

2009-2010
Student Health Insurance Plan



UNIVERSITY *of* ST. THOMAS

Underwritten by:
Aetna Life Insurance Company
(ALIC)

Policy Number 474922

WHERE TO FIND HELP

In case of an emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility. For non-emergency situations please visit or call the University of St. Thomas Student Health Service at **1-651-962-6750** or **1-800-328-6818** ext. **2-6750**

For questions about:

- * Insurance Benefits
- * Enrollment
- * Claims Processing
- * Pre-Certification Requirements

Please contact:

Aetna Student Health
P.O. Box 15708
Boston, MA 02215-0014
1-888-407-0445

For questions about:

- * ID Cards

ID cards will be issued as soon as possible. If you need medical attention before the ID card is received, benefits will be payable according to the Policy. You do not need an ID card to be eligible to receive benefits. Once you have received your ID card, present it to the provider to facilitate prompt payment of your claims.

For lost ID cards, contact:

Aetna Student Health
1-888-407-0445

For questions about:

- * Online student enrollment process
- * F-1Waiver Process

Please contact:

University of St. Thomas
Student Health Service
1-651-962-6759

For questions about:

- * Status of Pharmacy Claim
- * Pharmacy Claim Forms
- * Excluded Drugs and Pre-Authorization

Please contact:

Aetna Pharmacy Management
1-800-238-6279 (Available 24 hours)

For questions about:

- * Provider Listings

Please contact:

Aetna Student Health
1-888-407-0445

A complete list of providers can be found using Aetna's **DocFind®** Service at:
www.aetna.com/docfind/custom/studenthealth/index.html or: **www.aetnastudenthealth.com**

For questions about:

On Call International 24/7 Emergency Travel Assistance Services

Please contact:

On Call International at **866-525-1956 (within U.S.)**.

If outside the U.S., call collect by dialing **the U.S. access code** plus **603-328-1956**. Please also visit **www.aetnastudenthealth.com** and visit your school-specific site for further information.

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

IMPORTANT NOTE

Please keep this Brochure, as it provides a general summary of your coverage. A complete description of the benefits and full terms and conditions may be found in the Master Policy issued to the University of St. Thomas. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits. The Master Policy may be viewed at the University's Student Health Insurance Office during business hours.

This student Plan fulfills the definition of Creditable Coverage explained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. At any time should you wish to receive a certification of coverage, please call the customer service number on your ID card.

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STUDENT HEALTH SERVICE

The Student Health Service is your first stop when you are feeling ill or in need of a routine appointment. Our staff is committed to partnering with you in making informed health care decisions. We can provide you with medical care and information on how to minimize your potential for illness or injury, thus maximizing your potential for academic success. Student Health Service is staffed by Internal Medicine and Family Practice Physicians, Psychiatrists, Sports Medicine Physicians, Nurse Practitioners and Registered Nurses. Student Health Service is open weekdays from 8:00a.m. to 4:30p.m. during the Fall and Spring semesters, and 8:00a.m. to 12:00p.m during the Summer. Appointments are recommended.

Questions can be directed to studenthealth@stthomas.edu or call **651-962-6750**.

Services at Student Health Services

Physician's Office Visits 100% of the first 5 visits

Recommended Preventive Services are payable at 100% to a maximum of \$200 (UST Students Only).

Outpatient Mental Nervous Disorder visits are payable at 100% in recommended plan of care.

POLICY PERIOD

- 1) **Students:** Coverage for all insured students enrolled for the Fall Semester will become effective at 12:01a.m. on **August 15, 2009**, and will terminate at 12:01a.m. on **January 15, 2010**.
- 2) **Insured dependents:** Coverage will become effective on the same date that the insured student's coverage becomes effective, or the day after the postmarked date when the completed application and premium are sent, if later. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Master Policy. For more information on Termination of Covered Dependents see page 7 of this Brochure. Examples include, but are not limited to: the date the student's coverage terminates, the date the dependent no longer meets the definition of a dependent.

RATES

	Fall	Spring/Summer
Coverage Period	8/15/09 -1/14/10	1/15/10- 8/14/10
Student rate*	\$429	\$429
Spouse rate	\$1,457.50	\$1,457.50
Per Child rate	\$1,094	\$1,094

*The rates above include both premiums for the student health plan underwritten by Aetna Life Insurance Company, as well as University of St. Thomas administrative fee.

Contact the UST Student Health Insurance Office for summer only rates at **651-962-6752**.

UNIVERSITY OF ST. THOMAS

STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN

This is a brief description of the Accident and Sickness Medical Expense benefits available for the University of St. Thomas students and their eligible dependents. The plan is underwritten by Aetna Life Insurance Company (called Aetna). The exact provisions governing this insurance are contained in the Master Policy issued to the University and may be viewed at the University's Student Health Insurance Office during business hours.

STUDENT COVERAGE

ELIGIBILITY

All degree seeking undergraduate and graduate students and international students holding an F-1 or J-1 Visa, who are enrolled at the University of St. Thomas, and who actively attend classes for at least the first 31 days after the date when coverage becomes effective.

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

ENROLLMENT

Each semester, students will be asked to submit their health insurance information via UST's Murphy Online. When completing the online verification in Murphy Online, students can select the option to purchase the Aetna Student Health Insurance Plan or to enter their existing health insurance information. If the student chooses to enroll in the Aetna Student Health Insurance Plan, the premium will be added to their student account.

All degree seeking undergraduate students taking 12 or more credits and graduate, law, and professional students taking 9 or more credits are *required* to purchase the Student Health Insurance Plan unless they demonstrate coverage under another health plan. They will be automatically enrolled and billed for the Student Health Insurance Plan unless they have entered other insurance within the enrollment/waive deadline dates listed below.

All International students with an F-1 or J-1 visa are automatically enrolled in and billed for the Aetna Student Health Insurance Plan. If students on an F-1 visa have comparable coverage, they may request a waiver through Murphy Online during the enrollment/waive deadline dates listed below.

Exception: A Covered Person entering the armed forces of any country will not be covered under the Policy as of the date of such entry. A pro rata refund of premium will be made for such person, and any covered dependents, upon written request received by Aetna within 90 days of withdrawal from school.

WAIVER PROCESS/PROCEDURE

Degree seeking students that are required to purchase the Aetna Student Health Insurance Plan (undergraduates with 12 or more credits; graduates with 9 or more credits) can waive the Student Health Insurance Plan by entering their other health insurance coverage information into UST's Murphy Online before the waive deadline.

F-1 visa students may request a waiver in UST's Murphy Online if they have health insurance with comparable coverage. They must request the waive before the waive deadline.

Enrollment and Waiver Deadline Dates

Enrollment/Waive Period	
Fall	8/1/09 – 9/30/09
Spring/Summer	1/5/10 – 3/1/10

Waiver submissions may be audited by the University of St. Thomas or Aetna Student Health. By submitting the waiver request, you agree that your current insurance carrier may be contacted for confirmation that your coverage is in force for the applicable policy year and that it meets the school's waiver requirements. Knowingly providing false insurance information will result in penalties under the University's Code of Conduct.

PREMIUM REFUND POLICY

If you withdraw from school within the first 31 days of a coverage period, you will not be covered under the Policy and the full premium will be refunded, less any claims paid. After 31 days, you will be covered for the full period that you have paid the premium for, and no refund will be allowed. (This refund policy will not apply if you withdraw due to a covered Accident or Sickness.)

Exception: A Covered Person entering the armed forces of any country will not be covered under the Policy as of the date of such entry. In this case, a pro-rata refund of premium will be made for any such person and any covered dependents upon written request received by Aetna Student Health within 90 days of withdrawal from school.

DEPENDENT COVERAGE

ELIGIBILITY

Covered students may also enroll their lawful spouse, unmarried dependent natural and adopted children who are under the age of 25 years, dependent child of any age who is disabled, grandchildren who are financially dependent on grandparent for support and live with the grandparent since birth, or any other person whom state of federal law requires to be treated as a dependent for the purposes of health plans. Dependent child includes children appointed as legal guardian and an adoptive child.

ENROLLMENT

The Fall enrollment deadline is September 30, 2009. Dependent enrollment applications will not be accepted after **September 30, 2009**, unless there is a significant life change that directly affects their insurance coverage. (An example of a significant life change would be loss of health coverage under another health plan.) The Spring enrollment deadline is **March 1, 2010**.

NEWBORN INFANT AND ADOPTED CHILD COVERAGE

A newborn child shall be insured for illness, injury, congenital malformation, or premature birth for 31 days from the date of birth. "Newborn child" includes grandchildren who are financially dependent upon a covered grandparent. At the end of this 31 day period, coverage will cease under the University of St. Thomas Student Health Insurance Plan. To extend coverage for a newborn past the 31 days, the Covered Student must: 1) enroll the child within 31 days of birth, and 2) pay the additional premium, starting from the date of birth.

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

Please note: Previously Covered Persons must re-enroll for dependent coverage by **September 30, 2009** for the Fall Semester, and by **March 1, 2010** for the Spring Semester, in order to avoid a break in coverage for conditions which existed in prior policy years. Once a break in continuous coverage occurs, a condition existing during such a break which is a Pre-Existing Condition will not be payable. See Continuously Insured section of this Brochure.

For information or general questions on dependent enrollment, contact Aetna Student Health at **1-888-407-0445**.

CONTINUOUSLY INSURED

Persons who have remained continuously insured under this Policy or other policies will be covered for any Pre-Existing Condition, which manifests itself while continuously insured, except for expenses payable under prior policies in the absence of this Policy. Previously Covered Persons must re-enroll for coverage, including dependent coverage, by **September 30, 2009** for the Fall Semester, and by **March 1, 2010** for the Spring Semester in order to avoid a break in coverage for conditions which existed in prior policy years. Once a break in continuous coverage occurs, the Pre-Existing Conditions Limitation will apply (see page 9).

