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Aetna Student Health[SM]
Plan Design and Benefits Summary
Preferred Provider Organization (PPO)

The Juilliard School

Policy Year: 2020 – 2021
Policy Number: 686195
www.aetnastudenthealth.com
(800) 868-8577

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

JUILLIARD HEALTH AND COUNSELING SERVICES

Juilliard Health and Counseling Services is the School's on-campus health facility. For more information, call Health Services at (212) 799-5000 ext. 282. In the event of an emergency, call 911 or Juilliard Public Safety at (212) 496-4911 or (212) 799-5000 ext. 246.

Who is eligible?

All full-time and qualifying part-time undergraduate and graduate students, who are enrolled at The Juilliard School.

Remote learning due to COVID-19 and full-time Online students are eligible.

Coverage Dates and Rates

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

	Annual	Fall	Spring/Summer
Coverage Start Date	**08/15/2020**	**08/15/2020**	**01/01/2021**
Coverage End Date	**08/14/2021**	**12/31/2020**	**08/14/2021**
Student insurance premium	$2,375.00	$1,187.50	$1,187.50

Student insurance premium does not include on call travel assistance fee of $8 annual, $4 fall, and $4 spring.

Student Insurance premium does not include annual fee of $164 annual, $82 fall, and $82 spring.

Enrollment

If you need information, call Member Services at (800) 868-8577.

Participating Providers

Aetna Student Health offers Aetna's broad network of Participating Providers. You can save money by seeing Participating Providers because Aetna has negotiated special rates with them, and because the Plan's benefits are better when You receive benefits from a Participating Provider, and some benefits under the Plan may only be covered when received from a Participating Provider.

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

Preauthorization

Some services have to be preauthorized by Aetna beforehand if you want the Plan to cover them. Participating Providers are responsible for requesting preauthorization for their services. You are responsible for requesting preauthorization if you seek care from a Non- Participating Provider for any of the services listed in the Schedule of Benefits section of the Certificate. Preauthorization is not required for Participating facilities certified by the New York office of alcoholism and substance abuse services.

If you want the Plan to cover a service from a Non- Participating Provider that requires preauthorization, you must call Aetna at the number on your ID card. After Aetna receives a request for preauthorization, we will review the reasons for your planned treatment and determine if benefits are available.

You must contact Aetna to request preauthorization as follows:

- At least two (2) weeks prior to a planned admission or surgery when your provider recommends inpatient hospitalization. If that is not possible, then as soon as reasonably possible during regular business hours prior to the admission.
- At least two (2) weeks prior to ambulatory surgery or any ambulatory care procedure when your provider recommends the surgery or procedure be performed in an ambulatory surgical unit of a hospital or in an ambulatory surgical center.
- Within the first three (3) months of a pregnancy, or as soon as reasonably possible and again within 48 hours after the actual delivery date if your hospital stay is expected to extend beyond 48 hours for a vaginal birth or 96 hours for cesarean birth.
- Before air ambulance services are rendered for a non-emergency condition.

You must also contact Aetna to provide notification after the fact as follows:

- As soon as reasonably possible when air ambulance services are rendered for an emergency condition.
- If you are hospitalized in cases of an emergency condition, you must call Aetna within 48 hours after your admission or as soon thereafter as reasonably possible.

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.**

All coverage is based on the **Allowed Amount.**

"Allowed Amount" means the maximum amount Aetna will pay for the services or supplies covered under the certificate, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted.

- The Allowed Amount for Participating Providers is the amount we have negotiated with the Participating Provider.
- The Allowed Amount for Non-Participating Facilities is 140% of the Medicare rate.
- The Allowed Amount for all other providers is 105% of the Medicare rate.

Our Allowed Amount is not based on the "usual, customary and reasonable charge." If a Non-Participating Provider's actual charge is more than the Allowed Amount, you are responsible for the difference. Call us at the number on your ID card or visit **www.aetnastudenthealth.com** for information on your financial responsibility when you receive services from a Non-Participating Provider.

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

REFERRAL REQUIREMENT

You need a Referral from Student Health Services before receiving Specialist care from a Participating Provider in New York City. If You do obtain a written Referral, Your Cost-Sharing may be lower. See the Schedule of Benefits section of this Certificate for Your Cost-Sharing.

