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Aetna Student Health
Plan Design and Benefits Summary

Virginia Tech

Policy Year: 2017 - 2018
Policy Number: 474968

www.aetnastudenthealth.com
(866) 577-7027

This is a brief description of the Student Health Plan. The Plan is available for Virginia Tech students and their eligible dependents. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Certificate of Coverage and may be viewed online at **www.aetnastudenthealth.com.** If there is a difference between this Benefit Summary and the Certificate of Coverage, the Certificate of Coverage will control.

Virginia Tech Health Services

The Schiffert Health Center is the University's on-campus health facility. Staffed by physicians, nurse practitioners and registered nurses, it is open weekdays from 8:00 a.m. to 5:00 p.m., 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 Health Services at **(540) 231-6444**. In the event of an emergency, call **911**.

Coverage Periods

Students/Eligible Dependents: Coverage will become effective at 12:00 AM on the Coverage Start Date indicated below, and will terminate at 11:59 PM on the Coverage End Date indicated. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Certificate of Coverage.

Coverage Period	Coverage Start Date	Coverage End Date	Open Enrollment Deadline
Annual	08/01/2017	07/31/2018	09/18/2017
Spring /Summer	01/01/2018	07/31/2018	01/31/2018

Rates

	Annual	Spring Semester
Student	$2,924	$1,698
Spouse/Domestic Partner	$2,924	$1,698
Child	$2,924	$1,698
2+ Children	$5,848	$3,396

Refund Policy

If you withdraw from school within the first **31 days** of a coverage period, you will not be covered under the policy and the full premium will be refunded, less any claims paid. After **31 days**, you will be covered for the full period that you have paid the premium for, and no refund will be allowed. (This refund policy will not apply if you withdraw due to a covered Accident or Sickness.)

Exception: No premium refunds will be made except for situations where a Covered Person enters the armed forces of any country and 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 withdrawal from school.

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. The student shall then 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 in 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.
- Visiting Scholars are required to maintain health insurance either though the schools sponsored plan or a comparable plan during their stay at Virginia Tech.
- Language and Culture Institute students.

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 online or obtain an enrollment application for voluntary coverage, log on to **www.aetnastudenthealth.com** and search for your school, then click on Enroll to download the appropriate form.

Please note: Visiting Scholars and Language and Culture Institute students must enroll through the Virginia Tech Student Medical Insurance office.

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:

1. The policy must offer 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.)
2. The policy must have a deductible of **$500** per accident or illness or less.
3. The policy must provide major medical benefits of at least **$500,000** per accident or illness.
4. The policy must provide a minimum benefit of **$25,000** for repatriation of remains **and $50,000** medical evacuation to the home country. (Repatriation provides transportation to your home country in the event of death.)

5. Medical expenses for pregnancy, childbirth and complications of pregnancy must be treated as any other illness under the policy.
6. The policy must provide Prescription Medication coverage (after co-pays) with a minimum of **$500,000** per insured per policy year.
7. Coverage must be valid from either August 01, 2017, or the first day of enrollment at Virginia Tech, until July 31, 2018 or, if graduating, the last day of the month of the student's graduation.
8. The policy must cover Outpatient and Inpatient Mental Health Care as any other illness.
9. The policy **must not** have limits or internal dollar caps on coverage, including services, treatment or surgery.
10. The policy **must not** have a pre-existing condition waiting period.

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.

Waiver Deadline Dates
1. Students enrolling for the Fall Semester- 09/18/2017
2. Students enrolling for the Spring Semester- 01/31/2018

In order to avoid having a block placed on a student's account the student must enroll in the Student Medical Insurance Program or provide details of their current comparable coverage to the Student Medical Insurance Office before the deadline.

Dependent Coverage

Eligibility

Covered students may also enroll their lawful spouse or domestic partner (same-sex, opposite sex) and any dependent children up to the age of **26**. ***Verification of Dependent status may be required.***

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 when coverage would otherwise terminate for the dependent.

Enrollment

To enroll the dependent(s) of a covered student, please complete the Enrollment Form by visiting **www.aetnastudenthealth.com**, selecting the school name, and clicking on the "Enroll: Dependents" link. Please refer to the Coverage Periods section of this document for coverage dates and deadline dates. Dependent enrollment applications will not be accepted after the enrollment deadline 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 completed Enrollment Form and premium must be sent to Aetna Student Health.

Newborn Infant and Adopted Child Coverage

A child born to a Covered Person shall be covered for Accident, Sickness, and congenital defects including cleft lip/cleft palate or ectodermal dysplasia, for **60 days** from the date of birth. At the end of this **60-day** period, coverage will cease under the **Virginia Tech** Student Health Insurance Plan. To extend coverage for a newborn past the **60 days**, the Covered Student must: 1) enroll the child within **60 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 **60 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 **60 days**, the Covered Student must 1) enroll the child within **60 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 Student Medical Insurance at (540) 231-6226

Medicare Eligibility

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

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

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

Preferred Provider Network

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

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

Pre-certification

Some services have to be pre-certified by Aetna beforehand if you want the Plan to cover them. Preferred Providers are responsible for requesting precertification for their services. You are responsible for requesting precertification if you seek care from a Non- Preferred Provider for any of the services listed in the Schedule of Benefits section of the Certificate.

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

If you do not secure pre-certification for the below listed covered medical services and supplies obtained from a non-preferred provider your covered medical expenses may be subject to a **$200** per service, treatment, procedure, visit, or supply benefit reduction.

Pre-certification for the following inpatient and outpatient services or supplies may be needed*:

- All inpatient maternity and newborn care, after the initial 48 hours for a vaginal delivery or 96 hours for a cesarean section;
- Ambulance (non-emergency transportation);
- Autologous chondrocyte implantation, Carticel®
- Bariatric surgery (bariatric surgery is not covered under the policy unless specifically described in the policy);
- BRCA genetic testing;
- Cardiac rhythm implantable devices;
- Cochlear device and/or implantation;
- Dental implants and oral appliances;
- Dorsal column (lumbar) neurostimulators: trial or implantation;
- Drugs and Medical Injectables;
- Electric or motorized wheelchairs and scooters;
- Gender Reassignment (Sex Change) Surgery;
- Home health care related services (i.e. private duty nursing),
- Hyperbaric oxygen therapy;
- Infertility treatment (Comprehensive and ART infertility treatment is not covered under the plan unless specifically described in the policy);
- Inpatient Confinements (surgical and non-surgical); hospital, skilled nursing facility, rehabilitation facility, residential treatment facility for mental disorders and substance abuse, hospice care;
- Inpatient mental disorders treatment;
- Inpatient substance abuse treatment;
- Kidney dialysis;
- Knee surgery;
- Limb Prosthetics;
- Non-Preferred freestanding ambulatory surgical facility services when referred by a network provider;
- Oncotype DX;
- Orthognatic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint;
- Osseointegrated implant;
- Osteochondral allograft/knee;
- Outpatient back surgery not performed in a physician's office;
- Pediatric Congenital Heart Surgery;
- Pre-implantation genetic testing;
- Procedures that may be considered cosmetic. Cosmetic services and supplies are not covered under the plan unless specifically described in the policy;
- Proton beam radiotherapy;
- Referral or use of Non-Preferred providers for non-emergency services, unless the covered person understands and consents to the use of a Non-Preferred provider under their Non-Preferred Care benefits when available in their plan;
- Spinal Procedures;
- Transplant Services;

- Uvulopalatopharyngoplasty, including laser-assisted procedures; and
- Ventricular assist devices.

*Your Plan may not include coverage for all of the services and supplies listed above. Please check your Certificate of Coverage for confirmation of which services and supplies are covered and which services and supplies are excluded under your Plan. If you cannot locate the benefit you are looking for in your Certificate of Coverage, contact Customer Service at the number listed on your ID card for further assistance.

Pre-certification DOES NOT guarantee the payment of benefits for your inpatient stays, certain tests, procedures, outpatient surgeries, therapies and equipment, and prescribed medications

Each claim is subject to medical policy review, in accordance with the exclusions and limitations contained in the Certificate of Coverage. The Certificate of Coverage also includes information regarding your eligibility criteria, notification guidelines, and benefit coverage.

Pre-certification of non-emergency admissions

Non-emergency admissions must be requested at least **fifteen (15) days** prior to the date they are scheduled to be admitted.

Pre-certification of emergency admissions

Emergency admissions must be requested within **twenty-four (24) hours** or as soon as reasonably possible after the admission.

Pre-certification of urgent admissions

Urgent admissions must be requested before you are scheduled to be admitted.

