# Aetna Student Health

# Plan Design and Benefits Summary
# Virginia Tech

**Policy Year: 2015 - 2016**
**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 governing this insurance are contained in the Master Policy issued to Virginia Tech and may be viewed online at **www.aetnastudenthealth.com.** If any discrepancy exists between this Benefit Summary and the Policy, the Master Policy will govern and control the payment of benefits.

Please note that we have not yet received approval from the Virginia Bureau of Insurance for the 2015-2016 benefits described in this Plan Design and Benefits Summary. As part of the approval process, the Bureau may require us to make changes to the benefits. If that happens, we will provide you with an updated Plan Design & Benefits Summary.

## 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 Master Policy.

| Coverage Period | Coverage Start Date | Coverage End Date | Enrollment/Waiver Deadline |
|---|---|---|---|
| **Annual** | 08/01/2015 | 07/31/2016 | 09/15/2015 |
| **Spring /Summer** | 01/01/2016 | 07/31/2016 | 01/31/2016 |

## Rates

| Rates Undergraduates and Graduate Students | | |
|---|---|---|
| | Annual | Spring Semester |
| **Student** | **$2,330** | **$1,359** |
| **Spouse/Domestic Partner** | **$2,330** | **$1,359** |
| **Child** | **$2,330** | **$1,359** |
| **2+ Children** | **$4,660** | **$2,718** |

## 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 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.

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.

A person who is eligible for Medicare at the time of enrollment under this plan is not eligible for medical expense coverage and prescribed medicines expense coverage. If a covered person becomes eligible for Medicare after he or she is enrolled in this plan, such Medicare eligibility will not result in the termination of medical expense coverage and prescribed medicines expense coverage under this plan. As used within this provision, persons are "eligible for Medicare" if they are entitled to benefits under Part A (receiving free Part A) or enrolled in Part B or Premium Part A.

### 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, 2015, or the first day of enrollment at Virginia Tech, until July 31, 2016 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- 09/15/2015
2. Students enrolling for the Spring Semester- 01/31/2016

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 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 **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 certain services, such as inpatient stays, certain tests, procedures, outpatient surgery, therapies and equipment, and prescribed medications. Pre-certification simply means calling Aetna Student Health prior to treatment to get approval for coverage under your Plan for a medical procedure or service. For preferred care and designated care, the preferred care or designated care provider is responsible for obtaining pre-certification Since precertification is the preferred care or designated care provider's responsibility, there is no additional out-of-pocket cost to you as a result of a designated care provider's or a preferred care provider's failure to precertify services. **For non-preferred care, you are responsible for obtaining pre-certification which can be initiated by you, a member of your family, a hospital staff member or the attending physician.** The precertification process can be initiated by calling Aetna at the telephone number listed on your ID card.

- **If you do not secure pre-certification** for the below listed inpatient and outpatient covered medical services and supplies obtained from a **non-preferred provider** your covered medical expenses will 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 is needed:

- All inpatient maternity and newborn care, after the initial 48 hours for a vaginal delivery or 96 hours for a cesarean section;
- 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 (ie. 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 Care** freestanding ambulatory surgical facility services when referred by a **Preferred Care 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 Care Providers** for non-emergency services, unless the covered person understands and consents to the use of a **Non-Preferred Care Provider** under their under **Non-Preferred Care** benefits when available in their plan;
- Spinal Procedures;
- Transplant Services;
- Uvulopalatopharyngoplasty, including laser-assisted procedures; and
- Ventricular assist devices.

### 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 Master Policy/Certificate of Coverage. The Master Policy/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 listed above must be requested within **fifteen (15) day** before the outpatient services, treatments, procedures, visits or supplies are provided or scheduled.

### Pre-certification of prenatal care and delivery

Prenatal 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 "Precertification" provision in the Master Policy/Certificate of Coverage for a list of services under the Plan that require precertification. Please see the Certificate of Coverage/Schedule of Benefits for any penalty or benefit reduction that may apply to your coverage when precertification 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 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.