1. **Services Not Requiring a Referral from Student Health Services.** Student Health Services is responsible for determining the most appropriate treatment for Your health care needs. You do not need a Referral from Student Health Services to a Participating Provider for the following services:
    - Primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, treatment of Acute gynecologic conditions, or for any care related to a pregnancy from a qualified Participating Provider of such services;
    - Emergency Services;
    - Pre-Hospital Emergency Medical Services and emergency ambulance transportation;
    - Maternal depression screening;
    - Urgent Care;
    - When the Student Health Center is closed;
    - When outside of New York City; and
    - Laboratory tests

You may need to request Preauthorization before You receive certain services. See the Schedule of Benefits section of this Certificate for the services that require Preauthorization.

COST-SHARING	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	
Medical Deductible				
• Individual	$50	$50	$100	
Out-of-Pocket Limit				
• Individual	$7,150	$7,150	$10,000 See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how We calculate the Allowed Amount. Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible or Out-of-Pocket Limit. You must pay the amount of the Non-Participating Provider's charge that exceeds Our Allowed Amount.	

OFFICE VISITS	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	0% Coinsurance Not subject to Deductible	$20 Copayment after the Deductible then You pay 15% Coinsurance	$20 Copayment after the Deductible then You pay 40% Coinsurance	See benefit for description
Specialist Office Visits (or Home Visits) **Referral Required**	0% Coinsurance Not subject to Deductible	$20 Copayment after the Deductible then You pay 15% Coinsurance	$20 Copayment after the Deductible then You pay 40% Coinsurance	See benefit for description
PREVENTIVE CARE	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Well Child Visits and Immunizations*	Covered in full	Covered in full	30% Coinsurance after Deductible	See benefit for description
Adult Annual Physical Examinations*	Covered in full	Covered in full	30% Coinsurance after Deductible	
Adult Immunizations*	Covered in full	Covered in full	30% Coinsurance after Deductible	
Routine Gynecological Services/Well Woman Exams*	Covered in full	Covered in full	30% Coinsurance after Deductible	
Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	Covered in full	Covered in full	30% Coinsurance after Deductible	
Sterilization Procedures for Women *	Covered in full	Covered in full	30% Coinsurance after Deductible	
Vasectomy	Covered in full	Covered in full	30% Coinsurance after Deductible	
Bone Density Testing*	Covered in full	Covered in full	30% Coinsurance after Deductible	
Screening for Prostate Cancer	Covered in full	Covered in full	30% Coinsurance after Deductible	
All other preventive services required by USPSTF and HRSA.	Covered in full	Covered in full	30% Coinsurance after Deductible	
*When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Use Cost Sharing for Appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)			

EMERGENCY CARE	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	15% Coinsurance after Deductible	15% Coinsurance after Deductible	15% Coinsurance after Deductible	See benefit for description
Non-Emergency Ambulance Services	15% Coinsurance after Deductible	15% Coinsurance after Deductible	15% Coinsurance after Deductible	See benefit for description
Emergency Department Copayment /Coinsurance waived if Hospital admission.	$250 Copayment after the Deductible then You pay 15% Coinsurance	$250 Copayment after the Deductible then You pay 15% Coinsurance	$250 Copayment after the Deductible then You pay 15% Coinsurance	See benefit for description
Urgent Care Center	$50 Copayment after the Deductible then You pay 15% Coinsurance	$50 Copayment after the Deductible then You pay 15% Coinsurance	$50 Copayment after the Deductible then You pay 15% Coinsurance	See benefit for description
PROFESSIONAL SERVICES AND OUTPATIENT CARE	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Advanced Imaging Services				See benefit for description
• Performed in a Specialist Office	15% Coinsurance after Deductible	$20 Copayment after the Deductible then You pay 15% Coinsurance	$20 Copayment after the Deductible then You pay 40% Coinsurance	
• Performed in a Freestanding Radiology Facility	15% Coinsurance after Deductible	$20 Copayment after the Deductible then You pay 15% Coinsurance	$20 Copayment after the Deductible then You pay 40% Coinsurance	
• Performed as Outpatient Hospital Services **Referral Required**	15% Coinsurance after Deductible	$20 Copayment after the Deductible then You pay 15% Coinsurance	$20 Copayment after the Deductible then You pay 40% Coinsurance	

