

Aetna Student Health

Plan Design and Benefits Summary Virginia Tech

Policy Year: 2014 - 2015

Policy Number: 474968



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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 governing this insurance are contained in the Master Policy issued to the Virginia Tech and may be viewed online at www.aetnastudenthealth.com. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits.

Virginia Tech /Health Services

The Schiffert Health Center is the University's on-campus health facility. Staffed by 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 for all insured students and dependents enrolled for coverage in the Plan for the following Coverage Periods. 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 Master Policy.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	08/01/2014	07/31/2015	09/15/2014
Spring	01/01/2015	07/31/2015	01/31/2015
Summer	05/01/2015	07/31/2015	05/01/2015

Rates

Rates Undergraduates and Graduate Students

	Annual	Spring Semester
Student	\$1871	\$1087
Student + Spouse/Domestic Partner	\$5066	\$2943
Student + Child(ren)	\$4469	\$2596
Family	\$7664	\$4451

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 and 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.

Student Coverage

Eligibility

Students must be enrolled as full-time students at the university on the first day that coverage will be effective. Students in Cooperative Education and serving approved internships off-campus or performing credited research hours are considered to be full-time students of the university. However, if the student takes fewer than full-time hours but is enrolled in the maximum number of hours allowed toward graduation (i.e. working on a dissertation), the student may obtain a statement to this effect in writing on the department's letterhead and with the signature of the department head. This confirmation may be attached to the application for insurance. 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 enroll in the Virginia Tech sponsored plan.
- Graduate students who are defending their thesis are eligible to remain on the insurance program if previously insured through the end of the month in which they defend. Documentation from the department head must be provided to the Student Medical Insurance office.

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

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

Enrollment: To enroll 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.

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 **\$10,000** for repatriation of remains **and** 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, 2013, or the first day of enrollment at Virginia Tech, until July 31, 2014 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- 09/15/2014
2. Students enrolling for the Spring Semester- 01/31/2015
3. In order to avoid having a block placed on a student's account the student must enroll in the Student Medical
4. 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**.

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

Enrollment

To enroll the dependent(s) of a covered student, please complete the Enrollment Form by visiting www.aetnastudenthealth.com, selecting the school name, and clicking on the "Plans & Products Offered to You" link on the left hand side of the screen. 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 **31 days** from the date of birth. At the end of this **31 day** period, coverage will cease under the **Virginia Tech** Student Health Insurance Plan. To extend coverage for a newborn past the **31 days**, the Covered Student must: 1) enroll the child within **31 days** of birth, and 2) pay the additional premium, starting from the date of birth.

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

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

Preferred Provider Network

Aetna Student Health has arranged for you to access a Preferred Provider Network in your local community.

To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider. It is to your advantage to use a Preferred Provider because savings may be achieved from the Negotiated Charges these providers have agreed to accept as payment for their services.

Pre-certification Program

Your Plan requires pre-certification for a hospital stay. Pre-certification simply means calling Aetna Student Health prior to treatment to get approval for a medical procedure or service. Pre-certification may be done by you, your doctor, the hospital, or one of your relatives. Requests for certification must be obtained by contacting Aetna Student Health at **(866)577-7027**.

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

You'll need pre-certification for the following inpatient and outpatient services or supplies:

- All inpatient admissions, including length of stay, to a hospital, skilled nursing facility, a facility established primarily for the treatment of substance abuse, or a residential treatment facility;
- All inpatient maternity care, after the initial **48** hours for a vaginal delivery or **96** hours for a cesarean section;
- All partial hospitalization in a hospital, residential treatment facility, or facility established primarily for the treatment of substance abuse

Pre-certification DOES NOT guarantee the payment of benefits for your inpatient admission

Each claim is subject to medical policy review, in accordance with the exclusions and limitations contained in the Master Policy. Also you can view eligibility, notification guidelines, and benefit coverage.

Pre-certification of non-emergency inpatient admissions and partial hospitalization

Non-emergency admissions must be requested at least **three (3) business days** prior to the planned admission or prior to the date the services are scheduled to begin.

Pre-certification of emergency inpatient admissions

Emergency admissions must be requested within **one (1) business day** after the admission.

Description of Benefits

The Plan excludes coverage for certain services and contains 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 Master Policy issued to Virginia Tech, you may access it online at www.aetnastudenthealth.com. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits. All coverage is based on Recognized Charges unless otherwise specified.

