this schedule of benefits.

If you need care that is covered under the Plan but not available from a Preferred 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 a Non-Preferred Care Provider. When a pre-approval is issued by Aetna, the benefit level is the same as for Preferred Care Providers.

Pre-certification

You need pre-approval from Aetna for some eligible health services. Pre-approval is also called pre-certification.

Pre-certification for medical services and supplies

Preferred Care

Your Preferred Care physician is responsible for obtaining any necessary pre-certification before you get the care. If your Preferred Care physician doesn't get a required pre-certification, we won't pay the provider who gives you the care. You won't have to pay either if your Preferred Care physician fails to ask us for pre-certification. If your Preferred Care physician requests pre-certification and we refuse it, you can still get the care but the plan won't pay for it. You will find additional details on requirements in the Certificate of Coverage.

Non-Preferred Care

When you go to a Non-Preferred Care provider, it is your responsibility to obtain pre-certification from us for any services and supplies on the pre-certification list. If you do not pre-certify, your benefits may be reduced, or the plan may not pay any benefits. Refer to your schedule of benefits for this information. The list of services and supplies requiring pre-certification appears later in this section

Pre-certification call

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

Non-emergency admissions:	You, your physician or the facility will need to call and request pre-certification at least 15 days before the date you are scheduled to be admitted.
An emergency admission:	You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
An urgent admission:	You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or an injury.
Outpatient non-emergency services requiring pre-certification:	You or your physician must call at least 15 days before the outpatient care is provided, or the treatment or procedure is scheduled.
Delivery:	You, your physician, or the facility must call within 48 hours of the birth or as soon thereafter as possible. No penalty will be applied for the first 48 hours after delivery for a routine delivery and 96 hours for a cesarean delivery.

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

If you require an extension to the services that have been precertified, you, your physician, or the facility will need to call us at the number on your ID card as soon as reasonably possible, but no later than the final authorized day.

If pre-certification determines that the stay or outpatient services and supplies are not covered benefits, the notification will explain why and how you can appeal our decision. You or your provider may request a review of the pre-certification decision. See the *When you disagree - claim decisions and appeals procedures* section of Certificate of Coverage.

What if you don't obtain the required pre-certification?
If you don't obtain the required pre-certification:

- Your benefits may be reduced, or the plan may not pay any benefits. See the schedule of benefits *Pre-certification penalty* section.
- You will be responsible for the unpaid balance of the bills.
- Any additional out-of-pocket expenses incurred will not count toward your deductibles or maximum out-of-pocket limits.

What types of services and supplies require pre-certification?

Pre-certification is required for the following types of services and supplies:

Inpatient services and supplies	Outpatient services and supplies
Gender reassignment surgery	Applied behavior analysis
Obesity (bariatric) surgery	Certain **prescription drugs** and devices*****
Stays in a **hospice** facility	Complex imaging
Stays in a **hospital**	**Cosmetic** and reconstructive **surgery**
Stays in a **rehabilitation facility**	Emergency transportation by airplane
Stays in a **residential treatment facility** for treatment of **mental disorders** and **substance abuse**	Gender reassignment surgery
Stays in a **skilled nursing facility**	Home health care
	Hospice services
	Intensive outpatient program (IOP) – **mental disorder** and **substance abuse** diagnoses
	Kidney dialysis
	Knee **surgery**
	Medical **injectable drugs**, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, botox, hepatitis C medications)*****
	Outpatient back **surgery** not performed in a **physician's** office
	Partial hospitalization treatment – **mental disorder** and **substance abuse** diagnoses
	Private duty nursing services
	Psychological testing/neuropsychological testing
	Sleep studies
	Transcranial magnetic stimulation (TMS)
	Wrist **surgery**

For a current listing of the prescription drugs and medical injectable drugs that require pre-certification, contact Member Services by calling the toll-free number on your ID card in the How to contact us for help section or by logging onto the Aetna website at **www.aetnastudenthealth.com.*

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).

Here's how COB works

- When this is the primary plan, we will pay your medical claims first as if the other plan does not exist
- When this is the secondary plan, we will pay benefits after the primary plan and will coordinate the payment based on any amount the primary plan paid
- We will never pay an amount that, together with payments from your other coverage, add up to more than 100% of the allowable submitted expenses

For more information about the Coordination of Benefits provision, including determining which plan is primary and which is secondary, you may call the Member Services telephone number shown on your ID card. A complete description of the Coordination of Benefits provision is contained in the Policy issued to Virginia Tech, and may be viewed online at **www.aetnastudenthealth.com**.

Description of Benefits

The Plan excludes coverage for certain services (referred to as exceptions in the certificate of coverage) and has limitations on the amounts it will pay. While this Plan Design and Benefit Summary document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. To look at the full Plan description, which is contained in the Certificate of Coverage issued to you, go to **www.aetnastudenthealth.com.** If any discrepancy exists between this Benefit Summary and the Certificate of Coverage, the Certificate will control.

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

Metallic Level: Platinum, tested at 86.84%.

Policy year deductible	**Preferred Care Coverage**	**Non-Preferred Care Coverage**
You have to meet your policy year deductible before this plan pays for benefits.		
Student	$450 per policy year	$1,000 per policy year
Spouse	$450 per policy year	$1,000 per policy year
Each child	$450 per policy year	$1,000 per policy year
Family	$900 per policy year	$2,000 per policy year
Policy year deductible waiver		
The policy year deductible is waived for Preferred Care covered medical expenses that apply to Preventive Care Expense benefits. In addition to federal requirements for waiver of the policy year deductible, this Plan will waive the Deductible for: • Preferred and Non-Preferred Care Emergency Room Services, • Non-Preferred Care Preventive Health Care Services up to age 7, • Preferred and Non-Preferred Care Pediatric Care Vision Benefit Expenses, • Preferred Care Pediatric Dental Services Expenses, • Preferred and Non-Preferred Care Prescribed Medicines expenses, • Preferred Care Adult Vision Exam and Vision Supplies Expense, • Preferred Care Office Visit Expense, • Preferred Care Walk-in Clinic Visit Expense *(continued next page)*		

Policy year deductible	Preferred Care Coverage	Non-Preferred Care Coverage

Policy year deductible waiver (continued)

- Preferred Care Outpatient Treatment of Mental Disorders Expense,
- Preferred Care Outpatient Treatment of Substance Abuse Expense,
- Preferred Care Urgent Care Expense, and
- Preferred Care Non-Elective Second Surgical Opinion Expense.

Per visit or admission deductibles do not apply towards satisfying the policy year deductible.

Maximum out-of-pocket limits

Maximum out-of-pocket limit per policy year

Once the Individual or Family Out-of-Pocket Limit has been satisfied, Covered Medical Expenses will be payable at **100%** for the remainder of the policy year.

The following expenses do not apply toward meeting the plan's out-of-pocket limits:

- Non-covered medical expenses; and
- Expenses that are not paid or pre-certification benefit reductions or penalties because a required pre-certification for the service(s) or supply was not obtained from Aetna.

Student	$6,250 per policy year
Spouse	$6,250 per policy year
Each child	$6,250 per policy year
Family	$12,500 per policy year

Pre-certification covered benefit penalty

This only applies to Non-Preferred Care coverage: The certificate of coverage contains a complete description of the pre-certification program. You will find details on pre-certification requirements in the *Medical necessity and pre-certification requirements* section.

Failure to pre-certify your eligible health services when required will result in the following benefit penalties:

- A **$200** benefit penalty may be applied separately to each type of eligible health services.

