Quality Health Plans & Benefits
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Aetna Student Health
Plan Design and Benefits Summary
Houston Community College

Policy Year: 2019-2020
Policy Number: 686150

hccs.myahpcare.com
1-855-844-3018
Enrollment/Waiver
www.aetnastudenthealth.com
(877) 480-4161

Claims/Benefits

This is a brief description of the Student Health Plan. The Plan is available for Houston Community College students. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Policy issued to you and may be viewed online at **hccs.myahpcare.com**. If there is a difference between this Benefit Summary and the Policy, the Master Policy 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

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
Fall	08/22/2019	01/20/2020
Spring/Summer	01/21/2020	08/21/2020
Summer (New Students Only)	06/08/2020	08/21/2020

Coverage Period	Enrollment Deadline	Waiver Deadline
Fall	10/11/2019	09/24/2019
Spring/Summer	03/09/2020	02/18/2020
Summer (New Students Only)	07/24/2020	06/11/2020

Rates

The rates below include both premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna), as well as Houston Community College administrative fee.

Rates
Undergraduates and Graduate Students

	Fall	Spring/Summer	Summer Only (New Students Only)
Student	$849.00	$1195.00	$419.00
Spouse	$849.00	$1195.00	$419.00
Child	$849.00	$1195.00	$419.00
2 or more children	$1698.00	$2390.00	$838.00

Student Coverage

Eligibility

All international students holding an "F-1" or "J-1" visa and enrolled at Houston Community College will be automatically enrolled in and billed each semester for coverage under the Plan unless a waiver of coverage has been submitted and approved online at **https://hccs.myahpcare.com/waiver** by the waiver deadline date each semester. No waivers will be accepted after the waiver deadline date.

A student who initially waived coverage under the Plan but subsequently experiences ineligibility under another creditable coverage plan may elect to enroll for coverage under the Plan within 31 days of the date of ineligibility. Proof of ineligibility under another creditable coverage is required at the time the enrollment form is submitted.

An eligible student must actively attend classes at the College for at least the first 45 days of the period for which he or she is enrolled. Students who fully withdraw after 45 days will remain covered under the Plan and no refund will be made. Eligibility requirements must be met each time premium is paid to continue coverage. The Company maintains the right to investigate student status and attendance records to verify that the Plan eligibility requirements have been met. If it is discovered that the Plan eligibility requirements have not been met, the Company's only obligation is to refund premium, less any claims paid.

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

Eligible students will be automatically enrolled in this Plan, unless the completed waiver application has been received by Houston Community College by the specified enrollment deadline dates listed in the Coverage Periods section of this Plan Design and Benefits Summary. Eligible students may also insure their Dependents. Eligible Dependents are the student's legal spouse and dependent children under 26 years of age.

OR

To enroll online or obtain an enrollment application for voluntary dependent coverage, log on to **hccs.myahpcare.com** then click on Enrollment tab to enroll or download the appropriate form.

If you withdraw from school within the first **45 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 **45 days**, you will be covered for the full period that you have paid the premium for, and no refund will be allowed. (This refund policy will not apply if you withdraw due to a covered Accident or Sickness.)

Medicare Eligibility Notice

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

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

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

Coordination of Benefits (COB)

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB).

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

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

In-network Provider Network

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

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

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

Preauthorization

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

Preauthorization for medical services and supplies

In-network care

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

Out-of-network care

When you go to an out-of-network provider, it is your responsibility to obtain preauthorization from us for any services

and supplies on the preauthorization list. If you do not preauthorize, your benefits may be reduced, or the plan may not pay any benefits. Refer to your schedule of benefits for this information. The list of services and supplies requiring preauthorization appears later in this section.

Preauthorization call

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

Non-emergency admissions:	You, your physician or the facility will need to call and request preauthorization at least 3 days before the date you are scheduled to be admitted.
An emergency admission:	You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
An urgent admission:	You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or an injury.
Outpatient non-emergency services requiring preauthorization:	You or your physician must call at least 3 days before the outpatient care is provided, or the treatment or procedure is scheduled.

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

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

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

What if you don't obtain the required preauthorization?

If you don't obtain the required preauthorization:

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

What types of services and supplies require preauthorization?

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

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

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

Description of Benefits

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

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

Metallic Level: Gold, Tested at 80.35%

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	$1,500 per policy year
Spouse	$500 per policy year	$1,500 per policy year
Each child	$500 per policy year	$1,500 per policy year
Family	None	None
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; • In-network care for Pediatric Preventive Dental Benefits; • In-network and out-of-network care for Pediatric Vision Benefits and Immunizations covered for a dependent child from birth through the date of the child's sixth birthday.		
Maximum out-of-pocket limits **Maximum out-of-pocket limit** per **policy year**		
Student	$7,150 per policy year	$30,000 per policy year
Spouse	$7,150 per policy year	$30,000 per policy year
Each child	$7,150 per policy year	$30,000 per policy year
Family	$14,300 per policy year	$60,000 per policy year
Preauthorization covered benefit penalty		
This only applies to out-of-network coverage: The certificate of coverage contains a complete description of the preauthorization program. You will find details on preauthorization requirements in the *Medical necessity and preauthorization requirements* section. Failure to preauthorize your eligible health services when required will result in the following benefit penalties: - A $500 benefit penalty will be applied separately to each type of eligible health services. The additional percentage or dollar amount of the recognized charge which you may pay as a penalty for failure to obtain preauthorization is not a covered benefit and will not be applied to the policy year deductible amount or the maximum out-of-pocket limit, if any.		

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

Eligible health services	In-network coverage	Out-of-network coverage
Preventive care and wellness		
Routine physical exams		
Performed at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	50% (of the recognized charge) per visit
Routine physical exams for covered persons age 18 or more Maximum age and visit limits per policy year:		
Screening for abdominal aortic aneurysm	1 time for adults aged 65-75 who have ever smoked	
Screening for cholesterol at increased risk for coronary heart disease	Men age 35 and older Men under age 35 who have heart disease or risk factors for heart disease Women who have heart disease or risk factors for heart disease	
Colorectal cancer screening	For adults over 50	
Screening for aspirin use for the primary prevention of cardiovascular disease and colorectal cancer as recommended by their physician	For adults age 50-59 years of age who have a 10% or greater 10-year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years	
Routine physical exams for covered persons from birth to age 18: Maximum age and visits per policy year		
Autism screening	At intervals of 18 and 24 months	
Developmental screening	Under age 3 and surveillance throughout childhood	
Blood pressure screenings at certain intervals	0-11 months 1-4 years 5-10 years 11-14 years 15-17 years	
Covered persons through age 21: Maximum age and visit limits per policy year	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures//Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging onto your Aetna secure website at www.aetnastudenthealth.com or calling the toll-free number on your ID card in the *How to contact us for help* section.	
Covered persons age 22-27 and over: Maximum visits per policy year	1 visit	

Eligible health services	In-network coverage	Out-of-network coverage
Preventive care immunizations		
Performed in a facility or at a physician's office No policy year deductible, copayment or coinsurance applies for children from birth through age 6	100% (of the negotiated charge) per visit. No policy year deductible applies	50% (of the recognized charge) per visit No policy year deductible or copayment applies for children from birth through age 6
Additional maximums per policy year	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician or Member Services by logging onto your Aetna secure website at www.aetnastudenthealth.com or calling the toll-free number on your ID card in the *How to contact us for help* section.	
Well woman preventive visits **Routine gynecological exams (including Pap smears and cytology tests)**		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	50% (of the recognized charge) per visit
Pap smear or screening using liquid based cytology methods	1 Pap smear every 12 months for women age 18 and older	
Gynecological exam that includes a rectovaginal pelvic exam	1 exam every 12 months for women over age 25 who are at risk for ovarian cancer	
Diagnostic exam for the early detection of ovarian cancer, cervical cancer, and the CA 125 blood test	1 exam every 12 months for women age 18 and older	
Screening for osteoporosis	For women over age 60 depending on risk factors	
Additional maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	
Additional maximum visits per policy year	1 visit	

