

APPENDIX A: COVERED SERVICES AND CONDITIONS OF SERVICE: POS AND TRADITIONAL INDEMNITY OPTIONS

Covered Services and Conditions of Service

To be a “**covered service**” under the **POS** and **Traditional Indemnity** options, the service:

- Must be **medically necessary** for the treatment of illness or injury or it must be for the preventive care benefits that are specifically stated as **covered**,
- Must be provided by a licensed and accredited health care **provider** practicing within the scope of his or her license in the state in which the license applies,
- Must be listed as a **covered** service and satisfy all the required conditions of service as shown in this Appendix, and
- Must not be listed as excluded (see “Exclusions”).

This Appendix highlights **covered** services and conditions of service in alphabetical order.

For **covered** services and conditions of service under an **HMO**, contact your **HMO**.

Acupuncturist’s Services

The following **medically necessary acupuncturist’s** services are **covered** under the **POS** and **Traditional Indemnity** options:

- Use of acupuncture instead of traditional anesthesia during surgery, and
- Acupuncture to relieve pain, illness or impaired mobility in the muscles and joints.

The following conditions of service apply to **medically necessary covered** services provided by an **acupuncturist**:

- Limitations apply under the **Traditional Indemnity** option and **out-of-network** under the **POS** option (see “Benefit Limits and Maximums” under each of the medical options). However, use of acupuncture as a surgical anesthetic does not count toward the limit on your number of acupuncture visits.

- Coverage is provided only for an acute condition (one that is currently causing pain, illness or decreased mobility and for which improvement can be measured in the short term). Periodic visits for preventive care or to maintain a current state of health are not **covered**.

Ambulance

The following **ambulance** services are **covered** under the **POS** and **Traditional Indemnity** options:

- Transportation to the nearest appropriate medical facility in an **emergency** (a **physician's** order is not required)
- **Medically necessary emergency** services (including administering to wounds, electrocardiograms, cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions) delivered by appropriately licensed personnel employed by the **ambulance** company
- Transfer from a **non-network** to a **network hospital** (only applies if **covered** under the **POS** option)
- Transfer to the closest qualified **hospital** if the first **hospital** was not equipped to handle the patient's condition
- Transfer from a **hospital** to an **extended care facility** or transfer from a **hospital** or an **extended care facility** to the patient's home if the:
 - Patient is being discharged into a **home health care agency's** care,
 - Patient's condition requires a medical professional's attendance, and
 - The **extended care facility** or home health care was **precertified**.

Air **ambulance** is limited to a maximum payment of \$5,000 per occurrence, and is **covered** only when the participant is in a location that is inaccessible to ground **ambulance** or the patient's status and travel conditions indicate that delays resulting from the use of ground **ambulance** would create significant and unnecessary risk to the patient, and the risk would be clearly diminished with the use of an air **ambulance**.

Anesthesia

Anesthesia is **covered** when **medically necessary**, and includes services related to upper and lower gastrointestinal (GI) endoscopies.

Blood and Blood Derivatives

Blood and blood derivatives are **covered** when **medically necessary** for treatment or therapy due to an illness or injury, and include blood, blood plasma, and other blood products.

Centers of Excellence

Aetna has arrangements with certain facilities to act as **centers of excellence** to treat special conditions such as organ transplants. Under the **POS** option, if you are directed to a **center of excellence** by your **PCP** or **network specialist** or through the **precertification** process, you will receive **in-network** benefits. Under the **Traditional Indemnity** option, you must be referred through the **precertification** process to receive benefits.

Covered services include **medically necessary** services certified by the **health care company** as requiring the specialized care generally associated with a **center of excellence**, such as organ transplants.

Treatment at a **center of excellence** is subject to all conditions of service that apply to any treatment of illness or injury, including the exclusion of an **experimental or investigative treatment, drug or device**.

While you are encouraged to utilize these centers, you are not required to do so. You may obtain these specialized services from any facility licensed to provide them.

Travel and Lodging Benefit

If you or a **covered dependent** is referred to a **center of excellence** more than 50 miles from your home for non-experimental transplant surgeries, certain travel and lodging expenses are **covered** for the patient and an accompanying family member or individual approved by **Aetna**.

To be eligible:

- The patient must be certified by **Aetna** for admission to a **center of excellence** more than 50 miles from his or her residence.
- The patient must be a **covered** participant under the Medical Plan, and

- The travel companion must be essential to the patient's ability to secure the medical care.