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Allergy Testing & Treatment • Performed in a PCP Office • Performed in a Specialist Office **Referral Required**	0% Coinsurance not Subject to Deductible 0% Coinsurance not Subject to Deductible	$20 Copayment after the Deductible then You pay 15% Coinsurance $20 Copayment after the Deductible then You pay 15% Coinsurance	$20 Copayment after the Deductible then You pay 40% Coinsurance $20 Copayment after the Deductible then You pay 40% Coinsurance	See benefit for description
Ambulatory Surgical Center Facility Fee **Referral Required**	15% Coinsurance after Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Anesthesia Services (all settings) **Referral Required**	15% Coinsurance after Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Autologous Blood Banking **Referral Required**	15% Coinsurance after Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefits for description
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services **Referral Required**	0% Coinsurance not Subject to Deductible 0% Coinsurance not Subject to Deductible Included as Part of Inpatient Hospital Service Cost-Sharing	$20 Copayment after the Deductible then You pay 15% Coinsurance 15% Coinsurance after Deductible Included as Part of Inpatient Hospital Service Cost-Sharing	$20 Copayment after the Deductible then You pay 40% Coinsurance 40% Coinsurance after Deductible Included as Part of Inpatient Hospital Service Cost-Sharing	See benefits for description

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Chemotherapy • Performed in a PCP Office	0% Coinsurance not Subject to Deductible	$20 Copayment after the Deductible then You pay 15% Coinsurance	$20 Copayment after the Deductible then You pay 40% Coinsurance	See benefit for description
• Performed in a Specialist Office	0% Coinsurance not Subject to Deductible	$20 Copayment after the Deductible then You pay 15% Coinsurance	$20 Copayment after the Deductible then You pay 40% Coinsurance	
• Performed as Outpatient Hospital Services **Referral Required**	0% Coinsurance not Subject to Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	
Chiropractic Services **Referral Required**	0% Coinsurance not Subject to Deductible	15% Coinsurance after Deductible	$5 Copayment after the Deductible then You pay 40% Coinsurance	See benefit for description
Clinical Trials **Referral Required**	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description
Diagnostic Testing • Performed in a PCP Office	0% Coinsurance not Subject to Deductible	$20 Copayment after the Deductible then You pay 15% Coinsurance	$20 Copayment after the Deductible then You pay 40% Coinsurance	See benefit for description
• Performed in a Specialist Office	0% Coinsurance not Subject to Deductible	$20 Copayment after the Deductible then You pay 15% Coinsurance	$20 Copayment after the Deductible then You pay 40% Coinsurance	
• Performed as Outpatient Hospital Services **Referral Required**	0% Coinsurance not Subject to Deductible	$20 Copayment after the Deductible then You pay 15% Coinsurance	$20 Copayment after the Deductible then You pay 40% Coinsurance	

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Dialysis • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Center • Performed as Outpatient Hospital Services **Referral Required**	0% Coinsurance not Subject to Deductible	$20 Copayment after the Deductible then You pay 15% Coinsurance	$20 Copayment after the Deductible then You pay 40% Coinsurance	See benefit for description
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) • Performed in a PCP Office • Performed in a Specialist Office • Performed in an Outpatient Facility **Referral Required**	0% Coinsurance not Subject to Deductible	$20 Copayment after the Deductible then You pay 15% Coinsurance	$20 Copayment after the Deductible then You pay 40% Coinsurance	Unlimited visits per plan year

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Home Health Care **Referral Required**	15% Coinsurance after Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	Unlimited visits per plan year
Infertility Services **Referral Required**	Use Cost Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)			See benefit for description
Infusion Therapy				See benefit for description
• Performed in a PCP Office	0% Coinsurance not Subject to Deductible	$20 Copayment after the Deductible then You pay 15% Coinsurance	$20 Copayment after the Deductible then You pay 40% Coinsurance	
• Performed in Specialist Office	0% Coinsurance not Subject to Deductible	$20 Copayment after the Deductible then You pay 15% Coinsurance	$20 Copayment after the Deductible then You pay 40% Coinsurance	
• Performed as Outpatient Hospital Services	0% Coinsurance not Subject to Deductible	$20 Copayment after the Deductible then You pay 15% Coinsurance	$20 Copayment after the Deductible then You pay 40% Coinsurance	
• Home Infusion Therapy **Referral Required**	0% Coinsurance not Subject to Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	
Inpatient Medical Visits	15% Coinsurance after Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Interruption of Pregnancy				
• Medically Necessary Abortions	Covered in full not subject to Deductible	Covered in full not subject to Deductible	30% Coinsurance after Deductible	Unlimited
• Elective Abortions	0% Coinsurance not subject to Deductible	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Laboratory Procedures • Performed in a PCP Office	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 15% Coinsurance not subject to Deductible	$20 Copayment after the Deductible then You pay 40% Coinsurance	See Benefit for Description
• Performed in a Specialist Office	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 15% Coinsurance not subject to Deductible	$20 Copayment after the Deductible then You pay 40% Coinsurance	
• Performed in a Freestanding Laboratory Facility	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 15% Coinsurance not subject to Deductible	$20 Copayment after the Deductible then You pay 40% Coinsurance	
• Performed as Outpatient Hospital Services	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 15% Coinsurance not subject to Deductible	$20 Copayment after the Deductible then You pay 40% Coinsurance	
Maternity & Newborn Care • Prenatal Care • Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered in Full	Covered in Full	30% Coinsurance after Deductible	See Benefit for Description
• Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory	Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)	One (1) Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early

