Aetna Student Health
Plan Design and Benefits Summary

Preferred Provider Organization (PPO)

Sam Houston State University

Policy Year: 2023- 2024
Policy Number: 175364
www.aetnastudenthealth.com
(888) 407-0445

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

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

Sam Houston State University
Student Health Center
1608 Avenue J
Huntsville, TX 77340

Medical Clinic
8am to 5pm, Mon-Fri

Laboratory
8am to 5pm, Mon-Fri

Pharmacy
8am to 5pm, Mon-Fri

STUDENT HEALTH CENTER: The deductible will be waived, and covered expenses paid at 100% based upon Aetna allowable. Student prescription drug benefits at the Student Health Center provide coverage for medication prescribed for the treatment of acne, allergies and Mental Health Treatment if the medication is available on the Student Health formulary.

For more information, call the Health Services at **(936) 294-1805** , In the event of an emergency, call 911 or the Campus Police at **(936) 294-1000**

Student Coverage
Who is eligible?

Domestic & Distance Learning Students

All registered **Domestic Undergraduate Students** taking nine (9) or more credit hours (three (3) or more credit hours during summer sessions) to be eligible to participate in the plan on a voluntary basis.

All registered **Domestic Graduate Students, including College of Osteopathic Medicine** taking six (6) or more credit hours (three (3) or more credit hours during summer sessions) to be eligible to participate in the plan on a voluntary basis.

Distance Learning Students taking nine (9) or more credit hours and paying the SHSU Medical Services Fee are eligible to participate in the plan on a voluntary basis.

Voluntary coverage will only be sold by fall, spring/summer and summer semester, and student must meet eligibility requirements each semester. Dependent coverage is not offered for Domestic or Distance Learning Students.

International Students

All registered International Students taking one (1) or more credit hours are required to participate in this plan. International students are automatically enrolled, and the premium will be added to their tuition bill. All International Students with U.S. based employer and embassy plans are eligible to waive the plan as determined by the SHSU Student Health Services.

College of Osteopathic Students

All registered College of Osteopathic Medicine Students are automatically enrolled in the plan unless proof of comparable coverage is provided.

Visit the website shsu.myahpcare.com to enroll / renew your coverage online. For additional information, contact Student Health Services at (936) 294-1805.

You must actively attend classes for at least the first 31 days after the date your coverage becomes effective. You cannot meet this eligibility requirement if you take courses through:

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

Dependent Coverage
Eligibility

Dependent coverage is not offered for **Domestic or Distance Learning Students**

Eligible dependents of **International Students** may participate in the plan on a voluntary basis. Payment must be paid directly to Academic Health Plans and may not be billed to the student's account. Dependents will NOT automatically be re-enrolled. You will need to re-enroll them by each semester's deadline.

Dependent coverage is available for **College of Osteopathic Medicine Students**. Payment must be paid directly to Academic HealthPlans and may not be billed to the student's account. Dependents will NOT automatically be re-enrolled. You will need to re-enroll them by each semester's deadline

Coverage for all insured students and eligible dependents 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 for insured dependents terminates in accordance with the Termination Provisions described in the Certificate of Coverage.

Coverage Dates
Domestic & Distance Learning Students

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment Deadline
Fall	**08/15/2023**	**12/31/2023**	**09/13/2023**
Spring/Summer	**01/01/2024**	**08/14/2024**	**01/30/2024**
Summer	**05/08/2024**	**08/14/2024**	**06/11/2024**

Rates
Domestic & Distance Learning Students

	Fall	Spring/Summer	Summer
Student Only	$1,741.00	$2,843.00	$1,240.00

Coverage Dates
International Students

Coverage Period	Coverage Start Date	Coverage End Date	Enroll Deadline / Waive Deadline
Annual	08/15/2023	08/14/2024	Enroll/Waive deadline 09/13/2023
Spring/Summer	01/01/2024	08/14/2024	Enroll deadline 01/30/2024 Spring/Summer Waive deadline 01/30/2024

Rates
International Students

	Annual	Spring/Summer
Student	$2,193.00	$1,360.00
Spouse	$2,193.00	$1,360.00
Child	$2,193.00	$1,360.00
Child, Two or More	$4,386.00	$2,720.00

Coverage Dates
College of Osteopathic Medicine

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Fall	08/01/2023	12/31/2023	Enrollment/Waiver Deadline 08/01/2023
Spring/Summer	01/01/2024	07/31/2024	Enrollment Deadline 02/01/2024

Rates

College of Osteopathic Medicine

	Fall	Spring/Summer
Student	**$917.00**	**$1,276.00**
Spouse	**$917.00**	**$1,276.00**
Child	**$917.00**	**$1,276.00**
Child, Two or More	**$1,834.00**	**$2,552.00**

The rates above reflect premiums for the student health insurance plan, inclusive of administrative fees. This is prorated for other periods of enrollment.

Enrollment

To enroll online or obtain an enrollment application for voluntary coverage, log on to:

Domestic and Distance Learning Students - https://shsu-dom.myahpcare.com/

International Students - https://shsu-intl.myahpcare.com/

College of Osteopathic Medicine Students - https://shsu-com.myahpcare.com/

Important note regarding coverage for a newborn child, or adopted child:

- A newborn child - Your newborn child is covered on your health plan for the first 31 days from the moment of birth.
  - To keep your newborn covered, you must notify us (or our agent) of the birth and pay any required premium contribution during that 31-day period.
  - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional premium contribution for the newborn.
  - If you miss this deadline, your newborn will not have health benefits after the first 31 days.
  - If your coverage ends during this 31-day period, then your newborn's coverage will end on the same date as your coverage. This applies even if the 31-day period has not ended.

- An adopted child or a child legally placed with you for adoption - A child that you, or that you and your spouse or domestic partner adopts or is placed with you for adoption is covered on your plan for the first 31 days after you become party in a suit to adopt the child or the adoption or the placement is complete.
  - To keep your child covered, we must receive your completed enrollment information within 31 days after the adoption, after you become party in a suit to adopt the child, or after placement for adoption.
  - You must still enroll the child within 31 days of the adoption, you become party in a suit to adopt the child or placement for adoption even when coverage does not require payment of an additional premium contribution for the child.
  - If you miss this deadline, your adopted child, the child for whom you became a party in a suit to adopt, or the child placed with you for adoption will not have health benefits after the first 31 days.
  - If your coverage ends during this 31-day period, then coverage for your adopted child the child for whom you became a party in a suit to adopt, or the child placed with you for adoption will end on the same date as your coverage. This applies even if the 31-day period has not ended.

- A stepchild - You may put a child of your spouse or domestic partner on your plan.
  - You must complete your enrollment information and send it to us within 31 days after the date of your marriage or your Declaration of Domestic Partnership with your stepchild's parent.
  - Ask the policyholder when benefits for your stepchild will begin. It is either on the date of your marriage or the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.
  - To keep your stepchild covered, we must receive your completed enrollment information within 31 days after the date of your marriage or your Declaration of Domestic Partnership.
  - You must still enroll the stepchild within 31 days after the date of your marriage or your Declaration of Domestic Partnership even when coverage does not require payment of an additional premium contribution for the stepchild.
  - If you miss this deadline, your stepchild will not have health benefits after the first 31 days.
  - If your coverage ends during this 31-day period, then your stepchild's coverage will end on the same date as your coverage. This applies even if the 31-day period has not ended.

- Dependent coverage due to a court order: If you must provide coverage to a dependent because of a court order, your dependent is covered on your health plan for the first 31 days from the court order.
  - To keep your dependent covered, we must receive your completed enrollment information within 31 days of the court order.
  - You must still enroll the dependent within 31 days of the court order even when coverage does not require payment of an additional premium contribution for the dependent.
  - If you miss this deadline, your dependent will not have health benefits after the first 31 days.
  - If your coverage ends during this 31-day period, then your dependent's coverage will end on the same date as your coverage. This applies even if the 31-day period has not ended.

If you need information or have general questions on dependent enrollment, call Member Services at 1-888-407-0445.