Policy Year Maximum	Unlimited
<p>DEDUCTIBLE</p> <p><i>Unless otherwise indicated, the Policy Year Deductible must be met prior to benefits being payable.</i></p> <p><i>In compliance with Virginia State Mandate(s) the Policy Year Deductible is waived for: Preferred Care Preventive Health Care Services</i></p> <p><i>In addition to state and federal requirements for waiver of the Policy Year Deductible, this Plan will waive the Deductible for: Preventive Health Care Services up to age 7, and Preferred Care and Non Preferred care Deductible-waived for Pediatric Vision Services, Preferred Care Deductible (only) is Waived for Pediatric Preventive Dental</i></p> <p><i>Per visit or admission Deductibles do not apply towards satisfying the Policy Year Deductible.</i></p>	<p>Individual:</p> <p>Students: \$300 per Policy Year</p> <p>Spouse/Domestic Partner: \$300 per Policy Year</p> <p>Child: \$300 per Policy Year</p> <p>Family: \$600 per Policy Year</p>
COINSURANCE	<p>Covered Medical Expenses are payable at the coinsurance percentage specified below, after any applicable Deductible.</p>
<p>OUT OF POCKET MAXIMUMS</p> <p><i>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.</i></p> <p><i>The following expenses do not apply toward meeting the Out-of-Pocket Limit:</i></p> <ul style="list-style-type: none"> • <i>Expenses that are not covered medical expenses</i> • <i>Penalties, and</i> <p><i>Other expenses not covered by this policy</i></p>	<p>Combined Out-of-Pocket:</p> <p>Individual Out-of-Pocket: \$3,000 per Policy Year</p> <p>Family Out-of-Pocket: \$6,000 per Policy Year</p>

- 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.

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 a 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).

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

Inpatient Hospitalization Benefits	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Room and Board Expense	After a \$300 copay per admission, 90% of the Negotiated Charge	After a \$300 copay per admission, 80% of the Negotiated Charge	After a \$300 deductible per admission, 65% of the Recognized Charge for a semi-private room
Miscellaneous Hospital Expense <i>Includes, but not limited to: operating room, laboratory tests/X rays, oxygen tent, and drugs, medicines, dressings</i>	90% of the Negotiated Charge	80% of the Negotiated Charge	65% of the Recognized Charge
Non-Surgical Physicians Expense <i>Non-surgical services of the attending Physician, or a consulting Physician</i>	90% of the Negotiated Charge	80% of the Negotiated Charge	65% 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)	90% of the Negotiated Charge	80% of the Negotiated Charge	65% of the Recognized Charge
Anesthesia Expense (Inpatient and Outpatient)	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
Ambulatory Surgical Expense	90% of the Negotiated Charge	80% of the Negotiated Charge	65% of the Recognized Charge
Outpatient Expense	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Hospital Outpatient Department Expense	90% of the Negotiated Charge	80% of the Negotiated Charge	65% of the Recognized Charge
Walk-in Clinic Visit Expense	After a \$10 copay per visit, 100% of the Negotiated Charge	After a \$10 copay per visit, 100% of the Negotiated Charge	65% of the Recognized Charge
Emergency Room Expense <i>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</i>	After a \$200 copay per visit (waived if admitted), 100% of the Negotiated Charge (waived if admitted)	After a \$200 copay per visit (waived if admitted), 100% of the Negotiated Charge (waived if admitted)	After a \$200 copay per visit (waived if admitted), 100% of the Actual Charge of the Recognized Charge (waived if admitted)

Urgent Care Expense	After a \$10 copay per visit, 100% of the Negotiated Charge	After a \$10 copay per visit, 100% of the Negotiated Charge	65% of the Recognized Charge
Ambulance Expense	80% of the Negotiated Charge	80% of the Negotiated Charge	80% of the Recognized Charge
Physician's Office Visit Expense <i>Includes visits to specialists and telemedicine services</i>	After a \$10 copay per visit, 100% of the Negotiated Charge	After a \$25 copay per visit, 100% of the Negotiated Charge	65% of the Recognized Charge
Laboratory and X-ray Expense	90% of the Negotiated Charge	80% of the Negotiated Charge	65% of the Recognized Charge
High Cost Procedures Expense <i>Includes CT scans, MRIs, PET scans and Nuclear Cardiac Imaging Tests</i>	90% of the Negotiated Charge	80% of the Negotiated Charge	65% of the Recognized Charge
Therapy Expense <i>Includes Physical, Speech and Occupational Therapy</i> <i>Includes charges incurred by a covered person for the following types of therapy provided on an outpatient basis: Radiation therapy, Chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy, Dialysis, and Respiratory therapy</i> <i>Coverage for orally administered anticancer medications, prescribed by a prescribing practitioner, and used to kill or slow the growth of cancerous cells, are payable on the same basis as intravenously administered anticancer medications</i>	90% of the Negotiated Charge	80% of the Negotiated Charge	65% of the Recognized Charge