Pre-certification of outpatient non-emergency medical services

Outpatient non-emergency medical services must be requested within **fifteen (15) days** before the outpatient services, treatments, procedures, visits or supplies are provided or scheduled.

Pre-certification of prenatal care and delivery

Pre-natal care medical services must be requested as soon as possible after the attending physician confirms pregnancy. Delivery medical services, which exceed the first 48 hours after delivery for a routine delivery and 96 hours for a cesarean delivery, must be requested within **twenty-four (24) hours** of the birth or as soon thereafter as possible.

Please see the "Pre-certification" provision in the Certificate of Coverage for a list of services under the Plan that may require pre-certification. Please see the Schedule of Benefits for any penalty or benefit reduction that may apply to your coverage when pre-certification is not obtained for the listed services or supplies when received from a non-preferred care provider.

Network Benefits for Specialty Care Drugs

Specialty care drugs are covered at the network level of benefits only when dispensed through a **network retail pharmacy** or **Aetna's specialty pharmacy network pharmacy**. **Specialty care drugs** often include typically high-cost drugs that require special handling, special storage or monitoring and include but are not limited to oral, topical, inhaled and injected routes of administration. Refer to **Aetna's** website,**www.aetna.com** to review the list of **specialty care drugs** required to be dispensed through a **network pharmacy** or **specialty pharmacy network pharmacy**. The list may be updated from time to time.

The initial prescription for **specialty care drugs** must be filled at a **network retail pharmacy** or at **Aetna's specialty pharmacy network**.

You are required to obtain specialty care drugs at Aetna's specialty pharmacy network for all prescription drug refills after the second fill.

Description of Benefits

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

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

Metallic Level: Gold, tested at 83.25%.

DEDUCTIBLE	Preferred Care	Non-Preferred Care
The policy year deductible is waived for preferred care covered medical expenses that apply to Preventive Care Expense benefits. In compliance with Virginia State Mandate(s), the policy year deductible is waived for Preferred Care Preventive Health Care Services. In addition to state and federal requirements for waiver of the policy year deductible, this Plan will waive the Deductible for Emergency Room Services, Non-Preferred Care Preventive Health Care Services up to age **7**, Preferred Care and Non Preferred care Pediatric Care Vision Benefit Expenses, Preferred Care Pediatric Dental Services Expenses, Preferred Care and Non-Preferred Care Prescribed Medicines expenses, Preferred Care Adult Vision Exam and Vision Supplies Expense, Preferred Care Office Visit Expense, Preferred Care Walk-in Clinic Visit Expense, Preferred Care Outpatient Treatment of Mental Disorders Expense, Preferred Care Outpatient Treatment of Substance Abuse Expense, Preferred Care Urgent Care Expense, and Preferred Care Non-Elective Second Surgical Opinion Expense. Per visit or admission Deductibles do not apply towards satisfying the policy year deductible.	**Individual:** Students: **$450** per policy year Spouse: **$450** per policy year Child: **$450** per policy year **Family:** **$900** per policy year	**Individual:** Students: **$1,000** per policy year Spouse: **$1,000** per policy year Child: **$1,000** per policy year **Family:** **$2,000** per policy year
COINSURANCE Coinsurance is both the percentage of covered medical expenses that the plan pays, and the percentage of covered medical expenses that you pay. The percentage that the plan pays is referred to as “plan coinsurance” or the “payment percentage,” and varies by the type of expense. Please refer to the Schedule of Benefits for specific information on coinsurance amounts.	Covered Medical Expenses are payable at the plan coinsurance percentage specified below, after any applicable Deductible.	

OUT OF POCKET MAXIMUMS	
Once the Individual or Family Out-of-Pocket Limit has been satisfied, Covered Medical Expenses will be payable at **100%** for the remainder of the policy year. The following expenses do not apply toward meeting the plan's out-of-pocket limits: • Non-covered medical expenses; and • Expenses that are not paid or precertification benefit reductions or penalties because a required precertification for the service(s) or supply was not obtained from Aetna.	Individual Out-of-Pocket: **$5,750** Family Out-of-Pocket: **$11,500**

REFERRAL REQUIREMENTS

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 Preferred Aetna Providers as shown in Tier **1** of the benefit section of this brochure. **A new referral must be obtained each policy year.**
A referral is not required in the following circumstances:

- Emergency Room Services
- Treatment received when Schiffert Health Center is closed.
- Care received outside a **20** mile radius from the Blacksburg Campus
- Maternity
- Satellite Campus enrolled students
- Treatment is for an Emergency Medical Condition
- Obstetric and Gynecological Treatment
- Pediatric Care
- Preventive/Routine Services (services considered preventive according to Health Care Reform and/or services rendered not to diagnosis or treat an Accident or Sickness).

*Dependents and Visiting Scholars are not eligible to use the services of the School Health Service and therefore cannot received enhanced benefits shown in tier 1 of the schedule of benefits.

All labs and services provided at Schiffert Health Center are covered at **100%.** Students should submit their itemized paid statements to Aetna Student Health for reimbursement. Retroactive referral requests will not be accepted or processed.

Tier I: When a Schiffert Health Center 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.

	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Physician or Specialist Office Visit Expense Includes the charges made by the physician or specialist if a covered person requires the services of a physician or specialist in the physician's or specialist's office while not confined as an inpatient in a hospital.	**$25** copay then the plan pays **100%** of the Negotiated Charge*	**$25** copay then the plan pays **100%** of the Negotiated Charge*	**65%** of the Recognized Charge

***Annual Deductible does not apply to these services**

	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Urgent Care Expense	**$25** copay then the plan pays **100%** of the Negotiated Charge*	**$25** copay then the plan pays **100%** of the Negotiated Charge*	**$25** deductible then the plan pays **65%** of the Recognized Charge
OUTPATIENT EXPENSES	**Tier I** **Preferred Care with Referral**	**Tier II** **Preferred Care without Referral**	**Tier III** **Non-Preferred Care**
Laboratory and X-ray Expense	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**65%** of the Recognized Charge
Hospital Outpatient Department Expense	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**65%** of the Recognized Charge
Therapy Expense Covered medical expenses include charges incurred by a covered person for the following types of therapy provided on an outpatient basis: • Radiation therapy; • Inhalation therapy; • Chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy; • Kidney dialysis; and • Respiratory therapy.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**65%** of the Recognized Charge
Pre-Admission Testing Expense Includes charges incurred by a covered person for pre-admission testing charges made 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.	Payable in accordance with the type of expense incurred and the place where service is provided.		
Ambulatory Surgical Expense Covered medical expenses include expenses incurred by a covered person for outpatient surgery performed in an ambulatory surgical center. Covered medical expenses must be incurred on the day of the surgery or within 24 hours after the surgery.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**65%** of the Recognized Charge
Walk-in Clinic Visit Expense	**$25** copay then the plan pays **100%** of the Negotiated Charge*	**$25** copay then the plan pays **100%** of the Negotiated Charge*	**65%** of the Recognized Charge

***Annual Deductible does not apply to these services**

OUTPATIENT EXPENSES (continued)	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Emergency Room Expense Covered medical expenses incurred by a covered person for services received in the emergency room of a hospital while the covered person is not a full-time inpatient of the hospital. The treatment received must be emergency care for an emergency medical condition. There is no coverage for elective treatment, routine care or care for a non-emergency sickness. As to emergency care incurred for the treatment of an emergency medical condition or psychiatric condition, any referral requirement will not apply & any expenses incurred for non-preferred care will be paid at the same cost-sharing level as if they had been incurred for preferred care. **Important Notice:** A separate hospital emergency room visit benefit deductible or copay applies for each visit to an emergency room for emergency care. If a covered person is admitted to a hospital as an inpatient immediately following a visit to an emergency room, the emergency room visit benefit deductible or copay is waived. Covered medical expenses that are applied to the emergency room visit benefit deductible or copay cannot be applied to any other benefit deductible or copay under the plan. Likewise, covered medical expenses that are applied to any of the plan's other benefit deductibles or copays cannot be applied to the emergency room visit benefit deductible or copay. Separate benefit deductibles or copays may apply for certain services rendered in the emergency room that are not included in the hospital emergency room visit benefit. These benefit deductibles or copays may be different from the hospital emergency room visit benefit deductible or copay, and will be based on the specific service rendered.	**$300** copay (waived if admitted) then the plan pays **100%** of the Negotiated Charge*	**$300** copay (waived if admitted) then the plan pays **100%** of the Negotiated Charge*	**$300** copay (waived if admitted) then the plan pays **100%** of the Actual Charge*

