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Aetna Student Health

Plan Design and Benefits Summary

St. Mary's University

Policy Year: 2021 – 2022
Policy Number: 686167
stmarytx.myahpcare.com
(855) 357-0238

Disclaimer: These rates and benefits are pending approval by the Texas Department of Insurance and can change. If they change, we will update this information.

This is a brief description of the Student Health Plan. The Plan is available for St Mary's University students. 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 https://stmarytx.myahpcare.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

STUDENT HEALTH SERVICES (SHC)

The medical staff of the Student Health Center provides high quality primary health care services that are cost-effective and accessible to enrolled students of St. Mary's University. The provision of timely health care services on campus serves to minimize the academic interruptions that students may experience from an illness or injury. The Student Health Center staff offer services that are nondiscriminatory and nonjudgmental. Significant importance is placed in respecting the rights to privacy and confidentiality of each patient. It is through personalized evaluation; treatment and health education that students learn to make positive, long-lasting lifestyle choices. The SHC is staffed by a doctor and a physician's assistant. There is a copayment per visit and deductible is waived. Services not covered by the health plan will be charged to the student business account. If you carry the St. Mary's University Health Insurance and are treated for a covered benefit, a claim will be generated. Copayments are not reimbursable.
For more information, call the Health Services at (210) 436-3506 located on the 1st floor of Charles Francis Hall. In the event of an emergency, call 911 or the Campus Police.

Coverage Periods

Students: 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.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment Deadline	Waiver Deadline
Fall	08/02/2021	12/31/2021	09/08/2021	09/08/2021
Spring	01/01/2022	08/01/2022	02/04/2022	02/04/2022
Summer 1	05/31/2022	08/01/2022	06/03/2022	06/03/2022
Summer 2	07/05/2022	08/01/2022	07/01/2022	

Rates

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

Rates
Undergraduates and Graduate Students

	Fall Semester	Spring Semester	Summer 1	Summer 2
Student	$1,210.00	$1210.00	$418.00	$185.00

Student Coverage

Who is eligible?

All registered students residing on campus and all intercollegiate athletes will be automatically charged for the Student Health Insurance Plan at registration and premium will be added to your tuition bill unless proof of comparable coverage is provided.

All other registered undergraduate, graduate and doctoral students taking six (6) or more credit hours are eligible to participate in the Plan and may enroll online at stmarytx.myahpcare.com/enrollment or request to add premium to their tuition bill by the end of the period specified on stmarytx.myahpcare.com/enrollment. Graduate students completing thesis or dissertation and enrolled in their last semester are eligible to participate in the Plan. All registered "F", "J", and "H" International students, including "J" and "F" visa Intensive English Program (IEP) students, will be automatically charged for the Student Health Insurance Plan.

International students may submit an online waiver to remove the health insurance premium from their business accounts by the deadline.

There are strict requirements that must be met before a waiver is granted, including demonstration of medical evacuation and repatriation benefits. AHP reserves the right to deny waiver requests.

Deadline for online waiver requests can be found at stmarytx.myahpcare.com/waiver. Please visit Gateway for more information. You must actively attend classes for at least the first 31 days after the date your coverage becomes effective. You cannot meet this eligibility requirement if you take courses through:

- Home study
- Correspondence
- The internet.
- Television (TV)

If we find out that you do not meet this eligibility requirement, we are only required to refund any premium contribution minus any claims that we have paid.

Enrollment

To enroll, log on to https://stmarytx.myahpcare.com/.

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

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 [School Name], and may be viewed online at www.aetnastudenthealth.com.

In-network Provider Network

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

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

Preauthorization

You need pre-approval from us for some eligible health services. Pre-approval is also called preauthorization. Your in-network physician is responsible for obtaining any necessary preauthorization before you get the 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 when required, there is a [$0-$500 penalty] for each type of eligible

health service that was not preauthorized. For a current listing of the health services or prescription drugs that require preauthorization, contact Member Services or go to www.aetnastudenthealth.com.]

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.

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.