Eligible health services	In-network coverage	Out-of-network coverage
Preventive screening and counseling services		
Obesity and/or healthy diet counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	50% (of the recognized charge) per visit
Maximum visits per policy year (This maximum applies only to covered persons age 22 and older.)	26 visits (however, of these only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)	
Misuse of alcohol and/or drugs counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	50% (of the recognized charge) per visit
Maximum visits per policy year	5 visits	
Use of tobacco products counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	50% (of the recognized charge) per visit
Maximum visits per policy year	8 visits	
Depression screening counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	50% (of the recognized charge) per visit
Maximum visits per policy year	1 visit	
Sexually transmitted infection counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	50% (of the recognized charge) per visit
Maximum visits per policy year	2 visits	

Eligible health services	In-network coverage	Out-of-network coverage
Preventive screening and counseling services (continued)		
Genetic risk counseling for breast and ovarian cancer counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	50% (of the recognized charge) per visit
Routine cancer screenings performed at a physician's office, specialist's office or facility.		
Routine cancer screenings	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	50% (of the recognized charge) per visit
Mammogram maximums	1 low-dose mammogram every 12 months for covered persons age 35 or older For covered persons of any age, 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 • The comprehensive guidelines supported by the Health Resources and Services Administration	
Prostate specific antigen (PSA) tests maximums	1 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	
Fecal occult blood tests maximums	1 occult test every 12 months for covered persons age 50 or older	
Sigmoidoscopies maximums	1 flexible sigmoidoscopy every 5 years for covered persons age 50 or older	
Colonoscopies maximums	1 colonoscopy every 10 years for covered persons age 50 or older	
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. For details, contact your physician or Member Services by logging onto your Aetna secure website at www.aetnastudenthealth.com or calling the toll-free number on your ID card in the *How to contact us for help* section.	
Lung cancer screening maximums	1 screening every 12 months*	
***Important note:** Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.		

Eligible health services	In-network coverage	Out-of-network coverage
Prenatal care services (provided by a physician, an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)		
Preventive care services only	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	50% (of the recognized charge) per visit
Important note: You should review the *Maternity care and Well newborn nursery care* sections. They will give you more information on coverage levels for maternity care under this plan.		
Comprehensive lactation support and counseling services		
Lactation counseling services - facility or office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	50% (of the recognized charge) per visit
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits	
***Important note:** Any visits that exceed the lactation counseling services maximum are covered under the *Physicians and other health professionals* section.		
Breast pump supplies and accessories	100% (of the negotiated charge) per item No copayment or policy year deductible applies	50% (of the recognized charge) per visit
Important note: See the *Breast feeding durable medical equipment* section of the certificate of coverage for limitations on breast pump and supplies.		
Family planning services –Female contraceptives		
Female contraceptive counseling services office visit	100% (of the negotiated charge) per item No copayment or policy year deductible applies	50% (of the recognized charge) per visit
Contraceptive counseling services maximum visits per policy year either in a group or individual setting	2 visits	

Eligible health services	In-network coverage	Out-of-network coverage
Contraceptives (prescription drugs and devices)		
Female contraceptive prescription drugs and devices provided, administered, or removed, by a physician during an office visit	100% (of the negotiated charge) per item No copayment or policy year deductible applies	50% (of the recognized charge) per visit
Female voluntary sterilization		
Inpatient provider services	100% (of the negotiated charge) per item No copayment or policy year deductible applies	50% (of the recognized charge) per visit
Outpatient provider services	100% (of the negotiated charge) per item No copayment or policy year deductible applies	50% (of the recognized charge) per visit
Physicians and other health professionals		
Physician and specialist services		
Office hours visits (non-surgical and non-preventive care by a physician and specialist, includes telemedicine or telehealth consultations)	$35 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	$15 copayment then the plan pays 50% (of the balance of the recognized charge) per visit thereafter
Allergy testing and treatment		
Allergy testing performed at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Allergy injections treatment performed at a physician's, or specialist office when you see the physician	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Physician and specialist - inpatient surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon	80% (of the negotiated charge)	50% (of the recognized charge)
Anesthetist	80% (of the negotiated charge)	50% (of the recognized charge)
Surgical assistant	80% (of the negotiated charge)	50% (of the recognized charge)

Eligible health services	In-network coverage	Out-of-network coverage
Physician and specialist - outpatient surgical services		
Physician and specialist outpatient surgical services - Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Anesthetist	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Surgical assistant	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
In-hospital non-surgical physician services		
In-hospital non-surgical physician services	80% (of the negotiated charge)	50% (of the recognized charge)
Consultant services (non-surgical and non-preventive)		
Office hours visits (non-surgical and non-preventive care), includes telemedicine or telehealth consultations	$35 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	$15 copayment then the plan pays 50% (of the balance of the recognized charge) per visit thereafter
Second surgical opinion	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Alternatives to physician office visits		
Walk-in clinic visits(non-emergency visit)	$35 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	$15 copayment then the plan pays 50% (of the balance of the recognized charge) per visit thereafter

Eligible health services	In-network coverage	Out-of-network coverage
Hospital and other facility care		
Inpatient hospital (room and board) and other miscellaneous services and supplies) Subject to semi-private room rate unless intensive care unit required Room and board includes intensive care For physician charges, refer to the *Physician and specialist – inpatient surgical services* benefit	80% (of the negotiated charge) per admission	50% (of the recognized charge) per admission
Preadmission testing	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Alternatives to hospital stays		
Outpatient surgery (facility charges)		
Facility charges for surgery performed in the outpatient department of a hospital or surgery center For physician charges, refer to the *Physician and specialist - outpatient surgical services* benefit	80% (of the negotiated charge)	50% (of the recognized charge)
Home health care		
Outpatient	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Maximum visits per policy year	60	

Eligible health services	In-network coverage	Out-of-network coverage
Hospice care		
Inpatient facility (room and board and other miscellaneous services and supplies)	80% (of the negotiated charge) per admission	50% (of the recognized charge) per admission
Maximum per day of confinement policy year	unlimited	
Outpatient	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Respite care-maximum number of days per 30 day period	30	
Skilled nursing facility		
Inpatient facility (room and board and miscellaneous inpatient care services and supplies) Subject to semi-private room rate unless intensive care unit is required Room and board includes intensive care	80% (of the negotiated charge) per admission	50% (of the recognized charge) per admission
Maximum days of confinement per policy year	25	

Eligible health services	In-network coverage	Out-of-network coverage
Emergency services and urgent care		
Emergency services		
Hospital emergency room	$150 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit	Paid the same as in-network coverage
Non-emergency care in a hospital emergency room	Not covered	Not covered

Important note:

- As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment/coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on the back of your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill.
- A separate hospital emergency room copayment/coinsurance will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/coinsurance will be waived and your inpatient copayment/coinsurance will apply.
- Covered benefits that are applied to the hospital emergency room copayment/coinsurance cannot be applied to any other copayment/coinsurance under the plan. Likewise, a copayment/coinsurance that applies to other covered benefits under the plan cannot be applied to the hospital emergency room copayment/coinsurance.
- Separate copayment/coinsurance amounts may apply for certain services given to you in the hospital emergency room that are not part of the hospital emergency room benefit. These copayment/coinsurance amounts may be different from the hospital emergency room copayment/coinsurance. They are based on the specific service given to you.
- Services given to you in the hospital emergency room that are not part of the hospital emergency room benefit may be subject to copayment/coinsurance amounts that are different from the hospital emergency room copayment/coinsurance amounts.