PREFERRED PROVIDER NETWORK

Aetna Student Health has arranged for you to access a Preferred Provider Network in your local community. Acute care facilities and mental health networks are available nationally if you require hospitalization outside the immediate area of the University of St. Thomas campus.

To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider. It is to your advantage to use a Preferred Provider because savings may be achieved from the Negotiated Charges these providers have agreed to accept as payment for their services. Preferred Providers are independent contractors, and are neither employees nor agents of The University of St. Thomas, Aetna Student Health, or Aetna.

You may also obtain information regarding Preferred Providers by contacting Aetna Student Health at **888-407-0445**, or through the Internet by accessing DocFind at www.aetna.com/docfind/custom/studenthealth/index.html.

- 1) Click on "Enter DocFind"
- 2) Select zip code, city, or county
- 3) Enter criteria
- 4) Select Provider Category
- 5) Select Provider Type
- 6) Select Plan Type – Student Health Plans
- 7) Select "Start Search" or "More Options"
- 8) "More Options" enter criteria and "Search"

**Preferred providers are independent contractors and are neither employees nor agents of Aetna Life Insurance Company, Chickering Claims Administrators, Inc. or their affiliates. Neither Aetna Life Insurance Company, Chickering Claims Administrators, Inc. nor their affiliates provide medical care or treatment and they are not responsible for outcomes. The availability of a particular provider(s) cannot be guaranteed and network composition is subject to change.*

PRE-CERTIFICATION PROGRAM

Pre-certification simply means calling Aetna Student Health prior to treatment to obtain approval for a medical procedure or service. Pre-certification may be done by you, your doctor, a hospital administrator, or one of your relatives. All requests for certification must be obtained by contacting Aetna Student Health at **888-407-0445** (attention Managed Care Department).

The following inpatient and outpatient services or supplies require pre-certification:

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

Pre-Certification does not guarantee the payment of benefits for your inpatient admission. Each claim is subject to medical policy review, in accordance with the exclusions and limitations contained in the Policy, as well as a review of eligibility, adherence to notification guidelines, and benefit coverage under the student Accident and Sickness Plan.

Pre-Certification of Non-Emergency Inpatient Admissions, Partial Hospitalization, Identified Outpatient Services and Home Health Services: The patient, Physician or hospital must telephone at least **three (3) business days** prior to the planned admission or prior to the date the services are scheduled to begin.

Notification of Emergency Admissions: The patient, patient's representative, Physician or hospital must telephone within **one (1) business day** following inpatient (or partial hospitalization) admission.

PRE-EXISTING CONDITIONS/CONTINUOUSLY INSURED PROVISIONS

Pre-existing Condition

A preexisting condition is an injury or disease that was present before your first day of coverage under a group health insurance plan. If you received medical advice, treatment or services for that injury or disease or you took prescription drugs or medicines for that injury or disease during the 180 days prior to your first day of coverage, that injury or disease will be considered a pre-existing condition.

Limitation

Expenses incurred by a covered person as a result of a Preexisting Condition will not be considered Covered Medical Expense unless the covered person has been covered under this Policy for twelve consecutive months.

Continuously Insured

You have been continuously insured if you (i) had "creditable health insurance coverage" (such as COBRA, HMO, another group or individual policy, Medicare or Medicaid) prior to enrolling in this plan; and (ii) the creditable coverage ended within 63 days of the date you enrolled under this plan. If both of these tests are met, then the pre-existing limitation period under this plan will be reduced (and possibly eliminated altogether) by the number of days of your prior creditable coverage. You will be asked to provide evidence of your prior creditable coverage. Once a break of more than 63 days in your continuous coverage occurs, the definition of Pre-Existing Conditions will apply.

DESCRIPTION OF BENEFITS

Please Note: THE UNIVERSITY OF ST. THOMAS STUDENT INSURANCE PLAN MAY NOT COVER ALL OF YOUR HEALTH CARE EXPENSES.

The Plan excludes coverage for certain services and contains limitations on the amounts it will pay. Please read the University of St. Thomas Plan Brochure carefully before deciding whether this Plan is right for you. While this document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. If you want to look at the full Plan description, which is contained in the Master Policy issued to the University of St. Thomas, you may view it at the Student Health Insurance Office or you may contact Aetna Student Health at **888-407-0445**.

This Plan will never pay more than \$1,000,000 per condition per lifetime. Additional Plan maximums may also apply. Some illnesses or injuries may cost more to treat and health care providers may bill you for what the Plan does not cover.

Subject to the terms of the Policy, benefits are available for you and your eligible dependents only for the coverages listed below, and only up to the maximum amounts shown. Please refer to the Policy for a complete description of the benefits available.

SUMMARY OF BENEFITS CHART

<p>COINSURANCE Covered Medical Expenses are payable at the coinsurance percentage specified below, after any applicable deductible, up to a maximum benefit of \$1,000,000 per Condition per Lifetime.</p> <p>OUT-OF-POCKET MAXIMUMS Once the Individual Out-of-Pocket Limit has been satisfied, Covered Medical Expenses will be payable at 100% for the remainder of the Policy Year, up to any benefit maximum that may apply.</p> <p>Individual Out-of-Pocket: \$5,000</p>
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All coverage is based on Reasonable Charges unless otherwise specified.

Inpatient Hospitalization Benefits	
Hospital Room and Board Expense	<p>Covered Medical Expenses are payable as follows: <u>Preferred Care: 90%</u> of the Negotiated Charge. <u>Non-Preferred Care: 60%</u> of the Reasonable Charge for a semi-private room.</p>
Intensive Care Unit Expense	<p>Covered Medical Expenses are payable as follows: <u>Preferred Care: 90%</u> of the Negotiated Charge. <u>Non-Preferred Care: 60%</u> of the Reasonable Charge for the Intensive Care Room Rate for an overnight stay.</p>
Miscellaneous Hospital Expense	<p>Covered Medical Expenses include, but are not limited to: laboratory tests, x-rays, surgical dressings, anesthesia, supplies and equipment use, and medicines.</p> <p>Benefits are payable as follows: <u>Preferred Care: 90%</u> of the Negotiated Charge. <u>Non-Preferred Care: 60%</u> of the Reasonable Charge.</p> <p>Benefits also include up to 120 hours of services provided by a private duty nurse or personal care assistant to a ventilator-dependent covered person during the time the ventilator-dependent covered person is in a hospital. The private duty nurse or personal care assistant shall perform only the services of communicator or interpreter for the ventilator-dependent covered person to assure adequate training of the hospital staff to communicate with the patient and understand the unique comfort, safety, and personal care needs of the patient. Expense will be subject to the same copay/deductible, coinsurance percentages, and maximums that apply to hospital expenses.</p>
Physician Hospital Visit/Consultation Expenses	<p>Covered Medical Expenses for charges for the non-surgical services of the attending Physician, or a consulting Physician, are payable as follows: <u>Preferred Care: 90%</u> of the Negotiated Charge. <u>Non-Preferred Care: 60%</u> of the Reasonable Charge.</p>

Surgical Benefits (Inpatient and Outpatient)	
Surgical Expense	<p>Covered Medical Expenses for charges for surgical services, performed by a Physician, are payable as follows: <u>Preferred Care:</u> 90% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Reasonable Charge.</p>
Anesthetist and Assistant Surgeon Expense	<p>Covered Medical Expenses for the charges of an anesthetist and an assistant surgeon, during a surgical procedure, are payable up to 25% of the amount paid to the surgeon.</p>
Ambulatory Surgical Expense	<p>Covered Medical Expenses for outpatient surgery performed in an ambulatory surgical center are payable as follows: <u>Preferred Care:</u> 90% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Reasonable Charge.</p> <p>Covered Medical Expenses must be incurred on the day of the surgery or within 48 hours after the surgery.</p>
<p>Outpatient Benefits Covered Medical Expenses include but are not limited to: Physician's office visits, hospital or outpatient department or emergency room visits, durable medical equipment, clinical lab, or radiological facility.</p>	
Hospital Outpatient Department or Walk-In Clinic Expense	<p>Covered Medical Expenses for outpatient treatment in a hospital are payable as follows: <u>Preferred Care:</u> 90% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Reasonable Charge.</p>
Emergency Room Expense	<p>Covered Medical Expenses incurred for treatment of an Emergency Medical Condition are payable as follows: <u>Preferred Care:</u> After a \$100 Copay (waived if admitted) per visit, 90% of the Negotiated Charge. <u>Non-Preferred Care:</u> After a \$100 Deductible (waived if admitted) per visit, 90% of the Reasonable Charge.</p> <p>Please note: this per visit Copay/Deductible does not apply towards meeting the annual Deductible.</p>