The following charges are **covered** under the Travel and Lodging benefit:

- Subject to the maximums shown below, transportation costs are **covered** for the patient, and transportation and lodging costs are **covered** for one travel companion or, if the patient is under 23 years old, for both parents or guardians.
- Transportation costs are **covered** for one round trip to and from the **hospital** location. For airline travel, the generally available coach fare will be reimbursed. When travel by private automobile is used, mileage will be reimbursed at the per-mile rate in force at that time.
- Reasonable lodging and meal expenses are **covered**. Lodging must be pre-approved by **Aetna** to be **covered**. Benefits are limited to a maximum of \$50 per day per person (not including the patient), and up to \$10,000 per admission for transportation, lodging and meal expenses combined for patient and companion(s).

Chiropractic Services

The following **medically necessary** chiropractic services are **covered** under the **POS** and **Traditional Indemnity** options:

- Neuromuscular treatment and manipulation to relieve pain or restore mobility by maladjustment of the muscles and ligaments associated with the spinal column, and
- **Medically necessary** X-rays.

The following conditions of service apply to **covered** chiropractic services:

- Coverage is provided only for treatment of musculoskeletal conditions. That means conditions that are related to the muscles and ligaments. Conditions such as a stiff neck and lower back pain are **covered**. Conditions such as nausea and dizziness are not **covered** for treatment with chiropractic services.
- Coverage is provided only for the treatment of an acute condition -- that is, one that is currently causing pain or decreased mobility, and for which improvement can be measured in the short term. The Medical Plan does not cover for the treatment for maintenance conditions. Periodic visits for preventive care or to maintain a current state of health are not **covered**.

- Care must be provided in an office setting. Services are not **covered** if provided in your home, or if delivered in a **hospital** or other facility.
- A **chiropractor** may order X-rays when **medically necessary**. However, any other tests (for example, a magnetic resonance image, or MRI) must be ordered through a **physician**.
- Coverage is limited to 60 visits in a calendar year for **POS** and **Traditional Indemnity** option benefits. Under the **POS** option, **out-of-network** visits will apply to the **in-network** limit, and **in-network** visits will apply to the **out-of-network** limit.

Circumcision

Circumcision of a male is **covered** if performed by a **physician** or mohel. Under the **POS** option, only **out-of-network** benefits are available if a mohel performs the circumcision.

Colorectal Screening

Participants at least age 50 are **covered** for preventive colorectal screening under the **POS** option and **Traditional Indemnity option**.

Under the **POS** option or **Traditional Indemnity option**, benefits for routine colorectal screenings are limited to one screening (home test kit to check for blood in the stool) per Plan Year for those age 50 and over. This schedule applies only to colorectal screenings that are for preventive health screening. If a **physician** orders a colorectal screening to diagnose specific symptoms or observations, that is considered treatment of illness and is not subject to the schedule of this preventive care benefit.

Durable Medical Equipment

The following **medically necessary** durable medical equipment is **covered** under the **POS** and **Traditional Indemnity** options:

- Purchase or rental of durable medical equipment supplied by a properly licensed vendor. Examples include wheelchairs, kidney dialysis equipment, and mechanical equipment for the administration of oxygen.
- Prosthetic devices supplied by a properly licensed vendor. A prosthesis is a device designed to partially compensate for the loss of a body part. **Covered** prostheses include artificial legs or arms (or parts thereof, such as a foot), eyes, and portions of internal bodily organs.

- Orthotics necessary for daily living activities.
- Compression garments are covered in accordance with the **health care company's** guidelines

The following conditions of service apply to **covered** durable medical equipment:

- Supplies must be prescribed by a **physician**. Under the **POS** option, for **in-network** benefits to be available, the equipment must be prescribed by your **PCP** or a **network specialist**, and you must rent or purchase the equipment from a medical supplier that participates in the **network**.
- Supplies must be (a) manufactured specifically for medical use, (b) usable only by the patient (and not, for example, by the patient's **lawful spouse**), and (c) not for exercise, environmental control (such as air conditioners and humidifiers), or personal comfort.
- Purchase or rental of the original equipment is **covered**. Total **covered** charges for purchase and rental combined will not exceed the purchase price of the item.
- Repair and replacement of orthotics and durable medical equipment are **covered** when the equipment no longer fits the participant in the manner that is both the most efficient for the participant and the most cost effective for the **Participating Company**, as determined by the **health care company**.
- Replacement of prosthetic devices is **covered** only when made necessary by anatomical change.

