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# Aetna Student Health<sup>SM</sup>

## Plan Design and Benefits Summary

### Preferred Provider Organization (PPO)

## Pacific University

Policy Year: 2020 – 2021  
Policy Number: 686193  
[www.aetnastudenthealth.com](http://www.aetnastudenthealth.com)  
1-888-834-4704



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

## HEALTH SERVICES

Pacific University has a student health center that provides services to students on a fee schedule. For students who have chosen the University Student Health Plan, the yearly deductible is waived, and coverage is 100% for charges at the student health center.

Health Clinic Locations - Students May Use Clinic Services at Either Location:

Forest Grove Clinic: 2142 College Way, Forest Grove, OR 97116 (next to admissions office)

Hillsboro Clinic: 730 SE Oak Street, Suite D, Hillsboro, OR (3 blocks from campus)

All services are by appointment. Students may be seen at either the Forest Grove or Hillsboro clinic. Call 503-352-2269 to make an appointment.

### Who is eligible?

All students enrolled in 3 or more credit hours and Psychology Graduate students enrolled in 1 or more credit hours are required to participate in the Student Health Insurance Plan. The premium is automatically billed on the tuition billing statement. If a student has comparable coverage, a waiver may be completed online prior to the deadline.

You must actively attend classes for at least the first 31 days after the date your coverage becomes effective.

## Enrolling after the Initial Enrollment Period

### Special Enrollment Periods

You may decline coverage during your initial enrollment period. To do so, you must submit a completed qualifying waiver provided by your school before your school's required deadline. You may enroll in this plan later if you qualify under the Special Enrollment Rules below.

- **Special Enrollment Rule #1**  
If you declined enrollment for yourself because of other health insurance coverage, you may enroll in the plan later if the other coverage ends involuntarily. To do so, you must request enrollment within 31 days after the other health insurance coverage ends (or within 60 days after the other health insurance coverages ends if the other coverage is through Medicaid or a State Children's Health Insurance Program). Coverage will begin on the day after the other coverage ends.
- **Special Enrollment Rule #2**  
If you be eligible for a premium assistance subsidy under Medicaid or a state Children's Health Insurance Program (CHIP), you may be able to enroll yourself at that time. To do so, you must request enrollment within 60 days of the date you become eligible for such assistance. Coverage will begin on the first day of the month after becoming eligible for such assistance.

### Effective Date of Coverage

Coverage for each student who enrolls is effective on the first day of the period in which you are eligible, and premium has been paid. See Policyholder for premium payment requirements for you to enroll in this plan.

### Coverage Dates and Rates

Coverage for all insured students will become effective at 12:01 AM on the Coverage Start Date indicated below and will terminate at 11:59 PM on the Coverage End Date indicated.

### Students

Program	Coverage Dates	Waiver Deadline	Student Rates
Fall Annual (Domestic/International)	08/01/2020 – 07/31/2021	07/06/2020 – 08/13/2020	\$2,997.00
Athletics & Other Early Entry	06/01/2020 – 07/31/2020	04/15/2020 – 06/15/2020	\$501.00
MBA (Graduating)	08/01/2020 – 12/31/2020	07/06/2020 – 08/13/2020	\$1,256.00
Physician Asst. 1 yr, 2 yr	05/01/2020 – 04/30/2021	04/15/2020 – 05/15/2020	\$2,997.00
Physician Asst. (Graduating)	05/01/2020 – 12/31/2020	04/15/2020 – 05/15/2020	\$2,011.00
Physician Asst. (Spring Starts)	01/01/2021 – 04/30/2021	12/01/2020 – 01/13/2021	\$986.00
Spring New Starts	01/01/2021 – 07/31/2021	12/01/2020 – 01/13/2021	\$1,741.00

