

2012–2013



## Student Health Insurance Plan

### *Virginia Polytechnic Institute And State University*

Your student health insurance coverage, offered by Aetna Student Health\*, may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are \$1.25 million for policy years before September 23, 2013; and \$2 million for policy years beginning on or after September 23, 2013 but before January 1, 2014. Restrictions for annual dollar limits for student health insurance coverage are \$100,000 for policy years before September 23, 2013, and \$500,000 for policy years beginning on or after September 23, 2013, but before January 1, 2014. Your student health insurance coverage includes an annual limit of \$100,000 for Plan 1, or \$500,000 for Plan 2 on all covered services including Essential Health Benefits. Other internal maximums (on Essential Health Benefits and certain other services) are described more fully in the benefits chart included inside this Plan summary. If you have any questions or concerns about this notice, contact (866) 577-7027. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.

\* Fully insured Aetna Student Health Insurance Plans are underwritten by Aetna Life Insurance Company (Aetna) and administered by Chickering Claims Administrators, Inc. Aetna Student Health is the brand name for products and services provided by these companies and their applicable affiliated companies.

*Underwritten by:  
Aetna Life Insurance Company  
(ALIC)  
Policy Number 474968*

The Aetna logo, consisting of the word "aetna" in a bold, lowercase, sans-serif font, with a small "SM" trademark symbol to the upper right.

*Virginia Tech logo used with permission from Virginia Tech.*

## **WHERE TO FIND HELP**

---

In case of an emergency, call **911** or your local emergency hotline, or go directly to an emergency care facility.  
For non-emergency situations please visit or call The Charles Schiffert Health Center at **(540) 231-6444**.

### **For questions about:**

- Insurance Benefits
- Enrollment
- Waiver Process
- Claims Processing
- Pre-Certification Requirements

*Please contact:*

Aetna Student Health  
P.O. Box 981106  
El Paso, TX 79998  
**(866) 577-7027**

### **For questions about:**

- ID Cards

ID cards will be issued as soon as possible. If you need medical attention before the ID card is received, benefits will be payable according to the Policy. You do not need an ID card to be eligible to receive benefits. Once you have received your ID card, present it to the provider to facilitate prompt payment of your claims.

For lost ID cards, contact:

Aetna Student Health  
**(866) 577-7027**

### **For questions about:**

- Enrollment Forms
- Waiver Process
- Schiffert Health Center Referrals

*Please contact:*

Virginia Tech Student Medical Insurance Office  
**Email: SMI@vt.edu**  
**Telephone: (540) 231-6226**  
**Fax: (540) 231-6237**

### **Hours of Operation:**

**Monday-Friday: 8 a.m. – 12 p.m.**  
**1 p.m. – 5 p.m.**

### **For questions about:**

- Status of Pharmacy Claim
- Pharmacy Claim Forms
- Excluded Drugs and Pre-Authorization

*Please contact:*

Aetna Pharmacy Management  
**(888) RX AETNA** or **(888)792-3862** (Available 24 Hours)

**For questions about:**

- Provider Listings

*Please contact:*

Aetna Student Health  
**(866) 577-7027**

A complete list of providers can be found at the University Health Services Office, or you can use Aetna's **DocFind**<sup>®</sup> Service at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com).

**For questions about:**

- On Call International 24/7 Emergency Travel Assistance Services

*Please contact:*

On Call International at **(866) 525-1956 (within U.S.)**.

If outside the U.S., call collect by dialing **the U.S. access code** plus **(603) 328-1956**. Please also visit [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com) and visit your school-specific site for further information.

**Got Questions? Get Answers with Aetna's Navigator**<sup>®</sup>

As an Aetna Student Health insurance member, you have access to Aetna Navigator<sup>®</sup>, your secure member website, packed with personalized claims and health information. You can take full advantage of our interactive website to complete a variety of self-service transactions online. **By logging into Aetna Navigator, you can:**

- Review who is covered under your plan.
- Request member ID cards.
- View Claim Explanation of Benefits (EOB) statements.
- Estimate the cost of common health care services and procedures to better plan your expenses.
- Research the price of a drug and learn if there are alternatives.
- Find health care professionals and facilities that participate in your plan.
- Send an e-mail to Aetna Student Health Customer Service at your convenience.
- View the latest health information and news, and more!

**How do I register?**

- Go to [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com)
- Click on "Find Your School."
- Enter your school name and select
- Click on Aetna Navigator
- Follow the instructions for First Time User by clicking on the "Register Now" link.
- Select a user name, password and security phrase.

Your registration is now complete, and you can begin accessing your personalized information!

**Need help with registering onto Aetna Navigator?**

Registration assistance is available toll free, Monday through Friday, from 7 a.m. to 9 p.m. Eastern Time at **(800) 225-3375**.

**Aetna's Informed Health**<sup>®</sup> **Line**<sup>\*</sup>:

Call toll free **1-800-556-1555** 24 hours a day, 7 days a week.

Get health answers 24/7. When you have an Aetna health benefits and health insurance plan, you have instant access to the information you need. Our tools and resources can help you:

- Make more informed decisions about your care.
- Communicate better with your doctors.
- Save time and money, by showing you how to get the right care at the right time.

When you call our Informed Health Line, you can talk directly to a registered nurse. Our nurses can discuss a wide variety of health and wellness topics.

*\* While only your doctor can diagnose, prescribe or give medical advice, the Informed Health Line nurses can provide information on more than 5,000 health topics. Contact your doctor first with any questions or concerns regarding your health care needs.*

**The Virginia Tech Plan is underwritten by Aetna Life Insurance Company (ALIC) and administered by Chickering Claims Administrators, Inc.** Aetna Student Health<sup>SM</sup> is the brand name for products and services provided by these companies and their applicable affiliated companies.

**IMPORTANT NOTE**

Please keep this Brochure, as it provides a general summary of your coverage. A complete description of the benefits and full terms and conditions may be found in the Master Policy issued to Virginia Tech. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits. The Master Policy may be viewed at the Student Medical Insurance Office located at 110 Student Services during business hours.

This student Plan fulfills the definition of Creditable Coverage explained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. At any time should you wish to receive a certification of coverage, please call the customer service number on your ID card.

## TABLE OF CONTENTS

---

Page Numbers

Schiffert Health Center Services .....	6
Policy Period .....	6
Rates .....	6
Student Coverage – Eligibility.....	7
Waiver Process/Procedure.....	7
Refund Policy .....	8
Dependent Coverage – Eligibility .....	8
Preferred Provider Network .....	9
Enhanced Benefits .....	10
Pre-Certification Requirements .....	10
Deductibles.....	11
Inpatient Hospitalization Benefits .....	12
Surgical Benefits .....	13
Outpatient Benefits.....	14
Mental Health & Substance Abuse Benefits.....	34
Maternity Benefits .....	36
Additional Benefits.....	38
Additional Services and Discounts.....	61
General Provisions .....	63
Termination of Insurance.....	63
Exclusions .....	64
Definitions .....	67
Claim Procedure.....	79
Prescription Drug Claim Procedure.....	80
Accidental Death & Dismemberment Coverage.....	81

## SCHIFFERT STUDENT HEALTH CENTER

---

The Charles W. Schiffert Health Center is the University's on-campus health facility located in McComas Hall. Staffed by nurse practitioners and registered nurses, it is open weekdays from 8:00 a.m. to 5:00 p.m. weekdays and 9:00 a.m. to noon on Saturdays during the Fall and Spring semesters. A Physician and nurse practitioner are on call at all times, and conduct clinics during the week.

For more information, call The Charles Schiffert Health Center at (540) 231-6444. In the event of an emergency, call 911.

## POLICY PERIOD

---

1. **Students:** Coverage for all insured students enrolling during the Fall Semester open enrollment will become effective at 12:01 a.m. on **August 1, 2012**, and will terminate at 11:59 p.m. on **July 31, 2013**.
2. **New Spring Semester students:** Coverage for all insured students enrolled for the Spring Semester, will become effective at 12:01 a.m. on **January 1, 2013**, and will terminate at 11:59 p.m. on **July 31, 2013**.
3. **Insured dependents:** Coverage will become effective on the same date the insured student's coverage becomes effective, or the day after the postmarked date when the completed application and premium are sent, if later. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Master Policy. For more information on Termination of Covered Dependents see page (63) of this Brochure. Examples include, but are not limited to: the date the student's coverage terminates, the date the dependent no longer meets the definition of a dependent.

## RATES

---

<b>Plan 1- \$100,000 maximum</b>	<b>Annual</b>	<b>Spring Semester</b>
<b>Student</b>	\$1,881	\$1,097
<b>Spouse</b>	\$3,217	\$1,877
<b>Child(ren)</b>	\$2,614	\$1,525
<b>Family</b>	\$7,712	\$4,499
<b>Plan 2- \$500,000 maximum</b>		
<b>Student</b>	\$2,021	\$1,179
<b>Spouse</b>	\$3,456	\$2,016
<b>Child(ren)</b>	\$2,809	\$1,639
<b>Family</b>	\$8,286	\$4,834

## **VIRGINIA TECH STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN**

---

This is a brief description of the Accident and Sickness Medical Expense benefits available for Virginia Tech students and their eligible dependents. The plan is underwritten by Aetna Life Insurance Company (called Aetna). The exact provisions governing this insurance are contained in the Master Policy issued to the University and may be viewed at Student Medical Insurance Office located at 110 Student Services during business hours.

### **STUDENT COVERAGE**

---

#### ***ELIGIBILITY***

Students must be enrolled as full-time students at the university on the first day that coverage will be effective. Students in Cooperative Education and serving approved internships off-campus or performing credited research hours are considered to be full-time students of the university. However, if the student takes fewer than full-time hours but is enrolled in the maximum number of hours allowed toward graduation (i.e. working on a dissertation), the student may obtain a statement to this effect in writing on the department's letterhead and with the signature of the department head. This confirmation may be attached to the application for insurance. Then the student shall be considered as full-time and shall be eligible to enroll in the university's insurance plans.

- Undergraduate Eligibility: 12 or more credit hours
- Graduate Eligibility: 9 or more credit hours
- International Students & Veterinary Medicine DVM Students are required to maintain health insurance either through the school sponsored plan or a comparable plan.
- Eligible Graduate Assistants wishing to use the health care subsidy must enroll in the Virginia Tech sponsored plan.
- Graduate students who are defending their thesis are eligible to remain on the insurance program if previously insured through the end of the month in which they defend. Documentation from the department head must be provided to the Student Medical Insurance office.

Students must actively attend classes for at least the first 31 days, after the date when coverage becomes effective.

Home study, correspondence, Internet classes, and television (TV) courses, do not fulfill the eligibility requirement that the student actively attend classes. If it is discovered that this eligibility requirement has not been met, our only obligation is to refund premium, less any claims paid.

#### ***ENROLLMENT***

**To enroll, log on to [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com) and search for Virginia Tech, then click on Enroll to purchase insurance coverage online.**

**Exception:** A Covered Person entering the armed forces of any country will not be covered under the Policy as of the date of such entry. A pro rata refund of premium will be made for such person, and any covered dependents, upon written request received by Aetna within 90 days of withdrawal from school.

### **WAIVER PROCESS/PROCEDURE**

---

**International Students & Veterinary Medicine DVM Students are required to maintain health insurance either through the school sponsored plan or a comparable plan.**

**To meet the criteria of a comparable insurance plan, coverage must meet or exceed all of the following:**

- The plan provides adequate provider care within a 50 mile radius of the campus of enrollment. Coverage for emergency-only care does not satisfy this requirement. (adequate means in-network coverage for non-emergency care).
- The deductible on the plan does not exceed \$500 per accident or sickness per policy year.
- The plan offers major medical benefits of at least \$100,000 per accident or illness on an annual basis.
- The plan's provisions for pre-existing condition has a waiting period of less than or equal to three month. (Pre-existing means: a condition that began in the six month period before becoming insured or that treatment was recommended or received during that period before being insured under that policy).

- The plan provides coverage for inpatient mental health care paid at a minimum of 80% for the usual and customary fees with a 25 day cap.
- The plan provides coverage for outpatient mental health care paid at a minimum of 80% that provides for a minimum of 20 visits annually).
- The plan covers expenses for pregnancy, childbirth, and complications of pregnancy as any other illness under the policy.
- The plan provides prescription medication coverage (after co-pays) with a minimum of \$2,000 per insured per policy year.
- The plan provides at least \$10,000 coverage for Repatriation of remains AND Medical evacuation to the home country. (Repatriation provides transportation to your home country in the event of death).
- Coverage must be valid from either August 1, 2012 or the first day of enrollment at Virginia Tech until July 31, 2013 or, if graduating, the last day of the month of the student’s graduation.

*Waiver submissions will be audited by Virginia Tech, and/or their contractors or representatives. You may be required to provide, upon request, any coverage documents and/or other records demonstrating that you meet the school’s requirements for waiving the student health insurance plan.*

All International and Veterinary Medicine DVM Students records will be blocked and students will be unable to register for classes until the university-sponsored insurance or alternate approved insurance is purchased. There are no exemptions from this requirement. Waivers must be remitted by the deadlines listed below. Late waiver applications will not be accepted.

Category	Waiver Deadline Date
Students enrolling for the Fall Semester	10/1/12
Students enrolling for the Spring Semester	1/31/13

**In order to not have a block placed on a student’s account the student must either enroll in the student medical insurance program or provide details of their current comparable insurance coverage online at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com), select Virginia Tech and follow the waiver application instructions by the deadline.**

**Email notification will be sent upon completion of the audit of if coverage meets Virginia Tech’s requirements.**

**REFUND POLICY**

---

No premium refunds will be made except for situations where a Covered Person enters the armed forces of any country will not be covered under the Policy as of the date of such entry. In this case, a pro-rata refund of premium will be made for any such person and any covered dependents upon written request received by Aetna Student Health within 90 days of this event.

**DEPENDENT COVERAGE**

---

**ELIGIBILITY**

Covered students may also enroll their lawful spouse, and any dependent under the age of 26.

If a child is covered based on being a full-time student and he/she can’t attend school because of a medical condition, the plan must allow the child to stay on the plan, if certified by a physician as medically necessary, until the earlier of 12 months or coverage would otherwise terminate for the dependent.

**ENROLLMENT**

To enroll the dependent(s) of a covered student, please visit [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com), select Virginia Tech and following the instructions to enroll online. The Fall enrollment deadline is **October 1, 2012**. Dependent enrollment applications will not be accepted after **October 1, 2012** unless there is a significant life change, that directly affects their insurance coverage. (An example of a significant life change would be loss of health coverage, under another health plan.) **The Spring enrollment deadline is January 31, 2013.**

**Please contact Aetna Student Health at (866) 577-7027 with questions or for assistance in enrolling online.**



### **NEWBORN INFANT AND ADOPTED CHILD COVERAGE**

A child born to a Covered Person shall be covered for Accident, Sickness, and congenital defects, for 31 days from the date of birth. At the end of this 31 day period, coverage will cease under the Virginia Tech Student Health Insurance Plan. To extend coverage for a newborn past the 31 days, the Covered Student must: 1) enroll the child within 31 days of birth, and 2) pay the additional premium, starting from the date of birth.

Coverage is provided for a child legally placed for adoption with a Covered Student for 31 days from the moment of placement provided the child lives in the household of the Covered Student, and is dependent upon the Covered Student for support. To extend coverage for an adopted child past the 31 days, the Covered Student must 1) enroll the child within 31 days of placement of such child, and 2) pay any additional premium, if necessary, starting from the date of placement.

For information or general questions on dependent enrollment, contact Aetna Student Health at, **(866) 577-7027**.

### **PREFERRED PROVIDER NETWORK**

---

Aetna Student Health has arranged for you to access a Preferred Provider Network in your local community. Acute care facilities and mental health networks are available nationally if you require hospitalization outside the immediate area of the Virginia Tech campus.

To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider. It is to your advantage to use a Preferred Provider because savings may be achieved from the Negotiated Charges these providers have agreed to accept as payment for their services. Preferred Providers are independent contractors, and are neither employees nor agents of Virginia Tech, Aetna Student Health, or Aetna. A complete listing of participating providers is available online at **www.aetnastudenthealth.com**.

You may also obtain information regarding Preferred Providers by contacting Aetna Student Health at **(866) 577-7027** or through the Internet by accessing DocFind at **www.aetnastudenthealth.com**.

1. Click on "Enter DocFind"
2. Select zip code, city, or county
3. Enter criteria
4. Select Provider Category
5. Select Provider Type
6. Select Plan Type – Student Health Plans
7. Select "Start Search" or "More Options"
8. "More Options" enter criteria and "Search"

*Preferred providers are independent contractors and are neither employees nor agents of Aetna Life Insurance Company, Chickering Claims Administrators, Inc. or their affiliates. Neither Aetna Life Insurance Company, Chickering Claims Administrators, Inc. nor their affiliates provide medical care or treatment and they are not responsible for outcomes. The availability of a particular provider(s) cannot be guaranteed and network composition is subject to change.*

## ENHANCED BENEFITS

---

**Referrals are not required. However, students who have initiated care at Schiffert Health Center prior to seeking care in the community and have been referred to an outside provider for treatment are eligible to receive enhanced benefits for services when care is provided by a Preferred Aetna Providers as shown in Tier 1 of the benefit section of this brochure.**

**Referrals are not needed in the following instances in order to receive the enhanced level of benefits:**

- Emergency Room Services
- Urgent Care Services
- Obstetric and Gynecological Treatment
- Pediatric Care
- Treatment received when Student Health Services is closed.
- When care is provided outside a 20 Mile Radius from the Blacksburg Campus
- Satellite Campus enrolled students
- Preventive/Routine Services (services considered preventive according to Health Care Reform and/or services rendered not to diagnosis or treat an Accident or Sickness).

Retroactive referral requests will not be accepted or processed.

## PRE-CERTIFICATION PROGRAM

---

Pre-certification simply means calling Aetna Student Health prior to treatment to obtain approval for a medical procedure or service. Pre-certification may be done by you, your doctor, a hospital administrator, or one of your relatives. All requests for certification must be obtained by contacting Aetna Student Health at **(866-577-7027)** (attention Managed Care Department).

- **If you do not secure pre-certification** for non emergency inpatient admissions, or provide notification for emergency admissions, your **Covered Medical Expenses** will be subject to a **\$200** per admission Deductible.
- **If you do not secure pre-certification** for partial hospitalizations, your **Covered Medical Expenses** will be subject to a **\$200** Deductible.

The following inpatient and outpatient services or supplies require pre-certification:

- All inpatient admissions, including length of stay, to a hospital, convalescent facility, skilled nursing facility, a facility established primarily for the treatment of substance abuse, or a residential treatment facility.
- All inpatient maternity care, after the initial 48/96 hours.
- All partial hospitalization in a hospital, residential treatment facility, or facility established primarily for the treatment of substance abuse.

**Pre-Certification does not guarantee the payment of benefits for your inpatient admission.** Each claim is subject to medical policy review, in accordance with the exclusions and limitations contained in the Policy, as well as a review of eligibility, adherence to notification guidelines, and benefit coverage under the student Accident and Sickness Plan.

### **Pre-Certification of Non-Emergency Inpatient Admissions, Partial Hospitalization, Identified Outpatient Services and Home Health Services:**

The patient, Physician or hospital must telephone at least **three (3) business days** prior to the planned admission or prior to the date the services are scheduled to begin.

### **Notification of Emergency Admissions:**

The patient, patient's representative, Physician or hospital must telephone within **one (1) business day** following inpatient (or partial hospitalization) admission.

## DESCRIPTION OF BENEFITS\*

---

### Please Note:

**THE VIRGINIA TECH PLAN MAY NOT COVER ALL OF YOUR HEALTH CARE EXPENSES.**

The Plan excludes coverage for certain services and contains limitations on the amounts it will pay. Please read the Virginia Tech Plan Brochure carefully before deciding whether this Plan is right for you. While this document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. If you want to look at the full Plan description, which is contained in the Master Policy issued to Virginia Tech, you may view it at the Student Medical Insurance Office or you may contact Aetna Student Health at (866) 577-7027.

This Plan will never pay more than \$100,000 (Plan 1) or \$500,000 (Plan 2) per Condition per Policy Year for students or \$100,000 (Plan 1) or \$500,000 (Plan 2) per Condition per Policy Year for dependents, in a Policy Year. Additional Plan maximums may also apply. Some illnesses may cost more to treat and health care providers may bill you for what the Plan does not cover.

Subject to the terms of the Policy, benefits are available for you and your eligible dependents only for the coverages listed below, and only up to the maximum amounts shown. Please refer to the Certificate of Coverage for a complete description of the benefits available.

All insurance coverage is subject to the terms of the Master Policy and applicable state filings. Under health care reform legislation, student health plans may be required to eliminate or modify certain existing benefit plan provisions, including, but not limited to, exclusions and limitations. Aetna reserves the right to modify its products and services in response to federal and/or state legislation, regulation or requests of government authorities.

\*Benefit descriptions have been added to this brochure to help illustrate new Health Care Reform (HCR) requirements. HCR requirements are currently being filed for support in individual states and will appear in policy contracts and certificates of coverage once approved.

## SUMMARY OF BENEFITS CHART

---

**Plan 1: \$100,000 Maximum Per Condition Per Policy Year**

**Plan 2: \$500,000 Maximum Per Condition Per Policy Year**

### DEDUCTIBLES

The following Deductibles are applied before Covered Medical Expenses are payable:

Students: **\$300 per policy year**

Spouse: **\$300 per policy year**

Child: **\$300 per policy year**

Family: **\$600 per policy year**

### Waiver of Annual Deductible

In compliance with Federal Health Care Reform legislation, the Annual Deductible is waived for Preferred Care **Covered Medical Expenses** (refer to specific benefit types for list of services) rendered as part of the following benefit types: Routine Physical Exam Expense (Office Visits), Pap Smear Screening Expense, Mammogram Expense, Routine Screening for Sexually Transmitted Disease Expense, Routine Colorectal Cancer Screening, Routine Prostate Cancer Screening Expense, Well Woman Preventive Visits (*Office Visits*), Screening & Counseling Services (*Office Visits*), Routine Cancer Screenings (*Outpatient*), Prenatal Care (*Office Visits*), Comprehensive Lactation Support and Counseling Services (*Facility or Office Visits*), Breast Pumps & Supplies, Family Contraceptive Counseling Services (*Office Visits*), Female Voluntary Sterilization (*Inpatient and Outpatient*)

The Policy Year **Deductible** is not applicable to the following **covered expenses**:

- Female Brand Name and Generic Contraceptive Devices.
- Female Brand Name and Generic Contraceptive Prescription Drugs.
- Female Over-the-Counter Contraceptive Methods.

**COINSURANCE**

**Covered Medical Expenses** are payable at the coinsurance percentage specified below, after any applicable deductible, up to a maximum benefit **per Condition, per Policy Year**.

**Plan 1: \$100,000 Maximum Per Condition Per Policy Year**

**Plan 2: \$500,000 Maximum Per Condition Per Policy Year**

Out of Pocket Maximum-

Once the Out-of-Pocket Limit has been satisfied, **Covered Medical Expenses** will be payable at **100%** for the remainder of the Policy Year up to any benefit maximum that may apply.

Individual Out of Pocket: **\$1,500**

Family Out of Pocket: **\$3,000**

**Tier I:** When a referral is obtained, benefits will be paid at the Tier I Level when rendered by a **Preferred Care** provider.

**Tier II:** When a referral is not obtained but care is rendered by a **Preferred Care** provider, benefits will be paid at the Tier II Level.

**Tier III:** When care is rendered by a **Non-Preferred Care** provider, benefits will be paid at the Tier III Level.

**All coverage is based on Reasonable Charges unless otherwise specified.**

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
<b>Inpatient Hospitalization Benefits</b>			
Hospital Room and Board Expense	<b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care With Referral:</u> After a <b>\$300</b> copay per admission, <b>90%</b> of Negotiated Charges.	<b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care:</u> After a <b>\$300</b> copay per admission, <b>80%</b> of the Negotiated Charge.	<b>Covered Medical Expenses</b> are payable as follows: <u>Non-Preferred Care:</u> After a <b>\$300</b> deductible per admission, <b>65%</b> of the Recognized Charge.
Intensive Care Unit Expense	<b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care With Referral:</u> After a <b>\$300</b> copay per admission, <b>90%</b> of Negotiated Charges.	<b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care:</u> After a <b>\$300</b> copay per admission, <b>80%</b> of the Negotiated Charge.	<b>Covered Medical Expenses</b> are payable as follows: <u>Non-Preferred Care:</u> After a <b>\$300</b> copay per admission, <b>65%</b> of Recognized Charge for the Intensive Care Room Rate for an overnight stay.

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Miscellaneous Hospital Expense	<p><b>Covered Medical Expenses</b> include, but are not limited to: laboratory tests, X-rays, surgical dressings, anesthesia, supplies and equipment use, and medicines.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care With Referral:</u> <b>90%</b> of Negotiated Charges.</p>	<p><b>Covered Medical Expenses</b> include, but are not limited to: laboratory tests, X-rays, surgical dressings, anesthesia, supplies and equipment use, and medicines.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.</p>	<p><b>Covered Medical Expenses</b> include, but are not limited to: laboratory tests, X-rays, surgical dressings, anesthesia, supplies and equipment use, and medicines.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Non-Preferred Care:</u> <b>65%</b> of the Recognized Charge.</p>
Non-Surgical Physicians Expense	<p><b>Covered Medical Expenses</b> include, but are not limited to: laboratory tests, X-rays, surgical dressings, anesthesia, supplies and equipment use, and medicines.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care With Referral:</u> <b>90%</b> of Negotiated Charges.</p>	<p><b>Covered Medical Expenses</b> include, but are not limited to: laboratory tests, X-rays, surgical dressings, anesthesia, supplies and equipment use, and medicines.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.</p>	<p><b>Covered Medical Expenses</b> include, but are not limited to: laboratory tests, X-rays, surgical dressings, anesthesia, supplies and equipment use, and medicines.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Non-Preferred Care:</u> <b>65%</b> of the Recognized Charge.</p>
<b>Surgical Benefits (Inpatient and Outpatient)</b>			
Surgical Expense	<p><b>Covered Medical Expenses</b> for charges for surgical services, performed by a physician, are payable as follows:</p> <p><u>Preferred Care With Referral:</u> <b>90%</b> of Negotiated Charges.</p>	<p><b>Covered Medical Expenses</b> for charges for surgical services, performed by a physician, are payable as follows:</p> <p><u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.</p>	<p><b>Covered Medical Expenses</b> for charges for surgical services, performed by a physician, are payable as follows:</p> <p><u>Non-Preferred Care:</u> <b>65%</b> of the Recognized Charge.</p>
Anesthesia Expenses	<p><b>Covered Medical Expenses</b> for the charges of Anesthesia, during a surgical procedure, are payable as follows:</p> <p><u>Preferred Care With Referral:</u> <b>90%</b> of Negotiated Charges.</p>	<p><b>Covered Medical Expenses</b> for the charges of Anesthesia, during a surgical procedure, are payable as follows:</p> <p><u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.</p>	<p><b>Covered Medical Expenses</b> for the charges of Anesthesia, during a surgical procedure, are payable as follows:</p> <p><u>Non-Preferred Care:</u> <b>65%</b> of the Recognized Charge.</p>
Assistant Surgeon Expenses	<p><b>Covered Medical Expenses</b> for the charges of an assistant surgeon, during a surgical procedure, are payable as follows:</p> <p><u>Preferred Care With Referral:</u> <b>90%</b> of Negotiated Charges.</p>	<p><b>Covered Medical Expenses</b> for the charges of an assistant surgeon, during a surgical procedure, are payable as follows:</p> <p><u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.</p>	<p><b>Covered Medical Expenses</b> for the charges of an assistant surgeon, during a surgical procedure, are payable as follows:</p> <p><u>Non-Preferred Care:</u> <b>65%</b> of the Recognized Charge.</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Ambulatory Surgical Expense	Benefits are payable for <b>Covered Medical Expenses</b> incurred by a covered person for expenses incurred for outpatient surgery performed in a hospital outpatient surgery department or in an ambulatory surgical center.  <b>Covered Medical Expenses</b> must be incurred on the day of the surgery or within 48 hours after the surgery.  <u>Preferred Care With Referral:</u> <b>90%</b> of Negotiated Charges.	Benefits are payable for <b>Covered Medical Expenses</b> incurred by a covered person for expenses incurred for outpatient surgery performed in a hospital outpatient surgery department or in an ambulatory surgical center.  <b>Covered Medical Expenses</b> must be incurred on the day of the surgery or within 48 hours after the surgery.  <u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.	Benefits are payable for <b>Covered Medical Expenses</b> incurred by a covered person for expenses incurred for outpatient surgery performed in a hospital outpatient surgery department or in an ambulatory surgical center.  <b>Covered Medical Expenses</b> must be incurred on the day of the surgery or within 48 hours after the surgery.  <u>Non-Preferred Care:</u> <b>65%</b> of the Recognized Charge.
	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
<b>Outpatient Benefits</b>			
<b>Covered Medical Expenses</b> include but are not limited to: Physician's office visits, Hospital or Outpatient department or Emergency Room visits, Durable Medical Equipment, clinical lab, or radiological facility.			
Hospital Outpatient Department Expense	<b>Covered Medical Expenses</b> includes treatment rendered in a Hospital Outpatient Department. <b>Covered Medical Expenses</b> do not include Emergency Room/Urgent Care Treatment, Walk-in Clinic, Therapy Expenses, Chemotherapy and Radiation, and outpatient surgical services, including physician, anesthesia and facility charges, which are covered as outlined under the individual benefit types listed in this schedule of benefits.  <u>Preferred Care With Referral:</u> <b>90%</b> of Negotiated Charges.	<b>Covered Medical Expenses</b> includes treatment rendered in a Hospital Outpatient Department. <b>Covered Medical Expenses</b> do not include Emergency Room/Urgent Care Treatment, Walk-in Clinic, Therapy Expenses, Chemotherapy and Radiation, and outpatient surgical services, including physician, anesthesia and facility charges, which are covered as outlined under the individual benefit types listed in this schedule of benefits.  <u>Preferred Care:</u> <b>80%</b> of Negotiated Charges.	<b>Covered Medical Expenses</b> includes treatment rendered in a Hospital Outpatient Department. <b>Covered Medical Expenses</b> do not include Emergency Room/Urgent Care Treatment, Walk-in Clinic, Therapy Expenses, Chemotherapy and Radiation, and outpatient surgical services, including physician, anesthesia and facility charges, which are covered as outlined under the individual benefit types listed in this schedule of benefits.  <u>Non-Preferred Care:</u> <b>65%</b> of the Recognized Charge.

