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Aetna Student Health

Plan Design and Benefits Summary

Southern Methodist University

Policy Year: 2020 – 2021
Policy Number: 686199
www.aetnastudenthealth.com
(877) 850-6039

This is a brief description of the Student Health Plan. The Plan is available for Southern Methodist University 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 issued to you and may be viewed online at **www.aetnastudenthealth.com.** If there is a difference between this Benefit Summary and the Certificate, the Certificate will control. If you would like to obtain information about coverage under the Plan, please contact us at 877-480-4161, or call the Member Services number on the back of your ID card, or write to us at:

Aetna, Student Health
151 Farmington Avenue
Hartford, CT 06156

Southern Methodist University Student Health Center

The Dr. Bob Smith Health Center is the University's on-campus health facility. Staffed by nurse practitioners and registered nurses, it is open weekdays from 8:30 a.m. to 4:00 p.m., during the Fall and Spring semesters. Services provided include medical services, counseling services, dental services and health promotion.

The Deductible is waived and Covered Expenses at the Student Health Center (SHC) will be payable at 80% for insured students who have paid the SMU Student Health Center fee. Adult Immunizations covered at the Student Health Center include TB skin test, MMR#1, MMR#2, Tdap, Td and Meningitis.

At the SHC: Prescriptions are payable at 100% after a $15 Copayment for each Generic Drug and $40 Copayment for each Brand Name Drug. Prescriptions are available for a 90-day dispense at 3 times the copayment.

For more information, call the Health Center at (214) 768-2277. In the event of an emergency, call 911.

Coverage Periods

Students and Eligible Dependents: Coverage for all insured students enrolled for coverage in the Plan for the following Coverage Periods. Coverage 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.

Domestic and International Students

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Fall	08/01/2020	12/31/2020	09/07/2020
Spring/Summer	01/01/2021	07/31/2021	02/07/2021

Meadows Masters of Management Program Students

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment Deadline
Fall	08/10/2020	12/31/2020	09/07/2020

ESL/IEP Students

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Fall	09/09/2020	01/05/2021	10/10/2020
Spring	01/06/2021	05/04/2021	02/20/2021
Maymester	05/05/2021	06/22/2021	05/31/2021
Summer	06/23/2021	09/08/2021	07/30/2021

Rates

The rates below include both premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna), as well as Southern Methodist University administrative fee.

Domestic and International Students

	Fall	Spring/Summer	Summer
Student	$1628	$1628	$821
Spouse	$1628	$1628	$821
Each Child	$1628	$1628	$821

Meadows Masters of Management Program Students

	Fall
Student	$1285
Spouse	$1285
Each Child	$1285

ESL/IEP Students

	Fall	Spring	Maymester	Summer
Student	$1036	$1026	$427	$687
Spouse	$1036	$1026	$427	$687
Each Child	$1036	$1026	$427	$687

Student Coverage

Who is eligible?

DOMESTIC STUDENTS

All domestic students taking nine (9) credit hours or more are required to maintain health insurance as a condition of enrollment. A domestic student may waive out of the Policy by documenting current, comparable U.S. insurance coverage in the Student Center component of ***my.SMU.edu*** before the deadline each semester. Domestic students not waiving are required to enroll in the Student Health Insurance Plan.

To complete the waiver form or to elect coverage, go to the Student Center component of ***my.SMU.edu***. If you choose to elect coverage or do not waive coverage by the waiver deadline, the premium will be charged to your SMU student account. No changes will be made to a student's SMU account after August 7, 2020, for Fall 2020, or after December 7, 2020, for Spring 2021. For more detailed information, please visit ***smu.edu/healthinsurance***.

All degree seeking domestic students taking between four (4) and eight (8) credit/degree seeking hours are eligible to enroll on a voluntary basis during the open enrollment period (prior to the waiver deadline) and have their premium billed to their SMU Student Account. Students taking eight (8) hours or less will not be automatically enrolled. Exceptions would be for Graduate Students working on their dissertation or thesis who can be covered up to 4 semesters. Voluntary eligibility will be audited each semester. Students who are not admitted and, in a degree, seeking program are not eligible.

INTERNATIONAL STUDENTS

All International students who are enrolled in one (1) or more credit hours are required to maintain the Student Health Insurance Plan as a condition of enrollment International students must enroll in the Student Health Insurance Plan unless they have a special waiver personally granted by the SMU Health Center staff. To view the requirements necessary to apply for a waiver, please go to ***smu.edu/healthinsurance***.

After enrolling for classes each semester, international students must elect coverage online by going to the student Center component of ***my.SMU.edu*** and selecting the "Health Insurance" button. The semi-annual premium will be charged to the student's SMU student account after they enroll in ***my.SMU.edu***.

Any international student not enrolled by the enrollment/waiver deadline will be enrolled automatically and will have the premium charged to their SMU student account. No changes will be made to a student's SMU account after August 7, 2020, for Fall 2020, or after December 7, 2020, for Spring 2021. For more detailed information, including a Frequently Asked Questions page, please visit ***smu.myahpcare.com***.

INTENSIVE ENGLISH PROGRAM (IEP) STUDENTS

All Intensive English Program (IEP) students must enroll in the Student Health Insurance Plan unless they have a special waiver personally granted by the Health Center staff. To view the requirements necessary to apply for a waiver go to ***smu.edu/healthinsurance***.

MEADOWS MASTERS OF MANAGEMENT PROGRAM

All Meadows Masters of Management Program students will be automatically enrolled into the Student Health Insurance Plan from a list given to the Student Health Insurance Office from the Meadows Masters Department by Meadows, and the premium will be charged to their student account.

A student must actively attend classes for at least the first 31 days after the date for which coverage is purchased unless he or she withdraws from classes due to an Injury or Sickness and the absence is an approved medical leave. Home study, correspondence, Internet classes and television (TV) courses do not fulfill the eligibility requirements that the student must actively attend classes. The Company maintains its right to investigate student status and attendance records to verify that the eligibility requirements have been met. If the Company discovers the eligibility requirements have not been met, its only obligation is refund of premium

Dependent Coverage

Eligibility

Covered students may also enroll their lawful spouse, domestic partner (same-sex, opposite sex), and dependent children up to the age of 26.

Dependent enrollment must take place at the time of student enrollment (or within 30 days if tuition billed), with the exception of newborn or adopted children or a Qualifying Event. Dependent means an Insured Student's lawful spouse; an Insured Student's dependent biological child, adopted child or child pending adoption, child under a medical support order under an order issued under Chapter 154, Family Code, or enforceable by a court in this state, stepchild under age 26; and an Insured Student's grandchild who unmarried, under age 26 and dependent on the Insured Student for federal income tax purposes at the time application for coverage of the grandchild is made; and an Insured Student's covered dependent child who has reached age 26 and who is: a) primarily dependent upon the Insured Student for support and maintenance; and b) incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder or physical handicap. Proof of the child's incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when a Insured Student enrolls a new disabled child under the plan.

Coverage will continue for a child who is 26 or more years old, chiefly supported by the Insured and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to the Company within 31 days after the date the child ceases to qualify as a child for the reasons listed above. During the next two years, the Company may, from time to time, require proof of the continuation of such condition and dependence. After that, the Company may require proof no more than once a year. Dependent coverage is available only if the student is also insured. Dependent coverage must be the exact same coverage period of the Insured; and therefore, will expire concurrently with that of the student.

Newly Born Children A newborn child will automatically be covered for the first 31 days following the child's birth. To extend coverage for a newborn child past the 31 day period, the covered student must: 1) enroll the child within 31 days of birth, and 2) pay any required additional premium.

Qualifying Event: Eligible students who have a change in status and lose coverage under another Health Care Plan are eligible to enroll for coverage under the Policy provided, within 31 days of the qualifying event, students should send a copy of the Certificate of Creditable Coverage, and the letter of ineligibility to Academic HealthPlans. A change in status due to a qualifying event includes, but is not limited to, loss of a spouse, whether by death, divorce, annulment or legal separation. The premium will be the same as it would have been at the beginning of the semester. However, the effective date will be the later of the date the student enrolls for coverage under the Policy and pays the required premium, or the day after the prior coverage ends.