### Education Students

Program	Coverage Dates	Waiver Deadline	Student Rates
Fall Annual (Domestic/International)	08/01/2020 – 07/31/2021	07/06/2020 – 08/13/2020	\$2,997.00
EDUC (Early Entry)	05/01/2020 – 07/31/2020	04/15/2020 – 05/15/2020	\$755.00
EDUC (Spring Only)	01/01/2021 – 07/31/2021	12/01/2020 – 01/13/2021	\$1,741.00
MAT SPED EUG (Graduating)	05/01/2020 – 08/31/2020	04/15/2020 – 05/15/2020	\$1,009.00
MAT5Y EUG/Flex EUG (Graduating)	08/01/2020 – 01/31/2021	07/06/2020 – 08/13/2020	\$1,511.00
MAT5Y WB (New Starts)	05/18/2020 – 05/17/2021	04/15/2020 – 05/15/2020	\$2,997.00
MAT5y (New Starts)	06/15/2020 – 06/14/2021	04/15/2020 – 06/15/2020	\$2,997.00

### Master of Fine Arts

Program	Coverage Dates	Waiver Deadline	Student Rates
MFA	06/01/2020 – 05/31/2021	04/15/2020 – 06/01/2020	\$2,997.00
MFA (Graduating)	06/01/2020 – 06/30/2020	N/A	250.00
MFA (Spring Starts)	01/01/2021 – 05/31/2021	12/01/2020 – 01/13/2021	\$1,240.00

## Enrollment

To enroll online please visit [pacificu.myahpcare.com](https://pacificu.myahpcare.com), click on Enrollment tab and then select the appropriate enrollment link.

Aetna Student Health may rely on deletion requests submitted by the school as proof of a student's waiver of coverage or cancellation request. A request to remove an eligibility record where a student has either paid the premium or used the plan (that is, claims were filed and paid) will be handled prospectively. Termination in such cases will be effective at the end of the month and premium will be pro-rated accordingly.

## Medicare Eligibility Notice

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

## In-network Provider Network

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

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

## Precertification

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

## Precertification Call

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

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

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

## Coordination of Benefits (COB)

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

## Description of Benefits

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

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

Policy year deductible	In-network coverage	Out-of-network coverage
You have to meet your policy year deductible before this plan pays for benefits.		
<b>Student</b>	\$300 per policy year	\$550 per policy year
<b>Individual</b> This is the amount you owe for in-network and out-of-network eligible health services each policy year before the plan begins to pay for eligible health services. After the amount you pay for eligible health services reaches the policy year deductible, this plan will begin to pay for eligible health services for the rest of the policy year. Eligible health services applied to the out-of-network policy year deductibles will not be applied to satisfy the in-network policy year deductibles. Eligible health services applied to the in-network policy year deductibles will not be applied to satisfy the out-of-network policy year deductibles.		
<b>Policy year deductible waiver</b> The policy year deductible is waived for all of the following eligible health services: <ul style="list-style-type: none"><li>In-network care for Physician and specialist services, Consultant services, Walk-in clinic visits, Urgent Care, Pediatric Dental Type A services, Family planning services, Outpatient mental disorders treatment office visits, Outpatient substance abuse office visits, Chiropractic services, Hearing aid exams, and Pediatric Vision Care</li><li>In-network care and out-of-network care for Preventive care and wellness, Hospital emergency room, Well newborn nursery care, and outpatient prescription drugs</li></ul>		
<b>Maximum out-of-pocket limit per policy year</b>		
<b>Student</b>	\$5,000 per policy year	\$10,000 per policy year
Eligible health services applied to the out-of-network maximum out-of-pocket limit will not be applied to satisfy the Pacific University Health Center and in-network maximum out-of-pocket limit and eligible health services applied to the Pacific University Health Center and in-network maximum out-of-pocket limit will not be applied to satisfy the out-of-network maximum out-of-pocket limit.		