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Walk-In Clinic Visit Expense	<p>Benefits are payable for <b>Covered Medical Expenses</b> incurred by a covered person for the use of: diagnostic X-ray and laboratory services; consultants or specialists; etc.</p> <p><b>Covered Medical Expenses</b> do not include expenses incurred for an outpatient surgical facility.</p> <p><u>Preferred Care No Referral Required:</u> After a <b>\$10</b> Copay, <b>100%</b> of the Negotiated Charge.</p>	<p>Benefits are payable for <b>Covered Medical Expenses</b> incurred by a covered person for the use of: diagnostic X-ray and laboratory services; consultants or specialists; etc.</p> <p><b>Covered Medical Expenses</b> do not include expenses incurred for an outpatient surgical facility.</p> <p><u>Preferred Care:</u> After a <b>\$10</b> Copay, <b>100%</b> of the Negotiated Charge.</p>	<p>Benefits are payable for <b>Covered Medical Expenses</b> incurred by a covered person for the use of: diagnostic X-ray and laboratory services; consultants or specialists; etc.</p> <p><b>Covered Medical Expenses</b> do not include expenses incurred for an outpatient surgical facility.</p> <p><u>Non-Preferred Care:</u> <b>65%</b> of the Recognized Charge.</p>
Emergency Room Expense	<p><b>Covered Medical Expenses</b> incurred for treatment of an Emergency Medical Condition are payable as follows:</p> <p><u>Preferred Care With Referral:</u> After a <b>\$100</b> Copay (waived if admitted), <b>100%</b> of the Negotiated Charge.</p> <p><b>Important Note:</b>Please note that as <b>Non-Preferred Care Providers</b> do not have a contract with <b>Aetna</b>, the provider may not accept payment of your cost share (your <b>deductible</b> and <b>coinsurance</b>) 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. Please send <b>Aetna</b> the bill at the address listed on the back of your member ID card and <b>Aetna</b> will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.</p>	<p><b>Covered Medical Expenses</b> incurred for treatment of an Emergency Medical Condition are payable as follows:</p> <p><u>Preferred Care:</u> After a <b>\$100</b> Deductible (waived if admitted), <b>100%</b> the Negotiated Charge.</p> <p><b>Important Note:</b>Please note that as <b>Non-Preferred Care Providers</b> do not have a contract with <b>Aetna</b>, the provider may not accept payment of your cost share (your <b>deductible</b> and <b>coinsurance</b>) 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. Please send <b>Aetna</b> the bill at the address listed on the back of your member ID card and <b>Aetna</b> will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.</p>	<p><b>Covered Medical Expenses</b> incurred for treatment of an Emergency Medical Condition are payable as follows:</p> <p><u>Non-Preferred Care:</u> After a <b>\$100</b> Deductible (waived if admitted), <b>100%</b> of the Recognized Charge.</p> <p><b>Important Note:</b>Please note that as <b>Non-Preferred Care Providers</b> do not have a contract with <b>Aetna</b>, the provider may not accept payment of your cost share (your <b>deductible</b> and <b>coinsurance</b>) 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. Please send <b>Aetna</b> the bill at the address listed on the back of your member ID card and <b>Aetna</b> will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Urgent Care Expense	<p>Benefits include charges for treatment by an Urgent Care Provider.</p> <p><b>Please Note: A Covered Person should not seek medical care or treatment from an Urgent Care Provider if their illness, injury, or condition is an emergency condition.</b> The Covered Person should go directly to the emergency room of a Hospital, or call <b>911</b> for ambulance and medical assistance.</p> <p><b>Urgent Care</b> Benefits include charges for an Urgent Care provider to evaluate and treat an urgent condition. <b>Covered Medical Expenses</b> for Urgent Care treatment are payable as follows:</p> <p><u>Preferred Care No Referral Required:</u> After a <b>\$10</b> Copay, <b>100%</b> of the Negotiated Charge.</p>	<p>Benefits include charges for treatment by an Urgent Care Provider.</p> <p><b>Please Note: A Covered Person should not seek medical care or treatment from an Urgent Care Provider if their illness, injury, or condition is an emergency condition.</b> The Covered Person should go directly to the emergency room of a Hospital, or call <b>911</b> for ambulance and medical assistance.</p> <p><b>Urgent Care</b> Benefits include charges for an Urgent Care provider to evaluate and treat an urgent condition. <b>Covered Medical Expenses</b> for Urgent Care treatment are payable as follows:</p> <p><u>Preferred Care:</u> After a <b>\$10</b> Deductible, <b>100%</b> the Negotiated Charge.</p>	<p>Benefits include charges for treatment by an Urgent Care Provider.</p> <p><b>Please note: A Covered Person should not seek medical care or treatment from an Urgent Care Provider if their illness, injury, or condition is an emergency condition.</b> The Covered Person should go directly to the emergency room of a Hospital, or call <b>911</b> for ambulance and medical assistance.</p> <p><b>Urgent Care</b> Benefits include charges for an Urgent Care provider to evaluate and treat an urgent condition. <b>Covered Medical Expenses</b> for Urgent Care treatment are payable as follows:</p> <p><u>Non-Preferred Care:</u> <b>65%</b> of the Recognized Charge.</p>
Ambulance Expense	<p><b>Covered Medical Expenses</b> are payable for the services of a professional ambulance to or from a hospital, when required due to the emergency nature of a covered Accident.</p> <p><u>Preferred Care- No Referral Required:</u> <b>80%</b> of the Actual Charge.</p>	<p><b>Covered Medical Expenses</b> are payable for the services of a professional ambulance to or from a hospital, when required due to the emergency nature of a covered Accident.</p> <p><u>Preferred Care Without Referral:</u> <b>80%</b> of the Actual Charge.</p>	<p><b>Covered Medical Expenses</b> are payable for the services of a professional ambulance to or from a hospital, when required due to the emergency nature of a covered Accident.</p> <p><u>Non-Preferred Care:</u> <b>80%</b> of the Actual Charge.</p>
Pre-Admission Testing Expense	<p><b>Covered Medical Expenses</b> for Pre-Admission testing charges while an outpatient before scheduled surgery are payable as follows:</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p>	<p><b>Covered Medical Expenses</b> for Pre-Admission testing charges while an outpatient before scheduled surgery are payable as follows:</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p>	<p><b>Covered Medical Expenses</b> for Pre-Admission testing charges while an outpatient before scheduled surgery are payable as follows:</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p>



	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Physician's Office Visits Expense	<p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care With Referral:</u> After a <b>\$10</b> Copay, <b>100%</b> of the Negotiated Charge.</p> <p>This benefit includes visits to specialists.</p>	<p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care:</u> After a <b>\$25</b> Deductible, <b>100%</b> the Negotiated Charge.</p> <p>This benefit includes visits to specialists.</p>	<p><b>Covered Medical Expenses</b> are payable as follows: <u>Non-Preferred Care:</u> <b>65%</b> of the Recognized Charge.</p> <p>This benefit includes visits to specialists.</p>
Laboratory and X-ray Expense	<p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care With Referral:</u> <b>90%</b> of the Negotiated Charge.</p>	<p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.</p>	<p><b>Covered Medical Expenses</b> are payable as follows: <u>Non-Preferred Care:</u> <b>65%</b> of the Recognized Charge.</p>
High Cost Procedure Expense	<p><b>Covered Medical Expenses</b> include charges incurred by a <b>covered person</b> for High Cost Procedures that are required as a result of <b>injury</b> or <b>sickness</b>. Expenses for High Cost Procedures; which must be provided on an outpatient basis; may be incurred in the following:</p> <ul style="list-style-type: none"> <li>• A <b>physician's</b> office; or</li> <li>• <b>Hospital</b> outpatient department; or emergency room; or</li> <li>• Clinical laboratory; or</li> <li>• Radiological facility; or other similar facility; licensed by the applicable state; or the state in which the facility is located.</li> </ul> <p><b>Covered Medical Expenses</b> for High Cost Procedures include charges for the following procedures and services:</p> <ul style="list-style-type: none"> <li>• C.A.T. Scan;</li> <li>• Magnetic Resonance Imaging; and</li> <li>• Contrast Materials for these tests.</li> </ul> <p><u>Preferred Care With Referral:</u> <b>90%</b> of the Negotiated Charge.</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a <b>covered person</b> for High Cost Procedures that are required as a result of <b>injury</b> or <b>sickness</b>. Expenses for High Cost Procedures; which must be provided on an outpatient basis; may be incurred in the following:</p> <ul style="list-style-type: none"> <li>• A <b>physician's</b> office; or</li> <li>• <b>Hospital</b> outpatient department; or emergency room; or</li> <li>• Clinical laboratory; or</li> <li>• Radiological facility; or other similar facility; licensed by the applicable state; or the state in which the facility is located.</li> </ul> <p><b>Covered Medical Expenses</b> for High Cost Procedures include charges for the following procedures and services:</p> <ul style="list-style-type: none"> <li>• C.A.T. Scan;</li> <li>• Magnetic Resonance Imaging; and</li> <li>• Contrast Materials for these tests.</li> </ul> <p><u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a <b>covered person</b> for High Cost Procedures that are required as a result of <b>injury</b> or <b>sickness</b>. Expenses for High Cost Procedures; which must be provided on an outpatient basis; may be incurred in the following:</p> <ul style="list-style-type: none"> <li>• A <b>physician's</b> office; or</li> <li>• <b>Hospital</b> outpatient department; or emergency room; or</li> <li>• Clinical laboratory; or</li> <li>• Radiological facility; or other similar facility; licensed by the applicable state; or the state in which the facility is located.</li> </ul> <p><b>Covered Medical Expenses</b> for High Cost Procedures include charges for the following procedures and services:</p> <ul style="list-style-type: none"> <li>• C.A.T. Scan;</li> <li>• Magnetic Resonance Imaging; and</li> <li>• Contrast Materials for these tests.</li> </ul> <p><u>Non-Preferred Care:</u> <b>65%</b> of the Recognized Charge.</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Therapy Expense	<p><b>Covered Medical Expenses</b> include charges incurred by a Covered Person for the following types of therapy provided on an outpatient basis:</p> <ul style="list-style-type: none"> <li>• Physical therapy,</li> <li>• Chiropractic care,</li> <li>• Speech therapy,</li> <li>• Cardiac Rehabilitation,</li> <li>• Inhalation therapy,</li> <li>• Hearing Therapy, or</li> <li>• Occupational therapy.</li> </ul> <p>Expenses for Chiropractic Care are <b>Covered Medical Expenses</b>, if such care is related to neuromusculoskeletal conditions and conditions arising from the lack of normal nerve, muscle, and/or joint function.</p> <p>Expenses for Speech and Occupational Therapies are <b>Covered Medical Expenses</b>, only if such therapies are a result of Injury or Sickness.</p> <p>All therapy must be provided by a therapist who is licensed in accordance with state law, and practicing within the scope of their license.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care With Referral:</u> <b>90%</b> of the Negotiated Charge.</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a Covered Person for the following types of therapy provided on an outpatient basis:</p> <ul style="list-style-type: none"> <li>• Physical therapy,</li> <li>• Chiropractic care,</li> <li>• Speech therapy,</li> <li>• Cardiac Rehabilitation,</li> <li>• Inhalation therapy,</li> <li>• Hearing Therapy, or</li> <li>• Occupational therapy.</li> </ul> <p>Expenses for Chiropractic Care are <b>Covered Medical Expenses</b>, if such care is related to neuromusculoskeletal conditions and conditions arising from the lack of normal nerve, muscle, and/or joint function.</p> <p>Expenses for Speech and Occupational Therapies are <b>Covered Medical Expenses</b>, only if such therapies are a result of Injury or Sickness.</p> <p>All therapy must be provided by a therapist who is licensed in accordance with state law, and practicing within the scope of their license.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a Covered Person for the following types of therapy provided on an outpatient basis:</p> <ul style="list-style-type: none"> <li>• Physical therapy,</li> <li>• Chiropractic care,</li> <li>• Speech therapy,</li> <li>• Cardiac Rehabilitation,</li> <li>• Inhalation therapy,</li> <li>• Hearing Therapy, or</li> <li>• Occupational therapy.</li> </ul> <p>Expenses for Chiropractic Care are <b>Covered Medical Expenses</b>, if such care is related to neuromusculoskeletal conditions and conditions arising from the lack of normal nerve, muscle, and/or joint function.</p> <p>Expenses for Speech and Occupational Therapies are <b>Covered Medical Expenses</b>, only if such therapies are a result of Injury or Sickness.</p> <p>All therapy must be provided by a therapist who is licensed in accordance with state law, and practicing within the scope of their license.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Non-Preferred Care:</u> <b>65%</b> of the Recognized Charge.</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Chemotherapy Expense	<p><b>Covered Medical Expenses</b> also include charges incurred by a Covered Person for the following types of therapy provided on an outpatient basis:</p> <ul style="list-style-type: none"> <li>• Radiation therapy,</li> <li>• Chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy,</li> <li>• Dialysis, and</li> <li>• Respiratory therapy.</li> </ul> <p>Benefits for these types of therapies are payable for <b>Covered Medical Expenses</b> on the same basis as any other <b>Sickness</b>:</p> <p><u>Preferred Care With Referral:</u> <b>90%</b> of the Negotiated Charge.</p>	<p><b>Covered Medical Expenses</b> also include charges incurred by a Covered Person for the following types of therapy provided on an outpatient basis:</p> <ul style="list-style-type: none"> <li>• Radiation therapy,</li> <li>• Chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy,</li> <li>• Dialysis, and</li> <li>• Respiratory therapy.</li> </ul> <p>Benefits for these types of therapies are payable for <b>Covered Medical Expenses</b> on the same basis as any other <b>Sickness</b>:</p> <p><u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.</p>	<p><b>Covered Medical Expenses</b> also include charges incurred by a Covered Person for the following types of therapy provided on an outpatient basis:</p> <ul style="list-style-type: none"> <li>• Radiation therapy,</li> <li>• Chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy,</li> <li>• Dialysis, and</li> <li>• Respiratory therapy.</li> </ul> <p>Benefits for these types of therapies are payable for <b>Covered Medical Expenses</b> on the same basis as any other <b>Sickness</b>:</p> <p><u>Non-Preferred Care:</u> <b>65%</b> of the Recognized Charge.</p>
Durable Medical and Surgical Equipment Expense	<p>Benefits are payable for <b>Covered Medical Expenses</b> incurred by a covered person as a result of renting durable medical and surgical equipment.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care With Referral:</u> <b>80%</b> of the Negotiated Charge.</p> <p><b>Breast Feeding Durable Medical Equipment</b> Coverage includes the rental or purchase of breast feeding <b>durable medical equipment</b> for the purpose of lactation support (pumping and storage of breast milk) as follows.</p> <p><u>Preferred Care:</u> <b>100%</b> of the Negotiated Charge.</p> <p><i>Breast Pump</i> <b>Covered expenses</b> include the following:</p> <ul style="list-style-type: none"> <li>• The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a <b>hospital</b>.</li> </ul>	<p>Benefits are payable for <b>Covered Medical Expenses</b> incurred by a covered person as a result of renting durable medical and surgical equipment.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.</p> <p><b>Breast Feeding Durable Medical Equipment</b> Coverage includes the rental or purchase of breast feeding <b>durable medical equipment</b> for the purpose of lactation support (pumping and storage of breast milk) as follows.</p> <p><u>Preferred Care:</u> <b>100%</b> of the Negotiated Charge.</p> <p><i>Breast Pump</i> <b>Covered expenses</b> include the following:</p> <ul style="list-style-type: none"> <li>• The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a <b>hospital</b>.</li> </ul>	<p>Benefits are payable for <b>Covered Medical Expenses</b> incurred by a covered person as a result of renting durable medical and surgical equipment.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Non-Preferred Care:</u> <b>80%</b> of the Recognized Charge.</p> <p><b>Breast Feeding Durable Medical Equipment</b> Coverage includes the rental or purchase of breast feeding <b>durable medical equipment</b> for the purpose of lactation support (pumping and storage of breast milk) as follows.</p> <p><u>Non-Preferred Care:</u> <b>80%</b> of the Recognized Charge.</p> <p><i>Breast Pump</i> <b>Covered expenses</b> include the following:</p> <ul style="list-style-type: none"> <li>• The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a <b>hospital</b>.</li> </ul>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Durable Medical and Surgical Equipment Expense <i>(continued)</i>	<ul style="list-style-type: none"> <li>The purchase of: <ul style="list-style-type: none"> <li>an electric breast pump (non-hospital grade), if requested within 30 days from the date of the birth of the child. A purchase will be covered once every five years following the date of the birth; or</li> <li>a manual breast pump, if requested within 6-12 months from the date of the birth of the child. A purchase will be covered once every five years following the date of the birth.</li> </ul> </li> <li>If an electric breast pump was purchased within the previous one year period, the purchase of an electric or manual breast pump will <u>not</u> be covered until a five year period has elapsed from the last purchase of an electric pump.</li> </ul> <p><i>Breast Pump Supplies</i> Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.</p> <p>Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. The covered person is responsible for the entire cost of any additional pieces of the same or similar equipment that he or she purchases or rents for personal convenience or mobility.</p> <p><b>Aetna</b> reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The</p>	<ul style="list-style-type: none"> <li>The purchase of: <ul style="list-style-type: none"> <li>an electric breast pump (non-hospital grade), if requested within 30 days from the date of the birth of the child. A purchase will be covered once every five years following the date of the birth; or</li> <li>a manual breast pump, if requested within 6-12 months from the date of the birth of the child. A purchase will be covered once every five years following the date of the birth.</li> </ul> </li> <li>If an electric breast pump was purchased within the previous one year period, the purchase of an electric or manual breast pump will <u>not</u> be covered until a five year period has elapsed from the last purchase of an electric pump.</li> </ul> <p><i>Breast Pump Supplies</i> Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.</p> <p>Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. The covered person is responsible for the entire cost of any additional pieces of the same or similar equipment that he or she purchases or rents for personal convenience or mobility.</p> <p><b>Aetna</b> reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The</p>	<ul style="list-style-type: none"> <li>The purchase of: <ul style="list-style-type: none"> <li>an electric breast pump (non-hospital grade), if requested within 30 days from the date of the birth of the child. A purchase will be covered once every five years following the date of the birth; or</li> <li>a manual breast pump, if requested within 6-12 months from the date of the birth of the child. A purchase will be covered once every five years following the date of the birth.</li> </ul> </li> <li>If an electric breast pump was purchased within the previous one year period, the purchase of an electric or manual breast pump will <u>not</u> be covered until a five year period has elapsed from the last purchase of an electric pump.</li> </ul> <p><i>Breast Pump Supplies</i> Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.</p> <p>Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. The covered person is responsible for the entire cost of any additional pieces of the same or similar equipment that he or she purchases or rents for personal convenience or mobility.</p> <p><b>Aetna</b> reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Durable Medical and Surgical Equipment Expense <i>(continued)</i>	<p>decision to rent or purchase is at the discretion of <b>Aetna</b>.</p> <p><b>Limitations</b> Unless specified above, not covered under this benefit are charges incurred for:</p> <ul style="list-style-type: none"> <li>• Services which are covered to any extent under any other part of this Plan.</li> </ul>	<p>decision to rent or purchase is at the discretion of <b>Aetna</b>.</p> <p><b>Limitations</b> Unless specified above, not covered under this benefit are charges incurred for:</p> <ul style="list-style-type: none"> <li>• Services which are covered to any extent under any other part of this Plan.</li> </ul>	<p>decision to rent or purchase is at the discretion of <b>Aetna</b>.</p> <p><b>Limitations</b> Unless specified above, not covered under this benefit are charges incurred for:</p> <ul style="list-style-type: none"> <li>• Services which are covered to any extent under any other part of this Plan.</li> </ul>
Prosthetic Devices Expense	<p><b>Covered Medical Expenses</b> include charges for: artificial limbs, or eyes, and other non-dental prosthetic devices, as a result of an accident or sickness. Wigs required as a result of chemo or radiation therapy.</p> <p><b>Covered Medical Expenses</b> include coverage for such items as the fitting; adjustment and repair of such devices.</p> <p><b>Covered Medical Expenses do not</b> include: eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care With Referral</u>: <b>80%</b> of the Negotiated Charge.</p>	<p><b>Covered Medical Expenses</b> include charges for: artificial limbs, or eyes, and other non-dental prosthetic devices, as a result of an accident or sickness. Wigs required as a result of chemo or radiation therapy.</p> <p><b>Covered Medical Expenses</b> include coverage for such items as the fitting; adjustment and repair of such devices.</p> <p><b>Covered Medical Expenses do not</b> include: eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care</u>: <b>80%</b> of the Negotiated Charge.</p>	<p><b>Covered Medical Expenses</b> include charges for: artificial limbs, or eyes, and other non-dental prosthetic devices, as a result of an accident or sickness. Wigs required as a result of chemo or radiation therapy.</p> <p><b>Covered Medical Expenses</b> include coverage for such items as the fitting; adjustment and repair of such devices.</p> <p><b>Covered Medical Expenses do not</b> include: eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Non-Preferred Care</u>: <b>80%</b> of the Recognized Charge.</p>
Dental Injury Expense	<p><b>Covered Medical Expenses</b> include dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition:</p> <ul style="list-style-type: none"> <li>• natural teeth damaged, lost, or removed, or</li> <li>• other body tissues of the mouth fractured or cut due to Injury. The Accident causing the Injury must occur while the person is covered under this Plan.</li> </ul> <p>Any such teeth must have been:</p> <ul style="list-style-type: none"> <li>• free from decay, or</li> </ul>	<p><b>Covered Medical Expenses</b> include dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition:</p> <ul style="list-style-type: none"> <li>• natural teeth damaged, lost, or removed, or</li> <li>• other body tissues of the mouth fractured or cut due to Injury. The Accident causing the Injury must occur while the person is covered under this Plan.</li> </ul> <p>Any such teeth must have been:</p> <ul style="list-style-type: none"> <li>• free from decay, or</li> </ul>	<p><b>Covered Medical Expenses</b> include dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition:</p> <ul style="list-style-type: none"> <li>• natural teeth damaged, lost, or removed, or</li> <li>• other body tissues of the mouth fractured or cut due to Injury. The Accident causing the Injury must occur while the person is covered under this Plan.</li> </ul> <p>Any such teeth must have been:</p> <ul style="list-style-type: none"> <li>• free from decay, or</li> </ul>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Dental Injury Expense (continued)	<ul style="list-style-type: none"> <li>• in good repair, and</li> <li>• firmly attached to the jawbone at the time of the Injury. The treatment must be done in the calendar year of the Accident or the next one.</li> </ul> <p>If:</p> <ul style="list-style-type: none"> <li>• crowns (caps), or</li> <li>• dentures (false teeth), or</li> <li>• bridgework, or</li> <li>• in-mouth appliances, are installed due to such Injury.</li> </ul> <p><b>Covered Medical Expenses</b> include only charges for:</p> <ul style="list-style-type: none"> <li>• the first denture or fixed bridgework to replace lost teeth,</li> <li>• the first crown needed to repair each damaged tooth, and</li> <li>• an in-mouth appliance used in the first course of orthodontic treatment after the Injury.</li> </ul> <p>Surgery needed to:</p> <ul style="list-style-type: none"> <li>• Treat a fracture, dislocation, or wound.</li> <li>• Cut out cysts, tumors, or other diseased tissues.</li> <li>• Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.</li> </ul> <p>Non-surgical treatment of infections or diseases. This does not include those of, or related to, the teeth.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care With Referral:</u> <b>80%</b> of the Actual Charge.</p>	<ul style="list-style-type: none"> <li>• in good repair, and</li> <li>• firmly attached to the jawbone at the time of the Injury. The treatment must be done in the calendar year of the Accident or the next one.</li> </ul> <p>If:</p> <ul style="list-style-type: none"> <li>• crowns (caps), or</li> <li>• dentures (false teeth), or</li> <li>• bridgework, or</li> <li>• in-mouth appliances, are installed due to such Injury.</li> </ul> <p><b>Covered Medical Expenses</b> include only charges for:</p> <ul style="list-style-type: none"> <li>• the first denture or fixed bridgework to replace lost teeth,</li> <li>• the first crown needed to repair each damaged tooth, and</li> <li>• an in-mouth appliance used in the first course of orthodontic treatment after the Injury.</li> </ul> <p>Surgery needed to:</p> <ul style="list-style-type: none"> <li>• Treat a fracture, dislocation, or wound.</li> <li>• Cut out cysts, tumors, or other diseased tissues.</li> <li>• Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.</li> </ul> <p>Non-surgical treatment of infections or diseases. This does not include those of, or related to, the teeth.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care:</u> <b>80%</b> of the Actual Charge.</p>	<ul style="list-style-type: none"> <li>• in good repair, and</li> <li>• firmly attached to the jawbone at the time of the Injury. The treatment must be done in the calendar year of the Accident or the next one.</li> </ul> <p>If:</p> <ul style="list-style-type: none"> <li>• crowns (caps), or</li> <li>• dentures (false teeth), or</li> <li>• bridgework, or</li> <li>• in-mouth appliances, are installed due to such Injury.</li> </ul> <p><b>Covered Medical Expenses</b> include only charges for:</p> <ul style="list-style-type: none"> <li>• the first denture or fixed bridgework to replace lost teeth,</li> <li>• the first crown needed to repair each damaged tooth, and</li> <li>• an in-mouth appliance used in the first course of orthodontic treatment after the Injury.</li> </ul> <p>Surgery needed to:</p> <ul style="list-style-type: none"> <li>• Treat a fracture, dislocation, or wound.</li> <li>• Cut out cysts, tumors, or other diseased tissues.</li> <li>• Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.</li> </ul> <p>Non-surgical treatment of infections or diseases. This does not include those of, or related to, the teeth.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Non-Preferred Care:</u> <b>80%</b> of the Actual Charge.</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Impacted Wisdom Teeth Expense	<p><b>Covered Medical Expenses</b> for removal of one or more impacted wisdom teeth are payable as follows:</p> <p><u>Preferred Care With Referral:</u> <b>80%</b> of the Actual Charge</p>	<p><b>Covered Medical Expenses</b> for removal of one or more impacted wisdom teeth are payable as follows:</p> <p><u>Preferred Care:</u> <b>80%</b> of the Actual Charge.</p>	<p><b>Covered Medical Expenses</b> for removal of one or more impacted wisdom teeth are payable as follows:</p> <p><u>Preferred Care:</u> <b>80%</b> of the Actual Charge.</p>
Dental Anesthesia and Hospitalization	<p><b>Covered Medical Expenses</b> will include medically necessary general anesthesia and hospitalization or facilities charges for a licensed outpatient surgery facility for dental care if it is determined by provider that patient requires general anesthesia and admission to a hospital or outpatient surgery facility in order to effectively and safely provide dental care. It is provided for those covered persons under the age of five, severely disabled individuals, or persons who have a medical condition and requires admission to a hospital or outpatient surgery facility and general anesthesia for dental care treatment.</p> <p>Medical necessity is determined by the treating provider as to whether age, physical condition or mental condition of the covered person requires authorization for general anesthesia and the admission to a hospital or outpatient surgery facility to safely provide dental care.</p> <p>Benefits are payable on the same basis as any other condition.</p>	<p><b>Covered Medical Expenses</b> will include medically necessary general anesthesia and hospitalization or facilities charges for a licensed outpatient surgery facility for dental care if it is determined by provider that patient requires general anesthesia and admission to a hospital or outpatient surgery facility in order to effectively and safely provide dental care. It is provided for those covered persons under the age of five, severely disabled individuals, or persons who have a medical condition and requires admission to a hospital or outpatient surgery facility and general anesthesia for dental care treatment.</p> <p>Medical necessity is determined by the treating provider as to whether age, physical condition or mental condition of the covered person requires authorization for general anesthesia and the admission to a hospital or outpatient surgery facility to safely provide dental care.</p> <p>Benefits are payable on the same basis as any other condition.</p>	<p><b>Covered Medical Expenses</b> will include medically necessary general anesthesia and hospitalization or facilities charges for a licensed outpatient surgery facility for dental care if it is determined by provider that patient requires general anesthesia and admission to a hospital or outpatient surgery facility in order to effectively and safely provide dental care. It is provided for those covered persons under the age of five, severely disabled individuals, or persons who have a medical condition and requires admission to a hospital or outpatient surgery facility and general anesthesia for dental care treatment.</p> <p>Medical necessity is determined by the treating provider as to whether age, physical condition or mental condition of the covered person requires authorization for general anesthesia and the admission to a hospital or outpatient surgery facility to safely provide dental care.</p> <p>Benefits are payable on the same basis as any other condition.</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Diagnostic Testing for Attention Disorders and Learning Disabilities Expense	<p><b>Covered Medical Expenses</b> for diagnostic testing only for:</p> <ul style="list-style-type: none"> <li>• attention deficit disorder, or</li> <li>• attention deficit hyperactive disorder.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care With Referral:</u> <b>80%</b> of the Negotiated Charge.</p>	<p><b>Covered Medical Expenses</b> for diagnostic testing only for:</p> <ul style="list-style-type: none"> <li>• attention deficit disorder, or</li> <li>• attention deficit hyperactive disorder.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.</p>	<p><b>Covered Medical Expenses</b> for diagnostic testing only for:</p> <ul style="list-style-type: none"> <li>• attention deficit disorder, or</li> <li>• attention deficit hyperactive disorder.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Non-Preferred Care:</u> <b>80%</b> of the Recognized Charge.</p>
Allergy Testing and Treatment Expense	<p>Benefits include charges incurred for diagnostic testing and treatment of allergies and immunology services.</p> <p><b>Covered Medical Expenses</b> include, but are not limited to, charges for the following:</p> <ul style="list-style-type: none"> <li>• laboratory tests,</li> <li>• physician office visits, including visits to administer injections,</li> <li>• prescribed medications for testing and treatment of the allergy, including any equipment used in the administration of prescribed medication, and</li> <li>• other medically necessary supplies and services.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care With Referral:</u> <b>80%</b> of the Negotiated Charge.</p>	<p>Benefits include charges incurred for diagnostic testing and treatment of allergies and immunology services.</p> <p><b>Covered Medical Expenses</b> include, but are not limited to, charges for the following:</p> <ul style="list-style-type: none"> <li>• laboratory tests,</li> <li>• physician office visits, including visits to administer injections,</li> <li>• prescribed medications for testing and treatment of the allergy, including any equipment used in the administration of prescribed medication, and</li> <li>• other medically necessary supplies and services.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.</p>	<p>Benefits include charges incurred for diagnostic testing and treatment of allergies and immunology services.</p> <p><b>Covered Medical Expenses</b> include, but are not limited to, charges for the following:</p> <ul style="list-style-type: none"> <li>• laboratory tests,</li> <li>• physician office visits, including visits to administer injections,</li> <li>• prescribed medications for testing and treatment of the allergy, including any equipment used in the administration of prescribed medication, and</li> <li>• other medically necessary supplies and services.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Non-Preferred Care:</u> <b>65%</b> of the Recognized Charge.</p>
Routine Physical Exam Expense	<p>Benefits include expenses for a routine physical exam performed by a physician. If charges for a routine physical exam given to a child who is a covered dependent are covered under any other benefit section, those charges will not be covered under this section. A routine physical exam is a medical exam given by a physician, for a reason other than to diagnose or treat a suspected or identified injury or sickness. Included as a part of the exam are:</p>	<p>Benefits include expenses for a routine physical exam performed by a physician. If charges for a routine physical exam given to a child who is a covered dependent are covered under any other benefit section, those charges will not be covered under this section. A routine physical exam is a medical exam given by a physician, for a reason other than to diagnose or treat a suspected or identified injury or sickness. Included as a part of the exam are:</p>	<p>Benefits include expenses for a routine physical exam performed by a physician. If charges for a routine physical exam given to a child who is a covered dependent are covered under any other benefit section, those charges will not be covered under this section. A routine physical exam is a medical exam given by a physician, for a reason other than to diagnose or treat a suspected or identified injury or sickness. Included as a part of the exam are:</p>



