

SUMMARY OF BENEFITS CHART

Student Aggregate Maximum: \$250,000 per condition, per lifetime.
Dependent Aggregate Maximum: \$100,000 per condition, per lifetime.

ANNUAL PLAN DEDUCTIBLES

Preferred Care: \$350 per Covered Person, per Policy Year.
Non-Preferred Care: \$1,050 per Covered Person, per Policy Year.
(Does not apply to care rendered at any of the IU Health Centers.)

OUT OF POCKET MAXIMUMS

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

<u>Preferred Care</u> Individual Out-of-Pocket:	\$1,000
<u>Preferred Care</u> Family Out-of-Pocket:	\$2,000
<u>Non-Preferred Care</u> Individual Out-of-Pocket:	\$5,000
<u>Non-Preferred Care</u> Family Out-of-Pocket:	\$10,000

All coverage is based on Reasonable Charges unless otherwise specified.

Inpatient Hospitalization Benefits	
Hospital Room and Board Expenses	Covered Medical Expenses are payable as follows: <u>Preferred Care:</u> After a \$200 per admission Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge for a semi-private room. Benefits are limited to \$1,200 Aggregate Maximum per day.
Intensive Care Unit Expenses	Covered Medical Expenses are payable as follows: <u>Preferred Care:</u> After a \$200 per Admission Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge for the Intensive Care Room Rate for an overnight stay. Benefits are limited to \$1,200 maximum per day.

Miscellaneous Hospital Expenses	<p>Covered Medical Expenses are payable as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge. Benefits are limited to \$1,200 maximum per day.</p> <p>Covered Medical Expenses include, but are not limited to: laboratory tests, X-rays, surgical dressings, anesthesia, supplies and equipment use, and medicines.</p>
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Surgical Benefits (Inpatient and Outpatient)	
Surgical Expenses	<p>Covered Medical Expenses for charges for surgical services, performed by a Physician, are payable as follows: <u>Preferred Care:</u> After a \$100 per inpatient surgical procedure Copay, or \$50 per outpatient surgical procedure Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge.</p>
Anesthetist Expenses	<p>Covered Medical Expenses for the charges of an anesthetist and an assistant surgeon, during a surgical procedure, are payable as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge.</p>
Assistant Surgeon Expenses	<p>Covered Medical Expenses are payable as follows: <u>Preferred Care:</u> 50% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge.</p>
Outpatient Hospital Services for Surgery Expenses	<p>Covered Medical Expenses are payable as follows: <u>Preferred Care:</u> After a \$15 per visit Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge.</p>
Ambulatory Surgical Expenses	<p>Covered Medical Expenses for outpatient surgery performed in an ambulatory surgical center are payable as follows: <u>Preferred Care:</u> After a \$50 per surgical procedure Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge.</p> <p>Covered Medical Expenses must be incurred on the day of the surgery or within 48 hours after the surgery.</p>

Outpatient Benefits	
<p>Covered Medical Expenses include but are not limited to: Physician's office visits, hospital or outpatient department or emergency room visits, durable medical equipment, clinical lab, or radiological facility.</p>	
Hospital Outpatient Department Walk-in Clinic Visit Expenses	<p>Covered Medical Expenses for outpatient treatment in a hospital are payable as follows: <u>Preferred Care:</u> After a \$15 per visit Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge.</p>