Emergency Room

If you enrolled in the **POS** option, you pay the emergency room **copayment** for services provided in an emergency room during an **emergency**. This emergency room **copayment** is waived if you are admitted to the **hospital** for continued care.

Extended Care Facility

To receive the full amount of benefits available under the **Traditional Indemnity** option or for **out-of-network** care under the **POS** option, **precertification** is required for admission to an **extended care facility**. **Precertification** is done by your **PCP** for **extended care facility** services provided **in-network** under the **POS** option.

Covered expenses include:

- Room and board in a semi-private room.
- Prescription drugs administered during the stay.
- Nutritional support.
- Professional **physician** and nursing services provided by facility staff. The Medical Plan covers the initial consultation between your doctor and another **specialist** (or a number of different **specialists**, as **medically necessary**), as well as one **physician's** visit per day in addition to normal postoperative visits by your surgeon(s). Charges for **physician** visits in excess of one per day are **covered** if medically necessary.
- **Medically necessary physician's** visits.
- **Medically necessary** services provided on the order of a **physician** that are normally provided by an **extended care facility**, including, but not limited to, X-ray and laboratory tests, medical and surgical dressings, radiation therapy, and anesthetics and their administration.

The following conditions of service apply to **covered extended care facility** expenses:

- Generally, you must receive **precertification** for **extended care facility** benefits to be **covered**.
- Confinement must be on the order, and under the supervision, of a **physician**.
- Confinement must not be mainly for the convenience of the patient's family.
- Under the **POS** option, **out-of-network** benefits are limited to 60 days of **in-patient** care in a year. Any days incurred **in-network** count towards the maximum available days **out-of-network** and vice versa. **Traditional Indemnity** option benefits are limited to 120 days of **in-patient** care in a year. Under the **POS** and **Traditional Indemnity** options, these limits are combined with the number of days of **hospital** confinement if preceding confinement and for the same condition in the **extended care facility**. Days in the **hospital** count as full days toward this limit. Days in an **extended care facility** count as one-half day.

Family Planning Services

The following family planning services are **covered** under the **POS** and **Traditional Indemnity** options:

- Fertility testing and examination.

- Voluntary sterilization or reversal of voluntary sterilization.
- Birth control devices and medication, excluding those available over the counter. Birth control obtained through a pharmacy may be **covered** under the **Prescription Drug Program**.
- Certain medical and surgical procedures (including prescription drugs and devices not available over the counter) supporting treatment to improve a normally caused infertility problem (please note “Exclusions”).

No other family planning services are **covered**.

If family planning prescriptions or devices are provided directly by the doctor, they are **covered** under your medical option. If these items are provided through a pharmacy, they are **covered** by the **Prescription Drug Program**. No benefits are provided for over-the-counter products.

Home Health Care

To receive the full amount of benefits available under the **Traditional Indemnity** option or for **out-of-network** care under the **POS** option, **precertification** is required for **home health care agency** services. **Precertification** is done by your **network provider** for **in-network home health care agency** services under the **POS** option.

Covered services include:

- **Speech therapy, physical therapy and occupational therapy.**
- Services of a registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN).
- Services of a home health aide who is not a nurse, but only if nursing services are also being provided during the course of treatment.
- Services of licensed clinical social workers.
- Drugs and medications administered to you by the **home health care agency**. This does not include drugs and medications that may be picked up from a pharmacy and/or delivered to your home. Drugs received by filling a prescription at a pharmacy may be **covered** under the terms of the **Prescription Drug Program** (see “Prescription Drug Program”).

The following conditions of service apply to **covered home health care agency** expenses:

- Generally, you must receive **precertification** for home health care benefits to be **covered**.
- Care must be provided in accordance with a **physician's** written treatment plan. The treatment plan must be re-certified by the attending **physician** at least every 30 days if care continues.
- Care must be given in the patient's home and provided in lieu of **in-patient** care. That means that you are not physically able to go to a **provider's** office for treatment, and without home health care services you would have to be confined in a **hospital** or other facility.
- Services must be provided by a person who is employed by the **home health care agency**, or who has a subcontracting relationship with the agency.
- Custodial and domestic services are not **covered**.
- Under the **POS** option, **out-of-network** benefits are limited to a maximum of 100 visits in a calendar year. **Traditional Indemnity** option benefits are limited to a maximum of 200 visits in a calendar year. Under the **POS** option, any visits incurred **in-network** count toward the maximum available visits **out-of-network**. Each visit by a nurse or therapist, regardless of duration, is one visit. Up to four hours of care provided by a home health aide counts as one home health care visit.