The additional percentage or dollar amount of the recognized charge which you may pay as a penalty for failure to obtain pre-certification is not a covered benefit and will not be applied to the policy year deductible amount or the maximum out-of-pocket limit, if any.

Referral requirement

Students who have initiated care at Schiffert Health Center prior to seeking care in the community and have been referred to an outside provider for treatment are eligible to receive enhanced benefits for services when care is provided by a preferred care provider shown as preferred coverage with Referral in the below schedule of benefits. **A new referral must be obtained each policy year**.

If a referral is received, preferred care coinsurance increases from 80% to 90% for services rendered at a hospital.A referral is not required in the following circumstances:

- Emergency Room Services
- Treatment received when Schiffert Health Center is closed.
- Care received outside a 20-mile radius from the Blacksburg Campus
- Maternity
- Satellite Campus enrolled students
- Treatment is for an Emergency Medical Condition
- Obstetric and Gynecological Treatment

(continued next page)

Policy year deductible	Preferred Care Coverage	Non-Preferred Care Coverage
Referral requirement (continued)		
• Pediatric Care • Preventive/Routine Services (services considered preventive according to Health Care Reform and/or services rendered not to diagnosis or treat an Accident or Sickness). *Dependents and Visiting Scholars are not eligible to use the services of the School Health Service and therefore cannot received enhanced benefits shown in tier 1 of the schedule of benefits. All labs and services provided at Schiffert Health Center are covered at **100%.** Students should submit their itemized paid statements to Aetna Student Health for reimbursement. Retroactive referral requests will not be accepted or processed.		

The coinsurance listed in the schedule of benefits below reflects the plan coinsurance percentage. This is the coinsurance amount that the plan pays. You are responsible for paying any remaining coinsurance.

Tier I: When a Schiffert Health Center referral is obtained, benefits will be paid at the **Tier I** Level when rendered by a **Preferred Care** provider.
Tier II: When a referral is not obtained but care is rendered by a **Preferred Care** provider, benefits will be paid at the **Tier II** Level.
Tier III: When care is rendered by a **Non-Preferred Care** provider, benefits will be paid at the **Tier III** Level.

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Physician and specialist services			
Office hours visits (non-surgical and non-preventive care by a physician and specialist includes telemedicine consultations)	$25 copayment then the plan pays 100% of the negotiated charge per visit No policy year deductible applies	$25 copayment then the plan pays 100% of the negotiated charge per visit No policy year deductible applies	65% (of the recognized charge) per visit
Urgent care			
Urgent medical care provided by an urgent care provider – visit charge *For coverage of complex imaging services, lab work, and radiological services performed during an urgent medical care visit, refer to the "outpatient diagnostic testing" section.*	$25 copayment then the plan pays 100% of the negotiated charge per visit No policy year deductible applies	$25 copayment then the plan pays 100% of the negotiated charge per visit No policy year deductible applies	$25 copayment then the plan pays 65% of the recognized charge per visit
Alternatives to physician office visits			
Walk-in clinic visits (non-emergency visit)	$25 copayment then the plan pays 100% of the negotiated charge per visit No policy year deductible applies	$25 copayment then the plan pays 100% of the negotiated charge per visit No policy year deductible applies	65% (of the recognized charge) per visit

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Consultant services (non-surgical and non-preventive)			
Office hours visits (non-surgical and non-preventive care) includes telemedicine consultations **Eligible health services** include the services of a consultant to confirm a diagnosis made by your **physician** or to determine a diagnosis. Your **physician** must make the request for the consultant services. **Covered benefits** include treatment by the consultant.	80% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	80% (of the recognized charge) per visit
Second surgical opinion	$25 copayment then the plan pays 100% of the negotiated charge per visit No policy year deductible applies	$25 copayment then the plan pays 100% of the negotiated charge per visit No policy year deductible applies	65% (of the recognized charge) per visit
Preventive care and wellness			
Routine physical exams			
Performed at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Under 7 years of age – 100% of the recognized charge per visit, no copayment or deductible applies 7 years of age or older - 100% of the recognized charge per visit, policy year deductible applies
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 onto your Aetna Navigator® secure website at **www.aetnastudenthealth.com** or calling the toll-free number on your ID card.		
Covered persons age 22 and over: Maximum visits per policy year	1 visit		

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
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	Under 7 years of age – 100% of the recognized charge per visit, no copayment or deductible applies 7 years of age or older - 100% of the recognized charge per visit, policy year deductible applies
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 onto your Aetna Navigator® secure website at **www.aetnastudenthealth.com** or calling the toll-free number on your ID card.		
Well woman preventive visits **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	65% (of the recognized charge) per visit
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.		
Preventive screening and counseling services			
Obesity and/or healthy diet counseling office visits	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	65% (of the recognized charge) per visit
Maximum visits per policy year (This maximum applies only to covered persons age 22 and older.)	26 visits (however, of these only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)		

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Misuse of alcohol and/or drugs counseling office visits	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	65% (of the recognized charge) per visit
Maximum visits per policy year	5 visits		
Use of tobacco products counseling office visits	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	65% (of the recognized charge) per visit
Maximum visits per policy year	8 visits		
Depression screening counseling office visits	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	65% (of the recognized charge) per visit
Maximum visits per policy year	1 visit		
Sexually transmitted infection counseling office visits	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	65% (of the recognized charge) per visit
Maximum visits per policy year	2 visits		
Genetic risk counseling for breast and ovarian cancer counseling office visits	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	65% (of the recognized charge) per visit

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Routine cancer screenings performed at a physician's office, specialist's office or facility.			
Routine cancer screenings	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	65% (of the recognized charge) per visit
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 onto your Aetna Navigator® secure website at **www.aetnastudenthealth.com** or calling the toll-free number on your ID card.		
Lung cancer screening maximums	1 screening every 12 months*		
***Important note:** Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.			
Prenatal care services (provided by a physician, an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)			
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	65% (of the recognized charge) per visit
Important note: You should review the *Maternity care and Well newborn nursery care* sections. They will give you more information on coverage levels for maternity care under this plan.			
Comprehensive lactation support and counseling services			
Lactation counseling services - facility or office visits	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	65% (of the recognized charge) per visit
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits		
Important note: Any visits that exceed the lactation counseling services maximum are covered under the *Physicians and other health professionals* section.			

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
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
Maximums	An electric breast pump (non-hospital grade, cost is covered by your plan once every three years) or a manual breast pump (cost is covered by your plan once per pregnancy) If an electric breast pump was purchased within the previous three year period, the purchase of another electric breast pump will not be covered until a three year period has elapsed since the last purchase.		
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	65% (of the recognized charge) per visit
Contraceptives (prescription drugs and devices)			
Female contraceptive prescription drugs and devices provided, administered, or removed, by a physician during an office visit (a 12 month supply of hormonal contraceptives will be covered under the plan when dispensed or furnished at one time)	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	65% (of the recognized charge) per item
Female voluntary sterilization			
Inpatient provider services	100% (of the negotiated charge) per admission No copayment or policy year deductible applies	100% (of the negotiated charge) per admission No copayment or policy year deductible applies	65% (of the recognized charge) per admission
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	65% (of the recognized charge) per visit