Urgent care		
Urgent medical care provided by an urgent care provider	$15 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter	$15 copayment then the plan pays 50% (of the balance of the recognized charge) per visit thereafter
Non-urgent use of an urgent care provider	Not covered	Not covered

Eligible health services	In-network coverage	Out-of-network coverage
Pediatric dental care (Limited to covered persons through the end of the month in which the person turns age 19) The reimbursement percentage, copayment, deductible or no charge amount, for services rendered by a non-contracting dental provider will be reimbursed the same as a contracting dental provider.		
Type A services The reimbursement percentage, copayment, deductible or no charge amount, for services rendered by a non-contracting dental provider will be reimbursed the same as a contracting dental provider.	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 The reimbursement percentage, copayment, deductible or no charge amount, for services rendered by a non-contracting dental provider will be reimbursed the same as a contracting dental provider.	70% (of the negotiated charge) per visit No copayment or deductible applies	70% (of the recognized charge) per visit No copayment or deductible applies
Type C services The reimbursement percentage, copayment, deductible or no charge amount, for services rendered by a non-contracting dental provider will be reimbursed the same as a contracting dental provider.	50% (of the negotiated charge) per visit No copayment or deductible applies	50% (of the recognized charge) per visit No copayment or deductible applies
Orthodontic services The reimbursement percentage, copayment, deductible or no charge amount, for services rendered by a non-contracting dental provider will be reimbursed the same as a contracting dental provider.	50% (of the negotiated charge) per visit No copayment or deductible applies	50% (of the recognized charge) per visit No copayment or deductible applies
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.

Eligible health services	In-network coverage	Out-of-network coverage
Specific conditions		
Birthing center (facility charges)		
Inpatient (room and board and other miscellaneous services and supplies)	Paid at the same cost-sharing as hospital care.	Paid at the same cost-sharing as hospital care.
Diabetic services and supplies (including equipment and training)		
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received
Impacted wisdom teeth		
Impacted wisdom teeth	80% (of the negotiated charge)	80% (of the recognized charge)
Accidental injury to sound natural teeth		
Accidental injury to sound natural teeth	80% (of the negotiated charge)	80% (of the recognized charge)
Anesthesia and related facility charges for oral surgery a dental procedure ***Coverage is subject to certain conditions. See the benefit description in the certificate of coverage for details.***		
Anesthesia and related facility charges for oral surgery a dental procedure	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Temporomandibular joint dysfunction (TMJ)		
TMJ treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Dermatological treatment		
Dermatological treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maternity care		
Maternity care (includes delivery and postpartum care services in a hospital or birthing center)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Well newborn nursery care in a hospital or birthing center	80% (of the negotiated charge) No policy year deductible applies	50% (of the recognized charge) No policy year deductible applies
Note: *If applicable, the per admission copayment and/or policy year deductible amounts for newborns will be waived for nursery charges for the duration of the newborn's initial routine facility stay. The nursery charges waiver will not apply for non-routine facility stays.*		

Eligible health services	In-network coverage	Out-of-network coverage
Pregnancy complications		
Inpatient (room and board and other miscellaneous services and supplies) Subject to semi-private room rate unless intensive care unit required Room and board includes intensive care	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Family planning services – other		
Voluntary sterilization for males Inpatient physician or specialist surgical services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Voluntary sterilization for males Outpatient physician or specialist surgical services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Gender reassignment (sex change) treatment		
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Autism spectrum disorder		
Autism spectrum disorder diagnosis and testing	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Autism spectrum disorder treatment (includes physician and specialist 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
Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Applied behavior analysis	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Services for children with developmental delays	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage	Out-of-network coverage
Mental health treatment		
Mental health treatment – inpatient		
Inpatient hospital mental disorders treatment (room and board and other miscellaneous hospital services and supplies) Inpatient residential treatment facility mental disorders treatment (room and board and other miscellaneous residential treatment facility services and supplies) Subject to semi-private room rate unless intensive care unit is required Mental disorder room and board intensive care	80% (of the negotiated charge) per admission	50% (of the recognized charge) per admission
Mental health treatment - outpatient		
Outpatient mental disorder treatment office visits to a physician or behavioral health provider (includes telemedicine or telehealth consultation)	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Other outpatient mental disorders treatment (includes skilled behavioral health services in the home) Partial hospitalization treatment Intensive Outpatient Program	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Important note: **All mental health treatment coverage is provided under the same terms and conditions as any other illness.**		

Eligible health services	In-network coverage	Out-of-network coverage
Substance abuse related disorders treatment-inpatient		
Inpatient hospital substance abuse detoxification (room and board and other miscellaneous hospital services and supplies) Inpatient hospital substance abuse rehabilitation (room and board and other miscellaneous hospital services and supplies) Inpatient residential treatment facility substance abuse (room and board and other miscellaneous residential treatment facility services and supplies) Subject to semi-private room rate unless intensive care unit is required Substance abuse room and board intensive care	80% (of the negotiated charge) per admission	50% (of the recognized charge) per admission
Substance abuse related disorders treatment-outpatient: detoxification and rehabilitation		
Outpatient substance abuse office visits to a physician or behavioral health provider (includes telemedicine or telehealth consultations)	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Other outpatient substance abuse services Partial hospitalization treatment Intensive Outpatient Program	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Obesity (bariatric) Surgery		
Inpatient and outpatient facility and physician services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Oral and maxillofacial treatment (mouth, jaws, and teeth)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Reconstructive surgery and supplies		
Reconstructive surgery and supplies (includes reconstructive breast surgery)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage Network (IOE facility)	In-network coverage Network (Non-IOE facility)	Out-of-network coverage Network Non-IOE facility and out-of-network facility
Transplant services			
Inpatient and outpatient transplant facility services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Inpatient and outpatient transplant physician and specialist services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage	Out-of-network coverage
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.
Specific therapies and tests		
Outpatient diagnostic testing		
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit	50% (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	50% (of the recognized charge) per visit
Diagnostic follow-up care related to newborn hearing screening	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Cardiovascular disease testing	80% (of the negotiated charge) per visit	50% (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	
Chemotherapy		
Chemotherapy	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Oral anti-cancer prescription drugs	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Outpatient infusion therapy		
Outpatient infusion therapy performed in a covered person's home, physician's office, outpatient department of a hospital or other facility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient radiation therapy		
Outpatient radiation therapy	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Outpatient respiratory therapy		
Respiratory therapy	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.
Transfusion or kidney dialysis of blood		
Transfusion or kidney dialysis of blood	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Short-term cardiac and pulmonary rehabilitation services		
Cardiac rehabilitation	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.
Pulmonary rehabilitation	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Short-term rehabilitation and habilitation therapy services		
Outpatient physical, occupational, speech, and cognitive therapies Combined for short-term rehabilitation services and habilitation therapy services	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Acquired brain injury	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Alzheimer's disease	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Chiropractic services		
Chiropractic services	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Maximum visits per policy year	unlimited	