<p>Urgent Care Expense</p>	<p><i>Benefits include charges for treatment by an urgent care provider.</i></p> <p>Please note: A covered person <u>should not seek medical care or treatment from an urgent care provider if their illness, injury, or condition, is an emergency condition.</u> The covered person should go directly to the emergency room of a hospital or call 911 (or the local equivalent) for ambulance and medical assistance.</p> <p>Urgent Care Benefits include charges for an urgent care provider to evaluate and treat an urgent condition.</p> <p>Covered Medical Expenses for urgent care treatment are payable as follows: <u>Preferred Care: 90%</u> of the Negotiated Charge. <u>Non-Preferred Care: 60%</u> of the Reasonable Charge.</p> <p>When travel to a preferred care provider for treatment of an urgent condition is not feasible, a covered person may call Aetna to request authorization to see a non-preferred urgent care provider so that such treatment may be paid at the preferred level of benefits. If it is not feasible to request authorization prior to treatment, then it should be done as soon as possible after treatment but not later than:</p> <ul style="list-style-type: none"> • the next day during normal business hours, or • if the covered person is confined in a hospital directly after receiving urgent care, not later than 48 hours following the start of the confinement unless it is not possible for the covered person to request authorization within that time. In that case, it must be done as soon as reasonably possible. <p>However:</p> <ul style="list-style-type: none"> • if the treatment is received, or • the confinement occurs, <p>on a Friday or Saturday, authorization must be requested within 72 hours following treatment or the start of the confinement.</p> <p>If the covered person does not request authorization from Aetna to see a non-preferred urgent care provider, charges incurred for urgent care will be paid at the non-preferred covered percentage after the non-preferred deductible. The covered person should contact their primary care physician after medical care is provided to treat an urgent condition.</p> <p>Non-Urgent Care Covered Medical Expenses for charges made by an urgent care provider to treat a <i>non-urgent condition</i> are payable as follows: <u>Preferred Care: 90%</u> of the Negotiated Charge. <u>Non-Preferred Care: 60%</u> of the Reasonable Charge.</p> <p><i>No benefit will be paid under any other part of this Plan for charges made by an urgent care provider to treat a non-urgent condition.</i></p> <p>Non-urgent care includes, but is not limited to, the following:</p> <ul style="list-style-type: none"> • 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. <p>A separate preferred urgent care copay/deductible applies to each visit for urgent care by a covered person to an preferred urgent care provider. This does not apply if the covered person is admitted to a hospital as an inpatient right after a visit to an urgent care provider.</p>
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Ambulance Expense	Covered Medical Expenses are payable as follows: 90% of the Actual Charge for the services of a professional ambulance to or from a hospital, when required due to the emergency nature of a covered Accident or Sickness.
Pre-Admission Testing Expense	Covered Medical Expenses for Pre-Admission testing charges while an outpatient before scheduled surgery are payable as any other condition.
Physician's Office Visits	Covered Medical Expenses are payable as follows: <u>Preferred Care: 90%</u> of the Negotiated Charge. <u>Non-Preferred Care: 60%</u> of the Reasonable Charge.
Laboratory and X-Ray Expense	Covered Medical Expenses are payable as follows: <u>Preferred Care: 90%</u> of the Negotiated Charge. <u>Non-Preferred Care: 60%</u> of the Reasonable Charge.
High-Cost Procedures Expense	Covered Medical Expenses include charges incurred by a covered person are payable as follows: <u>Preferred Care: 90%</u> of the Negotiated Charge. <u>Non-Preferred Care: 60%</u> of the Reasonable Charge. For purposes of this benefit, "High-Cost Procedure" means any outpatient procedure costing over \$200. <i>Please see the Definition of High Cost Procedures on page 40 for more detailed information on this benefit.</i>
Therapy Expense	Covered Medical Expenses include charges incurred by a covered person for the following types of therapy provided on an outpatient basis: <ul style="list-style-type: none"> • Physical Therapy, • Speech Therapy, • Inhalation Therapy, or • Occupational Therapy Expenses for Speech and Occupational Therapies are Covered Medical Expenses, only if such therapies are a result of injury or sickness. Physical therapy must be for rehabilitation only after a surgery. All other therapy must be initiated within 6 months of the onset of symptoms. All therapy must be provided by a therapist who is licensed in accordance with state law, and practicing within the scope of their license. All therapy must be completed within 60 days of the date that it starts. Covered Medical Expenses are payable as follows: <u>Preferred Care: 90%</u> of the Negotiated Charge. <u>Non-Preferred Care: 60%</u> of the Reasonable Charge. After the 10th visit we may request verification of medical necessity in order to continue treatment.
Durable Medical Equipment Expense	Covered Medical Expenses are payable as follows: <u>Preferred Care: 90%</u> of the Negotiated Charge. <u>Non-Preferred Care: 60%</u> of the Reasonable Charge.

<p>Prosthetic Devices Expense</p>	<p>Benefits include charges for: artificial limbs, or eyes, scalp hair prostheses required for hair loss suffered as a result of alopecia areata, and other non-dental prosthetic devices, as a result of an accident or sickness.</p> <p>Covered Medical Expenses do not include: eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet.</p> <p>Covered Medical Expenses are payable as any other condition.</p>
<p>Outpatient Physical Therapy Expense</p>	<p>Covered Medical Expenses for physical therapy are payable as follows when provided by a licensed physical therapist and only when physical therapy begins within 6 months of the onset of symptoms:</p> <p><u>Preferred Care</u>: 90% of the Negotiated Charge.</p> <p><u>Non-Preferred care</u>: 60% of the Reasonable Charge.</p> <p>After the 10th visit we may request verification of medical necessity in order to continue treatment.</p>
<p>Dental Injury Expense</p>	<p>Covered Medical Expenses include dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition:</p> <ul style="list-style-type: none"> • Natural teeth damaged, lost, or removed, or • Other body tissues of the mouth fractured or cut due to injury. The accident causing the injury must occur while the person is covered under this Plan. <p>Any such teeth must have been:</p> <ul style="list-style-type: none"> • Free from decay, or • In good repair, and • Firmly attached to the jawbone at the time of the injury. <p><i>The treatment must be done in the calendar year of the accident or the next one.</i></p> <p>If:</p> <ul style="list-style-type: none"> • Crowns (caps), or • Dentures (false teeth), or • Bridgework, or • In-mouth appliances, <p>are installed due to such injury, Covered Medical Expenses include only charges for:</p> <ul style="list-style-type: none"> • 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. • Surgery needed to: <ul style="list-style-type: none"> • Treat a fracture, dislocation, or wound. • Cut out cysts, tumors, or other diseased tissues. • 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. <p>Covered Medical Expenses are payable as follows: 90% of actual charge.</p>

Dental Care Anesthesia and Hospital Expense	<p>Covered Medical Expenses include anesthesia and hospital charges for dental care provided to a covered person who is a child under age 5, is severely disabled, or has a medical condition and requires hospitalization or general anesthesia for dental care. Coverage is required whether in a hospital or a dental office.</p> <p><u>Preferred Care</u>: 90% of the Negotiated Charge.</p> <p><u>Non-Preferred Care</u>: 60% of the Reasonable Charge.</p>
Allergy Testing and Treatment Expense	<p><i>Benefits include charges incurred for diagnostic testing and treatment of allergies and immunology services.</i></p> <p>Covered Medical Expenses include, but are not limited to, charges for the following: laboratory tests, physician office visits, including visits to administer injections, prescribed medications for testing and treatment of the allergy, including any equipment used in the administration of prescribed medication, and other medically necessary supplies and services.</p> <p>Covered Medical Expenses are payable as any other condition.</p>
Routine Physical Exam Expense	<p><i>Benefits include expenses for a routine physical exam performed by a physician.</i></p> <p>A routine physical exam is a medical exam given by a physician, for a reason other than to diagnose or treat a suspected or identified injury or sickness. Included as a part of the exam are:</p> <ul style="list-style-type: none"> • X-rays, lab, and other tests given in connection with the exam, and • Materials for the administration of immunizations for infectious disease and testing for tuberculosis. <p><u>Preferred Care</u> visits are payable at 90%</p> <p><u>Non-Preferred Care</u> visits are payable at 60%</p> <p>For all exams given to a covered student or a spouse who is a covered dependent, Covered Medical Expenses will <u>not include</u> charges for <u>more than</u>:</p> <ul style="list-style-type: none"> • One exam in 24 months in a row, if the person is under age 65, and • One exam in 12 months in a row, if the person is age 65 or over. <p>Also included as Covered Medical Expenses are charges made by a physician for one annual routine gynecological exam.</p>

<p>Child Health Supervision Expense</p>	<p>Covered Medical Expenses include pediatric preventive services, appropriate immunizations, developmental assessments and laboratory services appropriate to the age of a child from birth to age 6, and appropriate immunizations from ages 6-18, as defined by Standards of Child Health Care issued by the American Academy of Pediatrics.</p> <p>Services provided for a routine physical exam of the child include:</p> <ul style="list-style-type: none"> • A review and written record of the child’s complete medical history. • Taking measurements and blood pressure. • Developmental and behavioral assessment. • Vision and hearing screening. • Other diagnostic screening tests including one series of hereditary and metabolic tests performed at birth, and urinalysis, tuberculin test, and blood tests such as hematocrit and hemoglobin tests. • Immunizations for infectious disease. • Counseling and guidance of the child and the child’s parents or guardian on the results of the physical examination. <p>Covered Medical Expenses will include charges incurred for child health supervision visits as follows:</p> <ul style="list-style-type: none"> • At least 5 visits from birth to 12 months. • 3 visits from 12 months to 24 months. • One visit during each year of life thereafter through age 6. <p>For a dependent child from 6 to 18 years of age, Covered Medical Expenses will include appropriate immunizations only.</p> <p>Benefits are payable as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge.</p>
<p>Hearing Aids for Children</p>	<p>Covered Medical Expenses include hearing aids for dependent children 18 years and younger. Benefits include one hearing aid for each ear every three years.</p> <p>Benefits are payable as follows: <u>Preferred Care:</u> 90% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Reasonable Charge.</p>
<p>Consultant or Specialist Expense</p>	<p>Covered Medical Expenses include the expenses for the services of a consultant or specialist. The services must be requested by the attending physician for the purpose of confirming or determining to confirm or determine a diagnosis.</p> <p>Covered Medical Expenses are covered as follows: <u>Preferred Care:</u> 90% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Reasonable Charge.</p>