Emergency Room Expenses	<p>Covered Medical Expenses incurred for treatment of an Emergency Medical Condition are payable as follows:</p> <p><u>Preferred Care</u>: After a \$50 per visit Copay (waived if admitted), 100% of the Negotiated Charge.</p> <p><u>Non-Preferred Care</u>: After a \$50 per visit Deductible (waived if admitted), 100% of the Reasonable Charge.</p>
Urgent Care Expenses	<p><i>Benefits include charges for treatment by an urgent care provider.</i></p> <p>Please Note: A Covered Person <u>should not seek medical care or treatment from an urgent care provider if their illness, injury, or condition, is an emergency condition.</u> The Covered Person should go directly to the emergency room of a hospital or call 911 (or the local equivalent) for ambulance and medical assistance.</p> <p><u>Urgent Care</u> Benefits include charges for an urgent care provider to evaluate and treat an urgent condition.</p> <p>Covered Medical Expenses for urgent care treatment are payable as follows:</p> <p><u>Preferred Care</u>: After a \$15 per visit Copay, 100% of the Negotiated Charge.</p> <p><u>Non-Preferred Care</u>: 50% of the Reasonable Charge.</p> <p>When travel to a Preferred Care Provider for treatment of an urgent condition is not feasible, a Covered Person may call Aetna to request authorization to see a Non-Preferred urgent care provider so that such treatment may be paid at the Preferred level of benefits. If it is not feasible to request authorization prior to treatment, then it should be done as soon as possible after treatment but not later than:</p> <ul style="list-style-type: none"> • the next day during normal business hours, or • if the Covered Person is confined in a hospital directly after receiving urgent care, not later than 48 hours following the start of the confinement unless it is not possible for the Covered Person to request authorization within that time. In that case, it must be done as soon as reasonably possible. <p>However:</p> <ul style="list-style-type: none"> • if the treatment is received, or • the confinement occurs, <p>on a Friday or Saturday, authorization must be requested within 72 hours following treatment or the start of the confinement.</p> <p>If the Covered Person does not request authorization from Aetna to see a Non-Preferred urgent care provider, charges incurred for urgent care will be paid at the Non-Preferred covered percentage after the Non-Preferred Deductible.</p> <p>The Covered Person should contact their primary care physician after medical care is provided to treat an urgent condition.</p>
Ambulance Expenses	<p>Covered Medical Expenses are payable as follows:</p> <p>100% of the Actual Charge for the services of a professional ambulance to or from a hospital, when required due to the emergency nature of a covered accident or sickness.</p> <p>Benefits are limited to a maximum of \$1,500 per trip for ground transportation, and \$1,500 per trip for transportation by air.</p>

Pre-Admission Testing Expenses	<p>Covered Medical Expenses for Pre-Admission testing charges while an outpatient before scheduled surgery are payable as any other expense.</p> <p><i>Please see the Definition of Pre-Admission Testing on page 42 for more detailed information on this benefit.</i></p>
Physician's Office Visits	<p>Covered Medical Expenses are payable as follows: <u>Preferred Care:</u> After a \$15 per visit Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge.</p>
Laboratory Expenses	<p>Covered Medical Expenses are payable as follows: <u>Preferred Care:</u> After a \$10 per visit Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge.</p>
X-ray Expenses	<p>Covered Medical Expenses are payable as follows: <u>Preferred Care:</u> After a \$20 per visit Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge.</p>
High Cost Procedures Expenses	<p>Covered Medical Expenses include charges incurred by a Covered Person are payable as follows: <u>Preferred Care:</u> After a \$20 per visit Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge.</p> <p>For purposes of this benefit, "High Cost Procedure" means any outpatient procedure costing over \$200.</p> <p><i>Please see the Definition of High Cost Procedures on page 38 for more detailed information on this benefit.</i></p>
Chemotherapy Expenses	<p>Covered Medical Expenses for chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy, radiation therapy, tests and procedures, physiotherapy (for rehabilitation only after a surgery), and expenses incurred at a radiological facility.</p> <p>Covered Medical Expenses also include expenses for the administration of chemotherapy and visits by a health care professional to administer the chemotherapy. Such expenses are payable as follows: <u>Preferred Care:</u> After a \$15 per visit Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge.</p>
Durable Medical Equipment Expenses	<p>Covered Medical Expenses are payable as follows: <u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred Care:</u> 80% of the Reasonable Charge.</p>
Prosthetic Devices Expenses	<p>Benefits include charges for: artificial limbs, or eyes, and other non-dental prosthetic devices, as a result of an accident or sickness.</p> <p>Covered Medical Expenses do not include: eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet.</p> <p>Covered Medical Expenses are payable as follows: <u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred Care:</u> 80% of the Reasonable Charge.</p>