Chiropractic Expense <i>Benefits are limited to 30 visits per Policy Year</i>	90% of the Negotiated Charge	80% of the Negotiated Charge	65% of the Recognized Charge
Durable Medical and Surgical Equipment Expense	80% of the Negotiated Charge	80% of the Negotiated Charge	80% of the Recognized Charge
Prosthetic Devices Expense	80% of the Negotiated Charge	80% of the Negotiated Charge	80% of the Recognized Charge
Dental Injury Expense	80% of the Actual Charge		
Allergy Testing and Treatment Expense	80% of the Negotiated Charge	80% of the Negotiated Charge	65% of the Recognized Charge
Diagnostic Testing For Learning Disabilities Expense <i>Once a covered person has been diagnosed with one of these conditions, medical treatment will be payable as detailed under the outpatient Treatment of Mental and Nervous Disorders portion of this Plan</i>	80% of the Negotiated Charge	80% of the Negotiated Charge	80% of the Recognized Charge
Dental Expense for Impacted Wisdom Teeth	80% of the Actual Charge		
Preventive Care	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
*Annual Deductible does not apply to these services			
Pap Smear Screening Expense	100% of the Negotiated Charge*	100% of the Negotiated Charge*	65% of the Recognized Charge
Mammogram Expense <i>Includes a baseline mammogram for women between the ages of 35 to 40, a mammogram every two years, or more frequently based on the recommendation of the woman's physician for women ages 40 to 50, or a mammogram on an annual basis for women 50 years of age and older</i>	100% of the Negotiated Charge*	100% of the Negotiated Charge*	65% of the Recognized Charge

Immunizations Expense <i>Includes travel immunizations and flu shots</i>	100% of the Negotiated Charge*	100% of the Negotiated Charge*	100% of the Recognized Charge
Routine Physical Exam Expense <i>Includes routine tests and related lab fees</i>	100% of the Negotiated Charge*	100% of the Negotiated Charge*	100% of the Recognized Charge
Routine Screening for Sexually Transmitted Disease Expense	100% of the Negotiated Charge*	100% of the Negotiated Charge*	65% of the Recognized Charge
Routine Colorectal Cancer Screening Expense <i>Includes charges incurred by a covered person for an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations</i>	100% of the Negotiated Charge*	100% of the Negotiated Charge*	65% of the Recognized Charge
Routine Prostate Cancer Screening <i>Includes charges incurred by a covered person for the screening of cancer as follows: for a male age 50 or over, and for a male age 40 and over who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society, one digital rectal exam and one prostate specific antigen test each Policy Year</i>	100% of the Negotiated Charge*	100% of the Negotiated Charge*	65% of the Recognized Charge
Vision Care Exam Expense	After a \$15 copay, 100% of the Negotiated Charge	After a \$15 copay, 100% of the Negotiated Charge	100% of the Recognized Charge