Mental Health Benefits	
Mental and Nervous Disorders Inpatient Expense	<p>Covered Medical Expenses for the treatment of a mental health condition while confined as an inpatient in a hospital or facility licensed for such treatment are payable as follows: <u>Preferred Care: 90%</u> of the Negotiated Charge. <u>Non-Preferred Care: 60%</u> of the Reasonable charge.</p> <p>Partial hospitalization for Treatment of Mental and Nervous Disorders require pre-certification.</p> <p>Inpatient mental health treatment is limited to a maximum of 60 days per Policy Year per Condition.</p> <p>Covered Medical Expenses also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission, whereby 2 days of partial hospitalization may be exchanged for 1 day of full hospitalization.</p>
Mental and Nervous Disorders Outpatient Expense	<p>Covered Medical Expenses for outpatient treatment of a mental health condition are payable as follows: <u>Preferred Care: 90%</u> of the Negotiated Charge. <u>Non-Preferred Care: 60%</u> of the Reasonable charge.</p> <p>Partial hospitalization for Treatment of Mental and Nervous Disorders require pre-certification.</p>

Substance Abuse Benefits	
Inpatient Expense	<p>Covered Medical Expenses for the treatment of a substance abuse condition while confined as a inpatient in a hospital or facility licensed for such treatment are payable on the same basis as any other sickness. <u>Preferred Care: 90%</u> of the Negotiated Charge. <u>Non-Preferred Care: 60%</u> of the Reasonable Charge.</p> <p>Partial hospitalization for Treatment Of Alcohol and Drug Addiction require pre-certification.</p> <p>Benefits are limited to 73 visits per Policy Year per Condition.</p>
Outpatient Expense	<p>Covered Medical Expenses for outpatient treatment of a substance abuse condition are payable on the same basis as any other sickness. <u>Preferred Care: 90%</u> of the Negotiated Charge. <u>Non-Preferred Care: 60%</u> of the Reasonable Charge.</p> <p>Partial hospitalization for Treatment Of Alcohol and Drug Addiction require pre-certification.</p> <p>Benefits are limited to 130 hours per 12 month period, 20 visits may be used for Family Counseling.</p>

Maternity Benefits	
Maternity Expense	<p>Covered Medical Expenses include inpatient care of the covered person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery.</p> <p>Any decision to shorten such minimum coverages shall be made by the attending Physician in consultation with the mother. In such cases, covered services may include: home visits, parent education, and assistance and training in breast or bottle-feeding.</p> <p>Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other sickness.</p>
Prenatal Care Services Expense	<p>Covered Medical Expenses include the following Prenatal Care services and supplies provided in connection with a pregnancy of the covered person:</p> <ul style="list-style-type: none"> • Risk assessment, • Serial surveillance, • Prenatal education, • Use of specialized skills and technology: such as, pregnancy tests, prenatal work ups, prescription vitamins, sonograms, genetic counseling and amniocentesis. <p>Not covered are charges incurred in connection with labor, delivery or postpartum care. Benefits are payable as any other condition.</p> <p>Covered Medical Expenses also include coverage for gestational diabetes I and II.</p>
Well Newborn Nursery Care Expense	<p>Benefits include charges for routine care of a covered person's newborn child as follows:</p> <ul style="list-style-type: none"> • hospital charges for routine nursery care during the mother's confinement, but for not more than four days for a normal delivery, • physician's charges for circumcision, and • physician's charges for visits to the newborn child in the hospital and consultations, but for not more than 1 visit per day. <p>Covered Medical Expenses are payable as any other condition.</p>

Additional Benefits	
<p>Prescription Drug Benefit</p>	<p>Prescription Drug Benefits are payable as follows: Benefits are payable at 100% following a \$50 Copay for each Brand Name Non-Formulary Prescription Drug, a \$25 Copay for each Brand Name Formulary Prescription Drug, or a \$5 Copay for each Generic Prescription Drug. Prescription Drugs are payable up to a maximum of \$2,000 per Policy Year.</p> <p>You must pay out of pocket for Prescriptions at a Non-Preferred Aetna Pharmacy and then submit the receipt with a Prescription Claim Form for reimbursement.</p> <p>This Pharmacy benefit is provided to cover Medically Necessary Prescriptions associated with a covered Sickness or Accident occurring during the Policy Year. Please use your Aetna Student Health ID card when obtaining your prescriptions.</p> <p>Prior Authorization is required for certain Prescription Drugs, including Imitrex, certain stimulants, hormonal medications and growth hormones and for any Prescription quantities larger than a 30-day supply. <i>(This is only a partial list.)</i></p> <p>Medications not covered by this benefit include, but are not limited to: allergy sera, inhalers, all acne medications, drugs whose sole purpose is to promote or to stimulate hair growth, appetite suppressants, smoking deterrents, immunization agents and vaccines, and non-self injectables. <i>(This is only a partial list.)</i></p> <p>For assistance or for a complete list of excluded medications, or drugs requiring prior authorization, please contact Aetna Pharmacy Management at 800-238-6279 (available 24 hours).</p> <p>Aetna Specialty Pharmacy provides specialty medications and support to members living with chronic conditions. The medications offered may be injected, infused or taken by mouth. For additional information please go to www.AetnaSpecialtyRx.com.</p> <p>Covered Medical Expenses include charges incurred by a covered person for antipsychotic drugs prescribed to treat emotional disturbance or mental illness, regardless of whether the prescription drug is in this plan's formulary, if the prescriber 1) indicates to the dispensing pharmacist that the prescription must be dispensed as communicated, 2) certifies in writing to Aetna that the provider has considered all equivalent drugs in the plan's drug formulary and has determined that the drug prescribed will best treat the covered person's condition, unless Aetna removed the prescription drug from the Plan's drug formulary for safety purposes. For antipsychotic prescription drugs as described in this paragraph, coverage will be on the same basis as any other prescription drug covered under this plan.</p>
<p>Diabetic Testing Supplies Expense</p>	<p>Benefits include charges for testing material used to detect the presence of sugar in the person's urine or blood for monitoring glycemic control.</p> <p>Diabetic Testing Supplies are limited to:</p> <ul style="list-style-type: none"> • Lancet devices, • glucose monitors, and • test strips. <p>Syringes, insulin, or other items used in the treatment of diabetes are not covered by this benefit.</p> <p>Covered Medical Expenses are payable as any other condition.</p>

Hypodermic Needles Expense	Covered Medical Expenses for hypodermic needles and syringes used in the treatment of diabetes are payable as any other condition.
Outpatient Diabetic Self-management Education Programs Expense	Covered Medical Expenses for outpatient diabetic self-management education programs are payable as any other condition. <i>Please see the definition on page 39 of this Brochure for more information on Diabetic Self-Management Education Programs.</i>
Non Prescription Enteral Formula Expense	Benefits include charges incurred by a covered person for non-prescription enteral formulas, for which a physician has issued a written order, and are for the treatment of malabsorption caused by: <ul style="list-style-type: none"> • Crohn’s Disease, • ulcerative colitis, • gastroesophageal reflux, • gastrointestinal motility, • chronic intestinal pseudoobstruction, and • inherited diseases of amino acids and organic acids. Covered Medical Expenses for inherited diseases of amino acids and organic acids, will also include food products modified to be low protein. Covered Medical Expenses are payable as any other condition.
Phenylketonuria Treatment Expense	Covered Medical Expenses include charges incurred for special dietary treatment, both tube-fed and oral, when medically necessary and physician recommended for the treatment of phenylketonuria. Benefits are payable as any other condition
Scalp Hair Prosthesis Expense	Covered Medical Expenses include charges for a scalp hair prosthesis worn for hair loss as a result of alopecia areata. Benefits are payable at 90% , up to a maximum of \$350 per Policy Year.
TMJ	Covered Medical Expenses include charges for surgical and non-surgical treatment of Temporomandibular Joint (TMJ) Dysfunction and craniomandibular disorder. Benefits are payable on the same basis as that for any other joint in the body, and will apply if the treatment is administered or prescribed by a physician or a dentist. Benefits are payable as any other condition.
Cleft Lip/ Cleft Palate Expense	Covered Medical Expenses include charges incurred by a dependent child under age 19 for treatment, including orthodontia and oral surgery treatment, of a congenital cleft lip or cleft palate or for any other condition related to or developed as a result of cleft lip or cleft palate. If the covered person has coverage for orthodontia for the treatment of cleft lip or cleft palate under a dental insurance plan, then the dental insurance plan shall be primary and this Policy shall be secondary in regard to the coverage described in this paragraph. Benefits are payable as any other condition.

Port Wine Stains Expense	<p>Covered Medical Expenses include elimination or maximum feasible treatment of port-wine stains for any covered person.</p> <p>Benefits are payable as follows: <u>Preferred Care: 90%</u> of the Negotiated Charge. <u>Non-Preferred Care: 60%</u> of the Reasonable Charge.</p>
Reconstruction Surgery Expense	<p>Covered Medical Expenses include reconstructive surgery when such service is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part or when such service is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician. Benefits are payable as any other condition.</p>
Treatment of Lyme Disease Expense	<p>Covered Medical Expenses for the treatment of diagnosed Lyme Disease are payable on the same basis as any other illness.</p> <p>Benefits are payable as follows: <u>Preferred Care: 90%</u> of the Negotiated Charge. <u>Non-Preferred Care: 60%</u> of the Reasonable Charge.</p>
Pap Smear Expense	<p>Covered Medical Expenses include charges incurred by a covered person for a Pap smear screening, when ordered or provided by a physician in accordance with the standard practice of medicine. Benefits are payable as any other condition.</p>
Mammography Expense	<p>Benefits are payable for charges for mammograms, when ordered or provided by a physician in accordance with the standard practice of medicine. Benefits are payable as any other condition.</p>
Mastectomy and Breast Reconstruction Expense Benefit	<p>Coverage will be provided to a covered person who is receiving benefits for a necessary mastectomy and who elects breast reconstruction after the mastectomy for:</p> <ul style="list-style-type: none"> • reconstruction of the breast on which a mastectomy has been performed, • surgery and reconstruction of the other breast to produce a symmetrical appearance, • prostheses, • treatment of physical complications of all stages of mastectomy, including lymphedemas, and • reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction. This is subject to the approval of the attending physician. <p>Covered Medical Expenses are payable as any other condition.</p>