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Family planning services – other			
Voluntary sterilization for males Inpatient physician or specialist surgical services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Voluntary sterilization for males Outpatient physician or specialist surgical services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Maternity care			
Maternity care (includes delivery postpartum care services)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Well newborn nursery care in a hospital or birthing center	90% (of the negotiated charge) No policy year deductible applies	90% (of the negotiated charge) No policy year deductible applies	65% (of the recognized charge) No policy year deductible applies
Note: *The per admission copayment amount and/or policy year deductible 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.*			
Care and treatment for the newborn to correct functional impairment caused by congenital defects and birth abnormalities (including inpatient and outpatient dental services, dental appliances, oral surgical, and orthodontic services that are medically necessary for the treatment of cleft lip, cleft palate or ectodermal dysplasia)	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
Birthing center (facility charges)			
Inpatient (room and board and other miscellaneous services and supplies)	Paid at the same cost-sharing as hospital care	Paid at the same cost-sharing as hospital care	Paid at the same cost-sharing as hospital care

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Pregnancy complications			
Inpatient (room and board and other miscellaneous services and supplies) Subject to semi-private room rate unless intensive care unit required Room and board includes intensive care	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Physician and specialist - inpatient surgical services			
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthesiologist, anesthetist and surgical assistant expenses)	90% (of the negotiated charge)	80% (of the negotiated charge)	65% (of the recognized charge)
Physician and specialist - outpatient surgical services			
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthesiologist, anesthetist and surgical assistant expenses)	90% (of the negotiated charge)	80% (of the negotiated charge)	65% (of the recognized charge)
Outpatient surgery (facility charges)			
Facility charges for surgery performed in the outpatient department of a hospital or surgery center For physician charges, refer to the *Physician and specialist - outpatient surgical services* benefit	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Hospital and other facility care			
Inpatient hospital (room and board) and other miscellaneous services and supplies) Subject to semi-private room rate unless intensive care unit required Room and board includes intensive care For physician charges, refer to the *Physician and specialist – inpatient surgical services* benefit	$300 copayment then the plan pays 90% of the negotiated charge per admission	$300 copayment then the plan pays 80% of the negotiated charge per admission	$300 copayment then the plan pays 65% of the recognized charge per admission
Preadmission testing	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
In-hospital non-surgical physician services			
In-hospital non-surgical physician services	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit
Adult vision care - Limited to covered persons age 19 and over			
Adult routine vision exams (including refraction) performed by a legally qualified ophthalmologist or optometrist Limited to covered persons age 19 and over	$15 copayment then the plan pays 100% of the negotiated charge per visit No policy year deductible applies	$15 copayment then the plan pays 100% of the negotiated charge per visit No policy year deductible applies	65% (of the recognized charge) per visit
Maximum visits per policy year	1 visit		
Vision correction after surgery or accident **Important note:** See the *Vision correction after surgery or accident (all ages)* section of the certificate of coverage for details.	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Adult vision care - Limited to covered persons age 19 and over (continued)			
Eyeglass frames, prescription lenses or prescription contact lenses*	$15 copayment then the plan pays 100% of the negotiated charge per visit No policy year deductible applies	$15 copayment then the plan pays 100% of the negotiated charge per visit No policy year deductible applies	$15 copayment then the plan pays 100% of the recognized charge per visit
Maximum per policy year eyeglass frames, prescription lenses or prescription contact lenses	$120 per policy year		
*__Important note__: Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies. Coverage does not include the office visit for the fitting of prescription contact lenses.			
Mental health treatment – inpatient			
Inpatient mental disorders treatment (room and board) Inpatient residential treatment facility (room and board) Coverage is provided under the same terms, conditions as any other illness	$300 copayment then the plan pays 90% of the negotiated charge per admission	$300 copayment then the plan pays 80% of the negotiated charge per admission	$300 copayment then the plan pays 65% of the recognized charge per admission
Other inpatient mental disorders treatment services and supplies (other than room and board) Other inpatient residential treatment facility services and supplies (other than room and board) Coverage is provided under the same terms, conditions as any other illness.	90% (of the negotiated charge) per admission	80% (of the negotiated charge) per admission	65% (of the recognized charge) per admission
Mental health treatment - outpatient			
Outpatient mental disorders treatment office visits to a physician or behavioral health provider (includes telemedicine cognitive behavioral therapy consultations)	$25 copayment then the plan pays 100% of the negotiated charge per visit No policy year deductible applies	$25 copayment then the plan pays 100% of the negotiated charge per visit No policy year deductible applies	65% (of the recognized charge) per visit

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Mental health treatment – outpatient (continued)			
Other outpatient mental disorders treatment (includes skilled behavioral health services in the home) Partial hospitalization treatment Intensive Outpatient Program	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit
Substance use disorders treatment-inpatient			
Inpatient substance use detoxification (room and board) Inpatient substance use rehabilitation (room and board) Inpatient residential treatment facility substance abuse (room and board) Coverage is provided under the same terms, conditions as any other illness.	$300 copayment then the plan pays 90% of the negotiated charge per admission	$300 copayment then the plan pays 80% of the negotiated charge per admission	$300 copayment then the plan pays 65% of the recognized charge per admission
Other inpatient substance abuse detoxification services and supplies (other than room and board) Other inpatient substance abuse rehabilitation services and supplies (other than room and board) Other inpatient residential treatment facility services and supplies (other than room and board) Coverage is provided under the same terms, conditions as any other illness.	90% (of the negotiated charge) per admission	80% (of the negotiated charge) per admission	65% (of the recognized charge) per admission

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Substance use disorders treatment-outpatient: detoxification and rehabilitation			
Outpatient substance use office visits to a physician or behavioral health provider (includes telemedicine consultation) Coverage is provided under the same terms, conditions as any other illness.	$25 copayment then the plan pays 100% of the negotiated charge per visit No policy year deductible applies	$25 copayment then the plan pays 100% of the negotiated charge per visit No policy year deductible applies	65% (of the recognized charge) per visit
Other outpatient substance abuse services (includes skilled behavioral health services in the home) Partial hospitalization treatment Intensive Outpatient Program	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit
Transplant services			
Inpatient and outpatient transplant facility services	Covered according to the type of benefit and the place where the service is received		
Inpatient and outpatient transplant physician and specialist services	Covered according to the type of benefit and the place where the service is received		
Transplant services- reasonable and necessary travel and lodging costs for the covered person and for one companion, or for two companions if the covered person is a minor child, and for the donor if the donor and the covered person are both covered under this plan.	100% of the actual charge	100% of the actual charge	100% of the actual charge
Pediatric dental care (Limited to covered persons through the end of the month in which the person turns age 19)			
Type A services	100% (of the negotiated charge) per visit No copayment or deductible applies	100% (of the negotiated charge) per visit No copayment or deductible applies	65% (of the recognized charge) per visit
Type B services	70% (of the negotiated charge) per visit No policy year deductible applies	70% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Pediatric dental care (continued) **(Limited to covered persons through the end of the month in which the person turns age 19)**			
Type C services	50% (of the negotiated charge) per visit No policy year deductible applies	50% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit
Orthodontic services	50% (of the negotiated charge) per visit No policy year deductible applies	50% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit
Dental emergency treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Pediatric vision care **(Limited to covered persons through the end of the month in which the person turns age 19)**			
Pediatric routine vision exams (including refraction)			
Performed by a legally qualified ophthalmologist or optometrist	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the negotiated charge) per visit No policy year deductible applies	65% (of the recognized charge) per visit No policy year deductible applies
Maximum visits per policy year	1 visit		
Pediatric comprehensive low vision evaluations			
Performed by a legally qualified ophthalmologist or optometrist	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the negotiated charge) per visit No policy year deductible applies	65% (of the recognized charge) per visit No policy year deductible applies
Maximum	One comprehensive low vision evaluation every 5 years 4 follow-up visits in any 5-year period		
Vision correction after surgery or accident			
Vision correction after surgery or accident	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

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Pediatric vision care (continued) **(Limited to covered persons through the end of the month in which the person turns age 19)**			
Pediatric vision care services and supplies			
Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the negotiated charge) per visit No policy year deductible applies	65% (of the recognized charge) per visit No policy year deductible applies
Maximum number of eyeglass frames per policy year Maximum number of prescription lenses per policy year	One set of eyeglass frames One pair of prescription lenses		
Maximum number of prescription contact lenses per policy year (includes non-conventional prescription contact lenses and aphakic lenses prescribed after cataract surgery)	Daily disposables: up to 3 month supply Extended wear disposable: up to 6-month supply Non-disposable lenses: one set		
Office visit for fitting of contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the negotiated charge) per visit No policy year deductible applies	65% (of the recognized charge) per visit No policy year deductible applies
Optical devices Maximum number of optical devices per policy year: One optical device	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the negotiated charge) per visit No policy year deductible applies	65% (of the recognized charge) per visit No policy year deductible applies
*__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.			