Hospice

The following **hospice** services are **covered** under the **POS** and **Traditional Indemnity** options:

- Room and board when the patient is confined as a **hospice in-patient**.
- Part-time nursing services for the provision of medical and palliative care. Palliative care is care that is rendered to relieve the symptoms or effects of a disease without curing the disease.
- Services of the **hospice's** non-clinical staff, such as home health aides.
- Counseling services provided to the patient and immediate family, when provided by duly licensed social workers, psychologists (Ph.D.) or pastoral counselors.

These services are part of the overall charge of the **hospice**; any separate charges made for these services are not **covered**.

- Bereavement counseling provided to **covered dependents**, when provided by duly licensed social workers, psychologists (Ph.D.) or pastoral counselors on staff or under contract to the **hospice**. Coverage is for a maximum of 15 sessions, provided within three months of the patient's death.
- Nutritional counseling and special meals.
- Administration of pain-relief medications.
- Drugs and medications administered to you by the **hospice**. This does not include drugs and medications you may obtain from a pharmacy and have delivered to your home. Drugs received by filling a prescription at a pharmacy come under the terms of the **Prescription Drug Program** (see "Covered Prescription Drug Items").

The following conditions of service apply to **covered hospice** expenses:

- **Hospice** services are **covered** only when provided to terminally ill patients. There must be a written prognosis from a **physician** that the patient's life expectancy will not exceed six months.
- Respite care is **covered** to a maximum of five days during a period of six months. Respite care is provided by a **hospice** so that an unpaid caretaker, such as a **lawful spouse**, may be temporarily relieved of caretaking duties.
- Services must be provided by a person who is employed by the **hospice** or who has a subcontracting relationship with the **hospice**.
- When services are provided in the patient's home, services of a nurse and home health aide are **covered** on a part-time basis (less than 24-hour care). Full-time (24-hour) care is not **covered**.
- **POS out-of-network** and **Traditional Indemnity** option benefits are subject to a maximum of 210 days in a lifetime. Under the **POS** option, **in-network** benefits are provided as authorized by your **PCP** or **network specialist**. **In-network** days count toward the **out-of-network** limit, and vice versa.

Hospitalization

To receive the maximum amount of benefits available under the **Traditional Indemnity** option or **out-of-network** under the **POS** option, **precertification** is required for all

hospital admissions. **Precertification** is done by the **PCP** or **network specialist** for **in-network** hospitalization under the **POS** option.

Covered hospital expenses include:

- Room and board charges for the appropriate unit for your condition (acute care, intensive care, isolation care or a rehabilitation unit).
- **Medically necessary** services provided on the order of a **physician** that are normally provided by a **hospital** (including, but not limited to, X-ray and laboratory tests, medical and surgical dressings, radiation therapy and anesthetics and their administration).
- Services in the emergency room, delivery room, operating room or therapy unit.
- Diagnostic and therapeutic services provided on an **out-patient** basis, such as pre-admission testing or **out-patient** surgery.
- Diagnostic services provided on an **in-patient** basis when you are hospitalized primarily for treatment (such as surgery).
- Professional **physician** and nursing services provided by facility staff (including the initial consultation between your doctor and another **specialist** -- or multiple **specialists**, if **medically necessary** -- as well as one in-hospital **physician's** visit a day in addition to normal postoperative visits by your surgeon(s); more than one visit a day is **covered** if **medically necessary**).
- Drugs and medications administered while you are in the **hospital** as an **in-patient** or **out-patient**.

The following conditions of service apply to **covered hospital** expenses:

- The **hospital** admission and services must be ordered by a **physician**. You cannot admit yourself to the **hospital**.
- Room and board charges are **covered** for a semi-private room. If you request a private room, you must pay the difference in cost between a semi-private room and a private room. Under the **Traditional Indemnity** option, if a non-**NAP network hospital** only has private rooms, the **allowable amount** will be 90% of the most prevalent room and board charge. However, if the patient's condition is contagious and a private room is **medically necessary** for the health of the other patients, eligible expenses for a private room will be covered.