<p>Outpatient Physical Therapy Expenses</p>	<p>Covered Medical Expenses for physical therapy are payable as follows when provided by a licensed physical therapist and only when physical therapy begins within six months of the onset of symptoms: <u>Preferred Care:</u> After a \$10 per visit Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge.</p>
<p>Therapy Expenses</p>	<p>Covered Medical Expenses include charges incurred by a Covered Person for the following types of therapy provided on an outpatient basis:</p> <ul style="list-style-type: none"> • Chiropractic Care; • Speech Therapy; • Inhalation Therapy; or • Occupational Therapy. <p>Expenses for Chiropractic Care are Covered Medical Expenses, if such care is related to neuromusculoskeletal conditions and conditions arising from: the lack of normal nerve, muscle, and/or joint function.</p> <p>Expenses for Speech and Occupational Therapies are Covered Medical Expenses, only if such therapies are a result of injury or sickness.</p> <p>Covered Medical Expenses also include charges incurred by a Covered Person for the following types of therapy provided on an outpatient basis:</p> <ul style="list-style-type: none"> • Radiation therapy; • Chemotherapy; including anti-nausea drugs used in conjunction with the chemotherapy; • Dialysis; and • Respiratory therapy. <p>Covered Medical Expenses are payable as follows: <u>Preferred Care:</u> After a \$15 per visit Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge.</p>
<p>Dental Injury Expenses</p>	<p>Covered Medical Expenses are payable at 100% of the Actual Charge for the treatment of an Injury to sound, natural teeth.</p>
<p>Allergy Testing and Treatment Expenses</p>	<p>Benefits include charges incurred for diagnostic testing and treatment of allergies and immunology services.</p> <p>Covered Medical Expenses include, but are not limited to, charges for the following:</p> <ul style="list-style-type: none"> • laboratory tests, • physician office visits, including visits to administer injections, • prescribed medications for testing and treatment of the allergy, including any equipment used in the administration of prescribed medication, and • other medically necessary supplies and services. <p>Covered Medical Expenses are payable on the same basis as any other expense.</p>

<p>Diagnostic Testing for Attention Disorders and Learning Disabilities Expenses</p>	<p>Covered Medical Expenses for diagnostic testing for:</p> <ul style="list-style-type: none"> • Attention Deficit Disorder, or • Attention Deficit Hyperactive Disorder, or • Dyslexia. <p>are payable as follows: <u>Preferred Care:</u> After a \$10 per visit Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge.</p> <p>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 Policy.</p> <p>Benefits are limited to diagnostic testing covered only; treatment is not a covered benefit.</p>
<p>Routine Physical Exam Expenses</p>	<p>Benefits include expenses for a routine physical exam performed by a physician. If charges for a routine physical exam given to a child who is a covered dependent are covered under any other benefit section, those charges will not be covered under this section.</p> <p>A routine physical exam is a medical exam given by a physician, for a reason other than to diagnose or treat a suspected or identified injury or sickness. Included as a part of the exam are:</p> <ul style="list-style-type: none"> • X-rays, lab, and other tests given in connection with the exam, and • Materials for the administration of immunizations for infectious disease and testing for Tuberculosis. <p><u>Preferred Care:</u> After a \$15 per visit Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge.</p> <p>For all exams given to a covered student or a spouse who is a covered dependent, Covered Medical Expenses will <u>not include</u> charges for more than:</p> <ul style="list-style-type: none"> • One exam in 24 months in a row, if the person is under age 65, and • One exam in twelve months in a row, if the person is age 65 or over. <p>Also included as Covered Medical Expenses are charges made by a physician for one annual routine gynecological exam.</p> <p>Benefits are limited to the \$300 per Policy Year routine care maximum.</p>
<p>Well Baby Care Expenses</p>	<p>Benefits include charges for routine preventive and primary care services, rendered to a covered dependent child on an outpatient basis.</p> <p>Routine preventive and primary care services are services rendered to a covered dependent child, from the date of birth through the attainment of two years of age. Services include: initial hospital check-ups, other hospital visits, physical examinations, including routine hearing and vision examinations, medical history, developmental assessments, and materials for the administration of appropriate and necessary immunizations and laboratory tests, when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics.</p> <p>Newborn examination coverage will include for the detection of the following disorders: Phenylketonuria, Hypothyroidism, Hemoglobinopathies, including sickle cell anemia, Galactosemia, Maple Syrup urine disease, Homocystinuria, Inborn errors of metabolism that result in mental retardation and that are designated by the state department, congenital adrenal hyperplasia, biotinidase deficiency, Disorders detected by tandem mass spectrometry or other technologies with the same or greater detection capabilities as tandem mass spectrometry, if the</p>