	Procedures and Diagnostic Testing)			
PROFESSIONAL SERVICES AND OUTPATIENT CARE	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
• Inpatient Hospital Services and Birthing Center	15% Coinsurance after Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Physician and Midwife Services for Delivery	15% Coinsurance after Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Breastfeeding Support, Counseling and Supplies including Breast Pumps, Nursing Bras	Covered in Full	Covered in Full	30% Coinsurance after Deductible	Covered for duration of breast feeding
• Postnatal Care	Covered in Full	Covered in Full	30% Coinsurance after Deductible	
Outpatient Hospital Surgery Facility Charge	15% Coinsurance after Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Preadmission Testing **Referral Required**	0% Coinsurance not Subject to Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Prescription Drugs Administered in Office or Outpatient Facilities				See benefit for description
• Performed in a PCP Office	0% Coinsurance not Subject to Deductible	$20 Copayment after the Deductible then You pay 15% Coinsurance	$20 Copayment after the Deductible then You pay 40% Coinsurance	
• Performed in Specialist Office	0% Coinsurance not Subject to Deductible	$20 Copayment after the Deductible then You pay 15% Coinsurance	$20 Copayment after the Deductible then You pay 40% Coinsurance	
• Performed in Outpatient Facilities **Referral required**	0% Coinsurance not Subject to Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Diagnostic Radiology Services • Performed in a PCP Office	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 15% Coinsurance not subject to Deductible	$20 Copayment after the Deductible then You pay 40% Coinsurance	See benefit for description
• Performed in a Specialist Office	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 15% Coinsurance not subject to Deductible	$20 Copayment after the Deductible then You pay 40% Coinsurance	
• Performed in a Freestanding Radiology Facility	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 15% Coinsurance not subject to Deductible	$20 Copayment after the Deductible then You pay 40% Coinsurance	
• Performed as Outpatient Hospital Services **Referral Required**	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 15% Coinsurance not subject to Deductible	$20 Copayment after the Deductible then You pay 40% Coinsurance	
Therapeutic Radiology Services				See benefit for description
• Performed in a Specialist Office	0% Coinsurance not Subject to Deductible	$20 Copayment after the Deductible then You pay 15% Coinsurance	$20 Copayment after the Deductible then You pay 40% Coinsurance	
• Performed in a Freestanding Radiology Facility	0% Coinsurance not Subject to Deductible	$20 Copayment after the Deductible then You pay 15% Coinsurance	$20 Copayment after the Deductible then You pay 40% Coinsurance	
• Performed as Outpatient Hospital Services **Referral Required**	0% Coinsurance not Subject to Deductible	$20 Copayment after the Deductible then You pay 15% Coinsurance	$20 Copayment after the Deductible then You pay 40% Coinsurance	

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) • Performed in a PCP Office • Performed in a Specialist Office • Performed in an Outpatient Facility **Referral Required**	0% Coinsurance not Subject to Deductible 0% Coinsurance not Subject to Deductible 0% Coinsurance not Subject to Deductible	$20 Copayment after the Deductible then You pay 15% Coinsurance $20 Copayment after the Deductible then You pay 15% Coinsurance 15% Coinsurance after Deductible	$20 Copayment after the Deductible then You pay 40% Coinsurance $20 Copayment after the Deductible then You pay 40% Coinsurance 40% Coinsurance after Deductible	Unlimited visits per Plan Year
Second Opinions on the Diagnosis of Cancer, Surgery & Other **Referral Required**	0% Coinsurance not Subject to Deductible	$20 Copayment after the Deductible then You pay 15% Coinsurance	$20 Copayment after the Deductible then You pay 40% Coinsurance Second Opinions on Diagnosis of Cancer are Covered at participating Cost-Sharing for non-participating Specialist when a Referral is obtained.	See benefit for description