Enrollment

To enroll online for voluntary coverage, go to **smu.myahpcare.com**, find your campus and then click on Enrollment tab.

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.)

Medicare Eligibility Notice

You are not 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.

Coordination of Benefits (COB)

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one 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).

The order of benefit determination rules tell you the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms. Payment is made without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

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 Southern Methodist University and may be viewed online at www.aetnastudenthealth.com.

In-network Provider Network

Under your plan, you can choose to receive care from an in-network provider or an out-of-network provider. An in-network provider is a provider who is listed in the directory for your plan and provides services at negotiated/reduced rates as agreed to with Aetna. An out-of-network provider is not an in-network provider, is not listed in the directory for your plan, and does not provide negotiated/reduced rates for their services.

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 a situation where there is are an inadequate number of network providers, Aetna may issue a pre-approval for you to receive the care from an Out-of-network Provider at the same benefit level that is provided for care received from In-network Providers.

Preauthorization

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

Preauthorization for medical services and supplies

In-network care

Your in-network physician is responsible for obtaining any necessary preauthorization before you get the care. If your in-network physician doesn't get a required preauthorization, we won't pay the provider who gives you the care. You won't have to pay either if your in-network physician fails to ask us for preauthorization. If your in-network physician requests preauthorization 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.

Out-of-network care

When you go to an out-of-network provider, it is your responsibility to obtain preauthorization from us for any services and supplies on the preauthorization list. If you do not preauthorize, 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 preauthorization appears later in this section

Preauthorization call

Preauthorization should be secured within the timeframes specified below. To obtain preauthorization, 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 preauthorization at least 3 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 preauthorization:	You or your physician must call at least 3 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 preauthorization decision, where required by state law. If your preauthorized 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 preauthorized, 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 preauthorization 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

preauthorization decision. See the *When you disagree - claim decisions and appeals procedures* section of Certificate of Coverage.

What if you don't obtain the required preauthorization?

If you don't obtain the required preauthorization:

- Your benefits may be reduced, or the plan may not pay any benefits. See the schedule of benefits *Preauthorization 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 preauthorization?

Preauthorization is required for the following types of services and supplies:

Inpatient services and supplies
Gene-based, cellular and other innovative therapies (GCIT)
Obesity (bariatric) surgery
Stays in a hospice facility
Stays in a hospital
Stays in a rehabilitation facility
Stays in a residential treatment facility for treatment of mental disorders and substance abuse
Stays in a skilled nursing facility

**For a current listing of the prescription drugs and medical injectable drugs that require preauthorization, 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 atwww.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 Texas 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.		
Student	$400 per policy year	$1,200 per policy year
Spouse	$400 per policy year	$1,200 per policy year
Each child	$400 per policy year	$1,200 per policy year
Family	$1,200 per policy year	$3,600 per policy year

Policy Year Deductible Provisions

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.

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. See the *Policy year deductibles* provision at the beginning of this schedule for any exceptions to this general rule. This policy year deductible applies separately to you and each of your covered dependents. 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.

Family

This is the amount you and your covered dependents owe for in-network and out-of-network eligible health services each policy year before the plan begins to pay for eligible health services. See the *Policy year deductibles* provision at the beginning of this schedule for any exceptions to this general rule. After the amount you and your covered dependents pay for eligible health services reaches this family policy year deductible, this plan will begin to pay for eligible health services that you and your covered dependents incur for the rest of the policy year.

To satisfy this family policy year deductible limit for the rest of the policy year, the following must happen:

- The combined eligible health services that you and each of your covered dependents incur towards the individual policy year deductibles must reach this family policy year deductible limit in a policy year.

When this occurs in a policy year, the individual policy year deductibles for you and your covered dependents will be considered to be met for the rest of the policy year.

Policy year deductible waiver

The policy year deductible is waived for all of the following eligible health services:

- In-network care for Preventive care and wellness, Physician and specialist services, Consultant services, Walk-in clinic visits, Urgent care, Outpatient mental disorder treatment office visits, Outpatient substance abuse office visits, and Pediatric Vision Care Services
- In-network care, and out-of-network care for Hospital emergency room, Pediatric Dental Type A Services, Well newborn nursery care and Outpatient prescription drugs

Maximum out-of-pocket limits **Maximum out-of-pocket limit** per **policy year**		
Student	$7,900 per policy year	$10,000 per policy year
Spouse	$7,900 per policy year	$10,000 per policy year
Each child	$7,900 per policy year	$10,000 per policy year
Family	$12,700 per policy year	$37,500 per policy year

Preauthorization covered benefit penalty

This only applies to out-of-network coverage:
The certificate of coverage contains a complete description of the preauthorization program. You will find details on preauthorization requirements in the *Medical necessity and preauthorization requirements* section.

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

- A $500 benefit penalty will 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 preauthorization 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.

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.

Eligible health services	In-network coverage	Out-of-network coverage
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	60% (of the recognized charge) per visit
Covered persons age 18 and over: Maximum visits per policy year	1 visit	

The following services apply to Routine physical exams for covered persons age 18 or more Maximum age and visit limits per policy year

Routine physical exams for covered persons age 18 or more

- Abdominal aortic aneurysm – a one-time screening for men who have ever smoked
- Alcohol misuse screening and counseling in a primary care setting
- Blood pressure screening
- Cholesterol screening for adults at increased risk for coronary heart disease
- Colorectal cancer screening for adults over 50
- Depression screening for adults when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up
- Prostate specific antigen (PSA) tests
- Diabetes (Type 2) screening for adults with high blood pressure
- HIV screening for all adults at higher risk
- Obesity screening and counseling for all adults
- Tobacco use screening for all adults and cessation interventions for tobacco users
- Syphilis screening for all adults at higher risk
- Sexually transmitted infection prevention counseling for adults at higher risk
- Diet counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease
- Screening for aspirin use for the primary prevention of cardiovascular disease and colorectal cancer as recommended by their physician

The following services apply to Routine physical exams for covered persons from birth to age 18

- Autism screening
- Behavioral assessments
- Cervical dysplasia screening for sexually active females
- Congenital hypothyroidism screening for newborns
- Developmental screening, and surveillance throughout childhood
- Dyslipidemia screening at higher risk of lipid disorders
- Hearing screening for all newborns
- Hematocrit or hemoglobin screening
- Hemoglobinopathies or sickle cell screening for newborns

- HIV screening for adolescents at higher risk
- Lead screening for covered persons at risk of exposure
- Obesity screening and counseling
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Tuberculin testing for covered persons at higher risk of tuberculosis
- Hearing and vision screening to determine the need for hearing and vision correction
- Alcohol and drug use assessments for adolescents
- Fluoride chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of all newborns
- Height, weight and body mass index measurements
- Iron supplements for covered persons ages 6 to 12 months at risk for anemia
- Medical history throughout development
- Oral health risk assessment
- Sexually transmitted infection prevention counseling for adolescents at higher risk
- Depression screening for adolescents
- Blood pressure screening

Routine physical exams for women

- Anemia screening on a routine basis for pregnant women
- Bacteriuria urinary tract or other infection screening for pregnant women
- BRCA counseling about genetic testing for women at higher risk
- Breast cancer mammography screenings
- Breast cancer chemoprevention counseling for women at higher risk
- Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
- Cervical cancer screening for sexually active women
- Pap smear; or screening using liquid-based cytology methods, either alone or in conjunction with a test approved by the United States Food and Drug Administration
- A gynecological exam that includes a rectovaginal pelvic exam for women who are at risk of ovarian cancer)
- Chlamydia infection screening for younger women and other women at higher risk
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs (see the contraception sections, below for more detail)
- Diagnostic exam for the early detection of ovarian cancer, cervical cancer, and the CA 125 blood test
- Domestic and interpersonal violence screening and counseling for all women
- Folic acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women
- Human Papillomavirus (HPV) DNA test: high risk HPV DNA testing
- Osteoporosis screening for women depending on risk factors
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users
- Sexually transmitted Infections counseling for sexually active women
- Syphilis screening for all pregnant women or other women at increased risk
- Well-woman visits to obtain recommended preventive services