	<p>state department determines that the technology is available for use by a designated laboratory.</p> <p>Newborn testing will also include testing for Human Immunodeficiency Virus (HIV) or antibody or antigen to HIV. Newborn coverage will also include a physiologic hearing screening examination at the earliest feasible time for the detection of hearing impairments.</p> <p>Covered Medical Expenses are payable as follows: <u>Preferred Care:</u> After a \$15 per visit Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge.</p> <p>Benefits are limited to the \$300 per Policy Year routine care maximum.</p> <p>Benefits are payable for scheduled visits in accordance with the prevailing clinical standards of the American Academy of Pediatrics.</p>
<p>Immunizations Expenses</p>	<p>Covered Medical Expenses include:</p> <ul style="list-style-type: none"> • charges incurred by a covered student and dependent spouse for the materials for the administration of appropriate and medically necessary immunizations, and testing for Tuberculosis, and • charges incurred by a covered dependent up to age 26, for the materials for the administration of appropriate and medically necessary immunizations, when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics. <p><u>Preferred Care:</u> After a \$15 per visit Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge.</p> <p>Benefits can be subject to the \$300 per Policy Year Routine Care Maximum.</p> <p>Covered Medical Expenses do not include a physician's office visit in connection with immunization or testing for Tuberculosis.</p>
<p>Consultant or Specialist Expenses</p>	<p>Covered Medical Expenses include the expenses for the services of a consultant or specialist, when referred by the School Health Services. The services must be requested by the attending physician for the purpose of confirming or determining to confirm or determine a diagnosis.</p> <p>Covered Medical Expenses are covered as follows: <u>Preferred Care:</u> After a \$15 per visit Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge.</p>

Mental Health Benefits	
<p>Mental and Emotional Disorders Inpatient Expenses</p>	<p>Covered Medical Expenses for the treatment of a mental health condition while confined as a inpatient in a hospital or facility licensed for such treatment are payable as follows: <u>Preferred Care:</u> After a \$200 per admission Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge subject to a maximum of \$1,200 per day, for any one or related mental health condition.</p> <p>Covered Medical Expenses also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission, whereby two days of partial hospitalization may be exchanged for one day of full hospitalization.</p>

Mental and Emotional Disorders Outpatient Expenses	<p>Covered Medical Expenses for outpatient treatment of a mental health condition are payable as follows: <u>Preferred Care:</u> After a \$15 Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge.</p> <p>Charges for marriage and family therapies are not Covered Medical Expenses.</p>
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Substance Abuse Benefits	
Inpatient Expenses	<p>Covered Medical Expenses for the treatment of a substance abuse condition while confined as a inpatient in a hospital or facility licensed for such treatment are payable on the same basis as any other sickness.</p> <p><u>Preferred Care:</u> After a \$200 per admission Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge, benefits are limited to \$1,200 per day.</p>
Outpatient Expenses	<p>Covered Medical Expenses for outpatient treatment of a substance abuse condition are payable as follows: <u>Preferred Care:</u> After a \$15 per visit Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge.</p>

Maternity Benefits	
Maternity Expenses	<p>Covered Medical Expenses include inpatient care of the Covered Person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery.</p> <p>If a person is discharged earlier, benefits will be payable for one at-home post-delivery care visit by a health care provider. The at-home post-delivery care visit shall be conducted not later than 48 hours following the discharge of the woman and her newborn child from a licensed hospital. However, at the mother's discretion, the visit may occur at the facility of the provider subject to the terms of the policy or group contract.</p> <p>As used in this benefit, “at-home post-delivery care” refers to health care provided to a woman at her residence by a physician, registered nurse, or advance practice nurse, whose scope of practice includes providing postpartum care in the area of maternal and child health care. The health care services provided must include, at a minimum:</p> <ul style="list-style-type: none"> • parent education; • assistance and training in breast or bottle feeding; and • performance of any maternal and neonatal test routinely performed during the usual course of inpatient care for the woman or her newborn child, including the collections of an adequate sample for the hereditary and metabolic newborn screening. <p>Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other sickness.</p>
Well Newborn Nursery Care Expenses	<p>Benefits include charges for routine care of a Covered Person’s newborn child as follows:</p> <ul style="list-style-type: none"> • hospital charges for routine nursery care during the mother’s confinement, but for not more than four days for a normal delivery, • physician’s charges for circumcision, and • physician’s charges for visits to the newborn child in the hospital and consultations, but for not more than one visit per day.