<p>Vision Care Supply Expense <i>Benefits are limited to a maximum of \$120 per Policy Year for adults</i></p>	<p>After a \$15 copay, 100% of the Actual Charge</p>	<p>After a \$15 copay, 100% of the Actual Charge</p>	<p>After a \$15 deductible, 100% of the Actual Charge</p>
<p>Pediatric Vision Care Exam Expense <i>Supplies are limited to 1 pair of glasses (lenses and frames) of contacts per Policy Year Covered Medical Expenses include routine vision exam (including refraction & Glaucoma Testing), non-cosmetic eyeglass frames, prescription lenses or prescription contact lenses (not both) Benefits are provided to covered persons through age 18</i></p>	<p>100% of the Negotiated Charge*</p>	<p>100% of the Negotiated Charge*</p>	<p>65% of the Recognized Charge*</p>
<p>Pediatric Routine Dental Exam Expense <i>Covered dental expenses include charges made by a dental provider for the dental services listed in the Pediatric Dental Care Schedule. To view the Pediatric Dental Care Schedule please refer to the Virginia Tech page on the Aetna Student Health website, www.aetnastudenthealth.com Benefits are provided to covered persons through age 18 Benefits are limited to 1 exam every 6 months</i></p>	<p>100% of the Negotiated Charge*</p>	<p>100% of the Negotiated Charge*</p>	<p>65% of the Recognized Charge</p>
<p>Pediatric Basic Dental Care Expense <i>Covered dental expenses include charges made by a dental provider for the dental services listed in the Pediatric Dental Care Schedule. To view the Pediatric Dental Care Schedule please refer to the Virginia Tech page on the Aetna Student Health website, www.aetnastudenthealth.com</i></p>	<p>70% of the Negotiated Charge*</p>	<p>70% of the Negotiated Charge*</p>	<p>50% of the Recognized Charge</p>

Benefits are provided to covered persons through age **18**

Pediatric Major Dental Care Expense	50% of the Negotiated Charge*	50% of the Negotiated Charge*	50% of the Recognized Charge
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Covered dental expenses include charges made by a dental provider for the dental services listed in the Pediatric Dental Care Schedule. To view the Pediatric Dental Care Schedule please refer to the Virginia Tech page on the Aetna Student Health website, www.aetnastudenthealth.com

Benefits are provided to covered persons through age **18**

Pediatric Orthodontia Expense	50% of the Negotiated Charge*	50% of the Negotiated Charge*	50% of the Recognized Charge
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Medically necessary comprehensive treatment. Replacement of retainer (limit one per lifetime)

Benefits are provided to covered persons through age **18**

Routine Foot Care Expense	Covered Medical Expenses are payable on the same basis as any other Sickness, member cost sharing is based on the type of service performed and the place of service where it is rendered		
<i>Routine or palliative foot care is covered for treatment of patients with diabetes or vascular disease only; Treatment of bunions only covered when associated with capsular or bone surgery</i>			

Treatment of Mental and Nervous Disorders	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
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Biologically Based Mental and Nervous Disorders Inpatient Expense	After a \$300 copay per admission, 90% of the Negotiated Charge	After a \$300 copay per admission, 80% of the Negotiated Charge	After a \$300 deductible per admission, 65% of the Recognized Charge
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Biologically Based Mental and Nervous Disorders Outpatient Expense	After a \$10 copay per visit, 100% of the Negotiated Charge	After a \$25 copay per visit, 100% of the Negotiated Charge	65% of the Recognized Charge
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Non-Biologically Based Mental and Nervous Disorders Inpatient Expense	After a \$300 copay per admission, 90% of the Negotiated Charge	After a \$300 copay per admission, 80% of the Negotiated Charge	After a \$300 deductible per admission, 65% of the Recognized Charge
Non-Biologically Based Mental and Nervous Disorders Outpatient Expense	After a \$10 copay per visit, 100% of the Negotiated Charge	After a \$25 copay per visit, 100% of the Negotiated Charge	65% of the Recognized Charge
Alcoholism and Drug Addiction Treatment	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Inpatient Expense	After a \$300 copay per admission, 90% of the Negotiated Charge	After a \$300 copay per admission, 80% of the Negotiated Charge	After a \$300 deductible per admission, 65% of the Recognized Charge
Outpatient Expense	After a \$10 copay per visit, 100% of the Negotiated Charge	After a \$25 copay per visit, 100% of the Negotiated Charge	65% of the Recognized Charge
Maternity Benefits	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Maternity Expense	Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other sickness, member cost sharing is based on the type of service performed and the place of service where it is rendered* *Tier I and II benefits are payable as a Tier I benefit.		
Prenatal Care/Comprehensive Lactation Support and Counseling Services	100% of the Negotiated Charge*	100% of the Negotiated Charge*	65% of the Recognized Charge
Breast Feeding Durable Medical Equipment	100% of the Negotiated Charge*	100% of the Negotiated Charge*	80% of the Recognized Charge
Well Newborn Nursery Care Expense	90% of the Negotiated Charge	90% of the Negotiated Charge	65% of the Recognized Charge