OUTPATIENT EXPENSES (continued)	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Emergency Room Expense (continued) Similarly, services rendered in the emergency room that are not included in the hospital emergency room visit benefit may be subject to coinsurance. **Important Note:** Please note that Non-Preferred Care Providers do not have a contract with Aetna. The provider may not accept payment of your cost share (your deductible and coinsurance) as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. Please send Aetna the bill at the address listed on the back of your member ID card and Aetna will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.	**$300** copay (waived if admitted) then the plan pays **100%** of the Negotiated Charge	**$300** copay (waived if admitted) then the plan pays **100%** of the Negotiated Charge	**$300** copay (waived if admitted) then the plan pays **100%** of the Actual Charge
Durable Medical and Surgical Equipment Expense Durable medical and surgical equipment would include: • Artificial arms and legs; including accessories; • Arm, back, neck braces, leg braces; including attached shoes (but not corrective shoes); • Surgical supports; • Scalp hair prostheses required as the result of hair loss due to injury; sickness; or treatment of sickness; and • Head halters.	**80%** of the Negotiated Charge	**80%** of the Negotiated Charge	**80%** of the Recognized Charge

PREVENTIVE CARE EXPENSES

Preventive Care is services provided for a reason other than to diagnose or treat a suspected or identified sickness or injury and rendered in accordance with the guidelines provided by the following agencies:

- 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 **uspreventiveservicestaskforce.org**.
- Services as recommended in the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents **http://brightfutures.aap.org/** .
- For females, screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration **http://www.hrsa.gov/index.html**.

PREVENTIVE CARE EXPENSES (continued)	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Routine Physical Exam Includes routine vision & hearing screenings given as part of the routine physical exam.	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	Covered persons up to age **7**: **100%** of the Recognized Charge* Ages **7** and older: **100%** of the Recognized Charge
Preventive Care Immunizations	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	Covered persons up to age **7**: **100%** of the Recognized Charge* Ages **7** and older: **100%** of the Recognized Charge
Well Woman Preventive Visits Routine well woman preventive exam office visit, including Pap smears.	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**65%** of the Recognized Charge
Preventive Care Screening and Counseling Services for Sexually Transmitted Infections Includes the counseling services to help a covered person prevent or reduce sexually transmitted infections. Maximum of **2** visits per policy year.	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**65%** of the Recognized Charge
Preventive Care Screening and Counseling Services for Obesity and/or Healthy Diet Screening and counseling services to aid in weight reduction due to obesity. Coverage includes: • Preventive counseling visits and/or risk factor reduction intervention; • Nutritional counseling; and • Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease. Maximum of **26** visits per policy year, of which **10** visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease).	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**65%** of the Recognized Charge

***Annual Deductible does not apply to these services**

PREVENTIVE CARE EXPENSES (continued)	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Preventive Care Screening and Counseling Services for Misuse of Alcohol and/or Drugs 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. Maximum of **5** visits per policy year.	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**65%** of the Recognized Charge
Preventive Care Screening and Counseling Services for Use of Tobacco Products Screening and counseling services to aid a covered person to stop the use of tobacco products. Coverage includes: • Preventive counseling visits; • Treatment visits; and • Class visits; to aid a covered person to stop the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including: • Cigarettes; • Cigars; • Smoking tobacco; • Snuff; • Smokeless tobacco; and • Candy-like products that contain tobacco. Maximum of **8** visits per policy year.	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**65%** of the Recognized Charge
Preventive Care Screening and Counseling Services for Depression Screening Screening or test to determine if depression is present. Maximum of **1** visit per policy year.	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**65%** of the Recognized Charge
Preventive Care Routine Cancer Screenings Covered expenses include but are not limited to: Pap smears; Mammograms; Fecal occult blood tests; Digital rectal exams; Prostate specific antigen (PSA) tests; Sigmoidoscopies; Double contrast barium enemas (DCBE); Colonoscopies (includes bowel preparation medications, anesthesia, removal of polyps performed during a screening procedure, and pathology exam on any removed polyps); and lung cancer screenings.	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**65%** of the Recognized Charge

***Annual Deductible does not apply to these services**

PREVENTIVE CARE EXPENSES (continued)	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Preventive Care Screening and Counseling Services for Genetic Risk for Breast and Ovarian Cancer Covered medical expenses include the counseling and evaluation services to help assess a covered person's risk of breast and ovarian cancer susceptibility.	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**65%** of the Recognized Charge
Preventive Care Prenatal Care Coverage for prenatal care under this Preventive Care Expense benefit is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure, fetal heart rate check, and fundal height). Refer to the Maternity Expense benefit for more information on coverage for maternity expenses under the policy, including other prenatal care, delivery and postnatal care office visits.	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**65%** of the Recognized Charge
Preventive Care Lactation Counseling Services Lactation support and lactation counseling services are covered medical expenses when provided in either a group or individual setting.	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**65%** of the Recognized Charge
Preventive Care Breast Pumps and Supplies	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**80%** of the Recognized Charge

***Annual Deductible does not apply to these services**

PREVENTIVE CARE EXPENSES (continued)	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Preventive Care Female Contraceptive Counseling Services, Preventive Care Female Contraceptive Generic, Brand Name, Biosimilar Prescription Drugs and Devices provided, administered, or removed, by a Physician during an Office Visit, Preventive Care Female Voluntary Sterilization (Inpatient), Preventive Care Female Voluntary Sterilization (Outpatient) Includes counseling services on contraceptive methods provided by a physician, obstetrician or gynecologist. Such counseling services are covered medical expenses when provided in either a group or individual setting. **Voluntary Sterilization** Includes charges billed separately by the provider for female voluntary sterilization procedures & related services & supplies including, but not limited to, tubal ligation and sterilization implants. Covered medical expenses under this 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. **Contraceptives** can be paid either under this benefit or the prescribed medicines expense depending on the type of expense and how and where the expense is incurred. Benefits are paid under this benefit for female contraceptive prescription drugs and devices (including any related services and supplies) when they are provided, administered, or removed, by a physician during an office visit.	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**65%** of the Recognized Charge

***Annual Deductible does not apply to these services**

OTHER FAMILY PLANNING SERVICES EXPENSE	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Voluntary Sterilization for Males (Outpatient) Covered medical expenses include charges for certain family planning services, even though not provided to treat a sickness or injury as follows: • Voluntary sterilization for males	Payable in accordance with the type of expense incurred and the place where service is provided.		
AMBULANCE EXPENSE	**Tier I Preferred Care with Referral**	**Tier II Preferred Care without Referral**	**Tier III Non-Preferred Care**
Ground, Air, Water and Non-Emergency Ambulance Includes charges incurred by a covered person for the use of a professional ambulance in an emergency. Covered medical expenses for the service are limited to charges for ground transportation to the nearest hospital equipped to render treatment for the condition. Air transportation is covered only when medically necessary.	**80%** of the Negotiated Charge	**80%** of the Negotiated Charge	**80%** of the Recognized Charge
SURGICAL EXPENSES	**Tier I Preferred Care with Referral**	**Tier II Preferred Care without Referral**	**Tier III Non-Preferred Care**
Surgical Expense (Inpatient and Outpatient) When injury or sickness requires two or more surgical procedures which are performed through the same approach, and at the same time or immediate succession, covered medical expenses only include expenses incurred for the most expensive procedure.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**65%** of the Recognized Charge
Anesthesia Expense (Inpatient and Outpatient) If, in connection with such operation, the covered person requires the services of an anesthetist who is not employed or retained by the hospital in which the operation is performed, the expenses incurred will be Covered Medical Expenses.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**65%** of the Recognized Charge
Assistant Surgeon Expense (Inpatient and Outpatient)	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**65%** of the Recognized Charge

INPATIENT HOSPITLALIZATION BENEFITS	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Room and Board Expense The covered room and board expense does not include any charge in excess of the daily room and board maximum.	**$300** copay per admission then the plan pays **90%** of the Negotiated Charge for a semi-private room	**$300** copay per admission then the plan pays **80%** of the Negotiated Charge for a semi-private room	**$300** deductible per admission then the plan pays **65%** of the Recognized Charge for a semi-private room
Intensive Care The covered room and board expense does not include any charge in excess of the daily room and board maximum.	**$300** copay per admission then the plan pays **90%** of the Negotiated Charge for a semi-private room	**$300** copay per admission then the plan pays **80%** of the Negotiated Charge for a semi-private room	**$300** deductible per admission then the plan pays **65%** of the Recognized Charge for a semi-private room
Miscellaneous Hospital Expense Includes but not limited to: operating room, laboratory tests/X rays, oxygen tent, drugs, medicines and dressings.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**65%** of the Recognized Charge
Licensed Nurse Expense Includes 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.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**65%** of the Recognized Charge
Well Newborn Nursery Care	**90%** of the Negotiated Charge*	**90%** of the Negotiated Charge*	**65%** of the Recognized Charge*
Mastectomy and Hysterectomy Expense Covered medical expenses following a mastectomy for the treatment of breast cancer include charges for: • a minimum stay of inpatient care in a hospital of not less than 48-hours following a radical or modified radical mastectomy; • a minimum stay of inpatient care in a hospital of not less than 24-hours following a total mastectomy or partial mastectomy with lymph node dissection; or • a shorter hospital stay, if the attending provider, in consultation with the covered person, determines that a shorter length of stay is appropriate.	Payable in accordance with the type of expense incurred and the place where service is provided.		