<p>Routine Colorectal Cancer Screening Expense</p>	<p>Covered Medical Expenses include charges for colorectal cancer examination and laboratory tests, for any nonsymptomatic person age 50 or more, or a symptomatic person under age 50, for the following:</p> <ul style="list-style-type: none"> • One fecal occult blood test every 12 months in a row • A Sigmoidoscopy at age 50 and every 3 years thereafter • One digital rectal exam every 12 months in a row • A double contrast barium enema, once every 5 years • A colonoscopy, once every 10 years • Virtual colonoscopy • Stool DNA <p>Benefits are payable as any other condition.</p>
<p>Routine Prostate Cancer Screening Expense</p>	<p>Covered Medical Expenses include charges incurred by a covered person for the screening of cancer as follows:</p> <ul style="list-style-type: none"> • For a male age 40 and over who is symptomatic, or in a high-risk category, and • for a male age 50 or over <p>The screening consists, at a minimum, of one digital rectal exam and one prostate specific antigen test each Policy Year. Benefits are payable as any other condition.</p>
<p>Surgical Second Opinion Expense</p>	<p>Covered Medical Expenses will include expenses incurred for a second opinion consultation by a specialist on the need for surgery which has been recommended by the covered person’s physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation.</p> <p>Benefits are payable as follows: <u>Preferred Care:</u> 90% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Reasonable Charge.</p>
<p>Elective Surgical Second Opinion Expense</p>	<p>Covered Medical Expenses will include expenses incurred for a second opinion consultation by a specialist on the need for non-emergency elective surgery which has been recommended by the covered person’s physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation.</p> <p>Benefits are payable as follows: <u>Preferred Care:</u> 90% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Reasonable Charge.</p>
<p>Acupuncture in Lieu of Anesthesia Expense</p>	<p>Covered Medical Expenses include acupuncture therapy, when acupuncture is used in lieu of other anesthesia, for a surgical or dental procedure covered under this Plan.</p> <p>The acupuncture must be administered by a health care provider who is a legally qualified physician, practicing within the scope of their license.</p> <p>Benefits are payable as follows: <u>Preferred Care:</u> 90% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Reasonable Charge.</p>

<p>Dermatological Expense</p>	<p>Covered Medical Expenses include charges for the diagnosis and treatment of skin disorders, excluding laboratory fees. Related laboratory expenses are covered under the Outpatient Expense Benefit. Benefits are payable as any other condition.</p> <p>Covered Medical Expenses do not include treatment for acne, or cosmetic treatment and procedures.</p>
<p>Podiatric Expense</p>	<p>Covered Medical Expenses include charges for podiatric services, provided on an outpatient basis following an injury. Benefits are payable as any other condition.</p> <p>Expenses for routine foot care, such as trimming of corns, calluses, and nails, are not Covered Medical Expenses.</p>

<p>Home Health Care Expenses</p>	<p>Covered Medical Expenses include charges incurred by a covered person for home health care services made by a home health agency pursuant to a home health care plan, but only if:</p> <ul style="list-style-type: none"> a) The services are furnished by, or under arrangements made by, a licensed home health agency b) The services are given under a home care plan. This plan must be established pursuant to the written order of a physician, and the physician must renew that plan every 60 days. Such physician must certify that the proper treatment of the condition would require inpatient confinement in a hospital or skilled nursing facility if the services and supplies were not provided under the home health care plan. The physician must examine the covered person at least once a month c) Except as specifically provided in the home health care services, the services are delivered in the patient's place of residence on a part-time, intermittent visiting basis while the patient is confined d) The care starts within 7 days after discharge from a hospital as an inpatient, and e) The care is for the same condition that caused the hospital confinement, or one related to it. <p>Home Health Care Services</p> <ul style="list-style-type: none"> 1) Part-time or intermittent nursing care by: a registered nurse (R. N.), a licensed Practical nurse (L.P.N.), or under the supervision on an R.N. if the services of an R. N. are not available, 2) Part time or intermittent home health aide services, that consist primarily of care of a medical or therapeutic nature by other than an R.N., 3) Physical, occupational. speech therapy, or respiratory therapy, 4) Medical supplies, drugs and medicines, and laboratory services. However, these items are covered only to the extent they would be covered if the patient was confined to a hospital, 5) Medical social services by licensed or trained social workers, 6) Nutritional counseling. <p>Covered Medical Expenses will not include: 1) services by a person who resides in the covered person's home, or is a member of the covered person's immediate family, 2) homemaker or housekeeper services, 3) maintenance therapy, 4) dialysis treatment, 5) purchase or rental of dialysis equipment, or 6) food or home delivered services.</p> <p>Home Health Care Expense benefits are payable as any other condition. A visit means a maximum of 4 continuous hours of home health service.</p>
<p>Transfusion or Dialysis of Blood Expense</p>	<p>Covered Medical Expenses include charges for the transfusion or dialysis of blood, including the cost of: whole blood, blood components, and the administration thereof.</p> <p>Benefits are payable as any other condition.</p>
<p>Hospice Benefit</p>	<p>Covered Medical Expenses include charges for hospice care provided for a terminally ill covered person during a hospice benefit period.</p> <p>Benefits are payable as any other condition.</p> <p><i>Please see definition on page 41 for more information on Hospice Care Expenses. Benefits for Hospice expenses require pre-certification.</i></p>

<p>Licensed Nurse Expense</p>	<p>Benefits include charges incurred by a covered person who is confined in a hospital as a resident bed-patient, and requires the services of a registered nurse or licensed practical nurse.</p> <p>Covered Medical Expenses for a Licensed Nurse are covered as follows: <u>Preferred Care: 90%</u> of the Negotiated Charge. <u>Non-Preferred Care: 60%</u> of the Reasonable Charge.</p>
<p>Skilled Nursing Facility Expense</p>	<p>Covered Medical Expenses include charges incurred by a covered person for confinement in a skilled nursing facility for treatment rendered:</p> <ul style="list-style-type: none"> • in lieu of confinement in a hospital as a full time inpatient, or • within 24 hours following a hospital confinement and for the same or related cause(s) as such hospital confinement. <p>Covered Medical Expenses are payable as follows: <u>Preferred Care: 90%</u> of the Negotiated Charge for the semi-private room rate. <u>Non-Preferred Care: 60%</u> of the Reasonable Charge for the semi-private room rate.</p> <p><i>Benefits for Skilled Nursing require pre-certification.</i></p>
<p>Rehabilitation Facility Expense</p>	<p>Covered Medical Expenses include charges incurred by a covered person for confinement as a full time inpatient in a rehabilitation facility. Confinement in the rehabilitation facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of hospital or skilled nursing facility confinement.</p> <p>Covered Medical Expenses for Rehabilitation Facility Expense are covered as follows: <u>Preferred Care: 90%</u> of the Negotiated Charge for the rehabilitation facility's daily room and board maximum for semi-private accommodations. <u>Non-Preferred Care: 60%</u> of the Reasonable Charge for the rehabilitation facility's daily room and board maximum for semi-private accommodations.</p> <p><i>Benefits for Rehabilitation Facility expenses require pre-certification.</i></p>

ADDITIONAL SERVICES AND DISCOUNTS

As a member of the Plan, you can also take advantage of the following services, discounts, and programs. These are not underwritten by Aetna. To learn more about these additional services and search for providers visit www.aetnastudenthealth.com.

Aetna VisionSM Discount Program: The Aetna Vision discount program helps you save on vision exams and many eye care products, including sunglasses, contact lenses, non-prescription sunglasses, contact lens solutions and other eye care accessories. Plus, you can receive up to a 15% discount on LASIK surgery (the laser vision correction procedure).

Aetna FitnessSM Discount Program: Aetna's Fitness discount program provides members with access to preferred membership rates at nearly 10,000 fitness clubs nationwide and in Canada in the GlobalFitTM network. Members can also save on GlobalFit's other programs and services, such as at-home weight loss programs, home fitness equipment and videos and even one-on-one health coaching services* to help them quit smoking, reduce stress, lose weight, or meet any other health goal.

*Offered by WellCall, Inc. through GlobalFit

Aetna Weight ManagementSM Discount Program: Helps you achieve your weight loss goals and develop a balanced approach to your active lifestyle. This program provides members and their eligible family members access to discounts on Jenny Craig[®] weight loss programs and products. Start with a FREE 30-day trial membership* then choose either a 6* -or 12* -month program** that's right for you. You also receive individual weight loss consultations, personalized menu planning, tailored activity planning, motivational materials and much more.

**Offers good at participating centers in the United States, Canada and Puerto Rico and through Jenny Direct at-home. Additional cost for all food purchases and shipping where applicable.*

***Additional weekly food discounts will grow throughout the year, based on active participation.*

Find a meal plan that works for you at eDiets[®]: Get a personalized plan for healthy eating that fits your lifestyle, and save 25 percent on weekly eDiets dues. You'll have access to customized weekly menus, recipes, support boards, chats, nutrition tools and fitness tips.

Use Zagat[®] reviews as a guide for your night out: Planning a night on the town? Or, want to visit a city where you've never been? Subscribe to Zagat online and get a 30 percent discount on their members-only services. You can sign up for access to restaurant reviews only, or choose full access and get ratings and reviews on hotels, restaurants, movies and other attractions. You can even order printed guides at a discount!

Give the gift of relaxation to yourself or a friend through SpaWish: Get a 10 percent discount when you buy a gift certificate of at least \$100, good for services at any of over 1,000 spas across the U.S. Choose a spa close to home or near your favorite place to visit!

Get trusted health information from the MayoClinic.com Bookstore: Choose from newsletters and books — with recipes for healthy living, advice on staying in shape, guides on living with certain health conditions and more. It's all at your fingertips — and at a discount! The size of the discount will depend on the item price and other available discounts.