Eligible health services	In-network coverage	Out-of-network coverage
Routine physical exams		
Performed at a physician’s office	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	60% (of the recognized charge) per visit  No copayment or policy year deductible applies
Maximum age and visit limits per policy year through age 21	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures//Health Resources and Services Administration guidelines for children and adolescents.	
Maximum visits per policy year age 22 and over	1 visit	
Preventive care immunizations		
Performed in a facility or at a physician's office	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	60% (of the recognized charge) per visit  No copayment or 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.	
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	60% (of the recognized charge) per visit  No copayment or policy year deductible applies
Maximum visits per policy year	1 visit	
Preventive screening and counseling services		
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, Depression Screening, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	60% (of the recognized charge) per visit  No copayment or policy year deductible applies
Obesity/Healthy Diet maximum per policy year (Applies to covered persons age 22 and older)	26 visits (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	In-network coverage	Out-of-network coverage
Misuse of Alcohol maximum per policy year	5 visits	
Tobacco Products Counseling maximum per policy year	8 visits	
Depression screening maximum per policy year	1 visit	
STI maximum per policy year	2 visits	
Routine cancer screenings	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	60% (of the recognized charge) per visit  No copayment or policy year deductible applies
Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> <li>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</li> <li>The comprehensive guidelines supported by the Health Resources and Services Administration.</li> </ul>	
Lung cancer screening maximums	1 screenings every 12 months	
Prenatal care services (Preventive care services only)	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	60% (of the recognized charge) per visit  No copayment or policy year deductible applies
Lactation support and counseling services	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	60% (of the recognized charge) per visit  No copayment or policy year deductible applies
Lactation counseling services maximum per policy year	6 visits	
Breast pump supplies and accessories	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	60% (of the recognized charge) per visit  No copayment or policy year deductible applies
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	60% (of the recognized charge) per visit  No copayment or policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Contraceptive counseling services maximum per policy year	2 visits	
Female contraceptive prescription drugs and devices	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	60% (of the recognized charge) per visit  No copayment or policy year deductible applies
Female voluntary sterilization-Inpatient & Outpatient provider services	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	60% (of the recognized charge) per visit  No copayment or policy year deductible applies
Physicians and other health professionals		
Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist)  (includes telemedicine consultations)	\$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter  No policy year deductible applies	60% (of the recognized charge) per visit
Allergy testing and treatment		
Allergy testing & Allergy injections treatment performed at a physician’s or specialist’s office	Covered according to the type of benefit and the place where the service is received.	
Physician and specialist - surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Outpatient surgery performed at a physician’s or specialist’s office or outpatient department of a hospital or surgery center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Alternatives to physician office visits		
Walk-in clinic visits (non-emergency visit)	\$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter  No policy year deductible applies	60% (of the recognized charge) per visit



Eligible health services	In-network coverage	Out-of-network coverage
<b>Hospital and other facility care</b>		
Inpatient hospital (room and board) and other miscellaneous services and supplies)  Includes birthing center facility charges	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
In-hospital non-surgical physician services	80% (of the negotiated charge)	60% (of the recognized charge)
<b>Alternatives to hospital stays</b>		
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	80% (of the negotiated charge)	60% (of the recognized charge)
Home health Care	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Hospice-Inpatient	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Hospice-Outpatient	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Respite care-maximum number of days per 30-day period	30	
Bereavement counseling-maximum number of sessions per policy year	30	
Skilled nursing facility-Inpatient	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Maximum days of confinement per policy year	60	

Eligible health services	In-network coverage	Out-of-network coverage
Hospital emergency room	<p>\$50 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit</p> <p>No policy year deductible applies</p>	Paid the same as in-network coverage
Non-emergency care in a hospital emergency room	Not covered	Not covered
<b>Important note:</b> <ul style="list-style-type: none"> <li>As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment/coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on the back of your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill.</li> <li>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.</li> <li>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.</li> <li>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.</li> <li>Services given to you in the hospital emergency room that are not part of the hospital emergency room benefit may be subject to copayment/coinsurance amounts that are different from the hospital emergency room copayment/coinsurance amounts.</li> </ul>		
Urgent Care	<p>\$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter</p> <p>No policy year deductible applies</p>	60% (of the recognized charge) per visit
Non-urgent use of urgent care provider	Not covered	Not covered