	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Routine Physical Exam Expense <i>(continued)</i>	<ul style="list-style-type: none"> <li>• Routine vision and hearing screenings given as part of the routine physical exam.</li> <li>• X-rays, lab, and other tests given in connection with the exam, and</li> <li>• Materials for the administration of immunizations for infectious disease and testing for tuberculosis.</li> </ul> <p><u>Preferred Care with Referral:</u> visits are payable at <b>100%</b> of the Negotiated Charge.</p> <p><u>Preferred Care with Referral:</u> <b>immunizations</b> are payable at <b>100%</b> of the Negotiated Charge.</p> <ul style="list-style-type: none"> <li>• In addition to any state regulations or guidelines regarding mandated Routine Physical Exam services, <b>Covered Medical Expenses</b> include services rendered in conjunction with,</li> <li>• 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.</li> <li>• For females, screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to: <ul style="list-style-type: none"> <li>- Screening and counseling services, such as: <ul style="list-style-type: none"> <li>Interpersonal and domestic violence;</li> <li>Sexually transmitted diseases; and</li> <li>Human Immune Deficiency Virus (HIV) infections.</li> </ul> </li> <li>- Screening for gestational diabetes.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Routine vision and hearing screenings given as part of the routine physical exam.</li> <li>• X-rays, lab, and other tests given in connection with the exam, and</li> <li>• Materials for the administration of immunizations for infectious disease and testing for tuberculosis.</li> </ul> <p><u>Preferred Care:</u> <b>visits</b> are payable at <b>100%</b> of the Negotiated Charge.</p> <p><u>Preferred Care:</u> <b>immunizations</b> are payable at <b>100%</b> of the Negotiated Charge.</p> <ul style="list-style-type: none"> <li>• In addition to any state regulations or guidelines regarding mandated Routine Physical Exam services, <b>Covered Medical Expenses</b> include services rendered in conjunction with,</li> <li>• 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.</li> <li>• For females, screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to: <ul style="list-style-type: none"> <li>- Screening and counseling services, such as: <ul style="list-style-type: none"> <li>Interpersonal and domestic violence;</li> <li>Sexually transmitted diseases; and</li> <li>Human Immune Deficiency Virus (HIV) infections.</li> </ul> </li> <li>- Screening for gestational diabetes.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Routine vision and hearing screenings given as part of the routine physical exam.</li> <li>• X-rays, lab, and other tests given in connection with the exam, and</li> <li>• Materials for the administration of immunizations for infectious disease and testing for tuberculosis.</li> </ul> <p><u>Non-Preferred Care:</u> <b>visits</b> are payable at <b>100%</b> of the Recognized Charge.</p> <p><u>Non-Preferred Care:</u> <b>immunizations</b> are payable at <b>100%</b> of the Recognized Charge.</p> <ul style="list-style-type: none"> <li>• In addition to any state regulations or guidelines regarding mandated Routine Physical Exam services, <b>Covered Medical Expenses</b> include services rendered in conjunction with,</li> <li>• 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.</li> <li>• For females, screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to: <ul style="list-style-type: none"> <li>- Screening and counseling services, such as: <ul style="list-style-type: none"> <li>Interpersonal and domestic violence;</li> <li>Sexually transmitted diseases; and</li> <li>Human Immune Deficiency Virus (HIV) infections.</li> </ul> </li> <li>- Screening for gestational diabetes.</li> </ul> </li> </ul>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Routine Physical Exam Expense <i>(continued)</i>	<ul style="list-style-type: none"> <li>- High risk Human Papillomavirus (HPV) DNA testing for women age 18 and older and limited to once every three years.</li> <li>• X-rays, lab and other tests given in connection with the exam.</li> <li>• Immunizations for infectious diseases and the materials for administration of immunizations that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.</li> <li>• If the plan includes dependent coverage, for covered newborns, an initial <b>hospital</b> checkup.</li> </ul> <p>For a <b>child</b> who is a covered dependent:</p> <ul style="list-style-type: none"> <li>• The physical exam must include at least: <ul style="list-style-type: none"> <li>- A review and written record of the patient's complete medical history,</li> <li>- A check of all body systems, and</li> <li>- A review and discussion of the exam results with the patient or with the parent or guardian.</li> </ul> </li> <li>• For all exams given to covered dependent <b>under age 2, Covered Medical Expenses</b> will <b>not include</b> charges for the following: <ul style="list-style-type: none"> <li>- <b>More than</b> 6 exams performed during the first year of the child's life,</li> <li>- <b>More than</b> 2 exams performed during the second year of the child's life.</li> </ul> </li> <li>• For all exams given to a covered dependent from <b>age 2 and over, Covered Medical Expenses</b> will <b>not include</b> charges for <b>more than</b> one exam in 12 months in a row.</li> </ul>	<ul style="list-style-type: none"> <li>- High risk Human Papillomavirus (HPV) DNA testing for women age 18 and older and limited to once every three years.</li> <li>• X-rays, lab and other tests given in connection with the exam.</li> <li>• Immunizations for infectious diseases and the materials for administration of immunizations that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.</li> <li>• If the plan includes dependent coverage, for covered newborns, an initial <b>hospital</b> checkup.</li> </ul> <p>For a <b>child</b> who is a covered dependent:</p> <ul style="list-style-type: none"> <li>• The physical exam must include at least: <ul style="list-style-type: none"> <li>- A review and written record of the patient's complete medical history,</li> <li>- A check of all body systems, and</li> <li>- A review and discussion of the exam results with the patient or with the parent or guardian.</li> </ul> </li> <li>• For all exams given to covered dependent <b>under age 2, Covered Medical Expenses</b> will <b>not include</b> charges for the following: <ul style="list-style-type: none"> <li>- <b>More than</b> 6 exams performed during the first year of the child's life,</li> <li>- <b>More than</b> 2 exams performed during the second year of the child's life.</li> </ul> </li> <li>• For all exams given to a covered dependent from <b>age 2 and over, Covered Medical Expenses</b> will <b>not include</b> charges for <b>more than</b> one exam in 12 months in a row.</li> </ul>	<ul style="list-style-type: none"> <li>- High risk Human Papillomavirus (HPV) DNA testing for women age 18 and older and limited to once every three years.</li> <li>• X-rays, lab and other tests given in connection with the exam.</li> <li>• Immunizations for infectious diseases and the materials for administration of immunizations that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.</li> <li>• If the plan includes dependent coverage, for covered newborns, an initial <b>hospital</b> checkup.</li> </ul> <p>For a <b>child</b> who is a covered dependent:</p> <ul style="list-style-type: none"> <li>• The physical exam must include at least: <ul style="list-style-type: none"> <li>- A review and written record of the patient's complete medical history,</li> <li>- A check of all body systems, and</li> <li>- A review and discussion of the exam results with the patient or with the parent or guardian.</li> </ul> </li> <li>• For all exams given to covered dependent <b>under age 2, Covered Medical Expenses</b> will <b>not include</b> charges for the following: <ul style="list-style-type: none"> <li>- <b>More than</b> 6 exams performed during the first year of the child's life,</li> <li>- <b>More than</b> 2 exams performed during the second year of the child's life.</li> </ul> </li> <li>• For all exams given to a covered dependent from <b>age 2 and over, Covered Medical Expenses</b> will <b>not include</b> charges for <b>more than</b> one exam in 12 months in a row.</li> </ul>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Routine Physical Exam Expense <i>(continued)</i>	<p>For all exams given to a covered student or a spouse who is a covered dependent, <b>Covered Medical Expenses</b> will <b><u>not include</u></b> charges for <b><u>more than:</u></b></p> <ul style="list-style-type: none"> <li>• One exam in 12 months in a row.</li> </ul> <p><b>Covered Medical Expenses</b> incurred by a woman, are charges made by a physician for,</p> <ul style="list-style-type: none"> <li>• one annual routine gynecological exam.</li> </ul> <p><b>Screening and Counseling Services:</b> <b>Covered Medical Expenses</b> include charges made by a <b>physician</b> in an individual or group setting for the following:</p> <p><b>Obesity</b> Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:</p> <ul style="list-style-type: none"> <li>• Preventive counseling visits and/or risk factor reduction intervention;</li> <li>• Medical nutrition therapy;</li> <li>• Nutritional counseling; and</li> <li>• Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.</li> </ul> <p><b>Misuse of Alcohol and/or Drugs</b> Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.</p>	<p>For all exams given to a covered student or a spouse who is a covered dependent, <b>Covered Medical Expenses</b> will <b><u>not include</u></b> charges for <b><u>more than:</u></b></p> <ul style="list-style-type: none"> <li>• One exam in 12 months in a row.</li> </ul> <p><b>Covered Medical Expenses</b> incurred by a woman, are charges made by a physician for,</p> <ul style="list-style-type: none"> <li>• one annual routine gynecological exam.</li> </ul> <p><b>Screening and Counseling Services:</b> <b>Covered Medical Expenses</b> include charges made by a <b>physician</b> in an individual or group setting for the following:</p> <p><b>Obesity</b> Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:</p> <ul style="list-style-type: none"> <li>• Preventive counseling visits and/or risk factor reduction intervention;</li> <li>• Medical nutrition therapy;</li> <li>• Nutritional counseling; and</li> <li>• Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.</li> </ul> <p><b>Misuse of Alcohol and/or Drugs</b> Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.</p>	<p>For all exams given to a covered student or a spouse who is a covered dependent, <b>Covered Medical Expenses</b> will <b><u>not include</u></b> charges for <b><u>more than:</u></b></p> <ul style="list-style-type: none"> <li>• One exam in 12 months in a row.</li> </ul> <p><b>Covered Medical Expenses</b> incurred by a woman, are charges made by a physician for,</p> <ul style="list-style-type: none"> <li>• one annual routine gynecological exam.</li> </ul> <p><b>Screening and Counseling Services:</b> <b>Covered Medical Expenses</b> include charges made by a <b>physician</b> in an individual or group setting for the following:</p> <p><b>Obesity</b> Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:</p> <ul style="list-style-type: none"> <li>• Preventive counseling visits and/or risk factor reduction intervention;</li> <li>• Medical nutrition therapy;</li> <li>• Nutritional counseling; and</li> <li>• Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.</li> </ul> <p><b>Misuse of Alcohol and/or Drugs</b> Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Routine Physical Exam Expense <i>(continued)</i>	<p><b><i>Use of Tobacco Products</i></b> Screening and counseling services to aid a covered person to stop the use of tobacco products.</p> <p>Coverage includes:</p> <ul style="list-style-type: none"> <li>• Preventive counseling visits;</li> <li>• Treatment visits; and</li> <li>• Class visits; to aid a covered person to stop the use of tobacco products.</li> </ul> <p>Tobacco product means a substance containing tobacco or nicotine including:</p> <ul style="list-style-type: none"> <li>• cigarettes;</li> <li>• cigars;</li> <li>• smoking tobacco;</li> <li>• snuff;</li> <li>• smokeless tobacco; and</li> <li>• candy-like products that contain tobacco.</li> </ul> <p><b>Limitations</b> Unless specified above, not covered under this Screening and Counseling Services benefit are charges incurred for:</p> <ul style="list-style-type: none"> <li>• Services which are covered to any extent under any other part of this Plan</li> </ul>	<p><b><i>Use of Tobacco Products</i></b> Screening and counseling services to aid a covered person to stop the use of tobacco products.</p> <p>Coverage includes:</p> <ul style="list-style-type: none"> <li>• Preventive counseling visits;</li> <li>• Treatment visits; and</li> <li>• Class visits; to aid a covered person to stop the use of tobacco products.</li> </ul> <p>Tobacco product means a substance containing tobacco or nicotine including:</p> <ul style="list-style-type: none"> <li>• cigarettes;</li> <li>• cigars;</li> <li>• smoking tobacco;</li> <li>• snuff;</li> <li>• smokeless tobacco; and</li> <li>• candy-like products that contain tobacco.</li> </ul> <p><b>Limitations</b> Unless specified above, not covered under this Screening and Counseling Services benefit are charges incurred for:</p> <ul style="list-style-type: none"> <li>• Services which are covered to any extent under any other part of this Plan</li> </ul>	<p><b><i>Use of Tobacco Products</i></b> Screening and counseling services to aid a covered person to stop the use of tobacco products.</p> <p>Coverage includes:</p> <ul style="list-style-type: none"> <li>• Preventive counseling visits;</li> <li>• Treatment visits; and</li> <li>• Class visits; to aid a covered person to stop the use of tobacco products.</li> </ul> <p>Tobacco product means a substance containing tobacco or nicotine including:</p> <ul style="list-style-type: none"> <li>• cigarettes;</li> <li>• cigars;</li> <li>• smoking tobacco;</li> <li>• snuff;</li> <li>• smokeless tobacco; and</li> <li>• candy-like products that contain tobacco.</li> </ul> <p><b>Limitations</b> Unless specified above, not covered under this Screening and Counseling Services benefit are charges incurred for:</p> <ul style="list-style-type: none"> <li>• Services which are covered to any extent under any other part of this Plan</li> </ul>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Well Baby Care Expense	<p>Covered Medical Expenses include charges incurred by a covered person for Well Baby Care. Well Baby Care includes routine preventive and primary care services; rendered to a covered dependent child on an outpatient basis.</p> <p>Routine preventive and primary care services are services rendered to a covered dependent child of a covered person; from the date of birth through the attainment of two (2) years of age. Services include: initial hospital check-ups; other hospital visits; physical examinations; including routine hearing and vision examinations; medical history; developmental assessments; and materials for the administration of appropriate and necessary immunizations and laboratory tests; when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics.</p> <p><u>Preferred Care with Referral:</u> <b>100%</b> of the Negotiated Charge. Benefits are payable for scheduled visits in accordance with the prevailing clinical standards of the American Academy of Pediatrics.</p>	<p>Covered Medical Expenses include charges incurred by a covered person for Well Baby Care. Well Baby Care includes routine preventive and primary care services; rendered to a covered dependent child on an outpatient basis.</p> <p>Routine preventive and primary care services are services rendered to a covered dependent child of a covered person; from the date of birth through the attainment of two (2) years of age. Services include: initial hospital check-ups; other hospital visits; physical examinations; including routine hearing and vision examinations; medical history; developmental assessments; and materials for the administration of appropriate and necessary immunizations and laboratory tests; when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics.</p> <p><u>Preferred Care:</u> <b>100%</b> of the Negotiated Charge. Benefits are payable for scheduled visits in accordance with the prevailing clinical standards of the American Academy of Pediatrics.</p>	<p>Covered Medical Expenses include charges incurred by a covered person for Well Baby Care. Well Baby Care includes routine preventive and primary care services; rendered to a covered dependent child on an outpatient basis.</p> <p>Routine preventive and primary care services are services rendered to a covered dependent child of a covered person; from the date of birth through the attainment of two (2) years of age. Services include: initial hospital check-ups; other hospital visits; physical examinations; including routine hearing and vision examinations; medical history; developmental assessments; and materials for the administration of appropriate and necessary immunizations and laboratory tests; when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics.</p> <p><u>Non-Preferred Care:</u> <b>100%</b> of the Recognized Charge. Benefits are payable for scheduled visits in accordance with the prevailing clinical standards of the American Academy of Pediatrics.</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Early Intervention Services Expense	<p><b>Covered Medical Expenses:</b> even though they may not be incurred in connection with a disease or injury. They are included only for: a dependent child under the age of 3 years who has been certified by the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Act. You must submit proof of such certification with the initial claim.</p> <p><b>Early Intervention Services:</b> These are services designed to help an individual attain or retain the capability to function age-appropriately within his or her environment, including services that enhance functional ability without effecting a cure. They include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>• Speech and language therapy given in connection with a speech impairment: which results from a congenital abnormality, disease, or injury.</li> <li>• Occupational or physical therapy expected to result in significant improvement of a body function: impaired by a congenital abnormality, disease, or injury.</li> <li>• Assistive technology services.</li> <li>• Assistive technology devices.</li> </ul> <p><u>Preferred Care with Referral:</u> Payable on the same basis as any other condition.</p>	<p><b>Covered Medical Expenses:</b> even though they may not be incurred in connection with a disease or injury. They are included only for: a dependent child under the age of 3 years who has been certified by the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Act. You must submit proof of such certification with the initial claim.</p> <p><b>Early Intervention Services:</b> These are services designed to help an individual attain or retain the capability to function age-appropriately within his or her environment, including services that enhance functional ability without effecting a cure. They include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>• Speech and language therapy given in connection with a speech impairment: which results from a congenital abnormality, disease, or injury.</li> <li>• Occupational or physical therapy expected to result in significant improvement of a body function: impaired by a congenital abnormality, disease, or injury.</li> <li>• Assistive technology services.</li> <li>• Assistive technology devices.</li> </ul> <p><u>Preferred Care:</u> Payable on the same basis as any other condition.</p>	<p><b>Covered Medical Expenses:</b> even though they may not be incurred in connection with a disease or injury. They are included only for: a dependent child under the age of 3 years who has been certified by the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Act. You must submit proof of such certification with the initial claim.</p> <p><b>Early Intervention Services:</b> These are services designed to help an individual attain or retain the capability to function age-appropriately within his or her environment, including services that enhance functional ability without effecting a cure. They include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>• Speech and language therapy given in connection with a speech impairment: which results from a congenital abnormality, disease, or injury.</li> <li>• Occupational or physical therapy expected to result in significant improvement of a body function: impaired by a congenital abnormality, disease, or injury.</li> <li>• Assistive technology services.</li> <li>• Assistive technology devices.</li> </ul> <p><u>Non-Preferred Care:</u> Payable on the same basis as any other condition.</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Preventive Health Care Services Expense	<p><b>Covered Medical Expenses</b> include charges incurred by a <b>covered person</b> for Preventive Health Care Services which includes routine preventive and primary care services, rendered to a <b>covered dependent</b> child under 7 years of age on an outpatient basis.</p> <p><b>Preventive Health Care Services</b> These are services provided for a routine physical exam of the child. Included are:</p> <ul style="list-style-type: none"> <li>• A review and written record of the child’s complete medical history.</li> <li>• Taking measurements and blood pressure.</li> <li>• Developmental and behavioral assessment.</li> <li>• Vision and hearing screening.</li> <li>• Other diagnostic screening tests including: <ul style="list-style-type: none"> <li>- one series of hereditary and metabolic tests performed at birth,</li> <li>- urinalysis, tuberculin test, and blood tests such as hematocrit and hemoglobin tests.</li> </ul> </li> <li>• Immunizations for infectious disease.</li> <li>• Counseling and guidance of the child and the child’s parents or guardian on the results of the physical exam.</li> </ul> <p><b>Covered Medical Expenses</b> will only include charges incurred for:</p> <ul style="list-style-type: none"> <li>• The first 9 exams performed during the first 2 years of the child’s life.</li> <li>• One exam performed during each year of life thereafter through age 6.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care with Referral</u>: 100% of the Negotiated Charge.</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a <b>covered person</b> for Preventive Health Care Services which includes routine preventive and primary care services, rendered to a <b>covered dependent</b> child under 7 years of age on an outpatient basis.</p> <p><b>Preventive Health Care Services</b> These are services provided for a routine physical exam of the child. Included are:</p> <ul style="list-style-type: none"> <li>• A review and written record of the child’s complete medical history.</li> <li>• Taking measurements and blood pressure.</li> <li>• Developmental and behavioral assessment.</li> <li>• Vision and hearing screening.</li> <li>• Other diagnostic screening tests including: <ul style="list-style-type: none"> <li>- one series of hereditary and metabolic tests performed at birth,</li> <li>- urinalysis, tuberculin test, and blood tests such as hematocrit and hemoglobin tests.</li> </ul> </li> <li>• Immunizations for infectious disease.</li> <li>• Counseling and guidance of the child and the child’s parents or guardian on the results of the physical exam.</li> </ul> <p><b>Covered Medical Expenses</b> will only include charges incurred for:</p> <ul style="list-style-type: none"> <li>• The first 9 exams performed during the first 2 years of the child’s life.</li> <li>• One exam performed during each year of life thereafter through age 6.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care</u>: 100% of the Negotiated Charge.</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a <b>covered person</b> for Preventive Health Care Services which includes routine preventive and primary care services, rendered to a <b>covered dependent</b> child under 7 years of age on an outpatient basis.</p> <p><b>Preventive Health Care Services</b> These are services provided for a routine physical exam of the child. Included are:</p> <ul style="list-style-type: none"> <li>• A review and written record of the child’s complete medical history.</li> <li>• Taking measurements and blood pressure.</li> <li>• Developmental and behavioral assessment.</li> <li>• Vision and hearing screening.</li> <li>• Other diagnostic screening tests including: <ul style="list-style-type: none"> <li>- one series of hereditary and metabolic tests performed at birth,</li> <li>- urinalysis, tuberculin test, and blood tests such as hematocrit and hemoglobin tests.</li> </ul> </li> <li>• Immunizations for infectious disease.</li> <li>• Counseling and guidance of the child and the child’s parents or guardian on the results of the physical exam.</li> </ul> <p><b>Covered Medical Expenses</b> will only include charges incurred for:</p> <ul style="list-style-type: none"> <li>• The first 9 exams performed during the first 2 years of the child’s life.</li> <li>• One exam performed during each year of life thereafter through age 6.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Non-Preferred Care</u>: 100% of the Recognized Charge.</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Immunization Expense	<p><b>Covered Medical Expenses</b> include charges for all routine and necessary immunizations such as (diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella, and such other immunizations as may be prescribed by the Commissioner of Health) for newborn children to age 3, and</p> <ul style="list-style-type: none"> <li>• charges incurred by a covered student and dependent spouse for the materials for the administration of appropriate and <b>medically necessary</b> immunizations, and testing for tuberculosis, and</li> <li>• charges incurred by a covered dependent up to age 19, for the materials for the administration of appropriate and <b>medically necessary</b> immunizations, when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care with Referral</u>: 100% of the Negotiated Charge.</p> <p><b>Covered Medical Expenses do not include</b> a physician’s office visit in connection with immunization or testing for tuberculosis.</p>	<p><b>Covered Medical Expenses</b> include charges for all routine and necessary immunizations such as (diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella, and such other immunizations as may be prescribed by the Commissioner of Health) for newborn children to age 3, and</p> <ul style="list-style-type: none"> <li>• charges incurred by a covered student and dependent spouse for the materials for the administration of appropriate and <b>medically necessary</b> immunizations, and testing for tuberculosis, and</li> <li>• charges incurred by a covered dependent up to age 19, for the materials for the administration of appropriate and <b>medically necessary</b> immunizations, when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care</u>: 100% of the Negotiated Charge.</p> <p><b>Covered Medical Expenses do not include</b> a physician’s office visit in connection with immunization or testing for tuberculosis.</p>	<p><b>Covered Medical Expenses</b> include charges for all routine and necessary immunizations such as (diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella, and such other immunizations as may be prescribed by the Commissioner of Health) for newborn children to age 3, and</p> <ul style="list-style-type: none"> <li>• charges incurred by a covered student and dependent spouse for the materials for the administration of appropriate and <b>medically necessary</b> immunizations, and testing for tuberculosis, and</li> <li>• charges incurred by a covered dependent up to age 19, for the materials for the administration of appropriate and <b>medically necessary</b> immunizations, when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Non-Preferred Care</u>: 100% of the Recognized Charge.</p> <p><b>Covered Medical Expenses do not include</b> a physician’s office visit in connection with immunization or testing for tuberculosis.</p>