Eligible health services also include: • 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 • Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents • Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. • Radiological services, lab and other tests given in connection with the exam • For covered newborns, an initial hospital checkup For additional details, contact your physician or Member Services by logging onto your Aetna secure website at www.aetnastudenthealth.com or calling the toll-free number on the back of your ID card.		
Preventive care immunizations		
Performed in a facility or at a physician's office Your plan does not cover immunizations that are not considered preventive care except for those required due to travel. No policy year deductible or copayment applies for children from birth through age 6	100% (of the negotiated charge) per visit. No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximums	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 secure member website at www.aetnastudenthealth.com or calling the number on the back of 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	60% (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. 1 Pap smear every 12 months for women age 18 and older 1 exam every 12 months for women over age 25 who are at risk for ovarian cancer 1 exam every 12 months for women age 18 and older For women over age 60 depending on risk factors	

Eligible health services	In-network coverage	Out-of-network coverage
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	60% (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)	
Misuse of alcohol and/or drugs counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (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	60% (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	60% (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	60% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
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	60% (of the recognized charge) per visit
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	60% (of the recognized charge) per visit
Maximums	1 low-dose mammogram every 12 months for covered persons age 35 or older 1 Prostate Specific Antigen (PSA) test every 12 months for covered persons age 50 and older 1 PSA test every 12 months for covered persons age 40 and older with a family history of prostate cancer, or other risk factor 1 fecal occult blood test every 12 months for covered persons age 50 or older 1 flexible sigmoidoscopy every 5 years for covered persons age 50 or older 1 colonoscopy every 10 years for covered persons age 50 or older 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 secure member website at www.aetnastudenthealth.com or calling the number on the back of 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.		

Eligible health services	In-network coverage	Out-of-network coverage
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	60% (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	60% (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.		
Breast pump supplies and accessories	100% (of the negotiated charge) per item No copayment or policy year deductible applies	60% (of the recognized charge) per item
Important note: See the *Breast feeding durable medical equipment* section of the certificate of coverage for limitations on breast pump and supplies.		
Family planning services –contraceptives		
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
Maximum	Contraceptive counseling services maximum visits per policy year either in a group or individual setting: 2	

Eligible health services	In-network coverage	Out-of-network coverage
Contraceptives (prescription drugs and devices)		
Contraceptive prescription drugs and devices provided, administered, or removed, by a physician during an office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per item
Voluntary sterilization		
Inpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Outpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Physicians and other health professionals		
Physician and specialist services		
Office hours visits (non-surgical and non-preventive care by a physician and specialist, includes telemedicine or telehealth consultations)	$30 copayment then the plan pays 100% (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 performed at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Allergy injections treatment performed at a physician's, or specialist office	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Physician and specialist - inpatient 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)	60% (of the recognized charge)

Eligible health services	In-network coverage	Out-of-network coverage
Physician and specialist - outpatient surgical services		
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 anesthetist and surgical assistant expenses)	80% (of the negotiated charge)	60% (of the recognized charge)
In-hospital non-surgical physician services		
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Consultant services (non-surgical and non-preventive)		
Office hours visits (non-surgical and non-preventive care includes telemedicine or telehealth consultations)	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No policy year deductible applies	60% (of the recognized charge) per visit
Second surgical opinion	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 physician office visits		
Walk-in clinic visits (non-emergency visit)	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No policy year deductible applies	60% (of the recognized charge) per visit
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	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission

Eligible health services	In-network coverage	Out-of-network coverage
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.
Anesthesia and related facility charges for a dental procedure		
Anesthesia and related facility charges for a dental procedure *Coverage is subject to certain conditions. See the benefit description in the certificate of coverage for details*.	80% (of the negotiated charge)	60% (of the recognized charge)
Alternatives to hospital stays		
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	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Home health care		
Outpatient	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Maximum visits per policy year	60	
Hospice care		
Inpatient facility (room and board and other miscellaneous services and supplies)	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Outpatient	80% (of the negotiated charge) per visit	60% (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	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Maximum days of confinement per policy year	25	

Eligible health services	In-network coverage	Out-of-network coverage
Emergency services and urgent care		
Emergency services		
Hospital emergency room	$250 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit No policy year deductible applies	Paid the same as in-network coverage
Non-emergency care in a hospital emergency room	Not covered	Not covered
Important note: • As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment/coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on the back of your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill. • A separate hospital emergency room copayment/coinsurance will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/coinsurance will be waived and your inpatient copayment/coinsurance will apply. • Covered benefits that are applied to the hospital emergency room copayment/coinsurance cannot be applied to any other copayment/coinsurance under the plan. Likewise, a copayment/coinsurance that applies to other covered benefits under the plan cannot be applied to the hospital emergency room copayment/coinsurance. • Separate copayment/coinsurance amounts may apply for certain services given to you in the hospital emergency room that are not part of the hospital emergency room benefit. These copayment/coinsurance amounts may be different from the hospital emergency room copayment/coinsurance. They are based on the specific service given to you. • Services given to you in the hospital emergency room that are not part of the hospital emergency room benefit may be subject to copayment/coinsurance amounts that are different from the hospital emergency room copayment/coinsurance amounts.		
Urgent care		
Urgent medical care provided by an urgent care provider **Does not include complex imaging services, lab work and radiological services performed during an urgent medical care visit	$50 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No policy year deductible applies	60% (of the recognized charge) per visit
**See the cost-sharing that applies to these covered benefits in this schedule of benefits.		
Non-urgent use of an 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. The payment or reimbursement for services rendered by a dentist of a non-contracting dental provider shall be reimbursed the same as a contracting dental provider		
Type A services	100% (of the negotiated charge) per visit No copayment or deductible applies	100% (of the recognized charge) per visit No copayment or deductible applies
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	Covered according to the type of benefit and the place where the service is received.
Specific conditions		
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.
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.
Impacted wisdom teeth		
Impacted wisdom teeth	80% (of the negotiated charge)	60% (of the recognized charge)
Accidental injury to sound natural teeth		
Accidental injury to sound natural teeth	80% (of the negotiated charge)	60% (of the recognized charge)
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.
Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment		
TMJ and **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.
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.

Eligible health services	In-network coverage	Out-of-network coverage
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.	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
Note: *If applicable, the per admission copayment and/or policy year deductible amounts for newborns will be waived for nursery charges for the duration of the newborn's initial routine facility stay. The nursery charges waiver will not apply for non-routine facility stays.*		
Pregnancy complications		
Pregnancy complications	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.
Family planning services – other		
Voluntary sterilization for males		
Inpatient physician or specialist surgical services	80% (of the negotiated charge)	60% (of the recognized charge)
Outpatient physician or specialist surgical services	80% (of the negotiated charge)	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.	Covered according to the type of benefit and the place where the service is received.
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.
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.
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.
Services for children with developmental delays	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage	Out-of-network coverage
Mental health treatment		
Mental health treatment – inpatient		
Inpatient hospital mental disorders treatment (room and board and other miscellaneous hospital services and supplies) Inpatient residential treatment facility mental disorders treatment (room and board and other miscellaneous residential treatment facility services and supplies) Subject to semi-private room rate unless intensive care unit is required Mental disorder room and board intensive care	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Mental health treatment - outpatient		
Outpatient mental disorder treatment office visits to a physician or behavioral health provider (includes telemedicine or telehealth cognitive behavioral therapy consultation)	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No policy year deductible applies	60% (of the recognized charge) per visit
Other outpatient mental disorders treatment (includes skilled behavioral health services in the home) Partial hospitalization treatment Intensive Outpatient Program	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Substance abuse related disorders treatment-inpatient		
Inpatient hospital substance abuse detoxification (room and board and other miscellaneous hospital services and supplies) Inpatient hospital substance abuse rehabilitation (room and board and other miscellaneous hospital services and supplies) Inpatient residential treatment facility substance abuse (room and board and other miscellaneous residential treatment facility services and supplies) Subject to semi-private room rate unless intensive care unit is required Substance abuse room and board intensive care	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Substance abuse related disorders treatment-outpatient: detoxification and rehabilitation		
Outpatient substance abuse office visits to a physician or behavioral health provider (includes telemedicine or telehealth cognitive behavioral therapy consultations)	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No policy year deductible applies	60% (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	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
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.