	<p>Covered Medical Expenses are payable as follows: <u>Preferred Care</u>: 100% of the Negotiated Charge. <u>Non-Preferred Care</u>: 50% of the Reasonable Charge, subject to a \$1,200 maximum per day.</p>
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Additional Benefits	
<p>Prescription Drug Benefit Expenses</p> <p><i>(Prescriptions filled at the Indiana University Health Center are covered at 100% with a \$10 Copay; contraceptives are covered at the IU Health Center.)</i></p>	<p>Prescription Drug Benefits are payable as follows: <u>Indiana University Health Center</u>: 100% after a \$10 Copay. Please Note: Contraceptives are only covered at the Health Centers.</p> <p><u>Preferred Care Pharmacy</u>: After a \$10 Copay, per Generic or \$20 Copay, per Brand Prescription Drug, 100% of the Negotiated Charge.</p> <p>Covered prescription expenses are payable up to a maximum of \$5,000 per Policy Year.</p> <p>This Pharmacy benefit is provided to cover medically necessary prescriptions associated with a covered sickness or accident occurring during the Policy Year. Please use your Aetna Student Health ID card when obtaining your prescriptions.</p> <p>Prior Authorization is required for certain Prescription Drugs, including Imitrex, certain stimulants, growth hormones and for any Prescription quantities larger than a 30-day supply. <i>(This is only a partial list.)</i></p> <p>Medications not covered by this benefit include, but are not limited to: allergy sera (see Allergy Testing and Treatment coverage), inhalers, all acne medications, drugs whose sole purpose is to promote or to stimulate hair growth, appetite suppressants, smoking deterrents, immunization agents and vaccines, and non-self injectables. <i>(This is only a partial list.)</i></p> <p>For assistance or for a complete list of excluded medications, or drugs requiring prior authorization, please contact Aetna Pharmacy Management at (800) 238-6279 (available 24 hours).</p> <p>Aetna Specialty Pharmacy provides specialty medications and support to members living with chronic conditions. The medications offered may be injected, infused or taken by mouth. For additional information please go to www.AetnaSpecialtyRx.com.</p> <p>Aetna_{Rx} Home Delivery[®] is the prescription mail service for Aetna pharmacy benefit members. You can order your maintenance medications through Aetna_{Rx} Home Delivery. Maintenance medications treat chronic conditions such as arthritis, asthma, diabetes, high cholesterol, heart conditions, hypertension and others.</p> <p>Aetna_{Rx} Home Delivery offers you:</p> <ul style="list-style-type: none"> • Savings - You can save money by using Aetna Rx Home Delivery, and standard shipping is always free. • Privacy - Confidential shipping of your prescriptions right to your home, workplace or any other location you choose. • Convenience - Reorder only once every three months. • Peace of mind - Registered pharmacists check orders for accuracy and are available 24 hours a day, seven days a week in case of emergency. <p>Please see the order form on your Student Connection website for more information and to enroll.</p>

<p>Diabetic Treatment, Supplies and Outpatient Self-Management Expenses</p>	<p>Covered Medical Expenses includes expenses incurred for the diagnosis and treatment of diabetes, including those for drugs and diabetic supplies, equipment and an outpatient diabetic self-management education program prescribed as part of a treatment plan. Benefits are payable on the same basis as any other sickness.</p> <p>Charges for a diabetic self-management education program are covered but only if:</p> <ul style="list-style-type: none"> • the training is medically necessary, ordered in writing by physician or podiatrist, and provided by a health care professional who is licensed, registered, or certified, and has specialized training in the management of diabetes; • the Covered Person is a diabetic who is covered under this Policy and is not confined in a hospital or skilled nursing facility as a full-time inpatient; or • the person is covered under this Policy and cares for or helps care for a diabetic who is covered under this Policy and is not confined in a hospital or skilled nursing facility as a full-time inpatient. <p>Covered Medical Expenses include:</p> <ul style="list-style-type: none"> • One visit after receiving a diagnosis that represents a significant change in the insured’s symptoms or condition. • One visit for re-education or refresher training. <p>Not covered are:</p> <ul style="list-style-type: none"> • Program expenses incurred for a diabetic education program whose only purpose is weight control. • Program expenses incurred for a diabetic education program that is available to the public at no cost. <p><i>Please see the definition on page 36 of this Brochure for more information on Diabetic Self-Management Education Courses.</i></p> <p><u>Preferred Care</u>: After a \$10 per visit Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care</u>: 50% of the Reasonable Charge.</p>
<p>Hypodermic Needles Expenses</p>	<p>Covered Medical Expenses for hypodermic needles and syringes used in the treatment of diabetes are payable on the same basis as any other sickness:</p> <p><u>Preferred Care</u>: After a \$10 Copay for Generic, or \$20 Copay for Brand Name Prescriptions, 100% of the Negotiated Charge. <u>Non-Preferred Care</u>: Not covered.</p> <p>Benefits are subject to the \$5,000 per Policy Year prescription benefit maximum.</p>
<p>Non-Prescription Enteral Formula Expenses</p>	<p>Benefits include charges incurred by a Covered Person for non-prescription enteral formulas, for which a physician has issued a written order, and are for the treatment of malabsorption caused by:</p> <ul style="list-style-type: none"> • Crohn’s Disease, • ulcerative colitis, • gastroesophageal reflux, • gastrointestinal motility, • chronic intestinal pseudoobstruction, and • inherited diseases of amino acids and organic acids. <p>Covered Medical Expenses for inherited diseases of amino acids and organic acids, will also include food products modified to be low protein.</p>