Eligible health services	In-network coverage	Out-of-network coverage
Pediatric dental care (Limited to covered persons through the end of the month in which the person turns age 19.)		
Type A services	100% (of the negotiated charge) per visit  No copayment or deductible applies	60% (of the recognized charge) per visit
Type B services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Type C services	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Orthodontic services	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Dental emergency treatment	Covered according to the type of benefit and the place where the service is received.	
Specific Conditions		
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received.	
Impacted wisdom teeth	80% (of the negotiated charge)	60% (of the recognized charge)
Accidental injury to sound natural teeth	80% (of the negotiated charge)	60% (of the recognized charge)
Maternity care		
Maternity care (includes delivery and postpartum care services in a hospital or birthing center)	Covered according to the type of benefit and the place where the service is received.	
Well newborn nursery care in a hospital or birthing center	80% (of the negotiated charge)  No policy year deductible applies	60% (of the recognized charge)  No policy year deductible applies
Family planning services – other		
Voluntary sterilization for males-surgical services	100% (of the negotiated charge)  No policy year deductible applies	60% (of the recognized charge)
Contraceptives - Male contraceptives	100% (of the negotiated charge)  No policy year deductible applies	60% (of the recognized charge)
Abortion-physician or specialist surgical services	100% (of the negotiated charge)  No policy year deductible applies	60% (of the recognized charge)
Gender reassignment (sex change) treatment		
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is received.	

Eligible health services	In-network coverage		Out-of-network coverage
Autism spectrum disorder			
Autism spectrum disorder treatment, diagnosis and testing and Applied behavior analysis	Covered according to the type of benefit and the place where the service is received.		
Pervasive development disorders			
Pervasive development disorders	Covered according to the type of benefit and the place where the service is received.		
Mental Health & Substance Abuse Treatment			
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission	
Outpatient office visits (includes telemedicine consultations)	\$10 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter  No policy year deductible applies	60% (of the recognized charge) per visit	
Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	
Craniofacial anomaly defects	Covered according to the type of benefit and the place where the service is received.		
Maxillofacial prosthetic services	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.		
Eligible health services	In-network coverage Network (IOE facility)	In-network coverage Network (Non-IOE facility)	Out-of-network coverage
Transplant services Inpatient and outpatient facility services	Covered according to the type of benefit and the place where the service is received.		
Transplant services Inpatient and outpatient physician and specialist services	Covered according to the type of benefit and the place where the service is received.		
Transplant services-travel and lodging	Covered	Covered	Covered
Lifetime Maximum Travel and Lodging Expenses for any one transplant	\$10,000	\$10,000	\$10,000
Maximum Lodging Expenses per IOE patient	\$50 per night	\$50 per night	\$50 per night
Maximum Lodging Expenses per companion	\$50 per night	\$50 per night	\$50 per night

Eligible health services	In-network coverage	Out-of-network coverage
Basic infertility services	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	80% (of the negotiated charge)	60% (of the recognized charge)
Diagnostic lab work and radiological services performed in a physician’s office, the outpatient department of a hospital or other facility	80% (of the negotiated charge)	60% (of the recognized charge)
Outpatient Chemotherapy, Radiation & Respiratory Therapy	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Chiropractic services	\$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter  No policy year deductible applies	60% (of the recognized charge) per visit
Other services and supplies		
Emergency ground, air, and water ambulance  (includes non-emergency ambulance)	80% (of the negotiated charge) per trip	Paid the same in-network coverage
Durable medical and surgical equipment	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Enteral formulas and nutritional supplements	Covered according to the type of benefit and the place where the service is received.	
Inborn errors of metabolism	Covered according to the type of benefit and the place where the service is received.	
Prosthetic Devices	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Cranial prosthetics (Medical wigs)  Coverage includes one wig per calendar year following chemotherapy or radiation therapy	80% (of the negotiated charge) per item	60% (of the recognized charge) per item

