

**WILLIAM MARSH RICE UNIVERSITY  
MEDICAL PLAN**

**APPENDIX C**

**RiceCare PPO  
Summary of Coverage**

**EFFECTIVE: JULY 1, 2003**

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## Introduction

Benefits under the William Marsh Rice University Medical Plan are provided under one or more Coverage Options. This Summary of Coverage for the RiceCare PPO Coverage Option (the "Plan" for purposes of this Appendix C) shall govern the types and amounts of benefits offered under the Plan, including, but not limited to, any conditions, limitations, exclusions, or coordination of benefits regarding coverage and benefits, effective as of July 1, 2003. This Summary of Coverage replaces any Summary of Coverage previously in effect for the Plan.

The University shall have the right at any time to add, amend, or terminate for any or no reason the Plan without written notice to Participants or Employees.

Benefits provided under the Plan are not insured with Aetna Life Insurance Company ("Aetna") but will be paid from the general assets of the University. Aetna is the Claims Administrator for the Plan and provides certain administrative services under the Plan as outlined in the Administrative Services Agreement between Aetna and the University as referenced below:

ASA:                   878783  
Booklet Base:       1  
Effective Date:     July 1, 2003

## **Summary of Coverage**

The maximums described in this Summary of Coverage apply to each Plan Year and the benefits described in this Summary of Coverage apply separately to each covered person for each Plan Year.

### **Benefits Summary**

For each Plan Year, a “*Benefits Summary*” or schedule(s) designated as such by the University shall be attached hereto and made a part of the Plan. The University may amend the *Benefits Summary* at any time and for any or no reason during the Plan Year and may effect such changes by the publication and distribution of separate written materials designed to communicate the changes.

### **Plan Year Deductibles**

The Plan Year Deductibles shall be set forth in the *Benefits Summary*.

#### ***Individual Deductible Limit***

When Covered Medical Expenses applied against a person's Plan Year Deductible in any Plan Year equal the Plan Deductible applicable to preferred care, the Plan Year Deductible will not apply to preferred care or other health care during the rest of that Plan Year. Covered Medical Expenses incurred during the rest of that Plan Year for preferred care and other health care will not be applied against the person's Plan Year Deductible.

#### ***Family Deductible Limit***

If Covered Medical Expenses incurred in a Plan Year by you and your dependents and applied against the separate family Plan Year Deductibles equal the Plan Deductible applicable to preferred care, the Plan Year Deductible will not apply to expenses incurred for preferred and other health care during the rest of that Plan Year for you and your dependents.

#### ***Application of Plan Year Deductibles***

The Plan Year Deductible applies to all expenses except:

The following expenses incurred for Preferred Care:

- Fees of a physician for non-surgical office visits.
- Routine Physical Exam Expenses
- Covered Medical Expenses incurred for a routine mammogram, a Pap smear, and prostate cancer screening

The following expenses incurred for Preferred or Non-Preferred Care:

- Covered Medical Expenses for Emergency use of the Emergency Room

## **Coinsurance Limits**

The Coinsurance Limits shall be set forth in the *Benefits Summary*.

These limits apply only to Covered Medical Expenses which are payable at a rate greater than 50% and not applied against any deductible or copay amount.

### ***Payment Limit which Applies to Expenses for a Person***

When a person's Covered Medical Expenses for which no benefits are paid because of the Payment Percentage reach the preferred Coinsurance Limit set for the Plan Year (refer to limit set forth for preferred care benefits in the *Benefits Summary*), benefits will be payable at 100% for all of his or her Covered Medical Expenses to which this limit applies and which are incurred in the rest of that Plan Year, except those for Non-Preferred Care. When the amount reaches the non-preferred Coinsurance Limit set for the Plan Year (refer to limit set forth for preferred care benefits in the *Benefits Summary*), then benefits will be payable at 100% for all of his or her Covered Medical Expenses to which this limit applies and which are incurred in the rest of that Plan Year, including those for Non-Preferred Care.

### ***Payment Limit which Applies to Expenses for a Family***

When a family's Covered Medical Expenses for which no benefits are paid because of the Payment Percentage reach the preferred Coinsurance Limit set for the Plan Year (refer to limit set forth for preferred care benefits in the *Benefits Summary*), benefits will be payable at 100% for all of their Covered Medical Expenses to which this limit applies and which are incurred in the rest of that Plan Year, except those for Non-Preferred Care. When the amount reaches the non-preferred Coinsurance Limit set for the Plan Year (refer to limit set forth for preferred care benefits in the *Benefits Summary*), then benefits will be payable at 100% for all of their Covered Medical Expenses to which this limit applies and which are incurred in the rest of that Plan Year, including those for Non-Preferred Care.

## **Lifetime Maximum**

There is no lifetime maximum benefit (overall limit) that applies to Covered Medical Expenses described in this Plan. The only maximum benefit limits are those specifically mentioned in this Plan.

## **Payment Percentage**

The Payment Percentage applies after any deductible amounts. After any applicable deductible, Covered Medical Expenses payable under this Plan for a Plan Year are paid at the Payment

Percentage which applies to the type of Covered Medical Expense which is incurred, except for any different benefit level which may be provided later in this Plan. Benefits may vary depending upon whether a Preferred Care Provider is utilized. A Preferred Care Provider is a health care provider who has agreed to provide services or supplies at a "negotiated charge."

Refer to payment percentages applicable for "*Preferred Care and Non-Preferred Care benefits*" in *Benefits Summary*.

## **Benefit Maximums**

All maximums included in this Plan are combined maximums between Preferred Care and Non-Preferred Care, where applicable, unless specifically stated otherwise.

*Convalescent Days* Refer to *Benefits Summary*

*Home Health Care  
Maximum Visits* Refer to *Benefits Summary*

*Private Duty Nursing Care  
Maximum Shifts* Refer to *Benefits Summary*

*National Medical Excellence  
Lodging Expenses Maximum* \$ 50.00  
*Travel and Lodging Maximum* \$ 10,000

*Private Room Limit* The institution's semiprivate rate.

## **Certification Requirement**

Certain types of care must be certified as necessary to avoid a reduction in the benefits payable. Read the Comprehensive Medical Expense Coverage Section under the Health Expense Coverage Section of this Plan for details of the types of care affected, how to get certification and the effect on your benefits of failure to obtain certification.

Certification is required for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Skilled Nursing Care.

If certification has not been requested and the confinement (or any day of such confinement) is not **necessary**, the Excluded Amount shall apply to certain expenses as described in the Health Expense Coverage Section below.

*Excluded Amount* Refer to *Benefits Summary*

This Excluded Amount applies separately to each type of admission and care listed above.

## **Physician Services**

Refer to "*Physician Services*" in *Benefits Summary*.

## **Hospital Services**

Refer to "*Hospital Services*" in *Benefits Summary*.

If a hospital or other health care facility does not separately identify the specific amounts of its room and board charges and its other charges, Aetna will apply the following allocations of these charges for the purposes of the Plan:

Room and board charges:	40%
Other charges:	60%

This allocation may be changed at any time if the University finds that such action is warranted by reason of a change in factors used in the allocation.

**Recognized Charge Percentage:** The charge determined on a semiannual basis to be in the 85th percentile of the charges made for a service or supply by providers in the geographic area where it is furnished.

### ***Confinement Deductible***

Confinement Deductible

Refer to *Benefits Summary*

For a confinement of a well newborn child that starts on the day of birth, this Inpatient Hospital Deductible will not exceed the hospital's actual charge for board and room for the first day of confinement on which the child's coverage is in force.

This Confinement Deductible (Inpatient Hospital Deductible) applies to all Inpatient Hospital Expenses, except those incurred for Preferred Care.

### ***Certification Requirement***

If you or one of your dependents requires confinement in a hospital, days in the hospital must be certified if full plan benefits are to be available. As soon as you or one of your dependents know confinement will be required, read the "Comprehensive Medical Expense Coverage" Section under the "Health Expense Coverage" Section of this Plan for details on how to get the certification.

## Other Covered Medical Expenses

An Other Covered Medical Expense is defined as a health care service or supply that is neither Preferred Care nor Non-Preferred Care. This includes care given by a provider who is not in a category represented in the network. Refer to *Benefits Summary* for Payment Percentage for these services.

Note that if the providers of services or supplies for which expenses are incurred are of a type that has contracted in sufficient numbers to furnish services or supplies for a Negotiated Charge, then the Payment Percentage will be the applicable Preferred Care or Non-Preferred Care Payment Percentage as specified in the *Benefits Summary*.

## Prescription Drugs

Refer to "*Prescription Drugs*" in *Benefits Summary*.

## Maternity

Benefits are payable for pregnancy-related expenses of female employees and dependents on the same basis as for a disease.

In the event of an inpatient confinement:

- Such benefits will be payable for inpatient care of the covered person and any newborn child for: a minimum of 48 hours following a vaginal delivery; and a minimum of 96 hours following a cesarean delivery. If, after consultation with the attending physician, a person is discharged earlier, benefits will be payable for 2 post-delivery home visits by a health care provider.
- Certification of the first 48 hours of such confinement following a vaginal delivery or the first 96 hours of such confinement following a cesarean delivery is not required. Any day of confinement in excess of such limits must be certified. You, your physician, or other health care provider may obtain such certification by calling the number shown on your ID Card.

Normally, the expenses must be incurred while the person is covered under this Plan. If expenses are incurred after the coverage ceases, they will be considered for benefits only if satisfactory evidence is furnished to the Plan Administrator that the person has been totally disabled since his or her coverage terminated.