	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Child Immunization Expense	<p><b>Covered Medical Expenses</b> include charges for all routine and necessary immunizations such as (diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella, and such other immunizations as may be prescribed by the Commissioner of Health) for newborn children to age 3, and</p> <ul style="list-style-type: none"> <li>charges incurred by a covered student and dependent spouse for the materials for the administration of appropriate and <b>medically necessary</b> immunizations, and testing for tuberculosis, and</li> <li>charges incurred by a covered dependent up to age 19, for the materials for the administration of appropriate and <b>medically necessary</b> immunizations, when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care with Referral</u>: 100% of the Negotiated Charge.</p> <p><b>Covered Medical Expenses do not include</b> a physician's office visit in connection with immunization or testing for tuberculosis.</p>	<p><b>Covered Medical Expenses</b> include charges for all routine and necessary immunizations such as (diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella, and such other immunizations as may be prescribed by the Commissioner of Health) for newborn children to age 3, and</p> <ul style="list-style-type: none"> <li>charges incurred by a covered student and dependent spouse for the materials for the administration of appropriate and <b>medically necessary</b> immunizations, and testing for tuberculosis, and</li> <li>charges incurred by a covered dependent up to age 19, for the materials for the administration of appropriate and <b>medically necessary</b> immunizations, when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care</u>: 100% of the Negotiated Charge.</p> <p><b>Covered Medical Expenses do not include</b> a physician's office visit in connection with immunization or testing for tuberculosis.</p>	<p><b>Covered Medical Expenses</b> include charges for all routine and necessary immunizations such as (diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella, and such other immunizations as may be prescribed by the Commissioner of Health) for newborn children to age 3, and</p> <ul style="list-style-type: none"> <li>charges incurred by a covered student and dependent spouse for the materials for the administration of appropriate and <b>medically necessary</b> immunizations, and testing for tuberculosis, and</li> <li>charges incurred by a covered dependent up to age 19, for the materials for the administration of appropriate and <b>medically necessary</b> immunizations, when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Non-Preferred Care</u>: 100% of the Recognized Charge.</p> <p><b>Covered Medical Expenses do not include</b> a physician's office visit in connection with immunization or testing for tuberculosis.</p>
Newborn Hearing Screening Expense	<p>Coverage for infant hearing screenings and all necessary audiological examinations for newborn children.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p>	<p>Coverage for infant hearing screenings and all necessary audiological examinations for newborn children.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p>	<p>Coverage for infant hearing screenings and all necessary audiological examinations for newborn children.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Consultant Expense	<p><b>Covered Medical Expenses</b> include the expenses for the services of a consultant or specialist, when referred by the Student Health Services. The services must be requested by the attending physician for the purpose of confirming or determining to confirm or determine a diagnosis.</p> <p><b>Covered Medical Expenses</b> are covered as follows:  <u>Preferred Care With Referral:</u>  <b>80%</b> of Negotiated Rate.</p>	<p><b>Covered Medical Expenses</b> include the expenses for the services of a consultant or specialist, when referred by the Student Health Services. The services must be requested by the attending physician for the purpose of confirming or determining to confirm or determine a diagnosis.</p> <p><b>Covered Medical Expenses</b> are covered as follows:  <u>Preferred Care:</u>  <b>80%</b> of Negotiated Rate.</p>	<p><b>Covered Medical Expenses</b> include the expenses for the services of a consultant or specialist, when referred by the Student Health Services. The services must be requested by the attending physician for the purpose of confirming or determining to confirm or determine a diagnosis.</p> <p><b>Covered Medical Expenses</b> are covered as follows:  <u>Non-Preferred Care:</u>  <b>80%</b> of the Recognized Charge.</p>
	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
<b>Mental Health and Substance Abuse Benefits</b>			
Biologically-Based Mental Disorders Inpatient Expense	<p><b>Covered Medical Expenses</b> for the diagnosis and treatment of biologically based mental illnesses are payable as follows:</p> <p><u>Preferred Care With Referral:</u>  After a <b>\$300</b> Copay, <b>90%</b> of the Negotiated Charge.</p>	<p><b>Covered Medical Expenses</b> for the diagnosis and treatment of biologically based mental illnesses are payable as follows:</p> <p><u>Preferred Care:</u> After a <b>\$300</b> Copay, <b>80%</b> of the Negotiated Charge.</p>	<p><b>Covered Medical Expenses</b> for the diagnosis and treatment of biologically based mental illnesses are payable as follows:</p> <p><u>Non-Preferred Care:</u> After a <b>\$300</b> Deductible, <b>65%</b> of the Recognized Charge.</p>
Biologically-Based Mental Disorders Outpatient Expense	<p><b>Covered Medical Expenses</b> for the diagnosis and treatment of biologically based mental illnesses are payable as follows:</p> <p><u>Preferred Care With Referral:</u>  After a <b>\$10</b> copay, <b>100%</b> of the Negotiated Charge.</p>	<p><b>Covered Medical Expenses</b> for the diagnosis and treatment of biologically based mental illnesses are payable as follows:</p> <p><u>Preferred Care:</u> After a <b>\$25</b> copay, <b>100%</b> of the Negotiated Charge.</p>	<p><b>Covered Medical Expenses</b> for the diagnosis and treatment of biologically based mental illnesses are payable as follows:</p> <p><u>Non-Preferred Care:</u>  <b>65%</b> of the Recognized Charge.</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Treatment of Non-Biologically Based Mental and Nervous Disorders, Alcoholism, or Substance Abuse Inpatient Expense	<p><b>Covered Medical Expenses</b> for the Treatment of Non-Biologically Based Mental and Nervous Disorders, Alcoholism, or Substance Abuse while confined as a inpatient in a hospital or facility licensed for such treatment are payable as follows:</p> <p><u>Preferred Care With Referral:</u> After a <b>\$300</b> Copay, <b>90%</b> of the Negotiated Charge.</p> <p><b>Covered Medical Expenses</b> also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission, whereby 2 days of partial hospitalization may be exchanged for 1 day of full hospitalization.</p>	<p><b>Covered Medical Expenses</b> for the Treatment of Non-Biologically Based Mental and Nervous Disorders, Alcoholism, or Substance Abuse while confined as a inpatient in a hospital or facility licensed for such treatment are payable as follows:</p> <p><u>Preferred Care:</u> After a <b>\$300</b> Copay, <b>80%</b> of the Negotiated Charge.</p> <p><b>Covered Medical Expenses</b> also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission, whereby 2 days of partial hospitalization may be exchanged for 1 day of full hospitalization.</p>	<p><b>Covered Medical Expenses</b> for the Treatment of Non-Biologically Based Mental and Nervous Disorders, Alcoholism, or Substance Abuse while confined as a inpatient in a hospital or facility licensed for such treatment are payable as follows:</p> <p><u>Non-Preferred Care:</u> After a <b>\$300</b> Deductible, <b>65%</b> of the Recognized Charge.</p> <p><b>Covered Medical Expenses</b> also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission, whereby 2 days of partial hospitalization may be exchanged for 1 day of full hospitalization.</p>
Treatment of Non-Biologically Based Mental and Nervous Disorders, Alcoholism, or Substance Abuse Outpatient Expense	<p><b>Covered Medical Expenses</b> for outpatient Treatment of Non-Biologically Based Mental and Nervous Disorders, Alcoholism, or Substance Abuse are payable as follows:</p> <p><u>Preferred Care With Referral:</u> After a <b>\$10</b> copay, <b>100%</b> of the Negotiated Charge.</p> <p><b>Medication management visits</b> shall be covered in the same manner as a medication management visit for the treatment of physical illness and shall not be counted as an outpatient treatment visit.</p>	<p><b>Covered Medical Expenses</b> for outpatient Treatment of Non-Biologically Based Mental and Nervous Disorders, Alcoholism, or Substance Abuse are payable as follows:</p> <p><u>Preferred Care:</u> After a <b>\$25</b> copay, <b>100%</b> of the Negotiated Charge.</p> <p><b>Medication management visits</b> shall be covered in the same manner as a medication management visit for the treatment of physical illness and shall not be counted as an outpatient treatment visit.</p>	<p><b>Covered Medical Expenses</b> for outpatient Treatment of Non-Biologically Based Mental and Nervous Disorders, Alcoholism, or Substance Abuse are payable as follows:</p> <p><u>Non-Preferred Care:</u> <b>65%</b> of the Recognized Charge.</p> <p><b>Medication management visits</b> shall be covered in the same manner as a medication management visit for the treatment of physical illness and shall not be counted as an outpatient treatment visit.</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Autism Spectrum Disorder Expense	<p><b>Covered Medical Expenses</b> include coverage for the diagnosis and treatment of autism spectrum disorder in individuals age 2 through 6.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other sickness.</p>	<p><b>Covered Medical Expenses</b> include coverage for the diagnosis and treatment of autism spectrum disorder in individuals age 2 through 6.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other sickness.</p>	<p><b>Covered Medical Expenses</b> include coverage for the diagnosis and treatment of autism spectrum disorder in individuals age 2 through 6.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other sickness.</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
<b>Maternity Benefits</b>			
Maternity Expense	<p><b>Covered Medical Expenses</b> include inpatient care of the covered person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery.</p> <p>Any decision to shorten such minimum coverages shall be made by the attending Physician in consultation with the mother. In such cases, covered services may include: home visits, parent education, and assistance and training in breast or bottle-feeding.</p> <p><b>Covered Medical Expenses</b> for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other sickness.</p> <p><b>Prenatal Care</b> Prenatal care will be covered for services received by a pregnant female in a <b>physician's</b>, obstetrician's, or gynecologist's office but only to the extent described below.</p> <p>Coverage for prenatal care under this benefit is limited to pregnancy-related <b>physician</b> office visits including the initial and subsequent history and physical exams of the pregnant</p>	<p><b>Covered Medical Expenses</b> include inpatient care of the covered person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery.</p> <p>Any decision to shorten such minimum coverages shall be made by the attending Physician in consultation with the mother. In such cases, covered services may include: home visits, parent education, and assistance and training in breast or bottle-feeding.</p> <p><b>Covered Medical Expenses</b> for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other sickness.</p> <p><b>Prenatal Care</b> Prenatal care will be covered for services received by a pregnant female in a <b>physician's</b>, obstetrician's, or gynecologist's office but only to the extent described below.</p> <p>Coverage for prenatal care under this benefit is limited to pregnancy-related <b>physician</b> office visits including the initial and subsequent history and physical exams of the pregnant</p>	<p><b>Covered Medical Expenses</b> include inpatient care of the covered person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery.</p> <p>Any decision to shorten such minimum coverages shall be made by the attending Physician in consultation with the mother. In such cases, covered services may include: home visits, parent education, and assistance and training in breast or bottle-feeding.</p> <p><b>Covered Medical Expenses</b> for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other sickness.</p> <p><b>Prenatal Care</b> Prenatal care will be covered for services received by a pregnant female in a <b>physician's</b>, obstetrician's, or gynecologist's office but only to the extent described below.</p> <p>Coverage for prenatal care under this benefit is limited to pregnancy-related <b>physician</b> office visits including the initial and subsequent history and physical exams of the pregnant</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Maternity Expense (continued)	<p>woman (maternal weight, blood pressure and fetal heart rate check).</p> <p><b>Comprehensive Lactation Support and Counseling Services</b> <b>Covered Medical Expenses</b> will include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy and in the postpartum period by a certified lactation support provider. The “postpartum period” means the 60 day period directly following the child’s date of birth. <b>Covered expenses</b> incurred during the post-partum period also include the rental or purchase of breast feeding equipment as described below.</p> <p>Lactation support and lactation counseling services are <b>covered expenses</b> when provided in either a group or individual setting.</p> <p><b>Covered Medical Expenses</b> for Prenatal Care and Comprehensive Lactation Support and Counseling Services are payable as follows: <u>Preferred Care: 100%</u> of the Negotiated Charge.</p>	<p>woman (maternal weight, blood pressure and fetal heart rate check).</p> <p><b>Comprehensive Lactation Support and Counseling Services</b> <b>Covered Medical Expenses</b> will include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy and in the postpartum period by a certified lactation support provider. The “postpartum period” means the 60 day period directly following the child’s date of birth. <b>Covered expenses</b> incurred during the post-partum period also include the rental or purchase of breast feeding equipment as described below.</p> <p>Lactation support and lactation counseling services are <b>covered expenses</b> when provided in either a group or individual setting.</p> <p><b>Covered Medical Expenses</b> for Prenatal Care and Comprehensive Lactation Support and Counseling Services are payable as follows: <u>Preferred Care: 100%</u> of the Negotiated Charge.</p>	<p>woman (maternal weight, blood pressure and fetal heart rate check).</p> <p><b>Comprehensive Lactation Support and Counseling Services</b> <b>Covered Medical Expenses</b> will include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy and in the post-partum period by a certified lactation support provider. The “postpartum period” means the 60 day period directly following the child’s date of birth. <b>Covered expenses</b> incurred during the postpartum period also include the rental or purchase of breast feeding equipment as described below.</p> <p>Lactation support and lactation counseling services are <b>covered expenses</b> when provided in either a group or individual setting.</p> <p><b>Covered Medical Expenses</b> for Prenatal Care and Comprehensive Lactation Support and Counseling Services are payable as follows: <u>Preferred Care: 100%</u> of the Negotiated Charge.</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Well Newborn Nursery Care Expense	<p>Benefits include charges for routine care of a Covered Person's newborn child as follows:</p> <ul style="list-style-type: none"> <li>• Hospital charges for routine nursery care during the mother's confinement, but for not more than four days for a normal delivery,</li> <li>• Physician's charges for circumcision, and</li> <li>• Physician's charges for visits to the newborn child in the Hospital and consultations, but for not more than 1 visit per day.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care With Referral:</u> <b>90%</b> of Negotiated Charges.</p>	<p>Benefits include charges for routine care of a Covered Person's newborn child as follows:</p> <ul style="list-style-type: none"> <li>• Hospital charges for routine nursery care during the mother's confinement, but for not more than four days for a normal delivery,</li> <li>• Physician's charges for circumcision, and</li> <li>• Physician's charges for visits to the newborn child in the Hospital and consultations, but for not more than 1 visit per day.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.</p>	<p>Benefits include charges for routine care of a Covered Person's newborn child as follows:</p> <ul style="list-style-type: none"> <li>• Hospital charges for routine nursery care during the mother's confinement, but for not more than four days for a normal delivery,</li> <li>• Physician's charges for circumcision, and</li> <li>• Physician's charges for visits to the newborn child in the Hospital and consultations, but for not more than 1 visit per day.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Non-Preferred Care:</u> <b>65%</b> of the Recognized Charge.</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
<b>Additional Benefits</b>			
Prescribed Medicines Expense	<p><b>Prescription Drug Benefits are payable as follows:</b> Covers Medically Necessary prescriptions associated with a covered Sickness or Accident occurring during the Policy Year. Please use your Aetna Student Health ID card when obtaining your prescriptions. <b>Preferred Pharmacy allowing for a 30-day supply fill option:</b> <b>100%</b> Negotiated Charge following:</p> <ul style="list-style-type: none"> <li>• <b>\$20</b> Copay for each Generic Prescription Drug.</li> <li>• <b>\$30</b> Copay for each Preferred Brand Name Prescription Drug.</li> <li>• <b>\$40</b> Copay for each Non-Preferred Brand Name Prescription Drug.</li> </ul> <p>Benefits are limited to a maximum of \$100,000 per Policy Year.</p>	<p><b>Prescription Drug Benefits are payable as follows:</b> Covers Medically Necessary prescriptions associated with a covered Sickness or Accident occurring during the Policy Year. Please use your Aetna Student Health ID card when obtaining your prescriptions. <b>Preferred Pharmacy allowing for a 30-day supply fill option:</b> <b>100%</b> Negotiated Charge following:</p> <ul style="list-style-type: none"> <li>• <b>\$20</b> Copay for each Generic Prescription Drug.</li> <li>• <b>\$30</b> Copay for each Preferred Brand Name Prescription Drug.</li> <li>• <b>\$40</b> Copay for each Non-Preferred Brand Name Prescription Drug.</li> </ul> <p>Benefits are limited to a maximum of \$100,000 per Policy Year.</p>	<p><b>Prescription Drug Benefits are payable as follows:</b> Covers Medically Necessary prescriptions associated with a covered Sickness or Accident occurring during the Policy Year. Please use your Aetna Student Health ID card when obtaining your prescriptions. <b>Non-Preferred Care Pharmacy 30 day supply fill option:</b> <b>100%</b> of the Recognized Charge following:</p> <ul style="list-style-type: none"> <li>• <b>\$20</b> Deductible for each Generic Prescription Drug.</li> <li>• <b>\$30</b> Deductible for each Preferred Brand Name Prescription Drug.</li> <li>• <b>\$40</b> Deductible for each Non-Preferred Drug.</li> </ul> <p>Benefits are limited to a maximum of \$100,000 per Policy Year.</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Prescribed Medicines Expense <i>(continued)</i>	<p>Prior Authorization is required for growth hormone and more than a 30-day fill per prescription at retail.</p> <p>This Pharmacy benefit is provided to cover Medically Necessary Prescriptions associated with a covered Sickness or Accident occurring during the Policy Year. Covered Medical Expenses also include prescription smoking cessations aids. Please use your Aetna Student Health ID card when obtaining your prescriptions.</p> <p>Prior Authorization may be required for certain Prescription <b>Drugs</b> and some medications may not be covered <b>under</b> this Plan. For assistance and <b>a complete list of excluded medications</b>, or drugs requiring <b>prior authorization</b>, please contact Aetna Pharmacy Management at <b>888 RX-AETNA</b> (available 24 hours).</p> <p>Aetna Specialty Pharmacy provides specialty medications and support to members living with chronic conditions. The medications offered may be injected, infused or taken by mouth. For additional information please go to <b>www.AetnaSpecialtyRx.com</b>.</p> <p><b>Please Note: Covered Medical Expenses</b> for prescribed supplies for the treatment of diabetes will not be subject to the listed per Policy Year Prescription Drug limit.</p> <p><b>Covered Medical Expenses</b> include drugs approved by the USFDA for use in the treatment of cancer, even if the drug has not specifically been approved for treatment of the specific</p>	<p>Prior Authorization is required for growth hormone and more than a 30-day fill per prescription at retail.</p> <p>This Pharmacy benefit is provided to cover Medically Necessary Prescriptions associated with a covered Sickness or Accident occurring during the Policy Year. Covered Medical Expenses also include prescription smoking cessations aids. Please use your Aetna Student Health ID card when obtaining your prescriptions.</p> <p>Prior Authorization may be required for certain Prescription <b>Drugs</b> and some medications may not be covered <b>under</b> this Plan. For assistance and <b>a complete list of excluded medications</b>, or drugs requiring <b>prior authorization</b>, please contact Aetna Pharmacy Management at <b>888 RX-AETNA</b> (available 24 hours).</p> <p>Aetna Specialty Pharmacy provides specialty medications and support to members living with chronic conditions. The medications offered may be injected, infused or taken by mouth. For additional information please go to <b>www.AetnaSpecialtyRx.com</b>.</p> <p><b>Please Note: Covered Medical Expenses</b> for prescribed supplies for the treatment of diabetes will not be subject to the listed per Policy Year Prescription Drug limit.</p> <p><b>Covered Medical Expenses</b> include drugs approved by the USFDA for use in the treatment of cancer, even if the drug has not specifically been approved for treatment of the specific</p>	<p>Prior Authorization is required for growth hormone and more than a 30-day fill per prescription at retail.</p> <p>This Pharmacy benefit is provided to cover Medically Necessary Prescriptions associated with a covered Sickness or Accident occurring during the Policy Year. Covered Medical Expenses also include prescription smoking cessations aids. Please use your Aetna Student Health ID card when obtaining your prescriptions.</p> <p>Prior Authorization may be required for certain Prescription <b>Drugs</b> and some medications may not be covered <b>under</b> this Plan. For assistance and <b>a complete list of excluded medications</b>, or drugs requiring <b>prior authorization</b>, please contact Aetna Pharmacy Management at <b>888 RX-AETNA</b> (available 24 hours).</p> <p>Aetna Specialty Pharmacy provides specialty medications and support to members living with chronic conditions. The medications offered may be injected, infused or taken by mouth. For additional information please go to <b>www.AetnaSpecialtyRx.com</b>.</p> <p><b>Please Note: Covered Medical Expenses</b> for prescribed supplies for the treatment of diabetes will not be subject to the listed per Policy Year Prescription Drug limit.</p> <p><b>Covered Medical Expenses</b> include drugs approved by the USFDA for use in the treatment of cancer, even if the drug has not specifically been approved for treatment of the specific</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Prescribed Medicines Expense <i>(continued)</i>	cancer for which the drug has been prescribed.  *Contraceptive Drugs and Device benefits are illustrated under the Family Planning Benefit of this Policy.	cancer for which the drug has been prescribed.  *Contraceptive Drugs and Device benefits are illustrated under the Family Planning Benefit of this Policy.	cancer for which the drug has been prescribed.  *Contraceptive Drugs and Device benefits are illustrated under the Family Planning Benefit of this Policy.
Diabetic Testing Supplies Expense	Benefits include charges for testing material used to detect the presence of sugar in the person's urine or blood for monitoring glycemic control. Diabetic Testing Supplies are limited to: <ul style="list-style-type: none"> <li>• Lancet devices,</li> <li>• Glucose monitors, and</li> <li>• Test strips, and</li> <li>• Hypodermic syringes.</li> </ul> Insulin, or other items used in the treatment of diabetes are not covered by this benefit.  <b>Covered Medical Expenses</b> are payable on the same basis as any other condition.  Diabetic related supplies may be filled directly at any Aetna participating pharmacy, without submission for reimbursement necessary.	Benefits include charges for testing material used to detect the presence of sugar in the person's urine or blood for monitoring glycemic control. Diabetic Testing Supplies are limited to: <ul style="list-style-type: none"> <li>• Lancet devices,</li> <li>• Glucose monitors, and</li> <li>• Test strips, and</li> <li>• Hypodermic syringes.</li> </ul> Insulin, or other items used in the treatment of diabetes are not covered by this benefit.  <b>Covered Medical Expenses</b> are payable on the same basis as any other condition.  Diabetic related supplies may be filled directly at any Aetna participating pharmacy, without submission for reimbursement necessary.	Benefits include charges for testing material used to detect the presence of sugar in the person's urine or blood for monitoring glycemic control. Diabetic Testing Supplies are limited to: <ul style="list-style-type: none"> <li>• Lancet devices,</li> <li>• Glucose monitors, and</li> <li>• Test strips, and</li> <li>• Hypodermic syringes.</li> </ul> Insulin, or other items used in the treatment of diabetes are not covered by this benefit.  <b>Covered Medical Expenses</b> are payable on the same basis as any other condition.  Diabetic related supplies may be filled directly at any Aetna participating pharmacy, without submission for reimbursement necessary.
Hypodermic Needles Expense	<b>Covered Medical Expenses</b> for hypodermic needles and syringes used in the treatment of diabetes are payable same basis as any other condition.	<b>Covered Medical Expenses</b> for hypodermic needles and syringes used in the treatment of diabetes are payable same basis as any other condition.	<b>Covered Medical Expenses</b> for hypodermic needles and syringes used in the treatment of diabetes are payable same basis as any other condition.
Outpatient Diabetic Self-management Education Programs Expense	<b>Covered Medical Expenses</b> for in-person, outpatient diabetic self-management education programs as follows:  <b>Covered Medical Expenses</b> are payable on the same basis as any other condition.	<b>Covered Medical Expenses</b> for in-person, outpatient diabetic self-management education programs are payable as follows:  <b>Covered Medical Expenses</b> are payable on the same basis as any other condition.	<b>Covered Medical Expenses</b> for in-person, outpatient diabetic self-management education programs are payable as follows:  <b>Covered Medical Expenses</b> are payable on the same basis as any other condition.