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery and Transplants				See benefit for description All transplants must be performed at Designated Facilities
• Inpatient Hospital Surgery	15% Coinsurance after Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Outpatient Hospital Surgery	0% Coinsurance not Subject to Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Surgery Performed at an Ambulatory Surgical Center	0% Coinsurance not Subject to Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Office Surgery **Referral Required**	0% Coinsurance not Subject to Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder **Referral Required**	0% Coinsurance not Subject to Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder **Referral Required**	15% Coinsurance after Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Diabetic Equipment, Supplies & Self-Management Education				See benefit for description
• Diabetic Equipment, Supplies, and Insulin (30-Day Supply)	15% Coinsurance not subject to Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Diabetic Education **Referral Required**	0% Coinsurance not Subject to Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description

ADDITIONAL SERVICES, EQUIPMENT & DEVICES	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Durable Medical Equipment & Braces **Referral Required**	15% Coinsurance not Subject to Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
External Hearing Aids **Referral Required**	15% Coinsurance after Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	Single purchase once every three (3) years
Cochlear Implants **Referral Required**	15% Coinsurance after Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	One (1) per ear per plan year
Hospice Care • Inpatient • Outpatient **Referral Required**	 15% Coinsurance after Deductible 15% Coinsurance after Deductible	 15% Coinsurance after Deductible 15% Coinsurance after Deductible	 40% Coinsurance after Deductible 40% Coinsurance after Deductible	Unlimited days per Plan Year Five (5) visits for family bereavement counseling
Medical Supplies **Referral Required**	15% Coinsurance after Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Prosthetic Devices • External • Internal **Referral Required**	15% Coinsurance after Deductible 15% Coinsurance after Deductible	15% Coinsurance after Deductible 15% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible	One (1) prosthetic device, per limb, per Plan Year Unlimited See benefit for description

INPATIENT SERVICES & FACILITIES	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care) Preauthorization Required. However, Preauthorization is not required for emergency admissions or services provided in a neonatal intensive care unit of a Hospital certified pursuant to Article 28 of the Public Health Law.	15% Coinsurance after Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Observation Stay **Referral Required**	15% Coinsurance after Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation) **Referral Required**	15% Coinsurance after Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	Unlimited days per plan year
Inpatient Habilitation Services (Physical Speech and Occupational Therapy) **Referral Required**	15% Coinsurance after Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	Unlimited days per plan year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) **Referral Required**	15% Coinsurance after Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	Unlimited days per plan year

MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment) Preauthorization Required. However, Preauthorization is not required for emergency admissions or for admissions at Participating OMH licensed Facilities for Members under 18.	15% Coinsurance after Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services) • Office Visits • All Other Outpatient Services **Referral Required**	0% Coinsurance not Subject to Deductible 0% Coinsurance not Subject to Deductible	$20 Copayment after the Deductible then You pay 15% Coinsurance 15% Coinsurance after Deductible	$20 Copayment after the Deductible then You pay 40% Coinsurance 40% Coinsurance after Deductible	See benefit for description
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment) Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions or for Participating OASAS-certified Facilities	15% Coinsurance after Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description

MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)				Up to twenty (20) visits a plan year may be used for family counseling
• Office Visits	0% Coinsurance not Subject to Deductible	$20 Copayment after the Deductible then You pay 15% Coinsurance	$20 Copayment after the Deductible then You pay 40% Coinsurance	
• All Other Outpatient Services	0% Coinsurance not Subject to Deductible	15% Coinsurance after Deductible	40% Coinsurance after Deductible	
Preauthorization Required However, Preauthorization is not required for Participating OASAS-certified Facilities. **Referral Required**				

PRESCRIPTION DRUGS ***Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an "A" or "B" rating from the USPSTF and obtained at a participating pharmacy	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Note: If You have an Emergency Condition, Preauthorization is not required for a five (5) day emergency supply of a Covered Prescription Drug used to treat a substance sue disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.				
Retail Pharmacy				
30-day supply Tier 1 (generic)	N/A	$20 Copayment per supply Not subject to Deductible	$20 Copayment per supply Not subject to Deductible	See benefit for description
Tier 2 (formulary brand)	N/A	$40 Copayment per supply Not subject to Deductible	$40 Copayment per supply Not subject to Deductible	
Tier 3 (non-formulary brand)	N/A	$60 Copayment per supply Not subject to Deductible	$60 Copayment per supply Not subject to Deductible	