*Prior Plans:* Any pregnancy benefits payable by previous group medical coverage will be subtracted from medical benefits payable for the same expenses under this Plan.

*Sterilization Coverage:* Benefits are payable for charges made in connection with any procedure performed for sterilization of a person, including voluntary sterilization, on the same basis as for a disease.

## **Mental Health Services, Alcoholism, and Drug Abuse**

Refer to “*Mental Health Services*” and “*Alcohol/Drug Abuse Services*” in *Benefits Summary*.

### **Adjustment Rule**

If, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted as provided elsewhere in the plan document for the William Marsh Rice University Medical Plan.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

## Health Expense Coverage

Health Expense Coverage is expense-incurred coverage only and not coverage for the disease or injury itself. This means that this Plan will pay benefits only for expenses incurred while this coverage is in force. Except as described in the extended benefits provisions of the William Marsh Rice University Medical Plan, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, Aetna will allocate to each service a pro rata share of the expense. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

The University assumes no responsibility for the outcome of any covered services or supplies. The University makes no express or implied warranties concerning the outcome of any covered services or supplies.

### Prescription Drug Expense Coverage

Prescription Drug Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all **prescription drugs**. There are exclusions, copayment features, and, if applicable to this Plan, deductible and maximum benefit features.

The “Benefits Summary” outlines the Payment Percentages that apply to the Covered Prescription Drug Expenses described below.

#### Covered Prescription Drug Expenses

This Plan pays the benefits shown below for certain **prescription drug** expenses incurred for the treatment of a disease or injury. These benefits apply separately to each covered person.

If a **prescription drug** is dispensed by a **preferred pharmacy** to a person for treatment of a disease or injury, a benefit will be paid, determined from the Benefit Amount subsection, but only if the **preferred pharmacy's** charge for the drug is more than the **copay per prescription** or refill.

Benefit amounts provided under this section will not be subject to any provision under this Plan for coordination of benefits with other plans, except the provision for coordinating benefits under this Plan with any Medicare benefits.

## Benefit Amount

The benefit amount for each covered **prescription drug** or refill dispensed by a **preferred pharmacy** will be an amount equal to the Payment Percentage of the total charges. The total charge is determined by:

- the **preferred pharmacy**; and
- the contract applicable to the University.

Any amount so determined will be paid to the **preferred pharmacy** on your behalf.

No benefit will be paid for a **prescription drug** dispensed by a **non-preferred pharmacy** under this benefit section except for an **emergency condition**, in which case the benefit will be payable at the preferred level of coverage.

This Plan's medical expense coverage may cover **prescription drugs** dispensed by a **non-preferred pharmacy**. Then, the benefit amount for each covered **prescription drug** or refill is equal to the Payment Percentage of the **non-preferred pharmacy's** charge for the drug after any applicable deductible.

## Limitations

No benefits are paid under this section:

- For a device of any type unless specifically included as a **prescription drug**.
- For any drug entirely consumed at the time and place it is prescribed.
- For less than a 30 day supply of any drug dispensed by a **mail order pharmacy**.
- For more than a 30 day supply per **prescription** or refill. However, this limitation does not apply to a supply of up to 90 days per **prescription** or refill for drugs which are provided by a **mail order pharmacy**.
- For the administration or injection of any drug.
- For the following injectable drugs:
  - fertility drugs;
  - allergy sera or extracts; and
  - Imitrex, if it is more than the 48th such kit or 96th such vial dispensed to the person in any year.

For any refill of a drug that is more than the number of refills specified by the **prescriber**. Before recognizing charges, Aetna may require a new **prescription** or evidence as to need:

- if the **prescriber** has not specified the number of refills; or
  - if the frequency or number of **prescriptions** or refills appears excessive under accepted medical practice standards.
- For any refill of a drug dispensed more than one year after the latest **prescription** for it or as permitted by the law of the jurisdiction in which the drug is dispensed.

- For any drug provided by or while the person is an inpatient in any health care facility; or for any drug provided on an outpatient basis in any health care facility to the extent benefits are paid for it under any other part of this Plan or under any other medical or **prescription drug** expense benefit plan carried or sponsored by the University.
- For any **prescription drug** also obtainable without a **prescription** on an "over the counter" basis.
- For immunization agents.
- For biological sera and blood products.
- For nutritional supplements.
- For any fertility drugs, except oral fertility drugs.
- For more than **10** unit doses per 30 day supply for the following drugs used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy:
  - sildenafil citrate;
  - phentolamine;
  - apomorphine;
  - alprostadil; or
  - any other **prescription drug** that is in a similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes.

This limitation applies whether or not the **prescription drug** is delivered in oral, injectable, or topical (including, but not limited to, gels, creams, ointments, and patches) forms. If the drug is not taken orally, the dosage covered will be determined by the Plan Administrator based on the comparable cost for a 30 day supply of pills.

- For any drug dispensed by a **mail order pharmacy** for use for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.
- For any smoking cessation aids or drugs.
- For appetite suppressants.
- For a **prescription drug** dispensed by a **mail order pharmacy** that is not a **preferred pharmacy**.

## **Comprehensive Medical Expense Coverage**

Comprehensive Medical Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all medical care. There are exclusions, deductibles, copayment features and stated maximum benefit amounts as described in this Plan. If any expense is covered under one type of Covered Medical Expense, it cannot be covered under any other type.

The "Benefits Summary" outlines the Payment Percentages that apply to the Covered Medical Expenses described below.

### **Covered Medical Expenses**

They are the expenses for certain **hospital** and other medical services and supplies. They must be for the treatment of an injury or disease.

Here is a list of Covered Medical Expenses.

## **Hospital Expenses**

### ***Inpatient Hospital Expenses***

**Charges** made by a **hospital** for giving **board and room** and other **hospital** services and supplies to a person who is confined as a full-time inpatient.

Not included is any **charge** for daily **board and room** in a private room over the Private Room Limit.

### ***Outpatient Hospital Expenses***

Charges made by a **hospital** for **hospital** services and supplies which are given to a person who is not confined as a full-time inpatient.

## **Convalescent Facility Expenses**

Charges made by a **convalescent facility** for the following services and supplies. They must be furnished to a person while confined to convalesce from a disease or injury.

- Board and room. This includes charges for services, such as general nursing care, made in connection with room occupancy. Not included is any **charge** for daily **board and room** in a private room over the Private Room Limit.
- Use of special treatment rooms.
- X-ray and lab work.
- Physical, occupational or speech therapy.
- Oxygen and other gas therapy.
- Other medical services usually given by a **convalescent facility**. This does not include private or special nursing, or **physician's** services.
- Medical supplies.

Benefits will be paid for up to the maximum number of convalescent days during any one Plan Year. This starts on the first day a person is confined in a **convalescent facility** if he or she:

- was confined in a **hospital** for at least 3 days in a row, while covered under this Plan, for treatment of a disease or injury; and
- is confined in the facility within 14 days after discharge from the **hospital**; and
- is confined in the facility for services needed to convalesce from the condition that caused the **hospital** stay. These include skilled nursing and physical restorative services.

### ***Limitations To Convalescent Facility Expenses***

This section does not cover charges made for treatment of:

- Drug addiction.

- Chronic brain syndrome.
- Alcoholism.
- Senility.
- Mental retardation.
- Any other mental disorder.

### **Home Health Care Expenses**

Home health care expenses are covered if:

- the charge is made by a **home health care agency**; and
- the care is given under a **home health care plan**; and
- the care is given to a person in his or her home.

Home health care expenses are charges for:

- Part-time or intermittent care by an **R.N.** or by an **L.P.N.** if an **R.N.** is not available.
- Part-time or intermittent home health aide services for patient care.
- Physical, occupational, and speech therapy.
- The following to the extent they would have been covered under this Plan if the person had been confined in a **hospital** or **convalescent facility**:

medical supplies;  
 drugs and medicines prescribed by a **physician**; and  
 lab services provided by or for a **home health care agency**.

There is a maximum to the number of visits covered in a Plan Year. Each visit by a nurse or therapist is one visit. Each visit of up to 4 hours by a home health aide is one visit.

### ***Limitations To Home Health Care Expenses***

This section does not cover charges made for:

- Services or supplies that are not a part of the **home health care plan**.
- Services of a person who usually lives with you or who is a member of your or your wife's or husband's family.
- Services of a social worker.
- Transportation.

### **Hospice Care Expenses**

Charges made for the following furnished to a person for **Hospice Care** when given as a part of a **Hospice Care Program** are included as Covered Medical Expenses.

### ***Facility Expenses***

The charges made in its own behalf by a:

- **hospice facility**;
- **hospital**;

- **convalescent facility**;

which are for:

- Board and room and other services and supplies furnished to a person while a full-time inpatient for:
  - pain control; and
  - other acute and chronic symptom management.
- Not included is any **charge** for daily **board and room** in a private room over the Private Room Limit.
- Services and supplies furnished to a person while not confined as a full-time inpatient.

### *Other Expenses*

Charges made by a **Hospice Care Agency** for:

- Part-time or intermittent nursing care by a **R.N.** or **L.P.N.** for up to 8 hours in any one day.
- Medical social services under the direction of a **physician**. These include:
  - assessment of the person's:
    - social, emotional, and medical needs; and
    - the home and family situation;
    - identification of the community resources which are available to the person; and
    - assisting the person to obtain those resources needed to meet the person's assessed needs.
- Psychological and dietary counseling.
- Consultation or case management services by a **physician**.
- Physical and occupational therapy.
- Part-time or intermittent home health aide services for up to 8 hours in any one day. These consist mainly of caring for the person.
- Medical supplies.
- Drugs and medicines prescribed by a **physician**.