Eligible health services	In-network coverage	Out-of-network coverage
Orthotic devices	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Cochlear implants	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Hearing aid exams	\$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter  No policy year deductible applies	60% (of the recognized charge) per visit
Hearing aid exam maximum	One hearing exam every policy year	
Hearing aids	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Hearing Aid Maximum per policy year	One hearing aid per ear every policy year	
Podiatric (foot care) treatment	Covered according to the type of benefit and the place where the service is received.	
Tobacco cessation  Coverage includes physician services, outpatient prescription drugs and over-the-counter medications prescribed by physician	Covered according to the type of benefit and the place where the service is received.	
Traumatic brain injury	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  Includes comprehensive low vision evaluations  Includes visit for fitting of contact lenses	100% (of the negotiated charge) per visit  No policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year	1 visit	
Low vision Maximum	One comprehensive low vision evaluation every policy year	
Fitting of contact Maximum	1 visit	
Pediatric vision care services & supplies-Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per item  No policy year deductible applies	60% (of the recognized charge) per item

Maximum number per year: Eyeglass frames Prescription lenses Contact lenses (includes non-conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery)	One set of eyeglass frames One pair of prescription lenses Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set
<b>*Important note: Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies.</b> 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.	
Biofeedback	Covered according to the type of benefit and the place where the service is received.
<b>Outpatient prescription drugs</b>	
<b>Policy year deductible and copayment/coinsurance waiver for risk reducing breast cancer</b>	
The policy year deductible and the per prescription copayment/coinsurance will not apply to risk reducing breast cancer prescription drugs when obtained at a retail in-network, pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.	
<b>Outpatient prescription drug copayment waiver for tobacco cessation prescription and over-the-counter drugs</b>	
The outpatient prescription drug copayment will not apply to the first two 90-day treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at a select care, in-network, and out-of-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%.	
Your outpatient prescription drug copayment will apply after those two regimens per policy year have been exhausted.	
<b>Copayment waiver for contraceptives</b>	
The outpatient prescription drug copayment will not apply to female contraceptive methods when obtained at a select care pharmacy, in-network, and out-of-network pharmacy.	
This means that such contraceptive methods are paid at 100% for:	
<ul style="list-style-type: none"> <li>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%.</li> <li>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%.</li> </ul>	
Your outpatient prescription drug copayment will continue to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at a select care pharmacy or in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.	

Eligible health services	In-network coverage	Out-of-network coverage
<b>Generic prescription drugs</b>		
For each fill up to a 30 day supply filled at a retail pharmacy	\$20 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)  No policy year deductible applies	\$20 copayment per supply then the plan pays 50% (of the balance of the recognized charge)  No policy year deductible applies
More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy	\$60 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)  No policy year deductible applies	Not Covered
<b>Preferred brand-name prescription drugs</b>		
For each fill up to a 30 day supply filled at a retail pharmacy	\$40 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)  No policy year deductible applies	\$40 copayment per supply then the plan pays 50% (of the balance of the recognized charge)  No policy year deductible applies
More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy	\$120 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)  No policy year deductible applies	Not Covered
<b>Non-preferred brand-name prescription drugs</b>		
For each fill up to a 30 day supply filled at a retail pharmacy	\$65 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)  No policy year deductible applies	\$65 copayment per supply then the plan pays 50% (of the balance of the recognized charge)  No policy year deductible applies
More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy	\$195 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)  No policy year deductible applies	Not Covered
<b>Specialty drugs</b>		
For each fill up to a 30 day supply filled at a retail pharmacy	\$65 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)  No policy year deductible applies	Not Covered
Orally administered anti-cancer prescription drugs- For each fill up to a 30 day supply filled at a retail pharmacy	100% (of the negotiated charge)  No policy year deductible applies	100% (of the recognized charge)  No policy year deductible applies
Preventive care drugs and supplements filled at a retail pharmacy	100% (of the negotiated charge per prescription or refill)	Paid according to the type of drug per the schedule of benefits, above



For each 30 day supply	No copayment or policy year deductible applies	
Risk reducing breast cancer prescription drugs filled at a pharmacy	100% (of the negotiated charge per prescription or refill	Paid according to the type of drug per the schedule of benefits, above
For each 30 day supply	No copayment or policy year deductible applies	
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.	
Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy	100% (of the negotiated charge per prescription or refill	Paid according to the type of drug per the schedule of benefits, above
For each 30 day supply	No copayment or policy year deductible applies	
Maximums:	Coverage is permitted for two 90-day treatment regimens only. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.	