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Physicians and other health professionals			
Allergy testing and treatment			
Allergy testing performed at a physician's or specialist's office Allergy injections treatment performed at a physician's, or specialist office Allergy sera and extracts administered via injection at a physician's or specialist's office	80% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit
Anesthesia and related facility charges for dental care			
Anesthesia and related facility charges for dental care	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Alternatives to hospital stays			
Home health care			
Outpatient	80% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	80% (of the recognized charge) per visit
Hospice care			
Inpatient facility (room and board and other miscellaneous services and supplies)	80% (of the negotiated charge) per admission	80% (of the negotiated charge) per admission	65% (of the recognized charge) per admission
Outpatient	80% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit
Skilled nursing facility			
Inpatient facility (room and board and miscellaneous inpatient care services and supplies) Subject to semi-private room rate unless intensive care unit is required Room and board includes intensive care	$300 copayment then the plan pays 80% of the negotiated charge)per admission	$300 copayment then the plan pays 80% of the negotiated charge per admission	$300 copayment then the plan pays 65% of the recognized charge per admission
Outpatient private duty nursing			
Outpatient private duty nursing	80% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	80% (of the recognized charge) per visit
Maximum hours per policy year	64 hours		

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Emergency services			
Hospital emergency room	$300 copayment then the plan pays 100% of the negotiated charge per visit No policy year deductible applies	$300 copayment then the plan pays 100% of the negotiated charge per visit No policy year deductible applies	Paid the same as Preferred Care coverage
Non-emergency care in a hospital emergency room	Not covered	Not covered	Not covered
Important note: • As Non-Preferred Care 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, 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.			
Adult dental care for cancer treatments and dental injuries			
Adult dental care for cancer treatments and dental injuries	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
Specific conditions			
Diabetic services and supplies (including equipment and training)			
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Impacted wisdom teeth			
Impacted wisdom teeth	80% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	80% (of the actual charge) per visit

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Accidental injury to sound natural teeth			
Accidental injury to sound natural teeth	80% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	80% (of the actual charge) per visit
Blood and body fluid exposure			
Blood and body fluid exposure	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Bones or joints of the head, neck, face or jaw treatment			
Jaw joint disorder, temporomandibular joint dysfunction (**TMJ)** and craniomandibular disorders (**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
Dermatological treatment			
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
Gender reassignment (sex change) treatment			
Surgical, hormone replacement therapy, and counseling treatment* **Pre-certification needed for some services. See important note below.*	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
***Important Note**: Just log into your Aetna Navigator® secure website at **www.aetnastudenthealth.com** for detailed information about this covered benefit, including eligibility requirements in Aetna's clinical policy bulletin #0615. You can also call *Member Services* at the toll-free number on the back of your ID card.			
Autism spectrum disorder			
Autism spectrum disorder treatment (includes physician and specialist office visits, diagnosis and testing)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Autism spectrum disorder (continued)			
Applied behavior analysis**	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
****Important note**: Applied behavior analysis requires pre-certification by Aetna. Your Preferred Care provider is responsible for obtaining pre-certification. You are responsible for obtaining pre-certification when you use a Non-Preferred Care provider.			
Obesity (bariatric) Surgery			
Inpatient and outpatient facility and physician services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Oral Surgery			
Oral surgery	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
Reconstructive surgery and supplies			
Reconstructive surgery and supplies (includes reconstructive breast surgery)	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
Treatment of infertility			
Basic infertility services Inpatient and outpatient care - basic infertility	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Specific therapies and tests			
Outpatient diagnostic testing			
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit
Diagnostic lab work and radiological services performed in a physician's office, the outpatient department of a hospital or other facility	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit
Chemotherapy			
Chemotherapy	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Outpatient infusion therapy			
Outpatient infusion therapy (including medical formulas) performed in a covered person's home, physician's office, outpatient department of a hospital or other facility	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Outpatient radiation therapy			
Outpatient radiation therapy	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit
Outpatient respiratory therapy			
Respiratory therapy	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit
Transfusion or kidney dialysis of blood			
Transfusion or kidney dialysis of blood	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
Cardiac and pulmonary rehabilitation services			
Cardiac rehabilitation	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit
Pulmonary rehabilitation	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit
Rehabilitation and habilitation therapy services			
Outpatient physical and occupational therapies Includes short-term rehabilitation services and habilitation therapy services	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit
Outpatient speech language therapies Includes short-term rehabilitation services and habilitation therapy services	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit
Outpatient cognitive therapies Combined for short-term rehabilitation services and habilitation therapy services	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Early intervention services			
Early intervention services include speech and language therapy, physical and occupational therapies and assistive technology services and devices Limited to covered dependents to age 3 No visit limit applies for physical, occupational or speech therapy services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Spinal manipulation (chiropractic, osteopathic and manipulation therapy services)			
Spinal manipulation (chiropractic, osteopathic, and manipulation therapy services) includes rehabilitation and habilitation services	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit
Diagnostic testing for learning disabilities			
Diagnostic testing for learning disabilities	80% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit
Specialty prescription drugs (Purchased and injected or infused by your provider in an outpatient setting)			
Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting	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
Other services and supplies			
Emergency ground, air, and water ambulance (includes non-emergency ambulance)	80% (of the negotiated charge) per trip	80% (of the negotiated charge) per trip	80% (of the recognized charge) per trip
Acupuncture in lieu of anesthesia	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit
Clinical trial therapies	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
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Other services and supplies (continued)			
Durable medical and surgical equipment including supplies and equipment needed for the use of DME	80% (of the negotiated charge) per item	80% (of the negotiated charge) per item	80% (of the recognized charge) per item
Lymphedema	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
Enteral formulas and nutritional supplements	90% (of the negotiated charge) per item	80% (of the negotiated charge) per item	65% (of the recognized charge) per item
Prosthetic devices			
Prosthetic devices Includes Cranial prosthetics *(Medical wigs)* after cancer treatment	80% (of the negotiated charge) per item	80% (of the negotiated charge) per item	80% (of the recognized charge) per item
Orthotic devices	80% (of the negotiated charge) per item	80% (of the negotiated charge) per item	80% (of the recognized charge) per item
Cochlear implants	80% (of the negotiated charge) per item	80% (of the negotiated charge) per item	80% (of the recognized charge) per item
Podiatric (foot care) treatment			
Physician and Specialist non-routine foot care treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Sleep Treatment			
Sleep 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