***Annual Deductible does not apply to these services**

INPATIENT HOSPITLALIZATION BENEFITS (continued)	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Mastectomy and Hysterectomy Expense (continued) Covered medical expenses following a hysterectomy include charges for: • a minimum stay in a hospital of not less than 23-hours following a laparoscopy-assisted vaginal hysterectomy; • a minimum stay in a hospital of not less than 48-hours following a vaginal hysterectomy; or • a shorter hospital stay, if the attending provider, in consultation with the covered person, determines that a shorter length of stay is appropriate.	Payable in accordance with the type of expense incurred and the place where service is provided.		
Non-Surgical Physicians Expense Includes hospital charges incurred by a covered person who is confined as an inpatient in a hospital for a surgical procedure for the services of a physician who is not the physician who may have performed surgery on the covered person.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**65%** of the Recognized Charge
ADDITIONAL BENEFITS	**Tier I Preferred Care with Referral**	**Tier II Preferred Care without Referral**	**Tier III Non-Preferred Care**
Allergy Testing and Treatment Expense Includes charges incurred by a covered person for diagnostic testing and treatment of allergies and immunology services.	**80%** of the Negotiated Charge	**80%** of the Negotiated Charge	**65%** of the Recognized Charge
Diagnostic Testing For Learning Disabilities Expense Covered medical expenses include charges incurred by a covered person for diagnostic testing for: • Attention deficit disorder; or • Attention deficit hyperactive disorder.	**80%** of the Negotiated Charge	**80%** of the Negotiated Charge	**65%** of the Recognized Charge
High Cost Procedures Expense Includes charges incurred by a covered person as a result of certain high cost procedures provided on an outpatient basis. Covered medical expenses for high cost procedures include; but are not limited to; charges for the following procedures and services: • Computerized Axial Tomography (C.A.T.) scans; • Magnetic Resonance Imaging (MRI); and • Positron Emission Tomography (PET)	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**65%** of the Recognized Charge

Scans.			
ADDITIONAL BENEFITS (continued)	**Tier I Preferred Care with Referral**	**Tier II Preferred Care without Referral**	**Tier III Non-Preferred Care**
Telemedicine Covered medical expenses include charges for the provision of health care services that are covered under this policy and are appropriately provided through telemedicine services. Telemedicine Services, as it pertains to the delivery of health care services, means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Telemedicine services do not include any audio-only telephone, electronic mail message or facsimile transmission.	Payable in accordance with the type of expense incurred and the place where service is provided.		
General Anesthesia For Dental Care Includes general anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care provided to a covered person, if the person is determined by a licensed dentist in consultation with the person's physician to require these services to effectively and safely provide dental care; and • is under 5 years of age; or • is severely disabled; or • has a medical condition that requires admission to a hospital or outpatient surgery facility and general anesthesia for dental care treatment. Coverage is NOT provided for dental services associated with general anesthesia and associated hospital or ambulatory facility charges, except as otherwise provided in this Plan.	Payable in accordance with the type of expense incurred and the place where service is provided.		
Oral and Maxillofacial Treatment Expense (Mouth, Jaws and Teeth) Includes charges made by a physician, a dentist and hospital for: • Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues. • Maxillary or mandibular frenectomy when not related to a dental procedure. • Alveolectomy when related to tooth	Payable in accordance with the type of expense incurred and the place where service is provided.		

extraction.			
ADDITIONAL BENEFITS (continued)	**Tier I Preferred Care with Referral**	**Tier II Preferred Care without Referral**	**Tier III Non-Preferred Care**
Oral and Maxillofacial Treatment Expense (Mouth, Jaws and Teeth) (continued) • Orthognathic surgery to attain functional capacity when required because of a medical condition or injury which prevents capacity of the affected part. • Surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures. • The repair of dental appliances damaged as a result of accidental injury to the jaw, mouth, or face. • The treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia.	Payable in accordance with the type of expense incurred and the place where service is provided.		
Coverage for Newborn Children Congenital defect and birth abnormalities Covered medical benefits include treatment of medically diagnosed congenital defects and birth abnormalities. Cleft lip, cleft palate, and ectodermal dysplasia Covered medical benefits include treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia including but not limited to: • Inpatient and outpatient dental work • Oral surgery • Orthodontic services	Payable in accordance with the type of expense incurred and the place where service is provided.		
Reconstructive Breast Surgery Expense Includes reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy, including lymphedema. Treatment of lymphedema includes charges for equipment, supplies, complex decongestive therapy, and outpatient self-management training and education for the treatment of lymphedema, when provided by a provider legally authorized to provide such items under law.	Payable in accordance with the type of expense incurred and the place where service is provided.		

ADDITIONAL BENEFITS (continued)	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Infant Hearing Screening Expenses Covered medical expenses include charges for infant hearing screenings and all necessary audiological examinations for newborn children that are provided pursuant to the Virginia Hearing Impairment Identification and Monitoring System and include the use of any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Coverage includes benefits for any follow-up audiological examinations as recommended by a physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss, for those infants whose hearing screenings indicated the need for a diagnostic audiological examination.	Payable in accordance with the type of expense incurred and the place where service is provided.		
Infusion Therapy Expense Includes charges made on an outpatient basis for infusion therapy by: • A free-standing facility; • The outpatient department of a hospital; or • A physician in their office or in your home. Coverage for inpatient infusion therapy is provided under the Inpatient Hospital and Skilled Nursing Facility Benefits sections of this policy. Certain infused medications may be covered under the pharmacy coverage or for certain prescription drugs. You can access the list of these specialty care prescription drugs to determine if the drugs are covered under your outpatient prescription drug coverage by contacting Member Services or by logging onto your Aetna Navigator® secure member website at www.Aetna.com or calling the number on the back of your ID card to determine if coverage is under the pharmacy or medical benefit. Benefits payable for services related to infusion therapy will not count toward any applicable home health care maximums.	Payable in accordance with the type of expense incurred and the place where service is provided.		

ADDITIONAL BENEFITS (continued)	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Early Intervention Services Includes charges for speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for a covered person if: • They are between the ages of birth and 3 years; • They are certified by the Department of Behavioral Health and Developmental Services as eligible for the services under Part H of the Individuals with Disabilities Education Act; • The services are designed to attain or retain the capacity to function age-appropriately within their environment; and • The services that enhance functional ability without affecting a cure.	Payable in accordance with the type of expense incurred and the place where service is provided.		
Bones or Joints of the Head, Neck, Face or Jaw Expense	Payable in accordance with the type of expense incurred and the place where service is provided.		
Dental Expense for Impacted Wisdom Teeth Includes charges incurred by a covered person for services of a dentist or dental surgeon for removal of one or more impacted wisdom teeth. Not more than the Maximum Benefit will be paid. Includes expenses for the treatment of: the mouth; teeth; and jaws; but only those for services rendered and supplies needed for the following treatment of; or related to conditions; of the: • mouth; jaws; jaw joints; or • supporting tissues; (this includes: bones; muscles; and nerves).	**80%** of the Negotiated Charge	**80%** of the Negotiated Charge	**80%** of the Actual Charge
Accidental Injury to Sound Natural Teeth Expense Covered medical expenses include charges incurred by a covered person for services of a dentist or dental surgeon as a result of an injury to sound natural teeth.	**80%** of the Negotiated Charge	**80%** of the Negotiated Charge	**80%** of the Actual Charge