Family Planning Expense

Unless specified below, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this Plan;
- Services and supplies incurred for an abortion;
- Services provided as a result of complications resulting from a voluntary sterilization
- Procedure and related follow-up care;
- Services which are for the treatment of an identified illness or injury;
- Services that are not given by a physician or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams;
- Any contraceptive methods that are only "reviewed" by the **FDA** and not "approved" by the **FDA**;
- Male contraceptive methods, or devices;

-The reversal of voluntary sterilization procedures, including any related follow-up care

Voluntary Sterilization Coverage for Tubal Ligation for voluntary sterilization	100% of the Negotiated Charge*	100% of the Negotiated Charge*	65% of the Recognized Charge
Voluntary Sterilization Coverage for Vasectomy for voluntary sterilization	90% of the Negotiated Charge	80% of the Negotiated Charge	65% of the Recognized Charge
Contraceptives <i>Important Note: Brand-Name Prescription Drug or Devices for a Preferred Provider will be covered at 100% of the Negotiated Charge, including waiver of per Policy Year Deductible if a Generic Prescription Drug or Device is not available in the same therapeutic drug class or the prescriber specifies Dispense as Written</i>	100% of the Negotiated Charge*	100% of the Negotiated Charge*	65% of the Recognized Charge

Prescription Drug Coverage	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Prescribed Medicines Expense <i>Prior Authorization may be required for certain Prescription Drugs and some medications may not be covered under this Plan. For assistance and a complete list of excluded medications, or drugs requiring prior authorization, please contact Aetna Pharmacy Management at 888 RX-AETNA (available 24 hours). Aetna Specialty Pharmacy provides specialty medications and support to members living with chronic conditions. The medications offered may be injected, infused or taken by mouth. For additional information please go to www.AetnaSpecialtyRx.com Includes drugs approved by the USFDA for use in the treatment of cancer, even if the drug has</i>	100% of the Negotiated Charge, following a \$20 Copay for each Generic Prescription Drug, \$40 Copay for each Preferred Brand Name Prescription Drug, \$60 Copay for each Non-Preferred Brand Name Prescription Drug, \$100 Copay for each Preferred Specialty Prescription Drug, and \$150 Copay for each Non-Preferred Specialty Prescription Drug.	100% of the Negotiated Charge, following a \$20 Copay for each Generic Prescription Drug, \$40 Copay for each Preferred Brand Name Prescription Drug, \$60 Copay for each Non-Preferred Brand Name Prescription Drug, \$100 Copay for each Preferred Specialty Prescription Drug, and \$150 Copay for each Non-Preferred Specialty Prescription Drug.	100% of the Recognized Charge, following a \$20 Copay for each Generic Prescription Drug, \$40 Copay for each Preferred Brand Name Prescription Drug, \$60 Copay for each Non-Preferred Brand Name Prescription Drug, \$100 Copay for each Preferred Specialty Prescription Drug, and \$150 Copay for each Non-Preferred Specialty Prescription Drug.

not specifically been approved for treatment of the specific cancer for which the drug has been prescribed
the specialty pharmacy benefit applies to prescriptions filled through Aetna Specialty Pharmacy

Additional Benefits	Tier I Preferred Care with Referral	Tier II Preferred Care without Referral	Tier III Non-Preferred Care
Diabetic Testing Supplies Expense	Covered Medical Expenses are payable on the same basis as any other Sickness, member cost sharing is based on the type of service performed and the place of service where it is rendered		
Outpatient Diabetic Self-Management Education Programs Expense	Covered Medical Expenses are payable on the same basis as any other Sickness, member cost sharing is based on the type of service performed and the place of service where it is rendered		
Temporomandibular Joint Dysfunction Expense	Covered Medical Expenses are payable on the same basis as any other Sickness, member cost sharing is based on the type of service performed and the place of service where it is rendered		
Hospice Benefit	80% of the Negotiated Charge	80% of the Negotiated Charge	65% of the Recognized Charge
Respite Care Expense <i>Benefits are limited to a minimum of 5 days every 90 days</i>	80% of the Negotiated Charge	80% of the Negotiated Charge	65% of the Recognized Charge
Home Health Care Expense	80% of the Negotiated Charge	80% of the Negotiated Charge	80% of the Recognized Charge
Licensed Nurse Expense	90% of the Negotiated Charge	80% of the Negotiated Charge	65% of the Recognized Charge
Skilled Nursing Facility Expense	After a \$300 copay per admission, 80% of the Negotiated Charge for the semi-private room rate	After a \$300 copay per admission, 80% of the Negotiated Charge for the semi-private room rate	After a \$300 deductible per admission, 65% of the Recognized Charge for the semi-private room rate
Rehabilitation Facility Expense	After a \$300 copay per admission, 80% of the Negotiated Charge for the rehabilitation facility's daily room and board maximum for semi-private	After a \$300 copay per admission, 80% of the Negotiated Charge for the rehabilitation facility's daily room and board maximum for semi-private	After a \$300 deductible per admission, 65% of the Recognized Charge for the rehabilitation facility's daily room and board maximum for semi-private