Oral and maxillofacial treatment (mouth, jaws, and teeth)	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. No policy year deductible applies	Covered according to the type of benefit and the place where the service is received. No policy year deductible applies	
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 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.		
Eligible health services	**In-network coverage**	**Out-of-network coverage**	
Treatment of infertility			
Basic infertility services			
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.	
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) per visit	60% (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	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	
Diagnostic follow-up care related to newborn hearing screening	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	
Cardiovascular disease testing	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	
Chemotherapy			
Chemotherapy	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	

Eligible health services	In-network coverage	Out-of-network coverage
Oral anti-cancer prescription drugs	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 infusion therapy		
Outpatient infusion therapy 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
Outpatient radiation therapy		
Outpatient radiation therapy	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Outpatient respiratory therapy		
Respiratory therapy	80% (of the negotiated charge) per visit	60% (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
Short-term cardiac and pulmonary rehabilitation services		
Cardiac rehabilitation	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Pulmonary rehabilitation	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Short-term rehabilitation and habilitation therapy services		
Outpatient physical, occupational, speech, and cognitive therapies Combined for short-term rehabilitation services and habilitation therapy services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Acquired brain injury	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.
Alzheimer's disease	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.
Chiropractic services		
Chiropractic services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Evaluation and therapy for learning and developmental disabilities		
Evaluation and therapy for learning and developmental disabilities	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.
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.
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Other services and supplies		
Acupuncture in lieu of anesthesia	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Emergency ground, air, and water ambulance (includes non-emergency ambulance)	80% (of the negotiated charge) per trip	Paid the same as in-network coverage
Clinical trial therapies (experimental or investigational)	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.
Durable medical and surgical equipment	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Enteral formulas and nutritional supplements	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Osteoporosis (non-preventive care)		
Physician's or specialist's office visits	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Prosthetic devices		
Cranial prosthetics *(Medical wigs)*	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Prosthetic devices	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Orthotic devices	80% (of the negotiated charge) per item	60% (of the recognized charge) per item

Eligible health services	In-network coverage	Out-of-network coverage
Hearing aids and cochlear implants and related services		
Hearing aids and cochlear implants and related 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.
Hearing aids maximum per ear	One per ear every three years	
Replacement of cochlear implant external speech processor and controller components maximum	Once every three years	
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.
Vision care		
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, optometrist, therapeutic optometrist, or any other providers acting within the scope of their license	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	
Pediatric comprehensive low vision evaluations		
Performed by a legally qualified ophthalmologist optometrist, therapeutic optometrist, or any other providers acting within the scope of their license	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum	One comprehensive low vision evaluation every policy year	
Pediatric vision care services and 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 of eyeglass frames per policy year	One set of eyeglass frames	
Maximum number of prescription lenses per policy year	One pair of prescription lenses	

Eligible health services	In-network coverage	Out-of-network coverage
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	60% (of the recognized charge) per visit
Maximum visits per policy year	1 visit	
Optical devices	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum number of optical devices per policy year	One optical device	

*__Important note__: Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies.

As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.

Outpatient prescription drugs

Outpatient prescription drug policy year deductible waiver

The policy year deductible is waived for all prescription drugs filled at a retail pharmacy or mail order pharmacy.

Outpatient prescription drug copayment waiver for risk reducing breast cancer

The prescription copayment will not apply to risk reducing breast cancer prescription drugs when obtained at a in-network, pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.

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

The 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 in-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%.

Your prescription drug copayment will apply after those two regimens per policy year have been exhausted.

Outpatient prescription drug copayment waiver for contraceptives

The prescription drug copayment will not apply to female contraceptive methods when obtained at a in-network pharmacy.

This means that such contraceptive methods are paid at 100% for:

- Certain over-the-counter (OTC) and generic contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%.
- If a 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 prescription drug copayment 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 in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.		
Generic prescription drugs (including specialty drugs)		
Per prescription copayment/coinsurance		
For each fill up to a 30-day supply filled at a retail pharmacy	$25 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$25 copayment per supply then the plan pays 60% (of the balance of the recognized charge) No policy year deductible applies
Preferred brand-name prescription drugs (including specialty drugs)		
Per prescription copayment/coinsurance		
For each fill up to a 30-day supply filled at a retail pharmacy	$50 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$50 copayment per supply then the plan pays 60% (of the balance of the recognized charge) No policy year deductible applies
Non-preferred brand-name prescription drugs (including specialty 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 balance of the negotiated charge) No policy year deductible applies	$75 copayment per supply then the plan pays 60% (of the balance of the recognized charge) 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 per prescription or refill No copayment or policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
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
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 preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure website at www.aetnastudenthealth.com or calling the toll-free number on the back of your ID card.	

Risk reducing breast cancer prescription drugs		
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
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 preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure website at www.aetnastudenthealth.com or calling the toll-free number on the back of your ID card.	
Tobacco cessation prescription and over-the-counter drugs		
Tobacco cessation prescription drugs and OTC 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
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. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna 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-authorization 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

General exceptions and exclusions

Acupuncture therapy

- Maintenance treatment
- Acupuncture when provided for the following conditions:
  - Acute low back pain
  - Addiction
  - AIDS
  - Amblyopia
  - Allergic rehinitis
  - Asthma
  - Autism spectrum disorders
  - Bell's Palsy
  - Burning mouth syndrome
  - Cancer-related dyspnea
  - Carpal tunnel syndrome
  - Chemotherapy-induced leukopenia
  - Chemotherapy-induced neuopathic 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
  - You are enrolled in the policyholder's "Bachelor of Science in Aviation" program

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

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
- Any related services including processing, storage or replacement expenses
- The services of blood donors, apheresis or plasmapheresis
- For allogenic and 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.

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* and *Outpatient Prescription Drug* 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, freestanding emergency medical care facility or comparable emergency 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, except if you have an acquired brain injury. See the Specific therapies and tests section.
• 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

- Services and supplies provided for an abortion except as described in the *Pregnancy complications* section and except when the pregnancy places the woman's life in serious danger or at serious risk of substantial impairment of a major bodily function
- 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

Gender reassignment (sex change) treatment

- Cosmetic services and supplies such as:
  - Rhinoplasty
  - Face-lifting
  - Lip enhancement
  - Facial bone reduction
  - Lepharoplasty
  - 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

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 and preauthorization requirements* section.

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

Therapies and treatments including:

- Cellular immunotherapies.
- Genetically modified viral therapy.

- Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain therapeutic conditions.
- All human gene therapy that seeks to change the usual function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using:
  - Luxturna® (Voretigene neparvovec)
  - Zolgensma® (Onasemnogene abeparvovec-xioi)
  - Spinraza® (Nusinersen)
- Products derived from gene editing technologies, including CRISPR-Cas9.
- Oligonucleotide-based therapies. Examples include:
  - Antisense. An example is Spinraza® (Nusinersen).
  - siRNA.
  - mRNA.
  - microRNA therapies.

GCIT are defined as any services that are:

- Gene-based
- Cellular and innovative therapeutics

The services have a basis in genetic/molecular medicine and are not covered under the **Institutes of Excellence™ (IOE)** programs.

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, except as provided in the Hearing aids and cochlear implants and other services section of the Eligible health services section

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
- 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.

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

Jaw joint disorder

• Non-surgical treatment of jaw joint disorders

• Jaw joint disorder treatment performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and 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 under the *Eligible health services under your plan – Habilitation therapy service*s section and under the *Eligible health services under your plan – Services for children with developmental delays* section.