ADDITIONAL BENEFITS (continued)	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Non-Elective Second Surgical Opinion Expense Includes charges incurred for a second opinion consultation by a specialist on the need for non- elective 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.	**$25** copay then the plan pays **100%** of the Negotiated Charge*	**$25** copay then the plan pays **100%** of the Negotiated Charge*	**65%** of the Recognized Charge
Consultant Expense Includes the charges incurred by covered person in connection with the services of a consultant. The services must be requested by the attending physician to confirm or determine a diagnosis. Coverage may be extended to include treatment by the consultant.	**80%** of the Negotiated Charge	**80%** of the Negotiated Charge	**80%** of the Recognized Charge
Skilled Nursing Facility Expense	**$300** copay per admission then the plan pays **80%** of the Negotiated Charge for a semi-private room	**$300** copay per admission then the plan pays **80%** of the Negotiated Charge for a semi-private room	**$300** deductible per admission then the plan pays **65%** of the Recognized Charge for a semi-private room
Rehabilitation Facility Expense Includes charges incurred by a covered person for confinement as a full time inpatient in a rehabilitation facility.	**$300** copay per admission then the plan pays **80%** of the Negotiated Charge for a semi-private room	**$300** copay per admission then the plan pays **80%** of the Negotiated Charge for a semi-private room	**$300** deductible per admission then the plan pays **65%** of the Recognized Charge for a semi-private room
Home Health Care Expense Covered medical expenses **will not** include: • Services by a person who resides in the covered person's home, or is a member of the covered person's immediate family; • Homemaker or housekeeper services; • Maintenance therapy; • Dialysis treatment; • Purchase or rental of dialysis equipment; • Food or home delivered services; or • Custodial care.	**80%** of the Negotiated Charge	**80%** of the Negotiated Charge	**80%** of the Recognized Charge

ADDITIONAL BENEFITS (continued)	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Temporomandibular Joint Dysfunction Expense Covered medical expenses include physician's charges incurred by a covered person for treatment of Temporomandibular Joint (TMJ) Dysfunction.	Payable in accordance with the type of expense incurred and the place where service is provided.		
Dermatological Expense Includes physician's charges incurred by a covered person for the diagnosis and treatment of skin disorders. Related laboratory expenses are covered under the Lab and X-ray Expense benefit. Unless specified above, not covered under this benefit are charges incurred for: • Treatment for acne; • Cosmetic treatment and procedures; and Laboratory fees.	Payable in accordance with the type of expense incurred and the place where service is provided.		
Prosthetic Devices Expense Includes charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by sickness, injury or congenital defect. Covered medical expenses also include instruction and incidental supplies needed to use a covered prosthetic device. The plan covers the first prosthesis a covered person need that temporarily or permanently replaces all or part of an body part lost or impaired as a result of sickness or injury or congenital defects as described in the list of covered devices below for an: • Internal body part or organ; or • External body part.	**80%** of the Negotiated Charge	**80%** of the Negotiated Charge	**80%** of the Recognized Charge
Podiatric Expense Includes charges incurred by a covered person for podiatric services; provided on an outpatient basis following an injury. Unless specified above, not covered under this benefit are charges incurred for routine foot care, such as trimming of corns, calluses, and nails.	Payable in accordance with the type of expense incurred and the place where service is provided.		
Hypodermic Needles Expense Includes expenses incurred by a covered person for hypodermic needles and syringes.	Payable in accordance with the type of expense incurred and the place where service is provided.		

ADDITIONAL BENEFITS (continued)	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Convalescent Facility Expense	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**65%** of the Recognized Charge
Maternity Expense Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other Sickness. In the event of an inpatient confinement, such benefits would be payable for 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. Any decision to shorten such minimum coverages shall be made by the attending Physician in consultation with the mother and done in accordance with the rules and regulations promulgated by State Mandate. Covered medical expenses may include home visits, parent education, and assistance and training in breast or bottle-feeding.	Payable in accordance with the type of expense incurred and the place where service is provided.		
Benefits for Vision correction after Surgery or Accident Includes changes for prescribed eyeglasses or contact lenses only when required as a result of surgery, or for treatment of an accident. Services for exams and replacement of these eyeglasses or contact lenses will be covered only if the prescription change is related to the condition that required the original prescription. The cost of materials, fitting and exams for eyeglasses or contact lenses are covered if: • prescribed to replace the human lens lost due to surgery or injury; • initial pair of "pinhole" glasses that are prescribed for use after surgery for a detached retina; or • lenses are prescribed instead of surgery in the following situations: • contact lenses are used for the treatment of infantile glaucoma; • corneal or scleral lenses are prescribed in connection with keratoconus;	**100%** of the Actual Charge		

ADDITIONAL BENEFITS (continued)	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Benefits for Vision correction after Surgery or Accident (continued) • scleral lenses are prescribed to retain moisture when normal tearing is not possible or not adequate; or • corneal or scleral lenses are required to reduce a corneal irregularity other than astigmatism.	**100%** of the Actual Charge		
Non-Prescription Enteral Formula Expense Includes charges incurred by a covered person, for non-prescription enteral formulas for which a physician has issued a written order, and are for the treatment of malabsorption caused by: • Crohn's Disease; • Ulcerative colitis; • Gastroesophageal reflux; • Gastrointestinal motility; • Chronic intestinal pseudo obstruction; and • Inherited diseases of amino acids and organic acids. Covered medical expenses for inherited diseases of amino acids; and organic acids; will also include food products modified to be low protein.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**65%** of the Recognized Charge
Vision Care Exam Expense Routine Eye Exam Expenses: Charges for a complete eye exam that includes refraction. A routine eye exam does not include charges for a contact lens exam. Contact Lens Exam Expenses: Charges for an eye exam performed for the sole purpose of the fitting of contact lenses. Benefits are limited to **1** routine eye exam per policy year.	**$15** copay per visit then the plan pays **100%** of the Negotiated Charge*	**$15** copay per visit then the plan pays **100%** of the Negotiated Charge*	**100%** of the Recognized Charge

***Annual Deductible does not apply to these services**

ADDITIONAL BENEFITS (continued)	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Vision Care Supply Expense Includes charges incurred by a covered person for eyeglasses (lenses and frames) and contact lenses; when prescribed by a legally qualified ophthalmologist or optometrist. 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. If contact lenses are required to correct visual acuity to 20/40 or better in the better eye; and such correction cannot be obtained with conventional lenses; or if aphakic lenses are prescribed after cataract surgery has been performed. Benefits are limited to a maximum of **$120** per policy year for adults.	**$15** copay then the plan pays **100%** of the Actual Charge*	**$15** copay then the plan pays **100%** of the Actual Charge*	**$15** copay then the plan pays **100%** of the Actual Charge
Acupuncture in Lieu of Anesthesia Expense Includes charges incurred by a covered person for 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.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**65%** of the Recognized Charge
Transfusion or Kidney Dialysis of Blood Expense Includes charges incurred by a covered person for the transfusion or kidney dialysis of blood, including the cost of: Whole blood; blood components; and the administration of whole blood and blood components.	Payable in accordance with the type of expense incurred and the place where service is provided.		
Hospice Expense	**80%** of the Negotiated Charge	**80%** of the Negotiated Charge	**65%** of the Recognized Charge

***Annual Deductible does not apply to these services**

ADDITIONAL BENEFITS (continued)	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Blood and Body Fluid Exposure / Needle Stick Coverage Expense Limited to those charges related to a clinical related injury. Any expense related to the treatment of any sickness resulting from a clinical related injury is not covered under this benefit. Incidents include, but are not limited to needle sticks, unprotected exposure to blood and body fluid, and unprotected exposure to highly contagious pathogens.	Payable in accordance with the type of expense incurred and the place where service is provided.		
Private Duty Nursing Includes private duty nursing services provided by an R.N. or L.P.N. if the covered person's condition requires skilled nursing care and visiting nursing care is not adequate. However, covered medical expenses will not include private duty nursing for any hours shifts during a policy year in excess of the Private Duty Nursing Care Maximum Shifts Hours. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift. Benefits are limited to **8** visits per policy year.	**80%** of the Negotiated Charge	**80%** of the Negotiated Charge	**80%** of the Recognized Charge
Diabetes Benefit Expense Includes charges for services, supplies, equipment, & training for the treatment of insulin and non-insulin dependent diabetes & elevated blood glucose levels during pregnancy. Self-management training provided by a licensed health care provider certified in diabetes self-management training.	Payable in accordance with the type of expense incurred and the place where service is provided.		
Autism Spectrum Disorder Expense Includes charges incurred for services and supplies required for the diagnosis & treatment of autism spectrum disorder when ordered by a physician or behavioral health provider as part of a treatment plan.	Payable in accordance with the type of expense incurred and the place where service is provided.		
Basic Infertility Expense Covered medical expenses include charges made by a physician to diagnose and to surgically treat the underlying medical cause of infertility.	Payable in accordance with the type of expense incurred and the place where service is provided.		