Eligible health services	Preferred Care coverage	Non-Preferred Care coverage
Outpatient prescription drugs		
Policy year deductible and copayment/coinsurance waiver for risk reducing breast cancer drugs, tobacco cessation prescription drugs, over-the-counter drugs, and contraceptives		
The policy year deductible and the per prescription copayment/coinsurance will not apply to risk reducing breast cancer prescription drugs when obtained at a retail Preferred Care pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%. The policy year deductible and the per prescription copayment/coinsurance will not apply to the first two 90-day treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at a retail Preferred Care pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%. Your policy year deductible and any prescription copayment/coinsurance will apply after those two regimens per policy year have been exhausted. The policy year deductible and the per prescription copayment/coinsurance will not apply to female contraceptive methods when obtained at a Preferred Care pharmacy. This means that such contraceptive methods are paid at 100% for: • Certain over-the-counter (OTC) and generic contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%. • If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drug or device for that method paid at 100%. The per prescription copayment/coinsurance 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 Preferred Care pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.		
Preferred Generic prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30-day supply filled at a retail pharmacy	$15 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$15 copayment per supply then the plan pays 100% (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	$45 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	Not covered
Preferred brand-name prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30-day supply filled at a retail pharmacy	$45 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$45 copayment per supply then the plan pays 100% (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	$135 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	Not covered

Eligible health services	Preferred Care coverage	Non-Preferred Care coverage
Outpatient prescription drugs (continued)		
Non-preferred generic prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30-day supply filled at a retail pharmacy	$75 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$75 copayment per supply then the plan pays 100% (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	$225 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	Not covered
Non-preferred brand-name prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30-day supply filled at a retail pharmacy	$75 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$75 copayment per supply then the plan pays 100% (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	$225 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	Not covered
Specialty drugs		
For each fill up to a 30-day* supply filled at a retail pharmacy *a 12 month supply of hormonal contraceptives will be covered under the plan when dispensed or furnished at one time, and the above 30-day cost sharing will be adjusted accordingly to 12 times the 30-day cost sharing amount for a 12 month supply.	Copayment is the greater of $250 or 20% (of the negotiated charge) but will be no more than $500 per supply No policy year deductible applies	Copayment is the greater of $250 or 20% (of the recognized charge) but will be no more than $500 per supply No policy year deductible applies
Orally administered anti-cancer prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30-day supply filled at a retail pharmacy	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies

Eligible health services	Preferred Care coverage	Non-Preferred Care coverage
Outpatient prescription drugs (continued)		
Preventive care drugs and supplements		
Preventive care drugs and supplements filled at a retail pharmacy For each 30-day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Risk reducing breast cancer prescription drugs filled at a pharmacy For each 30-day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy For each 30-day supply Coverage is permitted for two 90-day treatment regimens only.	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered risk reducing breast cancer prescription drugs, contact Member Services by logging onto your Aetna Navigator® secure website at **www.aetnastudenthealth.com** or calling the toll-free number on the back of your ID card.	
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		

What your plan doesn't cover – eligible health service exceptions and exclusions

We already told you about the many health care services and supplies that are eligible for coverage under your plan in the *Eligible health services under your plan* section. In that section we also told you that some health care services and supplies have exceptions and some are not covered at all which are called "exclusions".

In this section we tell you about the exceptions and exclusions that apply to your plan.

And just a reminder, you'll find coverage limitations in the schedule of benefits.

General exceptions and exclusions

The following are not **eligible health services** under your plan except as described in:

- The *Eligible health services under your plan* section of this certificate of coverage or
- A rider or amendment issued to you for use with this certificate of coverage

Exceptions are noted with asterisks(**).

Acupuncture therapy

Alternative health care

- *Services* and supplies given by a provider for alternative health care. This includes but is not limited to aromatherapy, naturopathic medicine, herbal remedies, homeopathy, energy medicine, Christian faith-healing medicine, Ayurvedic medicine, yoga, hypnotherapy, and traditional Chinese medicine.

Ambulance services

- Non-emergency fixed wing air ambulance from a Non-Preferred Care provider
- Non-emergency ambulance transports except as covered under the Eligible health services under your plan section of this certificate of coverage

Armed forces

- Services and supplies received from a provider as a result of an injury sustained, or illness contracted, while in the service of the armed forces of any country. When you enter the armed forces of any country, we will refund any unearned pro rata premium to the policyholder.

Artificial organs

- Any device that would perform the function of a body organ.

Behavioral health treatment

- Services for the following categories (or equivalent terms as listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association):
  - Stay in a facility for treatment for dementias and amnesia without a behavioral disturbance that necessitates mental health treatment
  - School and/or education service including special education, remedial education, wilderness treatment programs, or any such related or similar programs. Therapy by a licensed counselor will be covered if provided on an outpatient basis as part of a wilderness treatment program.
  - Services provided in conjunction with school, vocation, or work activities
  - Transportation

Beyond legal authority

- Services and supplies provided by a health professional or other provider that is acting beyond the scope of its legal authority

Blood, blood plasma, synthetic blood, blood derivatives or substitutes

Examples of these are:

- The provision of blood to the hospital, other than blood derived clotting factors
- The services of blood donors, apheresis or plasmapheresis
- For autologous blood donations, only administration and processing expenses are covered

**This exclusion does not apply to blood products for treatment of hemophilia and congenital bleeding disorders including, but not limited to, Factor VII, Factor VIII, Factor IX, and cryoprecipitate.

Bones or joints of the head, neck, face or jaw treatment
Except as covered in the *Eligible health services under your policy- Bones or joints of the head, neck, face or jaw treatment* section:

- Fixed or removable appliances that involve movement or repositioning of the teeth
- Repair of teeth (fillings)
- Prosthetics (crowns, bridges, dentures)

Breasts

- Services and supplies given by a provider for breast reduction or gynecomastia.

Cardiac rehabilitation

- Services for home programs, on-going conditioning, and maintenance care

Clinical trial therapies (experimental or investigational)

- Your plan does not cover clinical trial therapies (experimental or investigational), except as described in the *Eligible health services under your plan - Clinical trial therapies (experimental or investigational)* section

Clinical trial therapies (routine patient costs)

- Services and supplies related to data collection and record-keeping that is not used in the direct clinical management of the patient
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna's claim policies)
- Preferred Care coverage limited to benefits for routine patient services provided within the network

Cosmetic services and plastic surgery

- Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons. Injuries that occur during medical treatments are not considered accidental injuries even if unplanned or unexpected.

**This exclusion does not apply to:

- Surgery after an accidental injury when performed as soon as medically feasible
- Coverage that may be provided under the Eligible health services under your plan - Gender reassignment (sex change) treatment section.

Court-ordered services and supplies

- This includes court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding, unless they are a covered benefit under your plan

Custodial care
Examples are:

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

(continued next page)

- Institutional care. This includes room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training

Dermatological treatment
- Cosmetic treatment and procedures

Dental care for adults
- Dental services for adults including services related to:
  - The care, filling, removal or replacement of teeth and treatment of diseases of the teeth
  - Dental services related to the gums
  - Apicoectomy (dental root resection)
  - Orthodontics
  - Root canal treatment
  - Soft tissue impactions
  - Alveolectomy
  - Augmentation and vestibuloplasty treatment of periodontal disease
  - False teeth
  - Prosthetic restoration of dental implants
  - Dental implants

**This exclusion does not apply to services covered under the *Adult dental care for cancer treatments and dental injuries* section.