Eligible health services	In-network coverage	Out-of-network coverage
Evaluation and therapy for learning and developmental disabilities		
Evaluation and therapy for learning and developmental disabilities	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Specialty prescription drugs (Purchased and injected or infused by your provider in an outpatient setting)		
Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting	Covered according to the type of benefit or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Other services and supplies		
Acupuncture in lieu of anesthesia	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Emergency ground, air, and water ambulance (includes non-emergency ambulance)	80% (of the negotiated charge) per trip	Paid the same as in-network coverage
Clinical trial therapies (experimental or investigational)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Durable medical and surgical equipment	80% (of the negotiated charge) per item	50% (of the recognized charge) per item
Enteral formulas and nutritional supplements	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Osteoporosis (non-preventive care)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage	Out-of-network coverage
Prosthetic devices		
Prosthetic devices	80% (of the negotiated charge) per item	50% (of the recognized charge) per item
Orthotic devices	80% (of the negotiated charge) per item	50% (of the recognized charge) per item
Hearing aid exams		
Hearing aid exams	$15 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter	$15 copayment then the plan pays 50% (of the balance of the recognized charge) per visit thereafter
Hearing aid exam maximum	One hearing exam every 24 months consecutive period	
Hearing aids and cochlear implants and related services		
Hearing aids and cochlear implants and related services	80% (of the negotiated charge) per item	50% (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	Once every three years	
Podiatric (foot care) treatment		
Physician and Specialist non-routine foot care treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Vision care		
Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)		
Pediatric routine vision exams (including refraction)		
Performed by a legally qualified ophthalmologist, optometrist, therapeutic optometrist, or any other providers acting within the scope of their license	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit No policy year deductible applies
Maximum visits per policy year	1 visit	
Pediatric comprehensive low vision evaluations		
Performed by a legally qualified ophthalmologist optometrist, therapeutic optometrist, or any other providers acting within the scope of their license	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum	One comprehensive low vision evaluation every policy year	

Eligible health services	In-network coverage	Out-of-network coverage
Pediatric vision care services and supplies		
Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit No policy year deductible applies
Maximum number of eyeglass frames per policy year	One set of eyeglass frames	
Maximum number of prescription lenses per policy year	One pair of prescription lenses	
Maximum number of prescription contact lenses per policy year (includes non-conventional prescription contact lenses and aphakic lenses prescribed after cataract surgery)	Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set	
Office visit for fitting of contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit No policy year deductible applies
Maximum visits per policy year	1-2 visits	
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.

Coverage does not include the office visit for the fitting of prescription contact lenses.

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient prescription drugs		
Preferred generic prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a **retail pharmacy**	$20 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible	$20 copayment per supply then the plan pays 100% (of the recognized charge) No policy year deductible
Preferred brand-name prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a **retail pharmacy**	$40 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible	$40 copayment per supply then the plan pays 100% (of the recognized charge) No policy year deductible
Non-preferred generic prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a **retail pharmacy**	$80 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible	$80 copayment per supply then the plan pays 100% (of the recognized charge) No policy year deductible
Non-preferred brand-name prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a **retail pharmacy**	$80 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible	$80 copayment per supply then the plan pays 100% (of the recognized charge) No policy year deductible
Orally administered anti-cancer prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	100% (of the negotiated charge No copayment or policy year deductible applies	100% (of the recognized charge) No policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Preventive care drugs and supplements		
Preventive care drugs and supplements filled at a retail pharmacy For each 30 day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure website at www.aetnastudenthealth.com or calling the toll-free number on the back of your ID card.	
Risk reducing breast cancer prescription drugs		
Risk reducing breast cancer prescription drugs filled at a pharmacy For each 30 day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure website at www.aetnastudenthealth.com or calling the toll-free number on the back of your ID card.	
Tobacco cessation prescription and over-the-counter drugs		
Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy** For each 30 day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits above. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna secure website at www.aetnastudenthealth.com or calling the toll-free number on your ID card 1-877-480-4161.	

A covered person, a covered person's designee or a covered person's prescriber may seek an expedited medical exception process to obtain coverage for non-covered drugs in exigent circumstances. An "exigent circumstance" exists when a covered person is suffering from a health condition that may seriously jeopardize a covered person's life, health, or ability to regain maximum function or when a covered person is undergoing a current course of treatment using a non-formulary drug.

The request for an expedited review of an exigent circumstance may be submitted by contacting Aetna's *Pre-authorization Department* at **1-855-240-0535**, faxing the request to **1-877-269-9916**, or submitting the request in writing to:

CVS Health
ATTN: Aetna PA
1300 E Campbell Road
Richardson, TX 75081

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

General exceptions and exclusions

Acupuncture therapy

- Maintenance treatment
- Acupuncture when provided for the following conditions:
  - Acute low back pain
  - Addiction
  - AIDS
  - Amblyopia
  - Allergic rehinitis
  - Asthma
  - Autism spectrum disorders
  - Bell's Palsy
  - Burning mouth syndrome
  - Cancer-related dyspnea
  - Carpal tunnel syndrome
  - Chemotherapy-induced leukopenia
  - Chemotherapy-induced neuopathic pain
  - Chronic pain syndrome (e.g., RSD, facial pain)
  - Chronic obstructive pulmonary disease
    Diabetic peripheral neuropathy
    Dry eyes
  - Erectile dysfunction
  - Facial spasm
  - Fetal breech presentation
  - Fibromyalgia
  - Fibrotic contractures
  - Glaucoma
  - Hypertension
  - Induction of labor

- Infertility(e.g., to assist oocyte retrieval and embryo transfer during IVF treatment cycle)
- Insomnia
- Irritable bowel syndrome
- Menstrual cramps/dysmenorrhea
- Mumps
- Myofascial pain
- Myopia
- Neck pain/cervical spondylosis
- Obesity
- Painful neuropathies
- Parkinson's disease
- Peripheral arterial disease (e.g., intermittent claudication)
- Phantom leg pain
- Polycystic ovary syndrome
- Post-herpetic neuralgia
- Psoriasis
- Psychiatric disorders (e.g., depression)
- Raynaud's disease pain
- Respiratory disorders
- Rheumatoid arthritis
- Rhinitis
- Sensorineural deafness
- Shoulder pain (e.g., bursitis)
- Stroke rehabilitation (e.g., dysphagia)
- Tennis elbow/ epicondylitis
- Tension headache
- Tinnitus
- Tobacco Cessation
- Urinary incontinence
- Uterine fibroids
- Xerostomia
- Whiplash

Air or space travel

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

  This exclusion does not apply if:
  - You are traveling solely as a fare-paying passenger
  - You are traveling on a licensed, commercial, regularly scheduled non-military aircraft
  - You are traveling solely in a civil aircraft with a current valid "Standard Federal Aviation Agency Airworthiness Certificate" and:
    - The civil aircraft is piloted by a person with a current valid pilot's certificate with proper ratings for the type of flight and aircraft involved
    - You are as a passenger with no duties at all on an aircraft used only to carry passengers or you are a pilot or a part of the flight crew on an aircraft owned or leased by the policyholder performing duties for the policyholder

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.