ADDITIONAL BENEFITS (continued)	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Bariatric Surgery Expense Covered medical expenses for the treatment of morbid obesity include one bariatric surgical procedure including related outpatient services, within a two-year period, beginning with the date of the first bariatric surgical procedure, unless a multi-stage procedure is planned.	Payable in accordance with the type of expense incurred and the place where service is provided.		
Gender Reassignment (Sex Change) Treatment Expense Includes charges made in connection with a medically necessary gender reassignment surgery (sometimes called sex change surgery) as long the covered student or their covered dependent has obtained pre-certification from Aetna. Covered medical expenses include: • Charges made by a physician for: o Performing the surgical procedure; and o Pre-operative and post-operative hospital and office visits. • Charges made by a hospital for inpatient and outpatient services (including outpatient surgery. • Charges made by a Skilled Nursing Facility for inpatient services and supplies. • Charges made for the administration of anesthetics. • Charges for outpatient diagnostic laboratory and x-rays. • Charges for blood transfusion and the cost of unreplaced blood and blood products. • Charges made by a behavioral health provider for gender reassignment counseling. • Charges incurred for injectable and non-injectable hormone replacement therapy. No benefits will be paid for covered medical expenses under this benefit unless they have been precertified by Aetna. Refer to the Pre-certification section for more information.	Payable in accordance with the type of expense incurred and the place where service is provided.		

ADDITIONAL BENEFITS (continued)	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Clinical Trials Expense (Experimental or Investigational Treatment) Includes charges made by a provider for experimental or investigational drugs, devices, treatments or procedures "under an approved clinical trial" only when a covered person has cancer or a terminal illness.	Payable in accordance with the type of expense incurred and the place where service is provided.		
Chiropractic Treatment Expense Includes charges made by a physician on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**65%** of the Recognized Charge
Short-Term Cardiac and Pulmonary Rehabilitation Therapy Services Expense Inpatient rehabilitation benefits for the services listed will be paid as part of the *Hospital Expense* and *Skilled Nursing Facility Expense* benefits. *Cardiac Rehabilitation Benefits.* • Cardiac rehabilitation benefits received at a **hospital**, **skilled nursing facility**, or **physician's** office. This Plan will cover charges in accordance with a treatment plan as determined by a **covered person's** risk level when recommended by a **physician**. *Pulmonary Rehabilitation Benefits* • Pulmonary rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states.			
Cardiac Rehabilitation	Payable in accordance with the type of expense incurred and the place where service is provided.		
Pulmonary Rehabilitation	Payable in accordance with the type of expense incurred and the place where service is provided.		
Short-Term Rehabilitation Expense Includes charges for short-term rehabilitation services, as described below, when prescribed by a physician. Short-term rehabilitation services must follow a specific treatment plan that: • Details the treatment, and specifies frequency and duration; • Provides for ongoing reviews and is renewed only if continued therapy is appropriate; and • Allows therapy services, provided in a covered person's home, if the covered person is homebound. Inpatient rehabilitation benefits for the services listed will be paid as part of the inpatient hospital and skilled nursing facility benefits.			
Short-Term Rehabilitation Expense Outpatient Physical and Occupational Rehabilitation and Habilitation Therapy Services (combined)	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**65%** of the Recognized Charge
Outpatient Speech Rehabilitation and Habilitation Therapy Services	**90%** of the Negotiated Charge	**80%** of the Negotiated Charge	**65%** of the Recognized Charge

HEARING AIDS	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Cochlear Implants	**80%** of the Negotiated Charge	**80%** of the Negotiated Charge	**80%** of the Recognized Charge
TREATMENT OF MENTAL DISORDER EXPENSE	**Tier I** **Preferred Care with Referral**	**Tier II** **Preferred Care without Referral**	**Tier III** **Non-Preferred Care**
Inpatient Mental Health Expense Covered medical expenses include charges made by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider for the treatment of mental disorders for Inpatient room and board at the semi-private room rate, and other services and supplies related to a covered person's condition that are provided during a covered person's stay in a hospital, psychiatric hospital, or residential treatment facility.	**$300** copay per admission then the plan pays **90%** of the Negotiated Charge	**$300** copay per admission then the plan pays **80%** of the Negotiated Charge	**$300** deductible per admission then the plan pays **65%** of the Recognized Charge for a semi-private room
Outpatient Mental Health Expense	**$25** copay then the plan pays **100%** of the Negotiated Charge*	**$25** copay then the plan pays **100%** of the Negotiated Charge*	**65%** of the Recognized Charge
Outpatient Mental Health Partial Hospitalization Expense	**$300** copay per admission then the plan pays **90%** of the Negotiated Charge	**$300** copay per admission then the plan pays **80%** of the Negotiated Charge	**$300** deductible per admission then the plan pays **65%** of the Recognized Charge for a semi-private room
ALCOHOLISM AND DRUG ADDICTION TREATMENT	**Tier I** **Preferred Care with Referral**	**Tier II** **Preferred Care without Referral**	**Tier III** **Non-Preferred Care**
Inpatient Substance Abuse Treatment Covered medical expenses include charges made by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider for the treatment of mental disorders for Inpatient room and board at the semi-private room rate, and other services and supplies related to a covered person's condition that are provided during a covered person's stay in a hospital, psychiatric hospital, or residential treatment facility.	**$300** copay per admission then the plan pays **90%** of the Negotiated Charge	**$300** copay per admission then the plan pays **80%** of the Negotiated Charge	**$300** deductible per admission then the plan pays **65%** of the Recognized Charge for a semi-private room
Outpatient Substance Abuse Treatment	**$25** copay then the plan pays **100%** of the Negotiated Charge*	**$25** copay then the plan pays **100%** of the Negotiated Charge*	**65%** of the Recognized Charge

***Annual Deductible does not apply to these services**

TRANSPLANT SERVICE EXPENSE	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Transplant Services Expense Benefits may vary if an Institute of Excellence™ (IOE) facility or non-IOE or non-preferred care provider is used. Through the IOE network, the covered person will have access to a provider network that specializes in transplants. In addition, some expenses listed below are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure the covered person requires. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.	Payable in accordance with the type of expense incurred and the place where service is provided.		
Transplant Travel and Lodging Expense The plan will reimburse a covered person for the cost of their travel and lodging expenses.	**100%** of the Actual Charge		
PEDIATRIC DENTAL SERVICES EXPRENSE (Coverage is limited to covered persons until the end of the month in which the covered person turns 19.)	**Tier I** **Preferred Care with Referral**	**Tier II** **Preferred Care without Referral**	**Tier III** **Non-Preferred Care**
Type A Expense (Pediatric Routine Dental Exam Expense) Benefits are limited to **1** exam every **6** months	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**65%** of the Recognized Charge
Type B Expense (Pediatric Basic Dental Care Expense)	**70%** of the Negotiated Charge*	**70%** of the Negotiated Charge*	**50%** of the Recognized Charge
Type C Expense (Pediatric Major Dental Care Expense)	**50%** of the Negotiated Charge*	**50%** of the Negotiated Charge*	**50%** of the Recognized Charge
Pediatric Orthodontia Expense Orthodontics Medically necessary comprehensive treatment • Replacement of retainer (limit one per lifetime).	**50%** of the Negotiated Charge*	**50%** of the Negotiated Charge*	**50%** of the Recognized Charge

***Annual Deductible does not apply to these services**

PEDIATRIC ROUTINE VISION (Coverage is limited to covered persons until the end of the month in which the covered person turns 19.)	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Pediatric Routine Vision Exams (including refractions) Includes charges made by a legally qualified ophthalmologist or optometrist for a routine vision exam. The exam will include refraction & glaucoma testing.	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**65%** of the Recognized Charge*
Pediatric Visit for the fitting of prescription contact lenses, Pediatric Eyeglass Frames, Prescription Lenses or Prescription Contact Lenses Includes charges for the following vision care services and supplies: • Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses. • Eyeglass frames, prescription lenses or prescription contact lenses provided by a vision provider who is a preferred care provider. • Eyeglass frames, prescription lenses or prescription contact lenses provided by a vision provider who is a non-preferred care provider. Coverage includes charges incurred for: • Non-conventional prescription contact lenses that are required to correct visual acuity to 20/40 or better in the better eye and that correction cannot be obtained with conventional lenses. Aphakic prescription lenses prescribed after cataract surgery has been performed. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.	**100%** of the Negotiated Charge*	**100%** of the Negotiated Charge*	**65%** of the Recognized Charge*