Termination and Refunds

Withdrawal from Classes – Leave of Absence: If you withdraw from classes under a school-approved leave of absence, your coverage will remain in force through the end of the period for which payment has been received and no premiums will be refunded.

Withdrawal from Classes – Other than Leave of Absence: If you withdraw from classes other than under a school-approved leave of absence within 31 days after the policy effective date, you will be considered ineligible for coverage, your coverage will be terminated retroactively and any premiums collected will be refunded. If the withdrawal is more than 31 days after the policy effective date, your coverage will remain in force through the end of the period for which payment has been received and no premiums will be refunded. If you withdraw from classes to enter the armed forces of any country, coverage will terminate as of the effective date of such entry and a pro rata refund of premiums will be made if you submit a written request within 90 days of withdrawal from classes.

Medicare Eligibility Notice

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

Coordination of Benefits (COB)

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

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

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

In-network Provider Network

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

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

Preauthorization

You need pre-approval from us for some eligible health services. Pre-approval is also called preauthorization. Your in-network physician is responsible for obtaining any necessary preauthorization before you get the care. When you go to an out-of-network provider, it is your responsibility to obtain preauthorization from us for any services and supplies on the preauthorization list. If you do not preauthorize when required, there is a **$500** penalty for each type of eligible health service that was not preauthorized. For a current listing of the health services or prescription drugs that require preauthorization, contact Member Services or go to **www.aetna.com**.

Preauthorization call

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

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

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

Description of Benefits

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

Policy year deductible	In-network coverage	Out-of-network coverage
You have to meet your policy year deductible before this plan pays for benefits.		
Student	$500 per policy year	$1,000 per policy year
Spouse	$500 per policy year	$1,000 per policy year
Each child	$500 per policy year	$1,000 per policy year
Family	$1,000 per policy year	$2,000 per policy year

Policy Year Deductible Provisions

Eligible health services applied to the out-of-network policy year deductibles will not be applied to satisfy the in-network policy year deductibles. Eligible health services applied to the in-network policy year deductibles will not be applied to satisfy the out-of-network policy year deductibles.

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

Family deductible

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

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

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

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

Policy year deductible waiver

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

- In-network care for Preventive care and wellness, Physician and specialist services office visits, Consultant services office visits, Walk-in clinic visits, Urgent Care, Outpatient Mental Health & Substance Abuse Treatment Office Visits, and Pediatric Vision Care services
- In-network care and out-of-network care for Hospital Emergency Room, Pediatric Dental Type A services, Well newborn nursery care and Outpatient prescription drugs

Maximum out-of-pocket limits	In-network coverage	Out-of-network coverage
Student	$7,350 per policy year	$15,000 per policy year
Spouse	$7,350 per policy year	$15,000 per policy year
Each child	$7,350 per policy year	$15,000 per policy year
Family	$14,700 per policy year	$30,000 per policy year

Eligible health services	In-network coverage	Out-of-network coverage
Routine physical exams		
Performed at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Covered persons age 22 and over: Maximum visits per policy year	1 visit	
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 in to your Aetna website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Preventive care immunizations		
Performed in a facility or at a physician's office No policy year deductible or copayment applies for children from birth through age 6	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximums	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging onto your Aetna member website at www.aetnastudenthealth.com or calling the number on the back of your ID card.	
The following is not covered under this benefit: • Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment or travel		

Eligible health services	In-network coverage	Out-of-network coverage
Routine gynecological exams (including Pap smears and cytology tests)		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Additional Well women exam maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. • 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. For women over age 60 depending on risk factors.	
Maximum visits per policy year	1 visit	
Preventive screening and counseling services		
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Use of Tobacco Products, Depression Screening, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Obesity and/or healthy diet counseling - Maximum visits	Age 0-22: unlimited visits. Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	
Misuse of alcohol and/or drugs counseling - Maximum visits per policy year	5 visits	
Use of tobacco products counseling Maximum visits per policy year-	8 visits	
Depression screening counseling - Maximum visits per policy year	1 visit	
Sexually transmitted infection counseling - Maximum visits per policy year	2 visits	
Genetic risk counseling for breast and ovarian cancer limitations	Not subject to any age or frequency limitations	

Eligible health services	In-network coverage	Out-of-network coverage
Preventive screening and counseling services (continued)		
Routine cancer screenings	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Mammogram Maximums	Mammogram: 1 mammogram every 12 months for covered persons age 35 and older. When diagnostic imaging is used to evaluate a breast abnormality or where there is a personal history of breast cancer or dense breast tissue it is not subject to any age or frequency limitations.	
Prostate specific antigen (PSA) test maximums	Prostate specific antigen (PSA) test maximums: 1 Prostate Specific Antigen (PSA) test every 12 months for covered persons age 50 and older. 1 PSA test every 12 months for covered persons age 40 and older with a family history of prostate cancer, or other risk factor	
Additional Maximums	Subject to any age, family history, and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration	
Lung cancer screening maximum	1 screening every 12 months	
Prenatal care services (Preventive care services only)	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Lactation support and counseling services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits	
Breast pump supplies and accessories	100% (of the negotiated charge) per item No copayment or policy year deductible applies	60% (of the recognized charge) per item

Eligible health services	In-network coverage	Out-of-network coverage
Family planning services –contraceptives - Counseling services		
Contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Contraceptive counseling services maximum visits per policy year either in a group or individual setting	2 visits	
Female contraceptive prescription drugs and devices provided, administered, or removed, by a provider during an office visit	100% (of the negotiated charge) per item No copayment or policy year deductible applies	60% (of the recognized charge) per item
Female Voluntary sterilization - Inpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	60% (of the recognized charge)
Female Voluntary sterilization - Outpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
The following are not covered under this benefit: • Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care • Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA • Male contraceptive methods, sterilization procedures or devices, except for male condoms prescribed by a provider		
Physicians and other health professionals		
Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist, includes telemedicine, teledentistry or telehealth consultations)	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
Allergy testing and treatment		
Allergy testing performed at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Allergy injections treatment performed at a physician's or specialist's office	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
The following are not covered under this benefit: • Allergy sera and extracts administered via injection		

Eligible health services	In-network coverage	Out-of-network coverage
Physician and specialist surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge)	60% (of the recognized charge)
The following are not covered under this benefit: • The services of any other physician who helps the operating physician • A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section) • Services of another physician for the administration of a local anesthetic		
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
The following are not covered under this benefit: • The services of any other physician who helps the operating physician • A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic		
Alternatives to physician office visits		
Walk-in clinic visits (non-emergency visit)	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
Hospital and other facility care		
Inpatient hospital (room and board, including intensive care, and other miscellaneous services and supplies) Includes birthing center facility charges	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
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
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Alternatives to hospital stays		
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	80% (of the negotiated charge)	60% (of the recognized charge)
The following are not covered under this benefit: • The services of any other physician who helps the operating physician • A stay in a hospital (See the *Hospital care – facility charges* benefit in this section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic		
Home Health Care	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Maximum visits per policy year	60 visits	
The following are not covered under this benefit: • Services for infusion therapy • Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities) • Transportation • Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present • Homemaker or housekeeper services • Food or home delivered services • Maintenance therapy		
Hospice - Inpatient	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Hospice - Outpatient	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
The following are not covered under this benefit: • Funeral arrangements • Pastoral counseling • Respite care • Financial or legal counseling which includes estate planning and the drafting of a will • Homemaker or caretaker services that are services which are not solely related to your care and may include: - Sitter or companion services for either you or other family members - Transportation - Maintenance of the house		
Skilled nursing facility - Inpatient	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Maximum days of confinement per policy year	25 days	

Eligible health services	In-network coverage	Out-of-network coverage
Emergency services and urgent care		
Hospital emergency room	$150 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit No policy year deductible applies	Paid the same as in-network coverage
Non-emergency care in a hospital emergency room	Not covered	Not covered
Important note: • As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment/coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on the back of your ID card or call Member Services for an address at 1-888-407-0445 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.		
The following are not covered under this benefit: • Non-emergency services in a hospital emergency room facility, freestanding emergency medical care facility or comparable emergency facility		
Urgent care	$50 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
Non-urgent use of an urgent care provider	Not covered	Not covered
The following is not covered under this benefit: • Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)		