	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Temporomandibular Joint Dysfunction Expense	<p><b>Covered Medical Expenses</b> include charges incurred by a covered person for treatment of Temporomandibular Joint (TMJ) Dysfunction.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a covered person for treatment of Temporomandibular Joint (TMJ) Dysfunction.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a covered person for treatment of Temporomandibular Joint (TMJ) Dysfunction.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p>
Bones and Joints Expense	<p><b>Covered Medical Expenses</b> include charges incurred by a <b>covered person</b> for the diagnosis and surgical treatment involving any bone or joint of the head, neck, face or jaw if the treatment is required due to a medical condition or injury which prevents normal function of the bone or joint.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a <b>covered person</b> for the diagnosis and surgical treatment involving any bone or joint of the head, neck, face or jaw if the treatment is required due to a medical condition or injury which prevents normal function of the bone or joint.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a <b>covered person</b> for the diagnosis and surgical treatment involving any bone or joint of the head, neck, face or jaw if the treatment is required due to a medical condition or injury which prevents normal function of the bone or joint.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p>
Cleft Lip/Palate or Ectodermal Dysplasia Expense for Newborns	<p>Inpatient and outpatient dental, oral surgical and orthodontic services which are medically necessary for the treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia subject to deductibles, coinsurance and maximums no more restrictive than for any covered sickness or injury.</p> <p>Treatment may include:</p> <ol style="list-style-type: none"> <li>Oral surgery and facial surgery. This includes pre-operative and postoperative care performed by a <b>physician</b>.</li> <li>Oral prosthesis treatment, obturators and orthodontic appliances.</li> <li>Initial installation of partial or full removable dentures or of fixed bridgework</li> <li>Replacement of dentures by dentures or fixed bridgework by fixed bridgework when required</li> </ol>	<p>Inpatient and outpatient dental, oral surgical and orthodontic services which are medically necessary for the treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia subject to deductibles, coinsurance and maximums no more restrictive than for any covered sickness or injury.</p> <p>Treatment may include:</p> <ol style="list-style-type: none"> <li>Oral surgery and facial surgery. This includes pre-operative and postoperative care performed by a <b>physician</b>.</li> <li>Oral prosthesis treatment, obturators and orthodontic appliances.</li> <li>Initial installation of partial or full removable dentures or of fixed bridgework</li> <li>Replacement of dentures by dentures or fixed bridgework by fixed bridgework when required</li> </ol>	<p>Inpatient and outpatient dental, oral surgical and orthodontic services which are medically necessary for the treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia subject to deductibles, coinsurance and maximums no more restrictive than for any covered sickness or injury.</p> <p>Treatment may include:</p> <ol style="list-style-type: none"> <li>Oral surgery and facial surgery. This includes pre-operative and postoperative care performed by a <b>physician</b>.</li> <li>Oral prosthesis treatment, obturators and orthodontic appliances.</li> <li>Initial installation of partial or full removable dentures or of fixed bridgework</li> <li>Replacement of dentures by dentures or fixed bridgework by fixed bridgework when required as a result of</li> </ol>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Cleft Lip/Palate or Ectodermal Dysplasia Expense for Newborns <i>(continued)</i>	<p>as a result of structural changes in the mouth or jaw due to growth.</p> <p>e) Cleft orthodontic therapy.</p> <p>f) Diagnostic services of a <b>physician</b> to find out if and to what extent the child’s ability to speak or hear has been lost or impaired.</p> <p>g) Rehabilitative services given by a <b>physician</b> that is expected to restore or improve the child’s ability to speak. This includes speech aids and training in the use of such aids.</p> <p>h) Psychological assessment and counseling.</p> <p>i) Genetic assessment and counseling for the child and the child’s parents.</p> <p>j) Hearing aids.</p> <p>A legally qualified audiologist or speech therapist will be deemed to be a “<b>physician</b>” for the purposes of this section.</p> <p><b>Covered Medical Expenses</b> will be payable on the same basis as any other condition.</p>	<p>as a result of structural changes in the mouth or jaw due to growth.</p> <p>e) Cleft orthodontic therapy.</p> <p>f) Diagnostic services of a <b>physician</b> to find out if and to what extent the child’s ability to speak or hear has been lost or impaired.</p> <p>g) Rehabilitative services given by a <b>physician</b> that is expected to restore or improve the child’s ability to speak. This includes speech aids and training in the use of such aids.</p> <p>h) Psychological assessment and counseling.</p> <p>i) Genetic assessment and counseling for the child and the child’s parents.</p> <p>j) Hearing aids.</p> <p>A legally qualified audiologist or speech therapist will be deemed to be a “<b>physician</b>” for the purposes of this section.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p>	<p>structural changes in the mouth or jaw due to growth.</p> <p>e) Cleft orthodontic therapy.</p> <p>f) Diagnostic services of a <b>physician</b> to find out if and to what extent the child’s ability to speak or hear has been lost or impaired.</p> <p>g) Rehabilitative services given by a <b>physician</b> that is expected to restore or improve the child’s ability to speak. This includes speech aids and training in the use of such aids.</p> <p>h) Psychological assessment and counseling.</p> <p>i) Genetic assessment and counseling for the child and the child’s parents.</p> <p>j) Hearing aids.</p> <p>A legally qualified audiologist or speech therapist will be deemed to be a “<b>physician</b>” for the purposes of this section.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p>
Clinical Trial Expense	<p>Clinical Trial Expenses are payable for <b>Covered Medical Expenses</b> incurred by each <b>covered person</b>. A clinical trial meets the following conditions:</p> <ul style="list-style-type: none"> <li>• The clinical trial is intended to treat cancer in a patient who has been so diagnosed,</li> <li>• The clinical trial has been peer reviewed, and is approved by one of the</li> <li>• United States National Institutes of Health (NIH), a cooperative group or center of the NIH including the National Cancer Institute Clinical Cooperative Group and the National Cancer Institute Community Clinical Oncology Program, and</li> </ul>	<p>Clinical Trial Expenses are payable for <b>Covered Medical Expenses</b> incurred by each <b>covered person</b>. A clinical trial meets the following conditions:</p> <ul style="list-style-type: none"> <li>• The clinical trial is intended to treat cancer in a patient who has been so diagnosed,</li> <li>• The clinical trial has been peer reviewed, and is approved by one of the</li> <li>• United States National Institutes of Health (NIH), a cooperative group or center of the NIH including the National Cancer Institute Clinical Cooperative Group and the National Cancer Institute Community Clinical Oncology Program, and</li> </ul>	<p>Clinical Trial Expenses are payable for <b>Covered Medical Expenses</b> incurred by each <b>covered person</b>. A clinical trial meets the following conditions:</p> <ul style="list-style-type: none"> <li>• The clinical trial is intended to treat cancer in a patient who has been so diagnosed,</li> <li>• The clinical trial has been peer reviewed, and is approved by one of the</li> <li>• United States National Institutes of Health (NIH), a cooperative group or center of the NIH including the National Cancer Institute Clinical Cooperative Group and the National Cancer Institute Community Clinical Oncology Program, and</li> </ul>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Clinical Trial Expense <i>(continued)</i>	<p>With respect to Phase II, Phase III, or Phase IV clinical trials, the treatment shall be provided if approved by:</p> <ul style="list-style-type: none"> <li>a) The NIH,</li> <li>b) A National Cancer Institute cooperative group or center,</li> <li>c) The FDA in the form of an investigational new drug application,</li> <li>d) The federal Department of Veterans Affairs, and</li> <li>e) An institutional review board approved by the Office of Protection from Research Risks of the NCI.</li> </ul> <p>With respect to Phase I clinical trials, treatment may be provided on a case-by-case basis.</p> <p>The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training, and treat a sufficient volume of patients to maintain that expertise.</p> <p>Coverage shall apply only if:</p> <ul style="list-style-type: none"> <li>a) There is no clearly superior, non-investigational treatment alternative,</li> <li>b) The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative, and</li> <li>c) The <b>covered person</b> or <b>physician</b> or health care provider conclude that the covered person's participation in the clinical trial would be appropriate pursuant to this policy.</li> </ul> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p>	<p>With respect to Phase II, Phase III, or Phase IV clinical trials, the treatment shall be provided if approved by:</p> <ul style="list-style-type: none"> <li>a) The NIH,</li> <li>b) A National Cancer Institute cooperative group or center,</li> <li>c) The FDA in the form of an investigational new drug application,</li> <li>d) The federal Department of Veterans Affairs, and</li> <li>e) An institutional review board approved by the Office of Protection from Research Risks of the NCI.</li> </ul> <p>With respect to Phase I clinical trials, treatment may be provided on a case-by-case basis.</p> <p>The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training, and treat a sufficient volume of patients to maintain that expertise.</p> <p>Coverage shall apply only if:</p> <ul style="list-style-type: none"> <li>a) There is no clearly superior, non-investigational treatment alternative,</li> <li>b) The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative, and</li> <li>c) The <b>covered person</b> or <b>physician</b> or health care provider conclude that the covered person's participation in the clinical trial would be appropriate pursuant to this policy.</li> </ul> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p>	<p>With respect to Phase II, Phase III, or Phase IV clinical trials, the treatment shall be provided if approved by:</p> <ul style="list-style-type: none"> <li>a) The NIH,</li> <li>b) A National Cancer Institute cooperative group or center,</li> <li>c) The FDA in the form of an investigational new drug application,</li> <li>d) The federal Department of Veterans Affairs, and</li> <li>e) An institutional review board approved by the Office of Protection from Research Risks of the NCI.</li> </ul> <p>With respect to Phase I clinical trials, treatment may be provided on a case-by-case basis.</p> <p>The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training, and treat a sufficient volume of patients to maintain that expertise.</p> <p>Coverage shall apply only if:</p> <ul style="list-style-type: none"> <li>a) There is no clearly superior, non-investigational treatment alternative,</li> <li>b) The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative, and</li> <li>c) The <b>covered person</b> or <b>physician</b> or health care provider conclude that the covered person's participation in the clinical trial would be appropriate pursuant to this policy.</li> </ul> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Home Treatment of Hemophilia Expense	<p><b>Covered Medical Expenses</b> include charges incurred by a <b>covered person</b> for expenses incurred in connection with the treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. The benefits to be provided shall include coverage for the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders when the home treatment program is under the supervision of the state-approved hemophilia treatment center.</p> <ul style="list-style-type: none"> <li>• “Blood infusion equipment” includes, but is not limited to, syringes and needles.</li> <li>• “Blood product” includes, but is not limited to, Factor VII, Factor VIII, Factor IX, and cryoprecipitate.</li> <li>• “Hemophilia” means a lifelong hereditary bleeding disorder usually affecting males that results in prolonged bleeding primarily into joints and muscles</li> <li>• “Home treatment program” means a program where individuals or family members are trained to provide infusion therapy at home in order to achieve optimal health and cost effectiveness.</li> <li>• “State-approved hemophilia treatment center” means a hospital or clinic which receives federal or state Maternal and Child Health Bureau, and/or Centers for Disease Control funds to conduct comprehensive care for persons with hemophilia and other congenital bleeding disorders.</li> </ul>	<p><b>Covered Medical Expenses</b> include charges incurred by a <b>covered person</b> for expenses incurred in connection with the treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. The benefits to be provided shall include coverage for the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders when the home treatment program is under the supervision of the state-approved hemophilia treatment center.</p> <ul style="list-style-type: none"> <li>• “Blood infusion equipment” includes, but is not limited to, syringes and needles.</li> <li>• “Blood product” includes, but is not limited to, Factor VII, Factor VIII, Factor IX, and cryoprecipitate.</li> <li>• “Hemophilia” means a lifelong hereditary bleeding disorder usually affecting males that results in prolonged bleeding primarily into joints and muscles</li> <li>• “Home treatment program” means a program where individuals or family members are trained to provide infusion therapy at home in order to achieve optimal health and cost effectiveness.</li> <li>• “State-approved hemophilia treatment center” means a hospital or clinic which receives federal or state Maternal and Child Health Bureau, and/or Centers for Disease Control funds to conduct comprehensive care for persons with hemophilia and other congenital bleeding disorders.</li> </ul>	<p><b>Covered Medical Expenses</b> include charges incurred by a <b>covered person</b> for expenses incurred in connection with the treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. The benefits to be provided shall include coverage for the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders when the home treatment program is under the supervision of the state-approved hemophilia treatment center.</p> <ul style="list-style-type: none"> <li>• “Blood infusion equipment” includes, but is not limited to, syringes and needles.</li> <li>• “Blood product” includes, but is not limited to, Factor VII, Factor VIII, Factor IX, and cryoprecipitate.</li> <li>• “Hemophilia” means a lifelong hereditary bleeding disorder usually affecting males that results in prolonged bleeding primarily into joints and muscles</li> <li>• “Home treatment program” means a program where individuals or family members are trained to provide infusion therapy at home in order to achieve optimal health and cost effectiveness.</li> <li>• “State-approved hemophilia treatment center” means a hospital or clinic which receives federal or state Maternal and Child Health Bureau, and/or Centers for Disease Control funds to conduct comprehensive care for persons with hemophilia and other congenital bleeding disorders.</li> </ul>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Home Treatment of Hemophilia Expense <i>(continued)</i>	<b>Covered Medical Expenses</b> are payable on the same basis as any other condition.	<b>Covered Medical Expenses</b> are payable on the same basis as any other condition.	<b>Covered Medical Expenses</b> are payable on the same basis as any other condition.
Pap Smear Expense	<p><b>Covered Medical Expenses</b> include one annual routine pap smear screening for women age 18 and older. <b>Covered Medical Expenses</b> include gynecological exam.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care With Referral:</u> <b>100%</b> of the Negotiated Charge.</p>	<p><b>Covered Medical Expenses</b> include one annual routine pap smear screening for women age 18 and older. <b>Covered Medical Expenses</b> include gynecological exam.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care:</u> <b>100%</b> of the Negotiated Charge.</p>	<p><b>Covered Medical Expenses</b> include one annual routine pap smear screening for women age 18 and older. <b>Covered Medical Expenses</b> include gynecological exam.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Non-Preferred Care:</u> <b>65%</b> of the Negotiated Charge.</p>
Reconstructive Surgery Following a Mastectomy Expense	<p><b>Covered Medical Expenses</b> include expenses incurred by a covered person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy, for:</p> <ol style="list-style-type: none"> <li>1) reconstruction of the breast on which a mastectomy has been performed;</li> <li>2) surgery and reconstruction of the other breast to produce a symmetrical appearance;</li> <li>3) prostheses; and</li> <li>4) treatment of physical complications of all stages of mastectomy, including lymphedemas.</li> </ol> <p>Benefits are payable on the same basis as any other condition.</p>	<p><b>Covered Medical Expenses</b> include expenses incurred by a covered person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy, for:</p> <ol style="list-style-type: none"> <li>1) reconstruction of the breast on which a mastectomy has been performed;</li> <li>2) surgery and reconstruction of the other breast to produce a symmetrical appearance;</li> <li>3) prostheses; and</li> <li>4) treatment of physical complications of all stages of mastectomy, including lymphedemas.</li> </ol> <p>Benefits are payable on the same basis as any other condition.</p>	<p><b>Covered Medical Expenses</b> include expenses incurred by a covered person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy, for:</p> <ol style="list-style-type: none"> <li>1) reconstruction of the breast on which a mastectomy has been performed;</li> <li>2) surgery and reconstruction of the other breast to produce a symmetrical appearance;</li> <li>3) prostheses; and</li> <li>4) treatment of physical complications of all stages of mastectomy, including lymphedemas.</li> </ol> <p>Benefits are payable on the same basis as any other condition.</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Inpatient Coverage Following a Mastectomy Expense	<p><b>Covered Medical Expenses</b> include charges incurred by a covered person for inpatient coverage following a mastectomy while insured under this Policy. Benefits are payable for <b>Covered Medical Expenses</b> on the same basis as any other sickness.</p> <p><b>Covered Medical Expenses</b> include:</p> <ul style="list-style-type: none"> <li>a) In-patient care for a minimum of 48 hours following a radical or modified radical mastectomy; or</li> <li>b) In-patient care for a minimum of 24 hours following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer.</li> </ul> <p>Any decision to shorten such minimum coverages shall be made by the attending physician; in consultation with the covered person.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a covered person for inpatient coverage following a mastectomy while insured under this Policy. Benefits are payable for <b>Covered Medical Expenses</b> on the same basis as any other sickness.</p> <p><b>Covered Medical Expenses</b> include:</p> <ul style="list-style-type: none"> <li>a) In-patient care for a minimum of 48 hours following a radical or modified radical mastectomy; or</li> <li>b) In-patient care for a minimum of 24 hours following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer.</li> </ul> <p>Any decision to shorten such minimum coverages shall be made by the attending physician; in consultation with the covered person.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a covered person for inpatient coverage following a mastectomy while insured under this Policy. Benefits are payable for <b>Covered Medical Expenses</b> on the same basis as any other sickness.</p> <p><b>Covered Medical Expenses</b> include:</p> <ul style="list-style-type: none"> <li>a) In-patient care for a minimum of 48 hours following a radical or modified radical mastectomy; or</li> <li>b) In-patient care for a minimum of 24 hours following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer.</li> </ul> <p>Any decision to shorten such minimum coverages shall be made by the attending physician; in consultation with the covered person.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p>
Inpatient Coverage Following a Laparoscopy-Assisted Vaginal Hysterectomy and Vaginal Hysterectomy Expense	<p><b>Covered Medical Expenses</b> include charges incurred by a covered person for inpatient coverage following a <b>Covered Medical Expenses</b> include charges incurred by a covered person for inpatient coverage following a laparoscopy-assisted vaginal hysterectomy and vaginal hysterectomy while insured under this Policy. Benefits are payable for <b>Covered Medical Expenses</b> on the same basis as any other sickness.</p> <p><b>Covered Medical Expenses</b> include:</p> <ul style="list-style-type: none"> <li>• In-patient care for a minimum of 48 hours following a</li> </ul>	<p><b>Covered Medical Expenses</b> include charges incurred by a covered person for inpatient coverage following a <b>Covered Medical Expenses</b> include charges incurred by a covered person for inpatient coverage following a laparoscopy-assisted vaginal hysterectomy and vaginal hysterectomy while insured under this Policy. Benefits are payable for <b>Covered Medical Expenses</b> on the same basis as any other sickness.</p> <p><b>Covered Medical Expenses</b> include:</p> <ul style="list-style-type: none"> <li>• In-patient care for a minimum of 48 hours following a</li> </ul>	<p><b>Covered Medical Expenses</b> include charges incurred by a covered person for inpatient coverage following a <b>Covered Medical Expenses</b> include charges incurred by a covered person for inpatient coverage following a laparoscopy-assisted vaginal hysterectomy and vaginal hysterectomy while insured under this Policy. Benefits are payable for <b>Covered Medical Expenses</b> on the same basis as any other sickness.</p> <p><b>Covered Medical Expenses</b> include:</p> <ul style="list-style-type: none"> <li>• In-patient care for a minimum of 48 hours following a vaginal</li> </ul>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Inpatient Coverage Following a Laparoscopy-Assisted Vaginal Hysterectomy and Vaginal Hysterectomy Expense <i>(continued)</i>	<p>vaginal hysterectomy, or</p> <ul style="list-style-type: none"> <li>In-patient care for a minimum of 23 hours following a laparoscopy-assisted vaginal hysterectomy.</li> </ul> <p>Any decision to shorten such minimum coverages shall be made by the attending physician, in consultation with the covered person.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p>	<p>vaginal hysterectomy, or</p> <ul style="list-style-type: none"> <li>In-patient care for a minimum of 23 hours following a laparoscopy-assisted vaginal hysterectomy.</li> </ul> <p>Any decision to shorten such minimum coverages shall be made by the attending physician, in consultation with the covered person.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p>	<p>hysterectomy, or</p> <ul style="list-style-type: none"> <li>In-patient care for a minimum of 23 hours following a laparoscopy-assisted vaginal hysterectomy.</li> </ul> <p>Any decision to shorten such minimum coverages shall be made by the attending physician, in consultation with the covered person.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p>
Mammogram Expense	<p><b>Covered Medical Expenses</b> include one baseline mammogram for women between age 35 and 40. Coverage is also provided for one routine annual mammogram for women age 40 and older, as well as when medically indicated for women with risk factors who are under age 40. Risk factors for women under 40 are:</p> <ul style="list-style-type: none"> <li>Prior personal history of breast cancer</li> <li>Positive Genetic Testings</li> <li>Family history of breast cancer, or</li> <li>Other risk factors</li> </ul> <p>Mammogram screenings coverage must also include comprehensive ultrasound screening for the entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue and when determined to be Medically Necessary by a licensed physician.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care With Referral:</u> 100% of the Negotiated Charge</p>	<p><b>Covered Medical Expenses</b> include one baseline mammogram for women between age 35 and 40. Coverage is also provided for one routine annual mammogram for women age 40 and older, as well as when medically indicated for women with risk factors who are under age 40. Risk factors for women under 40 are:</p> <ul style="list-style-type: none"> <li>Prior personal history of breast cancer</li> <li>Positive Genetic Testings</li> <li>Family history of breast cancer, or</li> <li>Other risk factors</li> </ul> <p>Mammogram screenings coverage must also include comprehensive ultrasound screening for the entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue and when determined to be Medically Necessary by a licensed physician.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge</p>	<p><b>Covered Medical Expenses</b> include one baseline mammogram for women between age 35 and 40. Coverage is also provided for one routine annual mammogram for women age 40 and older, as well as when medically indicated for women with risk factors who are under age 40. Risk factors for women under 40 are:</p> <ul style="list-style-type: none"> <li>Prior personal history of breast cancer</li> <li>Positive Genetic Testings</li> <li>Family history of breast cancer, or</li> <li>Other risk factors</li> </ul> <p>Mammogram screenings coverage must also include comprehensive ultrasound screening for the entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue and when determined to be Medically Necessary by a licensed physician.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Non-Preferred Care:</u> 65% of the Recognized Charge</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Routine Colorectal Cancer Screening Expense	<p>Even though not incurred in connection with a sickness or injury, benefits include charges for colorectal cancer examination and laboratory tests, for any nonsymptomatic person age 50 or more, or a symptomatic person under age 50, for the following:</p> <ul style="list-style-type: none"> <li>• One fecal occult blood test every 12 months in a row</li> <li>• A sigmoidoscopy at age 50 and every 3 years thereafter</li> <li>• One digital rectal exam every 12 months in a row</li> <li>• A double contrast barium enema, once every 5 years</li> <li>• A colonoscopy, once every 10 years.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care With Referral:</u> 100% of the Negotiated Charge</p>	<p>Even though not incurred in connection with a sickness or injury, benefits include charges for colorectal cancer examination and laboratory tests, for any nonsymptomatic person age 50 or more, or a symptomatic person under age 50, for the following:</p> <ul style="list-style-type: none"> <li>• One fecal occult blood test every 12 months in a row</li> <li>• A sigmoidoscopy at age 50 and every 3 years thereafter</li> <li>• One digital rectal exam every 12 months in a row</li> <li>• A double contrast barium enema, once every 5 years</li> <li>• A colonoscopy, once every 10 years.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge</p>	<p>Even though not incurred in connection with a sickness or injury, benefits include charges for colorectal cancer examination and laboratory tests, for any nonsymptomatic person age 50 or more, or a symptomatic person under age 50, for the following:</p> <ul style="list-style-type: none"> <li>• One fecal occult blood test every 12 months in a row</li> <li>• A sigmoidoscopy at age 50 and every 3 years thereafter</li> <li>• One digital rectal exam every 12 months in a row</li> <li>• A double contrast barium enema, once every 5 years</li> <li>• A colonoscopy, once every 10 years.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Non-Preferred Care:</u> 65% of the Recognized Charge</p>
Bone Marrow and Stem Cell Transplants for Breast Cancer	<p>Expenses incurred for the treatment of breast cancer by dose-intensive chemotherapy/ autologous bone marrow transplants, or stem cell transplants when performed pursuant to protocols approved by the institutional review board of any United States medical teaching college including, but not limited to, National Cancer Institute protocols that have been favorably reviewed and utilized by hematologists or oncologist experienced in dose-intensive chemotherapy/ autologous bone marrow transplants or stem cell transplants.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p>	<p>Expenses incurred for the treatment of breast cancer by dose-intensive chemotherapy/ autologous bone marrow transplants, or stem cell transplants when performed pursuant to protocols approved by the institutional review board of any United States medical teaching college including, but not limited to, National Cancer Institute protocols that have been favorably reviewed and utilized by hematologists or oncologist experienced in dose-intensive chemotherapy/ autologous bone marrow transplants or stem cell transplants.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p>	<p>Expenses incurred for the treatment of breast cancer by dose-intensive chemotherapy/ autologous bone marrow transplants, or stem cell transplants when performed pursuant to protocols approved by the institutional review board of any United States medical teaching college including, but not limited to, National Cancer Institute protocols that have been favorably reviewed and utilized by hematologists or oncologist experienced in dose-intensive chemotherapy/ autologous bone marrow transplants or stem cell transplants.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p>



	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Lymphedema Expense	Coverage for prescribed equipment, supplies, complex decongestive therapy, and outpatient self-management training and education for the treatment of lymphedema.  <b>Covered Medical Expenses</b> are payable on the same basis as any other condition.	Coverage for prescribed equipment, supplies, complex decongestive therapy, and outpatient self-management training and education for the treatment of lymphedema.  <b>Covered Medical Expenses</b> are payable on the same basis as any other condition.	Coverage for prescribed equipment, supplies, complex decongestive therapy, and outpatient self-management training and education for the treatment of lymphedema.  <b>Covered Medical Expenses</b> are payable on the same basis as any other condition.
Morbid Obesity Expense	Coverage for the treatment of morbid obesity through gastric bypass surgery or such other methods as recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity.  <b>Covered Medical Expenses</b> are payable on the same basis as any other condition.	Coverage for the treatment of morbid obesity through gastric bypass surgery or such other methods as recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity.  <b>Covered Medical Expenses</b> are payable on the same basis as any other condition.	Coverage for the treatment of morbid obesity through gastric bypass surgery or such other methods as recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity.  <b>Covered Medical Expenses</b> are payable on the same basis as any other condition.
Routine Prostate Cancer Screening Expense	<b>Covered Medical Expenses</b> include charges incurred by a covered person for the screening of cancer as follows: <ul style="list-style-type: none"> <li>• for a male age 50 or over, and</li> <li>• for a male age 40 and over who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.</li> </ul> One digital rectal exam and one prostate specific antigen test each Policy Year.  <b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care with Referral:</u> 100% of the Negotiated Charge	<b>Covered Medical Expenses</b> include charges incurred by a covered person for the screening of cancer as follows: <ul style="list-style-type: none"> <li>• for a male age 50 or over, and</li> <li>• for a male age 40 and over who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.</li> </ul> One digital rectal exam and one prostate specific antigen test each Policy Year.  <b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge	<b>Covered Medical Expenses</b> include charges incurred by a covered person for the screening of cancer as follows: <ul style="list-style-type: none"> <li>• for a male age 50 or over, and</li> <li>• for a male age 40 and over who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.</li> </ul> One digital rectal exam and one prostate specific antigen test each Policy Year.  <b>Covered Medical Expenses</b> are payable as follows: <u>Non-Preferred Care:</u> 65% of the Recognized Charge