Aetna's Informed Health[®] Line: Get answers from a registered nurse at any time — just call our toll-free Informed Health Line. With one simple call, you can:

- Learn more about health conditions that you or your family members have.
- Find out more about a medical test or procedure.
- Come up with questions to ask your doctor.

Talk to a registered nurse: Our nurses can discuss more than 5,000 health and wellness topics. Call them anytime you have a health question.

Listen to our Audio Health Library:^{*} Call and learn about a topic that interests you. Choose from thousands of health conditions. Listen in English or Spanish. You can also transfer to a registered nurse at any time during your call.

**Not all topics discussed within the Audio Health Library are covered expenses under your health insurance plan.*

Go online for even more health information: If you like to go online for health information, check out the Healthwise[®] Knowledgebase. You can learn more about a health condition you have, medications you take, and more. Link to it through your secure Aetna Navigator[®] website at www.aetnanavigator.com.

Health and Wellness Portal: This dynamic, interactive website will give you health care and assessment tools to calculate body mass index, financial health, risk activities and health and wellness indicators. The site provides resources for wellness programs and activities.

Beginning RightSM Maternity Program: Give your baby a healthy start. Our Beginning Right Maternity Program comes with your health insurance plan. Use it throughout your pregnancy and after your baby is born. If you have health conditions or risk factors that may need special attention, we can help. Our nurses can give you personal case management to help you find ways to lower your risks. The more you know the better chance you have for good health ... for you and your baby.

Aetna Natural Products and ServicesSM Discount Program: Offers members access to reduced rates on services from natural therapy professionals, including acupuncturists, chiropractors, massage therapists and dietetic counselors, and access to discounts on over-the-counter vitamins, herbal and nutritional supplements and health-related products, such as foot care and natural body care products.

Quit Tobacco Cessation Program: Say good-bye to tobacco and hello to a healthier future! The one-year Quit Tobacco program is provided by Healthyroads, a leading provider of tobacco cessation programs. You'll get personal attention from health professionals that can help find what works for you.

Aetna Health ConnectionsSM Disease Management Program: This program offers support for over 35 conditions with smart technology and supportive services to ensure a healthier you. Our goal is to make it easier to manage your health and live your life well. Our CareEngine[®] system continuously scans your health data to identify safety risks and solutions. Using technology to look for opportunities for better care and programs and services helps to meet your individual needs. You may also receive a call or letter from the Aetna Health Connections Disease Management nurse. Call us at **1-866-269-4500** to get started.

With our **Aetna Dental[®] PPO** insurance plan, participating dentists have agreed to provide services at a negotiated rate for covered services, as well as reduced fees for certain non-covered services such as cosmetic tooth whitening, so you generally pay less out of pocket. Enroll and search dentists online at www.aetnastudenthealth.com.

In Texas, the Preferred Provider Organization (PPO) plan is known as the Participating Dental Network (PDN). Price: \$265 Student only, \$275 Spouse \$343 Child(ren)

Vital SavingsSM on Dental* is a dental discount program helping you and your dependents save an average of 15% to 50% on a wide array of dental services with one low annual fee of \$25 per person. Enroll online at www.aetnastudenthealth.com.

Price: \$29 Student only, \$51 Student Plus one Dependent, \$73 Student Plus 2 or more Dependents

**Actual costs and savings vary by provider and geographic area.*

Vital SavingsSM on Pharmacy is a discount program helping you and your dependents lower your prescription drug costs. Present your card to participating pharmacies and receive a discount at the time of purchase, no claims to file. Enroll online at www.aetnastudenthealth.com.

Price: \$29 Student only , \$51 Student Plus one Dependent, \$73 Student Plus 2 or more Dependents

Vital SavingsSM on Pharmacy and Dental is a discount program helping you and your dependents save on prescription drug costs and a wide array of dental services. Enroll online at www.aetnastudenthealth.com. Save time and money on enrollment fees by joining both programs in one step.

Price: \$46 Student only , \$81 Student Plus one Dependent, \$115 Student Plus 2 or more Dependents

**The Vital Savings by Aetna[®] program (the "Program") is not insurance. The Program provides Members with access to discounted fees pursuant to schedules negotiated by Aetna Life Insurance Company for the Vital Savings by Aetna[®] discount program. The Program does not make payments directly to the providers participating in the Program. Each Member is obligated to pay for all services or products but will receive a discount from the providers who have contracted with the Discount Medical Plan Organization to participate in the Program. Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, CT 06156, 1-877-698-4825, is the Discount Medical Plan Organization.*

All of the above services, programs or benefits may be offered by vendors who are independent contractors and not employees or agents of Aetna.

Discount programs provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Discounts are subject to change without notice. Discount programs may not be available in all states. Discount programs may be offered by vendors who are independent contractors and not employees or agents of Aetna.

Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professionals.

The Aetna Dental PPO and Dental Indemnity insurance plans are underwritten by Aetna Life Insurance Company.

The Aetna AdvantageTM Dental benefits and insurance plan is underwritten by Aetna Life Insurance Company, Aetna Dental Inc., Aetna Dental of California Inc. and/or Aetna Health Inc. In Arizona, Advantage Dental is underwritten by Aetna Health Inc.

The SAP is administered by Aetna Behavioral Health, LLC. All SAP calls are confidential, except as required by law (i.e., when a person's emotional condition is a threat to himself/herself or others, or there is suspected abuse of a minor child, and in some areas, spousal or elder abuse).

GENERAL PROVISIONS

STATE MANDATED BENEFITS

The Plan will pay benefits in accordance with any applicable Minnesota State Insurance Law(s).

SUBROGATION/REIMBURSEMENT

RIGHT OF RECOVERY PROVISION

Immediately upon paying or providing any benefit under this Plan, Aetna shall be subrogated to all rights of recovery a Covered Person has against any party potentially responsible for making any payment to a Covered Person, due to a Covered Person's Injuries or illness, to the full extent of benefits provided, or to be provided by Aetna. In addition, if a Covered Person receives any payment from any potentially responsible party, as a result of an Injury or illness, Aetna has the right to recover from, and be reimbursed by the Covered Person for all amounts this Plan has paid, and will pay as a result of that Injury or illness, up to and including the full amount the Covered Person receives, from all potentially responsible parties. A "Covered Person" includes for the purposes of this provision, anyone on whose behalf this Plan pays or provides any benefit, including but not limited to the minor child or Dependent of any Covered Person, entitled to receive any benefits from this Plan.

As used in this provision, the term "responsible party" means any party possibly responsible for making any payment to a Covered Person or on a Covered Person's behalf due to a Covered Person's injuries or illness or any insurance coverage responsible making such payment, including but not limited to:

- Uninsured motorist coverage,
- Underinsured motorist coverage,
- Personal umbrella coverage,
- Med-pay coverage,
- Workers compensation coverage,
- No-fault automobile insurance coverage, or
- Any other first party insurance coverage.

The Covered Person shall do nothing to prejudice Aetna's subrogation and reimbursement rights. The Covered Person shall, when requested, fully cooperate with Aetna's efforts to recover its benefits paid. It is the duty of the Covered Person to notify Aetna within 45 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim, to recover damages, due to injuries sustained by the Covered Person.

The Covered Person acknowledges that this Plan's subrogation and reimbursement rights are a first priority claim against all potential responsible parties, and are to be paid to Aetna before any other claim for the Covered Person's damages. This Plan shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the Plan will result in a recovery to the Covered Person, which is insufficient to make the Covered Person whole, or to compensate the Covered Person in part or in whole for the damages sustained. This Plan is not required to participate in or pay attorney fees to the attorney hired by the Covered Person to pursue the Covered Person's damage claim. In addition, this Plan shall be responsible for the payment of attorney fees for any attorney hired or retained by this Plan. The Covered Person shall be responsible for the payment of all attorney fees for any attorney hired or retained by the Covered Person or for the benefit of the Covered Person.

The terms of this entire subrogation and reimbursement provision shall apply. This Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party, and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits this Plan provided. This Plan is entitled to recover from any and all settlements or judgments, even those designated as "pain and suffering" or "non-economic damages" only. Full recovery does not include payments made by this Plan to or for the benefit of a covered person.

In the event any claim is made that any part of this subrogation and reimbursement provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Covered Person and this Plan agree that Aetna shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

COORDINATION OF BENEFITS

If the Covered Person is insured under more than one group health plan, the benefits of the plan that covers the insured student will be used before those of a plan that provides coverage as a dependent. When both parents have group health plans that provide coverage as a dependent, the benefits of the plan of the parent whose birth date falls earlier in the year will be used first. The benefits available under this Plan may be coordinated with other benefits available to the Covered Person under any auto insurance, Workers' Compensation, Medicare, or other coverage. The Plan pays in accordance with the rules set forth in the Policy.

EXTENSION OF BENEFITS

If Basic Sickness Expense, Supplemental Sickness Expense coverage for a **covered person** ends while he is **totally disabled**, benefits will continue to be available for expenses incurred for that person, only while the **covered person** continues to be **totally disabled**. Benefits will end three months from the date coverage ends.

If a Covered Person is confined to a hospital on the date his or her insurance terminates, expenses incurred after the termination date and during the continuance of that hospital confinement, shall be payable in accordance with the policy, but only while they are incurred during the 31 day period, following such termination of insurance.

TERMINATION OF INSURANCE

Benefits are payable under this policy only for those Covered Expenses incurred while the policy is in effect as to the Covered Person. No benefits are payable for expenses incurred after the date the insurance terminates, except as may be provided under the Extension of Benefits provision.

TERMINATION OF STUDENT COVERAGE

Insurance for a **covered student** will end on the first of these to occur:

- the date this Policy terminates,
- the last day for which any required premium has been paid,
- the date on which the **covered student** withdraws from the school because of entering the armed forces of any country. Premiums will be refunded on a pro-rata basis when application is made within 90 days from withdrawal,
- the date the **covered student** is no longer in an eligible class.