PRESCRIPTION DRUGS	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Mail Order Pharmacy				
Up to a 90-day supply				See benefit for description
Tier 1 (generic)	N/A	Copayment per supply of 2.5 times the 30 day Mail Order Pharmacy Tier 1 Copayment per supply Not subject to Deductible	Copayment per supply of 2.5 times the 30 day Mail Order Pharmacy Tier 1 Copayment per supply Not subject to Deductible	
Tier 2 (formulary brand)	N/A	Copayment per supply of 2.5 times the 30 day Mail Order Pharmacy Tier 1 Copayment per supply Not subject to Deductible	Copayment per supply of 2.5 times the 30 day Mail Order Pharmacy Tier 1 Copayment per supply Not subject to Deductible	
Tier 3 (non-formulary brand)	N/A	Copayment per supply of 2.5 times the 30 day Mail Order Pharmacy Tier 3 Copayment per supply Not subject to Deductible	Copayment per supply of 2.5 times the 30 day Mail Order Pharmacy Tier 3 Copayment per supply Not subject to Deductible	

PRESCRIPTION DRUGS	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Enteral Formulas				See benefit for description
Tier 1 (generic)	N/A	$20 Copayment per supply Not subject to Deductible	$20 Copayment per supply Not subject to Deductible	
Tier 2 (formulary brand)	N/A	$40 Copayment per supply Not subject to Deductible	$40 Copayment per supply Not subject to Deductible	
Tier 3 (non-formulary brand)	N/A	$60 Copayment per supply Not subject to Deductible	$60 Copayment per supply Not subject to Deductible	

WELLNESS BENEFITS	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Exercise Facility Reimbursement	Up to $200 per six (6) month period			
PEDIATRIC DENTAL & VISION CARE	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care • Preventive	15% Coinsurance after Deductible	15% Coinsurance after Deductible	15% Coinsurance after Deductible	One (1) dental exam & cleaning per six (6)-month period
• Routine Dental Care	15% Coinsurance after Deductible	15% Coinsurance after Deductible	15% Coinsurance after Deductible	Full mouth x-rays or panoramic x-rays at thirty-six (36) month intervals and bitewing x-rays at six (6) month intervals
• Major Dental Care (Oral Surgery, Endodontics, Periodontics & Prosthodontics)	15% Coinsurance after Deductible	15% Coinsurance after Deductible	15% Coinsurance after Deductible	
• Orthodontics **Orthodontia & Major Dental Require Preauthorization; Referral**	15% Coinsurance after Deductible	15% Coinsurance after Deductible	15% Coinsurance after Deductible	

PEDIATRIC DENTAL & VISION CARE	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Vision Care				
• Exams	15% Coinsurance after Deductible	15% Coinsurance after Deductible	15% Coinsurance after Deductible	One (1) exam per twelve (12)-month period
• Lenses & Frames	15% Coinsurance after Deductible	15% Coinsurance after Deductible	15% Coinsurance after Deductible	One (1) prescribed lenses & frames per twelve (12)-month period
• Contact Lenses	15% Coinsurance after Deductible	15% Coinsurance after Deductible	15% Coinsurance after Deductible	

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not covered under the Certificate, you will be responsible for the full cost of the services.

Exclusions

No coverage is available under the certificate for the following:

Aviation.

We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

Convalescent and Custodial Care.

We do not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

Conversion Therapy.

We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for any individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

Cosmetic Services.

We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Certificate unless medical information is submitted.

Coverage Outside of the United States, Canada or Mexico.

We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

Dental Services.

We do not Cover dental services except for care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services and Pediatric Dental Care sections of this Certificate.

Experimental or Investigational Treatment.

We do not Cover any health care service, procedure, treatment, device or Prescription Drug that is experimental or investigational. However, we will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Certificate, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, we will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

Felony Participation.

We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

Foot Care.

We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, we will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

Government Facility.

We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.

Medically Necessary.

In general, we will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, we will Cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this Certificate.

Medicare or Other Governmental Program.