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Second Surgical Opinion Expense	<p>To the extent that this Plan provides coverage for surgery, this Plan shall provide coverage for expenses incurred for a second opinion consultation by a specialist on the need for surgery which has been recommended by the Covered Person's physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation.</p> <p><b>Covered Medical Expenses</b> will not include any charge in excess of the daily room and board maximum for semi-private accommodations. <b>Covered Medical Expenses</b> for Surgical Second Opinion Expense are covered as follows:</p> <p><u>Preferred Care With Referral:</u> <b>100%</b> of the Negotiated Charge following a <b>\$10</b> Copay.</p>	<p>To the extent that this Plan provides coverage for surgery, this Plan shall provide coverage for expenses incurred for a second opinion consultation by a specialist on the need for surgery which has been recommended by the Covered Person's physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation.</p> <p><b>Covered Medical Expenses</b> will not include any charge in excess of the daily room and board maximum for semi-private accommodations. <b>Covered Medical Expenses</b> for Surgical Second Opinion Expense are covered as follows:</p> <p><u>Preferred Care:</u> <b>100%</b> of the Negotiated Charge following a <b>\$25</b> Copay.</p>	<p>To the extent that this Plan provides coverage for surgery, this Plan shall provide coverage for expenses incurred for a second opinion consultation by a specialist on the need for surgery which has been recommended by the Covered Person's physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation.</p> <p><b>Covered Medical Expenses</b> will not include any charge in excess of the daily room and board maximum for semi-private accommodations. <b>Covered Medical Expenses</b> for Surgical Second Opinion Expense are covered as follows:</p> <p><u>Non-Preferred Care:</u> <b>65%</b> of the Recognized Charge.</p>
Acupuncture in Lieu of Anesthesia Expense	<p><b>Covered Medical Expenses</b> include acupuncture therapy, when acupuncture is used in lieu of other anesthesia, for a surgical or dental procedure covered under this Plan. The acupuncture must be administered by a health care provider who is a legally qualified physician, practicing within the scope of their license.</p> <p><u>Preferred Care With Referral:</u> <b>90%</b> of the Negotiated Charge.</p>	<p><b>Covered Medical Expenses</b> include acupuncture therapy, when acupuncture is used in lieu of other anesthesia, for a surgical or dental procedure covered under this Plan. The acupuncture must be administered by a health care provider who is a legally qualified physician, practicing within the scope of their license.</p> <p><u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.</p>	<p><b>Covered Medical Expenses</b> include acupuncture therapy, when acupuncture is used in lieu of other anesthesia, for a surgical or dental procedure covered under this Plan. The acupuncture must be administered by a health care provider who is a legally qualified physician, practicing within the scope of their license.</p> <p><u>Non-Preferred Care:</u> <b>65%</b> of the Recognized Charge.</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Dermatological Expense	<p>Benefits include charges for the diagnosis and treatment of skin disorders, excluding laboratory fees. Related laboratory expenses are covered under the Outpatient Expense Benefit.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p> <p><b>Covered Medical Expenses</b> do not include cosmetic treatment and procedures.</p>	<p>Benefits include charges for the diagnosis and treatment of skin disorders, excluding laboratory fees. Related laboratory expenses are covered under the Outpatient Expense Benefit.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p> <p><b>Covered Medical Expenses</b> do not include cosmetic treatment and procedures.</p>	<p>Benefits include charges for the diagnosis and treatment of skin disorders, excluding laboratory fees. Related laboratory expenses are covered under the Outpatient Expense Benefit.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Non-Preferred Care</u>: Payable on the same basis as any other condition.</p> <p><b>Covered Medical Expenses</b> do not include cosmetic treatment and procedures.</p>
Podiatric Expense	<p>Benefits include charges for podiatric services, provided on an outpatient basis following an <b>Injury</b>.</p> <p>Payable on the same basis as any other condition.</p> <p>Expenses for routine foot care, such as trimming of corns, calluses, and nails, are <b>not Covered Medical Expenses</b>.</p>	<p>Benefits include charges for podiatric services, provided on an outpatient basis following an <b>Injury</b>.</p> <p>Payable on the same basis as any other condition.</p> <p>Expenses for routine foot care, such as trimming of corns, calluses, and nails, are <b>not Covered Medical Expenses</b>.</p>	<p>Benefits include charges for podiatric services, provided on an outpatient basis following an <b>Injury</b>.</p> <p>Payable on the same basis as any other condition.</p> <p>Expenses for routine foot care, such as trimming of corns, calluses, and nails, are <b>not Covered Medical Expenses</b>.</p>
Home Health Care Expense	<p><b>Covered Medical Expenses</b> include charges incurred by a Covered Person for home health care services made by a home health agency pursuant to a home health care plan, but only if:</p> <ul style="list-style-type: none"> <li>• The services are furnished by, or under arrangements made by, a licensed home health agency.</li> <li>• The services are given under a home care plan. This plan must be established pursuant to the written order of a physician, and the physician must renew that plan every 60 days. Such physician must certify that the proper treatment of the condition would require inpatient confinement in a Hospital or skilled nursing facility if the services and supplies were not provided under the home</li> </ul>	<p><b>Covered Medical Expenses</b> include charges incurred by a Covered Person for home health care services made by a home health agency pursuant to a home health care plan, but only if:</p> <ul style="list-style-type: none"> <li>• The services are furnished by, or under arrangements made by, a licensed home health agency.</li> <li>• The services are given under a home care plan. This plan must be established pursuant to the written order of a physician, and the physician must renew that plan every 60 days. Such physician must certify that the proper treatment of the condition would require inpatient confinement in a Hospital or skilled nursing facility if the services and supplies were not provided under the home</li> </ul>	<p><b>Covered Medical Expenses</b> include charges incurred by a Covered Person for home health care services made by a home health agency pursuant to a home health care plan, but only if:</p> <ul style="list-style-type: none"> <li>• The services are furnished by, or under arrangements made by, a licensed home health agency.</li> <li>• The services are given under a home care plan. This plan must be established pursuant to the written order of a physician, and the physician must renew that plan every 60 days. Such physician must certify that the proper treatment of the condition would require inpatient confinement in a Hospital or skilled nursing facility if the services and supplies were not provided under the home health care plan. The physician must examine the Covered Person at</li> </ul>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Home Health Care Expense <i>(continued)</i>	<p>health care plan. The physician must examine the Covered Person at least once a month.</p> <ul style="list-style-type: none"> <li>• Except as specifically provided in the home health care services, the services are delivered in the patient's place of residence on a part-time, intermittent visiting basis while the patient is confined.</li> <li>• The care starts within 7 days after discharge from a hospital as an inpatient, and the care is for the same condition that caused the Hospital confinement, or one related to it.</li> </ul> <p><u>Preferred Care With Referral:</u> <b>80%</b> of the Negotiated Charge.</p>	<p>health care plan. The physician must examine the Covered Person at least once a month.</p> <ul style="list-style-type: none"> <li>• Except as specifically provided in the home health care services, the services are delivered in the patient's place of residence on a part-time, intermittent visiting basis while the patient is confined.</li> <li>• The care starts within 7 days after discharge from a hospital as an inpatient, and the care is for the same condition that caused the Hospital confinement, or one related to it.</li> </ul> <p><u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.</p>	<p>least once a month.</p> <ul style="list-style-type: none"> <li>• Except as specifically provided in the home health care services, the services are delivered in the patient's place of residence on a part-time, intermittent visiting basis while the patient is confined.</li> <li>• The care starts within 7 days after discharge from a hospital as an inpatient, and the care is for the same condition that caused the Hospital confinement, or one related to it.</li> </ul> <p><u>Non-Preferred Care:</u> <b>80%</b> of the Recognized Charge.</p>
Transfusion or Dialysis of Blood Expense	<p>Benefits include charges for the transfusion or dialysis of blood, including the cost of: whole blood, blood components, and the administration thereof.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p>	<p>Benefits include charges for the transfusion or dialysis of blood, including the cost of: whole blood, blood components, and the administration thereof.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p>	<p>Benefits include charges for the transfusion or dialysis of blood, including the cost of: whole blood, blood components, and the administration thereof.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition.</p>
Hospice Expense	<p>Benefits include charges for hospice care provided for a terminally ill Covered Person during a hospice benefit period.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care With Referral:</u> <b>80%</b> of the Negotiated Charge.</p>	<p>Benefits include charges for hospice care provided for a terminally ill Covered Person during a hospice benefit period.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.</p>	<p>Benefits include charges for hospice care provided for a terminally ill Covered Person during a hospice benefit period.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Non-Preferred Care:</u> <b>65%</b> of the Recognized Charge.</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Licensed Nurse Expense	<p><b>Covered Medical Expenses</b> include charges incurred by a Covered Person who is confined in a Hospital as a resident bed-patient, and requires the services of a registered nurse or licensed practical nurse.</p> <p><b>Covered Expenses</b> for a Licensed Nurse are covered as follows:  <u>Preferred Care With Referral:</u>  <b>90%</b> of the Negotiated Charge.</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a Covered Person who is confined in a Hospital as a resident bed-patient, and requires the services of a registered nurse or licensed practical nurse.</p> <p><b>Covered Expenses</b> for a Licensed Nurse are covered as follows:  <u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a Covered Person who is confined in a Hospital as a resident bed-patient, and requires the services of a registered nurse or licensed practical nurse.</p> <p><b>Covered Expenses</b> for a Licensed Nurse are covered as follows:  <u>Non-Preferred Care:</u> <b>65%</b> of the Recognized Charge.</p>
Skilled Nursing Facility Expense	<p><b>Covered Medical Expenses</b> include charges incurred by a Covered Person for confinement in a skilled nursing facility for treatment rendered:</p> <ul style="list-style-type: none"> <li>• in lieu of confinement in a Hospital as a full time inpatient, or</li> <li>• within 24 hours following a Hospital confinement and for the same or related cause(s) as such Hospital confinement.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows:  <u>Preferred Care With Referral:</u>  After a <b>\$300</b> Copay per admission, <b>80%</b> of the Negotiated Charge for the semi-private room rate.</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a Covered Person for confinement in a skilled nursing facility for treatment rendered:</p> <ul style="list-style-type: none"> <li>• in lieu of confinement in a Hospital as a full time inpatient, or</li> <li>• within 24 hours following a Hospital confinement and for the same or related cause(s) as such Hospital confinement.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows:  <u>Preferred Care:</u> After a <b>\$300</b> Copay per admission, <b>80%</b> of the Negotiated Charge for the semi-private room rate.</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a Covered Person for confinement in a skilled nursing facility for treatment rendered:</p> <ul style="list-style-type: none"> <li>• in lieu of confinement in a Hospital as a full time inpatient, or</li> <li>• within 24 hours following a Hospital confinement and for the same or related cause(s) as such Hospital confinement.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows:  <u>Non-Preferred Care:</u> After a <b>\$300</b> Copay per admission, <b>65%</b> of the Recognized Charge for the semi-private room rate.</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Rehabilitation Facility Expense	<p><b>Covered Medical Expenses</b> include charges incurred by a Covered Person for confinement as a full time inpatient in a rehabilitation facility. Confinement in the rehabilitation facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of Hospital or skilled nursing facility confinement.</p> <p><b>Covered Medical Expenses</b> for Rehabilitation Facility Expense are covered as follows:</p> <p><u>Preferred Care With Referral:</u> After a <b>\$300</b> Copay per admission, <b>80%</b> of the Negotiated Charge for the semi-private room rate.</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a Covered Person for confinement as a full time inpatient in a rehabilitation facility. Confinement in the rehabilitation facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of Hospital or skilled nursing facility confinement.</p> <p><b>Covered Medical Expenses</b> for Rehabilitation Facility Expense are covered as follows:</p> <p><u>Preferred Care:</u> After a <b>\$300</b> Copay per admission, <b>80%</b> of the Negotiated Charge for the semi-private room rate.</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a Covered Person for confinement as a full time inpatient in a rehabilitation facility. Confinement in the rehabilitation facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of Hospital or skilled nursing facility confinement.</p> <p><b>Covered Medical Expenses</b> for Rehabilitation Facility Expense are covered as follows:</p> <p><u>Non-Preferred Care:</u> After a <b>\$300</b> Copay per admission, <b>65%</b> of the Recognized Charge for the semi-private room rate.</p>
Vision Care Exam Expense	<p>Benefits include charges for any service shown below, which is furnished by a legally qualified ophthalmologist or optometrist.</p> <p><b>Routine Eye Exam Expenses:</b> Charges for a complete eye exam that includes refraction. A routine eye exam does not include charges for a contact lens exam.</p> <p><b>Contact Lens Exam Expenses:</b> Charges for an eye exam performed for the sole purpose of the fitting of contact lenses.</p> <p>Benefits are limited to one routine eye exam and one contact lens exam per Policy Year.</p> <p><b>Covered Medical Expenses</b> will be payable as follows:</p> <p><u>Preferred Care With Referral:</u> After a <b>\$15</b> per visit Copay, <b>100%</b> of the Negotiated Charge.</p>	<p>Benefits include charges for any service shown below, which is furnished by a legally qualified ophthalmologist or optometrist.</p> <p><b>Routine Eye Exam Expenses:</b> Charges for a complete eye exam that includes refraction. A routine eye exam does not include charges for a contact lens exam.</p> <p><b>Contact Lens Exam Expenses:</b> Charges for an eye exam performed for the sole purpose of the fitting of contact lenses.</p> <p>Benefits are limited to one routine eye exam and one contact lens exam per Policy Year.</p> <p><b>Covered Medical Expenses</b> will be payable as follows:</p> <p><u>Preferred Care:</u> After a <b>\$15</b> per visit Copay, <b>100%</b> of the Negotiated Charge.</p>	<p>Benefits include charges for any service shown below, which is furnished by a legally qualified ophthalmologist or optometrist.</p> <p><b>Routine Eye Exam Expenses:</b> Charges for a complete eye exam that includes refraction. A routine eye exam does not include charges for a contact lens exam.</p> <p><b>Contact Lens Exam Expenses:</b> Charges for an eye exam performed for the sole purpose of the fitting of contact lenses.</p> <p>Benefits are limited to one routine eye exam and one contact lens exam per Policy Year.</p> <p><b>Covered Medical Expenses</b> will be payable as follows:</p> <p><u>Non-Preferred Care:</u> <b>100%</b> of the Recognized Charge up to a maximum of <b>\$43</b> per Policy Year.</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Vision Care Exam Expense <i>(continued)</i>	<p><b>Limitations</b> The following limitations apply:</p> <p>No benefits will be payable for a charge which is:</p> <ul style="list-style-type: none"> <li>• For any eye exam to diagnose or treat a disease or Injury.</li> <li>• For drugs or medicines.</li> <li>• For a vision care service that is a <b>Covered Medical Expense</b> in whole or in part, under any other part of this Policy, or under any other group plan.</li> <li>• For a vision care service for which a benefit is provided in whole or in part, under any workers' compensation law or any other law of like purpose.</li> <li>• For special procedures. This means things such as orthoptics or vision training.</li> <li>• For any vision care supply.</li> <li>• For an eye exam which: <ul style="list-style-type: none"> <li>- Is required by an employer as a condition of employment, or</li> <li>- An employer is required to provide under a labor agreement, or</li> <li>- Is required by any law of a government.</li> </ul> </li> <li>• For a service received while the person is not a Covered Person.</li> <li>• For a service which does not meet professionally accepted standards.</li> <li>• For any exams given while the person is confined in a hospital or other facility for medical care.</li> </ul>	<p><b>Limitations</b> The following limitations apply:</p> <p>No benefits will be payable for a charge which is:</p> <ul style="list-style-type: none"> <li>• For any eye exam to diagnose or treat a disease or Injury.</li> <li>• For drugs or medicines.</li> <li>• For a vision care service that is a <b>Covered Medical Expense</b> in whole or in part, under any other part of this Policy, or under any other group plan.</li> <li>• For a vision care service for which a benefit is provided in whole or in part, under any workers' compensation law or any other law of like purpose.</li> <li>• For special procedures. This means things such as orthoptics or vision training.</li> <li>• For any vision care supply.</li> <li>• For an eye exam which: <ul style="list-style-type: none"> <li>- Is required by an employer as a condition of employment, or</li> <li>- An employer is required to provide under a labor agreement, or</li> <li>- Is required by any law of a government.</li> </ul> </li> <li>• For a service received while the person is not a Covered Person.</li> <li>• For a service which does not meet professionally accepted standards.</li> </ul> <p>For any exams given while the person is confined in a hospital or other facility for medical care.</p>	<p><b>Limitations</b> The following limitations apply:</p> <p>No benefits will be payable for a charge which is:</p> <ul style="list-style-type: none"> <li>• For any eye exam to diagnose or treat a disease or Injury.</li> <li>• For drugs or medicines.</li> <li>• For a vision care service that is a <b>Covered Medical Expense</b> in whole or in part, under any other part of this Policy, or under any other group plan.</li> <li>• For a vision care service for which a benefit is provided in whole or in part, under any workers' compensation law or any other law of like purpose.</li> <li>• For special procedures. This means things such as orthoptics or vision training.</li> <li>• For any vision care supply.</li> <li>• For an eye exam which: <ul style="list-style-type: none"> <li>- Is required by an employer as a condition of employment, or</li> <li>- An employer is required to provide under a labor agreement, or</li> <li>- Is required by any law of a government.</li> </ul> </li> <li>• For a service received while the person is not a Covered Person.</li> <li>• For a service which does not meet professionally accepted standards.</li> </ul> <p>For any exams given while the person is confined in a hospital or other facility for medical care.</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Vision Care Supply Expense	<p>Benefits include charges for eyeglasses (lenses and frames) and contact lenses, when prescribed by a legally qualified ophthalmologist or optometrist.</p> <p><b>Covered Medical Expenses</b> for vision care supplies will be payable as follows:</p> <p><u>Preferred Care With Referral:</u> After a <b>\$15</b> Copay, <b>100%</b> of the Negotiated Charge.</p> <p>Maximum benefit of <b>\$120</b> per Policy Year.</p> <p><i>Covered Medical Expenses will not include charges for more than one pair of eyeglasses (lenses and frames) or one pair of contact lenses per Policy Year.</i></p> <p><b>Limitations</b> The following limitations apply: No benefits will be payable for a charge which is:</p> <ul style="list-style-type: none"> <li>• For a vision care supply that is a <b>Covered Medical Expense</b> in whole or in part, under any other part of this Policy, or under any other group plan.</li> <li>• For a vision care supply for which a benefit is provided in whole or in part, under any workers' compensation law, or any other law of like purpose.</li> <li>• For special procedures. This means things such as orthoptics or vision training.</li> <li>• For special supplies. This means things such as nonprescription sunglasses and subnormal vision aids.</li> <li>• For anti-reflective coatings.</li> <li>• For tinting.</li> <li>• For any eye exam.</li> <li>• For prescription sunglasses or light sensitive lenses, in excess of the amount which would be covered for non-tinted lenses.</li> </ul>	<p>Benefits include charges for eyeglasses (lenses and frames) and contact lenses, when prescribed by a legally qualified ophthalmologist or optometrist.</p> <p><b>Covered Medical Expenses</b> for vision care supplies will be payable as follows:</p> <p><u>Preferred Care:</u> After a <b>\$15</b> Copay, <b>100%</b> of the Negotiated Charge.</p> <p>Maximum benefit of <b>\$120</b> per Policy Year.</p> <p><i>Covered Medical Expenses will not include charges for more than one pair of eyeglasses (lenses and frames) or one pair of contact lenses per Policy Year.</i></p> <p><b>Limitations</b> The following limitations apply: No benefits will be payable for a charge which is:</p> <ul style="list-style-type: none"> <li>• For a vision care supply that is a <b>Covered Medical Expense</b> in whole or in part, under any other part of this Policy, or under any other group plan.</li> <li>• For a vision care supply for which a benefit is provided in whole or in part, under any workers' compensation law, or any other law of like purpose.</li> <li>• For special procedures. This means things such as orthoptics or vision training.</li> <li>• For special supplies. This means things such as nonprescription sunglasses and subnormal vision aids.</li> <li>• For anti-reflective coatings.</li> <li>• For tinting.</li> <li>• For any eye exam.</li> <li>• For prescription sunglasses or light sensitive lenses, in excess of the amount which would be covered for non-tinted lenses.</li> </ul>	<p>Benefits include charges for eyeglasses (lenses and frames) and contact lenses, when prescribed by a legally qualified ophthalmologist or optometrist.</p> <p><b>Covered Medical Expenses</b> for vision care supplies will be payable as follows:</p> <p><u>Non-Preferred Care:</u> After a <b>\$15</b> Copay, <b>100%</b> of the Recognized Charge.</p> <p>Maximum benefit of <b>\$120</b> per Policy Year.</p> <p><i>Covered Medical Expenses will not include charges for more than one pair of eyeglasses (lenses and frames) or one pair of contact lenses per Policy Year.</i></p> <p><b>Limitations</b> The following limitations apply: No benefits will be payable for a charge which is:</p> <ul style="list-style-type: none"> <li>• For a vision care supply that is a <b>Covered Medical Expense</b> in whole or in part, under any other part of this Policy, or under any other group plan.</li> <li>• For a vision care supply for which a benefit is provided in whole or in part, under any workers' compensation law, or any other law of like purpose.</li> <li>• For special procedures. This means things such as orthoptics or vision training.</li> <li>• For special supplies. This means things such as nonprescription sunglasses and subnormal vision aids.</li> <li>• For anti-reflective coatings.</li> <li>• For tinting.</li> <li>• For any eye exam.</li> <li>• For prescription sunglasses or light sensitive lenses, in excess of the amount which would be covered for non-tinted lenses.</li> </ul>



	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Vision Care Supply Expense <i>(continued)</i>	<ul style="list-style-type: none"> <li>• For replacement of lenses or frames that are lost or stolen or broken.</li> <li>• For duplicate or spare eyeglasses or lenses or frames for them.</li> <li>• For any supply which does not meet professionally accepted standards.</li> <li>• For a supply received while the person is not covered.</li> <li>• For lenses and frames furnished or ordered because of an eye exam that was done before the date the person becomes a covered person.</li> </ul>	<ul style="list-style-type: none"> <li>• For replacement of lenses or frames that are lost or stolen or broken.</li> <li>• For duplicate or spare eyeglasses or lenses or frames for them.</li> <li>• For any supply which does not meet professionally accepted standards.</li> <li>• For a supply received while the person is not covered.</li> <li>• For lenses and frames furnished or ordered because of an eye exam that was done before the date the person becomes a covered person.</li> </ul>	<ul style="list-style-type: none"> <li>• For replacement of lenses or frames that are lost or stolen or broken.</li> <li>• For duplicate or spare eyeglasses or lenses or frames for them.</li> <li>• For any supply which does not meet professionally accepted standards.</li> <li>• For a supply received while the person is not covered.</li> </ul> <p>For lenses and frames furnished or ordered because of an eye exam that was done before the date the person becomes a covered person.</p>
Telemedicine Expense	<p>Requires coverage and reimbursement to the treating or consulting provider for the diagnosis, consultation, or treatment of the insured, delivered through telemedicine services, on the same basis that reimbursement is made for the same services through face to face consultation or contact.</p> <p>Benefits are payable on the same basis as any other condition.</p>	<p>Requires coverage and reimbursement to the treating or consulting provider for the diagnosis, consultation, or treatment of the insured, delivered through telemedicine services, on the same basis that reimbursement is made for the same services through face to face consultation or contact.</p> <p>Benefits are payable on the same basis as any other condition.</p>	<p>Requires coverage and reimbursement to the treating or consulting provider for the diagnosis, consultation, or treatment of the insured, delivered through telemedicine services, on the same basis that reimbursement is made for the same services through face to face consultation or contact.</p> <p>Benefits are payable on the same basis as any other condition.</p>
Family Planning Expense	<p>For females with reproductive capacity, <b>Covered Medical Expenses</b> include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this benefit must be approved by the Food and Drug Administration (FDA).</p> <p>Coverage includes counseling services on contraceptive methods provided by a <b>physician</b>, obstetrician or gynecologist. Such counseling services are <b>Covered Medical Expenses</b> when provided in either a group or individual setting.</p>	<p>For females with reproductive capacity, <b>Covered Medical Expenses</b> include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this benefit must be approved by the Food and Drug Administration (FDA).</p> <p>Coverage includes counseling services on contraceptive methods provided by a <b>physician</b>, obstetrician or gynecologist. Such counseling services are <b>Covered Medical Expenses</b> when provided in either a group or individual setting.</p>	<p>For females with reproductive capacity, <b>Covered Medical Expenses</b> include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this benefit must be approved by the Food and Drug Administration (FDA).</p> <p>Coverage includes counseling services on contraceptive methods provided by a <b>physician</b>, obstetrician or gynecologist. Such counseling services are <b>Covered Medical Expenses</b> when provided in either a group or individual setting.</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Family Planning Expense <i>(continued)</i>	<p>The following contraceptive methods are <b>covered expenses</b> under this benefit:</p> <p><i>Voluntary Sterilization</i> <b>Covered expenses</b> include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.</p> <p><b>Covered expenses</b> under this <i>Preventive Care</i> benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.</p> <p><i>Contraceptives</i> <b>Covered expenses</b> include charges made by a <b>physician</b> or <b>pharmacy</b> for:</p> <ul style="list-style-type: none"> <li>• Female contraceptives that are <b>generic prescription drugs</b>. The prescription must be submitted to the pharmacist for processing. <i>This contraceptives benefit covers only generic prescription drugs.</i></li> <li>• Female contraceptive devices and related services and supplies that are generic prescription devices when prescribed in writing by a <b>physician</b>. <i>This contraceptives benefit covers only those devices that are generic prescription devices.</i></li> <li>• FDA-approved female over-the-counter contraceptive methods that are prescribed by your <b>physician</b>. The <b>prescription</b> must be submitted to the pharmacist for processing. These items are limited to one per day and a 30 day supply per <b>prescription</b>.</li> </ul>	<p>The following contraceptive methods are <b>covered expenses</b> under this benefit:</p> <p><i>Voluntary Sterilization</i> <b>Covered expenses</b> include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.</p> <p><b>Covered expenses</b> under this <i>Preventive Care</i> benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.</p> <p><i>Contraceptives</i> <b>Covered expenses</b> include charges made by a <b>physician</b> or <b>pharmacy</b> for:</p> <ul style="list-style-type: none"> <li>• Female contraceptives that are <b>generic prescription drugs</b>. The prescription must be submitted to the pharmacist for processing. <i>This contraceptives benefit covers only generic prescription drugs.</i></li> <li>• Female contraceptive devices and related services and supplies that are generic prescription devices when prescribed in writing by a <b>physician</b>. <i>This contraceptives benefit covers only those devices that are generic prescription devices.</i></li> <li>• FDA-approved female over-the-counter contraceptive methods that are prescribed by your <b>physician</b>. The <b>prescription</b> must be submitted to the pharmacist for processing. These items are limited to one per day and a 30 day supply per <b>prescription</b>.</li> </ul>	<p>The following contraceptive methods are <b>covered expenses</b> under this benefit:</p> <p><i>Voluntary Sterilization</i> <b>Covered expenses</b> include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.</p> <p><b>Covered expenses</b> under this <i>Preventive Care</i> benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.</p> <p><i>Contraceptives</i> <b>Covered expenses</b> include charges made by a <b>physician</b> or <b>pharmacy</b> for:</p> <ul style="list-style-type: none"> <li>• Female contraceptives that are <b>generic prescription drugs</b>. The prescription must be submitted to the pharmacist for processing. <i>This contraceptives benefit covers only generic prescription drugs.</i></li> <li>• Female contraceptive devices and related services and supplies that are generic prescription devices when prescribed in writing by a <b>physician</b>. <i>This contraceptives benefit covers only those devices that are generic prescription devices.</i></li> <li>• FDA-approved female over-the-counter contraceptive methods that are prescribed by your <b>physician</b>. The <b>prescription</b> must be submitted to the pharmacist for processing. These items are limited to one per day and a 30 day supply per <b>prescription</b>.</li> </ul>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Family Planning Expense (continued)	<p><b>Limitations</b> Unless specified above, not covered under this benefit are charges for:</p> <ul style="list-style-type: none"> <li>• Services which are covered to any extent under any other part of this Plan;</li> <li>• Services and supplies incurred for an abortion;</li> <li>• Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care;</li> <li>• Services which are for the treatment of an identified <b>illness or injury</b>;</li> <li>• Services that are not given by a <b>physician</b> or under his or her direction;</li> <li>• Psychiatric, psychological, personality or emotional testing or exams;</li> <li>• Any contraceptive methods that are only “reviewed” by the FDA and not “approved” by the FDA;</li> <li>• <u>Male</u> contraceptive methods, sterilization procedures or devices;</li> <li>• The reversal of voluntary sterilization procedures, including any related follow-up care.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care with a referral:</u> <b>100%</b> of the Negotiated Charge.</p> <p><b>Important Note:</b> Brand-Name Prescription Drug or Devices will be covered at 100% of the Negotiated Charge, including waiver of Annual Deductible if a Generic Prescription Drug or Device is not available in the same therapeutic drug class or the prescriber specifies Dispense as Written.</p>	<p><b>Limitations</b> Unless specified above, not covered under this benefit are charges for:</p> <ul style="list-style-type: none"> <li>• Services which are covered to any extent under any other part of this Plan;</li> <li>• Services and supplies incurred for an abortion;</li> <li>• Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care;</li> <li>• Services which are for the treatment of an identified <b>illness or injury</b>;</li> <li>• Services that are not given by a <b>physician</b> or under his or her direction;</li> <li>• Psychiatric, psychological, personality or emotional testing or exams;</li> <li>• Any contraceptive methods that are only “reviewed” by the FDA and not “approved” by the FDA;</li> <li>• <u>Male</u> contraceptive methods, sterilization procedures or devices;</li> <li>• The reversal of voluntary sterilization procedures, including any related follow-up care.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care:</u> <b>100%</b> of the Negotiated Charge.</p> <p><b>Important Note:</b> Brand-Name Prescription Drug or Devices will be covered at 100% of the Negotiated Charge, including waiver of Annual Deductible if a Generic Prescription Drug or Device is not available in the same therapeutic drug class or the prescriber specifies Dispense as Written.</p>	<p><b>Limitations</b> Unless specified above, not covered under this benefit are charges for:</p> <ul style="list-style-type: none"> <li>• Services which are covered to any extent under any other part of this Plan;</li> <li>• Services and supplies incurred for an abortion;</li> <li>• Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care;</li> <li>• Services which are for the treatment of an identified <b>illness or injury</b>;</li> <li>• Services that are not given by a <b>physician</b> or under his or her direction;</li> <li>• Psychiatric, psychological, personality or emotional testing or exams;</li> <li>• Any contraceptive methods that are only “reviewed” by the FDA and not “approved” by the FDA;</li> <li>• <u>Male</u> contraceptive methods, sterilization procedures or devices;</li> <li>• The reversal of voluntary sterilization procedures, including any related follow-up care.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Non-Preferred Care:</u> <b>65%</b> of the Recognized Charge.</p> <p><b>Important Note:</b> Brand-Name Prescription Drug or Devices will be covered at 100% of the Negotiated Charge, including waiver of Annual Deductible if a Generic Prescription Drug or Device is not available in the same therapeutic drug class or the prescriber specifies Dispense as Written.</p>

	<b>Tier I Preferred Care With Referral</b>	<b>Tier II Preferred Care Without Referral</b>	<b>Tier III Non-Preferred Care</b>
Chlamydia Screening Test Expense	<p>Benefits include charges incurred for an annual Chlamydia screening test.</p> <p>Benefits will be paid for Chlamydia screening expenses incurred for:</p> <ul style="list-style-type: none"> <li>• Women who are: <ul style="list-style-type: none"> <li>- under the age of 20 if they are sexually active, and</li> <li>- at least 20 years old if they have multiple risk factors.</li> </ul> </li> <li>• Men who have multiple risk factors.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows:  <u>Preferred Care with a referral:</u>  100% of the Negotiated Charge.</p>	<p>Benefits include charges incurred for an annual Chlamydia screening test.</p> <p>Benefits will be paid for Chlamydia screening expenses incurred for:</p> <ul style="list-style-type: none"> <li>• Women who are: <ul style="list-style-type: none"> <li>- under the age of 20 if they are sexually active, and</li> <li>- at least 20 years old if they have multiple risk factors.</li> </ul> </li> <li>• Men who have multiple risk factors.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows:  <u>Preferred Care:</u> 100% of the Negotiated Charge.</p>	<p>Benefits include charges incurred for an annual Chlamydia screening test.</p> <p>Benefits will be paid for Chlamydia screening expenses incurred for:</p> <ul style="list-style-type: none"> <li>• Women who are: <ul style="list-style-type: none"> <li>- under the age of 20 if they are sexually active, and</li> <li>- at least 20 years old if they have multiple risk factors.</li> </ul> </li> <li>• Men who have multiple risk factors.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows:  <u>Non-Preferred Care:</u> 65% of the Recognized Charge.</p>

**OPTIONAL DENTAL PLAN:**

**Aetna Dental® Indemnity** insurance plan

Gives you the freedom to visit any licensed dentist in the country for covered services – with no referrals required. Enroll and search dentists online at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com). Graduate Students beginning their academic enrollment in the Spring 2013 semester may enroll during the open enrollment period of **1/1/12-1/31/12** for the annual rate.