Eligible health services	Contracting dental provider coverage	Non-contracting dental provider coverage
Pediatric dental care **Limited to covered persons through the end of the month in which the person turns age 19.** The payment or reimbursement for services rendered by a dentist of a non-contracting dental provider shall be reimbursed the same as a contracting dental provider		
Type A services	100% (of the negotiated charge) per visit No copayment or deductible applies	100% (of the recognized charge) per visit No copayment or deductible applies
Type B services	80% (of the negotiated charge) per visit	80% (of the recognized charge) per visit
Type C services	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Orthodontic services	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Dental emergency 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

Pediatric dental care exclusions

The following are not covered under this benefit:

- Any instruction for diet, plaque control and oral hygiene
- Asynchronous dental treatment
- Cosmetic services and supplies including:
  - Plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance
  - Augmentation and vestibuloplasty, and other substances to protect, clean, whiten, bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons, except to the extent coverage is specifically provided in the Eligible health services and exclusions section
  - Facings on molar crowns and pontics will always be considered cosmetic
- Crown, inlays, onlays, and veneers unless:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants and braces (that are determined not to be medically necessary), mouth guards, and other devices to protect, replace or reposition teeth
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - For splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint dysfunction disorder (TMJ) and craniomandibular joint dysfunction disorder (CMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Eligible health services and exclusions – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another eligible health service

(continued on next page)

Pediatric dental care exclusions (continued)

The following are not covered under this benefit:

- Mail order and at-home kits for orthodontic treatment
- Orthodontic treatment except as covered above and in the *Pediatric dental care* section of the schedule of benefits
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication or analgesia (nitrous oxide)
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Routine dental exams and other preventive services and supplies, except as specifically provided in the *Pediatric dental care* section of the schedule of benefits
- Services and supplies:
  - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
  - Provided for your personal comfort or convenience or the convenience of another person, including a provider
  - Provided in connection with treatment or care that is not covered under your policy
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a dental provider that is legally qualified to furnish dental services or supplies

Eligible health services	In-network coverage	Out-of-network coverage
Specific conditions		
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Impacted wisdom teeth	80% (of the negotiated charge)	80% (of the recognized charge)
Accidental injury to sound natural teeth	80% (of the negotiated charge)	80% (of the recognized charge)
The following are not covered under this benefit: • The care, filling, removal or replacement of teeth and treatment of diseases of the teeth • Dental services related to the gums • Apicoectomy (dental root resection) • Orthodontics • Root canal treatment • Soft tissue impactions • Bony impacted teeth • Alveolectomy • Augmentation and vestibuloplasty treatment of periodontal disease • False teeth • Prosthetic restoration of dental implants • Dental implants		
Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Dental implants		

Eligible health services	In-network coverage	Out-of-network coverage
Specific conditions (continued)		
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 (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
Dermatology	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Cosmetic treatment and procedures		
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
The following are not covered under this benefit: • Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries		
Well newborn nursery care in a hospital or birthing center	80% (of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies
Family planning services – other		
Voluntary sterilization for males - surgical services - Inpatient	80% (of the negotiated charge)	60% (of the recognized charge)
Voluntary sterilization for males - surgical services - Outpatient	80% (of the negotiated charge)	60% (of the recognized charge)
The following are not covered under this benefit: • Abortion except when the pregnancy places the woman's life in serious danger or poses a serious risk of substantial impairment of a major bodily function • Reversal of voluntary sterilization procedures, including related follow-up care • Services provided as a result of complications resulting from a male voluntary sterilization procedure and related follow-up care		
Gender affirming treatment		
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not eligible health services under this benefit: • Any treatment, surgery, service or supply that is not listed in the certificate as eligible health services		
Autism spectrum disorder		
Autism spectrum disorder treatment, diagnosis and testing and Applied behavior analysis	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Eligible health services	In-network coverage	Out-of-network coverage
Mental Health & Substance Abuse Treatment		
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Outpatient office visits (includes telemedicine or telehealth consultations)	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

Eligible health services	In-network coverage Network (IOE facility)	In-network coverage Network (Non-IOE facility)	Out-of-network coverage 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		
Inpatient and outpatient transplant physician and specialist services	Covered according to the type of benefit and the place where the service is received		
The following are not covered under this benefit: • Services and supplies furnished to a donor when the recipient is not a covered person • Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness • Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness			

Eligible health services	In-network coverage	Out-of-network coverage
Treatment of infertility		
Basic infertility services - Inpatient and outpatient 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
The following are not covered services under the infertility treatment benefit: • Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists. • All charges associated with: - Surrogacy for you or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father - Cryopreservation (freezing) and storage of eggs, embryos, sperm, or reproductive tissue - Thawing of cryopreserved (frozen) eggs, sperm, or reproductive tissue - 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 - Home ovulation prediction kits or home pregnancy tests - The purchase of donor embryos, donor oocytes, or donor sperm - Reversal of voluntary sterilizations, including follow-up care • Ovulation induction with menotropins, Intrauterine insemination and any related services, products or procedures • In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), Cryopreserved embryo transfers and any related services, products or procedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery)		
Specific therapies and tests		
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	80% (of the negotiated charge)	60% (of the recognized charge)
Diagnostic lab work and radiological services performed in a physician's office, the outpatient department of a hospital or other facility	80% (of the negotiated charge)	60% (of the recognized charge)
Diagnostic follow-up care related to newborn hearing screening	80% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit No policy year deductible applies
Cardiovascular disease testing	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Maximum visits per policy year	1 screening every 5 years Limited to: Men age 45 and over but less than 76 and women age 55 and over but less than 76	
Outpatient Chemotherapy, Radiation & Respiratory Therapy	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Specific therapies and tests (continued)		
Outpatient infusion therapy performed in a covered person's home, physician's office, outpatient department of a hospital or other facility	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan • Enteral nutrition • Blood transfusions and blood products • Dialysis		
Oral anti-cancer prescription drugs	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Outpatient infusion therapy performed in a covered person's home, physician's office, outpatient department of a hospital or other facility	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy) Combined for short-term rehabilitation services and habilitation therapy services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Chiropractic services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Other services and supplies		
Emergency ground, air, and water ambulance	80% (of the negotiated charge) per trip	Paid the same as in-network coverage
The following are not covered under this benefit: • Ambulance services for routine transportation to receive outpatient or inpatient care		

Eligible health services	In-network coverage	Out-of-network coverage
Other services and supplies (continued)		
Durable medical and surgical equipment	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
The following are not covered under this benefit: • Whirlpools • Portable whirlpool pumps • Sauna baths • Massage devices • Over bed tables • Elevators • Communication aids • Vision aids • Telephone alert systems • Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician		
Nutritional support	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as described above		
Osteoporosis (non-preventive care) - Physician's or specialist's office visits	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Prosthetic Devices & Orthotics (includes Cranial prosthetics *(Medical wigs)*)	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
The following are not covered under Prosthetics benefit: • Services covered under any other benefit • Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace • Trusses, corsets, and other support items • Repair and replacement due to loss, misuse, abuse or theft • Communication aids • Cochlear implants The following are not covered services under Orthotics benefit: • Services covered under any other benefit • Repair and replacement due to loss, misuse, abuse or theft		

Eligible health services	In-network coverage	Out-of-network coverage
Other services and supplies (continued)		
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
The following are not covered under this benefit: • Services and supplies for: - The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies except for complications of diabetes. See the *Diabetic services and supplies (including equipment and training)* section. - Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet		
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
The following are not covered under this benefit: • Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs) • Services and supplies provided by the trial sponsor without charge to you • The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna's claim policies)		
Hearing aids and cochlear implants and related services		
Hearing aids and cochlear implants and related services	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Hearing aids maximum per ear	One per ear every three years	
Replacement of cochlear implant external speech processor and controller components	One per ear every three years	
The following are not covered under this benefit: • A replacement of: - A hearing aid that is lost, stolen or broken - A hearing aid installed within the prior 36-month period • Replacement parts or repairs for a hearing aid • Batteries or cords • A hearing aid that does not meet the specifications prescribed for correction of hearing loss • Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist or other provider not acting within the scope of their license		