Description of Benefits

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

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	$500 per policy year	$500 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. 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.		
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 Office Visit, Consultant Services Office Visit, Walk-in Clinic Office Visit, Hospital Emergency Room, Urgent Care, Outpatient Mental Health and Substance Abuse Treatment Office Visit, and Pediatric Vision Care services • In-network care and out-of-network care for Well newborn nursery care, Pediatric Dental Type A services, and outpatient prescription drugs		
Maximum out-of-pocket limits		
Student	$8,550 per policy year	$17,100 per policy year

Eligible health services	In-network coverage	Out-of-network coverage
Routine physical exams		
Performed at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Covered persons age 22 and over: Maximum visits per policy year	1 visit	
Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures//Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging in to your Aetna website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.		
Preventive care immunizations		
Performed in a facility or at a physician's office 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 member website at www.aetnastudenthealth.com or calling the number on the back of your ID card. **The following is not covered under this benefit:** Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment or travel		
Routine gynecological exams (including Pap smears and cytology tests)		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	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		
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, Depression Screening, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Obesity and/or healthy diet counseling Maximum visits	Age 0-22: unlimited visits. Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	
Misuse of alcohol and/or drugs counseling Maximum visits per policy year	5 visits	
Use of tobacco products counseling Maximum visits per policy year	8 visits	
Depression screening counseling Maximum visits per policy year	1 visit	
Sexually transmitted infection counseling Maximum visits per policy year	2 visits	
Genetic risk counseling for breast and ovarian cancer limitations	Not subject to any age or frequency limitations	
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

- Coverage for diagnostic mammograms will be considered the same as mammograms performed for routine cancer screenings
- 1 low-dose mammogram every 12 months, including digital mammography and breast tomosynthesis, for covered persons age 35 or older
- For females of any age as described below for additional routine cancer screenings
- Diagnostic mammograms are not subject to any age or frequency limitation.
- 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

Eligible health services	In-network coverage	Out-of-network coverage
Additional Maximums Subject to any age, family history, and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration		
Lung cancer screening maximums	1 screening every 12 months*	
Prenatal care services (Preventive care services only)	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Lactation support and counseling services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits	
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
Family planning services – female contraceptives		
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Contraceptive counseling services maximum visits per policy year either in a group or individual setting	2 visits	
Female contraceptive prescription drugs and devices provided, administered, or removed, by a provider during an office visit	100% (of the negotiated charge) per item No copayment or policy year deductible applies	60% (of the recognized charge) per item

Eligible health services	In-network coverage	Out-of-network coverage
Female Voluntary sterilization-Inpatient & Outpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	60% (of the recognized charge)
The following are not covered under this benefit: • Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care • Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA • Male contraceptive methods, sterilization procedures or devices		
Physicians and other health professionals		
Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist) includes telemedicine 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 & Allergy injections treatment performed at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Allergy sera and extracts administered via injection		
Physician and specialist surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge)	60% (of the recognized charge)
The following are not covered under this benefit: • 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 and exclusions – Hospital and other facility care* section) • Services of another physician for the administration of a local anesthetic		
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
The following are not covered under this benefit: • 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 and exclusions – 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		

Eligible health services	In-network coverage	Out-of-network coverage
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) Includes birthing center facility charges	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Alternatives to hospital stays		
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
The following are not covered under this benefit: • The services of any other physician who helps the operating physician • A stay in a hospital (See the *Hospital care – facility charges* benefit in this section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic		
Home health Care	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Maximum visits per policy year	60	
The following are not covered under this benefit: • 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-Inpatient	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Hospice-Outpatient	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Respite care-maximum number of days per 30 day period	30	

<table>
<tr><th>Eligible health services</th><th>In-network coverage</th><th>Out-of-network coverage</th></tr>
<tr><td colspan="3">The following are not covered under this benefit:
Funeral arrangements
Pastoral counseling
Financial or legal counseling which includes estate planning and the drafting of a will
Homemaker or caretaker services that are services which are not solely related to your care and may include:
Sitter or companion services for either you or other family members
Transportation
Maintenance of the house</td></tr>
<tr><td>Skilled nursing facility-
Inpatient</td><td>80% (of the negotiated charge) per admission</td><td>60% (of the recognized charge) per admission</td></tr>
<tr><td>Maximum days per policy year</td><td colspan="2">25</td></tr>
<tr><td>Hospital emergency room</td><td>$200 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit

No policy year deductible applies</td><td>Paid the same as in-network coverage</td></tr>
<tr><td>Non-emergency care in a hospital emergency room</td><td>Not covered</td><td>Not covered</td></tr>
<tr><td colspan="3">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.
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.</td></tr>
<tr><td colspan="3">The following are not covered under this benefit:
Non-emergency services in a hospital emergency room facility, freestanding emergency medical care facility or comparable emergency facility</td></tr>
</table>