Charges made by the providers below, but only if: the provider is not an employee of a **Hospice Care Agency**; and such Agency retains responsibility for the care of the person.

- A **physician** for consultant or case management services.
- A physical or occupational therapist.
- A **Home Health Care Agency** for:
  - physical and occupational therapy;
  - part-time or intermittent home health aide services for up to 8 hours in any one day; these consist mainly of caring for the person;
  - medical supplies;
  - drugs and medicines prescribed by a **physician**; and
  - psychological and dietary counseling.

Not included are charges made:

- For bereavement counseling.
- For funeral arrangements.
- For pastoral counseling.
- For financial or legal counseling. This includes estate planning and the drafting of a will.
- For homemaker or caretaker services. These are services which are not solely related to care of the person. These include: sitter or companion services for either the person who is ill or other members of the family; transportation; housecleaning; and maintenance of the house.
- For respite care. This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.

### **Contraception Expenses**

Covered Medical Expenses include:

- charges incurred for contraceptive drugs and contraceptive devices that by law need a physician's prescription; and that have been approved by the FDA.
- related outpatient contraceptive services such as:
  - consultations;
  - exams;
  - procedures; and
  - other medical services and supplies.

Not covered are:

- charges for services which are covered to any extent under any other part of this Plan or any other group plan sponsored by the University; and
- charges incurred for contraceptive services while confined as an inpatient.

### **Routine Physical Exams**

The charges made by a **physician** for a routine physical exam given to you, your spouse, or your dependent child may be included as Covered Medical Expenses. If charges made by a **physician** in connection with a routine physical exam given to a dependent child are Covered Medical Expenses under any other benefit section, no charges in connection with that physical exam will be considered Covered Medical Expenses under this section. A routine physical exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified injury or disease. Included as a part of the exam are:

- 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.

For your dependent child:

- The physical exam must include at least:
  - a review and written record of the patient's complete medical history;
  - a check of all body systems; and
  - a review and discussion of the exam results with the patient or with the parent or guardian.
- For all exams given to your dependent child under age 2, Covered Medical Expenses will not include charges for:
  - more than 6 exams performed during the first year of the child's life;
  - more than 2 exams performed during the second year of the child's life.
- For all exams given to your dependent child age 2 up to age 18, Covered Medical Expenses will not include charges for more than one exam in 12 months in a row.
- For all exams given to your dependent child age 18 and over, Covered Medical Expenses will not include charges for more than one exam in 24 months in a row.

For all exams given to you and your spouse, Covered Medical Expenses will not include charges for more than:

- one exam in 12 months in a row, if the person is under age 65; and
- one exam in 12 months in a row, if the person is age 65 or over.

Also included as Covered Medical Expenses are charges made by a **physician** for one annual routine gynecological exam.

Not covered are charges for:

- Services which are covered to any extent under any other group plan of the University.
- Services which are for diagnosis or treatment of a suspected or identified injury or disease.
- Exams given while the person is confined in a **hospital** or other facility for medical care.
- Services which are not given by a **physician** or under his or her direct supervision.
- Medicines, drugs, appliances, equipment, or supplies.
- Psychiatric, psychological, personality or emotional testing or exams.
- Exams in any way related to employment.
- Premarital exams.
- Vision, hearing, or dental exams.
- A **physician's** office visit in connection with immunizations or testing for tuberculosis.

### **Routine Eye Exam Expenses**

Covered Medical Expenses include charges for a complete eye exam, including refraction, which is furnished by a legally qualified ophthalmologist or optometrist to a person.

Covered Medical Expenses will not include charges for more than one routine eye exam for any period of 12 months in a row.

Not included are charges for:

- For any eye exam to diagnose or treat a disease or injury.
- For drugs or medicines.
- For a vision care service that is a covered expense in whole or in part under any other part of this Plan or under any other plan of group benefits provided through the University.
- For a vision care service for which a benefit is provided in whole or in part under any workers' compensation law or any other law of like purpose.
- For special procedures. This means things such as orthoptics or vision training.
- For any vision care supply.
- For an eye exam which:
  - is required by an employer as a condition of employment; or
  - an employer is required to provide under a labor agreement; or
  - is required by any law of a government.
- For a service received while the person is not covered.
- For a service or supply which does not meet professionally accepted standards.
- For any exams given while the person is confined in a **hospital** or other facility for medical care.
- For an eye exam, or any part of an eye exam, performed for the purpose of the fitting of contact lenses
- For any service or supply furnished by other than a **Preferred Care Provider**.

### **Other Medical Expenses**

- Charges made by a **physician**.
- Charges made by a **R.N.** or **L.P.N.** or a nursing agency for skilled nursing care.

As used here, "skilled nursing care" means these services:

Visiting nursing care by a **R.N.** or **L.P.N.** Visiting nursing care means a visit of not more than 4 hours for the purpose of performing specific skilled nursing tasks.

Private duty nursing by a **R.N.** or **L.P.N.** if the person's condition requires skilled nursing services and visiting nursing care is not adequate.

Benefits will not be paid during a Plan Year for private duty nursing for any shifts in excess of the Private Duty Nursing Care Maximum Shifts. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.

Not included as "skilled nursing care" is:

that part or all of any nursing care that does not require the education, training, and technical skills of a **R.N.** or **L.P.N.**; such as transportation, meal preparation, charting of vital signs, and companionship activities; or

any private duty nursing care given while the person is an inpatient in a **hospital** or other health care facility; or

care provided to help a person in the activities of daily life; such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting; or

care provided solely for skilled observation except as follows:

for no more than one 4 hour period per day for a period of no more than 10 consecutive days following the occurrence of:

change in patient medication;

need for treatment of an **emergency condition** by a **physician** or the onset of symptoms indicating the likely need for such treatment;

surgery; or

release from inpatient confinement; or

any service provided solely to administer oral medicines; except where applicable law requires that such medicines be administered by a **R.N.** or **L.P.N.**

- Charges for the following:

Drugs and medicines which by law need a **physician's** prescription and for which no coverage is provided under the Prescription Drug Expense Coverage.

Diagnostic lab work and X-rays.

X-ray, radium, and radioactive isotope therapy.

Anesthetics and oxygen.

Rental of **durable medical and surgical equipment**. In lieu of rental, the following may be covered:

The initial purchase of such equipment if it is shown that: long term care is planned; and that such equipment: either cannot be rented; or is likely to cost less to purchase than to rent.

Repair of purchased equipment.

Replacement of purchased equipment if it is shown that it is needed due to a change in the person's physical condition; or it is likely to cost less to purchase a replacement than to repair existing equipment or to rent like equipment.

Professional ambulance service to transport a person from the place where he or she is injured or stricken by disease to the first **hospital** where treatment is given.

Artificial limbs and eyes. Not included are charges for:

eyeglasses;

vision aids;

hearing aids;

communication aids; and

orthopedic shoes, foot orthotics, or other devices to support the feet, unless **necessary** to prevent complications of diabetes.

### **National Medical Excellence Program ® (NME)**

The NME Program coordinates all solid organ and bone marrow transplants and other specialized care that can not be provided within an **NME Patient's** local geographic area. When care is directed to a facility ("Medical Facility") more than 100 miles from the person's home, this Plan will pay a benefit for Travel and Lodging Expenses, but only to the extent described below.

#### ***Travel Expenses***

These are expenses incurred by an **NME Patient** for transportation between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

Also included are expenses incurred by a **Companion** for transportation when traveling to and from an **NME Patient's** home and the Medical Facility to receive such services.

#### ***Lodging Expenses***

These are expenses incurred by an **NME Patient** for lodging away from home while traveling between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

Also included are expenses incurred by a **Companion** for lodging away from home:

- while traveling with an **NME Patient** between the **NME Patient's** home and the Medical Facility to receive services in connection with any listed procedure or treatment; or
- when the **Companion's** presence is required to enable an **NME Patient** to receive such services from the Medical Facility on an inpatient or outpatient basis.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

For the purpose of determining NME Travel Expenses or Lodging Expenses, a **hospital** or other temporary residence from which an **NME Patient** travels in order to begin a period of treatment at the Medical Facility, or to which he or she travels after discharge at the end of a period of treatment, will be considered to be the **NME Patient's** home.

### ***Travel and Lodging Benefit Maximum***

For all Travel Expenses and Lodging Expenses incurred in connection with any one procedure or treatment type:

- The total benefit payable will not exceed the Travel and Lodging Maximum per episode of care.
- Benefits will be payable only for such expenses incurred during a period which begins on the day a covered person becomes an **NME Patient** and ends on the earlier to occur of:
  - one year after the day the procedure is performed; and
  - the date the **NME Patient** ceases to receive any services from the facility in connection with the procedure.

### ***Limitations***

Travel Expenses and Lodging Expenses do not include, and no benefits are payable for, any charges which are included as Covered Medical Expenses under any other part of this Plan.

Travel Expenses do not include expenses incurred by more than one **Companion** who is traveling with the **NME Patient**.

Lodging Expenses do not include expenses incurred by more than one **Companion** per night.

## **Limitations**

### **Preexisting Conditions**

A "preexisting condition" is an injury or disease for which a person:

received treatment or services; or  
took prescribed drugs or medicines;

during the 90 days right before the person's effective date of coverage.

For the first 365 days following such date, Covered Medical Expenses incurred for treatment of a preexisting condition only include the first \$ 4,000 of Covered Medical Expenses for which no benefit is payable: under any other part of this Plan; or under any other group plan of the University.