Eligible health services	In-network coverage	Out-of-network coverage
Hearing aids and cochlear implants and related services (continued)		
Hearing exams	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Hearing exam maximum	1 hearing exam every policy year	
The following are not covered under this benefit: • Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay		
Pediatric vision care **Limited to covered persons through the end of the month in which the person turns age 19.**		
Pediatric routine vision exams (including refraction) performed by a legally qualified ophthalmologist, optometrist or therapeutic optometrist, or any other providers acting within the scope of their license Includes comprehensive low vision evaluations Includes visit for fitting of contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year Low vision Maximum Fitting of contact Maximum	1 visit One comprehensive low vision evaluation every policy year 1 visit	
Pediatric vision care services & supplies-Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per item No policy year deductible applies	60% (of the recognized charge) per item
Maximum number Per year: Eyeglass frames Prescription lenses Contact lenses (includes non-conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery)	One set of eyeglass frames One pair of prescription lenses Daily disposables: up to 3-month supply Extended wear disposable: up to 6-month supply Non-disposable lenses: one set	
Optical devices	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Maximum number of optical devices per policy year	One optical device	
***Important note**: Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.		
The following are not covered under this benefit: • Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes		

Outpatient prescription drugs

Outpatient prescription drug copayment waiver for risk reducing breast cancer drugs

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

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

The outpatient prescription drug copayment will not apply to the first two 90-day treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at a retail or mail order in-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%.

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

Outpatient prescription drug copayment waiver for contraceptives

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

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

- Certain over-the-counter (OTC) and generic contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%.
- If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drug or device for that method paid at 100%.

The outpatient prescription drug copayment will continue to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at an in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.

Eligible health services	In-network coverage	Out-of-network coverage
Preferred generic prescription drugs (including specialty drugs)		
For each fill up to a 30-day supply filled at a retail pharmacy	$20 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies
More than a 30-day supply but less than a 90-day supply filled at a mail order pharmacy	$50 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient prescription drugs (continued)		
Preferred brand-name prescription drugs (including specialty drugs)		
For each fill up to a 30-day supply filled at a retail pharmacy	$40 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies
More than a 30-day supply but less than a 90-day supply filled at a mail order pharmacy	$100 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies
Preferred generic prescription drugs (including specialty drugs)		
For each fill up to a 30-day supply filled at a retail pharmacy	$60 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies
More than a 30-day supply but less than a 90-day supply filled at a mail order pharmacy	$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies
Non-preferred brand-name prescription drugs (including specialty drugs)		
For each fill up to a 30-day supply filled at a retail pharmacy	$60 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies
More than a 30-day supply but less than a 90-day supply filled at a mail order pharmacy	$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient prescription drugs (continued)		
Diabetic insulin		
30-day supply at retail pharmacy	Paid according to the type of drug per the schedule of benefits above	Paid according to the type of drug per the schedule of benefits above
90-day supply at mail order pharmacy	Paid according to the type of drug per the schedule of benefits above	Paid according to the type of drug per the schedule of benefits above
Important note: Your cost share will not exceed $25.00 per 30-day supply of a covered prescription insulin drug filled at a network pharmacy. No deductible applies for insulin.		
Important note: When an emergency refill of diabetes supplies is provided, the emergency refill of insulin may not exceed a 30-day supply. The quantity of an emergency refill of insulin-related equipment or supplies may not exceed the lesser of a 30-day supply or the smallest available package.		
Orally administered anti-cancer prescription drugs For each fill up to a 30-day supply filled at a retail or mail order pharmacy	100% (of the negotiated charge No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
Contraceptives (birth control)		
For each fill up to a 30-day supply of generic and OTC drugs and devices filled at a retail or mail order pharmacy	100% (of the negotiated charge No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
For each fill up to a 30-day supply of brand name prescription drugs and devices filled at a retail or mail order pharmacy	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above
Preventive care drugs and supplements filled at a retail or mail order pharmacy For each 30–day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna website at www.aetnastudenthealth.com or calling the toll-free number on the back of your ID card.	

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

Outpatient prescription drugs exclusions

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

- Abortion drugs
- Allergy sera and extracts administered via injection
- Any services related to the dispensing, injecting or application of a drug
- Biological sera unless specified on the preferred drug guide
- Cosmetic drugs including medications and preparations used for cosmetic purposes
- Devices, products and appliances, except those that are specially covered
- Dietary supplements including medical foods
- Drugs or medications
  - Administered or entirely consumed at the time and place it is prescribed or provided
  - Which do not, by federal or state law, require a prescription order (i.e. over-the-counter (OTC) drugs), even if a prescription is written except as specifically provided above
  - That are therapeutically equivalent or therapeutically alternative to a covered prescription drug (unless a medical exception is approved)
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while an inpatient of a healthcare facility
  - Recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by our Pharmacy and Therapeutics Committee

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Outpatient prescription drugs exclusions (continued)

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

- Drugs or medications
  - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - For which the cost is covered by a federal, state, or government agency (for example: Medicaid or Veterans Administration)
  - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
  - That are used for the purpose of weight gain or reduction, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications
  - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the covered person meets one or more clinical criteria detailed in our preauthorization and clinical policies
- Duplicative drug therapy (e.g. two antihistamine drugs)
- Genetic care
  - Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects
- Immunizations related to travel or work
- Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate
- Implantable drugs and associated devices except as specifically provided above
- Infertility
- Injectable prescription drugs used primarily for the treatment of infertility
- Injectables
  - Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by us except as described in the Diabetic services and supplies (including equipment and training) section.
  - Needles and syringes, except for those used for insulin administration.
  - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting. This exception does not apply to Depo Provera and other injectable drugs used for contraception.
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- Prescription drugs:
  - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth, or prescription drugs for the treatment of a dental condition.
  - That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the preferred drug guide.
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the person identified on the ID card.
- Replacement of lost or stolen prescriptions
- Test agents except diabetic test agents
- Tobacco cessation drugs, unless recommended by the United States Preventive Services Task Force (USPSTF)

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Outpatient prescription drugs exclusions (continued)

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

- We reserve the right to exclude:
  - A manufacturer's product when the same or similar drug (that is, a drug with the same active ingredient or same therapeutic effect), supply or equipment is on the preferred drug guide
  - Any dosage or form of a drug when the same drug is available in a different dosage or form on our preferred drug guide

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

The request for an expedited review of an exigent circumstance may be submitted by contacting Aetna's *Pre-authorization Department* at **1-855-240-0535**, faxing the request to **1-877-269-9916**, or submitting the request in writing to:
CVS Health
ATTN: Aetna PA
1300 E Campbell Road
Richardson, TX 75081

General Exclusions

Abortion

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

Acupuncture

- Acupuncture
- Acupressure

Air or space travel

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

This exclusion does not apply if:

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

Alternative health care

- Services and supplies given by a provider for alternative health care. This includes but is not limited to aromatherapy, naturopathic medicine, herbal remedies, homeopathy, energy medicine, Christian faith-healing medicine, Ayurvedic medicine, yoga, hypnotherapy, and traditional Chinese medicine.

Armed forces
- Services and supplies received from a provider as a result of an injury sustained, or illness contracted, while in the service of the armed forces of any country. When you enter the armed forces of any country, we will refund any unearned pro rata premium.

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

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

Blood, blood plasma, synthetic blood, blood derivatives or substitutes
Examples of these are:
- The provision of blood to the hospital, other than blood derived clotting factors
- The services of blood donors, apheresis or plasmapheresis
- For autologous blood donations, only administration and processing expenses are covered

Clinical trial therapies (experimental or investigational)
- Your plan does not cover clinical trial therapies (experimental or investigational), except as described in the *Eligible health services and exclusions - Clinical trial therapies (experimental or investigational)* section

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

Cosmetic services and plastic surgery
- Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body.