***Annual Deductible does not apply to these services**

PRESCRIBED MEDICINES EXPENSE

Covered Percentage***	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Preventive Care Drugs and Supplements **Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.**			
Risk Reducing Breast Cancer Prescription Drugs For each **30**-day supply filled at a retail **pharmacy.**	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits	**100%** of the recognized charge
Other preventive care drugs and supplements For each **30**-day supply filled at a retail **pharmacy.**	**100%** per supply	**100%** per supply	**100%** of the recognized charge
Tobacco Cessation Prescription Drugs and Over-the-Counter Drugs (for two **90**-day treatment regimens only)	**100%** per supply	**100%** per supply	**100%** of the recognized charge
Contraceptives	**Tier I Preferred Care with Referral**	**Tier II Preferred Care without Referral**	**Tier III Non-Preferred Care**
For each **30**-day supply filled at a retail **pharmacy.**	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits	**100%** of the recognized charge
All Other Prescription Drugs			
For each **30**-day supply filled at a retail **pharmacy.**	**100%** of the **negotiated charge**	**100%** of the **negotiated charge**	**100%** of the **recognized charge**

*****The prescription drug plan covered percentage is the percentage of prescription drug covered medical expenses that the plan pays after any applicable deductibles and copays have been met.**

OUT-OF-POCKET LIMITS

The prescription drug plan is subject to the medical plan's out-of-pocket limits. These out-of-pocket limit provisions can be found in this Schedule of Benefits under the Out-of Pocket Maximums section.

PRESCRIBED MEDICINE EXPENSE POLICY YEAR DEDUCTIBLES

The prescription drug plan is not subject to the medical plan's policy year deductibles.

IMPORTANT INFORMATION

- Refer to The Prescribed Medicine Expense Coverage for details about outpatient prescription drug coverage.
- The covered person will pay less for prescriptions if they:
  - Use generic prescription drugs rather than brand name prescription drugs ;
  - Obtain prescription drugs from preferred pharmacies rather than non-preferred pharmacies;
  - Use prescription drugs that are on the preferred drug list;
  - Obtain injectable, self-injectable, or specialty care prescription drugs from the specialty pharmacy network or preferred pharmacies.
- Precertification may be required to obtain certain prescription drugs.

- If the covered person or their prescriber request a covered brand-name prescription drug when a covered generic prescription drug equivalent or generic prescription drug alternative is available, the covered person will be responsible for the cost difference between the generic prescription drug and the brand-name prescription drug, plus the increased cost sharing applicable to brand name-prescription drugs.

A generic prescription drug equivalent contains the identical amounts of the same active ingredients as the brand-name prescription drug or device. A generic prescription drug alternative is used for the same purpose, but can have different ingredients or different amounts of ingredients.

Per Prescription Copay/Deductible

	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Generic Prescription Drugs For each **30**-day supply filled at a retail **pharmacy.**	**$20 copay** per supply	**$20 copay** per supply	**$20 deductible** per supply
Preferred Brand-Name Prescription Drug For each **30**-day supply filled at a retail **pharmacy.**	**$40 copay** per supply	**$40 copay** per supply	**$40 deductible** per supply
Non-Preferred Brand-Name Prescription Drugs For each **30**-day supply filled at a retail **pharmacy.**	**$60 copay** per supply	**$60 copay** per supply	**$60 deductible** per supply
Specialty Prescription Drugs	**80%** of the negotiated charge, minimum **$200 copay** per supply and maximum **$500 copay** per supply	**80%** of the negotiated charge, minimum **$200 copay** per supply and maximum **$500 copay** per supply	**80%** of the recognized charge, minimum **$200 deductible** per supply and maximum **$500 deductible** per supply

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

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

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

Aetna will make a coverage determination within 24 hours after receipt of the request and will notify the covered person, the covered person's designee or the covered person's prescriber of Aetna's decision.

Copay and Deductible Waiver

Waiver for Risk-Reducing Breast Cancer Prescription Drugs

The per prescription copay/deductible and policy year deductible will not apply to risk-reducing breast cancer generic, prescription drugs when obtained at a preferred care pharmacy. This means that such risk-reducing breast cancer generic prescription drugs will be paid at 100%.

Waiver for Prescription Drug Contraceptives

The per prescription copay/deductible and policy year deductible will not apply to:

- Female contraceptives that are:
  - Oral prescription drugs that are generic prescription drugs.
  - Injectable prescription drugs that are generic prescription drugs.
  - Vaginal ring prescription drugs that are generic prescription drugs, brand-name prescription drugs and biosimilar prescription drugs.
  - Transdermal contraceptive patch prescription drugs that are generic prescription drugs, brand-name prescription drugs, and biosimilar prescription drugs.
- Female contraceptive devices.
- FDA-approved female:
  - generic emergency contraceptives; and
  - generic over-the-counter (OTC) emergency contraceptives.

when obtained at a preferred care pharmacy. This means that such contraceptive methods will be paid at 100%.

The per prescription copay/deductible and policy year deductible continue to apply:

- When the contraceptive methods listed above are obtained at a non-preferred pharmacy.
- To female contraceptives that are:
  - Oral prescription drugs that are brand-name prescription drugs and biosimilar prescription drugs.
  - Injectable prescription drugs that are brand-name prescription drugs and biosimilar prescription drugs.
- To female contraceptive devices that are brand-name devices.
- To FDA-approved female:
  - brand-name and biosimilar emergency contraceptives; and
  - brand-name over-the-counter (OTC) emergency contraceptives.
- To FDA-approved female brand-name over-the-counter (OTC) contraceptives.
- To FDA-approved male brand-name over-the-counter (OTC) contraceptives.

However, the per prescription copay/deductible and policy year deductible will not apply to such contraceptive methods if:

- A generic equivalent, biosimilar or generic alternative, within the same therapeutic drug class is not available; or
- A covered person is granted a medical exception; or
- A physician specifies “Dispense as Written” (DAW).

A covered person's prescriber may seek a medical exception by submitting a request to Aetna's Pre-certification Department. Any waiver granted as a result of a medical exception shall be based upon an individual, case by case medically necessary determination and coverage will not apply or extend to other covered persons.

To the extent**:**

- FDA-approved female **generic prescription drugs** are not available, **brand name prescription drugs** will be covered;
- FDA-approved female generic vaginal rings are not available, brand name vaginal rings will be covered.
- FDA-approved female generic devices are not available, brand name devices will be covered.
- One of the FDA-approved female emergency contraceptive methods are not available as generic, a brand name emergency contraceptive will be covered.

Exclusions

This Plan does not cover nor provide benefits for:

1. Expense incurred for adult dental treatment, services and supplies except for those resulting from injury to teeth or for extraction of impacted wisdom teeth and those as specially covered under the policy.

2. 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.

3. 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.

4. Expense incurred for treatment provided in a governmental hospital unless there is a legal or regulatory obligation to pay such charges in the absence of insurance.

5. 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:
   - 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.
   - 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 the policy. Surgery must be performed in the policy year of the accident which causes the injury or in the next policy year.

6. Expense incurred for voluntary or elective abortions unless specifically covered under the policy or when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself, or when the pregnancy is the result of an alleged act of rape or incest.

7. Expense incurred after the date insurance terminates for a covered person except as may be specifically provided in the Extension of Benefits provision.

8. Services provided by the Health Service of the policyholder or services covered or provided by the student health fee.

9. 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.

10. Expense for or related to artificial insemination, in-vitro fertilization or embryo transfer procedures, male elective sterilization, or elective abortion unless specifically covered under the policy.

11. Expense incurred for the male or female reversal of voluntary sterilizations, including related follow-up care and treatment of complications of such procedures.

12. Expense incurred for which no member of the covered person's immediate family has any legal obligation for payment.

13. Expense incurred for custodial care.

14. 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 except as specifically covered in the policy. This limitation does not apply to a donation by a covered person to a spouse, child, brother, sister, or parent.

15. Expense incurred for, or in connection with, drugs, devices, procedures, or treatments that are, as determined by Aetna to be, experimental or investigational except as specifically covered under the policy.

16. Expenses incurred for breast reduction/mammoplasty.

17. Expenses incurred for gynecomastia (male breasts).

18. Expense incurred for acupuncture except as specifically covered under the policy.

19. Expense incurred for alternative holistic medicine and/or therapy including, but not limited to, yoga and hypnotherapy unless specifically covered under the policy.