### **Special Rules As To A Preexisting Condition**

If a person had creditable coverage and such coverage terminated within 90 days prior to the date he or she enrolled (or was enrolled) in this Plan, then any limitation as to a preexisting condition under this Plan will not apply for that person.

Also, if a person enrolls (or is enrolled) in this Plan immediately after any applicable probationary period has been served, and that person had creditable coverage which terminated within 90 days prior to the first day of such probationary period, then any limitation as to a preexisting condition will not apply for that person.

As used above: "creditable coverage" means a person's prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. Such coverage includes the following: coverage issued on a group or individual basis, Medicare, Medicaid, military-sponsored health care, a program of the Indian Health Service, a state health benefits risk pool, the Federal Employees' Health Benefit Plan (FEHBP), a public health plan as defined in the regulations, and any health benefit plan under Section 5(e) of the Peace Corps Act.

### **Routine Mammogram and Prostate Cancer Screening**

Even though not incurred in connection with a disease or injury, Covered Medical Expenses include charges incurred by a female age 40 or over for one mammogram each **Plan Year**;

**by a male age 40 or over in connection with an annual screening for cancer of the prostate, including:**

**a digital rectal exam, and  
a prostate specific antigen (PSA) test.**

### **Mouth, Jaws, and Teeth**

Expenses for the treatment of the mouth, jaws, and teeth are Covered Medical Expenses, but only those for:

- services rendered; and
- supplies needed;

for the following treatment of or related to conditions of the:

- teeth, mouth, jaws, jaw joints; or
- supporting tissues (this includes bones, muscles, and nerves).

For these expenses, **physician** includes a **dentist**.

Surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out:
  - teeth partly or completely impacted in the bone of the jaw;
  - teeth that will not erupt through the gum;
  - other teeth that cannot be removed without cutting into bone;
  - the roots of a tooth without removing the entire tooth;
  - cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement, or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Non-surgical treatment of infections or diseases. This does not include those of or related to the teeth.

Dental work, surgery, and **orthodontic treatment** needed to remove, repair, replace, restore, or reposition:

- natural teeth damaged, lost, or removed; or
- other body tissues of the mouth fractured or cut;

due to injury.

Any such teeth must have been:

- free from decay; or
- in good repair; and
- firmly attached to the jaw bone at the time of the injury.

The treatment must be done in the Plan Year of the accident or the next one.

If:

- crowns (caps); or
- dentures (false teeth); or
- bridgework; or
- in-mouth appliances;

are installed due to such injury, Covered Medical Expenses include only charges for:

- the first denture or fixed bridgework to replace lost teeth;
- the first crown needed to repair each damaged tooth; and
- an in-mouth appliance used in the first course of **orthodontic treatment** after the injury.

Except as provided for injury, not included are charges:

- for in-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services; whether or not the purpose of such services or supplies is to relieve pain;
- for root canal therapy;
- for routine tooth removal (not needing cutting of bone).

Not included are charges:

- to remove, repair, replace, restore or reposition teeth lost or damaged in the course of biting or chewing;
- to repair, replace, or restore fillings, crowns, dentures or bridgework;
- for non-surgical periodontal treatment;
- for dental cleaning, in-mouth scaling, planing or scraping;
- for myofunctional therapy; this is:
  - muscle training therapy; or
  - training to correct or control harmful habits.

## **Emergency Room Treatment**

### ***Emergency Care***

If treatment:

- is received in the emergency room of a **hospital** while a person is not a full-time inpatient; and
- the treatment is **emergency care**;

Covered Medical Expenses for charges made by the **hospital** for such treatment will be paid at the Payment Percentage.

### ***Non-Emergency Care***

If treatment:

- is received in the emergency room of a **hospital** while a person is not a full-time inpatient; and
- the treatment is not **emergency care**;

Covered Medical Expenses for charges made by the **hospital** for such treatment will be paid at the Reduced Payment Percentage.

No benefit will be paid under any other part of this Plan for charges made by a **hospital** for care in an emergency room that is not **emergency care**.

## **Treatment by an Urgent Care Provider**

*You should not seek medical care or treatment from an **Urgent Care Provider** if your illness; injury; or condition; is an **emergency condition**. Please go directly to the emergency room of a **hospital** or call 911 (or the local equivalent) for ambulance and medical assistance.*

### ***Urgent Care***

This Plan pays for the charges made by an **Urgent Care Provider** to evaluate and treat an urgent condition. When travel to an Urgent Care Provider, who is a Preferred Care Provider, for treatment of an urgent condition is not feasible, such treatment may be paid at the Preferred level of benefits. If a claim for treatment of an urgent condition is paid at the Non-Preferred level and you believe that it should have been paid at the Preferred level, please contact Member Services at the toll-free number on your I.D. card.

### ***Non-Urgent Care***

Covered Medical Expenses for charges made by an **Urgent Care Provider** to treat a non-urgent condition will be paid on the same basis as those made by a provider who is not an **Urgent Care Provider**.

Non-urgent care includes, but is not limited to, the following:

- routine or preventive care (this includes immunizations);
- follow-up care;
- physical therapy;
- elective surgical procedures; and
- any lab and radiologic exams which are not related to the treatment of the urgent condition.

### **Certification For Hospital Admissions**

This certification section applies to admissions other than those for the treatment of alcoholism, drug abuse or **mental disorders**. A separate section applies to such admissions.

If:

- a person becomes confined in a **hospital** as a full-time inpatient; and
- it has not been certified that such confinement (or any day of such confinement) is **necessary**; and
- the confinement has not been ordered and prescribed by a **physician** who is a **Preferred Care Provider**;

Covered Medical Expenses incurred on any day not certified during the confinement will be paid as follows:

- As to Hospital Expenses incurred during the confinement:

If certification has been requested and denied:

No benefits will be paid for Hospital Expenses incurred for board and room.

Benefits for all other Hospital Expenses will be paid at the Payment Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is not **necessary**:

No benefits will be paid for Hospital Expenses incurred for board and room.

- As to all other Hospital Expenses:

Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

Benefits for such expenses in excess of the Excluded Amount will be paid at the Payment Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is **necessary**:

Hospital Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

Benefits for all other Hospital Expenses will be payable at the Payment Percentage.

- As to other Covered Medical Expenses:

Benefits will be paid at the Payment Percentage.

Whether or not a day of confinement is certified, no benefit will be paid for expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Plan; except that, if certification has been given for a day of confinement, the exclusion of services and supplies because they are not **necessary** will not be applied to expenses for **hospital** room and board.

Certification of days of confinement can be obtained as follows:

If the admission is a **non-urgent admission**, you must get the days certified by calling the number shown on your ID card. This must be done at least 14 days before the date the person is scheduled to be confined as a full-time inpatient. If the admission is an **emergency** or an **urgent admission**, you, the person's **physician**, or the **hospital** must get the days certified by calling the number shown on your ID card. This must be done:

- before the start of a confinement as a full-time inpatient which requires an **urgent admission**; or
- not later than 48 hours following the start of a confinement as a full-time inpatient which requires an **emergency admission**; unless it is not possible for the **physician** to request certification within that time. In that case, it must be done as soon as reasonably possible. In the event the confinement starts on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours.

If, in the opinion of the person's **physician**, it is necessary for the person to be confined for a longer time than already certified, you, the **physician**, or the **hospital** may request that more days be certified by calling the number shown on your ID card. This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent promptly to the **hospital**. A copy will be sent to you and to the **physician**.

### **Certification For Convalescent Facility Admissions, Home Health Care Expenses, Hospice Care Expenses, and Skilled Nursing Care**

If a person incurs Covered Medical Expenses:

- while confined in a **convalescent facility** or a **hospice facility**; or
- for a service or a supply for home health care or hospice care while not confined as an inpatient or skilled nursing care; and

it has not been certified that:

- such confinement or any day of it is **necessary**; or
- such other services or supplies (either specifically or as a part of a planned program of care) are **necessary**, and
- the confinement or service or supply has not been ordered or prescribed by a **physician** who is a **Preferred Care Provider**;

such Covered Medical Expenses will be paid only as follows:

- As to Convalescent Facility Expenses and Hospice Care Facility Expenses incurred while confined in a **convalescent facility** or a **hospice facility**:

If certification has been requested and denied:

No benefits will be paid for Convalescent Facility Expenses or Hospice Care Facility Expenses incurred for board and room.

Benefits for all other Convalescent Facility Expenses or Hospice Care Facility Expenses incurred during the confinement will be paid at the Payment Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is not **necessary**:

No benefits will be paid for Convalescent Facility Expenses or Hospice Care Facility Expenses incurred for board and room.

As to all other Convalescent Facility Expenses or Hospice Care Facility Expenses incurred during the confinement:

Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses. Benefits for all other such expenses will be paid at the Payment Percentage.

If certification has not been requested and the confinement or (any day of such confinement) is **necessary**:

Convalescent Facility Expenses or Hospice Care Facility Expenses, incurred during the confinement, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

Benefits for all other such expenses, incurred during the confinement, will be paid at the Payment Percentage.

As to all other Covered Medical Expenses incurred during the confinement, benefits will be paid at the Payment Percentage.

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As to Covered Medical Expenses incurred for services or supplies either as stated or as a part of a planned program of care for home health care, hospice care while not confined as an inpatient, or skilled nursing care:

If certification for a service or supply has been requested and denied or if certification has not been requested and the service or supply is not **necessary**, no benefits will be paid for the denied or unnecessary service or supply.

If certification has not been requested for a service or supply and the service or supply is **necessary**, benefits for the necessary service or supply will be paid as follows:

Expenses incurred for the service or supply, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

Benefits for all other Covered Medical Expenses incurred for the service or supply will be paid at the Payment Percentage.