- Charges for room and board on a Saturday or Sunday will not be **covered** if you enter the **hospital** on Friday, Saturday or Sunday for a non-**emergency** condition and surgery is not performed on the admission date.
- If you are admitted for surgery, it must be performed on the admission date (unless an earlier admission was precertified as **medically necessary**).
- If you enter a **hospital** as an **in-patient** primarily for diagnostic studies, lab tests or physical therapy, room and board charges are not **covered**.

Under the Newborn's and Mothers' Health Protection Act, you are entitled to minimum **hospital** coverage of 48 hours following a vaginal birth and 96 hours following a cesarean birth. Care beyond this point must be precertified to be **covered**. The Medical Plan cannot require you to obtain **precertification** for this minimum length of stay. Mother and child may leave earlier if the care **provider**, in consultation with the mother, decides to discharge the patients earlier.

For admissions for treatment of mental health or **chemical dependency** conditions, see "Mental Health and Chemical Dependency Program."

Mammograms

Female participants are **covered** for routine mammogram testing under the **POS** and **Traditional Indemnity** options, in accordance with age/frequency guidelines established by the **Claims Administrator**.

The age/frequency guidelines apply to mammograms that are for preventive health screening. If a **physician** orders a mammogram to diagnose specific symptoms or observations, that is considered treatment of illness and is not subject to the schedule of this preventive care benefit.

Maternity Care

Maternity benefits cover prenatal care (periodic exams during pregnancy), childbirth, routine nursery care for a newborn and postpartum care. For **POS in-network** benefits, care may be provided by a **PCP** or a **network** obstetrician.

The following maternity expenses are **covered** under the **POS** and **Traditional Indemnity** options:

- Prenatal visits on a schedule approved by the attending **physician**.
- Hospitalization for delivery.

- Services of a **birthing center** in lieu of a **hospital**.
- Services of a licensed midwife. A licensed midwife may bill as an independent **provider** for services provided in the **hospital, birthing center**, or home, or provide services as part of a **birthing center's** services.
- Routine nursery care provided to the newborn during the mother's stay at the **hospital**. Under **POS in-network**, such care is provided as authorized or furnished by the **PCP** or **network specialist**; however under **POS out-of-network** and **Traditional Indemnity** option benefits, this includes one pediatric examination by a **hospital** staff **physician**. Medical services for newborns by an outside **physician** or beyond routine care are considered treatment of an illness and may be **covered** services as long as the newborn is enrolled within 31 days of the birth.

Mental Health and Chemical Dependency

See "Mental Health and Chemical Dependency Program" for more information.

A **provider** may treat only those conditions, either mental health or **chemical dependency**, appropriate to his or her certification and licensing status, in order for such services to be **covered** under the Medical Plan.

If **out-patient** treatment is provided through a facility, the following conditions of service apply:

- Services must be provided at a facility that is a general acute care **hospital**, an acute care psychiatric **hospital** or an acute care **chemical dependency** facility, and
- Services must be provided by a professional who meets the requirements of a **covered** mental health professional.

The following conditions of service apply to **covered in-patient** care under the **Mental Health and Chemical Dependency Program**:

- Services must be ordered by a **physician**. You cannot admit yourself to the **hospital**.
- Room and board charges are **covered** for a semi-private room. If you request a private room, you must pay the difference in cost between a semi-private room and a private room.

For **partial hospitalization, residential treatment** or services of a **group home or halfway house (alternative care)**:

- Services are **covered** only if provided **in-network**. Services received **out-of-network** are not **covered**.
- Services must be provided with the prior approval of **Aetna** and rendered by a **network provider**.

Nutritional Counseling

Nutritional counseling is **covered** under the **POS** option only if it is coordinated by your **network provider**.

Covered services include:

- Nutritional education and planning by a certified nutritionist, upon the initial diagnosis or change in severity of a medical condition that can be partially managed through special diets. Diabetes is one example of such a condition.

The following conditions of service apply to **medically necessary** nutritional counseling services **covered** under the **POS** option:

- Services are **covered** under the **POS** option only when provided **in-network** by a licensed nutritionist as directed by your **PCP** or **network specialist**. Services are not **covered** under the **Traditional Indemnity** option or **out-of-network** under the **POS** option.
- Services are intended to assist a person in defining and managing a dietary plan in response to a newly recognized medical condition. Services are not intended to be ongoing. Meal preparation is not **covered**.
- Services are not **covered** for general health or wellness, or weight loss or gain objectives that are not associated with a diagnosed illness.