We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid). When You are eligible for Medicare, we will reduce Our benefits by the amount Medicare would have paid for the Covered Services. Except as otherwise required by law, this reduction is made even if You fail to enroll in Medicare or You do not pay Your Medicare premium. Benefits for Covered Services will not be reduced if We are required by federal law to pay first or if You are not eligible for premium-free Medicare Part A.

Military Service.

We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

No-Fault Automobile Insurance.

We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

Services Not Listed.

We do not Cover services that are not listed in this Certificate as being Covered.

Services Provided by a Family Member.

We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of You or Your Spouse.

Services Separately Billed by Hospital Employees.

We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

Services with No Charge.

We do not Cover services for which no charge is normally made.

Vision Services.

We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the Pediatric Vision Care section(s) of this Certificate.

War.

We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

Workers' Compensation.

We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

Fully Insured Disclaimer

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

Sanctioned Countries

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

Assistive Technology

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

Smartphone or Tablet

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

Non-Discrimination

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

Aetna:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:

  ○ Qualified sign language interpreters

  ○ Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:

  ○ Qualified interpreters

  ○ Information written in other languages

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

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462,

Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

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

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

TTY:711

English	To access language services at no cost to you, call the number on your ID card.
Albanian	Për shërbime përkthimi falas për ju, telefononi në numrin që gjendet në kartën tuaj të identitetit.
Amharic	የ ቋንቋ አገ ልግሎ ቶችን ያለክፍያ ለማግኘት፣ በመ ታወቂያ ዎት ላይ ያለ ውን ቁጥር ይደውሉ። :
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Armenian	Ձեր նախընտրած լեզվով ավելճար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հեռախոսահամարով
Bantu-Kirundi	Kugira uronke serivisi z'indimi ata kiguzi, hamagara inomero iri ku karangamuntu kawe
Bengali	আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে আপনার পরিচয়পত্রে দেওয়া নম্বরে টেলিফোন করুন।
Burmese	သင့်အနေဖြင့် အခကြေးငွေ မပေးရပဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန်၊ သင့် ID ကတ်ပေါ်တွင်ရှိသော ဖုန်းနံပတ်အား ခေါ်ဆိုပါ။
Catalan	Per accedir a serveis lingüístics sense cap cost per a vostè, telefoni al número indicat a la seva targeta d'identificació.
Cebuano	Aron maakses ang mga serbisyo sa lengguwahe nga wala kay bayran, tawagi ang numero nga anaa sa imong kard sa ID.
Chamorro	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang i numiru gi iyo-mu kard aidentifikasion.
Cherokee	ᏩᎩᏍᏗ ᎦᎾᏂᎯᏍᏗ ᎢᏅᎾᏓᏅᏛᏁᏗ Ꮷ ᎪᎢᏍᏗ ᏗᏣᎬᏩᎳᏁᏗ ᏯᎩ, ᎾᏥᎯᏏᎳᏅᏛᏏ ᎾᏍᎩᎩ ᏗᏎᏍᏗ ᏂᎦᏚᎯᏧᏒ ᎤᎾᎢ ID ᏆᏂᏲᏍᏗ ᏣᏉᏢᎢ.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Choctaw	Anumpa tosholi i toksvli ya peh pilla ho ish i payahinla kvt chi holisso kallo iskitini holhtena takanli ma i payah
Chuukese	Ren omw kopwe angei aninisin eman chon awewei (ese kamé), kopwe kééri ewe nampa mei mak won noum ena katen ID
Cushitic-Oromo	Tajaajiiloota afaanii gatii bilisaa ati argaachuuf,lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili.
Dutch	Voor gratis taaldiensten, bel het nummer op uw ziekteverzekeringskaart.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Greek	Για πρόσβαση στις υπηρεσίες γλώσσας χωρίς χρέωση, καλέστε τον αριθμό στην κάρτα ασφάλισής σας.
Gujarati	તમારે કોઇ પણ જાતના ખર્ચ વિના ભાષા સેવાઓ મેળવવા માટે, તમારા આઇડી કાર્ડ પર રહેલ નંબર પર કૉલ કરવો.