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

Breasts

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

Contraceptive methods, procedures, services, and supplies for contraceptive purposes

- Contraceptive methods, procedures, services, and supplies for contraceptive purposes as elected by the policyholder due to an exemption or accommodation in accordance with applicable federal or state law and regulation
- Services provided as a result of complications resulting from voluntary sterilization procedure and related follow-up care

Cosmetic services and plastic surgery

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

This exclusion does not apply to:

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

Custodial care

Examples are:

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

Dental care for adults

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

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

Durable medical equipment (DME)

Examples of these items are:

- Whirlpools
- Portable whirlpool pumps
- Sauna baths
- Massage devices
- Over bed tables
- Elevators
- Communication aids
- Vision aids
- Telephone alert systems
- Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician

Early intensive behavioral interventions

Examples of these services are:

- Certain early intensive behavioral interventions (Denver, LEAP, TEACCH, Rutgers, floor time, Lovaas and similar programs) and other intensive educational interventions

Educational services

Examples of these services are:

- Any service or supply for education, training or retraining services or testing. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment program
  - Job training
  - Job hardening programs
- Services provided by a governmental school district

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

Experimental or investigational

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

Emergency services and urgent care

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

Facility charges

For care, services or supplies provided in:

- Rest homes
- Assisted living facilities, except if you have an acquired brain injury. See the Specific therapies and tests section.
- Similar institutions serving as a persons' main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

Family planning services - other

- Abortion except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger
- Reversal of voluntary sterilization procedures, including related follow-up care
- Family planning services received while confined as an inpatient in a hospital or other facility
- Services provided as a result of complications resulting from a male voluntary sterilization procedure and related follow-up care

Felony

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

Gender reassignment (sex change) treatment

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

Genetic care

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

Growth/Height care

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

Hearing aids and exams

The following services or supplies:

- A replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within the prior 24 month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- Cochlear implants
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist
- Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay
- Any tests, appliances and devices to:
  - Improve your hearing. This includes hearing aid batteries, amplifiers, and auxiliary equipment
  - Enhance other forms of communication to make up for hearing loss or devices that simulate speech

Home health care

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

Hospice care

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

Incidental surgeries

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

Jaw joint disorder

- Non-surgical treatment of Temporomandibular joint dysfunction disorder (TMJ)

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

Medicare

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

Mental health treatment

- Mental health services for the following categories (or equivalent terms as listed in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association):
  - Stays in a facility for treatment of dementias and amnesia without a behavioral disturbance that necessitates mental health treatment
  - Sexual deviations and disorders except for gender identity disorders
  - Tobacco use disorders except as described in the *Eligible health services under your plan – Preventive care and wellness* section
  - Pathological gambling, kleptomania, pyromania
  - School and/or education service including special educational, remedial education, wilderness treatment programs, or any such related or similar programs
  - Services provided in conjunction with school, vocation, work or recreational activities
  - Transportation

Motor vehicle accidents

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

Non-medically necessary services and supplies

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

Non-U.S .citizen

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

Obesity (bariatric) surgery

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

Organ removal

- Services and supplies given by a provider to remove an organ from your body for the purpose of donating or selling the organ except as described in the Eligible health services under your plan section. This does not apply if you are donating the organ to a spouse, domestic partner, civil union partner, child partner, brother, sister, or parent.

Personal care, comfort or convenience items

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

Private duty nursing (outpatient only)

Prosthetic devices

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

Riot

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

Routine exams

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

School health services

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

  Pharmacy or by health professionals who
  - Are employed by
  - Are Affiliated with
  - Have an agreement or arrangement with, or
  - Are otherwise designated by the policyholder.

Services provided by a family member

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

Sinus surgery

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

Sleep apnea

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

Sports

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

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

Therapies and tests

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

Tobacco cessation

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

Treatment in a federal, state, or governmental entity

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

Treatment of infertility

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

Vision Care

Pediatric vision care services and supplies

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

Adult vision care

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

Adult vision care services and supplies

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

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

Work related illness or injuries

- Coverage available to you under worker's compensation or under a similar program under local, state or federal law for any illness or injury related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered "non-occupational" regardless of cause.

Exceptions and exclusions that apply to outpatient prescription drugs

Contraceptive methods, procedures, services, and supplies for contraceptive purposes

• Contraceptive methods, procedures, services, and supplies for contraceptive purposes as elected by the policyholder due to an exemption or accommodation in accordance with applicable federal or state law and regulation

• Services provided as a result of complications resulting from voluntary sterilization procedure and related follow-up care

Drugs or medications

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

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.

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 Houston Community College, and may be viewed online at www.aetnastudenthealth.com.

Directory

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

Aetna, Student Health
151 Farmington Avenue
Hartford, CT 06156

Aetna service areas

The approximate number of students and their dependents insureds in Aetna's service area for Dallas, Austin, Houston and additional areas is 5,426. The numbers of available providers in Aetna's service area for the following provider areas are indicated below:

Service Area	Provider Type: Psychiatry	Provider Type: Anesthesiology	Provider Type: Family Medicine	Provider Type: General Practice	Provider Type: Internal Medicine	Provider Type: General Surgery	Provider Type: Obstetrics & Gynecology	Provider Type: Pediatric PCPs
Abernathy			1	1	1			
Abilene	47	33	56	56	56	9	14	17
Addison	20	157	14	14	14			1
Alamo			7	7	7		1	5
Albany	1		3	3	3			
Aledo	3		2	2	2			3
Alfred			1	1	1			
Alice	2	1	11	11	11	2	2	6
Allen	65	86	30	30	30	7	8	13
Alpine			4	4	4	4	3	1
Alton	3		6	6	6		1	6
Alvarado			1	1	1			
Alvin	8		21	21	21		1	9
Alvord			3	3	3			
Amarillo	78	86	116	116	116	28	30	25
Anahuac		1	4	4	4			
Andrews		1	6	6	6	1		
Angleton	28	141	10	10	10	2	21	3
Anson	1		3	3	3			
Aransas Pass	11	2	6	6	6			2
Argyle	1					1		
Arlington	162	231	148	148	148	26	52	73
Aspermont	3		2	2	2			
Atascocita			3	3	3			9
Athens	6	19	30	30	30	2	4	1
Atlanta	1		12	12	12			
Aubrey			4	4	4			
Austin	534	387	441	441	441	79	175	167
Azle	3		11	11	11	1		1
Baird			2	2	2			
Ballinger			5	5	5			
Bandera	2		6	6	6			
Bartonville	1		2	2	2			1
Bastrop	17	7	16	16	16	2	6	2
Bay City	14	6	9	9	9	2	4	4

Baytown	48	165	76	76	76	10	10	38
Beaumont	147	10	61	61	61	16	22	16
Bedford	66	124	40	40	40	10	22	6
Bedias	1							
Bee Cave	1		3	3	3			
Bee Caves		1						
Beeville	4	3	13	13	13	3	1	2
Bellaire	44	54	26	26	26	16	15	33
Bellmead			4	4	4			
Bells			1	1	1			
Bellville		1	15	15	15			
Belton	16		25	25	25	1	2	3
Benbrook	2		9	9	9			
Bertram	1		1	1	1			
Big Sandy	1		1	1	1			
Big Spring	3		17	17	17	7	3	4
Big Wells			1	1	1			
Blanco			3	3	3			
Bluff Dale	2							
Boerne	16	2	19	19	19	3	6	8
Bonham	2		5	5	5	1		
Booker			1	1	1			
Borger	1	3	6	6	6	4	2	2
Bowie	3		5	5	5	1		
Boyd	1		3	3	3			
Brady		1	5	5	5			
Brazoria			1	1	1			
Breckenridge	1		6	6	6			
Bremond			1	1	1			1
Brenham	6	8	39	39	39	3	4	5
Bridge City			4	4	4			
Bridgeport		1	6	6	6	2		
Brookshire	2							
Brookeland			2	2	2			
Brownfield			5	5	5			
Brownsville	16	22	68	68	68	10	26	37
Brownwood	11	1	21	21	21	2	6	3
Bryan	26	52	92	92	92	6	12	7
Buda	6	5	3	3	3			2
Buffalo			9	9	9			
Bullard	1		4	4	4			
Bulverde	2		3	3	3			1
Burkburnett			4	4	4			