20. Expense incurred when the person or individual is acting beyond the scope of his/her/its legal authority.

21. Expense incurred for hearing exams, hearing aids, the fitting or prescription of hearing aids except as specifically covered under the policy. Not covered are:
    - Any hearing service or supply that does not meet professionally accepted standards;
    - Hearing exams given during a stay in a hospital or other facility;
    - Any tests, appliances, and devices for the improvement of hearing, including aids, hearing aids and amplifiers, or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech; and
    - Routine hearing exams, except for routine hearing screenings as specifically described under Preventive Care Benefits.

22. 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.

23. Expense for telephone consultations (except for telemedicine), charges for failure to keep a scheduled visit, or charges for completion of a claim form.

24. 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.

25. Expense incurred for any non-emergency charges incurred outside of the United States 1) if you traveled to such location to obtain prescription drugs, or supplies, even if otherwise covered under this policy, or 2) such drugs or supplies are unavailable or illegal in the United States, or 3) the purchase of such prescription drugs or supplies outside the United States is considered illegal.

26. Expense for incidental surgeries and standby charges of a physician.

27. Expense incurred for any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum except as specifically covered under the policy.

28. Expenses incurred for massage therapy.

29. Expense incurred for non-preferred care charges that are not recognized charges.

30. Expense incurred for a treatment, service, prescription drug, or supply which is not medically necessary as determined by Aetna for the diagnosis, care, or treatment of the sickness or injury involved, the restoration of physiological functions, or covered preventive services. This includes behavioral health services that are not primarily aimed at treatment of sickness, injury, restoration of physiological functions or that do not have a physiological or organic basis. This applies even if they are prescribed, recommended, or approved by the person's attending physician, dentist, or vision provider.

31. Expenses incurred for vision-related services and supplies, except as specifically covered in the policy. In addition, the plan does not cover:
    - Special supplies such as non-prescription sunglasses;
    - Vision service or supply which does not meet professionally accepted standards;
    - Special vision procedures, such as orthoptics or vision training;
    - Eye exams during a stay in a hospital or other facility for health care;
    - Eye exams for contact lenses or their fitting;
    - Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
    - Replacement of lenses or frames that are lost or stolen or broken;
    - Acuity tests; and
    - Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures
    - Services to treat errors of refraction.

32. Expense incurred for behavioral health services for the following categories (or equivalent terms as listed in the most recent version of the International Classification of Diseases (ICD)) except as specifically covered in the policy:
    - Dementias and amnesias without behavioral disturbances;
    - Sexual deviations and disorders except for gender identity disorders;
    - Antisocial or dissocial personality disorder;
    - Pathological gambling, kleptomania, pyromania;
    - Specific delays in development (learning disorders, academic underachievement); and
    - Mental retardation.

33. Expense incurred in a facility for care, services or supplies provided in:

- Rest homes;
- Assisted living facilities;
- Similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;
- Health resorts;
- Spas, sanitariums;
- Infirmaries at schools, colleges or camps; and
- Wilderness Treatment Programs or any such related or similar program, school and/or education service.

34. Expense incurred for early intensive behavioral interventions (including Applied Behavior Analysis, Denver, LEAP, TEACHH, Rutgers, floor time, Lovaas and similar programs) except as specifically covered in the policy.

35. Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).

36. Expense incurred for drugs, medications and supplies, except as specifically covered in the policy. Not covered are:
    - Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a prescription including vitamins;
    - Services related to the dispensing, injection or application of a drug;
    - A prescription drug purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
    - Needles, syringes and other injectable aids, except as covered for diabetic supplies, and for a covered drug;
    - Drugs related to the treatment of non-covered medical expenses;
    - Performance enhancing steroids;
    - Implantable drugs and associated devices;
    - Injectable drugs if an alternative oral drug is available, unless medically necessary
    - Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy whether functional or organic.

    Any expenses for prescription drugs, and supplies covered under the Pharmacy Plan will not be covered under this medical expense plan. Prescription drug exclusions that apply to the Aetna Pharmacy plan will apply to the medical expense coverage.

37. Expense incurred for educational services:
    - Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
    - Evaluation or treatment of learning disabilities, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause; and
    - Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills
    - Services eligible under the Individuals with Disabilities in Education Act (IDEA).

38. Expenses incurred for food items except as specifically covered under the policy: Any food item, including infant formulas, nutritional supplements, vitamins, including prescription vitamins, medical foods and other nutritional items.

39. Expense incurred in relation to genetics: Except as specifically covered in the policy, the plan does not cover any treatment, device, drug, service or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects.

40. Expense incurred for any treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth, including surgical procedures, devices to stimulate growth, and growth hormones except as specifically covered in the policy.

41. Expense incurred for outpatient cognitive therapy, physical therapy, and occupational therapy, except as specifically covered in the policy. Not covered under the policy are charges for:
    - Educational services;
    - Any services unless provided in accordance with a specific treatment plan;
    - Any services which are covered medical expenses in whole or in part under any other group plan sponsored by an employer;
    - Services provided by a physician or treatment covered as part of Chiropractic Treatment. This applies whether or not benefits have been paid under the Chiropractic Treatment benefit;
    - Services not performed by a physician, occupational or physical therapist or under the direct supervision of a physician;
    - Services provided by a physician or physical or occupational therapist who resides in your home; or who is a member of your family, or a member of your spouse's or your domestic partner's family; and
    - Special education to instruct a person to function. This includes lessons in sign language.

42. Expense incurred for outpatient speech therapy. Except as specifically covered in the policy, not covered are charges for:
    - Any services unless provided in accordance with a specific treatment plan;
    - Services not performed by a physician, or speech therapist or under the direct supervision of a physician;
    - Services provided by a physician or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse's or your domestic partner's family; and
    - Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

43. Expense incurred for therapies and tests: Any of the following treatments or procedures including but not limited to:
    - Aromatherapy;
    - Bio-feedback and bioenergetic therapy;
    - Carbon dioxide therapy;
    - Chelation therapy (except for heavy metal poisoning);
    - Computer-aided tomography (CAT) scanning of the entire body;
    - Early intensive behavioral interventions (including Applied Behavior Analysis, Denver, LEAP, TEACHH, Rutgers programs) except as specifically covered in the What the Medical Plan Covers Section;
    - Educational therapy;
    - Gastric irrigation;
    - Hair analysis;
    - Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
    - Hypnosis, and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery;
    - Lovaas therapy;
    - Massage therapy;
    - Megavitamin therapy;
    - Primal therapy;
    - Psychodrama;
    - Purging;
    - Recreational therapy;

- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy;
- Thermograms and thermography

Additional Pediatric Dental Services Exclusions and Limitations

The Pediatric Dental Services benefit is subject to the following additional exclusions and limitations:

44. Expenses incurred for any instruction for diet, plaque control and oral hygiene.

45. Expenses incurred for cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve, alter, or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth whether or not for psychological or emotional reasons except to the extent coverage is specifically covered in the policy. Facings on molar crowns and pontics will always be considered cosmetic.

46. Expenses incurred for crown, inlays and onlays, and veneers unless:
    - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or
    - The tooth is an abutment to a covered partial denture or fixed bridge.

47. Expenses incurred for dental examinations that are:
    - Required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
    - Required by any law of a government, securing insurance or school admissions, or professional or other licenses;
    - Required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
    - Any special medical reports not directly related to treatment except when provided as part of a covered service.

48. Expenses incurred for dental implants, braces (that are not determined to be medically necessary), mouth guards, and other devices to protect, replace or reposition teeth and removal of implants.

49. Expenses incurred for dental services and supplies that are covered in whole or in part under any other part of this plan.

50. Expenses incurred for dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, abfraction or erosion.

51. Expenses incurred for general anesthesia and intravenous sedation, except as specifically covered in the policy and only when done in connection with another medically necessary covered service or supply.

52. Expenses incurred for orthodontic treatment except as specifically covered in the policy.

53. Expenses incurred for replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures.

54. Expenses incurred for replacement of teeth beyond the normal complement of 32.

55. Expenses incurred for routine dental exams and other preventive services and supplies, except as specifically covered in the policy.

56. Expenses incurred for space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.

57. Expenses incurred for the surgical removal of impacted wisdom teeth only for orthodontic reasons.

58. Expenses incurred for treatment by other than a dentist or dental provider that is legally qualified to furnish dental services or supplies.

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

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

IMPORTANT NOTICES:

Sanctioned Countries:

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

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

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

If you need a qualified interpreter, written information in other formats, translation or other services, call 1-866-577-7027.

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

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

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TTY: 711

To access language services at no cost to you, call 1-866-577-7027.

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