Whether or not a day of confinement or a service or supply has been certified, no benefit will be paid if the charges for such confinement or service or supply are excluded by any other terms of this Plan; except that:

- To the extent that a day of confinement has been certified, the exclusion of services and supplies because they are not **necessary** will not apply to:

Convalescent Facility Expenses for room and board; or

Hospice Care Facility Expenses for room and board.

- To the extent that such service or supply has been certified for home health care, hospice care, or skilled nursing care, the exclusion of services or supplies because they are not **necessary** will not apply to such service or supply.

To get certification you must call the number shown on your ID card. Such certification must be obtained before an expense is incurred.

If a person's **physician** believes that the person needs more days of confinement or services or supplies beyond those which have been already certified you must call to certify more days of confinement or services or supplies.

Prompt written notice will be provided to you of the days of confinement and services or supplies which have been certified.

If:

- services and supplies for hospice care provided to a person have been certified; and
- the person later requires confinement in a **hospital** for pain control or acute symptom management;

any other certification requirement in the Plan will be waived for any such day of confinement in a **hospital**.

#### **Certification For Hospital and Treatment Facility Admissions for Alcoholism, Drug Abuse or Mental Disorders**

If, in connection with the **effective treatment of alcoholism or drug abuse** or treatment of **mental disorders**, a person incurs Covered Medical Expenses while confined in a **hospital** or **treatment facility**; and

- it has not been certified that such confinement (or any day of such confinement) is **necessary**; and
- the confinement has not been ordered and prescribed by a **physician** who is a **Preferred Care Provider**;

Covered Medical Expenses incurred on any day not certified during the confinement will be paid only as follows:

With respect to expenses for **hospital** and **treatment facility** board and room:

If certification has been requested and denied, or if certification has not been requested and the confinement (or any day of it) is not **necessary**, no benefits will be paid.

If certification has not been requested and the confinement is **necessary**, such expenses, up to the Excluded Amount, will not be Covered Medical Expenses.

With respect to all other **hospital** and **treatment facility** expenses:

If certification has been requested and denied, or if certification has not been requested and the confinement is **necessary**, such expenses, up to the Excluded Amount, will not be Covered Medical Expenses.

Benefits for such expenses in excess of the Excluded Amount will be paid at the Payment Percentage.

If certification has not been requested and the confinement is not **necessary**, no benefits will be paid.

Whether or not a day of confinement is certified, no benefits will be payable for Covered Medical Expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Plan; except that, if certification has been given for any day of confinement, the exclusions of services and supplies because they are not **necessary** will not be applied to **hospital** and **treatment facility** board and room.

To get the days certified, you must call the number shown on your ID card. Such certification must be obtained before confinement as a full-time inpatient, or in the case of an **emergency admission**, within 48 hours after the start of a confinement as a full-time inpatient or as soon as reasonably possible.

If the person's **physician** believes that the person needs more days of confinement beyond those which have already been certified, additional days of confinement must be certified. This must be done no later than on the last day that has already been certified.

### **Treatment of Alcoholism, Drug Abuse, or Mental Disorders**

Certain expenses for the treatment shown below are Covered Medical Expenses.

#### ***Inpatient Treatment***

If a person is a full-time inpatient either:

- in a **hospital**; or
- in a **treatment facility**;

then the coverage is as shown below.

#### ***Hospital***

Expenses for the following are covered:

- Treatment of the medical complications of alcoholism or drug abuse. This means things such as cirrhosis of the liver, delirium tremens, or hepatitis.
- **Effective treatment of alcoholism or drug abuse.**
- Treatment of **mental disorders**.

#### ***Treatment Facility***

Certain expenses for the **effective treatment of alcoholism or drug abuse** or the treatment of **mental disorders** are covered. The expenses covered are those for:

- Board and room. Not covered is any **charge** for daily **board and room** in a private room over the Private Room Limit.
- Other **necessary** services and supplies.

### ***Plan Year Maximum Benefit***

A Special Inpatient Plan Year Maximum Days applies to the **hospital** and **treatment facility** expenses described above.

### ***Outpatient Treatment***

If a person is not a full-time inpatient either:

- in a **hospital**; or
- in a **treatment facility**;

then the coverage is as shown below.

Expenses for the **effective treatment of alcoholism or drug abuse** or the treatment of **mental disorders** are covered.

For such treatment given by a **hospital, treatment facility** or **physician**, benefits will not be payable for more than the Special Outpatient Plan Year Maximum Visits in any one Plan Year.

## **General Exclusions Applicable to Health Expense Coverage**

Coverage under this Plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational diseases** are covered. Any coverage for charges for services and supplies is provided only if they are furnished to a person while covered.

Coverage is not provided for the following charges:

- Those for services and supplies not **necessary**, as determined by the Plan Administrator, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those for or in connection with services or supplies that are, as determined by the Plan Administrator, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:

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

if required by the FDA, approval has not been granted for marketing; or

a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or

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 the Plan Administrator determines that:

the disease can be expected to cause death within one year, in the absence of effective treatment; and

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 the Plan Administrator will take into account the results of a review by a panel of independent medical professionals as selected by the Plan Administrator. This panel will include professionals who treat the type of disease involved.

Also, this exclusion will not apply with respect to drugs that:

have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or

are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute;

if the Plan Administrator determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

- Those for or related to services, treatment, education testing, or training related to learning disabilities or developmental delays.
- Those for care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury.
- Those for or related to the following types of treatment: primal therapy; rolfing; psychodrama; megavitamin therapy; bioenergetic therapy; vision perception training; or carbon dioxide therapy.
- Those for treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field.
- Those for services of a resident **physician** or intern rendered in that capacity.
- Those that are made only because there is health coverage.
- Those that a covered person is not legally obliged to pay.
- Those that are determined by the Plan Administrator to be for **custodial care**.
- To the extent allowed by the law of the jurisdiction where the group contract is delivered, those for services and supplies:

Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.

Furnished, paid for, or for which benefits are provided or required under any law of a government. (This exclusion will not apply to "no fault" auto insurance if it: is required by law; is provided on other than a group basis; and is included in the definition of Other Plan in

the section entitled Effect of Benefits Under Other Plans Not Including Medicare. In addition, this exclusion will not apply to: a plan established by government for its own employees or their dependents; or Medicaid.)

- Those for or related to any eye surgery mainly to correct refractive errors.
- Those for education, special education, or job training whether or not given in a facility that also provides medical or psychiatric treatment.
- Those for therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Those for or related to sex change surgery or to any treatment of gender identity disorders.
- Those for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures, except to the extent coverage for such procedures is specifically provided for in this Plan.
- Infertility services, except as described under “Your Benefits.” The Plan does not cover:
  - purchase of donor sperm and any charges for the storage of sperm.
  - purchase of donor eggs, and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers.
  - cryopreservation and storage of cryopreserved embryos.
  - all charges associated with a gestational carrier program (surrogate parenting) for the Plan participant or the gestational carrier.
  - drugs related to the treatment of non-covered benefits or related to the treatment of infertility that are not medically necessary.
  - injectable infertility drugs.
  - the costs for home ovulation prediction kits.
  - services for couples in which one of the partners has had a previous sterilization procedure, with or without reversal.
  - services for females with FSH levels greater than 19 mIU/ml on day 3 of the menstrual cycle.
- Those for routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is specifically provided for in this Plan.
- Those for or in connection with marriage, family, child, career, social adjustment, pastoral, or financial counseling.
- Those for acupuncture therapy. Not excluded is acupuncture when it is performed by a **physician** as a form of anesthesia in connection with surgery that is covered under this Plan.
- Those for or in connection with speech therapy. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words, and form sentences) as the result of a disease or injury.
- Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to:

Improve the function of a part of the body that:

is not a tooth or structure that supports the teeth; and

is malformed:

as a result of a severe birth defect; including cleft lip, webbed fingers, or toes; or

as a direct result of:

disease; or

surgery performed to treat a disease or injury.

Repair an injury. Surgery must be performed:

in the Plan Year of the accident which causes the injury; or  
in the next Plan Year.

- Those to the extent they are not **reasonable charges** as determined by the Plan Administrator.
- Those for the reversal of a sterilization procedure.
- Those for a service or supply furnished by a **Preferred Care Provider** in excess of such provider's **Negotiated Charge** for that service or supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are paid.

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

These excluded charges will not be used when figuring benefits.

The law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

## Effect of Benefits Under Other Plans

### Other Plans Not Including Medicare

Some persons have health coverage in addition to coverage under this Plan. When this is the case, the benefits from "other plans" will be taken into account. This may mean a reduction in benefits under this Plan. The combined benefits will not be more than the expenses recognized under these plans.

In a Plan Year, this Plan will pay:

- its regular benefits in full; or
- a reduced amount of benefits. To figure this amount, subtract B. from A. below:
  - A. 100% of "Allowable Expenses" incurred by the person for whom claim is made.
  - B. The benefits payable by the "other plans". (Some plans may provide benefits in the form of services rather than cash payments. If this is the case, the cash value will be used.)

"Allowable Expenses" means any **necessary** and reasonable health expense, part or all of which is covered under any of the plans covering the person for whom claim is made.

The difference between the cost of a private **hospital** room and the **semiprivate rate** is not considered an Allowable Expense under the above definition unless the patient's stay in a private **hospital** room is medically necessary, either in terms of generally accepted medical practice or as specifically defined in this Plan.