Eligible health services	In-network coverage	Out-of-network coverage
Urgent care	$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
Non-urgent use of an urgent care provider	Not covered	Not covered
The following is not covered under this benefit: • Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)		
Eligible health services	**Contracting dental provider coverage***	**Non-contracting dental provider 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	50% (of the negotiated charge) per visit	50% (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.
Pediatric dental care exclusions **The following are not covered under this benefit:** • 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 and exclusions* 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 and exclusions – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another eligible health service
- Mail order and at-home kits for orthodontic treatment
- Orthodontic treatment except as covered in the *Pediatric dental care* section of the schedule of benefits
- 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 *Pediatric dental care* section of the schedule of benefits
- 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 that is legally qualified to furnish dental services or supplies

Eligible health services	In-network coverage	Out-of-network coverage
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	80% (of the negotiated charge)	80% (of the recognized charge)
Accidental injury to sound natural teeth	80% (of the negotiated charge)	80% (of the recognized charge)

The following are not covered under this benefit:

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

Eligible health services	In-network coverage	Out-of-network coverage
Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Dental implants		
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
The following are not covered under this benefit: • Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries		
Family planning services – other		
Voluntary sterilization for males-surgical services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Abortion except when the pregnancy places the woman's life in serious danger or poses a serious risk of substantial impairment of a major bodily function • Reversal of voluntary sterilization procedures, including related follow-up care • Services provided as a result of complications resulting from a male voluntary sterilization procedure and related follow-up care		
Gender affirming treatment		
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
All other cosmetic services and supplies not listed under eligible health services above are not covered under this benefit. This includes, but is not limited to the following: • Rhinoplasty • Face-lifting • Lip enhancement • Facial bone reduction • Blepharoplasty • Breast augmentation • Liposuction of the waist (body contouring) • Reduction thyroid chondroplasty (tracheal shave) • Nipple reconstruction • 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 • Voice and communication therapy • Chest binders • Chin implants, nose implants, and lip reduction, which are used to assist masculinization, are considered cosmetic		

Eligible health services	In-network coverage	Out-of-network coverage
Autism spectrum disorder		
Autism spectrum disorder treatment, diagnosis and testing and Applied behavior analysis	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Mental Health & Substance Abuse Treatment		
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Outpatient office visits (includes telemedicine consultations)	$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 treatment (includes Partial hospitalization and Intensive Outpatient Program)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

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.		

The following are not covered under this benefit:

- 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

Treatment of infertility		
Basic infertility services Inpatient and outpatient care - basic infertility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

The following are not covered services under the infertility treatment benefit:

- Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists.
- All charges associated with:
  - Surrogacy for you or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father
  - Cryopreservation (freezing) of eggs, embryos or sperm
  - Storage of eggs, embryos, or sperm
  - Thawing of cryopreserved (frozen) eggs, embryos or sperm

- The care of the donor in a donor egg cycle which includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers
- The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which the person is not genetically related
- Obtaining sperm from a person not covered under this plan for ART services

- Home ovulation prediction kits or home pregnancy tests
- The purchase of donor embryos, donor oocytes, or donor sperm
- Reversal of voluntary sterilizations, including follow-up care

- Ovulation induction with menotropins, Intrauterine insemination and any related services, products or procedures
- In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), Cryopreserved embryo transfers and any related services, products or procedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery)

Eligible health services	In-network coverage	Out-of-network coverage
Specific therapies and tests		
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
Maximum visits per policy year	1 screening every 5 years Limited to: Men age 45 and over but less than 76 and women age 55 and over but less than 76	
Outpatient Chemotherapy, Radiation & Respiratory Therapy	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
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.
The following are not covered under this benefit: • 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		
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

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy) Combined for short-term rehabilitation services and habilitation therapy services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Chiropractic services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Maximum visits per policy year	35	
Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting	Covered according to the type of benefit or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.
Other services and supplies		
Emergency ground, air, and water ambulance (includes non-emergency ambulance)	80% (of the negotiated charge) per trip	Paid the same as in-network coverage
The following are not covered under this benefit: • Non-emergency fixed wing air ambulance from an out-of-network provider • Ambulance services for routine transportation to receive outpatient or inpatient care		
Durable medical and surgical equipment	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
The following are not covered under this benefit: • 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		
Enteral formulas and nutritional supplements	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
The following are not covered under this benefit: • Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as described above		
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 & Orthotics Includes Cranial prosthetics *(Medical wigs)*	80% (of the negotiated charge) per item	60% (of the recognized charge) per item