	<p>Covered Medical Expenses are payable as follows: <u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred Care:</u> 80% of the Reasonable Charge.</p> <p>Covered Medical Expenses are covered up to a maximum of \$10,000 per lifetime.</p>
Pap Smear Expenses	<p>Covered Medical Expenses include one annual routine Pap smear screening for women age 18 and older.</p> <p>Benefits are payable as follows: <u>Preferred Care:</u> After a \$10 per visit Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge.</p>
Mammography Expenses	<p>Covered Medical Expenses include one baseline mammogram for women between age 35 and 40. Coverage is also provided for one routine annual mammogram for women age 40 and older, as well as when medically indicated for women with risk factors who are under age 40. Risk factors for women under 40 are:</p> <ul style="list-style-type: none"> • A woman who has a personal history of breast cancer. • A woman who has a personal history of breast disease that was proven benign by biopsy. • A woman whose mother, sister, or daughter has had breast cancer. • A woman who is at least 30 years of age and has not given birth. <p>Mammogram screenings coverage must also include comprehensive ultrasound screening for the entire breast or breasts if a mammogram demonstrates heterogenous or dense breast tissue and when determined to be medically necessary by a licensed physician.</p> <p>Benefits are payable as follows: <u>Preferred Care:</u> After a \$20 per visit Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge.</p>
Mastectomy and Breast Reconstruction Expense Benefits	<p>Coverage will be provided to a Covered Person who is receiving benefits for a necessary mastectomy and who elects breast reconstruction after the mastectomy for:</p> <ul style="list-style-type: none"> • reconstruction of the breast on which a mastectomy has been performed, • surgery and reconstruction of the other breast to produce a symmetrical appearance, • prostheses, • treatment of physical complications of all stages of mastectomy, including lymphedemas, and • reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction. This is subject to the approval of the attending physician. <p>Covered Medical Expenses are payable on the same basis as any other expense.</p> <p>This coverage will be provided in consultation with the attending physician and the patient. It will be subject to the same annual Deductibles and coinsurance provisions that apply to the mastectomy.</p>
Chlamydia Screening Test Expenses	<p>Benefits include charges incurred for an annual Chlamydia screening test.</p> <p>Benefits will be paid for Chlamydia screening expenses incurred for:</p> <ul style="list-style-type: none"> • Women who are: <ul style="list-style-type: none"> • under the age of 20 if they are sexually active, and • at least 20 years old if they have multiple risk factors. • Men who have multiple risk factors.

	<p>Covered Medical Expenses are payable as follows: <u>Preferred Care</u>: After a \$15 per screening Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care</u>: 50% of the Reasonable Charge.</p> <p><i>Please see definition on page 34 for more information on this benefit.</i></p> <p>Benefits are limited to the \$300 per Policy Year routine care benefit maximum.</p>
Routine Screening for Sexually Transmitted Disease Expenses	<p>Covered Medical Expenses include charges for Covered Persons who are at least 18 years old and who are sexually active for annual routine screening for sexually transmitted diseases.</p> <p>Benefits are payable as follows: <u>Preferred Care</u>: After a \$10 per screening Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care</u>: 50% of the Reasonable Charge.</p> <p><i>Please see definition on page 45 for more information on this benefit.</i></p> <p>Benefits are limited to the \$300 per Policy Year routine care benefit maximum.</p>
Elective Surgical Second Opinion Expenses	<p>Covered Medical Expenses will include a second opinion consultation by a specialist on the need for non-emergency elective surgery which has been recommended by the Covered Person's physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation.</p> <p>Benefits are payable as follows: <u>Preferred Care</u>: After a \$10 per visit Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care</u>: 50% of the Reasonable Charge.</p>
Acupuncture in Lieu of Anesthesia Expenses	<p>Covered Medical Expenses include acupuncture therapy, when acupuncture is used in lieu of other anesthesia, for a surgical or dental procedure covered under this Plan.</p> <p>The acupuncture must be administered by a health care provider who is a legally qualified physician, practicing within the scope of their license.</p> <p><u>Preferred Care</u>: 100% of the Negotiated Charge. <u>Non-Preferred Care</u>: 50% of the Reasonable Charge.</p>
Dermatological Expenses	<p>Covered Medical Expenses include charges for the diagnosis and treatment of skin disorders, excluding laboratory fees. Related laboratory expenses are covered under the Outpatient Expense Benefit.</p> <p>Benefits are payable as follows: <u>Preferred Care</u>: After a \$15 per visit Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care</u>: 50% of the Reasonable Charge.</p> <p><i>Covered Medical Expenses do not include treatment for acne, or cosmetic treatment and procedures.</i></p>