Burleson	55	13	35	35	35	4	12	7
Burnet	2	1	6	6	6	2	1	
Caldwell			23	23	23			
Cameron	1	7	23	23	23	3	7	4
Canadian			4	4	4			
Canton	2		11	11	11	1		
Canutillo	2		7	7	7			3
Canyon	1		6	6	6			
Canyon Lake	2		3	3	3			
Carrizo Springs			8	8	8	1	1	1
Carrollton	25	30	68	68	68	15	9	26
Carthage			14	14	14		2	1
Castle Hills			1	1	1			
Castroville	2		18	18	18			
Cedar Hill	8		19	19	19	3	4	8
Cedar Park	18	228	56	56	56	8	13	22
Celina			1	1	1		5	6
Center	3		7	7	7			
Center Point	12							
Centerville			2	2	2			
Chandler			5	5	5			
Channelview	1	1	7	7	7			
Chappell Hill	1							
Cherokee	1							
Childress	1	1	7	7	7	1		
China			1	1	1			
China Spring			1	1	1			
Cisco	1		3	3	3			
Clarendon			1	1	1			
Clarksville		4	4	4	4			
Claude			1	1	1			
Clean Lake Shores	1							
Cleburne	18	16	22	22	22	4	3	1
Cleveland	3	42	14	14	14	1	2	6
Clifton			8	8	8			
Clint								1
Clyde			2	2	2			1
Coldspring			2	2	2			

Coleman	2		4	4	4			
College Station	24	68	107	107	107	7	22	21
Colleyville	18	1	37	37	37	2	4	1
Colorado City			3	3	3	1		
Columbus		5	10	10	10	2	1	1
Comanche			7	7	7	1		
Comfort	1		6	6	6	2		
Commerce			4	4	4			
Conroe	28	22	56	56	56	8	15	39
Converse	54		2	2	2			2
Cooper			2	2	2			
Coppell	10	2	16	16	16		1	13
Copperas Cove	5	4	8	8	8			1
Corinth	4		6	6	6			2
Corpus Christi	84	71	126	126	126	25	49	62
Corsicana	10	11	13	13	13	3	7	4
Cotulla			3	3	3			1
Crandall								1
Crane			3	3	3			
Crockett		4	18	18	18	1		
Crosby	1		2	2	2			
Crosbyton								1
Cross Plains	1		3	3	3			
Crossroads	3		5	5	5		3	1
Crowell			2	2	2			
Crowley	1		10	10	10			
Crystal Beach			1	1	1			
Crystal City			5	5	5			2
Cuero		1	15	15	15	3	1	
Cypress	27	29	56	56	56	6	15	55
Daingerfield			1	1	1			
Dalhart	1		5	5	5	2		1
Dallas	547	982	571	571	571	186	302	197
Dayton			3	3	3		1	
De Kalb			1	1	1			
De Leon	3		5	5	5			
Decatur	15	3	16	16	16	6	5	3
Deer Park	4		7	7	7		2	

Del Rio	2		11	11	11	2	2	4
Del Valle								1
Denison	8	40	19	19	19	5	5	7
Denton	83	98	60	60	60	16	43	19
Denver City	1		3	3	3	1	1	
Deport			1	1	1			
DeSoto	15		14	14	14	4	4	7
Devine	1		9	9	9			
Dickinson	8	139	15	15	15		18	3
Dilley			3	3	3			1
Dimmitt			6	6	6			
Donna			11	11	11			13
Double Oak			2	2	2			
Douglass	1							
Dripping Springs	6		5	5	5			2
Dublin			1	1	1			
Dumas	1	2	11	11	11	1	4	
Duncanville	19	3	11	11	11	5	2	2
Eagle Lake		4	3	3	3			
Eagle Pass			10	10	10	2	2	1
Early			3	3	3		1	
East Bernard			2	2	2			
Eastland			6	6	6			
Edcouch	1		3	3	3			
Eden			1	1	1			
Edgewood	1							
Edinburg	33	5	53	53	53	15	18	43
Edna		1	3	3	3			1
El Campo	1	6	10	10	10	1		2
El Paso	175	253	209	209	209	57	85	89
Eldorado			1	1	1			
Elgin			8	8	8	1	1	1
Elkhart			8	8	8			
Elsa	1		4	4	4			4
Emory	2		3	3	3			
Ennis	3	3	10	10	10	1	4	6
Euless	10		27	27	27	1	12	1
Fabens			7	7	7		1	2
Fairfield	1		7	7	7			
Falfurrias			3	3	3			1

Farmers Branch	3	1	9	9	9		1	1
Farmersville			4	4	4			
Fate	1							
Ferris			2	2	2			
Flatonia	1		1	1	1			
Flint			12	12	12			
Floresville	3		20	20	20	2	2	1
Flower Mound	19	19	52	52	52	8	26	21
Floydada			1	1	1			
Forest Hill			1	1	1			
Forney	12		12	12	12	2	3	6
Fort Davis			1	1	1			
Fort Hancock			1	1	1			
Fort Stockton		1	9	9	9	1	1	1
Fort Worth	334	500	356	356	356	89	144	114
Franklin			9	9	9		1	
Frankston			1	1	1			
Fredericksburg	4	31	23	23	23	5	2	2
Freeport	9							
Freer			1	1	1			
Fresno	1							
Friendswood	25	4	19	19	19	5	5	36
Friona			2	2	2			
Frisco	15	258	83	83	83	15	58	42
Fulshear			1	1	1			3
Gainesville	6	3	10	10	10	2	4	1
Galveston	68	78	78	78	78	27	44	41
Ganado			1	1	1			
Garden Ridge	5							
Garland	26	69	89	89	89	15	8	45
Gatesville	2	1	20	20	20	1		3
George West			1	1	1			
Georgetown	48	14	53	53	53	6	9	8
Giddings	3		8	8	8	4		1
Gilmer	2		7	7	7			

Gladewater			10	10	10			
Glen Rose	2		9	9	9	1		
Goldthwaite			8	8	8			
Goliad	1		4	4	4			
Gonzales			7	7	7	2	3	2
Gordon			1	1	1			
Gorman			1	1	1			
Graham	3		7	7	7	1	1	
Granbury	19	16	18	18	18	2	8	5
Grand Prairie	8	110	47	47	47	3	8	12
Grand Saline			2	2	2			
Grandview			1	1	1			
Granger			1	1	1			
Grapevine	29	93	30	30	30	20	37	20
Greenville	30	2	24	24	24	7	5	5
Groesbeck	1		5	5	5			
Groves			4	4	4			
Groveton			1	1	1			
Gun Barrel City	1		9	9	9			
Hale Center			5	5	5			
Hallettsville		9	5	5	5			
Hallsville			2	2	2	1		
Haltom City	3		4	4	4		5	
Hamilton		1	9	9	9	1		
Hamlin			2	2	2			
Harker Heights	17	4	16	16	16	1	6	12
Harlingen	14	22	82	82	82	5	19	32
Haskell			4	4	4			
Haslet	3		2	2	2			3
Hawkins	1		6	6	6			
Hearne	1		26	26	26		1	
Heath		35	7	7	7	1		
Hebbronville			3	3	3		7	1
Helotes	9		4	4	4			2
Hemphill			6	6	6			
Hempstead			3	3	3			
Henderson	4	3	20	20	20	1	3	2
Henrietta		28	4	4	4			
Hereford	2		11	11	11	1	1	2

Hewitt			3	3	3			
Hickory Creek	3		3	3	3			
Hico			7	7	7			
Highland Village	9	1	15	15	15			4
Highlands			2	2	2			
Hillsboro	1		9	9	9	1	1	1
Hitchcock			1	1	1			
Hondo	2	10	11	11	11	2		
Honey Grove			2	2	2			
Horizon City	1		1	1	1		1	4
Horseshoe Bay			3	3	3			
Houston	1171	1482	1201	1201	1201	305	512	534
Hughes Springs			4	4	4			
Huffman	1							
Humble	40	169	47	47	47	6	8	46
Hunt	2		1	1	1			
Huntington			1	1	1			
Huntsville	8	1	21	21	21	5	4	
Hurst	34	150	14	14	14	5	3	14
Hutto	3		5	5	5			5
Idalou			1	1	1			
Ingleside	2		2	2	2			1
Iowa Park			1	1	1			
Iraan			2	2	2			
Irving	82	102	117	117	117	24	39	30
Italy			1	1	1			
Jacksboro			8	8	8			
Jacksonville	6	29	34	34	34	5	3	5
Jasper	5		13	13	13	1		1
Jayton			5	5	5			
Jefferson	1		6	6	6			
Joaquin			1	1	1			
Johnson City			3	3	3			
Joshua			7	7	7			
Jourdanton		5	4	4	4	2	2	2
Junction			2	2	2			