Eligible health services	In-network coverage	Out-of-network coverage
The following are not covered under Prosthetics benefit: • Services covered under any other benefit • Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace • Trusses, corsets, and other support items • Repair and replacement due to loss, misuse, abuse or theft • Communication aids • Cochlear implants **The following are not covered services under Orthotics benefit:** • Services covered under any other benefit • Repair and replacement due to loss, misuse, abuse or theft		
Hearing aids and cochlear implants and related services		
Hearing aid exams	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Hearing aids and cochlear implants and related services	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Hearing aids maximum per ear	One per ear every three years	
Replacement of cochlear implant external speech processor and controller components maximum	One per ear every three years	
The following are not covered under this benefit: • A replacement of: - A hearing aid that is lost, stolen or broken - A hearing aid installed within the prior 24 month period • Replacement parts or repairs for a hearing aid • Batteries or cords • A hearing aid that does not meet the specifications prescribed for correction of hearing loss • Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist or other provider not acting within the scope of their license		
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 or therapeutic optometrist, or any other providers acting within the scope of their license Includes comprehensive low vision evaluations Includes visit for fitting of contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year Low vision Maximum Fitting of contact Maximum	1 visit One comprehensive low vision evaluation every policy year 1 visit	
Pediatric vision care services & supplies-Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per item No policy year deductible applies	60% (of the recognized charge) per item

Eligible health services	In-network coverage	Out-of-network coverage
Maximum number Per year: Eyeglass frames Prescription lenses Contact lenses (includes non-conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery)	One set of eyeglass frames One pair of prescription lenses Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set	
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.		
The following are not covered under this benefit: • 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		

Outpatient prescription drugs		
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Outpatient prescription drug copayment waiver for risk reducing breast cancer		
The outpatient prescription drug 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 outpatient prescription drug copayment will not apply to the first two 90-day treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at a in-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%. Any prescription drug copayment will apply after those two regimens per policy year have been exhausted.		
Outpatient prescription drug copayment waiver for contraceptives		
The outpatient 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 outpatient prescription drug copayment continues 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.		

Preferred generic prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	$15 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$15 copayment per supply then the plan pays 60% (of the recognized charge) No policy year deductible applies
More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy	$45 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$45 copayment per supply then the plan pays 60% (of the recognized charge) No policy year deductible applies
Preferred brand-name prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30-day supply filled at a retail pharmacy	$30 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$30 copayment per supply then the plan pays 60% (of the recognized charge) No policy year deductible applies
More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy	$90 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$90 copayment per supply then the plan pays 60% (of the recognized charge) No policy year deductible applies
Non-preferred generic prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30-day supply filled at a retail pharmacy	$60 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$60 copayment per supply then the plan pays 60% (of the recognized charge) No policy year deductible applies
More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy	$180 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$180 copayment per supply then the plan pays 60% (of the recognized charge) No policy year deductible applies
Non-preferred brand-name prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30-day supply filled at a retail pharmacy	$60 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$60 copayment per supply then the plan pays 60% (of the recognized charge) No policy year deductible applies
More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy	$180 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$180 copayment per supply then the plan pays 60% (of the recognized charge) No policy year deductible applies
Specialty prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30-day supply filled at a retail pharmacy	80% (of the negotiated charge)	80% (of the recognized charge)

	No policy year deductible applies	No policy year deductible applies
Orally administered anti-cancer prescription drugs For each fill up to a 30 day supply filled at a retail pharmacy	100% (of the negotiated charge 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 filled at a retail or mail order pharmacy For each 30 day supply	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
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 website at www.aetnastudenthealth.com or calling the toll-free number on the back of your ID card.	
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 website at www.aetnastudenthealth.com or calling the toll-free number on the back of your ID card.	
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 website at www.aetnastudenthealth.com or calling the toll-free number on the back of your ID card.	