Maternity 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. These items are usually included in the cost of other services and are not billed separately. Examples of these are:

- Sheaths
- Bags
- Elastic garments
- Support hose
- Bandages
- Bedpans
- Syringes, except for treatment of diabetes
- Blood or urine testing supplies, except for treatment of diabetes
- 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

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, 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
- Preventive contraceptives and **brand-name prescription drug** forms of contraception in each of the methods identified by the FDA
- 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
- Orthodontic treatment for 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

Podiatric (foot care) treatment

• Services and supplies for:
- The treatment of calluses, bunions, toenails, hammertoes, or 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 (other than as specifically described in the Eligible health services under your plan section), arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, except for complications of diabetes. See the Specific conditions section.
- Routine pedicure services, such as such as routine cutting of nails, when there is no illness or injury in the nails

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
- 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
- Repair and replacement due to loss, misuse, abuse or theft
- Communication aids
- Cochlear implants except as provided in the *Eligible health services under your plan - Hearing aids and cochlear implants and related services--Other services* section

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 parent, child, step-child, brother, sister, in-law or any household member, except when that family member is a dentist who is licensed in the State of Texas to provide the service rendered

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 90 day supplies

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

Sports

- Any services or supplies given by providers as a result from play or practice of collegiate or intercollegiate sports, not including intercollegiate club sports and intramurals

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 and telehealth

- 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 for transplants

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 of eggs, embryos or sperm
- Storage of eggs, embryos, or sperm
- Thawing of cryopreserved 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 males who are not covered under this planfor 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)
• ART services are not provided for out-of-network care

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.

Exceptions and exclusions that apply to outpatient prescription drugs

Abortion 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 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 insured meets one or more clinical criteria detailed in our preauthorization 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. See the Eligible health services under your policy – Diabetic equipment, supplies and education section for covered equipment and supplies.
• Needles and syringes, except for those used for self-administration of an injectable drug.
• For 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.
- 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.

In case of a medical emergency

When you experience an emergency medical condition, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance assistance. If possible, call your physician but only if a delay will not harm your health.

After-hours care — available 24/7

Call your doctor when you have medical questions or concerns. Your doctor should have an answering service if you call after the office closes. You can also go to an urgent care center, which may have limited hours. To find a center near you, log in at https://myaetna.com and search our list of doctors and other health care providers. Check your plan documents to see how much you must pay for urgent care services.

Out-of-area services and benefits

You may not have access to an in-network provider when you are traveling outside of the plan's service area. If you must receive medically necessary services or supplies when traveling outside of the plan's service area, we will reimburse you as shown in the table below.

Type of provider	Your cost share
In-network provider	• You pay the copayment/coinsurance.
Out-of-network provider	• You pay the pharmacy directly for the cost of the prescription. Then you fill out and send a prescription drug refund form to us, including all itemized pharmacy receipts. • Submission of a claim doesn't guarantee payment. If your claim is approved, you will be reimbursed the cost of your prescription less your copayment/coinsurance.

Keeping a provider you go to now (continuity of care)

You may have to find a new provider when:

- You join the plan and the provider you have now is not in the network
- You are already covered under another Aetna plan and your provider stops being in our network

However, in some cases, you may be able to keep going to your current provider to complete a treatment or to have treatment that was already scheduled. This is called continuity of care.

	If you are a new enrollee and your provider is an out-of-network provider	If you are a current enrollee and your provider stops participation with Aetna
Request for approval	You need to complete a Transition Coverage Request form and send it to us. You can get this form by contacting Member Services at the toll-free number on the back of your ID card.	You or your provider should call Aetna for approval to continue any care.

Length of transitional period	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition.	Care will continue during a transitional period, usually 90 days, this date is based on the date the provider terminated their participation with Aetna.

	If you have a terminal illness and your provider stops participation with Aetna
Request for approval	Your provider should call us for approval to continue any care. You can call Member Services at the toll-free number on the back of your ID card for information on continuity of care.
Length of transitional period	Care will continue during a transitional period for up to nine (9) months. This date is based on the date the provider terminated their participation with Aetna.
How claim is paid	Your claim will be paid at not less than the negotiated charge during the transitional period.

	If you are pregnant and have entered your second trimester and your provider stops participation with Aetna
Request for approval	Your provider should call us for approval to continue any care. You can call Member Services at the toll-free number on the back of your ID card for information on continuity of care.
Length of transitional period	Care will continue during a transitional period through delivery, including the time required for postpartum care directly related to the delivery. This includes a post-delivery checkup within six weeks.
How claim is paid	Your claim will be paid at not less than the negotiated charge during the transitional period.

We will authorize coverage for the transitional period only if the provider agrees to our usual terms and conditions for contracting providers.

Complaints and Appeals

If you are dissatisfied with the service you receive from the Plan or you want to complain about a preferred care provider, you may call the Member Services telephone number shown on your ID card or write to Aetna at:

Aetna Life Insurance Company
Appeals Resolution Team
PO Box 14464
Lexington, KY 40512

The complaint must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. You may submit an appeal if Aetna gives notice of an adverse benefit determination. A final adverse benefit determination notice may also provide an option to request an External Review (if available).

For more information about the Complaints and Appeals Procedure or External Review processes, you may call the Member Services telephone number shown on your ID card. A complete description of the Complaints and Appeals

Procedure and External Review processes are contained in the Master Policy/Certificate of Coverage issued to School Name, and may be viewed online at www.aetnastudenthealth.com.

Directory

The list of in-network providers, which includes complete descriptions of the providers' networks and a disclosure of which PPOs will not accept new patients for your plan appears at www.aetnastudenthealth.com under the DocFind® label. When searching DocFind®, you need to make sure that you are searching for providers that participate in your specific plan. In-network providers may only be considered for certain Aetna plans. When searching for in-network dental providers, you need to make sure you are searching under Pediatric Dental plan. Upon your request, we will send you a non-electronic version of the directory at no cost to you. Please contact us at 877-480-4161, or call the Member Services number on the back of your ID card, or write to us at:

Aetna, Student Health
151 Farmington Avenue
Hartford, CT 06156

Aetna service areas

The approximate number of students and their dependents insureds in Aetna's service area for Dallas, Austin, Houston and additional areas is 13,164. The numbers of available providers in Aetna's service area for the following provider areas are indicated below:

Service Area	Provider Type: Psychiatry	Provider Type: Anesthesiology	Provider Type: Family Medicine	Provider Type: General Practice	Provider Type: Internal Medicine	Provider Type: General Surgery	Provider Type: Obstetrics & Gynecology	Provider Type: Pediatric PCPs
Abernathy			1	1	1			
Abilene	5	6	56	56	56		13	15
Addison	2	1	5	5	5	1		1
Alamo			3	3	3			1
Albany								
Aledo			3	3	3			2
Alfred								
Alice			5	5	5	3		5
Allen	8	31	33	33	33	5	9	11
Alpine			4	4	4	3	1	1
Alton			4	4	4			1
Alvarado			1	1	1			
Alvin			12	12	12		1	4
Alvord			1	1	1			
Amarillo	13	105	93	93	93	21	25	19
Anahuac		1	3	3	3			
Andrews		1	5	5	5	2		
Angleton			9	9	9	1	10	3

Anson			2	2	2	1		
Aransas Pass			5	5	5			
Argyle	1							
Arlington	22	14	108	108	108	19	32	43
Aspermont								
Atascocita								3
Athens	3	16	28	28	28	1	3	2
Atlanta			11	11	11			2
Aubrey			1	1	1			
Austin	121	88	431	431	431		168	156
Azle	1	5	9	9	9	1		1
Baird			1	1	1			
Balch Springs								
Ballinger			3	3	3			
Bandera			5	5	5			
Bartonville			2	2	2			
Bastrop	2		12	12	12	1		2
Bay City	1	2	9	9	9	2	5	5
Baytown	3		48	48	48	9	12	9
Beaumont	9	5	52	52	52	15	19	17
Bedford	10	34	28	28	28	4	10	7
Bedias								1
Bee Cave			4	4	4			
Bee Caves			1	1	1			
Beeville		1	8	8	8	2	2	2
Bellaire	12		25	25	25	2	8	7
Bellmead			2	2	2			1
Bells			1	1	1			
Bellville			1	1	1	1		1
Belton			21	21	21	1	1	2
Benbrook			4	4	4			
Bertram			1	1	1			
Big Sandy								
Big Spring			6	6	6	3	2	2
Big Wells								
Blanco						1		
Bluff Dale								
Boerne	1		24	24	24	6	7	7