## Exclusions

### Acupuncture therapy

- Maintenance treatment
- Acupuncture when provided for the following conditions:
  - Acute low back pain
  - Addiction
  - AIDS
  - Amblyopia
  - Allergic rhinitis
  - Asthma
  - Autism spectrum disorders
  - Bell's Palsy
  - Burning mouth syndrome
  - Cancer-related dyspnea
  - Carpal tunnel syndrome
  - Chemotherapy-induced leukopenia
  - Chemotherapy-induced neuropathic pain
  - Chronic pain syndrome (e.g., RSD, facial pain)
  - Chronic obstructive pulmonary disease
  - Diabetic peripheral neuropathy
  - Dry eyes
  - Erectile dysfunction
  - Facial spasm
  - Fetal breech presentation
  - Fibromyalgia
  - Fibrotic contractures
  - Glaucoma
  - Hypertension
  - Induction of labor
  - Infertility(e.g., to assist oocyte retrieval and embryo transfer during IVF treatment cycle)
  - Insomnia
  - Irritable bowel syndrome
  - Menstrual cramps/dysmenorrhea
  - Mumps
  - Myofascial pain
  - Myopia
  - Neck pain/cervical spondylosis
  - Obesity
  - Painful neuropathies
  - Parkinson's disease
  - Peripheral arterial disease (e.g., intermittent claudication)
  - Phantom leg pain
  - Polycystic ovary syndrome
  - Post-herpetic neuralgia
  - Psoriasis
  - Psychiatric disorders (e.g., depression)
  - Raynaud's disease pain

- Respiratory disorders
- Rheumatoid arthritis
- Rhinitis
- Sensorineural deafness
- Shoulder pain (e.g., bursitis)
- Stroke rehabilitation (e.g., dysphagia)
- Tennis elbow/ epicondylitis
- Tension headache
- Tinnitus
- Tobacco Cessation
- Urinary incontinence
- Uterine fibroids
- Xerostomia
- Whiplash

### **Air or space travel**

- Traveling in, on or descending from any aircraft, including a hang glider, while the aircraft is in flight. This includes descending by a parachute, wingsuit or any other similar device.

This exclusion does not apply if:

- You are traveling solely as a fare-paying passenger
- You are traveling on a licensed, commercial, regularly scheduled non-military aircraft
- You are traveling solely in a civil aircraft with a current valid "Standard Federal Aviation Agency Airworthiness Certificate" and:
  - The civil aircraft is piloted by a person with a current valid pilot's certificate with proper ratings for the type of flight and aircraft involved
  - You are as a passenger with no duties at all on an aircraft used only to carry passengers or you are a pilot or a part of the flight crew on an aircraft owned or leased by the policyholder performing duties for the policyholder

### ***Allergy testing and allergy injections treatment***

- Allergy sera and extracts administered via injection

### **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 an out-of-network 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
  - Services provided in conjunction with school, vocation, work or recreational 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 and body fluid exposure**

- Services and supplies provided for the treatment of an illness that results from your clinical related injury as these are covered elsewhere in the student policy

#### **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
- Any related services including processing, storage or replacement expenses
- The services of blood donors, apheresis or plasmapheresis
- For autologous blood donations, only administration and processing expenses are covered

#### **Breasts**

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

### **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 solely needed due to the clinical trial (i.e. protocol-induced costs)
- 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)
- Select care or in-network coverage limited to benefits for routine patient services provided within the network

### **Cornea or cartilage transplants**

- Cornea (corneal graft with amniotic membrane)
- Cartilage (autologous chondrocyte implant or osteochondral allograft or autograft) transplants