Outpatient prescription drugs exclusions
The following are not covered under the outpatient prescription drugs benefit:

- Abortion drugs
- Allergy sera and extracts administered via injection

- Any services related to the dispensing, injecting or application of a drug
- Biological sera
- Compounded prescriptions containing bulk chemicals not approved by the U.S. Food and Drug Administration (FDA) including compounded bioidentical hormones
- Cosmetic drugs including medications and 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 provided
  - 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 above
  - That include the same active ingredient or a modified version of an active ingredient as a covered prescription drug (unless a medical exception is approved)
  - That are therapeutically equivalent or therapeutically alternative to a covered prescription drug (unless a medical exception is approved)
  - That are 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 or 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 our Pharmacy and Therapeutics Committee
  - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - For which the cost is covered by a federal, state, or government agency (for example: Medicaid or Veterans Administration)
  - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
  - That are used for the purpose of weight gain or reduction, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications
  - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the covered person 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 except as specifically stated in the schedule of benefits or the certificate
- Implantable drugs and associated devices except as specifically provided above
- 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 except as described in the *Diabetic services and supplies (including equipment and training)* section.
  - Needles and syringes, except for those used for self-administration of an injectable drug.

- Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting. This exception does not apply to Depo Provera and other injectable drugs used for contraception.

- Prescription drugs:
  - For which there is an over-the-counter (OTC) product which has the same active ingredient and strength even I a prescription is written.
  - Packaged in a 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 and 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 to 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 person identified on the ID card.
- 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 products unless recommended by the United States Preventive Services Task Force (USPSTF)
- We reserve the right to exclude:
  - A manufacturer's product when the 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

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

General Exclusions

Abortion

- Abortion except when the pregnancy places the woman's life in serious danger or at serious risk of substantial impairment of a major bodily function

Acupuncture therapy

- Maintenance treatment
- Acupuncture when provided for the following conditions:
  - Acute low back pain
  - Addiction
  - AIDS
  - Amblyopia
  - Allergic rhinitis
  - Asthma
  - Autism spectrum disorders
  - Bell's Palsy
  - Burning mouth syndrome
  - Cancer-related dyspnea
  - Carpal tunnel syndrome
  - Chemotherapy-induced leukopenia
  - Chemotherapy-induced 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

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.

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.

Behavioral health treatment

- Services for the following based on categories, conditions, diagnoses or equivalent terms as listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association:
  - Stay in a facility for treatment for dementias and amnesia without a behavioral disturbance that necessitates mental health treatment
  - School and/or education service including special education, remedial education, wilderness treatment programs, or any such related or similar programs
  - Services provided in conjunction with school, vocation, work or recreational activities
  - Transportation
  - Sexual deviations and disorders except for gender identity disorders
  - Tobacco use disorders except as described in the *Eligible health services and exclusions – 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

Beyond legal authority

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

Blood and body fluid exposure

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

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

Examples of these are:

- The provision of blood to the hospital, other than blood derived clotting factors
- Any related services including processing, storage or replacement expenses
- The services of blood donors, apheresis or plasmapheresis
- For 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)

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.

This exclusion does not apply to:

- Surgery after an accidental injury when performed as soon as medically feasible. (Injuries that occur during medical treatments are not considered accidental injuries even if unplanned or unexpected.)
- Coverage that may be provided under the *Eligible health services and exclusions - Gender reassignment (sex change) treatment* section.

Court-ordered services and supplies

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

Custodial care

Examples are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- Respite care except in connection with hospice care, adult (or child) day care, or convalescent care Institutional care. This includes room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training

Dermatological treatment

- Cosmetic treatment and procedures

Dental care for adults

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

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

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

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 and exclusions – Other services* section.

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

Felony

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

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

Incidental surgeries

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

Jaw joint disorder

- 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 diagnostic or therapeutics services related to jaw joint disorders including associated myofascial pain

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

Judgment or settlement

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

Mandatory no-fault laws

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

Maintenance care

- Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services. See the *Eligible health services and exclusions – Habilitation therapy service*s and *Services for children with developmental delays* sections

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device. 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

Non-medically necessary services and supplies

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

Non-U.S .citizen

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

Obesity (bariatric) surgery and services

- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity except as described in the Eligible health services and exclusions – Preventive care and wellness section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery
  - Surgical procedures, medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including morbid obesity
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis or other forms of therapy
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Other primary payer

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

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

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, flat feet, hammertoes, fallen arches
  - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
  - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies except for complications of diabetes. See the *Diabetic services and supplies (including equipment and training)* section.
  - Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injur**y** of the feet

Private duty nursing (outpatient only)

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 and exclusions* 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 for when that family member is a **dentist** who is licensed in the State of Texas to provide the dental 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 60-100 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

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 or Telehealth

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

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 and exclusions – Preventive care and wellness* section
  - Hypnosis and other therapies

- Medications, except as specifically provided in the *Eligible health services and exclusions – Outpatient prescription drugs* section
- Nicotine patches
- Gum

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

Vision care for adults

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

Wilderness treatment programs

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.