Bonham			7	7	7	1		
Booker								
Borger		4	8	8	8	1	2	2
Bowie			3	3	3	1		
Boyd			2	2	2			
Brady		1	3	3	3			
Brazoria			1	1	1			
Breckenridge			4	4	4			
Bremond			1	1	1			
Brenham	1	3	14	14	14	2	3	4
Bridge City			4	4	4	3		
Bridgeport			4	4	4	1		
Brookshire								
Brookeland			1	1	1			
Brownfield			3	3	3			
Brownsville			46	46	46	10	22	28
Brownwood	2		16	16	16	3	4	3
Bryan	11	2	54	54	54	6	8	7
Buda			2	2	2			2
Buffalo			1	1	1			
Bullard			1	1	1			
Bulverde			2	2	2			1
Burkburnett			4	4	4			
Burleson	3	2	24	24	24	4	6	
Burnet			2	2	2	1		
Caldwell			5	5	5			
Cameron			4	4	4			
Canadian			4	4	4			
Canton			7	7	7			
Canutillo			1	1	1			
Canyon	1		1	1	1			
Canyon Lake			2	2	2			
Carrizo Springs			6	6	6	1	1	1

Carrollton	5	26	56	56	56	7	5	17
Carthage		1	7	7	7			1
Castle Hills			1	1	1			
Castroville			13	13	13			
Cedar Hill	2		13	13	13		1	3
Cedar Park	7	2	36	36	36	11	10	25
Celina			1	1	1			2
Center			2	2	2			
Center Point								
Centerville								
Chandler			4	4	4			
Channelview			5	5	5			
Chappell Hill								
Cherokee								
Childress		1	10	10	10			
China								
China Spring								
Cibola								
Cisco								
Clarendon			1	1	1			
Clarksville			3	3	3			
Claude								
Clean Lake Shores								
Cleburne	1	8	13	13	13	3	4	2
Cleveland	1		8	8	8	1		6
Clifton			8	8	8	1		
Clint								1
Clyde			1	1	1			
Coldspring			2	2	2			
Coleman			3	3	3			
College Station	10	53	71	71	71	5	19	21
Colleyville	2		27	27	27	2	3	2
Colorado City			2	2	2	1		

Columbus		3	8	8	8	2	2	1
Comanche			5	5	5	1	1	
Comfort			1	1	1	1		
Commerce			2	2	2			
Conroe		10	41	41	41	8	9	7
Converse	1		1	1	1			
Cooper								
Coppell	1		7	7	7		1	10
Copperas Cove			6	6	6			
Corinth	2		3	3	3			
Corp Christi						1		
Corpus Christi	13	4	107	107	107	17	43	46
Corsicana	3	5	9	9	9	2	2	4
Cotulla								
Crandall								2
Crane			2	2	2			
Crockett			5	5	5	1		
Crosby			2	2	2			
Crosbyton								
Cross Plains								
Crossroads			3	3	3		3	
Crowell			1	1	1			
Crowley			7	7	7			
Crystal Beach			1	1	1			
Crystal City			3	3	3			1
Cuero	1		10	10	10	2		
Cypress	1	23	47	47	47	2	8	26
Daingerfield			1	1	1			
Dalhart			4	4	4	1		
Dallas	116	590	491	491	491	148	240	133
Dayton			3	3	3			2
Dell City			1	1	1			2
De Kalb			1	1	1			
De Leon			3	3	3			
Decatur	1	5	11	11	11	4	4	3

Deer Park			6	6	6			1
Del Rio	1		8	8	8	4	3	4
Del Valle								
Denison	2	42	18	18	18	5	4	7
Denton	13	3	39	39	39	10	22	14
Denver City			3	3	3	1	1	
Deport			1	1	1		1	
DeSoto	5		15	15	15	2	1	7
Devine			2	2	2		1	
Dickinson			8	8	8		6	2
Dilley			1	1	1			
Dimmitt			3	3	3			
Donna			8	8	8			3
Double Oak			1	1	1			
Douglass								
Dripping Springs	1		3	3	3		6	2
Dublin			1	1	1			
Dumas		2	10	10	10		3	
Duncanville	1		6	6	6	4	1	2
Eagle Lake			1	1	1			
Eagle Pass			9	9	9	3	2	2
Early							1	
East Bernard			3	3	3			
Eastland			4	4	4			
Edcouch	1		1	1	1			
Eden			1	1	1			
Edgewood			1	1	1			1
Edinburg	5		30	30	30	6	21	22
Edna			4	4	4			1
Egypt			2	2	2			
El Campo	0	4	1	1	1			
El Paso	10	196	196	196	196	47	92	87
Eldorado			1	1	1			
Elgin			2	2	2			1
Elkhart			1	1	1			
Elsa			1	1	1			
Emory	2							
Ennis			11	11	11			4

Euless			10	10	10		12	2
Fabens			7	7	7			
Fairfield			1	1	1			
Falfurrias			2	2	2			1
Farmers Branch			4	4	4			
Farmersville			2	2	2			
Fate								
Ferris			3	3	3			
Flatonia								
Flint	1		1	1	1			
Floresville	1	1	8	8	8	1	1	1
Flower Mound	3	2	33	33	33	4	12	13
Floydada								
Forest Hill			1	1	1			
Forney			3	3	3	2		3
Fort Davis			1	1	1			
Fort Hancock								
Fort Sam Houston								
Fort Stockton			1	1	1	1	1	1
Fort Worth	44	376	284	284	284	75	100	81
Franklin			1	1	1			
Frankston								
Fredericksburg		29	24	24	24	4	1	3
Freeport								
Freer								
Fresno								
Friendswood	11		16	16	16	2	3	10
Friona			2	2	2			
Frisco	9	104	76	76	76	10	35	33
Ft Worth	1							
Fulshear			1	1	1			8
Gainesville	1	5	5	5	5	3	3	
Galveston	8	89	41	41	41	11	14	20
Ganado			1	1	1			

Garden Ridge								
Garland			51	51	51	3	5	15
Gatesville			19	19	19	2		2
George West			1	1	1			
Georgetown	8		44	44	44	1	3	7
Giddings	1		1	1	1	4		1
Gilmer			3	3	3			
Gladewater			3	3	3			
Glen Rose			6	6	6	1	1	
Goldthwaite			4	4	4			
Goliad			1	1	1			
Gonzales	1		7	7	7	2		1
Gordon								
Gorman			1	1	1			
Graham	2		7	7	7	1		
Granbury	1	15	17	17	17	2	2	5
Grand Prairie			29	29	29	1	3	6
Grand Saline			1	1	1			
Grandview			1	1	1			
Granger								
Grapevine	6	31	16	16	16	14	27	13
Greenville	3		18	18	18	2	3	6
Groesbeck			2	2	2			
Groves			2	2	2			
Groveton								
Gun Barrel City			5	5	5			1
Hale Center								
Hallettsville		5	11	11	11			
Hallsville			1	1	1			
Haltom City			2	2	2			
Hamilton			2	2	2			
Hamlin			1	1	1			

Harker Heights			6	6	6		2	6
Harlingen	2	11	41	41	41	4	10	21
Haskell			3	3	3			
Haslet			2	2	2			3
Hawkins								
Hearne			2	2	2			
Heath			1	1	1			1
Hebbronville			1	1	1			
Helotes	1		3	3	3			1
Hemphill			2	2	2			
Hempstead								
Henderson	1	2	8	8	8			2
Henrietta			3	3	3			
Hereford			3	3	3	1		
Hewitt			5	5	5			
Hickory Creek			1	1	1			
Hico			2	2	2			
Highland Village	3		10	10	10			4
Highlands			2	2	2			
Hillsboro			5	5	5	1	1	
Hitchcock								
Hondo			5	5	5	2		
Honey Grove			1	1	1			
Horizon City			2	2	2		1	5
Horseshoe Bay			4	4	4			
Houston	174	1228	1105	1105	1105	293	505	504
Hughes Springs								
Huffman								
Humble	5	22	42	42	42	5	8	14
Hunt			1	1	1			
Huntington			1	1	1			
Huntsville			20	20	20	4	4	7
Hurst	5	27	6	6	6	3	1	7