To find out whether the regular benefits under this Plan will be reduced, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.
2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:
  - secondary to the plan covering the person as a dependent; and
  - primary to the plan covering the person as other than a dependent;

the benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

- covers the person as other than a dependent; and
- is secondary to Medicare.

3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4. In the case of a dependent child whose parents are divorced or separated:
  - a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.
  - b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.
  - c. If there is not such a court decree:

If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

The benefits of a plan which covers the person on whose expenses claim is based as a:

- laid-off or retired employee; or
- the dependent of such person;

shall be determined after the benefits of any other plan which covers such person as:

- an employee who is not laid-off or retired; or

- a dependent of such person.

If the other plan does not have a provision:

- regarding laid-off or retired employees; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:

- regarding right of continuation pursuant to federal or state law; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The Plan Administrator has the right to release or obtain any information and make or recover any payment it considers necessary in order to administer this provision.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a Plan Year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this Plan.

### **Other Plan**

This means any other plan of health expense coverage under:

- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

### **Effect of Medicare**

Health Expense Coverage will be changed for any person while eligible for Medicare.

A person is "eligible for Medicare" if he or she:

- is covered under it;
- is not covered under it because of:

having refused it;

having dropped it;

having failed to make proper request for it.

These are the changes:

- All health expenses covered under this Plan will be reduced by any Medicare benefits available for those expenses. This will be done before the health benefits of this Plan are figured.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.
- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.
- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules. Allowable Expenses will be reduced by any Medicare benefits available for those expenses.

Coverage will not be changed at any time if federal law requires this Plan's benefits for a person to be figured before benefits are figured under Medicare.

### **Effect of Prior Coverage - Transferred Business**

If the coverage of any person under any part of this Plan replaces any prior coverage of the person, the rules below apply to that part.

"Prior coverage" is any plan of group accident and health coverage that has been replaced by coverage under part or all of this Plan; it must have been sponsored by the University (i.e., transferred business). The replacement can be complete or in part for the Eligible Class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this Plan.

Coverage under any section of this Plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this Plan.

### **Recovery of Benefits Paid**

As a condition to payment of benefits under this Plan for expenses incurred by a covered person due to injury or illness for which a third party may be liable:

- The Plan shall, to the extent of benefits it has paid, be subrogated to (has the right to pursue) all rights of recovery of covered persons against:

such third party; or

a person's insurance carrier in the event of a claim under the uninsured or underinsured auto coverage provision of an auto insurance policy.

- The Plan shall have the right to recover from the covered person amounts received by judgment, settlement, or otherwise from:
  - such third party or his or her insurance carrier; or
  - any other person or entity, which includes the auto insurance carrier which provides the covered person's uninsured or underinsured auto insurance coverage.
- The covered person (or person authorized by law to represent the covered person if he or she is not legally capable) shall:
  - execute and deliver any documents that are required; and
  - do whatever else is necessary to secure such rights.

## **Recovery of Overpayment**

If a benefit payment is made by Aetna, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the group contract, this Plan has the right:

- to require the return of the overpayment on request; or
- to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery this Plan may have with respect to such overpayment.

## Glossary

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

### **Board and Room Charges**

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

### **Brand Name Drug**

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

### **Companion**

This is a person whose presence as a **Companion** or caregiver is necessary to enable an **NME Patient**:

- to receive services in connection with an NME procedure or treatment on an inpatient or outpatient basis; or
- to travel to and from the facility where treatment is given.

### **Convalescent Facility**

This is an institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:
  - professional nursing care by a **R.N.**, or by a **L.P.N.** directed by a full-time **R.N.**; and
  - physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**
- Is supervised full-time by a **physician** or **R.N.**
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Makes charges.

### **Copay**

This is a fee, charged to a person, which represents a portion of the applicable expense. It is specified in the "Benefits Summary".

As to a **prescription drug** dispensed by a **preferred pharmacy**, this is the fee charged to a person at the time the **prescription drug** is dispensed payable directly to the **pharmacy** for each

**prescription** or refill at the time the **prescription** or refill is dispensed. For drugs dispensed as packaged kits, the fee applies to each kit at the time it is dispensed. In no event will the copay be greater than the **prescription**, kit, or refill.

### **Custodial Care**

This means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes board and room 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.

### **Dentist**

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

### **Directory**

This is a listing of all **Preferred Care Providers** for the class of employees of which you are a member. A current list of participating providers is also available through Aetna's on-line provider directory, DocFind, at [www.aetna.com](http://www.aetna.com).

### **Durable Medical and Surgical Equipment**

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

- made to withstand prolonged use;
- made for and mainly used in the treatment of a disease or injury;
- suited for use in the home;
- not normally of use to persons who do not have a disease or injury;
- not for use in altering air quality or temperature;
- not for exercise or training.

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

### **Effective Treatment of Alcoholism Or Drug Abuse**

This means a program of alcoholism or drug abuse therapy that is prescribed and supervised by a **physician** and either:

- has a follow-up therapy program directed by a **physician** on at least a monthly basis; or
- includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.

These are not effective treatment:

- Detoxification. This means mainly treating the aftereffects of a specific episode of alcoholism or drug abuse.

- Maintenance care. This means providing an environment free of alcohol or drugs.

### **Emergency Admission**

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

- which requires confinement right away as a full-time inpatient; and
- for which if immediate inpatient care was not given could, as determined by the Plan Administrator, reasonably be expected to result in:

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

### **Emergency Care**

This means the treatment given in a **hospital's** emergency room to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

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

### **Emergency Condition**

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

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

### **Family Deductible Limit**

If Covered Medical Expenses incurred in a Plan Year by you and your dependents and applied against the separate Plan Year Deductibles equal the Family Deductible Limit, you and your dependents will be considered to have met the separate Plan Year Deductibles for the rest of that Plan Year.

### **Generic Drug**

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

### **Home Health Care Agency**

This is an agency that:

- mainly provides skilled nursing and other therapeutic services; and
- is associated with a professional group which makes policy; this group must have at least one **physician** and one **R.N.**; and
- has full-time supervision by a **physician** or a **R.N.**; and
- keeps complete medical records on each person; and
- has a full-time administrator; and
- meets licensing standards.

### **Home Health Care Plan**

This is a plan that provides for care and treatment of a disease or injury.

The care and treatment must be:

- prescribed in writing by the attending **physician**; and
- an alternative to confinement in a **hospital** or **convalescent facility**.

### **Hospice Care**

This is care given to a **terminally ill** person by or under arrangements with a **Hospice Care Agency**. The care must be part of a **Hospice Care Program**.

### **Hospice Care Agency**

This is an agency or organization which:

- Has **Hospice Care** available 24 hours a day.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Provides:
  - skilled nursing services; and
  - medical social services; and
  - psychological and dietary counseling.
- Provides or arranges for other services which will include:
  - services of a **physician**; and
  - physical and occupational therapy; and
  - part-time home health aide services which mainly consist of caring for **terminally ill** persons; and
  - inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has personnel which include at least:
  - one **physician**; and
  - one **R.N.**; and
  - one licensed or certified social worker employed by the Agency.
- Establishes policies governing the provision of **Hospice Care**.
- Assesses the patient's medical and social needs.

- Develops a **Hospice Care Program** to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the Agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Utilizes volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

### **Hospice Care Program**

This is a written plan of **Hospice Care**, which:

- Is established by and reviewed from time to time by:
  - a **physician** attending the person; and
  - appropriate personnel of a **Hospice Care Agency**.
- Is designed to provide:
  - palliative and supportive care to **terminally ill** persons; and
  - supportive care to their families.
- Includes:
  - an assessment of the person's medical and social needs; and
  - a description of the care to be given to meet those needs.

### **Hospice Facility**

This is a facility, or distinct part of one, which:

- Mainly provides inpatient **Hospice Care** to **terminally ill** persons.
- Charges its patients.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program; this includes reviews by **physicians** other than those who own or direct the facility.
- Is run by a staff of **physicians**; at least one such **physician** must be on call at all times.
- Provides, 24 hours a day, nursing services under the direction of a **R.N.**
- Has a full-time administrator.

### **Hospital**

This is a place that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons.
- Is supervised by a staff of **physicians**.
- Provides 24 hour a day **R.N.** service.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.
- Makes charges.

**Inpatient Hospital Deductible**

This is the amount of Inpatient Hospital Expenses you pay for each **hospital** confinement of a person.

The Inpatient Hospital Deductible will only be applied once to all **hospital** confinements, regardless of cause, which are separated by less than 10 days.

Expenses used to meet the Inpatient Hospital Deductible cannot be used to meet any other applicable deductible. Expenses used to meet any other applicable deductible cannot be used to meet the Inpatient Hospital Deductible.

**L.P.N.**

This means a licensed practical nurse.

**Mail Order Pharmacy**

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

**Medication Formulary**

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

**Mental Disorder**

This is a disease commonly understood to be a mental disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist, a psychologist or a psychiatric social worker. A mental disorder includes; but is not limited to:

- Alcoholism and drug abuse.
- Schizophrenia.
- Bipolar disorder.
- Pervasive Mental Developmental Disorder (Autism).
- Panic disorder.
- Major depressive disorder.
- Psychotic depression.
- Obsessive compulsive disorder.

For the purposes of benefits under this Plan, mental disorder will include alcoholism and drug abuse only if any separate benefit for a particular type of treatment does not apply to alcoholism and drug abuse.

**NME Patient**

This is a person who:

- requires any of the NME procedure and treatment types for which the charges are a Covered Medical Expense; and

- contacts Aetna and is approved by Aetna as an **NME Patient**; and
- agrees to have the procedure or treatment performed in a **hospital** designated by the Plan Administrator as the most appropriate facility.