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

| **Policy Year Maximum** | **Unlimited** | |
|---|---|---|
| | **Preferred Care** | **Non-Preferred Care** |
| **DEDUCTIBLE**<br>Unless otherwise indicated, the Policy Year Deductible must be met prior to benefits being payable.<br>In compliance with Virginia State Mandate(s), the Policy Year Deductible is waived for Preferred Care Preventive Health Care Services<br>In addition to state and federal requirements for waiver of the Policy Year Deductible, this Plan will waive the Deductible for Prescribed Medicines Expense, 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.<br>Per visit or admission Deductibles do not apply towards satisfying the Policy Year Deductible. | **Individual:**<br>Students: **$400** per policy year<br>Spouse: **$400** per policy year<br>Child: **$400** per policy year<br>**Family:**<br>**$800** per policy year | **Individual:**<br>Students: **$1,000** per policy year<br>Spouse: **$1,000** per policy year<br>Child: **$1,000** per policy year<br>**Family:**<br>**$2,000** per policy year |
| **COINSURANCE** | Covered Medical Expenses are payable at the coinsurance percentage specified below, after any applicable Deductible. | |
| | **Preferred Care** | **Non-Preferred Care** |
| **OUT OF POCKET MAXIMUMS**<br>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.<br>The following expenses do not apply toward meeting the Out-of-Pocket Limit:<br>• expenses that are not covered medical expenses;<br>• penalties, and<br>• other expenses not covered by this Policy | Individual Out-of-Pocket:<br>**$5,000**<br>Family Out-of-Pocket:<br>**$10,000** | |

## 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%.** 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 Heath 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.

| Inpatient Hospitalization Benefits | Tier I<br>Preferred Care with Referral | Tier II<br>Preferred Care without Referral | Tier III<br>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** per admission Deductible, **65%** of the Recognized Charge for a semi-private room |
| **Intensive Care**<br>The covered room and board expense does not include any charge in excess of the daily room and board maximum. | 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** per admission Deductible, **65%** of the Recognized Charge |
| **Miscellaneous Hospital Expense**<br>Includes, but not limited to: operating room, laboratory tests/X rays, oxygen tent, and drugs, medicines, dressings. | **90%** of the Negotiated Charge | **80%** of the Negotiated Charge | **65%** of the Recognized Charge |

| Inpatient Hospitalization Benefits (continued) | Tier I Preferred Care with Referral | Tier II Preferred Care without Referral | Tier III Non-Preferred Care |
|---|---|---|---|
| **Licensed Nurse Expense**<br>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 |
| **Non-Surgical Physicians Expense**<br>Non-surgical services of the attending Physician, or a consulting Physician. | **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 **$25** Copay per visit, **100%** of the Negotiated Charge | After a **$25** Copay per visit, **100%** of the Negotiated Charge | **65%** of the Recognized Charge |
| **Emergency Room Expense**<br>**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. | After a **$250** Copay per visit (waived if admitted), **100%** of the Negotiated Charge | After a **$250** Copay per visit (waived if admitted), **100%** of the Negotiated Charge | After a **$250** per visit Deductible (waived if admitted), **100%** of the Actual Charge |

| Outpatient Expense (continued) | Tier I<br>Preferred Care with Referral | Tier II<br>Preferred Care without Referral | Tier III<br>Non-Preferred Care |
|---|---|---|---|
| **Urgent Care Expense** | After a **$25** Copay per visit, **100%** of the Negotiated Charge | After a **$25** Copay per visit, **100%** of the Negotiated Charge | After a **$25** per visit Deductible, **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**<br>Includes visits to specialists and telemedicine services. | After a **$25** Copay per visit, **100%** of the Negotiated Charge | After a **$25** Copay per visit, **100%** of the Negotiated Charge | **65%** of the Recognized Charge |
| **Consultant Expense** | **80%** of the Negotiated Charge | **80%** of the Negotiated Charge | **80%** of the Recognized Charge |
| **Second Surgical Opinion Expense** | After a **$25** 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**<br>Includes CT scans, MRIs, PET scans and Nuclear Cardiac Imaging Tests. | **90%** of the Negotiated Charge | **80%** of the Negotiated Charge | **65%** of the Recognized Charge |
| **Physical Therapy Expense** | **90%** of the Negotiated Charge | **80%** of the Negotiated Charge | **65%** of the Recognized Charge |
| **Therapy Expense**<br>Includes Physical, Speech and Occupational Therapy. | **90%** of the Negotiated Charge | **80%** of the Negotiated Charge | **65%** of the Recognized Charge |
| **Therapy Expense**<br>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.<br><br>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. | **90%** of the Negotiated Charge | **80%** of the Negotiated Charge | **65%** of the Recognized Charge |