	accommodations	accommodations	accommodations
Convalescent Facility Expense	90% of the Negotiated Charge	80% of the Negotiated Charge	65% of the Recognized Charge
Morbid Obesity Expense <i>Includes treatment of morbid obesity through gastric bypass surgery or such other methods as recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity</i>	Covered Medical Expenses are payable on the same basis as any other Sickness, member cost sharing is based on the type of service performed and the place of service where it is rendered		
Autism Spectrum Disorder	Covered Medical Expenses are payable on the same basis as any other Sickness, member cost sharing is based on the type of service performed and the place of service where it is rendered		
Early Intervention Services Expenses <i>The charges below are included as Covered Medical Expenses for a dependent child under the age of 3 years (who has been certified by the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Act) even though they may not be incurred in connection with a disease or injury. You must submit proof of such certification with the initial claim</i> <i>The services covered are designed to help an individual attain or retain the capability to function age-appropriately within his or her environment, including services that enhance functional ability without effecting a cure. They include, but are not limited to, the following:</i> <i>1. Speech and language therapy given in connection with a speech impairment: which results from a congenital</i>	Covered Medical Expenses are payable on the same basis as any other Sickness, member cost sharing is based on the type of service performed and the place of service where it is rendered		

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- abnormality, disease, or injury*
 - 2. *Occupational or physical therapy expected to result in significant improvement of a body function: impaired by a congenital abnormality, disease, or injury*
 - 3. *Assistive technology services*
 - 4. *Assistive technology devices*
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Transplant Expense

Human organ and tissue transplants are covered when provided as part of physician office services, inpatient facility services, and outpatient facility services

Covered Medical Expenses are payable on the same basis as any other Sickness, member cost sharing is based on the type of service performed and the place of service where it is rendered

Private Duty Nursing Expense

Includes the services of an RN or LPN in the home. Nurse must not be a relative. Doctor must certify that private duty nursing services are medically necessary and not merely custodial. Home nursing services provided through home health care are not subject to this limit. Benefit does not include private duty nursing services provided in an inpatient setting

Benefits are limited to a minimum of 2 visits per Policy Year

80% of the Negotiated Charge

80% of the Negotiated Charge

80% of the Recognized Charge

Vision Correction after Surgery or Accident Expense

Includes charges for Medically Necessary prescription glasses or contact lenses when required as a result of surgery or for the treatment of accidental injury. Includes cost of materials and fitting as well as exams and replacement of these eyeglasses or contact

100% of the Actual Charge

*lenses if the prescription
change is related to the
condition that required the
original prescription*

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

Exclusions

This Plan does not cover nor provide benefits for:

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

11. Expense incurred for voluntary or elective abortions unless otherwise provided in this Policy.
12. Expense incurred after the date insurance terminates for a covered person except as may be specifically provided in the Extension of Benefits Provision.
13. Services provided by the Health Service of the Policyholder or services covered or provided by the student health-fee.
14. Expense incurred for any services rendered by a member of the covered person's immediate family or a person who lives in the covered person's home.
15. Treatment for injury to the extent benefits are payable under any state no-fault automobile coverage, first party medical benefits payable under any other mandatory No-fault law.
16. Expense for or related to artificial insemination, in-vitro fertilization, or embryo transfer procedures, elective sterilization or its reversal or elective abortion unless specifically provided for in this Policy.
17. Expenses for treatment of injury or sickness to the extent that payment is made, as a judgment or settlement, by any person deemed responsible for the injury or sickness (or their insurers).
18. Expense incurred for which no member of the covered person's immediate family has any legal obligation for payment.
19. Expense incurred for custodial care. Custodial care means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes room and board and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to: by whom they are prescribed, or by whom they are recommended, or by whom or by which they are performed.
20. Expense incurred for the removal of an organ from a covered person for the purpose of donating or selling the organ to any person or organization. This limitation does not apply to a donation by a covered person to a spouse, child, brother, sister, or parent.
21. Expenses incurred for or in connection with: procedures, services, or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if: a) There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature, to substantiate its safety and effectiveness, for the disease or injury involved, or b) If required by the FDA, approval has not been granted for marketing, or c) A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes, or d) The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility, or by another facility studying the same drug, device, procedure, or treatment, states that it is experimental, investigational, or for research purposes. However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease, if Aetna determines that: a) The disease can be expected to cause death within one year, in the absence of effective treatment, and b) The care or treatment is effective for that disease, or shows promise of being effective for that disease, as demonstrated by scientific data. In making this determination, Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved. Also, this exclusion will not apply with respect to drugs that: a) Have been granted treatment investigational new drug (IND), or b) Group c/treatment IND status, or c) Are being studied at