### **Necessary**

A service or supply furnished by a particular provider is necessary if the Plan Administrator determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be appropriate, the service or supply must:

- be care or treatment, as 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 disease or injury involved and the person's overall health condition;
- be a diagnostic procedure, 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 disease or injury involved and the person's overall health condition; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the 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, the Plan Administrator will take into consideration:

- information provided on the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized healthcare 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 the Plan Administrator's attention.

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

- those that do not require the technical skills of a medical, a mental health or a dental professional; or
- those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility; or
- those furnished solely because the person is an inpatient on any day on which the person's disease 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.

### **Negotiated Charge**

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

### **Non-Occupational Disease**

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

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from a disease that does.

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

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

### **Non-Occupational Injury**

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

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from an injury which does.

### **Non-Preferred Care**

This is a health care service or supply furnished by a health care provider that is not a **Preferred Care Provider**; if, it is determined by the Plan Administrator:

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

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

This is:

- a health care provider that has not contracted to furnish services or supplies at a **Negotiated Charge**; or
- a **Preferred Care Provider** that is furnishing services or supplies without the referral of a **Primary Care Physician**.

### **Non-Preferred Pharmacy**

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

### **Non-Specialist**

A **physician** who is not a **specialist**.

### **Non-urgent Admission**

One which is not an **emergency admission** or an **urgent admission**.

### **Plan Year Deductible**

This is the amount of Covered Medical Expenses you pay each Plan Year before benefits are paid. There is a Plan Year Deductible that applies to each person.

### **Orthodontic Treatment**

This is any:

- medical service or supply; or
- dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- of the teeth; or
- of the bite; or
- of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

Not included is:

- the installation of a space maintainer; or
- a surgical procedure to correct malocclusion.

### **Other Health Care**

This is a health care service or supply that is neither **Preferred Care** nor **Non-Preferred Care**.

### **Pharmacy**

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

### **Physician**

This means a legally qualified physician.

### **Preferred Care**

This is a health care service or supply furnished by:

- a **Preferred Care Provider**; or
- a health care provider for an **emergency condition** when travel to a **Preferred Care Provider** is not feasible; or
- a Non-Preferred Urgent Care Provider when travel to a Preferred Urgent Care Provider for treatment is not feasible.

### **Preferred Care Provider**

This is a health care provider that has contracted to furnish services or supplies for a **Negotiated Charge**; but only if the provider is, with Aetna's consent, included in the **Directory** as a Preferred Care Provider for:

- the service or supply involved; and
- the class of employees of which you are member.

### **Preferred Pharmacy**

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

- while the contract remains in effect; and
- while such a **pharmacy** dispenses a **prescription drug** under the terms of its contract with the University.

### **Prescriber**

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

### **Prescription**

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

### **Prescription Drugs**

Any of the following:

- A drug, biological, compounded **prescription** or contraceptive device which, by Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription".
- An injectable contraceptive drug prescribed to be administered by a paid healthcare professional.
- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.
- Disposable needles and syringes which are purchased to administer a covered injectable **prescription drug**.
- Disposable diabetic supplies.

### **R.N.**

This means a registered nurse.

### **Reasonable Charge**

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

- the provider's usual charge for furnishing it; and
- the charge that the Plan Administrator determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- the charge that the Plan Administrator determines to be the prevailing charge level made for it in the geographic area where it is furnished.

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

- unusual; or
- not often provided in the area; or
- provided by only a small number of providers in the area;

The Plan Administrator may be taken into account:

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

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

### **Semiprivate Rate**

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

### **Specialist**

A **physician** who:

practices in any generally accepted medical or surgical sub-specialty; and  
is providing other than routine medical care.

A **physician** who:

practices in such a sub-specialty; and  
is providing routine medical care (such as could be given by a **primary care physician**),

will not be considered a Specialist for purposes of applying this Plan's **copay** provisions.

### **Terminally Ill**

This is a medical prognosis of 6 months or less to live.

### **Treatment Facility (Mental Disorder)**

This is an institution that:

- Mainly provides a program for the diagnosis, evaluation, and effective treatment of **mental disorders**.
- Is not mainly a school or a custodial, recreational or training institution.

- Provides infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical service that may be required.
- Is supervised full-time by a psychiatrist who is responsible for patient care and is there regularly.
- Is staffed by **psychiatric physicians** involved in care and treatment.
- Has a **psychiatric physician** present during the whole treatment day.
- Provides, at all times, psychiatric social work and nursing services.
- Provides, at all times, skilled nursing care by licensed nurses who are supervised by a full-time **R.N.**
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **psychiatric physician**.
- Makes charges.
- Meets licensing standards.

### **Urgent Admission**

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

- the onset of or change in a disease; or
- the diagnosis of a disease; or
- an injury caused by an accident;

which, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.

### **Urgent Condition**

This means a sudden illness; injury; or condition; that:

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



PLAN DESIGN AND BENEFITS  
 ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	PREFERRED CARE		NON-PREFERRED CARE	
<b>Deductible (per plan year)</b>	\$500	Employee	\$1,000	Employee
	\$1,500	Family	\$3,000	Family

All covered expenses, including prescription drugs, accumulate toward both the preferred and non-preferred Deductible. Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Members with a Family Deductible do not have an Individual Deductible to satisfy. Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the plan year.

<b>Member Coinsurance</b>	20%		40%	
Applies to all expenses unless otherwise stated.				
<b>Coinsurance Limit (per plan year)</b>	\$3,000	Employee	\$7,000	Employee
	\$9,000	Family	\$21,000	Family

All covered expenses, excluding prescription drugs, accumulate toward both the preferred and non-preferred Payment Limit.

Certain member cost sharing elements may not apply toward the Coinsurance Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage (except any deductibles, copays, and penalty amounts) may be used to satisfy the Payment Limit. Members with a Family Out-of-Pocket Maximum do not have an Individual Out-of-Pocket Maximum to satisfy. Once Family Coinsurance Limit is met, all family members will be considered as having met their Coinsurance Limit for the remainder of the plan year.

<b>Lifetime Maximum</b>	Unlimited except where otherwise indicated.		Unlimited except where otherwise indicated.	
All covered expenses, including prescription drugs, accumulate toward both the preferred and non-preferred Lifetime				
<b>Primary Care Physician Selection</b>	Not applicable		Not applicable	

**Certification Requirements -**

Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is \$400 per occurrence.

<b>Referral Requirement</b>	None		None	
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PREVENTIVE CARE	PREFERRED CARE	NON-PREFERRED CARE
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<b>Routine Adult Physical Exams/ Immunizations</b>	\$25 office visit copay; deductible waived	40% after deductible
1 exam per 12 months for members age 18 to age 65; 1 exam per 12 months for adults age 65 and older.		

<b>Routine Well Child Exams/Immunizations</b>	\$25 office visit copay; deductible waived	40% after deductible
7 exams in the first 12 months of life, 2 exams in the 13th-24th months of life; 1 exam per 12 months thereafter to age 18.		

<b>Routine Gynecological Care Exams</b>	\$35 office visit copay; deductible waived	40% after deductible
Included Pap smear and related lab fees, limited to 1 exam per plan year.		

<b>Routine Mammograms</b>	Covered 100%; deductible waived	40% after deductible
For covered females age 40 and over, limited to 1 mammogram per calendar year.		

<b>Routine Digital Rectal Exam / Prostate-specific Antigen Test</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
For covered males age 40 and over		



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<b>Colorectal Cancer Screening</b> For all members age 50 and over.	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
<b>Routine Eye Exams</b> 1 routine exam per 12 months.	\$35 office visit copay after deductible	Not Covered
<b>Routine Hearing Exams</b> 1 routine exam per 24 months.	\$35 office visit copay after deductible	Not Covered
<b>PHYSICIAN SERVICES</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Office Visits to Non-Specialist</b> (non-surgical)	\$25 office visit copay; deductible waived	40% after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
<b>Specialist Office Visits</b> (non-surgical)	\$35 office visit copay; deductible waived	40% after deductible
<b>Office Visits for Surgery</b>	20% after deductible	40% after deductible
<b>Maternity OB Visits</b>	Covered same as Specialist Office Visit for initial visit only; thereafter covered 100%; deductible waived	40%
<b>Allergy Testing</b>	Covered as either PCP or specialist office visit; deductible waived	40% after deductible
<b>Allergy Injections</b>	20% after deductible	40% after deductible
<b>DIAGNOSTIC PROCEDURES</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Diagnostic Laboratory and X-ray</b> except for Complex Imaging Services	20% after deductible	40% after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing		
<b>EMERGENCY MEDICAL CARE</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Urgent Care Provider</b> (benefit availability may vary by location)	20% after deductible	40% after deductible
<b>Non-Urgent Use of Urgent Care Provider</b>	50% after deductible	50% after deductible
<b>Emergency Room</b>	20%; deductible waived	Same as preferred care.
<b>Non-Emergency care in an Emergency Room</b>	50% after deductible	50% after deductible
<b>Ambulance</b>	20% after deductible	40% after deductible
<b>HOSPITAL CARE</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Inpatient Coverage</b>	20% after deductible	40% after \$200 per confinement deductible after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
<b>Inpatient Maternity Coverage</b>	20% after deductible	40% after \$200 per confinement
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
<b>Outpatient Hospital Expenses</b> (including surgery)	20% after deductible	40% after deductible
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
<b>MENTAL HEALTH SERVICES</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Inpatient</b>	20% after deductible	20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
<b>Outpatient</b>	\$35 copay after deductible	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
<b>ALCOHOL/DRUG ABUSE SERVICES</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>



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<b>Inpatient</b>	20% after deductible	40% after \$200 per confinement deductible after deductible
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The member cost sharing applies to all covered benefits incurred during a member's inpatient stay

<b>Outpatient</b>	\$35 copay after deductible	40% after deductible
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The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit

<b>OTHER SERVICES</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Convalescent Facility</b>	20% after deductible	40% after \$200 per confinement deductible after deductible

Limited to 60 days per plan year.