Hutto	1		5	5	5			5
Idalou			1	1	1			
Ingleside	1		2	2	2			1
Iowa Park			1	1	1			
Iraan			1	1	1			
Irving	11	40	75	75	75	4	14	31
Italy								
Jacksboro			4	4	4			
Jacksonville	1	10	18	18	18	3	3	4
Jasper			5	5	5	1		3
Jayton			2	2	2			
Jefferson			1	1	1			
Jersey Village			5	5	5		2	1
Joaquin								
Johnson City			1	1	1			
Joshua			3	3	3			
Jourdanton		3	3	3	3	3	2	
Junction			1	1	1			
Justin			1	1	1			
Karnes City								
Katy	4	59	63	63	63	13	24	39
Kaufman	1	2	9	9	9	1		2
Keene			1	1	1			
Keller	2		26	26	26	4	3	9
Kemp								
Kenedy			2	2	2			
Kennedale								
Kermit			1	1	1			
Kerrville	5	2	23	23	23	5	5	2
Kilgore			8	8	8			
Killeen	6	8	36	36	36	9	9	12
Kingsland	1		5	5	5			
Kingsville			7	7	7	1	2	3
Kingwood	3	3	27	27	27	4	20	6
Kirbyville								
Knox City								
Kountze			1	1	1			

Krugerville								
Krum			1	1	1			
Kyle			20	20	20	9	6	6
La Feria			1	1	1			
La Grange		1	6	6	6	5	1	1
La Joya			1	1	1			1
La Marque			1	1	1			
La Mesa								
La Porte			7	7	7			1
La Vernia			2	2	2		1	
Lacy Lakeview			1	1	1			1
Lago Vista			1	1	1			
Laguna Vista								
Lake Dallas								
Lake Jackson	3	1	16	16	16	4	4	5
Lake Worth			3	3	3		1	3
Lake hills			1	1	1			
Lakeway	1	16	7	7	7	1	4	2
Lamesa			1	1	1	1		
Lampasas		3	7	7	7	2		1
Lancaster			4	4	4	1		
Laredo		10	51	51	51	9	18	15
Lavon								
League City	10		36	36	36	15	19	10
Leander			8	8	8			
Leonard								
Levelland			5	5	5	1	2	3
Lewisville	1	2	21	21	21	3	6	7
Lexington								
Liberty			4	4	4			
Liberty Hill								
Lindale			11	11	11			1
Linden								
Little Elm			2	2	2			8
Littlefield			3	3	3			

Live Oak			5	5	5	1	1	2
Livingston			16	16	16	1	2	2
Llano		7	21	21	21	1	2	1
Lockhart			3	3	3	1		3
Lockney			4	4	4		1	
Lone Star								
Longview	2	66	57	57	57	10		17
Los Fresnos								1
Lubbock	16	92	101	101	101	42	35	51
Lucas								2
Lufkin	2	24	42	42	42	2	7	3
Luling		13	4	4	4	1	1	2
Lumberton	2		6	6	6			
Lytle			5	5	5			1
Mabank			1	1	1			
Madisonville			7	7	7			
Magnolia	0		9	9	9			1
Malakoff			1	1	1			
Manchaca								
Manor			5	5	5		1	2
Mansfield	5	3	31	31	31	7	26	12
Manvel			1	1	1			
Marathon			2	2	2			
Marble Falls	1	3	9	9	9	1	5	4
Marfa			2	2	2			
Marlin	1					1		1
Marshall	2	11	8	8	8	2	1	4
Mart	1		1	1	1			
Mathis			1	1	1			2
Mc Camey			1	1	1			
Mc Gregor			3	3	3	1		
Mc Kinney								
McAllen	5	14	79	79	79	30	25	31
McKinney	13	23	48	48	48	5	14	33
Meadowlakes								
Medina								
Melissa								
Memphis								

Menard								
Mercedes			7	7	7	1	1	3
Meridian			1	1	1			
Merkel			1	1	1			
Mesquite	2		44	44	44	8	14	20
Mexia		2	4	4	4		0	1
Midland	4		32	32	32	10	21	22
Midlothian			18	18	18		1	3
Millsap			1	1	1			
Mineola			4	4	4			
Mineral Wells		10	6	6	6	2	4	1
Mission	3	1	31	31	31	1	5	11
Missouri City	3		16	16	16			8
Monahans			2	2	2	1		
Mont Belvieu								
Montgomery	1		12	12	12			3
Moody								
Morton								
Moulton								
Mountain Home	1							
Mt. Enterprise								
Mt. Pleasant	5	11	7	7	7	2	4	9
Mt. Vernon			2	2	2			
Muenster	1		2	2	2	1		
Muleshoe			2	2	2			
Munday								
Murphy			7	7	7			5
N Richland Hls	1							
Nacogdoches		11	20	20	20	8	5	7
Naples			1	1	1			
Nassau Bay			1	1	1		1	1
Navasota			6	6	6			

Nederland	1		12	12	12		3	1
Needville			2	2	2			
New Boston			4	4	4			1
New Braunfels	4		33	33	33	6	6	10
New Caney								
Newton			1	1	1			1
Nixon			1	1	1			
Nocona			2	2	2			
Normange e			1	1	1		1	
North Richland Hills	1	29	13	13	13	1	3	
Odessa	1	44	48	48	48	5	21	18
Odonnell								
Olney			2	2	2			
Olton								
Orange			10	10	10	1		3
Orange Grove			1	1	1			
Ore City								
Overton			2	2	2			
Ovilla								
Ozona			1	1	1			
Paducah								
Palacios								
Palestine	1	1	17	17	17	2	3	3
Palmhurst								1
Palmview			1	1	1			
Pampa		1	5	5	5	2	1	1
Panhandle								
Pantego								
Paris	1	3	15	15	15	4	8	5
Pasadena	2	31	57	57	57	8	15	30
Pearland	5		42	42	42	7	18	22
Pearsall			5	5	5	1		
Pecos			3	3	3	1	2	
Penitas			1	1	1			
Perryton			4	4	4			

Pflugerville	4		22	22	22		1	8
Pharr			15	15	15			7
Pilot Point			3	3	3			
Pineland			1	1	1			
Pipe Creek								
Pittsburg		2	4	4	4		1	
Plains								
Plainview		1	10	10	10		3	2
Plano	23	96	147	147	147	27	61	61
Pleasanton			6	6	6			
Port Aransas	1		1	1	1			
Port Arthur	1	22	16	16	16	2	6	5
Port Isabel								1
Port Lavaca			7	7	7	1	1	
Port Neches			4	4	4	1		
Porter			3	3	3			1
Portland	1		7	7	7			6
Post			19	19	19			6
Poteet								
Poth			3	3	3			
Pottsboro			2	2	2			
Premont								
Presidio			3	3	3			
Princeton			1	1	1			
Prosper	1		8	8	8	1		2
Quanah			1	1	1			
Quinlan			4	4	4			
Quitman			7	7	7			1
Runger			1	1	1			
Rancho Viejo								
Raymondville			5	5	5			2
Red Oak			5	5	5			1
Refugio			3	3	3			
Rhome			1	1	1			
Richardson	13	2	77	77	77	12	13	19

Richland Hills							1	1
Richmond		19	13	13	13	4	8	12
Rio Grande								
Rio Grande City			8	8	8	3	1	2
Rio Hondo								
Rising Star								
River Oaks								
Roanoke	1		2	2	2			
Robinson								
Robstown			1	1	1			1
Roby			1	1	1			
Rockdale		7	19	19	19	2	6	2
Rockport	1		6	6	6	1		
Rockwall	16		24	24	24	7	9	10
Roma								1
Rosebud			2	2	2			
Rosenberg			5	5	5		1	2
Rosharon								
Rotan								
Round Rock	9	8	68	68	68	8	29	38
Rowlett		1	9	9	9	4	6	3
Royse City			3	3	3	2		1
Rusk			2	2	2			1
Sachse			3	3	3	1		
Saginaw			6	6	6			1
Salado			4	4	4			
San Angelo	7	15	70	70	70	6	12	20
San Antonio	113	192	571	571	571	162	207	222
San Augustine			3	3	3		1	
San Benito			6	6	6	1		1
San Diego								
San Elizario			1	1	1			
San Juan			6	6	6		3	2