Justin			2	2	2			
Karnes City			1	1	1			
Katy	66	202	74	74	74	14	25	74
Kaufman	3	4	12	12	12	5	1	1
Keene			2	2	2			
Keller	36	20	36	36	36	8	12	21
Kemp	1		1	1	1			
Kenedy	1		7	7	7			
Kennedale			1	1	1			
Kermit			1	1	1			
Kerrville	18	11	38	38	38	6	8	3
Kilgore			19	19	19			
Killeen	72	157	55	55	55	6	11	22
Kingsland	1		8	8	8			
Kingsville	3	6	7	7	7	1	3	3
Kingwood	61	36	47	47	47	8	28	44
Kirbyville			4	4	4			
Knox City			3	3	3			
Kountze			1	1	1			
Krugerville			1	1	1			
Krum	1		1	1	1			
Kyle	9	214	22	22	22	13	10	8
La Feria			2	2	2			
La Grange	2	2	9	9	9	4	2	2
La Joya			1	1	1			
La Marque	1		2	2	2			
La Mesa	1		2	2	2			1
La Porte			4	4	4			1
La Vernia			3	3	3		1	
Lago Vista			2	2	2			
Laguna Vista	1		1	1	1			
Lake Dallas		1						
Lake Jackson	24	43	16	16	16	3	5	6
Lake Worth	2		2	2	2		3	3
Lakehills			1	1	1			
Lakeway	6	2	4	4	4	1	2	2
Lamesa			6	6	6	2		1
Lampasas	1	9	10	10	10	2		1
Lancaster	2	1	6	6	6	1		1
Laredo	7	4	57	57	57	10	24	18
Lavon			1	1	1			

League City	56	46	52	52	52	18	26	26
Leander	3		11	11	11		1	1
Leonard			1	1	1			
Levelland			8	8	8	2	2	4
Lewisville	48	76	35	35	35	5	16	7
Lexington	1		19	19	19			
Liberty	7		7	7	7			
Liberty Hill	2		1	1	1			
Lindale	4	2	26	26	26	1		
Linden			6	6	6			
Little Elm	4		2	2	2			7
Littlefield			7	7	7			
Live Oak		18	7	7	7	4	1	1
Livingston	7	27	25	25	25	3	5	5
Llano	1	17	30	30	30	1	2	2
Lockhart	2		8	8	8	1	3	3
Lockney			6	6	6		1	
Lone Star			4	4	4			
Longview	30	91	68	68	68	10	29	20
Los Fresnos								1
Lubbock	60	113	143	143	143	40	40	54
Lucas								5
Lufkin	12	28	45	45	45	2	6	7
Luling		14	5	5	5	2	1	1
Lumberton	35		10	10	10			1
Lytle			11	11	11		1	1
Mabank			2	2	2			
Madisonville			21	21	21			
Magnolia	2		10	10	10		1	4
Malakoff			1	1	1			
Manchaca	7							
Manor			4	4	4		2	
Mansfield	40	25	36	36	36	14	33	19
Manvel	9		2	2	2			
Marathon			6	6	6			
Marble Falls	10	19	37	37	37	3	4	11
Marfa	1		5	5	5			
Marlin	1		3	3	3	1		1
Marshall	5	1	22	22	22	2	4	4
Mart			1	1	1			
Mathis			1	1	1			2

Mc Camey			2	2	2			
Mc Gregor	1		3	3	3	1		1
Mc Kinney	2		2	2	2			
McAllen	27	42	99	99	99	25	30	53
McKinney	111	149	70	70	70	18	26	38
Meadowlakes			1	1	1			
Medina	2							
Melissa			3	3	3			
Memphis			1	1	1			
Menard			1	1	1			
Mercedes	1		4	4	4			6
Meridian			1	1	1			
Merkel			1	1	1			
Mesquite	13	49	58	58	58	7	14	23
Mexia	1	11	4	4	4	1		1
Midland	31	2	57	57	57	11	29	40
Midlothian	5		17	17	17		1	5
Millsap			1	1	1			
Mineola	6		7	7	7			
Mineral Wells		17	18	18	18	7	6	2
Mission	6	3	52	52	52	2	7	23
Missouri City	28		22	22	22	1	2	11
Monahans		1	2	2	2			
Mont Belvieu			3	3	3			
Montgomery	1		11	11	11		1	4
Moody			1	1	1			
Morton			1	1	1			
Moulton			3	3	3			
Mountain Home	1							
Mt. Enterprise			2	2	2			
Mt. Pleasant	5	12	9	9	9	3	4	8
Mt. Vernon			3	3	3			
Muenster	1		4	4	4			
Muleshoe			7	7	7			1
Munday			1	1	1			
Murphy		1	8	8	8			4

Nacogdoches	20	15	31	31	31	8	8	8
Naples			1	1	1			
Nassau Bay	1		3	3	3	1	2	1
Navasota		45	30	30	30		1	
Nederland	11	1	20	20	20	1	5	
Needville	1		3	3	3			
New Boston			8	8	8			5
New Braunfels	42	9	45	45	45	13	11	19
New Caney	1							
Newton			1	1	1			1
Nixon			3	3	3			
Nocona			4	4	4			
Normangee			13	13	13		1	
North Richland Hills	9	71	24	24	24	5	6	1
Odessa	16	52	71	71	71	9	23	22
Olney		1	2	2	2			
Olton			2	2	2			
Orange	23	3	15	15	15			2
Orange Grove			2	2	2			1
Ore City			1	1	1			
Overton	2	1	4	4	4			
Ovilla	1		1	1	1			
Ozona			1	1	1			
Paducah			1	1	1			
Palacios			2	2	2			
Palestine	7	19	24	24	24	2	4	5
Palmhurst								2
Palmview			3	3	3			1
Pampa	2		9	9	9	3	2	1
Panhandle			1	1	1			
Pantego	3							
Paris	19	18	25	25	25	6	9	6
Pasadena	30	44	65	65	65	14	21	57
Pearland	60	9	34	34	34	6	28	50
Pearsall	1		8	8	8			1
Pecos			4	4	4	1	1	

Penitas			2	2	2			
Perryton			6	6	6			
Pflugerville	11		28	28	28		2	6
Pharr	1		18	18	18		1	15
Pilot Point	1		1	1	1			
Pineland			1	1	1			
Pipe Creek			1	1	1			
Pittsburg	4	8	7	7	7		1	1
Plains			2	2	2	1		
Plainview	3	14	18	18	18	2	2	2
Plano	190	394	208	208	208	51	93	124
Pleasanton	3		19	19	19		1	1
Port Aransas			1	1	1			
Port Arthur	34		20	20	20	2	7	6
Port Isabel							1	1
Port Lavaca	1	24	10	10	10	1	2	1
Port Neches	2		7	7	7	1	1	
Porter	1		3	3	3			1
Portland	5		9	9	9			6
Poteet			1	1	1			
Poth			2	2	2			
Pottsboro			1	1	1			
Premont	1							
Presidio			6	6	6		1	1
Princeton			1	1	1			
Prosper	3		5	5	5	1		5
Quanah			2	2	2			
Quinlan			3	3	3			
Quitman	1		11	11	11			1
Rancho Viejo		1						
Raymondville	1		11	11	11		2	6
Red Oak		1	6	6	6			1
Refugio			4	4	4			
Rhome	1		1	1	1			
Richardson	91	176	76	76	76	12	32	27
Richland Hills	2						1	1
Richmond	8	31	14	14	14	4	11	10
Rio Grande			1	1	1		3	