Durable medical equipment (DME)
Appliances, devices, and medical supplies that have both a non-therapeutic and therapeutic use.
Examples of these items are:
- Whirlpools
- Portable whirlpool pumps
- Sauna baths
- Massage devices
- Over bed tables
- Elevators
- Communication aids
- Vision aids
- Telephone alert systems
- Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician

Educational services
Examples of these services are:
- Any service or supply for education, training or retraining services or testing, except where described in the *Eligible health services under your plan – Diabetic services and supplies (including equipment and training)* section. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
  - Job training
  - Job hardening programs

(continued next page)

- Services provided by a governmental school district Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Elective treatment or elective surgery
- Elective treatment or elective surgery except as specifically covered under the student policy and provided while the student policy is in effect

Enteral formulas and nutritional supplements
- Any food item, including infant formulas, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered in the *Eligible health services under your plan – Enteral formulas and nutritional supplements* section

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

Experimental or investigational
- Experimental or investigational drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies (experimental or investigational) or covered under clinical trials (routine patient costs). See the *Eligible health services under your plan – Other services* section.

Emergency services and urgent care
- Non-emergency services in a hospital emergency room facility
- Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)

Facility charges
For care, services or supplies provided in:
- Rest homes
- Assisted living facilities
- Similar institutions serving as a persons' main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at camps

Family planning services - other
- Voluntary termination of pregnancy except when the life of the mother is endangered by a physical disorder, physical illness or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself, or when the pregnancy is the result of an alleged act of rape or incest
- Reversal of voluntary sterilization procedures, including related follow-up care
- Services provided as a result of complications resulting from a male voluntary sterilization procedure and related follow-up care

Felony
- Services and supplies that you receive as a result of an injury due to your commission of a felony.

Foot care

- Unless specifically required for the treatment or to prevent complications of diabetes or vascular disease services and supplies for:
  - The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches
  - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
  - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
  - Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet

Gender reassignment (sex change) treatment

- Cosmetic services and supplies such as:
  - Rhinoplasty
  - Face-lifting
  - Lip enhancement
  - Facial bone reduction
  - Blepharoplasty
  - Breast augmentation
  - Liposuction of the waist (body contouring)
  - Reduction thyroid chondroplasty (tracheal shave)
  - Hair removal (including electrolysis of face and neck)
  - Voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which are used in feminization
  - Chin implants, nose implants, and lip reduction, which are used to assist masculinization, are considered cosmetic

Genetic care

- Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects

Gene-based, cellular and other innovative therapies (GCIT)

The following are not eligible health services unless you receive prior written approval from us:

- GCIT services received at a facility or with a provider that is not a GCIT-designated facility/provider
- All associated services when GCIT services are not covered. Examples include infusion, laboratory, radiology, anesthesia, and nursing services.

Please refer to the Medical necessity, referral, and precertification requirements section.

Growth/Height care

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

Hearing aids and exams

Unless otherwise covered under the *Eligible health services* section, the following services or supplies:

- A replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within the prior 12 month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist
- Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay
- Any tests, appliances and devices to:
  - Improve your hearing. This includes hearing aid batteries, amplifiers, and auxiliary equipment
  - Enhance other forms of communication to make up for hearing loss or devices that simulate speech

Home health care

- Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present
- Homemaker or housekeeper services
- Food or home delivered services
- Maintenance therapy

Hospice care

- Funeral arrangements
- Pastoral counseling
- Financial or legal counseling which includes estate planning and the drafting of a will
- Services which are not related to your care and may include:
  - Sitter or companion services for either you or other family members except for respite care
  - Transportation
  - Maintenance of the house

Incidental surgeries

- Charges made by a physician for incidental surgeries. These are non-medically necessary surgeries performed during the same procedure as a medically necessary surgery.

Judgment or settlement

- Services and supplies for the treatment of an injury or illness to the extent that payment is made as a judgment or settlement by any person deemed responsible for the injury or illness (or their insurers)

Mandatory no-fault laws

- Treatment for an injury to the extent benefits are payable under any state no fault automobile coverage or first party medical benefits payable under any other mandatory no fault law

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 under your plan — Outpatient rehabilitation and habilitation, physical, occupational, and speech therapy* section

Maternity and related newborn care

- Any services and supplies related to births that take place in the home, except for home delivery by a certified nurse midwife, or in any other place not licensed to perform deliveries

Medical supplies – outpatient disposable

- Examples of these are:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Other home test kits
  - Compresses

Medicare

- Services and supplies available under Medicare, if you are entitled to premium-free Medicare Part A or enrolled in Medicare Part B, or if you are not entitled to premium-free Medicare Part A or enrolled in Medicare Part B because you refused it, terminated it, or did not make a proper request for it

Mental health and substance use related disorders treatment

- The following categories (or equivalent terms as listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association) are not covered:
  - Sexual deviations and disorders except for gender identity disorders
  - Tobacco use disorders except as described in the *Eligible health services under your plan – Preventive care and wellness* section
  - Pathological gambling, kleptomania, pyromania
  - Specific developmental disorders of scholastic skills (learning disorders/learning disabilities)
  - Specific developmental disorder of motor functions, except as described in the Eligible health services – Early intervention services section
  - Specific developmental disorders of speech and language, except as described in the *Eligible health services – Early intervention services* section
  - Other disorders of psychological development

Motor vehicle accidents

- Services and supplies given by a provider for injuries sustained from a motor vehicle accident but only when benefits are payable under other valid and collectible insurance. This applies whether or not a claim is made for such benefits.

Non-medically necessary services and supplies

- Services and supplies which are not medically necessary for the diagnosis, care, or treatment of an illness or injury or the restoration of physiological functions This includes behavioral health services that are not primarily aimed at the treatment of illness, injury, restoration of physiological functions or that do not have a physiological or organic basis. This applies even if they are prescribed, recommended, or approved by your physician, dental provider, or vision care provider.

**This exclusion does not apply to *Preventive care and wellness* benefits.

Obesity (bariatric) surgery

- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity except as described in the *Eligible health services under your plan – Preventive care and wellness* section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis or other forms of therapy
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Organ removal

- Services and supplies given by a provider to remove an organ from your body for the purpose of donating or selling the organ except as described in the *Eligible health services under your plan* section.

**This exclusion does not apply if you are donating the organ to a spouse, domestic partner, child, brother, sister, or parent.

Other primary payer

- Payment for a portion of the charge that Medicare or another party is responsible for as the primary payer.

**This exclusion does not apply to laws that make the government program the secondary payer after benefits under this policy have been paid.