Organ Donation

Under certain circumstances, the costs for a living person to donate an organ are **covered** under the **POS** and **Traditional Indemnity** options.

Covered expenses may include necessary medical and surgical charges (including **hospital** charges) for extraction of the donated organ or bone marrow and necessary follow-up care.

The following conditions of service apply to **covered** organ donation services:

- If both the donor and recipient are **covered** under the Medical Plan, the recipient's **health care company** must have precertified the transplant procedure. Benefits will be provided to both the donor and recipient.
- If the donor is **covered** under the Medical Plan and the recipient is not **covered** under the Medical Plan, the transplant must be one that the **health care company** would precertify if the recipient were **covered** under the Medical Plan. If the recipient's coverage does not provide for donor expenses, the Medical Plan will provide benefits for the donor for his or her expenses only. No benefits will be provided for the recipient.
- If the donor is not **covered** under the Medical Plan and the recipient is **covered** under the Medical Plan, the recipient's **health care company** must precertify the transplant procedure. Additionally, benefits for the donor are available from the Medical Plan only if the donor has no other coverage of his or her own for the procedure.

Out-Patient Medical Facilities

The following **out-patient medical facility** expenses are **covered** under the **POS** and **Traditional Indemnity** options:

- Services of a medical laboratory in the taking and analysis of fluid or tissue samples.
- Services of an **out-patient** surgical center for surgeries that may be safely performed on an **out-patient** basis.
- **Birthing centers** for childbirth, including the services of a licensed midwife.
- Services of an **urgent** care facility for treatment of **emergency** and **urgent** medical conditions.
- Services of an **out-patient** rehabilitation facility for rehabilitation services (see "Rehabilitation Therapy").

Out-patient medical facility services must be ordered by and under the direction of a **physician**. For example, if you go to a lab to request your own blood test without a **physician's** order, the lab fee is not **covered**.

Physician's Services

The following **physician's** services are **covered** under the **POS** and **Traditional Indemnity** options:

- General medical services (the diagnosis and treatment of illness within generally accepted parameters of **physician** practice)
- Obstetrical (maternity) services, including delivery (for more information, see "Maternity")
- Surgery
- Administration of anesthesia
- Pathology (laboratory) services
- Radiology (X-rays), chemotherapy, nuclear medicine, diagnostic ultrasound services and any imaging or scanning techniques
- Services provided by the **physician's** nursing staff
- Preventive services (generally not **covered** for **out-of-network** care under the **POS** option or under the **Traditional Indemnity** option; for more information, see "Preventive Services")
- Medical supplies such as casts and dressings provided as part of the **physician's** services

Podiatric Services

Covered podiatric services include all **medically necessary** services within the scope of a Doctor of Podiatric Medicine's license.

Prescription Drugs

See "Prescription Drug Program."

Preventive Care

Preventive care including mammograms, pap tests and prostate cancer screenings are **covered** under the **POS** option and **Traditional Indemnity** option according to age/frequency guidelines followed by the **Claims Administrator**.

Covered services include:

- Routine physical examinations - in accordance with age, frequency and range of service guidelines followed by the **Claims Administrator**. As of this publication: Age 18 through 64 – once every 24 months; age 65+ - once every 12 months.
- Mammograms – see separate listing “Mammograms”
- Prostate cancer screening - see separate listing “Prostate Cancer Screenings”

Covered services **in-network** under the **POS** option also include

- Well-woman care -- annual gynecological exam and certain appropriate diagnostic tests, including pap smears
- Well-child care -- in accordance with age, frequency and range of service guidelines as established by the **Claims Administrator**. As of this publication: Up to age 1 – 7 exams; between age 1-2 – 2 exams; ages 2 through 17 – 1 per year.
- Immunizations - routine immunizations as appropriate.

Private Duty Nursing

To receive the full amount of benefits available under the **Traditional Indemnity** option or for **out-of-network** care under the **POS** option, **precertification** is required for **private duty nursing**. **Precertification** is done by your **PCP** or **network specialist** for **private duty nursing** services provided by an **in-network provider** under the **POS** option. **Covered private duty nursing** services include nursing services of a registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN) delivered to a **covered** individual who is confined in the home due to a medical condition.

The following conditions of service apply to **covered private duty nursing** services:

- You must receive **precertification** for **private duty nursing** benefits. Without **precertification**, there is no benefit.
- Custodial and domestic services are not **covered**.