**Annual**

- Student - \$314
- Spouse - \$330
- Child(ren) - \$402

<b>Dental Indemnity Benefit Summary</b>	
<b>Plan Maximum</b>	<b>\$1,250</b>
<b>Plan Deductible</b>	Individual <b>\$50</b> / Family <b>\$150</b>
<b>Coinsurance</b>	<p><b>Preventative</b>  Preferred: <b>100%</b>  Non-Preferred: <b>100 %</b></p> <p><b>Basic</b>  Preferred: <b>80%</b>  Non-Preferred: <b>80 %</b></p> <p><b>Major</b>  Preferred: <b>50%</b>  Non-Preferred: <b>50%</b></p>

The Aetna Dental® Indemnity insurance plan is underwritten by Aetna Life Insurance Company.

## **ADDITIONAL SERVICES AND DISCOUNTS**

---

As a member of the Plan, you can also take advantage of the following services, discounts, and programs. These are not underwritten by Aetna and are not insurance. Please note that these programs are subject to change. To learn more about these additional services and search for providers visit, [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com).

**Aetna Book<sup>SM</sup> discount program:** Access to discounts on books and other items from the American Cancer Society Bookstore, the [MayoClinic.com](http://MayoClinic.com) Bookstore and Pranamaya.

**Aetna Fitness<sup>SM</sup> discount program:** Access to preferred rates on gym memberships and discounts on at-home weight loss programs, home fitness options and one-on-one health coaching services through GlobalFit<sup>TM</sup>.

**Aetna Hearing<sup>SM</sup> discount program:** Access to discounts on hearing aids and hearing tests from HearPO. Guaranteed lowest pricing\* on over 1000 models from seven leading manufacturers.

*\*Competitor copy required for verification of price and model. Limited to manufacturers offered through the HearPO program. Local provider quotes only will be matched, no internet quotes.*

**Aetna Natural Products and Services<sup>SM</sup> discount program:** Access to reduced rates on services from participating providers for acupuncture, chiropractic care, massage therapy and dietetic counseling. Also, access to discounts on over-the-counter vitamins, herbal and nutritional supplements and natural products. All products and services are provided through American Specialty Health Incorporated (ASH) and its subsidiaries.

**Aetna Vision<sup>SM</sup> discount program:** Access to discounts on vision exams, lenses and frames when a member utilizes a provider participating in the EyeMed Select Network.

**Aetna Weight Management<sup>SM</sup> discount program:** Access to discounts on eDiets<sup>®</sup> diet plans and products, Jenny Craig<sup>®</sup> weight loss programs and products, and Nutrisystem<sup>®</sup> weight loss meal plans.

**Oral Health Care discount program:** Access to discounts on oral health care products. Save on xylitol mints, mouth rinses, gum, candies and toothpaste from Epic. Additionally, receive exclusive savings on Waterpik<sup>®</sup> dental water jets and sonic toothbrushes.

**At Home Products discount program:** Access to discounts on health care products that members can use in the privacy and comfort of their home.

**Aetna Specialty Pharmacy:** Provides specialty medications and support to members living with chronic conditions and illnesses. These medications are usually injected or infused, or some may be taken by mouth. Custom compounded doses and forms are also available. For additional information please go to [www.AetnaSpecialtyRx.com](http://www.AetnaSpecialtyRx.com).

**Quit Tobacco Cessation Program:** Say good-bye to tobacco and hello to a healthier future! The one-year Quit Tobacco program is provided by Healthyroads, a leading provider of tobacco cessation programs. You'll get personal attention from health professionals that can help find what works for you.

**Beginning Right<sup>®</sup> Maternity Program:** Make healthy choices for you and your baby. Learn what decisions are good ones for you and your baby. Our Beginning Right maternity program helps prepare you for the exciting changes pregnancy brings.

*These services, programs or benefits are offered by vendors who are independent contractors and not employees or agents of Chickering Claims Administrators, Inc., Aetna Life Insurance Company or their affiliates. Discount programs and other programs above provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Discount programs may be offered by vendors who are independent contractors and not employees or agents of Aetna. Aetna may receive a percentage of the fee you pay to the discount vendor.*

Listen to the **Audio Health Library**:\*It explains thousands of health conditions in English and Spanish. Transfer easily to a registered nurse at any time during the call.

*\* Not all topics in the audio health service are covered expenses under your plan.*

Use the **Healthwise® Knowledgebase** to find out more about a health condition you have or medications you take. It explains things in terms that are easy to understand.

Get to it through your secure Aetna Navigator® member website, at **[www.aetnastudenthealth.com](http://www.aetnastudenthealth.com)**.

## GENERAL PROVISIONS

---

### STATE MANDATED BENEFITS

The Plan will pay benefits in accordance with any applicable Virginia State Insurance Law(s).

#### *Coordination of Benefits*

If the Covered Person is insured under more than one group health plan, the benefits of the plan that covers the insured student will be used before those of a plan that provides coverage as a dependent. When both parents have group health plans that provide coverage as a dependent, the benefits of the plan of the parent whose birth date falls earlier in the year will be used first. The benefits available under this Plan may be coordinated with other benefits available to the Covered Person under any auto insurance, Workers' Compensation, Medicare, or other coverage. The Plan pays in accordance with the rules set forth in the Policy.

### TERMINATION OF INSURANCE

---

Benefits are payable under this policy only for those Covered Expenses incurred while the policy is in effect as to the Covered Person. No benefits are payable for expenses incurred after the date the insurance terminates, except as may be provided under the Extension of Benefits provision.

### TERMINATION OF STUDENT COVERAGE

Insurance for a **covered student** will end on the first of these to occur:

- a) the date this Policy terminates,
- b) the last day for which any required premium has been paid,
- c) the date on which the **covered student** withdraws from the school because of entering the armed forces of any country. Premiums will be refunded on a pro-rata basis when application is made within 90 days from withdrawal,
- d) at end of the current coverage period for which the **covered student** has enrolled and is no longer in an eligible class.

If withdrawal from school is for other than entering the armed forces, no premium refund will be made. Students will be covered for the Policy term for which they are enrolled, and for which premium has been paid.

### TERMINATION OF DEPENDENT COVERAGE

Insurance for a **covered student's dependent** will end when insurance for the **covered student** ends. Before then, coverage will end:

- a) For a child, on the last day of the Policy Period following the child's 26th birthday.
- b) The date the **covered student** fails to pay any required premium.
- c) For the spouse, at end of the period for which the spouse is enrolled and the marriage ends in divorce or annulment.
- d) The date **dependent** coverage is deleted from this Policy.
- e) At end of the current coverage period for which the **dependent** ceases to be in an eligible class.

Termination will not prejudice any claim for a charge that is incurred prior to the date coverage ends.

### INCAPACITATED DEPENDENT CHILDREN

Insurance may be continued for incapacitated **dependent** children who reach the age at which insurance would otherwise cease. The **dependent** child must be chiefly dependent for support upon the **covered student** and be incapable of self-sustaining employment because of mental or physical handicap.

Due proof of the child's incapacity and dependency must be furnished to Aetna by the **covered student** within 31 days after the date insurance would otherwise cease. Such proof will not be required more often than once each year after 2 years from the date the child reached the age at which insurance would have ceased if the child were not incapacitated. The premium due for the child's insurance will be the same as for a child who is not so incapacitated. Such child will be considered a **covered dependent**, so long as the **covered student** submits proof to Aetna each year, that the child remains physically or mentally unable to earn his own living. The premium due for the child's insurance will be the same as for a child who is not so incapacitated.

The child's insurance under this provision will end on the earlier of:

- a) the date specified under the provision entitled Termination of Dependent Coverage, or
- b) the date the child is no longer incapacitated and dependent on the **covered student** for support.

### **Conversion**

A **covered student** and their **covered dependents** who has graduated or is otherwise ineligible for coverage under this policy, and has been continuously insured for twelve months under the Aetna Student Health plan offered by the Policyholder, have the right to convert to an individual policy. **Covered persons** are required to apply for the conversion policy within 31 days after the Policyholder has given written notice of the option to convert to an individual policy, but in no event beyond the 60 day period following the date of the termination of the **covered person's** eligibility. Please contact Aetna at **(866) 901-2922** for more information.

## **EXCLUSIONS**

---

This Policy does not cover nor provide benefits for:

1. Expense incurred as a result of dental treatment, except for treatment resulting from injury to sound, natural teeth or for extraction of impacted wisdom teeth as provided elsewhere in this Policy.
2. Expense incurred as a result of injury due to participation in a riot. "Participation in a riot" means taking part in a riot in any way, including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense, so long as they are not taken against persons who are trying to restore law and order.
3. Expense incurred as a result of an accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.
4. Expense incurred as a result of an injury or sickness due to working for wage or profit or for which benefits are payable under any Workers' Compensation or Occupational Disease Law.
5. Expense incurred as a result of an injury sustained or sickness contracted while in the service of the Armed Forces of any country. Upon the covered person entering the Armed Forces of any country, the unearned pro-rata premium will be refunded to the Policyholder.
6. Expense incurred for treatment provided in a governmental hospital unless there is a legal obligation to pay such charges in the absence of insurance.
7. Expense incurred for elective treatment or elective surgery except as specifically provided elsewhere in this Policy and performed while this Policy is in effect.
8. Expense incurred for cosmetic surgery, reconstructive surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons, except to the extent needed to: a) Improve the function of a part of the body that is not a tooth or structure that supports the teeth, and is malformed as a result of a severe birth defect, including harelip, webbed fingers, or toes, or as direct result of disease, or surgery performed to treat a disease or injury. b) Repair an injury (including reconstructive surgery for prosthetic device for a covered person who has undergone a mastectomy) which occurs while the covered person is covered under this Policy. Surgery must be performed in the calendar year of the accident which causes the injury, or in the next calendar year.
9. Expense covered by any other valid and collectible medical, health or accident insurance to the extent that benefits are payable under other valid and collectible insurance whether or not a claim is made for such benefits.
10. Expense incurred as a result of commission of a felony.
11. Expense incurred for voluntary or elective abortions unless otherwise provided in this Policy.
12. Expense incurred after the date insurance terminates for a covered person except as may be specifically provided in the Extension of Benefits Provision.
13. Services provided by the Health Service of the Policyholder or services covered or provided by the student health-fee.



14. Expense incurred for any services rendered by a member of the covered person's immediate family or a person who lives in the covered person's home.
15. Treatment for injury to the extent benefits are payable under any state no-fault automobile coverage, first party medical benefits payable under any other mandatory No-fault law.
16. Expense for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures, elective sterilization or its reversal or elective abortion unless specifically provided for in this Policy.
17. Expenses for treatment of injury or sickness to the extent that payment is made, as a judgment or settlement, by any person deemed responsible for the injury or sickness (or their insurers).
18. Expense incurred for which no member of the covered person's immediate family has any legal obligation for payment.
19. Expense incurred for custodial care. Custodial care means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes room and board and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to: by whom they are prescribed, or by whom they are recommended, or by whom or by which they are performed.
20. Expense incurred for the removal of an organ from a covered person for the purpose of donating or selling the organ to any person or organization. This limitation does not apply to a donation by a covered person to a spouse, child, brother, sister, or parent.
21. Expenses incurred for or in connection with: procedures, services, or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if: a) There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature, to substantiate its safety and effectiveness, for the disease or injury involved, or b) If required by the FDA, approval has not been granted for marketing, or c) A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes, or d) The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility, or by another facility studying the same drug, device, procedure, or treatment, states that it is experimental, investigational, or for research purposes. However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease, if Aetna determines that: a) The disease can be expected to cause death within one year, in the absence of effective treatment, and b) The care or treatment is effective for that disease, or shows promise of being effective for that disease, as demonstrated by scientific data. In making this determination, Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved. Also, this exclusion will not apply with respect to drugs that: a) Have been granted treatment investigational new drug (IND), or b) Group c/treatment IND status, or c) Are being studied at the Phase III level in a national clinical trial, sponsored by the National Cancer Institute, d) If Aetna determines that available, scientific evidence demonstrates that the drug is effective, or shows promise of being effective, for the disease.
22. Expenses incurred for gastric bypass, and any restrictive procedures, for weight loss except for the treatment of morbid obesity.
23. Expenses incurred for breast reduction/mammoplasty.
24. Expenses incurred for gynecomastia (male breasts).
25. Expense incurred by a covered person, not a United States citizen, for services performed within the covered person's home country, if the covered person's home country has a socialized medicine program.
26. Expense incurred for acupuncture, unless services are rendered for anesthetic purposes.
27. Expense incurred for alternative, holistic medicine, and/or therapy, including but not limited to, yoga and hypnotherapy.
28. Expense for injuries sustained as the result of a motor vehicle accident, to the extent that benefits are payable under other valid and collectible insurance, whether or not claim is made for such benefits. The Policy will only pay for those losses, which are not payable under the automobile medical payment insurance Policy.
29. Expense incurred when the person or individual is acting beyond the scope of his/her/its legal authority.
30. Expense incurred for hearing aids, the fitting, or prescription of hearing aids.

31. Expenses incurred for hearing exams.
32. Expense for care or services to the extent the charge would have been covered under Medicare Part A or Part B, even though the covered person is eligible, but did not enroll in Part B.
33. Expense for charges for failure to keep a scheduled visit, or charges for completion of a claim form.
34. Expense for personal hygiene and convenience items, such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if such items are prescribed by a physician.
35. Expense for incidental surgeries, and standby charges of a physician.
36. Expense incurred for outpatient treatment in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion, or subluxation, in the human body, for purposes of removing nerve interference as a result of or related to: distortion, misalignment, or subluxation in the vertebral column, except as provided elsewhere in the Policy.
37. Expense incurred for injury resulting from the play or practice of intercollegiate sports (participating in sports clubs, or intramural athletic activities, is not excluded).
38. Expenses incurred for massage therapy.
39. Expense for charges that are not recognized charges, as determined by Aetna, except that this will not apply if the charge for a service, or supply, does not exceed the recognized charge for that service or supply, by more than the amount or percentage, specified as the Allowable Variation.
40. Expense for treatment of covered students who specialize in the mental health care field, and who receive treatment as a part of their training in that field.
41. Expense incurred for a treatment, service, or supply, which is not medically necessary, as determined by Aetna, for the diagnosis care or treatment of the sickness or injury involved. This applies even if they are prescribed, recommended, or approved, by the person's attending physician, or dentist. In order for a treatment, service, or supply, to be considered medically necessary, the service or supply must: a) be care, or treatment, which is likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the sickness or injury involved, and the person's overall health condition, b) be a diagnostic procedure which is indicated by the health status of the person, and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the sickness or injury involved, and the person's overall health condition, and c) as to diagnosis, care, and treatment, be no more costly (taking into account all health expenses incurred in connection with the treatment, service, or supply), than any alternative service or supply to meet the above tests. In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration: information relating to the affected person's health status, reports in peer reviewed medical literature, reports and guidelines published by nationally recognized health care organizations that include supporting scientific data, generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment, the opinion of health professionals in the generally recognized health specialty involved, and any other relevant information brought to Aetna's attention. In no event will the following services or supplies be considered to be medically necessary: a) those that do not require the technical skills of a medical, a mental health, or a dental professional, or b) those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, or any persons who is part of his or her family, any healthcare provider, or healthcare facility, or c) those furnished solely because the person is an inpatient on any day on which the person's sickness or injury could safely, and adequately, be diagnosed, or treated, while not confined, or those furnished solely because of the setting, if the service or supply could safely and adequately be furnished in a physician's or a dentist's office, or other less costly setting.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

## DEFINITIONS

---

### **Accident**

An occurrence which (a) is unforeseen, (b) is not due to or contributed to by **sickness** or disease of any kind, and (c) causes **injury**.

### **Actual Charge**

The charge made for a covered service by the provider who furnishes it.

### **Aggregate Maximum**

The maximum benefit that will be paid under this Policy for all **Covered Medical Expenses** incurred by a **covered person** that accumulate in one **Policy Year**.

### **Ambulatory Surgical Center**

A freestanding ambulatory surgical facility that:

Meets licensing standards.

- Is set up, equipped and run to provide general surgery.
- Makes charges.
- Is directed by a staff of physicians. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery which requires general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
  - **Physicians** who practice surgery in an area **hospital**, and
  - **Dentists** who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by a R.N.
- Is equipped and has trained staff to handle medical emergencies.
- It must have:
  - A physician trained in cardiopulmonary resuscitation, and
  - A defibrillator, and
  - A tracheotomy set, and
  - A blood volume expander.
- Has a written agreement with a **hospital** in the area for immediate emergency transfer of patients. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. The program must include reviews by physicians who do not own or direct the facility.
- Keeps a medical record on each patient.

### **Biologically-Based Mental Illness**

Disorders Are:

- Schizophrenia;
- Schizoaffective disorder;
- Major depressive disorder;
- Bipolar disorder;
- Panic disorder;
- Obsessive-compulsive disorder;
- Attention Deficit Hyperactivity Disorder
- Autism, and
- Drug and Alcoholism addiction.

**Birth Center**

A freestanding facility that:

- Meets licensing standards.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
- Makes charges.
- Is directed by at least one physician who is a specialist in obstetrics and gynecology.
- Has a physician or certified nurse midwife present at all births and during the immediate postpartum period.
- Extends staff privileges to physicians who practice obstetrics and gynecology in an area hospital.
- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.
- Provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by a R.N. or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
- Is equipped and has trained staff to handle medical emergencies and provide immediate support measures to sustain life if complications arise during labor and if a child is born with an abnormality which impairs function or threatens life.
- Accepts only patients with low risk pregnancies.
- Has a written agreement with a **hospital** in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. This includes reviews by physicians who do not own or direct the facility.
- Keeps a medical record on each patient and child.

**Bone Marrow Transplant**

Use of high doses chemotherapy and radiation in conjunction with transplantation of autologous bone marrow or peripheral blood stem cells, which originate in the bone marrow.

**Brand Name Prescription Drug or Medicine**

A **prescription drug** which is protected by trademark registration.

**Chlamydia Screening Test**

This is any laboratory test of the urogenital tract that specifically detects for infection by one or more agents of Chlamydia trachomatis, and which test is approved for such purposes by the FDA.

**Coinsurance**

The percentage of Covered Medical Expenses payable by Aetna under this Accident and Sickness Insurance Plan.

**Complications of Pregnancy**

Conditions which require **hospital** stays before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy. These conditions are:

- Acute nephritis or nephrosis, or
- Cardiac decompensation or missed abortion, or
- Similar conditions as severe as these.
- non-elective cesarean section, and
- termination of an ectopic pregnancy, and
- spontaneous termination when a live birth is not possible. (This does not include voluntary abortion.)

Not included are (a) false labor, occasional spotting or **physician** prescribed rest during the period of pregnancy, (b) morning **sickness**, (c) hyperemesis gravidarum and preclampsia, and (d) similar conditions not medically distinct from a difficult pregnancy.

**Convalescent Facility**

This is an institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:
  - professional nursing care by a **R.N.**, or by a **L.P.N.** directed by a full-time **R.N.**, and

- physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time R.N.
- Is supervised full-time by a physician or R.N.
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Makes charges.

### **Copay**

This is a fee charged to a person for **Covered Medical Expenses**.

For Prescribed Medicines Expense, the **copay** is payable directly to the **pharmacy** for each: **prescription**, kit, or refill, at the time it is dispensed. In no event will the **copay** be greater than the **pharmacy's** charge per: **prescription**, kit, or refill.

### **Covered Dental Expenses**

Those charges for any treatment, service, or supplies, covered by this Plan which are:

- Not in excess of the **reasonable and customary charges**, or
- Not in excess of the charges that would have been made in the absence of this coverage,
- And incurred while this Policy is in force as to the covered person.

### **Covered Dependent**

A covered student's dependent who is insured under this Policy.

### **Covered Medical Expense**

Those charges for any treatment, service or supplies covered by this Plan which are:

- Not in excess of the **reasonable and customary charges**, or
- Not in excess of the charges that would have been made in the absence of this coverage, and
- Incurred while this Plan is in force as to the covered person except with respect to any expenses payable under the Extension of Benefit Provisions.

### **Covered Person**

A **covered student** and any **covered dependent** while coverage under this Plan is in effect.

### **Covered Student**

A student of the Policyholder who is insured under this Plan.

### **Deductible**

The amount of **Covered Medical Expenses** that are paid by each **covered person** during the **policy year** before benefits are paid.

### **Dental Consultant**

A **dentist** who has agreed to provide consulting services in connection with the Dental Expense Benefit.

### **Dental Provider**

This is any **dentist**, group, organization, dental facility, or other institution, or person legally qualified to furnish dental services or supplies.

### **Dentist**

A legally qualified **dentist**. Also, a **physician** who is licensed to do the dental work he or she performs.

**Dependent**

(a) the covered student's spouse residing with the covered student or (b) the covered student's child up to the age of 26.

The term "child" includes a **covered student's** biological child, step-child, adopted child whose coverage is effective upon the earlier of the date of placement for the purpose of adoption, or the date of the entry of an order granting the adoptive parent custody of the child for purposes of adoption.

The term **dependent** does not include a person who is: (a) an eligible student, or (b) a member of the armed forces.

**Designated Care**

Care provided by a **Designated Care Provider** upon referral from the **School Health Services**.

**Designated Care Provider**

A health care provider or **pharmacy**, that is affiliated with, and has an agreement with, the **School Health Services** to furnish services and supplies at a **negotiated charge**.

**Diabetic Self-Management Education Course**

A scheduled program on a regular basis which is designed to instruct a covered person in the self-management of diabetes. It is a day care program of educational services and self-care training, including medical nutritional therapy. The program must be under the supervision of an appropriately licensed, registered, or certified health care professional whose scope of practice includes diabetic education or management.

*The following are not considered Diabetic Self-Management Education Courses for the purposes of this Plan:*

- A Diabetic Education program whose only purpose is weight control, or which is available to the public at no cost; or
- A general program not just for diabetics; or
- A program made up of services not generally accepted as necessary for the management of diabetes.

**Directory**

A listing of **Preferred Care Providers** in the **service area** covered under this Plan, which is given to the Policyholder.

**Durable Medical and Surgical Equipment**

No more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

- Made to withstand prolonged use,
- Made for and mainly used in the treatment of a disease or injury,
- Suited for use in the home,
- Not normally of use to person's who do not have a disease or injury,
- Not for use in altering air quality or temperature,
- Not for exercise or training.

Not included is equipment such as: whirlpools, portable whirlpool pumps, sauna baths, massage devices, overbed tables, elevators, communication aids, vision aids, and telephone alert systems.

**Elective Treatment**

Medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the **covered person's** effective date of coverage. **Elective treatment** includes, but is not limited to:

- Tubal ligation,
- Vasectomy,
- Breast reduction,
- Sexual reassignment surgery,

### **Emergency Admission**

One where the **physician** admits the person to the **hospital** or **residential treatment facility** right after the sudden and at that time; unexpected onset of a change in a person's physical or mental condition which:

- Requires confinement right away as a full-time inpatient; and
- If immediate inpatient care was not given could; as determined by Aetna; reasonably be expected to result in:
  - loss of life or limb, or
  - significant impairment to bodily function; or
  - permanent dysfunction of a body part.

### **Emergency Condition**

This is any traumatic injury or condition which:

- Occurs unexpectedly,
- Requires immediate diagnosis and treatment, in order to stabilize the condition, and
- Is characterized by symptoms such as severe pain and bleeding.

### **Emergency Medical Condition**

This means a recent and severe medical condition; including; but not limited to; severe pain which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, **sickness**, or **injury**, is of such a nature that failure to get immediate medical care could result in:

- Placing the person's health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman; serious jeopardy to the health of the fetus.