| Outpatient Expense (continued) | Tier I<br>Preferred Care with Referral | Tier II<br>Preferred Care without Referral | Tier III<br>Non-Preferred Care |
|---|---|---|---|
| **Chiropractic Expense**<br>Benefits are limited to a maximum of **30** visits per Policy Year. | **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** | 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. | | |
| **Diagnostic Testing For Learning Disabilities Expense**<br>Covered Medical Expenses include charges incurred by a covered student for diagnostic testing for:<br>• attention deficit disorder; or<br>• attention deficit hyperactive disorder<br>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. | **80%** of the Negotiated Charge | **80%** of the Negotiated Charge | **80%** of the Recognized Charge |
| **Morbid Obesity 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. | | |
| **Dental Anesthesia and Hospitalization 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. | | |
| **Dental Expense for Impacted Wisdom Teeth** | **80%** of the Actual Charge | | |

| Preventive Care | Tier I<br>Preferred Care with Referral | Tier II<br>Preferred Care without Referral | Tier III<br>Non-Preferred Care |
|---|---|---|---|
| **Pap Smear Screening Expense** | **100%** of the Negotiated Charge* | **100%** of the Negotiated Charge* | **65%** of the Recognized Charge |
| **Mammogram Expense**<br>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. | **100%** of the Negotiated Charge* | **100%** of the Negotiated Charge* | **65%** of the Recognized Charge |
| **Immunizations Expense**<br>Includes travel immunizations and flu shots. | **100%** of the Negotiated Charge* | **100%** of the Negotiated Charge* | **100%** of the Recognized Charge* |
| **Routine Physical Exam Expense**<br>Includes routine tests and related lab fees. | **100%** of the Negotiated Charge* | **100%** of the Negotiated Charge* | **100%** of the Recognized Charge* |
| **Preventive Health Care Services Expense**<br><br>For covered dependent child under **7** years of age on an outpatient basis. | **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**<br>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. | **100%** of the Negotiated Charge* | **100%** of the Negotiated Charge* | **65%** of the Recognized Charge |

| Preventive Care (continued) | Tier I<br>Preferred Care with Referral | Tier II<br>Preferred Care without Referral | Tier III<br>Non-Preferred Care |
|---|---|---|---|
| **Routine Prostate Cancer Screening**<br>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. | **100%** of the Negotiated Charge* | **100%** of the Negotiated Charge* | **65%** of the Recognized Charge |
| **Vision Care Exam Expense**<br>Limited to **1** visit per Policy Year | **100%** of the Negotiated Charge | **100%** of the Negotiated Charge | **100%** of the Recognized Charge |
| **Vision Care Supply Expense**<br>Benefits are limited to a maximum of **$120** per Policy Year for adults. | After a **$15** Copay, **100%** of the Actual Charge | After a **$15** Copay, **100%** of the Actual Charge | After a **$15** Deductible, **100%** of the Actual Charge |
| **Pediatric Vision Care Services and Supplies**<br>Supplies are limited to **1** pair of glasses (lenses and frames) or contacts per Policy Year.<br>Covered Medical Expenses include routine vision exam (including refraction & Glaucoma Testing), non-cosmetic eyeglass frames, prescription lenses **or** prescription contact lenses (not both.)<br>Benefits are provided to covered persons through age **18**. | **100%** of the Negotiated Charge* | **100%** of the Negotiated Charge* | **65%** of the Recognized Charge* |
| **Pediatric Routine Dental Exam Expense**<br>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.**<br>Benefits are limited to **1** exam every **6** months.<br>Benefits are provided to covered persons through age **18**. | **100%** of the Negotiated Charge* | **100%** of the Negotiated Charge* | **65%** of the Recognized Charge |

| Preventive Care (continued) | Tier I Preferred Care with Referral | Tier II Preferred Care without Referral | Tier III Non-Preferred Care |
|---|---|---|---|
| **Pediatric Basic Dental Care Expense**<br>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**<br>Benefits are provided to covered persons through age **18**. | **70%** of the Negotiated Charge* | **70%** of the Negotiated Charge* | **50%** of the Recognized Charge |
| **Pediatric Major Dental Care Expense**<br>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** .<br>Benefits are provided to covered persons through age **18**. | **50%** of the Negotiated Charge* | **50%** of the Negotiated Charge* | **50%** of the Recognized Charge |
| **Pediatric Orthodontia Expense**<br>Medically necessary comprehensive treatment. Replacement of retainer (limit one per lifetime).<br><br>Benefits are provided to covered persons through age **18**. | **50%** of the Negotiated Charge* | **50%** of the Negotiated Charge* | **50%** of the Recognized Charge |
| **Routine Foot Care Expense**<br>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. | 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. | | |
| **Treatment of Mental and Nervous Disorders** | **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** per admission Deductible, **65%** of the Recognized Charge |
| **Outpatient Expense** | After a **$25** 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** per admission Deductible, **65%** of the Recognized Charge |
| **Outpatient Expense** | After a **$25** 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 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. | | |
| **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 |