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

Court-ordered testing
- Court-ordered testing or care unless medically necessary

Custodial care
Services and supplies meant to help you with activities of daily living or other personal needs.
Examples of these are:
- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- Respite care except in connection with hospice care, adult (or child) day care, or convalescent care
- Institutional care. This includes room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training
- For behavioral health (mental health treatment and substance related disorders treatment):
  - Services provided when you have reached the greatest level of function expected with the current level of care, for a specific diagnosis
  - Services given mainly to:
    - Maintain, not improve, a level of function
    - Provide a place free from conditions that could make your physical or mental state worse

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 completely bony impacted teeth, bone fractures, removal of tumors, and odontogenic cysts.

Educational services
Examples of these services are:
- Any service or supply for education, training or retraining services or testing, except where described in the *Eligible health services and exclusions – Diabetic services and supplies (including equipment and training)* section. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
  - Job training
  - Job hardening programs
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Examinations
Any health or dental examinations needed:
- Because a third party requires the exam. Examples are, examinations to get or keep a job, or examinations required under a labor agreement or other contract
- Because a law requires it
- To buy insurance or to get or keep a license
- To travel
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity

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

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

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

Gene-based, cellular and other innovative therapies (GCIT)
The following are not eligible health services unless you receive prior written approval from us:
- GCIT services received at a facility or with a provider that is not a GCIT-designated facility/provider.
- All associated services when GCIT services are not covered. Examples include infusion, laboratory, radiology, anesthesia, and nursing services.

Please refer to the *Medical necessity and preauthorization requirements* section.

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

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

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

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

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

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

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

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

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

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, except for emergency services

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

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

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

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

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

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

by health professionals who

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

the policyholder.

Services provided by a family member
- Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law or any household member, except for when that family member is a dentist who is licensed in the State of Texas to provide the dental service rendered.

Sexual dysfunction and enhancement
- Any treatment, prescription drug, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services
- Not eligible for coverage are prescription drugs in 60-day supplies

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

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

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

Strength and performance
- Services, devices and supplies such as drugs or preparations designed primarily for enhancing your:
  - Strength
  - Physical condition
  - Endurance
  - Physical performance

Students in mental health field
- Any services and supplies provided to a covered student who is specializing in the mental health care field and who receives treatment from a provider as part of their training in that field

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

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

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

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

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

Wilderness treatment programs
See *Educational services* within this section

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

In case of a medical emergency

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

After-hours care — available 24/7

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

Out-of-area services and benefits

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

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

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

You may have to find a new provider when:

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

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

	If you are a new enrollee and your provider is an out-of-network provider	If you are a current enrollee and your provider stops participation with Aetna
Request for approval	You need to complete a Transition Coverage Request form and send it to us. You can get this form by contacting Member Services at the toll-free number on the back of your ID card.	You or your provider should call Aetna for approval to continue any care.
Length of transitional period	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition.	Care will continue during a transitional period, usually 90 days, this date is based on the date the provider terminated their participation with Aetna.

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

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

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

Complaints and Appeals

If you are dissatisfied with the service you receive from the Plan or you want to complain about a preferred care provider, you may call the Member Services telephone number shown on your ID card or write to Aetna at:
Aetna Life Insurance Company
Appeals Resolution Team
PO Box 14464
Lexington, KY 40512

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

For more information about the Complaints and Appeals Procedure or External Review processes, you may call the Member Services telephone number shown on your ID card. A complete description of the Complaints and Appeals Procedure and External Review processes are contained in the Master Policy/Certificate of Coverage issued to Lamar University 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 888-407-0445, 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 15,606. The numbers of available providers in Aetna's service area for the following provider areas are indicated below:

Service Area	Provider Type: Hospital Based Providers-Anesthesiology, Neonatology, Pathology, Radiology	Provider Type: Psychiatry	Provider Type: General Practice, Family Practice and Internal Medicine	Provider Type: Specialty-General Surgery	Provider Type: Specialty-Obstetrics & Gynecology	Provider Type: Pediatric PCPs	Provider Type: Specialty (All other Specialists)	Provider Type: Emergency Medicine
Abernathy								
Abilene	5276	91	6346	96	2520	2028	197	1
Addison	31059	10	812		23		47	
Adkins								
Alamo			42			22		
Alamo Heights							1	
Albany			11					1
Aledo			34			23	4	
Alfred								
Alice	201	11	57	14	23	56	21	
Allen	71109	91	3647	43	1211	1517	133	676
Alpine	5		68	17	13	22	10	
Alton			27		1	25		
Alvarado			2					
Alvin	22	101	195		1	15	36	
Alvord			1					
Amarillo	180198	92	18193	2122	2524	3046	329	253
Anahuac	6		12					
Andrews	1		9	2	1		9	

Angleton	30	14	4	1	7	2	49	
Anson	2		2	1			1	
Apple Springs								
Aransas Pass		1	3			14	4	
Anna	1						15	
Aquilla		3						
Argyle	7	7	3			1	13	1
Arlington	1131	29	112	24	47	40	557	124
Aspermont	2		1				1	
Atascocita	1		1			3	4	
Athens	49	1	18	2	4	2	66	
Atlanta	2		4			2	14	1
Aubrey	16		4				14	
Austin	475	146	434	116	288	154	2560	331
Azle	275	4	10	2		1	19	69
Baird			1		5			
Balch Springs			1			1	2	
Ballinger			2				2	
Bandera	1		7			1	10	
Bartonville			2					
Bastrop	7	2	14	1	2	5	73	
Bay City	4	2	9	3	3	3	26	
Baytown	80	10	44	11	10	13	180	1
Beaumont	186	27	47	13	18	18	225	2
Bedford	52	19	30	11	13	8	136	68
Bedias								
Bee Cave	23		7			1	22	
Bee Caves	1		1				9	1
Beeville	45	1	5	1	2	4	14	1
Bellaire	35	2	25	12	12	11	174	
Bellmead			2			1		
Bells			1					
Bellville	2		2	1		1	11	75
Belton		4	23			4	15	16
Benbrook			2				9	
Bertram			1					
Big Sandy								
Big Lake								
Big Spring		5	7	2	2	3	31	
Big Wells								

Blanco			1	1			8	1
Bluff Dale								
Boerne	37	3	31	8	10	15	154	
Bogata			1					
Bonham	37		6	1		4	10	1
Booker								
Borger	4	1	5	2	1	2	13	
Bowie	4		6				5	
Boyd			2					1
Brady			3				8	
Bracketville				1			2	
Brazoria			1					
Breckenri dge	2		2		1		6	
Bremond			1			1		
Brenham	30		18	5	9	6	68	20
Bridge City			4					
Bridgeport			2	2			6	
Brookshire							1	
Brookeland			3					
Brownfield	8		4				4	
Brownsville	10	2	52	20	31	31	177	2
Brownwood	3		16	2	15	3	37	
Bryan	107	7	61	5	5	7	129	111
Buda	18		7	5	5	2	34	19
Buffalo			2				2	
Bullard			1					
Bulverde			1			7	9	
Burkburnett			3				1	
Burleson	81	6	24	5	8	8	120	12
Burnet	1	1	2	1	2	1	29	31
Caldwell	2		3				2	98
Cameron	2		3	1		1	16	1
Canadian			5					
Canton		2	15				15	33
Canutillo			1				2	
Canyon			6	1		3	10	
Canyon Lake	1		3				1	
Carrizo Springs	24		2	1	1	1	3	3
Carrollton	70	16	43	16	3	16	193	128
Carthage	7		10	2	3		20	
Castle Hills			1					