### **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 except in connection with hospice care, adult (or child) day care, or convalescent care
- Institutional care. This includes room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, 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 injuries to or diseases of the teeth
  - Dental services related to the gums
  - Apicoectomy (dental root resection)
  - Orthodontics
  - Root canal treatment
  - Soft tissue impactions
  - Alveolectomy
  - Augmentation and vestibuloplasty treatment of periodontal disease
  - False teeth
  - Prosthetic restoration of dental implants
  - Dental implants

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

### **Durable medical equipment (DME)**

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
- 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**

Any 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 schools, colleges, or camps

## **Family planning services - other**

- Reversal of voluntary sterilization procedures, including related follow-up care
- Family planning services received while confined as an inpatient in a hospital or other facility
- Services 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**

- 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

## **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**

The following services or supplies:

- A replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within the prior 24 month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- Cochlear implants
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist
- 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

- Services for infusion therapy
- 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
- Respite care
- Bereavement counseling
- Financial or legal counseling which includes estate planning and the drafting of a will
- Homemaker or caretaker services that are services which are not solely related to your care and may include:
  - Sitter or companion services for either you or other family members
  - Transportation
  - Maintenance of the house

### 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.

### Jaw joint disorder

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

This exclusion does not apply to covered benefits for treatment of TMJ and CMJ as described in the *Eligible health services under your plan –Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment* section.

**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 – Habilitation therapy services* section

**Maternity and related newborn care**

- Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries

**Medical supplies – outpatient disposable**

- Any outpatient disposable supply or device. Examples of these are:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Syringes
  - Blood or urine testing supplies
  - Other home test kits
  - Splints
  - Neck braces
  - Compresses
  - Other devices not intended for reuse by another patient

## 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, dropped it, or did not make a proper request for it

## Mental health and substance abuse 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
  - Specific developmental disorders of speech and language
  - 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 exception does not apply to *Preventive care and wellness* benefits.

## Non-U.S .citizen

- Services and supplies received by a covered person (who is not a United States citizen) within the covered person's home country but only if the home country has a socialized medicine program

## 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:

- Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery
- Surgical procedures, medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including morbid obesity
- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
- Hypnosis or other forms of therapy
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

### **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 does not apply if you are donating the organ to a spouse, domestic partner, civil union 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

### **Outpatient infusion therapy**

- Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan
- Enteral nutrition
- Blood transfusions and blood products
- Dialysis

### **Outpatient 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**

- The services of any other physician who helps the operating physician
- 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
- Dental implants and braces(that are determined not to be medically necessary mouth guards, and other devices to protect, replace or reposition teeth
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - For splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint dysfunction disorder (TMJ) 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 or analgesia (nitrous oxide)
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Routine dental exams and other preventive services and supplies, except as specifically provided in the *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 only for orthodontic reasons
- Treatment by other than a dental provider

## 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 (outpatient only)**

### **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
- Cochlear implants

### **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

### **School health services**

- Services and supplies normally provided by the policyholder's:
  - School health services
  - Infirmary
  - Hospital
  - Pharmacy or

by health professionals who

- Are employed by
- Are Affiliated with
- Have an agreement or arrangement with, or
- Are otherwise designated by

the policyholder.

### **Services provided by a family member**

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

### **Sinus surgery**

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

### **Sleep apnea**

- Any services or supplies given by providers for the treatment of obstructive sleep apnea and sleep disorders

### **Specialty prescription drugs**

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

### **Strength and performance**

- Services, , devices and supplies such as drugs or preparations designed primarily for 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**

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

### **Temporomandibular joint dysfunction treatment (TMJ) and craniomandibular joint dysfunction treatment (CMJ)**

- Dental implants

### **Therapies and tests**

- Full body CT scans
- 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
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
- Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness
- Travel and lodging expenses

## 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 for you or the surrogate. 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 from a person not covered under this plan 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

- 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

- 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.