If withdrawal from school is for other than entering the armed forces, no premium refund will be made. Students will be covered for the Policy term for which they are enrolled, and for which premium has been paid.

TERMINATION OF DEPENDENT COVERAGE

Insurance for a **covered student's dependent** will end when insurance for the **covered student** ends. Before then, coverage will end:

- For a child, on the first premium due date following the first to occur of:
 - the date the child is no longer chiefly dependent upon the student for support and maintenance,
 - the date of the child's marriage, and
 - the child's 25th birthday,
- The date the **covered student** fails to pay any required premium.
- For the spouse, the date the marriage ends in divorce or annulment.
- The date **dependent** coverage is deleted from this Policy.
- For a domestic partner, the earlier to occur of:
 - the date this Policy no longer allows coverage for domestic partners, and
 - the date of termination of the domestic partnership. In that event, a completed and signed declaration of Termination of Domestic Partnership must be provided to the Policyholder.
- The date the **dependent** ceases to be in an eligible class.

Termination will not prejudice any claim for a charge that is incurred prior to the date coverage ends.

INCAPACITATED DEPENDENT CHILDREN

Insurance may be continued for incapacitated **dependent** children who reach the age at which insurance would otherwise cease. The **dependent** child must be chiefly dependent for support upon the **covered student** and be incapable of self-sustaining employment because of mental or physical handicap.

Due proof of the child's incapacity and dependency must be furnished to Aetna by the **covered student** within 31 days after the date insurance would otherwise cease. Such child will be considered a **covered dependent**, so long as the **covered student** submits proof to Aetna each annually, after the two-year period following the child's attainment of the limiting age; that the child remains physically or mentally unable to earn his own living. The premium due for the child's insurance will be the same as for a child who is not so incapacitated.

The child's insurance under this provision will end on the earlier of:

- a) the date specified under the provision entitled Termination of Dependent Coverage, or
- b) the date the child is no longer incapacitated and dependent on the **covered student** for support.

Continuation of Coverage

A **covered student** who has graduated or is otherwise ineligible for coverage under this Policy, and has been continuously insured under the plan offered by the Policyholder (regular student plan), may be covered for up to 6 months provided that: 1) a written request for continuation has been forwarded to Aetna 31 days prior to the termination of coverage, and 2) premium payment has been made. Coverage under this provision ceases on the date this Policy terminates.

Continuation of Coverage for a covered Student's Dependent Child

If medical coverage for a **covered student's** child would terminate because the child ceases to meet this Policy's definition of **dependent**, such child may continue the coverage provided premium payments are continued. The child has to request continuation within 60 days of the date the child ceases to meet this Policy's definition of **dependent**. Coverage will not continue beyond the first to occur of:

- The end of a 36 month period following the date the child ceases to meet this Policy's definition of **dependent**.
- The date the child becomes eligible for like group coverage.
- The end of the period for which any required contributions have been made.
- The date the **covered student** is no longer covered under this Policy.
- The date all **dependent** coverage ceases under this Policy as to the covered student's eligible class of which he is a member.

If coverage is provided under a group policy, any required premium contributions for the coverage shall be paid by the insured on a monthly basis to the policyholder for remittance to Aetna. The contribution required may be up to 102% of the cost of the plan, without regard to whether the cost is paid by the policyholder or the insured.

Continuation of Coverage for a covered Student's Former Spouse and Children

If medical coverage for covered dependents of a covered student would terminate because of divorce, such covered dependents may continue the coverage in force while premium payments are continued. Written request for such continuation must be made within 60 days following the date of the divorce. At any time during the request period or while coverage is being continued, written verification from Aetna of the cost to continue coverage may be requested from the Policyholder. The cost will not be more than 102% of the cost to this Policy. Coverage will not be continued beyond the first to occur of:

- The date the **covered student** is no longer covered under this Policy.
- The date the former spouse and children become covered for like benefits under any group plan.
- The date **dependent** coverage ceases under this Policy for the **covered student's** eligible class.
- The end of the period for which required contributions have been made.

Continuation of Coverage for Covered Dependents after a Covered Student's Death

If a covered student dies while covered under any part of this Policy, any medical coverage then in force for a covered student's covered dependents may be continued; provided written request for such continuation is made within 90 days following the covered student's death and premium payments are made.

At any time during the request period or while coverage is being continued, written verification from Aetna of the cost to continue coverage may be requested from the Policyholder. The cost will not be more than 102% of the cost to this Policy. Failure of the survivor to make premium payments within 90 days after notice of the requirement to pay the premiums shall be a basis for the termination of the coverage without written consent. In the event of termination by reason of the survivor's failure to make the required premium contributions, written notice of cancellation must be mailed to the survivor's last known address at least 30 days before the cancellation. If the coverage is provided under a group policy, any premium contributions for the coverage shall be paid by the survivor to the policyholder for remittance to Aetna.

Any **dependent's** coverage will cease when any one of following occurs:

- The date a **dependent** ceases to meet this Policy's definition of a **dependent**.
- The date the surviving spouse becomes covered for like group coverage.
- The date **dependent** coverage ceases under this Policy as to the **covered student's** eligible class of which the **covered student** was a member just before his death.
- The end of the period for which any required contributions have been made if written notice of termination is sent to the last known address of the **covered student's** surviving **dependents** at least 30 days before termination of coverage.

For purposes of this section, "survivor" means a person who would be entitled to and dependent upon economic support by the covered student, if that covered student were alive; including a spouse, child, or children as defined the Policy.

Coverage may also be provided under this Policy for a **covered student's** child, born after his death, as long as coverage for the **covered student's** other dependents are being continued.

Continuation of Coverage for Covered Dependents after the Covered Student Becomes Eligible for Medicare

If coverage for the **covered student's covered dependents** would terminate because the **covered student** enrolls in Medicare, any medical coverage then in force for such **covered dependents** may be continued provided premium payments for the coverage are made.

Coverage will not continue beyond the first to occur:

- The end of a 36 month period following the date the **covered student** enrolls in Medicare.
- The date a **dependent** becomes eligible for like group coverage.
- The date **dependent** coverage under this Policy ceases as to the **covered student's** eligible class of which the **covered student** is a member just before he enrolled in Medicare.
- The end of the period for which any required contributions have been made.
- The date the **covered student** is no longer covered under this Policy.

If coverage is provided under a group policy, any required premium contributions for the coverage shall be paid by the insured on a monthly basis to the policyholder for remittance to Aetna. The contribution required may be up to 102% of the cost of the plan, without regard to whether the cost is paid by the policyholder or the insured.

EXCLUSIONS

This Policy does not cover nor provide benefits for:

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

- 13) Expense for **injuries** sustained as the result of a motor vehicle accident to the extent that benefits are payable under other valid and collectible insurance whether or not claim is made for such benefits.
- 14) Expense incurred as a result of preventive medicines, serums, vaccines or oral contraceptive.
- 15) Expense incurred as a result of commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.
- 16) Expense incurred for voluntary or elective abortions unless otherwise provided in this Policy.
- 17) Expense incurred after the date insurance terminates for a **covered person** except as may be specifically provided in the Extension of Benefits Provision.
- 18) Expense incurred for services normally provided without charge by the school and covered by the school fee for services.
- 19) Expense incurred for any services rendered by a member of the **covered person's** immediate family or a person who lives in the **covered person's** home.
- 20) Expense incurred for **custodial care**. **Custodial care** means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes **room and board** and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:
 - by whom they are prescribed, or
 - by whom they are recommended, or
 - by whom or by which they are performed.
- 21) Expense incurred for the removal of an organ from a **covered person** for the purpose of donating or selling the organ to any person or organization. This limitation does not apply to a donation by a **covered person** to a spouse, child, brother, sister, or parent.
- 22) Expenses incurred for or in connection with: procedures, services, or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:
 - 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 Aetna 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, Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

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

- 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 Aetna determines that available, scientific evidence demonstrates that the drug is effective, or shows promise of being effective, for the disease.

- 23) Expenses incurred for gastric bypass, and any restrictive procedures, for weight loss.
- 24) Expenses incurred for breast reduction/mamoplasty.
- 25) Expenses incurred for gynecal mastea (male breasts).
- 26) Expenses incurred for: care, treatment, services, or supplies for or related to obstructive sleep apnea, and sleep disorders, including CPAP, and UPP.
- 27) Expense incurred by a **covered person**, not a United States citizen, for services performed within the **covered person's** home country, if the **covered person's** home country has a socialized medicine program.
- 28) Expense incurred for, or related to, services, treatment, testing, educational testing, training, or medication for Attention Deficit Disorder, Attention Deficit Hyperactive Disorder, or Learning Disabilities, or other developmental delays.
- 29) Expense incurred for acupuncture, unless services are rendered for anesthetic purposes.
- 30) Expense incurred for alternative, holistic medicine, and/or therapy, including but not limited to, yoga and hypnotherapy.
- 31) Expense for: a) care of flat feet, b) supportive devices for the foot, c) care of corns, bunions, or calluses, d) care of toenails, and e) care of fallen arches, weak feet, or chronic foot strain, except that c) and d) are not excluded when **medically necessary**, because the **covered person** is diabetic, or suffers from circulatory problems.
- 32) Expense incurred when the person or individual is acting beyond the scope of his/her/its legal authority.
- 33) Expense incurred for hearing aids, the fitting, or prescription of hearing aids.
- 34) Expenses incurred for hearing exams.
- 35) Expense for care or services to the extent the charge would have been covered under Medicare Part A or Part B, even though the **covered person** is eligible, but did not enroll in Part B.
- 36) Expense for telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
- 37) Expense for personal hygiene and convenience items, such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if such items are prescribed by a **physician**.
- 38) Expense for services or supplies provided for the treatment of obesity and/or weight control.
- 39) Expense for incidental surgeries; and standby charges of a physician.
- 40) Expense for treatment and supplies for programs involving cessation of tobacco use.
- 41) Expense incurred for injury resulting from the plan or practice of intercollegiate sports; in excess of \$75,000 (participating in sports clubs; or intramural athletic activities; is not excluded).