Castroville			15	1		2	31	1
Cedar Hill	15		12	1	2	5	50	
Cedar Park	36	4	35	9	20	30	278	128
Celina			2			1	15	1
Center		1	4		1		17	
Center Point								
Centerville			1					
Chandler			2					
Channelview			3				3	
Chappell Hill								
Cherokee								
Chico							1	
Childress	1		8	1			5	
China			1				1	
China Spring			1					
Cibola								
Cisco			2				2	
Clarendon			2					
Clarksville			1	1			1	1
Claude			1					
Clean Lake Shores								
Cibolo						3	5	
Cleburne	181	1	18	2	4	1	48	67
Cleveland	30	1	12	1	2	3	34	
Clifton	2	1	14	3			5	
Clint						1		
Clute							2	
Clyde			2					1
Coldspring			1					
Coleman	2		3	1			4	
College Sta							2	
College Station	115	3	65	14	35	21	249	65
Colleyville	4	2	28	2	2	2	42	
Colorado City			2	1			3	
Columbus	3		6	2	9	1	24	2
Comanche			8	1	1		5	
Comfort			3	1			23	
Commerce	1		2				1	
Conroe	76	6	68	17	11	14	317	113
Converse	1		2			1	3	

Cooper								
Coppell	1	1	13		1	12	36	3
Copperas Cove			9				11	
Corinth			4	1		2	14	
Corp Christi	1	4	5			2	6	1
Corpus Christi	120	28	95	20	48	64	390	2
Corsicana	38	2	8	2	3	1	55	5
Cottonwood								
Cotulla			2					
Crandall						2	1	
Crane			1					
Crockett	16		4	1			30	1
Crosby			2				5	1
Crosbyton						1		
Cross Plains								
Crossroad s		9	3		3		8	
Crowell			1					
Crowley			8				3	
Crystal Beach			2					
Crystal City			2					
Cuero	6		9	1			21	
Cypress	101	2	54	18	18	45	323	15
Daingerfield			3					
Dalhart	6		7	4			11	1
Dallas	3739	168	548	338	424	117	5666	597
Dayton			2		1	2	6	
Dell City						1		
De Kalb								1
De Leon			1				1	
Decatur	38	1	19	8	4	2	79	1
Deer Park		2	5		3	2	9	
De Soto							1	
Del Rio	7	2	7	7	5	2	54	
Del Valle		1	3			1		
Denison	48		15	5	4	7	115	
Denton	116	12	44	19	17	15	327	324
Denver City	24		2	1	1		2	
Deport								

DeSoto	3	5	11	2	1	3	62	1
Devine			3		1		3	
Dickinson	24	1	6	1	6	2	33	1
Dilley			1					
Dimmitt			4					
Donna			10			5	1	
Double Oak			1					
Douglass								
Dripping Springs	3	2	7	1	2	9	46	
Dublin			1				1	
Dumas	2		7	1	1		10	2
Duncanville	25	1	3	1	2	2	34	
Eagle Lake	3	1	5	1	1		4	1
Eagle Pass			10	3	2	3	59	
Early			1		1		8	
East Bernard			2	1			2	
Eastland	2		3				4	
Edcouch			2					
Eden			1					
Edgewood			2			1		1
Edinburg	20	7	44	13	26	30	207	8
Edna	3		2	2		1	8	
Egypt		3						
El Campo	23		8	1	1		25	8
El Paso	718	89	212	56	140	101	987	716
Eldorado			1				1	
Electra			3					
Elgin		4	1	1	2	1	10	1
Elkhart			2					
Elsa			2		1	3	1	
Emory		1	1				3	
Encino							1	
Ennis	4	3	10	2		3	20	1
Euless	4	5	16		11	2	29	1
Everman								
Fabens			2					
Fairfield			2				7	
Fairview							1	
Fair oaks								
Falfurrias			4			1	13	
Farmers			9	1			7	1

Branch								
Farmersville			2				1	
Flint							7	
Fate								
Ferris			3					
Flatonia			1					
Flint	2		3					3
Floresville	1	1	7	1	1	2	27	1
Flower Mound	13	5	32	9	18	12	177	15
Floydada			1					
Forest Hill			1					
Forney		1	6	1	1	5	28	2
Fort Davis			1					
Fort Hancock			1					
Fort Sam Houston							1	
Fort Stockton	3	1	7	1	1		3	
Fort Worth	2961	43	290	111	113	124	1595	576
Franklin			1					
Frankston			3					
Fredericks-burg	114	2	20	6	7	3	88	1
Freeport		2						
Freer								
Fresno								
Friendswood	4	13	19	2	5	7	73	3
Friona			1				1	
Frisco	854	25	98	34	53	50	601	51
Ft Worth					1		3	
Fulshear			2	1	1	5	5	
Gainesville	12		6	7	4	3	44	1
Galena Park	2				1	1		
Galveston	25	8	1	2	1	58	336	2
Ganado			1					
Garden Ridge								
Garland	64	2	45	9	5	24	173	1
Gatesville	4	1	9	3		1	25	1
George West			1					
Georgetown	10	12	45	6	17	10	179	3
Giddings			3			1	3	

Gilmer			5				10	
Gladewater			1					
Glen Rose	31		5	2	2		7	
Godley							2	
Goldthwaite			1				2	
Goliad			4				1	
Gonzales	1		9	2	5	1	23	31
Goodrich								
Gordon								
Gorman			1					
Graham	32		7	3			11	3
Granbury	167		21	4	3	4	93	16
Grand Prairie	26		47	1	18	5	67	8
Grand Saline			1					
Grandview			1					
Granger			1					
Grapevine	326	16	17	19	37	5	249	226
Greenville	34	29	15	2	3	5	88	67
Groesbeck	5		2	1			10	
Groves			2				3	
Groveton			1					
Gun Barrel City			11			1	52	
Hale Center			2					
Hallettsville	7		5	3			27	4
Hallsville				1			1	
Haltom City		2	3		5	1	4	2
Hamilton	1		6	1			6	
Hamlin	2		2					
Harker Heights	1	1	4	2	21	5	52	85
HARKER HTS					1			
Harlingen	33	12	51	8	18	13	151	99
Haskell	2		1					
Haslet			1		1	6	4	
Hawkins			1					
Hearne			1					
Heath	8		4			2	5	
Hebbronville			2		1	1	1	
Helotes			1		1	8	14	
Hemphill			1				2	
Hempstead			5				1	

Henderson	44		9	1	3	1	54	
Henrietta	42		3					
Hereford	1		5	1	2		6	
Hewitt			4			1		
Hickory Creek			2				7	
Hico		4	2					
Highland Village			6			6	17	
Hidalgo								1
Highlands			2					
Hillsboro			6	5			20	
Hitchcock								
Hondo	1		6	1			34	
Honey Grove			2					
Horizon City			1		3	3	1	
Horseshoe Bay			3				7	
Houston	3177	239	1098	441	732	518	7950	1410
Hubbard							1	
Hughes Springs								
Huffman							1	
Humble	37		57	12	9	20	319	37
Hunt		1	1					
Huntington			1					
Huntsville	8		31	4	7	7	81	110
Hurst	453	3	11	3	1	6	102	2
Hutto			5			5	12	1
Idalou								
Ingleside			2					
Iowa Park			2				1	
Iraan			1					
Irving	281	7	90	21	75	29	405	294
Italy								
Jacksboro	2		2					1
Jacksonville	60		12	5	4	4	96	55
Jasper	1	1	6	1		2	18	
Jayton								
Jefferson			1				3	
Jersey Village		1	2		2	1	3	
Joaquin			1					

Johnson City			1	1			5	
Joshua	2		3				4	
Jourdanton	28		1	2	3		43	1
Junction			4					
Justin			4				1	1
Karnes City			1		1	2		
Katy	298	7	83	24	30	68	480	39
Kaufman	171		7	3		2	18	64
Keene			1					
Keller	18	3	32	6	7	9	118	2
Kemah		1					3	
Kemp								
Kenedy			4				2	
Kennedale								
Kermit			1					1
Kerrville	19	1	25	4	5	1	119	25
Kilgore	2		5			2	15	
Killeen	280	11	28	11	12	16	156	93
Kingsland			5				1	
Kingsville	2		8	2	3	2	11	1
Kingwood	118	6	30	10	25	11	272	1
Kirbyville			2					
Knox City			1					1
Kountze			1					
Krugerville								
Krum								
Kyle	41		19	5	14	12	127	132
La Feria			4				1	
La Grange	2		6	5	8	2	42	2
La Joya			3			1	6	
La Marque		8	5			1	7	
La Mesa						1		
La Porte			5			2	10	
La Vernia			2		1		14	1
Lacy Lakeview			2			1		
Lago Vista			1				3	
Laguna Vista			1					
Lake Dallas	2						3	
Lake Jackson	48	2	16	4	3	3	82	1/
Lake Worth		1	3			3	5	
Lake hills			1					