| Family Planning Expense (continued) | Tier I Preferred Care with Referral | Tier II Preferred Care without Referral | Tier III Non-Preferred Care |
|---|---|---|---|
| **Contraceptives**<br><br>**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. | **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**<br>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).<br><br>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.**<br><br>**Prescribed Medicines Expense (continued)**<br>Includes drugs approved by the USFDA for use in the treatment of cancer, even if the drug has not specifically been approved for treatment of the specific cancer for which the drug has been prescribed. | **100%** of the Negotiated Charge, following a<br>**$20** Copay for each Generic Prescription Drug,<br>**$40** Copay for each Preferred Brand Name Prescription Drug,<br>**$60** Copay for each Non-Preferred Brand Name Prescription Drug,<br>**$200** Copay for each Preferred or Non-Preferred Specialty Prescription Drug. | **100%** of the Negotiated Charge, following a<br>**$20** Copay for each Generic Prescription Drug,<br>**$40** Copay for each Preferred Brand Name Prescription Drug,<br>**$60** Copay for each Non-Preferred Brand Name Prescription Drug,<br>**$200** Copay for each Preferred or Non-Preferred Specialty Prescription Drug. | **100%** of the Recognized Charge, following a<br>**$20** Copay for each Generic Prescription Drug,<br>**$40** Copay for each Preferred Brand Name Prescription Drug,<br>**$60** Copay for each Non-Preferred Brand Name Prescription Drug,<br>**$200** Copay for each Preferred or Non-Preferred Specialty Prescription Drug. |
| **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. | | |
| **Non-Prescription Enteral Formula Expense** | **90%** of the Negotiated Charge | **80%** of the Negotiated Charge | **65%** of the Recognized Charge |

| Additional Benefits (continued) | Tier I Preferred Care with Referral | Tier II Preferred Care without Referral | Tier III Non-Preferred Care |
|---|---|---|---|
| **Clinical Trials 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. | | |
| **Transfusion or Dialysis of Blood 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. | | |
| **Lymphedema 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. | | |
| **Home Treatment of Hemophelia 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. | | |
| **Cleft Lip/Palate or Ectodermal Dysplasia Expense for Newborns 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. | | |
| **Bones & Joints 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. | | |
| **Acupuncture In Lieu Of Anesthesia Expense** | **90%** of the Negotiated Charge | **80%** of the Negotiated Charge | **65%** of the Recognized Charge |
| **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. | | |
| **Dermatological 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**<br>Benefits are limited to **5** days every **90** days. | **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 |
| **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** per admission Deductible, **65%** of the Recognized Charge for the semi-private room rate |

| Additional Benefits (continued) | Tier I Preferred Care with Referral | Tier II Preferred Care without Referral | Tier III Non-Preferred Care |
|---|---|---|---|
| **Rehabilitation 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** per admission Deductible, **65%** of the Recognized Charge for the semi-private room rate |
| **Convalescent Facility Expense** | **90%** of the Negotiated Charge | **80%** of the Negotiated Charge | **65%** of the Recognized Charge |
| **Morbid Obesity Expense**<br>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 | 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**<br>For covered dependent child under the age of **3**. | 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. | | |
| **Reconstructive Surgery Following a Mastectomy 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. | | |
| **Inpatient Coverage Following a Mastectomy 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. | | |
| **Inpatient Coverage Following a Laparoscopy-Assisted Vaginal Hysterectomy & Vaginal Hysterectomy 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. | | |
| **Podiatric 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. | | |
| **Hypodermic Needles 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. | | |
| **Transplant Expense**<br>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. | | |

| Additional Benefits (continued) | Tier I<br>Preferred Care with Referral | Tier II<br>Preferred Care without Referral | Tier III<br>Non-Preferred Care |
|---|---|---|---|
| **Private Duty Nursing Expense**<br><br>Benefits are limited to a maximum 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**<br>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 lenses if the prescription change is related to the condition that required the original prescription. | **100%** of the Actual Charge | | |

***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 extend 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.

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 (ALIC) and administered by Chickering Claims Administrators, Inc. Aetna Student Health℠ is the brand name for products and services provided by these companies and their applicable affiliated companies.