### **Generic Prescription Drug or Medicine**

A **prescription drug** which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

### **Home Health Agency**

- An agency licensed as a **home health agency** by the state in which **home health care services** are provided, or
- An agency certified as such under Medicare, or
- An agency approved as such by Aetna.

### **Home Health Aide**

A certified or trained professional who provides services through a **home health agency** which are not required to be performed by an RN, LPN, or LVN, primarily aid the **covered person** in performing the normal activities of daily living while recovering from an **injury** or **sickness**, and are described under the written **Home Health Care Plan**.

### **Home Health Care**

Health services and supplies provided to a **covered person** on a part-time, intermittent, visiting basis. Such services and supplies must be provided in such person's place of residence, while the person is confined as a result of **injury** or **sickness**. Also, a **physician** must certify that the use of such services and supplies is to treat a condition as an alternative to confinement in a **hospital** or **skilled nursing facility**.

### **Home Health Care Plan**

A written plan of care established and approved in writing by a **physician**, for continued health care and treatment in a **covered person's** home. It must either follow within 24 hours of and be for the same or related cause(s) as a period of **hospital** or skilled nursing confinement, or be in lieu of **hospital** or skilled nursing confinement.

### **Hospice**

A facility; or program; providing a coordinated program of home and inpatient care; which treats terminally ill patients. The program provides care to meet the special needs of the patient during the final stages of a terminal illness. Care is provided by a team made up of trained medical personnel; counselors; and volunteers. The team acts under an **independent hospice** administration; and it helps the patient cope with physical; psychological; spiritual; social; and economic stresses. The **hospital** administration must meet the standards of the National Hospice Organization; and any licensing requirements.

**Hospice Benefit Period**

A period that begins on the date the attending **physician** certifies that the **covered person** is a terminally ill patient who has less than 6 months to live. It ends after 6 months (or such later period for which treatment is certified) or on the death of the patient, if sooner.

**Hospice Care Expenses**

The reasonable and customary charges made by a hospice for the following services or supplies: charges for inpatient care, charges for drugs and medicines, charges for part-time nursing by an R.N., L.P.N., or L.V.N., charges for physical and respiratory therapy in the home, charges for the use of medical equipment, charges for visits by licensed or trained social workers, psychologists or counselors, charges for bereavement counseling of the covered person's immediate family prior to, and within 3 months after, the covered person's death, and charges for respite care for up to 5 days in any 30 day period.

**Hospital**

A facility which meets all of these tests:

- It provides in-patient services for the care and treatment of injured and sick people, and
- It provides room and board services and nursing services 24 hours a day, and
- It has established facilities for diagnosis and major surgery, and
- It is run as a **hospital** under the laws of the jurisdiction which it is located.

**Hospital** does not include a place run mainly: (a) for alcoholics or drug addicts, (b) as a convalescent home, or (c) as a nursing or rest home. The term "**hospital**" includes an alcohol and drug addiction treatment facility during any period in which it provides effective treatment of alcohol and drug addiction to the **covered person**.

**Hospital Confinement**

A stay of 18 or more hours in a row as a resident bed patient in a **hospital**.

**Injury**

Bodily **injury** caused by an **accident**. This includes related conditions and recurrent symptoms of such **injury**.

**Intensive Care Unit**

A designated ward, unit, or area within a **hospital** for which a specified extra daily surcharge is made and which is staffed and equipped to provide, on a continuous basis, specialized or intensive care or services, not regularly provided within such **hospital**.

**Jaw Joint Disorder**

This is a Temporomandibular Joint Dysfunction or any similar disorder in the relationship between the jaws or jaw joint, and the muscles, and nerves.

**Mail Order Pharmacy**

An establishment where **prescription drugs** are legally dispensed by mail.

**Medically Necessary**

A service or supply that is: necessary, and appropriate, for the diagnosis or treatment of a **sickness**, or **injury**, based on generally accepted current medical practice.

In order for a treatment, service, or supply to be considered **medically necessary**, the service or supply must:

- Be care or treatment which is likely to produce as significant positive outcome as any alternative service or supply, both as to the **sickness or injury** involved and the person's overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply, both as to the sickness or injury involved and the person's overall health condition
- Be a diagnostic procedure which is indicated by the health status of the person. It must be as likely to result in information that could affect the course of treatment as any alternative service or supply, both as to the sickness or injury involved and the person's overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply, both as to the sickness or injury involved and the person's overall health condition, and
- As to diagnosis, care, and treatment, be no more costly (taking into account all health expenses incurred in connection with the treatment, service, or supply,) than any alternative service or supply to meet the above tests.



In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- Information relating to the affected person's health status,
- Reports in peer reviewed medical literature,
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data,
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment,
- The opinion of health professionals in the generally recognized health specialty involved, and
- Any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered to be **medically necessary**:

- Those that do not require the technical skills of a medical, a mental health, or a dental professional, or
- Those furnished mainly for: the personal comfort, or convenience, of the person, any person who cares for him or her, or any person who is part of his or her family, any **healthcare provider**, or healthcare facility, or
- Those furnished solely because the person is an inpatient on any day on which the person's sickness or injury could safely and adequately be diagnosed or treated while not confined, or
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished, in a **physician's** or a **dentist's** office, or other less costly setting.

#### **Medication Formulary**

A listing of **prescription drugs** which have been evaluated and selected by Aetna clinical pharmacists, for their therapeutic equivalency and efficacy. This listing includes both brand name and **generic prescription drugs**. This listing is subject to periodic review, and modification by Aetna.

#### **Medication Management Visit**

A visit no more than twenty minutes in length with a licensed physician or other licensed health care provider with prescriptive authority for the sole purpose of monitoring and adjusting medications prescribed for mental health or substance abuse treatment.

#### **Negotiated Charge**

The maximum charge a **Preferred Care Provider** or **Designated Provider** has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

#### **Non-Occupational Disease**

A **non-occupational disease** is a disease that does not:

- Arise out of (or in the course of) any work for pay or profit, or
- Result in any way from a disease that does.

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the **covered student**:

- Is covered under any type of workers' compensation law, and
- Is not covered for that disease under such law.

#### **Non-Occupational Injury**

A non-occupational injury is an accidental bodily **injury** that does not:

- Arise out of (or in the course of) any work for pay or profit, or
- Result in any way from an **injury** which does.

#### **Non-Preferred Care**

A health care service or supply furnished by a health care provider that is not a **Designated Care Provider**, or that is not a **Preferred Care Provider**, if, as determined by Aetna:

- The service or supply could have been provided by a **Preferred Care Provider**, and
- The provider is of a type that falls into one or more of the categories of providers listed in the directory.

#### **Non-Preferred Care Provider**

A health care provider that has not contracted to furnish services or supplies at a **negotiated charge**.

**Non-Preferred Pharmacy**

A **pharmacy** not party to a contract with Aetna, or a **pharmacy** who is party to such a contract but who does not dispense **prescription drugs** in accordance with its terms.

**Non-Preferred Prescription Drug Expense**

An expense incurred for a **prescription drug** that is not a **preferred prescription drug expense**.

**One Sickness**

A **sickness** and all recurrences and related conditions which are sustained by a **covered person**.

**Orthodontic Treatment**

Any

- Medical service or supply, or
- Dental service or supply,
- Furnished to prevent or to diagnose or to correct a misalignment:
  - Of the teeth, or
  - Of the bite, or
  - Of the jaws or jaw joint relationship,
- Whether or not for the purpose of relieving pain. Not included is:
  - The installation of a space maintainer, or
  - Surgical procedure to correct malocclusion.

**Out-of-Pocket Limit**

The amount that must be paid, by the **covered student**, or the **covered student** and their **covered dependents**, before **Covered Medical Expenses** will be payable at 100% for the remainder of the **Policy Year**. The **Out-of-Pocket Limit** applies only to **Covered Medical Expenses** for preferred care and non-preferred care, which accrues on a **combined basis**.

The following expenses do not apply toward meeting the **Out-of-Pocket Limit**:

- deductibles,
- copays,
- expenses that are not Covered Medical Expenses,
- penalties,
- expenses for prescription drugs, and
- other expenses not covered by this Policy.

**Outpatient Diabetic Self-Management Education Program**

A scheduled program on a regular basis, which is designed to instruct a covered person in the self-management of diabetes (insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes). It is a day care program of educational services and self-care training, (including medical nutritional therapy). The program must be under the supervision of an appropriately licensed, registered, or certified health care professional whose scope of practice includes diabetic education or management.

**Partial Hospitalization**

Continuous treatment consisting of not less than four hours and not more than twelve hours in any twenty-four hour period under a program based in a **hospital**.

**Pervasive Developmental Disorder**

A neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

**Pharmacy**

An establishment where **prescription drugs** are legally dispensed.

### **Physician**

(a) legally qualified **physician** licensed by the state in which he or she practices; and (b) any licensed nurse midwife; registered nurse; anesthesia; or other licensed medical practitioner; whose services are required to be covered by law; and who renders such services within the scope of his or her license. For the treatment of **Mental Illness**; the “**physician**” also includes a licensed clinical psychologist; licensed clinical social worker; and a licensed clinical psychiatric nurse practitioner; who is acting within the scope of his or her license; and any other practitioner whose services are required to be covered by law; when rendered by that practitioner.

### **Policy Year**

The period of time from anniversary date to anniversary date except in the first year when it is the period of time from the effective date to the first anniversary date.

### **Pre-Admission Testing**

Tests done by a hospital, surgery center, licensed diagnostic lab facility, or physician, in its own behalf, to test a person while an outpatient before scheduled surgery if:

- the tests are related to the scheduled surgery,
- the tests are done within the 7 days prior to the scheduled surgery,
- the person undergoes the scheduled surgery in a **hospital** or **surgery center**, this does not apply if the tests show that surgery should not be done because of his physical condition,
- the charge for the surgery is a **Covered Medical Expense** under this Plan,
- the tests are done while the person is not confined as an inpatient in a **hospital**,
- the charges for the tests would have been covered if the person was confined as an inpatient in a **hospital**,
- the test results appear in the person's medical record kept by the **hospital** or **surgery center** where the surgery is to be done, and
- the tests are not repeated in or by the **hospital** or **surgery center** where the surgery is done.

If the person cancels the scheduled surgery, benefits are paid at the Covered Percentage that would have applied in the absence of this benefit.

### **Preferred Care**

Care provided by:

- a **covered person's primary care physician**, or a **preferred care provider** on the referral of the **primary care physician**, or
- a health care provider that is not a **Preferred Care Provider** for an emergency medical condition when travel to a **Preferred Care Provider**, [or referral by a covered person's primary care physician prior to treatment], is not feasible, or
- a **Non-Preferred Urgent Care Provider** when travel to a **Preferred Urgent Care Provider** for treatment is not feasible, and if authorized by Aetna.

### **Preferred Care Provider**

A health care provider that has contracted to furnish services or supplies for a **negotiated charge**, but only if the provider is, with Aetna's consent, included in the **directory** as a **Preferred Care Provider** for:

- The service or supply involved, and
- The class of **covered persons** of which you are member.

### **Preferred Pharmacy**

A **pharmacy**, including a **mail order pharmacy**, which is party to a contract with Aetna to dispense drugs to persons covered under this Policy, but only:

- While the contract remains in effect, and
- While such a pharmacy dispenses a **prescription drug**, under the terms of its contract with Aetna.

### **Preferred Prescription Drug Expense**

An expense incurred for a **prescription drug** that:

- Is dispensed by a **Preferred Pharmacy**, or for an emergency medical condition only, by a non-preferred pharmacy, and
- Is dispensed upon the Prescription of a Prescriber who is:
  - A **Designated Care Provider**, or
  - A **Preferred Care Provider**, or

- A Non-Preferred Care Provider, but only for an emergency condition, or on referral of a person's **Primary Care Physician**, or
- A dentist who is a **Non-Preferred Care Provider**, but only one who is not of a type that falls into one or more of the categories of providers listed in the directory of **Preferred Care Providers**.

### **Prescriber**

Any person, while acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

### **Prescription**

An order of a **prescriber** for a **prescription drug**. If it is an oral order, it must be promptly put in writing by the **pharmacy**.

### **Prescription Drugs**

Any of the following:

- A drug, biological, or compounded **prescription**, which, by Federal law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without **prescription**".
- Injectable insulin; disposable needles and syringes; when prescribed and purchased at the same time as insulin; and disposable diabetic supplies.

Prescription drugs include: Drugs for cancer treatment, provided such drugs are approved by the Federal Food and Drug Administration for use in the treatment of cancer, even if the drug has not been approved by the Federal Food and Drug Administration for the specific type of cancer for which the drug has been prescribed.

### **Primary Care Physician**

This is the **Preferred Care Provider** who is:

- Selected by a person from the list of Primary Care Physicians in the directory,
- Responsible for the person's on-going health care, and
- Shown on Aetna's records as the person's Primary Care Physician.

For purposes of this definition, a **Primary Care Physician** also includes the **School Health Services**.

### **Recognized Charge**

Only that part of a charge which is recognized is covered. The **recognized charge** for a service or supply is the lowest of:

- The provider's usual charge for furnishing it, and
- The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply, and the manner in which charges for the service or supply are made, and
- The charge Aetna determines to be the **recognized charge** percentage made for that service or supply.

In some circumstances, Aetna may have an agreement, either directly or indirectly, through a third party, with a provider which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the **recognized charge** is the rate established in such agreement.

In determining the **recognized charge** for a service or supply that is:

- Unusual, or
- Not often provided in the area, or
- Provided by only a small number of providers in the area.

Aetna may take into account factors, such as:

- The complexity,
- The degree of skill needed,
- The type of specialty of the provider,
- The range of services or supplies provided by a facility, and
- The **recognized charge** in other areas.

**Residential Treatment Facility**

A treatment center for children and adolescents, which provides residential care and treatment for emotionally disturbed individuals, and is licensed by the department of children and youth services, and is accredited as a residential treatment center by the council on accreditation or the joint commission on accreditation of health organizations.

**Respite Care**

Care provided to give temporary relief to the family or other care givers in emergencies and from the daily demands for caring for a terminally ill **covered person**.

**Room and Board**

Charges made by an institution for board and room and other necessary services and supplies. They must be regularly made at a daily or weekly rate.

**Routine Screening for Sexually Transmitted Disease**

This is any laboratory test approved for such purposes by the FDA that specifically detects for infection by one or more agents of:

- Gonorrhea,
- Syphilis,
- Hepatitis,
- HIV, and
- Genital Herpes

**School Health Services**

Any organization, facility, or clinic operated, maintained, or supported by the school or other entity under contract to the school which provides health care services to enrolled students.

**Semi-private Rate**

The charge for **room and board** which an institution applies to the most beds in its semiprivate rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

**Service Area**

The geographic area, as determined by Aetna, in which the **Preferred Care Providers** are located.

**Sickness**

Disease or illness including related conditions and recurrent symptoms of the **sickness**. **Sickness** also includes pregnancy, and **complications** of **pregnancy**. All **injuries** or **sickness** due to the same or a related cause are considered one **injury** or **sickness**.

**Skilled Nursing Facility**

A lawfully operating institution engaged mainly in providing treatment for people convalescing from **injury** or **sickness**. It must have:

- Organized facilities for medical services,
- 24 hours nursing service by RNs,
- A capacity of six or more beds,
- A daily medical records for each patient, and
- A **physician** available at all times.

**Sound Natural Teeth**

Natural teeth, the major portion of the individual tooth which is present regardless of fillings and is not carious, abscessed, or defective. **Sound natural teeth** shall not include capped teeth.

**Stem Cells**

A human or animal cell that has the ability to reproduce itself for long periods of time.

### **Surgery Center**

A free standing ambulatory surgical facility that:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Makes charges.
- Is directed by a staff of physicians. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery which requires general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
  - **Physicians** who practice surgery in an area **hospital**, and
  - **Dentists** who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by a registered nurse.
- Is equipped and has trained staff to handle medical emergencies.
- It must have:
  - A **physician** trained in cardiopulmonary resuscitation, and
  - A defibrillator, and
  - A tracheotomy set, and
  - A blood volume expander.
- Has a written agreement with a **hospital** in the area for immediate emergency transfer of patients. Written procedures for such a transfer must be displayed, and the staff must be aware of them.
- Provides an ongoing quality assurance program. The program must include reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient.

### **Surgical Assistant**

A medical professional trained to assist in surgery in both the preoperative and postoperative periods under the supervision of a **physician**.

### **Surgical Expense**

Charges by a **physician** for,

- A surgical procedure,
- A necessary preoperative treatment during a hospital stay in connection with such procedure, and
- Usual postoperative treatment.

### **Surgical Procedure**

- A cutting procedure,
- Suturing of a wound,
- Treatment of a fracture,
- Reduction of a dislocation,
- Radiotherapy (excluding radioactive isotope therapy), if used in lieu of a cutting operation for removal of a tumor,
- Electrocauterization,
- Diagnostic and therapeutic endoscopic procedures,
- Injection treatment of hemorrhoids and varicose veins,
- An operation by means of laser beam,
- Cryosurgery.

### **Totally Disabled**

Due to disease or **injury**, the **covered person** is not able to engage in most of the normal activities of a person of like age and sex in good health.

### **Urgent Admission**

One where the **physician** admits the person to the **hospital** due to:

- The onset of or change in a disease, or
- The diagnosis of a disease, or
- An **injury** caused by an **accident**,
- which, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.

### **Urgent Condition**

This means a sudden illness, **injury**, or condition, that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of the **covered person's** health,
- Includes a condition which would subject the covered person to severe pain that could not be adequately managed without urgent care or treatment,
- Does not require the level of care provided in the emergency room of a **hospital**, and
- Requires immediate outpatient medical care that cannot be postponed until the **covered person's physician** becomes reasonably available.

### **Urgent Care Provider**

This is:

- A freestanding medical facility which:
  - Provides unscheduled medical services to treat an **urgent condition** if the **covered person's physician** is not reasonably available.
  - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
  - Makes charges.
  - Is licensed and certified as required by any state or federal law or regulation.
  - Keeps a medical record on each patient.
  - Provides an ongoing quality assurance program. This includes reviews by **physicians** other than those who own or direct the facility.
  - Is run by a staff of **physicians**. At least one such **physician** must be on call at all times.
  - Has a full-time administrator who is a licensed **physician**.
- A **physician's** office, but only one that:
  - Has contracted with Aetna to provide urgent care, and
  - Is, with Aetna's consent, included in the Provider Directory as a Preferred Urgent Care Provider.

**It is not the emergency room or outpatient department of a hospital.**

### **Walk-in Clinic**

A clinic with a group of **physicians**, which is not affiliated with a **hospital**, that provides: diagnostic services, observation, treatment, and rehabilitation on an outpatient basis.

## **CLAIM PROCEDURE**

---

On occasion, the claims investigation process will require additional information in order to properly adjudicate the claim. This investigation will be handled directly by Aetna

Customer Service Representatives are available 8:30 a.m. to 5:30 p.m., Monday through Friday, ET for any questions.

Claim forms can be downloaded at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com). Claim forms are located in the Help tab.

Please send claims to:  
Aetna Student Health  
PO Box 981106  
El Paso, TX 79998

1. Bills must be submitted within 90 days from the date of treatment.
2. Payment for Covered Medical Expenses will be made directly to the hospital or physician concerned, unless bill receipts and proof of payment are submitted.
3. If itemized medical bills are available at the time the claim form is submitted, attach them to the claim form. Subsequent medical bills should be mailed promptly to the above address.
4. You will receive an "Explanation of Benefits" when your claims are processed. The Explanation of Benefits will explain how your claim was processed, according to the benefits of your Student Accident and Sickness Insurance Plan.

## **HOW TO APPEAL A CLAIM**

### **Appeals and Complaints Procedure**

Our complaints and appeals process is designed to address member coverage issues, complaints and problems. If you have a coverage issue or other problem, call the Customer Service toll-free number on your ID card or review your plan documents for more information.

You can also contact Customer Services at the toll-free number on your ID card for more information. A representative will address your concern. If you are dissatisfied with the outcome of your initial contact, you may appeal the decision. Your appeal will be decided in accordance with the procedure applicable to your Plan.

You may also submit your request, in writing, along with all pertinent correspondence, to:

Aetna Student Health  
P.O. Box 14464  
Lexington, KY 40512

You may also seek additional information on the web page for the applicable State Insurance Department or other agency regarding your rights, including how to obtain regulatory review of member concerns. The applicable internet address for the State Insurance Department for your Plan is [www.state.va.us/scc/division/boi/index.htm](http://www.state.va.us/scc/division/boi/index.htm)

## **EXTERNAL REVIEW**

Aetna has developed an external review process to give members an added option of requesting an objective and timely external review of certain coverage denials. Once the Aetna internal coverage decision review process is exhausted, members may elect external review if the coverage denial for which the member would be financially responsible for involves more than \$500 and is based on lack of Medical Necessity or on the experimental or investigational nature of the proposed service or treatment.

An external review organization will refer the case to review by a neutral, independent Physician with appropriate expertise in the area in question. After all necessary information is submitted, external review generally will be decided within 30 days of the request. Expedited reviews are available when a member's Physician certifies that a delay in service would jeopardize the member's health. Once the review is complete, the Plan will abide by the decision of the external reviewer.

Certain states mandate external review of additional benefit or service issues or require a filing fee. In addition, certain states mandate the use of their own external review providers for Medical Necessity and experimental/investigational coverage decisions. For further details regarding your Plan's grievance and external review process, call the Customer Services toll-free number on your ID card, or visit Aetna's website at [www.aetna.com](http://www.aetna.com), where you may obtain an external review request form. You may also call your State Insurance or Health Department for additional information regarding state mandated external review procedures.

## **PRESCRIPTION DRUG CLAIM PROCEDURE**

---

When obtaining a covered prescription, please present your ID card to a Preferred Pharmacy, along with your applicable copay. The pharmacy will bill Aetna for the cost of the drug, plus a dispensing fee, less the copay amount.

When you need to fill a prescription, and do not have your ID card with you, you may obtain your prescription from an Aetna Preferred Pharmacy, and be reimbursed by submitting a completed Aetna Prescription Drug claim form. You will be reimbursed for covered medications, less your copay.



## **WORLDWIDE TRAVEL ASSISTANCE SERVICES**

---

### **On Call International**

Chickering Claims Administrators, Inc. (CCA) has contracted with On Call International (On Call) to provide **Covered Persons** with access to certain accidental death and dismemberment benefits, worldwide emergency medical, travel and security assistance services and other benefits.

A brief description of these benefits is outlined below.

### **Accidental Death and Dismemberment (ADD) Benefits**

These benefits are underwritten by United States Fire Insurance Company (USFIC) and include the following:

Benefits are payable for the Accidental Death and Dismemberment of **Covered Persons**, up to a maximum of **\$10,000**.

### **Medical Evacuation and Repatriation (MER) Benefits**

The following benefits are underwritten by United States Fire Insurance Company (USFIC) with medical and travel assistance services provided by On Call. These benefits are designed to assist **Covered Persons** when traveling more than 100 miles from home, anywhere in the world.

- Unlimited Emergency Medical Evacuation
- Unlimited Medically Supervised Repatriation
- Unlimited Return of Deceased Remains
- Unlimited Family Reunion
- \$2,500 Return of Traveling Companion
- \$2,500 Bereavement Reunion - in the event of a Covered Person's death, On Call will fly a family member to identify the remains and accompany the remains back to the deceased's home country.
- \$2,500 Emergency Return Home in the event of death or life-threatening illness of a parent, sibling or spouse.

### **Natural Disaster and Political Evacuation (NDPE) Services**

The following benefits are underwritten by United States Fire Insurance Company (USFIC), with security assistance services provided by On Call. If a **Covered Person** requires emergency evacuation due to governmental or social upheaval, which places him/her in imminent bodily harm (as determined by On Call security personnel in accordance with local and U.S. authorities), On Call will arrange and pay for his/her transportation to the nearest safe location, and then to the his/her home country. If a **Covered Person** requires emergency evacuation due to a natural disaster, which makes his/her location Uninhabitable, On Call will arrange and pay for his/her evacuation from a safe departure point to the nearest safe haven, and then home. Benefits are payable up to \$100,000 per event per person.

### **Worldwide Emergency Travel Assistance (WETA) Services**

On Call provides the following travel assistance services:

- 24/7 Emergency Travel Arrangements
- Translation Assistance
- Emergency Travel Funds Assistance
- Lost Luggage and Travel Documents Assistance
- Assistance with Replacement of Credit Card/Travelers Checks
- Medical/Dental/Pharmacy Referral Service
- Hospital Deposit Arrangements
- Dispatch of **Physician**
- Emergency Medical Record Assistance
- Legal Consultation and Referral
- Bail Bonds Assistance

The On Call International Global Response Center can be reached 24 hours a day, 365 days a year.

**The information contained above is a just summary of the ADD, MER, WETA, and NDPE benefits and services available through On Call. For a copy of the plan documents applicable to the ADD, MER, WETA and NDPE coverage, including a full description of coverage, exclusions and limitations, please contact Aetna Student Health at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com) or (800) 966-7772.**

**NOTE: In order to obtain coverage, all MER, WETA and NDPE services must be provided and arranged through On Call. Reimbursement will not be provided for any services not provided and arranged through On Call. Although certain emergency medical services may be covered under the terms of the Covered Person's student health insurance plan (the "Plan"), neither On Call nor its contracted insurance providers provide coverage for emergency medical treatment rendered by doctors, hospitals, pharmacies or other health care providers. Coverage for such services will be provided in accordance with the terms of the Plan and exclusions, limitations and benefit maximums may apply. Neither CCA, nor Aetna Life Insurance Company, nor their affiliates provide medical care or treatment and they are not responsible for outcomes.**

**To file a claim for ADD benefits, or to obtain MER, WETA or NDPE benefits/services, or for any questions related to those benefits/services, please call On Call International at the following numbers listed on the On Call ID card provided to Covered Persons when they enroll in the Plan: Toll Free at (866) 525-1956 or Collect at (603) 328-1956. All Covered Persons should carry their On Call ID card when traveling.**

CCA and On Call are independent contractors and not employees or agents of the other. CCA provides access to ADD, MER, WETA and NDPE benefits/services through a contractual arrangement with On Call. However, neither CCA nor any of its affiliates provides or administers ADD, MER, WETA or NDPE benefits/services and neither CCA nor any of its affiliates is responsible in any way for the benefits/services provided by or through On Call, USFIC, VSC or CV. Premiums/fees for benefits/services provided through On Call, USFIC, VSC and CV are included in the Rates outlined in this brochure.

*These services, programs or benefits are offered by vendors who are independent contractors and not employees or agents of Aetna.*

## NOTICE

---

Aetna considers nonpublic personal member information confidential and has policies and procedures in place to protect the information against unlawful use and disclosure. When necessary for your care or treatment, the operation of your health Plan, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals, and other caregivers), vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. Participating Network/Preferred Providers are also required to give you access to your medical records within a reasonable amount of time after you make a request. By enrolling in the Plan, you permit us to use and disclose this information as described above on behalf of yourself and your dependents. To obtain a copy of our Notice of Privacy Practices describing in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Customer Services number on your ID card or visit [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com).

Administered by:  
Aetna Student Health  
P.O. Box 981106  
El Paso, TX 79998  
**(866) 577-7027**  
[www.aetnastudenthealth.com](http://www.aetnastudenthealth.com)

Underwritten by:  
Aetna Life Insurance Company (ALIC)  
151 Farmington Avenue  
Hartford, CT 06156  
**(860) 273-0123**

Policy No. 474968

The Virginia Tech plan is underwritten by Aetna Life Insurance Company (ALIC) and administered by Chickering Claims Administrators, Inc. Aetna Student Health<sup>SM</sup> is the brand name for products and services provided by these companies and their applicable affiliated companies.

The Aetna logo consists of the word "aetna" in a bold, lowercase, sans-serif font, followed by a small "SM" trademark symbol.