Home Health Care Expenses	<p>Covered Medical Expenses include charges incurred by a Covered Person for home health care services made by a home health agency pursuant to a home health care plan, but only if:</p> <ul style="list-style-type: none"> (a) The services are furnished by, or under arrangements made by, a licensed home health agency, (b) The services are given under a home care plan. This plan must be established pursuant to the written order of a physician, and the physician must renew that plan every 60 days. Such physician must certify that the proper treatment of the condition would require inpatient confinement in a hospital or skilled nursing facility if the services and supplies were not provided under the home health care plan. The physician must examine the Covered Person at least once a month, (c) Except as specifically provided in the home health care services, the services are delivered in the patient's place of residence on a part-time, intermittent visiting basis while the patient is confined, (d) The care starts within seven days after discharge from a hospital as an inpatient, and (e) The care is for the same condition that caused the hospital confinement, or one related to it. <p><u>Preferred Care:</u> 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge.</p> <p>Benefits are limited to 40 visits per Policy Year.</p>
Transfusion or Dialysis of Blood Expenses	<p>Covered Medical Expenses include charges for the transfusion or dialysis of blood, including the cost of: whole blood, blood components, and the administration thereof.</p> <p>Benefits are payable as follows: <u>Preferred Care:</u> After a \$10 per visit Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge.</p>
Hospice Benefit Expenses	<p>Covered Medical Expenses include charges for hospice care provided for a terminally ill Covered Person during a hospice benefit period.</p> <p>Benefits are payable as follows: <u>Preferred Care:</u> After a \$15 per visit Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge.</p> <p><i>Please see definition on page 38 for more information on Hospice Care Expenses.</i></p> <p><i>Benefits for Hospice expenses require pre-certification.</i></p>
Licensed Nurse Expenses	<p>Benefits include charges incurred by a Covered Person who is confined in a hospital as a resident bed-patient, and requires the services of a registered nurse or licensed practical nurse.</p> <p>Covered Expenses for a Licensed Nurse are covered as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge.</p>
Skilled Nursing Facility Expenses	<p>Covered Medical Expenses include charges incurred by a Covered Person for confinement in a skilled nursing facility for treatment rendered:</p> <ul style="list-style-type: none"> • in lieu of confinement in a hospital as a full time inpatient, or • within 24 hours following a hospital confinement and for the same or related cause(s) as such hospital confinement.

	<p>Covered Medical Expenses are payable as follows: <u>Preferred Care:</u> After a \$200 per confinement Copay, 100% of the Negotiated Charge for the semi-private room rate. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge for the semi-private room rate. Benefits are limited to \$1,200 per Policy Year.</p> <p><i>Benefits for Skilled Nursing require pre-certification.</i></p>
<p>Rehabilitation Facility Expenses</p>	<p>Covered Medical Expenses include charges incurred by a Covered Person for confinement as a full time inpatient in a rehabilitation facility. Confinement in the rehabilitation facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of hospital or skilled nursing facility confinement.</p> <p>Covered Medical Expenses for Rehabilitation Facility Expense are covered as follows: <u>Preferred Care:</u> After a \$200 per confinement Copay, 100% of the Negotiated Charge for the rehabilitation facility’s daily room and board maximum for semi-private accommodations. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge for the rehabilitation facility’s daily room and board maximum for semi-private accommodations. Benefits are limited to \$1,200 per Policy Year.</p> <p><i>Benefits for Rehabilitation Facility expenses require pre-certification.</i></p>