The member cost sharing applies to all covered benefits incurring during a member's inpatient stay

<b>Home Health Care</b>	20% after deductible	40% after deductible
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Limited to 120 visits per plan year.

Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.

<b>Hospice Care - Inpatient</b>	Covered 100% after deductible	Covered 100% after \$200 per confinement deductible after deductible
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The member cost sharing applies to all covered benefits incurred during a member's inpatient stay

<b>Hospice Care - Outpatient</b>	Covered 100% after deductible	Covered 100% after deductible
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The member cost sharing applies to all covered benefits incurred during a member's outpatient visit

<b>Private Duty Nursing - Outpatient (Limited to 70 eight hour shifts per plan year)</b>	20% after deductible	40% after deductible
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<b>Outpatient Short-Term Rehabilitation</b>	20% after deductible	40% after deductible
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Includes speech, physical, and occupational therapy.

<b>Spinal Manipulation Therapy</b>	20% after deductible	40% after deductible
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Limited to 25 visits per plan year

<b>Durable Medical Equipment</b>	20% after deductible	40% after deductible
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<b>Diabetic Supplies</b>	Not Covered	Not Covered
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<b>Prescription Drugs</b>	Not Covered	Not Covered
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<b>Transplants</b>	20% Preferred coverage is provided at an IOE contracted facility only; after deductible	40% after \$200 per confinement deductible after deductible Non-Preferred coverage is provided at a Non-IOE facility.
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**"Other" Health Care – 20% member coinsurance after the preferred (per plan year) deductible for services that are neither "preferred" nor "non-preferred"**

<b>FAMILY PLANNING</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Infertility Treatment</b> Diagnosis and treatment of the underlying medical condition.	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
<b>Voluntary Sterilization</b> Including tubal ligation and vasectomy	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible

**GENERAL PROVISIONS**



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**Dependents Eligibility (Includes dependent grandchildren)** Spouse, children from birth to age 19 or to age 25 if in school

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**Pre-existing Conditions Exclusion** On effective date: Waived  
After effective date: Full Postponement

This plan imposes a pre-existing condition exclusion, which may be waived in some circumstances and may not be applicable to you. A pre-existing condition exclusion means that if you have a medical condition before coming to this plan, you may have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received or for which the individual took prescribed drugs within 90 days. Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, 90 days ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 365 days from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. If you had prior creditable coverage within 90 days immediately before the date you enrolled under this plan, then the pre-existing conditions exclusion in your plan, if any, will be waived.

If you had no prior creditable coverage within the 90 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 90 day gap from the date your prior coverage terminated to your enrollment date), we will apply your plan's pre-existing conditions exclusion. In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any certificates of creditable coverage you have. Please contact Aetna Member Services at 1-888-982-3862 if you need assistance in obtaining a certificate of creditable coverage from your prior carrier or if you have any questions on the information noted above. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 31 days of birth, adoption, or placement for adoption. Note: For late enrollees, coverage will be delayed until the plan's next open enrollment, and the pre-existing condition exclusion will be applied from the individual's effective date of coverage.

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This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

Plans are administered by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services.

The following is a list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval.
- Durable medical Equipment
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.



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- Hearing aids
- Home births
- Immunizations for travel or work except where medically necessary or indicated.
- Implantable drugs and certain injectible drugs including injectible infertility drugs.
- Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.
- Orthotics except diabetic orthotics.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Treatment of behavioral disorders.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. . Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at **1-888-98-AETNA (1-888-982-3862)**.

Puede estar disponible la traducción de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-98-AETNA (1-888-982-3862)**.

Plan features and availability may vary by location and group size.  
For more information about Aetna plans, refer to **www.aetna.com**.

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Toll-Free: 1-800-361-4542

Fax: 330-405-8081

Your prescription drug benefit is administered by EnvisionRxOptions. Headquartered in Twinsburg, Ohio, EnvisionRxOptions has been providing pharmacy benefit management services nationally since 2001. Additional information about EnvisionRxOptions and your prescription benefit can be found by registering at [www.envisionrx.com](http://www.envisionrx.com). The following information is an overview of the Rice University prescription drug benefit being administered by EnvisionRxOptions.

Your prescription drug benefit features a formulary drug list. A formulary is a list of preferred medications organized into groups or "Tiers". Enclosed is a pocket formulary which lists the most frequently prescribed medications. For a full formulary listing please visit [www.envisionrx.com](http://www.envisionrx.com).

Copays, the portion of the drug cost that you are responsible to pay, are listed in the table below.

	30-Day Retail				90-Day Mail Order		
	Tier 1 Generic	Tier 2 Formulary Brand	Tier 3 Non-Formulary Brand	Tier 4 Specialty Medications	Tier 1 Generic	Tier 2 Formulary Brand	Tier 3 Non-Formulary Brand
Copay	\$10.00	\$30.00	\$50.00	25% up to \$75.00	\$20.00	\$60.00	\$100.00

Your benefit plan may have certain restrictions regarding refills. Please refer to the Summary Benefit Plan provided by your plan or contact your Plan Administrator. You may also call our Customer Service Help Desk at 1-800-361-4542.

To access our Pharmacy Locator, please visit [www.envisionrx.com](http://www.envisionrx.com). You may also call the EnvisionRxOptions Help Desk at 1-800-361-4542 to see if your pharmacy is in the network.

## **Orchard Pharmaceutical Services**

As a valued client of EnvisionRxOptions, we are pleased to provide mail order services through our affiliate company, Orchard Pharmaceutical Services, located in North Canton, Ohio.

Mail order is an excellent way to receive prescriptions you will be taking for a long time with no worries about weather or availability of supply at the local pharmacy. For individuals who are taking maintenance medications, you may want to consider utilizing the mail order service for the convenience of home or office delivery.

Please refer to the enclosed Orchard Pharmaceutical Services Brochure for instructions on how to use the Orchard Mail Order Pharmacy. **You will need to obtain NEW 90 Day supply prescriptions from your physician.** Mail the original prescription(s) written for a 90 day supply of your medication (plus refills, if applicable) with the enclosed brochure, along with your first payment or payment information.

Before you mail in a new prescription, you must REGISTER your information with Orchard Mail Order Pharmacy. You may use any of the following 3 easy registration options:

1. **Online: (Recommended method)** Visit [www.orchardrx.com](http://www.orchardrx.com) and select **Not registered? Click here to register.** Your account will activate within 24 hours. By registering online, members can also track the progress of their orders.
2. **Phone:** Call Orchard Pharmaceutical Services Customer Service at 1-866-909-5170 to speak with a representative.
3. **Mail:** Complete the Registration and Prescription Order Form enclosed in this packet.

Once registered, your Physician can fax your prescription(s) to Orchard at 1-866-909-5171. Only faxes sent from a physician's office will be valid.

## **Walgreens Specialty Pharmacy**

EnvisionRxOptions has selected Walgreens Specialty Pharmacy as an exclusive provider for specialty medications as part of your prescription drug plan. What this means is that you and your family will receive the personalized care and expertise of Walgreens Specialty Pharmacy's dedicated pharmacists, which is essential to successful therapy. This is because Walgreens Specialty Pharmacy goes beyond traditional retail pharmacy, helping you get the most from your specialty medication therapy.

Because specialty medications can be more difficult to manage, Walgreens Specialty Pharmacy offers the following patient support services at no charge:

- Personalized support to help you achieve the best results from your prescribed therapy
- Convenient delivery to your home or prescriber's office
- Easy access to a Care Team who can answer medication questions, provide educational materials about your condition, help you manage any potential medication side effects, and provide confidential support—all with one toll-free phone call
- Assistance with your specialty medication refills

*As a convenience, you can choose to receive your first specialty prescription through the mail or pick it up at a retail Walgreens location. After that first fill you will be required to use Walgreens Specialty Pharmacy for all of your specialty medication needs.* If you have any questions, or to begin taking advantage of these complimentary patient support services, please call Walgreens Specialty Pharmacy toll free at **1-866-823-2712**.

## **Glucometer Replacement**

EnvisionRxOptions has a program available to members that allows them to receive a free glucometer. Call **1-866-224-8892** for an Abbott Diabetes Care Glucometer (FreeStyle and the Precision Xtra<sup>®</sup> Blood Glucose & Ketone Monitoring Systems) or **1-877-229-3777** for a Bayer HealthCare, Diabetes Care Glucometer (Ascensia<sup>®</sup> CONTOUR<sup>®</sup> and Ascensia<sup>®</sup> BREEZE<sup>®</sup>). **Please identify EnvisionRxOptions as your pharmacy benefits administrator**, and Abbott or Bayer will take care of the rest. There is a limit of one glucometer per member.

## **Complaints and Appeals**

If you have a complaint or need assistance, please call our Customer Service Help Desk at 1-800-361-4542. Please refer to the Summary Benefit Plan provided by your plan or contact your Plan Administrator for instructions on how to file a grievance with your plan or appeal a coverage determination.

If you have any questions regarding your prescription drug benefit, please call the EnvisionRxOptions Customer Service Help Desk at 1-800-361-4542.

Sincerely,

***EnvisionRxOptions***