Lakeway	34	9	14	8	14	2	146	12
Lamesa			5	1			3	1
Lampasas			2	1	1	1	16	1
Lancaster	91		3	5			11	2
Lantana							1	
Laredo	21	3	56	13	30	18	154	5
Lavon								
League City	166	2	17	1	3	4	234	2
Leander		4	10			5	28	
Leonard								
Levelland			9	2		2	5	
Lewisville	74	1	29	9	13	8	144	62
Lexington			9			1		
Liberty	18	1	5				11	1
Liberty Hill		2	1				3	
Lindale	1		9	1		2	11	4
Linden	9		1				2	
Little Elm			6			3	11	1
Littlefield	19		2				1	
Live Oak	11	1	9	9	1	5	92	
Livingston	27	1	17	3	3	3	62	11
Llano	2		4	2	1	2	23	
Lockhart		1	5		1	2	24	3
Lockney			4					
Lone Star			1					
Longview	393	1	48	9	31	17	289	66
Los Fresnos						1	1	
Lubbock	154	12	113	51	37	45	462	19
Lucas						2		
Lufkin	33	2	38	3	8	5	125	1
Luling	14		3	1	2	2	11	56
Lumberton		1	3	1			4	1
Lytle			1				4	
Mabank			2				2	
Madisonville	1		6				2	
Magnolia	8	2	11			2	27	
Malakoff			1					
Manchaca								
Manor		2	5		1	1	12	
Mansfield	312	3	36	19	33	12	236	27
Manvel		3	1				1	

Marathon								
Marble Falls	65		18	7	20	4	159	9
Marfa			2					
Marlin	8		2			1	5	1
Marshall	132		11	2	1	4	48	4
Mart			1					
Mason			2				3	
Mc Dade							2	
Mathis			1			3		
Mc Camey			1					
Mc Gregor			2	1				
Mc Kinney	1						31	
McAllen	1	1	64	30	28	38	290	17
McKinney	33	2	71	20	19	24	388	265
Meadow-lakes	456	36						
Medina								
Melissa			2			1	6	
Memphis			1					
Menard			1					
Mercedes			7	1	2	5	3	
Meridian							4	
Merkel			1					
Mesquite	3	1	40	7	14	29	185	3
Mexia	10		4	1		1	10	
Midland	1	8	40	10	20	17	142	6
Midlothian	11		23	5	6	5	39	1
Millsap								
Mineola		2	5				7	
Mineral Wells	14		6	2	2	1	28	
Mission	7		34	4	5	1	70	
Missouri City	1	5	22	1	2	13	52	3
Monahans	8		4	1			4	1
Mont Belvieu			2				1	
Montgomery	1	1	7			4	29	35
Moody								
Morton								
Moulton								
Mountain Home								
Mt.								

Enterprise								
Mt Pleasant	1							
Mt. Pleasant	40	1	5	3	4	10	74	1
Mt. Vernon			1				1	
Muenster	37		2	1	1		2	3
Muleshoe			1					
Munday			1					
Murphy	17		9	1		7	9	1
N Richland Hls							3	
Nacogdoches	29	2	24	9	17	6	97	
Naples			1					
Nassau Bay	4		1	1	1	1	9	
Navasota	36	1	18		1	1	1	117
Nederland	14	1	15		3	3	34	
Needville			3					
New Boston			2			3	6	1
New Braunfels	32	2	38	9	23	28	236	2
New Caney			4				5	
Newton			1			1		
Nixon								
Nocona	7		3					
Normangee			11			1		
North Richland Hills	401	2	17	4	5	3	109	34
Northlake			5				1	
Odessa	111	3	56	12	32	11	157	2
Odonnell			2			2	2	
Olney	5		4					
Olton								
Onalaska			1					
Orange	2	1	10	1		2	13	
Orange Grove								
Ore City								
Overton	1		2					
Ovilla	3		1					
Ozona			2					
Paducah								
Palacios	3		2					
Palestine	17	3	13	3	3	2	55	1

Palmhurst			1			2		
Palmview			1			3		
Pampa	2	2	5	1	2	1	15	
Panhandle								
Pantego							1	
Paris	5	3	16	3	7	2	93	28
Pasadena	126	10	57	12	14	28	284	145
Pearland	43	17	61	15	31	33	353	247
Pearsall	4	1	5	1	1		20	1
Pecos			1	2	6		9	
Penitas			1			5		
Perryton	3		8				2	
Pflugerville	58	2	25	7	9	5	65	26
Pharr		2	15		1	16	8	1
Pinehurst							1	
Pilot Point			1					
Pineland								
Pipe Creek								
Pittsburg	15		7		1	1	20	
Plains								
Plainview	9	1	10	2	1	2	12	1
Plano	2094	58	186	67	72	69	1397	583
Pleasanton			8		1	1	10	
Port Aransas		1	1					
Port Arthur	64	3	15	3	4	4	65	
Port Isabel						1		
Port Lavaca	20		5	3	1	2	15	
Port Neches			2	1			5	
Porter	2	3	12	1	1	3	8	
Portland		2	7			5	7	
Post			2			1		
Poteet								
Poth								
Pottsboro			1					
Premont								
Presidio			4		1			
Princeton					1		2	
Prosper	3	1	10	3	1	1	54	
Providence Village							1	
Quanah			3					
Quinlan			1				1	

Quitman	17		8	2		1	34	
Ranger	3		1					
Rancho Viejo								
Raymondville			6	1		3	2	
Red Oak	12		7		7	1	12	
Refugio			2				2	
Rhome			1					
Richardson	326	21	75	9	14	22	242	4
Richland Hills		1	1		1	4	5	
Richmond	68	9	22	3	15	12	73	1
Rio Grande				1	1	2	3	
Rio Grande City			11	5	4	4	51	1
Rio Hondo								
Rising Star			1					
River Oaks								
Roanoke	1		3	1			27	2
Robinson		2						
Robstown		1	3			2	1	
Roby								
Rockdale	1		4	1	1	2	2	
Rockport		2	4	1	1	1	12	
Rockwall	127	3	28	11	14	14	252	68
Rollingwood							5	
Roscoe							1	
Roma			3			3		
Rosebud			1					
Rosenberg		1	10		1	2	19	1
Rosharon						1		
Rotan	2		1					
Round Rock	324	33	77	25	48	43	564	272
Rowlett	76		16	5	6	2	89	101
Royse City			4			1	6	2
Rusk			4			4	2	
Sachse			2	1			3	
Saginaw			3			1	13	13
Salado			2				2	
San Angelo	39	3	39	9	20	19	152	26
San Antonio	1153	242	625	221	335	249	3856	1159
San Augustine	1		3		1		1	
San Benito			7	1	1	1	8	
San Diego								

San Elizario			2			1		
San Juan		1	8		2	2		
San Marcos	20	2	26	4	11	6	117	1
San Saba			2				3	
Sanderson			2					
Sanger			1				1	
Santa Fe		1	1				7	
Santa Rosa			1					
Santo								
Schertz	6	1	5	1	22	17	88	
Schulenburg			1			1	2	
Scroggins			1					
Seabrook		1	3				4	
Seagoville			1					
Sealy			2				14	
Seguin	26		17	6	4	4	66	195
Selma	1		2				5	
Seminole	9		1	3	3		10	13
Seven Points								
Seymour			3			2		
Shady Shores								
Shallowater			1					
Shamrock			3				1	
Shavano Park			3	1			9	
Shenandoah	3	5	51	9	21	7	239	5
Shepherd		1	1					
Sherman	75	5	24	5	8	7	134	
Shiner			1	1			2	
Sierra Blanca		1	1			1		
Silsbee			3				7	
Silverton						2		
Sinton			4					
Slaton								
Smithville		4	4	1	1		9	16
Snyder	24		8		2		6	2
Socorro			2			3		
Somerset			1				3	
Somerville			1					
Smyrna	1							
Socorro	1							