Hawaiian	No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i ka helu kelepona ma kāu kāleka ID. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi	बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
Igbo	Inweta enyemaka asụsụ na akwughi ụgwọ obụla, kpọọ nọmba nọ na kaadi njirimara gị
Ilocano	Tapno maakses dagiti serbisio ti pagsasao nga awanan ti bayadna, awagan ti numero nga adda ayan ti ID kardmo.
Indonesian	Untuk mengakses layanan bahasa tanpa dikenakan biaya, silakan hubungi nomor telepon di kartu asuransi Anda.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Karen	လၢတၢ်ကမၤန့ၢ်ကျိာ်တၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖဉ် လၢတအိဉ်ဒီးအပူၤလၢနကဘဉ်ဟ့ဉ်အီၤအဂီၤ,ကိးဘဉ်လီတဲစိနိဉ်ဂ်ၢ်လၢအအိဉ်လၢနခိဉ်ဂီၤ (ID) အလိၤန့ဉ်တက့ၢ်.
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Kru-Bassa	I nyuu kosna mahola ni language services ngui nsaa wogui wo, sebel i nsinga i ye ntilga i kat yong matibla
Kurdish	بۆ دەستپێڕاگەیشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی سەر ئای دی(ID) کارتی خۆت.
Lao	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.
Marathi	आपल्याला कोणत्याही शुल्काशिवाय भाषा सेवांपर्यंत पोहोचण्यासाठी, आपल्या ID कार्डावरील क्रमांकावर फोन करा.
Marshallese	Ṇan bōk jipañ kōn kajin ilo an ejjeḷọk wōṇean ñan kwe, kwōn kallok nōṃba eo ilo kaat in ID eo aṃ.
Micronesian-Ponapean	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih nempe nan amhw doaropwe en ID.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T’áá ni nizaad k’ehjí bee níká a’doowoł doo bą́ą́h ílínígóó naaltsoos bee atah nílı̨́go nanitinígíí bee néého’dólzinígíí béésh bee hane’í biká’ígíí áajı̨’ hólne’.
Nepali	भाषासम्बन्धी सेवाहरूमाथि निःशुल्क पहुँच राख्न आफ्नो कार्डमा रहेको नम्बरमा कल गर्नुहोस्।
Nilotic-Dinka	Të kɔɔr yïn ran de wëër de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke yïn cɔl ran ye kɔc kuɔny në namba de abac tɔ në ID kard duɔ̈n de tïït de nyin de panakim kɔ̈u.
Norwegian	For tilgang til kostnadsfri språktjenester, ring nummeret på ID-kortet ditt.

Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.
Persian Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Romanian	Pentru a accesa gratuit serviciile de limbă, apelați numărul de pe cardul de membru.
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Samoan	Mō le mauaina o 'au'aunaga tau gagana e aunoa ma se totogi, vala'au le numera i luga o lau pepa ID.
Serbo-Croatian	Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici.
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Sudanic Fulfulde	Heeɓa a naasta nder ekkitol jaangirde woldeji walla yoɓugo, ewnu lamba je ɗon windi ha do ɗerowol maaɗa.
Swahili	Kupata huduma za lugha bila malipo kwako, piga nambari iliyo kwenye kadi yako ya kitambulisho.
Syriac-Assyrian	ܟܕ ܚܫܚܬܐ ܬܠܘܢ ܥܠ ܝܘܠܦܢܐ ܕܡܫܘܕܥܬܐ ܕܠܫܢܐ ܡܓܢܐܝܬ، ܩܪܘܢ ܡܢܝܢܐ ܥܠ ܦܬܩܐ ܕܗܘܝܬܐ ܕܝܘܟܘܢ.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Telugu	భాష సేవలను మీకు ఖర్చు లేకుండా అందుకునేందుకు, మీ ఐడి కార్డుపై ఉన్న నంబరుకు కాల్ చేయండి.
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน
Tongan	Kapau ‘oku ke fiema’u ta’etōtōngi ‘a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he fika ‘oku hā atu ‘i ho’o ID kaati.
Turkish	Dil hizmetlerine ücretsiz olarak erişmek için kimlik kartınızdaki numarayı arayın.
Ukrainian	Щоб безкоштовнj отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікайній картці.
Urdu	لسانی خدمات تک مُفت رسائی کے لیے، اپنے بیمہ کے ID کارڈ پر درج نمبر پر کال کریں۔
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.
Yiddish	צו באקומען שפראך סערוויסעס פריי פון אפצאל, רופט דעם נומער אויף אייער ID קארטל.
Yoruba	Láti ráyèsí àwọn iṣẹ́ èdè fún ọ lọ́fẹ̀ẹ́, pe nọ́mbà tó wà lórí káàdì ìdánimọ̀ rẹ.