Rio Grande City			10	10	10	10	2	11
Rio Hondo			1	1	1			
Rising Star			2	2	2			
River Oaks	16							
Roanoke	2		2	2	2			
Robinson	1		1	1	1			
Robstown			2	2	2		1	4
Roby			3	3	3			
Rockdale	1	12	25	25	25	3	7	4
Rockport	7		16	16	16	1		1
Rockwall	41	155	31	31	31	11	17	13
Roma			5	5	5			7
Rosebud			1	1	1			
Rosenberg	24		9	9	9		3	1
Rosharon			1	1	1			
Rotan			4	4	4			
Round Rock	87	387	87	87	87	24	42	54
Rowlett	7	68	17	17	17	8	12	8
Royse City	2		3	3	3	2		
Rusk			2	2	2			
Sachse			4	4	4	1		
Saginaw			6	6	6			1
Salado			3	3	3			1
San Angelo	42	36	66	66	66	6	14	14
San Antonio	768	569	621	621	621	164	229	231
San Augustine			4	4	4			
San Benito	1		12	12	12	1	1	6
San Diego			1	1	1			
San Elizario	2		4	4	4			3
San Juan			6	6	6		4	6
San Marcos	32	10	35	35	35	5	11	8
San Saba	1		4	4	4			
Sanderson			5	5	5			
Sanger			2	2	2			
Santa Fe	5		2	2	2			
Santa Rosa			9	9	9		1	3
Santo			1	1	1			
Schertz	1	5	14	14	14	2	20	15

Schulenburg			2	2	2	4		1
Scroggins			1	1	1			
Seabrook	4		2	2	2			
Seagoville			4	4	4			
Sealy	1		4	4	4			
Seguin	7	19	24	24	24	3	10	6
Selma	1		2	2	2	1		
Seminole	1	7	8	8	8	4	4	
Seven Points			1	1	1			
Seymour			2	2	2			1
Shady Shores	1							
Shallowater			1	1	1			
Shamrock			3	3	3			
Shavano Park			2	2	2			
Shenandoah	3	163	25	25	25	9	2	2
Shepherd			2	2	2			
Sherman	37	22	23	23	23	7	8	6
Shiner			3	3	3			
Silsbee			8	8	8			
Silverton			1	1	1			
Sinton	1		3	3	3			2
Slaton			1	1	1			
Smithville			3	3	3		1	3
Snyder	1		9	9	9			
Socorro								1
Somerville			4	4	4			
Sonora			3	3	3			
Sour Lake			1	1	1			
South Lake	1							
South Padre Island	1		1	1	1			
Southlake	55	181	42	42	42	12		12
Spearman			2	2	2	1		1
Splendora			4	4	4			
Spring	45	161	80	80	80	2	10	58
Spring Branch	4		2	2	2			
Springtown			2	2	2			
Spur			1	1	1			
Stafford	17		3	3	3	9	4	1

Stamford			4	4	4			
Stanton		9	2	2	2			
Stephenville	14	2	18	18	18	2	6	3
Stockdale	1		2	2	2			
Stratford			1	1	1			
Sudan			1	1	1			
Sugar Land	73	143	125	125	125	28	67	245
Sulphur Springs	8	4	14	14	14	5	4	5
Sumner	1							
Sundown			1	1	1			
Sunnyvale	2	28	7	7	7	1	4	12
Sunray			1	1	1			
Sweeny		1	9	9	9	2		
Sweetwater	5	4	11	11	11	2	1	
Taft			1	1	1			
Tahoka			2	2	2			
Tatum			4	4	4			
Taylor	3	144	24	24	24	1		1
Telephone	1							
Temple	45	206	112	112	112	29	20	55
Terrell	6	12	12	12	12	1	1	1
Texarkana	16	29	40	40	40	13	17	10
Texas City	33	6	35	35	35	2	7	8
Texline			1	1	1			
The Colony	10	118	13	13	13			2
The Hills	1							
The Woodlands	70	303	84	84	84	15	35	230
Three Rivers			1	1	1			
Throckmorton			1	1	1			
Timpson			1	1	1			
Tomball	17	179	34	34	34	3	7	14
Trinidad			1	1	1			
Trinity			3	3	3			1
Trophy Club	1	52	7	7	7			1
Troup						1		
Tulia			4	4	4			
Tyler	76	157	132	132	132	26	45	31

Universal City	9		5	5	5			
University Park		21						
Uvalde	2	4	10	10	10	3	1	1
Van	2		4	4	4			
Van Alstyne	1							
Van Horn			1	1	1			
Vanderpool	1							
Vernon	2	4	4	4	4	2	1	
Victoria	36	26	59	59	59	13	13	11
Vidor	1		3	3	3			
Vinton			3	3	3		1	
Waco	45	215	127	127	127	16	27	26
Waller			1	1	1			3
Wallis			1	1	1			
Waskom			1	1	1			
Watauga			6	6	6			
Waxahachie	23	22	28	28	28	13	9	6
Weatherford	15	25	28	28	28	3	5	3
Webster	29	13	46	46	46	15	36	215
Weimar			3	3	3			
Wellington			2	2	2			
Weslaco	3	4	34	34	34	3	8	22
West			2	2	2			
West Columbia			2	2	2			
West Lake Hills	4	3	1	1	1		1	1
Wharton	1	2	7	7	7	2	4	4
Wheeler			2	2	2			
Whitehouse			6	6	6	1		
Whitesboro			4	4	4			
Whitewright			1	1	1			
Whitney	1		3	3	3			
Wichita Falls	38	34	44	44	44	9	9	15
Willis			13	13	13		2	
Willow Park	8		5	5	5		7	4
Wills Point	2	3						

Wimberley	4		6	6	6			2
Windcrest	1							
Winnie			5	5	5		1	
Winnsboro	2	10	11	11	11	3		2
Winona	1							
Winters			4	4	4			
Wolfforth			2	2	2			
Woodsboro			1	1	1			
Woodville	2		5	5	5			2
Woodway	2	1	1	1	1			2
Wortham			1	1	1			
Suite 201			1	1	1			
Wylie	4		12	12	12	2		13
Yoakum		1	6	6	6	1		
Yorktown			1	1	1			
Zapata			6	6	6	1	7	1

Learn about our network demographics and local market access plans

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

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

Texas Department of Insurance Notice

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

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

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

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

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

The Houston Community College 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**.

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

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TTY: 711

To access language services at no cost to you, call 1-877-480-4161.
Para acceder a los servicios de idiomas sin costo, llame al 1-877-480-4161. (Spanish)
如欲使用免費語言服務，請致電 1-877-480-4161。(Chinese)
Afin d'accéder aux services langagiers sans frais, composez le 1 877 480-4161. (French)
Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-877-480-4161. (Tagalog)
Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-877-480-4161 an. (German)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-877-480-4161. (Arabic)
Pou jwenn sèvis lang gratis, rele 1-877-480-4161. (French Creole-Haitian)
Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-877-480 -4161. (Italian)

言語サービスを無料でご利用いただくには、1-877-480-4161 までお電話ください。(Japanese)

무료 언어 서비스를 이용하려면 1-877-480-4161 번으로 전화해 주십시오. (Korean)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-877-480-4161 تماس بگیرید. (Persian-Farsi)

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Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-877-480-4161. (Russian)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-877-480-4161. (Vietnamese)