the Phase III level in a national clinical trial, sponsored by the National Cancer Institute, d) If Aetna determines that available, scientific evidence demonstrates that the drug is effective, or shows promise of being effective, for the disease.

22. Expenses incurred for breast reduction/mammoplasty.
23. Expenses incurred for gynecomastia (male breasts).
24. Expense incurred by a covered person, not a United States citizen, for services performed within the covered person's home country, if the covered person's home country has a socialized medicine program.
25. Expense incurred for acupuncture, unless services are rendered for anesthetic purposes.
26. Expense incurred for alternative, holistic medicine, and/or therapy, including but not limited to, yoga and hypnotherapy.
27. Expense for injuries sustained as the result of a motor vehicle accident, to the extent that benefits are payable under other valid and collectible insurance, whether or not claim is made for such benefits. The Policy will only pay for those losses, which are not payable under the automobile medical payment insurance Policy.
28. Expense incurred when the person or individual is acting beyond the scope of his/her/its legal authority.
29. Expenses incurred for hearing exams not performed in conjunction with a routine physical exam.
30. 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.
31. Expense for telephone consultations (except telemedicine services), charges for failure to keep a scheduled visit, or charges for completion of a claim form.
32. 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.
33. Expense for incidental surgeries, and standby charges of a physician.
34. Expense incurred for outpatient treatment in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion, or subluxation, in the human body, for purposes of removing nerve interference as a result of or related to: distortion, misalignment, or subluxation in the vertebral column, except as provided elsewhere in the Policy.
35. Expenses incurred for massage therapy.
36. Expense incurred for, or related to, sex change surgery.
37. Expense for charges that are not recognized charges, as determined by Aetna, except that this will not apply if the charge for a service, or supply, does not exceed the recognized charge for that service or supply, by more than the amount or percentage, specified as the Allowable Variation.
38. Expense for treatment of covered students who specialize in the mental health care field, and who receive treatment as a part of their training in that field.

39. Expense incurred for a treatment, service, or supply, which is not medically necessary, as determined by Aetna, for the diagnosis care or treatment of the sickness or injury involved. This applies even if they are prescribed, recommended, or approved, by the person's attending physician, or dentist. In order for a treatment, service, or supply, to be considered medically necessary, the service or supply must: a) be care, or treatment, which is likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the sickness or injury involved, and the person's overall health condition, b) be a diagnostic procedure which is indicated by the health status of the person, and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the sickness or injury involved, and the person's overall health condition, and c) as to diagnosis, care, and treatment, be no more costly (taking into account all health expenses incurred in connection with the treatment, service, or supply), than any alternative service or supply to meet the above tests. In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration: information relating to the affected person's health status, reports in peer reviewed medical literature, reports and guidelines published by nationally recognized health care organizations that include supporting scientific data, generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment, the opinion of health professionals in the generally recognized health specialty involved, and any other relevant information brought to Aetna's attention. In no event will the following services or supplies be considered to be medically necessary: a) those that do not require the technical skills of a medical, a mental health, or a dental professional, or b) those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, or any persons who is part of his or her family, any healthcare provider, or healthcare facility, or c) those furnished solely because the person is an inpatient on any day on which the person's sickness or injury could safely, and adequately, be diagnosed, or treated, while not confined, or those furnished solely because of the setting, if the service or supply could safely and adequately be furnished in a physician's or a dentist's office, or other less costly setting.

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