Sonora			3	1			1	1
South Houston			1			1	1	
South Lake	599	4			2	11	224	5
South Padre Island			1					
Southlake		1	33	9	2	19		
Spearman			3					
Splendora			2					
Spicewood		1				3	2	
Spring	65	22	92	13	10	29	410	157
Spring Branch		3	4	2	4		21	
Springtown			1					
Spur			1					
Stafford	1	1	1		5		6	
Stamford	1						2	
Stanton	4		1					1
Stephenville		4	13	4	4	2	32	63
Stockdale			1					
Stratford			1					
Sudan								
Sugar Land	126	19	153	40	50	146	688	272
Sulphur Springs	24	1	10	5	4	2	35	67
Sumner								
Sundown								
Sunnyvale	64		8	1	3	11	36	1
Sunset Valley							1	
Sunray			1					
Sweeny	20		1	2		1	5	10
Sweetwater	4		6	1	1	1	7	
Taft	235	1	1					
Tahoka			1					
Tatum			1					
Taylor	5		9	1			35	125
Teague			1				1	
Telephone			1					
Temple	483	10	102	50	32	48	494	162
Tenaha			1		1			
Terrell	19	3	9		3	1	17	1
Texarkana	25	4	33	12	29	12	215	2

Texas City	9	16	13	1	2	1	109	2
Texline								
The Colony	34		8				19	
The Hills								
The Woodlands	189	3	52	17	49	66	463	537
Thorndale			1		2			
Three Rivers			1		1	2		
Throckmorton	2						1	
Tilden			1		1	2		
Timpson			1					
Tomball	1		36	3	7	8	218	10
Trinidad								
Trinity								
Trophy Club	336		3			2	9	
Troup				1			1	
Tulia	19		5					
Tyler	244	20	93	37	54	28	698	101
Universal City			6				7	
University Park	3							
Uvalde	30	2	4	1	1	1	60	
Valley View			1					
Van								
Van Alstyne			5			1	2	1
Van Horn								
Vanderpool								
Vernon	20		2	2		1	9	1
Victoria	122	7	52	37	13	19	177	8
Vidor			2					
Vinton			2		1			
Waco	322	6	133	43	37	34	430	92
Waller			1			3	4	
Wallis								
Waskom				1			1	
Watauga	3		4				11	
Waxahachie	48	2	24	14	16	7	131	7
Weatherford	187	2	16	6	1	2	94	12
Webster	67	1	53	10	32	30	383	2
Weimar			3				3	
Wellington			1					

Weslaco	19		27	4	6	10	118	2
West			2				2	
West Columbia			4				5	
West Lake Hills	2	8	4	1	1	2	31	
Westlake							1	
Westworth Village							1	
Wharton	13		5		3	2	26	1
White Oak							3	
Wheeler			1					
White Settlement			2				1	
Whitehouse			1	1			1	
Whitesboro			2				5	
Whitewright			1					
Whitney			4	1			2	1
Wichita Falls	60	4	30	7	12	11	134	2
Willis			9	2	3	1	3	
Willow Park		5	7		8	4	7	1
Wills Point	1		1				3	
Wimberley		1	5			2	8	
Windcrest			2				3	
Winnie			2					
Winnsboro	192		4	1	1	1	22	54
Winona								
Winters	2		1					1
Wolfforth			1			1		
Woodsboro			1					
Woodville	11	3	3			2	5	
Woodway	1	1	3		1	1	26	
Wortham			1					
Wylie			11	2		11	28	2
Yoakum	8		3	2			11	
Yorktown			3				2	
Zapata			3		1		1	
Zavalla			1					

Important note:
Although health care services may be or have been provided to you at a health care facility that is a member of the provider network used by your health benefit plan, other professional services may be or have been provided at or through the facility by physicians and other health care practitioners who are not members of that network. You may be responsible for payment of all or part of the fees for those professional services that are not paid or covered by your health benefit plan unless balance billing for those services is prohibited.

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 888-407-0445 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.

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

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

Sanctioned Countries

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

For more information, visit **http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx**.

Assistive Technology

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

Smartphone or Tablet

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

Non-Discrimination

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

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

These aids and services include:
- Qualified language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Qualified interpreters
- Information written in other languages

If you need these services, contact the number on your ID card. Not an Aetna member? Call us at 1-888-407-0445.

If you have questions about our nondiscrimination policy or have a discrimination-related concern that you would like to discuss, please call us at 1-888-407-0445.

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

Language accessibility statement

Interpreter services are available for free.

Attention: If you speak English, language assistance service, free of charge, are available to you. Call **1-888-407-0445** (TTY: **711**).

Español/Spanish

Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-407-0445** (TTY: **711**).

አማርኛ/Amharic

ልብ ይበሉ: አማርኛ ቋንቋ የሚናገሩ ከሆነ፥ የትርጉም ድጋፍ ሰጪ ድርጅቶች፣ ያለምንም ክፍያ እርስዎን ለማገልገል ተዘጋጅተዋል። የሚከተለው ቁጥር ላይ ይደውሉ **1-888-407-0445** (መስማት ለተሳናቸው: **711**).

العربية/Arabic

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-888-407-0445** (رقم الهاتف النصي: **711**).

Ɓàsɔ̀ɔ̀ Wùɖù/Bassa

Dè dɛ nìà kɛ dyɛ́dɛ́ gbo: Ɔ jǔ kɛ́ m̀ dyi Ɓàsɔ̀ɔ̀-wùɖù-po-nyɔ̀ jǔ nɨ́, nɨ̀ì à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ m̀ gbo kpáa. Ɖá **1-888-407-0445** (TTY: **711**).

中文/Chinese

注意：如果您说中文，我们可为您提供免费的语言协助服务。请致电 **1-888-407-0445** (TTY: **711**)。

فارسی/Farsi

توجه: اگر به زبان فارسی صحبت می کنید، خدمات زبانی رایگان به شما ارایه میگردد، با شماره **1-888-407-0445** (TTY: **711**) تماس بگیرید.

Français/French

Attention : Si vous parlez français, vous pouvez disposer d’une assistance gratuite dans votre langue en composant le **1-888-407-0445** (TTY: **711**).

ગુજરાતી/Gujarati

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો ભાષાકીય સહાયતા સેવા તમને નિ:શુલ્ક ઉપલબ્ધ છે. કૉલ કરો **1-888-407-0445** (TTY: **711**).

Kreyòl Ayisyen/Haitian Creole

Atansyon: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-888-407-0445** (TTY: **711**).

Igbo

Nrụbama: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-888-407-0445** (TTY: **711**).

한국어/Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스가 무료로 제공됩니다. **1-888-407-0445** (TTY: **711**)번으로 전화해 주십시오.

Português/Portuguese

Atenção: a ajuda está disponível em português por meio do número **1-888-407-0445** (TTY: **711**). Estes serviços são oferecidos gratuitamente.

Русский/Russian

Внимание: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Звоните по телефону **1-888-407-0445** (TTY: **711**).

Tagalog

Paunawa: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-888-407-0445** (TTY: **711**).

اردو/Urdu

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت دستیاب ہیں ۔ (TTY: **711**) **1-888-407-0445** پر کال کریں.

Tiếng Việt/Vietnamese

Lưu ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số **1-888-407-0445** (TTY: **711**).

Yorùbá/Yoruba

Àkíyèsí: Bí o bá nsọ èdè Yorùbá, ìrànlọ́wọ́ lórí èdè, lófẹ̀ẹ́, wà fún ọ. Pe **1-888-407-0445** (TTY: **711**).

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