- **POS out-of-network** benefits are limited to 100 shifts in a calendar year and **Traditional Indemnity** benefits are limited to a maximum of 200 visits in a calendar year. Under the **POS** option, any shifts incurred **in-network** count toward the maximum available shifts **out-of-network**.

Prostate Cancer Screenings

Under the **Traditional Indemnity** and **POS** options, routine screenings, a digital rectal examination and blood test for PSA (prostate-specific antigen) are **covered** for male participants subject to age/frequently guidelines established by the **Claims Administrator**.

These guidelines apply to services that are for preventive health screening. If a **physician** orders a service to diagnose specific symptoms or observations, that is considered treatment of illness and is not subject to the schedule of this preventive care benefit.

Rehabilitation Therapy

The following **rehabilitation therapy** expenses are **covered** under the **POS** and **Traditional Indemnity** options:

- **Physical therapy** services that assist in the restoration of normal, necessary physical movement, after movement has been acutely impaired by illness or injury. Medically necessary physical therapy services must be for restorative or for the purpose of designing and teaching a maintenance program for the patient to carry out at home.
- **Speech therapy** services that assist in the correction of communication abilities that have been impaired by illness, injury or birth defect.
- **Occupational therapy** services that assist a person in regaining the ability to perform normal activities of daily living after those abilities have been acutely impaired by illness or injury.

The following conditions of service apply to **covered rehabilitation therapy** services:

- Care must be provided under the direct order of a **physician** who determines that you need the services and prescribes how many treatments are necessary. For example, if you go directly to a physical therapist and request services without seeing a **physician** first, the services will not be **covered**.
- The services must be likely to result in clear and reasonable improvement in your condition within three months.

- Generally, rehabilitation services provided in the home are **covered** only when services are provided as part of a **home health care agency's** services and the home health care has been precertified.
- Generally, rehabilitation services provided during an **in-patient** stay in a **hospital** or **extended care facility** are **covered** only when the **in-patient** stay has been precertified.
- **POS out-of-network** and **Traditional Indemnity** option benefits for **speech therapy** are limited to a maximum of 30 **out-patient** visits in a calendar year. Under the **POS** option, any visits incurred **in-network** count toward the maximum available visits **out-of-network**.

The Individual Development Enhancement Act (IDEA) requires that school systems provide this care from age 3 through 18. The Medical Plan will pay benefits for **medically necessary** services that are **covered** under the Medical Plan, but are not otherwise provided through a school system. The Medical Plan will also pay benefits for **medically necessary covered** services outside this age range.

Restorative Surgery

Cosmetic surgery (surgery primarily to improve appearance) is generally not **covered** under the Medical Plan. However, certain restorative surgeries in response to a more serious condition may also be for the purpose of improving appearance. Under these circumstances, restorative surgery and any necessary related services would be **covered**.

The following restorative surgery expenses are **covered** under the **POS** and **Traditional Indemnity** options:

- Surgery to restore an area seriously injured in an accident
- Surgery to correct a birth defect that causes a functional disability
- Surgery to restore breast tissue that was surgically removed, wholly or partially, in response to an illness. In accordance with the Women's Health and Cancer Rights Act of 1988, if a participant is receiving benefits in connection with a mastectomy and elects breast reconstruction in connection with the mastectomy, the following are **covered**:
 - Reconstruction of the breast on which the mastectomy was performed,
 - Surgery and reconstruction of the other breast to produce a symmetrical appearance, and

- Prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedemas.

Post-mastectomy bras are covered in accordance with the **health care company's** guidelines.

The following conditions of service apply to **covered** restorative surgery expenses:

- The treatment must be to correct a condition that represents a serious malformation.
- The treatment must be for the least expensive medically accepted procedure that will adequately restore the malformation.

Second Surgical Opinion

Second surgical opinions are not required, but they are **covered** under the **POS** and **Traditional Indemnity** options. A second opinion is not a substitute for any required **precertification**.

The following expenses are **covered**:

- A second **physician's** opinion concerning the need for a surgery that was recommended by your treating **physician**.
- A third **physician's** opinion if the second opinion conflicts with the first recommendation.

The second and, when warranted, third surgical opinions must be rendered by a **physician** with the appropriate specialty for the recommended procedure.

Wigs

Under special conditions, the **POS** and **Traditional Indemnity** options cover the cost of a wig used for temporary hair loss due to disease or treatment of disease such as chemotherapy. Charges for wigs are **covered** up to a maximum of \$300 in any calendar year.