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

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 St Mary's 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 is committed to being an inclusive health care company. Aetna does not discriminate on the basis of ancestry, race, ethnicity, color, religion, sex/gender (including pregnancy), national origin, sexual orientation, gender identity or expression, physical or mental disability, medical condition, age, veteran status, military status, marital status, genetic information, citizenship status, unemployment status, political affiliation, or on any other basis or characteristic prohibited by applicable federal, state or local law.

Aetna provides free aids and services to people with disabilities and free language services to people whose primary language is not English.

These aids and services include:

- Qualified language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Qualified interpreters
- Information written in other languages

If you need these services, contact the number on your ID card. Not an Aetna member? Call us at 1-877-480-4161.

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

Please note, Aetna covers health services in compliance with applicable federal and state laws. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations, and conditions of coverage.

Language accessibility statement

Interpreter services are available for free.

Attention: If you speak English, language assistance service, free of charge, are available to you. Call **1-877-480-4161** (TTY: **711**).

Español/Spanish

Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-480-4161** (TTY: **711**).

አማርኛ/Amharic

ልብ ይበሉ: አማርኛ ቋንቋ የሚናገሩ ከሆነ፥ የትርጉም ድጋፍ ሰጪ ድርጅቶች፣ ያለምንም ክፍያ እርስዎን ለማገልገል ተዘጋጅተዋል። የሚከተለው ቁጥር ላይ ይደውሉ **1-877-480-4161** (መስማት ለተሳናቸው: **711**).

العربية/Arabic

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-480-4161** (رقم الهاتف النصي: **711**).

Ɓàsɔ̀ɔ̀ Wùɖù/Bassa

Dè dɛ nìà kɛ dyɛ́ɖɛ́ gbo: Ɔ jǔ ké m̀ dyi Ɓàsɔ̀ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ m̀ gbo kpáa.
Ɖá **1-877-480-4161** (TTY: **711**).

中文/Chinese

注意：如果您说中文，我们可为您提供免费的语言协助服务。请致电 **1-877-480-4161** (TTY: **711**)。

فارسی/Farsi

توجه: اگر به زبان فارسی صحبت می کنید، خدمات زبانی رایگان به شما ارایه میگردد، با شماره **1-877-480-4161** (TTY: **711**) تماس بگیرید.

Français/French

Attention : Si vous parlez français, vous pouvez disposer d'une assistance gratuite dans votre langue en composant le **1-877-480-4161** (TTY: **711**).

ગુજરાતી/Gujarati

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો ભાષાકીય સહાયતા સેવા તમને નિ:શુલ્ક ઉપલબ્ધ છે.
કૉલ કરો **1-877-480-4161** (TTY: **711**).

Kreyòl Ayisyen/Haitian Creole

Atansyon: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-877-480-4161** (TTY: **711**).

Igbo

Nrụbama: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-877-480-4161** (TTY: **711**).

한국어/Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스가 무료로 제공됩니다. **1-877-480-4161**(TTY: **711**)번으로 전화해 주십시오.

Português/Portuguese

Atenção: a ajuda está disponível em português por meio do número **1-877-480-4161** (TTY: **711**). Estes serviços são oferecidos gratuitamente.

Русский/Russian

Внимание: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Звоните по телефону **1-877-480-4161** (TTY: **711**).

Tagalog

Paunawa: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-480-4161** (TTY: **711**).

Urdu/اردو

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت دستیاب ہیں ۔ (**711** :TTY) **1-877-480-4161** پر کال کریں.

Tiếng Việt/Vietnamese

Lưu ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị.
Gọi số **1-877-480-4161** (TTY: **711**).

Yorùbá/Yoruba

Àkíyèsí: Bí o bá nsọ èdè Yorùbá, ìrànlọ́wọ́ lórí èdè, lófẹ̀ẹ́, wà fún ọ. Pe **1-877-480-4161** (TTY: **711**).