San Marcos	5	10	30	30	30	2	7	6
San Saba								
Sanderson			3	3	3		1	
Sanger								
Santa Fe			1	1	1			
Santa Rosa			1	1	1			1
Santo								
Schertz			2	2	2	1	12	8
Schulenburg			1	1	1	4		1
Scroggins								
Seabrook	1		1	1	1			
Seagoville								
Sealy			3	3	3			
Seguin		10	17	17	17	4	6	6
Selma			2	2	2	1		
Seminole		4	5	5	5	1	2	
Seven Points			1	1	1			
Seymour								1
Shady Shores								
Shallowater								5
Shamrock			2	2	2			1
Shavano Park			2	2	2	1		
Shenandoah			22	22	22	6	10	4
Shepherd								
Sherman	5		20	20	20	7	6	5
Shiner								
Sierra Blanca								1
Silsbee			6	6	6			
Silverton								
Sinton			2	2	2			
Slaton								
Smithville			3	3	3		1	1
Snyder		2	9	9	9	1	2	
Socorro			1	1	1			3
Somerset	1		1	1	1			

Somerville								
Sonora			1	1	1			
South Lake	1							9
South Padre Island			1	1	1			
Southlake	7	126	47	47	47	6		10
Spearman			2	2	2			1
Splendora								
Spring	2		57	57	57		6	13
Spring Branch						1		
Springtown			1	1	1			
Spur								
Stafford	1					9	4	1
Stamford								
Stanton		6	2	2	2			
Stephenville		3	13	13	13	2	4	3
Stockdale								
Stratford								
Sudan								
Sugar Land	7	73				32	49	74
Sulphur Springs		2	15	15	15	3	4	3
Sumner								
Sundown								
Sunnyvale		9	6	6	6	1	3	12
Sunray			1	1	1			
Sweeny		1	3	3	3	2		
Sweetwater		3	6	6	6	3	1	1
Taft			1	1	1			
Tahoka			3	3	3			1
Tatum								
Taylor	13	2	9	9	9			
Teague			1	1	1			
Telephone								
Temple	9	69	88	88	88	28	15	39
Tenaha							2	
Terrell	2		7	7	7	1		1

Texarkana	3	23	30	30	30	11	18	8
Texas City			30	30	30	2	2	7
Texline								
The Colony			6	6	6			2
The Hills								
The Woodlands	8	65	48	48	48	15	30	36
Three Rivers			6	6	6		1	2
Throckmorton								
Tilden								
Timpson								
Tomball		17	26	26	26	1	7	3
Trinidad								
Trinity			1	1	1			1
Trophy Club		13	3	3	3			1
Troup						1		
Tulia			4	4	4			
Tyler	13	133	97	97	97	28	33	30
Universal City	1		3	3	3			
University Park								
Uvalde	1	3	13	13	13	2	1	1
Van	1							
Van Alstyne								
Van Horn								
Vanderpool								
Vernon		3	2	2	2	2		
Victoria	2	23	48	48	48	10	7	15
Vidor			2	2	2			
Vinton								
Waco	23	191	119	119	119	22	29	24
Waller			1	1	1			
Wallis								
Waskom								
Watauga			1	1	1			

Waxahachie	3	1	20	20	20	8	12	4
Weatherford			18	18	18	1	4	3
Webster	1		45	45	45	12	29	19
Weimar			3	3	3			
Wellington			1	1	1			
Weslaco		4	20	20	20	2	5	7
West			1	1	1			
West Columbia			2	2	2			
West Lake Hills			4	4	4		1	1
Wharton			15	15	15	1	1	3
Wheeler			1	1	1			
Whitehouse			2	2	2	1		
Whitesboro			4	4	4			
Whitewright								
Whitney	1		2	2	2			
Wichita Falls	5	38	44	44	44	5	12	11
Willis			3	3	3			1
Willow Park	1		3	3	3			4
Wills Point			1	1	1			
Wimberley			5	5	5			1
Windcrest								
Winnie			1	1	1			
Winnsboro			2	2	2	1		1
Winona								
Winters			1	1	1			
Wolfforth			1	1	1			1
Woodsboro			1	1	1			
Woodville	1		3	3	3			1
Woodway			1	1	1			1
Wortham			1	1	1			
Suite 201								
Wylie			9	9	9	1		4

Yoakum		1	5	5	5			
Yorktown			1	1	1			
Zapata			6	6	6			
Zavalla			1	1	1			

Learn about our network demographics and local market access plans

We annually report health plan data and information to the Texas Department of Insurance (TDI) to assist the TDI in evaluating the adequacy of our networks. If a waiver or a local market access plan applies to facility services or to internal medicine, family or general practice, pediatric practitioner practice, obstetrics and gynecology, anesthesiology, psychiatry, or general surgery services, you may view the plan information on our website at **http://www.aetna.com/dse/cms/codeAssets/html/Texas_Network_Adequacy.html**

If you do not have Internet access or prefer a printed copy of the results, contact us at 877-480-4161, or call the Member Services number on the back of your ID card.

Texas Department of Insurance Notice

You have the right to an adequate network of preferred providers (also known as "network providers"). If you believe the network is inadequate, you may file a complaint with the Texas Department of Insurance. If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network deductible and out-of-pocket maximum. You have the right, in most cases, to obtain estimates in advance:

- From out-of-network providers of what they will charge for their services; and
- From your insurer of what it will pay for the services.

You may obtain a current directory of preferred providers at the following website: **www.aetna.com/docfind** or by calling the number on your Aetna ID card (if you're not yet enrolled, call **1-888-982-3862**) for assistance in finding available preferred providers. If the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits. If you are treated by a provider or hospital that is not a preferred provider, you may be billed for anything not paid by the insurer.

If the amount you owe to an out-of-network hospital-based radiologist, anesthesiologist, pathologist, emergency department physician, assistant surgeon or neonatologist is greater than $500 (not including your copayment, coinsurance and deductible responsibilities) for services received in a network hospital, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you.

You can learn more about mediation at the Texas Department of Insurance website: **www.tdi.texas.gov/consumer/cpmmediation.html**.

The Southern Methodist University 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 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. 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.

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፣ በሜዲኬያዎት ላይ ያለውን ቁጥር ይደውሉ፡ ፡
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Armenian	Ձեր նախընտրած լեզվով ավվճար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հէրախոսահամարով
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	ᏩᎩᏍᏗ ᏕᏅᏂᎯᏍᏗ ᎢᏳᎾᏓᏛᏁᏗ Ꮭ ᎪᎱᏍᏗ ᏗᏣᏋᏩᏁᏗ ᎰᎩ, ᎫᏰᎯᏓᎳᏛᏏ ᎾᏍᎩ ᏗᏎᏍᏗ ᏥᏚᎪᏪᎵ ᎤᎾᎢ ID ᏆᏂᏲᏍᏗ ᏣᏤᎵᎢ.
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	လၢတၢ်ကမၤန့ၢ်ကျိာ်တၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖၣ် လၢတအိၣ်ဒီးအပှၤလၢနကဘၣ်ဟ့ၣ်အီၤအဂီၢ်,ကိးဘၣ်လီတဲစိနိၣ်ဂ်ၢ်လၢအအိၣ်လၢနခိၣ်ဂီၤ (ID) အလိၤန့ၣ်တက့ၢ်.
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 nílı́jgo nanitinígíí bee néého’dólzinígíí béésh bee hane’í biká’ígíí áajı́’ 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 tɔ̈ 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 yobugo, 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	[illegible]
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 безкоштовнj 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.