## Exclusions that apply to outpatient prescription drugs

### **Allergy sera and extracts administered via injection**

### **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 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 shape 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 insured meets one or more clinical criteria detailed in our precertification 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 travel or work**

#### **Immunization or immunological agents**

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

#### **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 services and supplies (including equipment and training)* 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.
- 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 include 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 Pacific University Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student Health<sup>SM</sup> 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 that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, [CRCoordinator@aetna.com](mailto: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 electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

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

**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.**



<b>English</b>	<b>To access language services at no cost to you, call the number on your ID card.</b>
Albanian	Për shërbime përkthimi falas për ju, telefononi në numrin që gjendet në kartën tuaj të identitetit.
Amharic	የ ቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመስመረ ድምፅ ላይ ያለውን ቁጥር ይደውሉ፡፡
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Armenian	Ձեր նախընտրած լեզվով սկսվածքը խորհրդատվությունն 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 မပေးရဲဘဲ ဘာသာစကားပြန်ဆောင်ရွက်ပေး ရရှိနိုင်ရန်၊ သင့် ID ကတ်ပေါ်တွင်ရှိသော ဖုန်းနံပါတ်အား 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 lenggua'hi ni dibåtde para hægu, ågang i numiru gi iyo-mu kard aidentifikasion.
Cherokee	Ⴀႃႆ႔႗ Ⴑႏ႕႐႗႗ Ⴑ႓႙ႚ႗႗႗ Ⴑ Ⴑ႗႗႗ Ⴑ႒႒႗႗႗႗ Ⴑ႗, Ⴑ႗႗႗႗႗႗ Ⴑ႗႗႗ Ⴑ႗႗႗ Ⴑ႗႗႗႗႗ Ⴑ႗႗႗ Ⴑ႗႗႗ Ⴑ႗႗႗ Ⴑ႗႗႗ Ⴑ႗႗႗.
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 pillá ho ish i payahinla kv́t chi holisso kallo iskitini holhtena takanli ma i payah
Chuukese	Ren omw kopwe angei anininisin 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 આઈડી કાર્ડ પર રહેલ નંબર પર કોલ 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 obula, kpọọ nomba nọ na kaadi njirimara gi
Ilocano	Tapno maaksas 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	လၢတၢ်ကမၤန့ၣ်တၢ်မၤစၢၤအတၢ်ဖဲတၢ်မၤတဖၣ် လၢတၢ်အိၣ်ဒီးအပူၤလၢနကဘၣ်ဟ့ၣ်အီၤအဂီၢ်,ကိးဘၣ်လီၤတဲၣ်နီၣ်ဂံၢ်လၢအအိၣ်လၢနခိၣ်ဂီၤ (ID) အလီၤန့ၣ်တက့ၢ်.
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 دەستگیر ئەگەشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی سەر ئای دی (ID) کارتی خۆت.
Lao	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໃບຫາເບີໂທລະສັບໃນບັດປະຈຳຕົວຂອງທ່ານ.
Marathi	आपल्याला कोणत्याही शुल्काशिवाय भाषा सेवांपर्यंत पोहोचण्यासाठी, आपल्या ID कार्डवरील क्रमांकावर फोन करा.
Marshallese	Ñan bōk jipañ kōn kajin ilo an ejjelok wōñean ñan kwe, kwōn kallok nōmba eo ilo kaat in ID eo am̧.
Micronesian-Ponapean	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih nempe nan amhw doaropwe en ID.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាភាសាដែលគេគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T'áá ni nizaad k'éhjí bee níká a'doowoł doo b'ááq'íh ílínígóó naaltsoos bee atah nílíggo nanitinígíí bee n'éého'dólzínígíí béésh bee hane'í biká'ígíí áají' hólne'.
Nepali	भाषासम्बन्धी सेवाहरूमाथि निःशुल्क पहुँच राख्न आफ्नो कार्डमा रहेको नम्बरमा कल गर्नुहोस्।
Nilotic-Dinka	Të koor yin ran de wëër de thokic ke c'in wëu kor keek tënɔŋ yin. Ke yin col ran ye koc kuony në namba de abac tö në ID kard duön de tiit de nyin de panakim kōu.
Norwegian	For tilgang til kostnadsfri språktjenester, ring nummeret på ID-kortet ditt.