Outpatient infusion therapy

- Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan

Outpatient prescription or non-prescription drugs and medicines

- Outpatient prescription drugs or non-prescription drugs and medicines provided by the policyholder
- Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan

Outpatient surgery

- A stay in a hospital (Hospital stays are covered in the Eligible health services under your plan – Hospital and other facility care section)
- A separate facility charge for surgery performed in a physician's office
- Services of another physician for the administration of a local anesthetic

Pediatric dental care

- Any instruction for diet, plaque control and oral hygiene
- Asynchronous dental treatment
- Cosmetic services and supplies including:
  - Plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance,
  - Augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the Eligible health services under your plan section.
  - Facings on molar crowns and pontics will always be considered cosmetic.
- Crown, inlays, onlays, and veneers unless:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material or
  - The tooth is an abutment to a covered partial denture or fixed bridge *(continued next page)*

- Dental implants and braces (that are determined not to be medically necessary mouth guards, and other devices to protect, replace or reposition teeth
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint dysfunction disorder (TMJ) and craniomandibular joint dysfunction disorder (CMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Eligible health services under your plan – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another eligible health service
- Mail order and at-home kits for orthodontic treatment
- Orthodontic treatment except as covered in the Eligible health services under your plan –Pediatric dental care section
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Routine dental exams and other preventive services and supplies, except as specifically provided in the Eligible health services under your plan —Pediatric dental care section
- Services and supplies:
  - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
  - Provided for your personal comfort or convenience or the convenience of another person, including a provider
  - Provided in connection with treatment or care that is not covered under your policy
- Surgical removal of impacted wisdom teeth that is not medically necessary and only for orthodontic reasons
- Treatment by other than a dental provider that is legally qualified to furnish dental services or supplies

Personal care, comfort or convenience items

- Any service or supply primarily for your convenience and personal comfort or that of a third party

Preventive care and wellness

- Services for diagnosis or treatment of a suspected or identified illness or injury
- Exams given during your stay for medical care
- Services not given by or under a physician's direction
- Psychiatric, psychological, personality or emotional testing or exams
- Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- Male contraceptive methods or devices
- The reversal of voluntary sterilization procedures, including any related follow-up care
- Female voluntary sterilization procedures that were not billed separately by the provider or were not the primary purpose of a confinement

Private duty nursing in an inpatient setting

Prosthetic devices
- Services covered under any other benefit
- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft
- Communication aids

Riot
- Services and supplies that you receive from providers as a result of an injury from your "participation in a riot". This means when you take part in a riot in any way such as inciting, or conspiring to incite, the riot. It does not include actions that you take in self-defense as long as they are not against people who are trying to restore law and order.

Routine exams
- Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *Eligible health services under your plan* section

Services provided by a family member
- Services provided by a spouse, domestic partner, child, step-child, brother, sister, in-law or any household member

Sexual dysfunction and enhancement
- Any treatment, prescription drug, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services
- Not eligible for coverage are prescription drugs in 60-day supplies

Sinus surgery
- Any services or supplies given by providers for sinus surgery except for acute purulent sinusitis

Strength and performance
- Services, devices and supplies such as drugs or preparations designed primarily for the purpose of enhancing your:
  - Strength
  - Physical condition
  - Endurance
  - Physical performance

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

Telemedicine
- Any services that are audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire.

Temporomandibular joint dysfunction treatment (TMJ) and craniomandibular joint dysfunction treatment (CMJ)
- Dental implants

Therapies and tests

- Full body CT scans unless medically necessary
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used as a physical therapy modality
- Sensory or auditory integration therapy

Tobacco cessation

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

Transplant services

- Services and supplies furnished to a donor when the recipient is not a covered person

Treatment in a federal, state, or governmental entity

- Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws

Treatment of infertility

- Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists.
- All charges associated with:
  - Surrogacy when the surrogate is not a covered person under your plan. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father
  - Cryopreservation (freezing) of eggs, embryos or sperm
  - Storage of eggs, embryos, or sperm
  - Thawing of cryopreserved (frozen) eggs, embryos or sperm
  - The care of the donor in a donor egg cycle which includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers
  - The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which the person is not genetically related
  - Obtaining sperm for ART services
- Home ovulation prediction kits or home pregnancy tests
- The purchase of donor embryos, donor oocytes, or donor sperm
- Reversal of voluntary sterilizations, including follow-up care
- Ovulation induction with menotropins, Intrauterine insemination and any related services, products or procedures
- In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), Cryopreserved embryo transfers and any related services, products or procedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery)

Vision Care

Pediatric vision care services and supplies

- Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes

Vision correction after surgery or accident

- Eyeglass frames, prescription lenses or prescription contact lenses that are not related to a surgery or accidental injury

Other adult vision care

- Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses
- Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes

Adult vision care services and supplies

Your plan does not cover adult vision care services and supplies, except as described in the *Eligible health services under your plan – Other services* section.

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

Wilderness Treatment Programs

- See Educational services within this section

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.

Exceptions and exclusions that apply to outpatient prescription drugs

Abortion drugs

Any services related to the dispensing, injection or application of a drug

Biological sera

Compounded prescriptions

- Compound prescriptions containing bulk chemicals that have not been approved by the U.S. Food and Drug Administration (FDA) including compounded bioidentical hormones

Cosmetic drugs
- Medications or preparations used for cosmetic purposes

Devices, products and appliances, except those that are specially covered

Dietary supplements including medical foods

Drugs or medications
- Administered or entirely consumed at the time and place it is prescribed or dispensed
- Which do not, by federal or state law, require a prescription order (i.e. over-the-counter (OTC) drugs), even if a prescription is written except as specifically provided in the Eligible health services under your plan – Outpatient prescription drugs section
- That includes the same active ingredient or a modified version of an active ingredient as a covered prescription drug (unless a medical exception is approved)
- That is therapeutically equivalent or therapeutically alternative to a covered outpatient prescription drug including biosimilar (unless a medical exception is approved)
- That is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product (unless a medical exception is approved)
- Not approved by the FDA or not proven safe and effective
- Provided under your medical plan while an inpatient of a healthcare facility
- Recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by Aetna's Pharmacy and Therapeutics Committee
- That includes vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
- For which the cost is covered by a federal, state, or government agency (for example: Medicaid or Veterans Administration)
- 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 share or appearance of a sex organ
- That are used for the purpose of weight gain or reduction, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications
- That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the covered person meets one or more clinical criteria detailed in our pre-certification and clinical policies

Duplicative drug therapy (e.g. two antihistamine drugs)

Genetic care
- Any treatment, device, drug, service or supply to alter the body’s genes, genetic make-up, or the expression of the body’s genes except for the correction of congenital birth defects.

Immunizations related to work

Immunization agents

Implantable drugs and associated devices except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section

Infertility
- Injectable prescription drugs used primarily for the treatment of infertility

Injectables
- Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by us
- Needles and syringes, except for those used for self-administration of an injectable drug
- 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. This exception does not apply to Depo Provera and other injectable drugs used for contraception.

Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps except as specifically provided in the *Eligible health services under your plan – Diabetic equipment, supplies and education* section.

Prescription drugs:
- For which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a prescription is written, except for injectable insulin and drugs that must be covered as recommended for preventive care.
- Packaged in unit dose form.
- Filled prior to the effective date or after the termination date of coverage under this plan.
- Dispensed by a mail order pharmacy that include prescription drugs that cannot be shipped by mail due to state or federal laws or regulations, or when the plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants.
- That includes an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and are not clinically superior to that drug as determined by the plan.
- That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth, or prescription drugs for the treatment of a dental condition.
- That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the preferred drug guide.
- That are non-preferred drugs, unless non-preferred drugs are specifically covered as described in your schedule of benefits. However, a non-preferred drug will be covered if in the judgment of the prescriber there is no equivalent prescription drug on the preferred drug guide or the product on the preferred drug guide is ineffective in treating your disease or condition or has caused or is likely to cause an adverse reaction or harm you.
- That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not medically necessary, or otherwise improper, and drugs obtained for use by anyone other than the identified on the ID card.

Refills
- Refills dispensed more than one year from the date the latest prescription order was written.

Replacement of lost or stolen prescriptions

Test agents except diabetic test agents

Tobacco cessation
- Tobacco cessation products unless recommended by the United States Preventive Services Task Force (USPSTF)

We reserve the right to exclude:

- A manufacturer's product when a same or similar drug (that is, a drug with the same active ingredient or same therapeutic effect), supply or equipment is on the preferred drug guide.
- Any dosage or form of a drug when the same drug (that is, a drug with the same active ingredient or same therapeutic effect) is available in a different dosage or form on our preferred drug guide.

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

Sanctioned Countries

If coverage provided by this policy violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a written Office of Foreign Asset Control (OFAC) license. For more information, visit **http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx**.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call the number listed on your ID card at no cost.

Smartphone or Tablet

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

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

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

If you need these services, contact our Civil Rights Coordinator.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379, **CRCoordinator@aetna.com**.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY:711

English	**To access language services at no cost to you, call the number on your ID card.**
Albanian	Për shërbime përkthimi falas për ju, telefononi në numrin që gjendet në kartën tuaj të identitetit.
Amharic	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በሜታወቂያዎት ላይ ያለውን ቁጥር ይደውሉ፡ ፡
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Armenian	Ձեր նախընտրած լեզվով անվճար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հեռախոսահամարով
Bantu-Kirundi	Kugira uronke serivisi z'indimi ata kiguzi, hamagara inomero iri ku karangamuntu kawe
Bengali	আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে আপনার পরিচয়পত্রে দেওয়া নম্বরে টেলিফোন করুন।
Burmese	သင့်အနေဖြင့် အခကြေးငွေ မပေးရပဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန်၊ သင့် ID ကတ်ပေါ်တွင်ရှိသော ဖုန်းနံပတ်အား ခေါ်ဆိုပါ။
Catalan	Per accedir a serveis lingüístics sense cap cost per a vostè, telefoni al número indicat a la seva targeta d’identificació.
Cebuano	Aron maakses ang mga serbisyo sa lengguwahe nga wala kay bayran, tawagi ang numero nga anaa sa imong kard sa ID.
Chamorro	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang i numiru gi iyo-mu kard aidentifikasion.
Cherokee	ᏣᎩᏍᏗ ᏕᏬᏂᎯᏍᏗ ᎢᏅᎾᏓᏛᏁᏗ Ꮭ ᎠᎱᏍᏗ ᏗᏟᎬᏣᎳᏁᏗ ᏱᎩ, ᏫᎵᎯᏏᏔᏛᏏ ᎾᏍᎩ ᏗᏎᏍᏗ ᏥᏕᎠᏯᏭᎲ ᎤᎾᎢ ID ᏆᏂᏱᏍᏗ ᏟᏤᎵᎢ.
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
Choctaw	Anumpa tosholi i toksvli ya peh pilla ho ish i payahinla kvt chi holisso kallo iskitini holhtena takanli ma i payah
Chuukese	Ren omw kopwe angei aninisin eman chon awewei (ese kamé), kopwe kééri ewe nampa mei mak won noum ena katen ID
Cushitic-Oromo	Tajaajiiloota afaanii gatii bilisaa ati argaachuuf,lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili.
Dutch	Voor gratis taaldiensten, bel het nummer op uw ziekteverzekeringskaart.
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.

Hawaiian	No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i ka helu kelepona ma kāu kāleka ID. Kāki ‘ole ‘ia kēia kōkua nei.
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.
Igbo	Inweta enyemaka asụsụ na akwughi ụgwọ obụla, kpọọ nọmba nọ na kaadi njirimara gị
Ilocano	Tapno maakses dagiti serbisio ti pagsasao nga awanan ti bayadna, awagan ti numero nga adda ayan ti ID kardmo.
Indonesian	Untuk mengakses layanan bahasa tanpa dikenakan biaya, silakan hubungi nomor telepon di kartu asuransi Anda.
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	လၢတၢ်ကမၤန့ၢ်ကျိာ်တၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖဉ် လၢတအိဉ်ဒီးအပူၤလၢနကဘဉ်ဟ့ဉ်အီၤအဂီၢ်,ကိးဘဉ်လီတဲစိနိဉ်ဂ်ၢ်လၢအအိဉ်လၢနခိဉ်ဂီၤ (ID) အလိၤန့ဉ်တက့ၢ်.
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Kru-Bassa	I nyuu kosna mahola ni language services ngui nsaa wogui wo, sebel i nsinga i ye ntilga i kat yong matibla
Kurdish	بۆ دەستپێڕاگەیشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی سەر ئای دی(ID) کارتی خۆت.
Lao	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.
Marathi	आपल्याला कोणत्याही शुल्काशिवाय भाषा सेवांपर्यंत पोहोचण्यासाठी, आपल्या ID कार्डावरील क्रमांकावर फोन करा.
Marshallese	Ṇan bōk jipañ kōn kajin ilo an ejjeḷọk wōṇean ñan kwe, kwōn kallok nōṃba eo ilo kaat in ID eo aṃ.
Micronesian-Ponapean	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih nempe nan amhw doaropwe en ID.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T’áá ni nizaad k’ehjí bee níká a’doowoł doo bą́ą́h ílínígóó naaltsoos bee atah nílı̨go nanitinígíí bee néého’dólzinígíí béésh bee hane’í biká’ígíí áajı̨’ hólne’.
Nepali	भाषासम्बन्धी सेवाहरूमाथि निःशुल्क पहुँच राख्न आफ्नो कार्डमा रहेको नम्बरमा कल गर्नुहोस्।
Nilotic-Dinka	Të kɔɔr yïn ran de wëër de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke yïn cɔl ran ye kɔc kuɔny në namba de abac tɔ në ID kard duɔ̈n de tïït de nyin de panakim kɔ̈u.
Norwegian	For tilgang til kostnadsfri språktjenester, ring nummeret på ID-kortet ditt.

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।
Romanian	Pentru a accesa gratuit serviciile de limbă, apelați numărul de pe cardul de membru.
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.
Sudanic Fulfulde	Heeɓa a naasta nder ekkitol jaangirde woldeji walla yoɓugo, ewnu lamba je ɗon windi ha do ɗerowol maaɗa.
Swahili	Kupata huduma za lugha bila malipo kwako, piga nambari iliyo kwenye kadi yako ya kitambulisho.
Syriac-Assyrian	ܐܢ ܣܢܝܩܐ ܝܬܘܢ ܥܠ ܡܫܡܫܢܘܬܐ ܕܡܫܘܕܥܢܘܬܐ ܕܠܫܢܐ ܡܓܢܐܝܬ، ܩܪܘ ܠܡܢܝܢܐ ܥܠ ܦܬܩܐ ܕܡܫܘܕܥܢܘܬܐ ܕܝܠܘܟܘܢ.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Telugu	భాష సేవలను మీకు ఖర్చు లేకుండా అందుకునేందుకు, మీ ఐడి కార్డుపై ఉన్న నంబరుకు కాల్ చేయండి.
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน
Tongan	Kapau ‘oku ke fiema’u ta’etōtōngi ‘a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he fika ‘oku hā atu ‘i ho’o ID kaati.
Turkish	Dil hizmetlerine ücretsiz olarak erişmek için kimlik kartınızdaki numarayı arayın.
Ukrainian	Щоб безкоштовнј отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікайній картці.
Urdu	لسانی خدمات تک مُفت رسائی کے لیے، اپنے بیمہ کے ID کارڈ پر درج نمبر پر کال کریں۔
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.
Yiddish	צו באקומען שפראך סערוויסעס פריי פון אפצאל, רופט דעם נומער אויף אייער ID קארטל.
Yoruba	Láti ráyèsí àwọn iṣẹ́ èdè fún ọ lọ́fẹ̀ẹ́, pe nọ́mbà tó wà lórí káàdì ìdánimọ̀ rẹ.