- 42) Expense for contraceptive methods, devices or aids, and charges for services and supplies for or related to gamete intrafallopian transfer, artificial insemination, in-vitro fertilization (except as required by the state law), or embryo transfer procedures, elective sterilization or its reversal, or elective abortion, unless specifically provided for in this Policy.
- 43) Expenses incurred for massage therapy.
- 44) Expense incurred for, or related to, sex change surgery, or to any treatment of gender identity disorder.
- 45) Expense for charges that are not reasonable charges, as determined by Aetna.
- 46) Expense for charges that are not recognized charges, as determined by Aetna, except that this will not apply if the charge for a service, or supply, does not exceed the recognized charge for that service or supply, by more than the amount or percentage, specified as the Allowable Variation.
- 47) Expense for treatment of covered students who specialize in the mental health care field, and who receive treatment as a part of their training in that field.
- 48) Expenses for treatment of injury or sickness to the extent payment is made, as a judgment or settlement, by any person deemed responsible for the injury or sickness (or their Insurers).
- 49) Expenses arising from a pre-existing condition.
- 50) Expenses for routine physical exams, including expenses in connection with well newborn care, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage of such exams, immunizations, services, or supplies is specifically provided in the Policy.
- 51) Expense incurred for a treatment, service, or supply, which is not medically necessary, as determined by Aetna, for the diagnosis care or treatment of the sickness or injury involved. This applies even if they are prescribed, recommended, or approved, by the person's attending physician, or dentist.

In order for a treatment, service, or supply, to be considered **medically necessary**, the service or supply must:

- be care, or treatment, which is likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the **sickness or injury** involved, and the person's overall health condition,
- be a diagnostic procedure which is indicated by the health status of the person, and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the **sickness or injury** involved, and the person's overall health condition, and
- as to diagnosis, care, and treatment, be no more costly (taking into account all health expenses incurred in connection with the treatment, service, or supply), than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- information relating to the affected person's health status,
- reports in peer reviewed medical literature,
- reports and guidelines published by nationally recognized health care organizations that include supporting scientific data,
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment,
- the opinion of health professionals in the generally recognized health specialty involved, and any other relevant information brought to Aetna's attention.

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

- 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, or any persons 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 **sickness or injury** could safely, and adequately, be diagnosed, or treated, while not confined, or those furnished solely because of the setting, if the service or supply could safely and adequately be furnished in a **physician's** or a **dentist's** office, or other less costly setting.

52) Expenses incurred for chiropractic care.

53) Expenses incurred for the treatment of acne.

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

DEFINITIONS

Accident

An occurrence which a) is unforeseen, b) is not due to or contributed to by sickness or disease of any kind, and c) causes injury.

Actual Charge

The charge made for a covered service by the provider who furnishes it.

Aggregate Maximum

The maximum benefit that will be paid under this Policy for all Covered Medical Expenses incurred by a covered person that accumulate from one Policy Year to the next.

Ambulatory Surgical Center

A freestanding ambulatory surgical facility that:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Makes charges.
- Is directed by a staff of physicians. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery which requires general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
 - physicians who practice surgery in an area hospital, and
 - dentists who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by a R.N.
- Is equipped and has trained staff to handle medical emergencies.
- It must have:
 - a physician trained in cardiopulmonary resuscitation, and
 - a defibrillator, and
 - a tracheotomy set, and
 - a blood volume expander.
- Has a written agreement with a hospital in the area for immediate emergency transfer of patients. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. The program must include reviews by physicians who do not own or direct the facility.
- Keeps a medical record on each patient.

Birthing Center

A freestanding facility that:

- Meets licensing standards.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
- Makes charges.
- Is directed by at least one physician who is a specialist in obstetrics and gynecology.
- Has a physician or certified nurse midwife present at all births and during the immediate postpartum period.
- Extends staff privileges to physicians who practice obstetrics and gynecology in an area hospital.
- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.
- Provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by a R.N. or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.

- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
- Is equipped and has trained staff to handle medical emergencies and provide immediate support measures to sustain life if complications arise during labor and if a child is born with an abnormality which impairs function or threatens life.
- Accepts only patients with low risk pregnancies.
- Has a written agreement with a hospital in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. This includes reviews by physicians who do not own or direct the facility.
- Keeps a medical record on each patient and child.

Brand Name Prescription Drug or Medicine

A prescription drug which is protected by trademark registration.

Chlamydia Screening Test

This is any laboratory test of the urogenital tract that specifically detects for infection by one or more agents of Chlamydia trachomatis, and which test is approved for such purposes by the FDA.

Coinsurance

The percentage of Covered Medical Expenses payable by Aetna under this Accident and Sickness Insurance Plan.

Complications of Pregnancy

Conditions which require hospital stays before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy. These conditions are:

- acute nephritis or nephrosis, or
- cardiac decompensation or missed abortion, or
- similar conditions as severe as these.

Not included are a) false labor, occasional spotting or physician prescribed rest during the period of pregnancy, b) morning sickness, c) hyperemesis gravidarum and preclampsia, and d) similar conditions not medically distinct from a difficult pregnancy.

Complications of Pregnancy also include:

- non-elective cesarean section, and
- termination of an ectopic pregnancy, and
- spontaneous termination when a live birth is not possible. (This does not include voluntary abortion.)

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 for Covered Medical Expenses. For Prescribed Medicines Expense, the copay is payable directly to the pharmacy for each: prescription, kit, or refill, at the time it is dispensed. In no event will the copay be greater than the pharmacy's charge per: prescription, kit, or refill.

Covered Dental Expenses

Those charges for any treatment, service, or supplies, covered by this Policy which are:

- not in excess of the reasonable and customary charges, or
- not in excess of the charges that would have been made in the absence of this coverage,
- and incurred while this Policy is in force as to the covered person.

Covered Dependent

A covered student's dependent who is insured under this Policy.

Covered Medical Expense

Those charges for any treatment, service or supplies covered by this Policy which are:

- not in excess of the reasonable and customary charges, or
- not in excess of the charges that would have been made in the absence of this coverage, and
- incurred while this Policy is in force as to the covered person except with respect to any expenses payable under the Extension of Benefit Provisions.

Covered Person

A covered student and any covered dependent while coverage under this Policy is in effect.

Covered Student

A student of the Policyholder who is insured under this Policy.

Deductible

The amount of Covered Medical Expenses that are paid by each covered person during the policy year before benefits are paid.

Dental Consultant

A dentist who has agreed to provide consulting services in connection with the Dental Expense Benefit.

Dental Provider

This is any dentist, group, organization, dental facility, or other institution, or person legally qualified to furnish dental services or supplies.

Dentist

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

Dependent

a) the covered student's spouse residing with the covered student; or b) the person identified as a domestic partner in the "Declaration of Domestic Partnership" which is completed and signed by the covered student; c) a dependent child of any age who is handicapped (refer to "INCAPACITATED DEPENDENT CHILDREN" on page 29), d) the covered student's unmarried child under the age of 19 years (or 25 if a full-time student, e) or any other person whom state or federal law requires to be treated as a dependent for purposes of health plans. For the purpose of this definition, a child includes a child for whom the covered student or the covered student's spouse has been appointed legal guardian and an adoptive child. A dependent child must be fully supported by the covered student.

The term "child" includes a covered student's step-child; adopted child; and a child for whom a petition for adoption is pending; and who is residing with the covered student.

The term dependent does not include a person who is: a) an eligible student; or b) a member of the armed forces.

As used in these paragraphs, the term "full-time student" includes any student who by reason of illness; injury; or physical; or mental disability; as documented by a physician; is unable to carry what the educational institution considers a full-time

course load; so long as the student's course load is at least 60 percent of what otherwise is considered by the institution to be a full-time course load.

Designated Care

Care provided by a Designated Care Provider upon referral from the School Health Services.

Designated Care Provider

A health care provider or pharmacy that is affiliated with, and has an agreement with, the School Health Services to furnish services and supplies at a negotiated charge.

Diabetic Self-Management Education Course

A scheduled program on a regular basis which is designed to instruct a covered person in the self-management of diabetes. It is a day care program of educational services and self-care training, including medical nutritional therapy. The program must be under the supervision of an appropriately licensed, registered, or certified health care professional whose scope of practice includes diabetic education or management.

The following are not considered Diabetic Self-Management Education Courses for the purposes of this Plan:

- a Diabetic Education program whose only purpose is weight control, or which is available to the public at no cost; or
- a general program not just for diabetics; or
- a program made up of services not generally accepted as necessary for the management of diabetes.

Directory

A listing of Preferred Care Providers in the service area covered under this Policy, which is given to the Policyholder.

Durable Medical and Surgical Equipment

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 person's 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.

Elective Treatment

Medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the covered person's effective date of coverage. Elective treatment includes, but is not limited to:

- tubal ligation,
- vasectomy,
- breast reduction,
- sexual reassignment surgery,
- submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis,
- treatment for weight reduction,
- learning disabilities,
- temporomandibular joint dysfunction (TMJ),
- immunization,
- treatment of infertility, and
- routine physical examinations.

Emergency Admission

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

- requires confinement right away as a full-time inpatient, and
- if immediate inpatient care was not given could, as determined by Aetna, reasonably be expected to result in:
 - loss of life or limb, or
 - significant impairment to bodily function, or
 - permanent dysfunction of a body part.

Emergency Condition

This is any traumatic injury or condition which:

- occurs unexpectedly,
- requires immediate diagnosis and treatment, in order to stabilize the condition, and
- is characterized by symptoms such as severe pain and bleeding.

Emergency Medical 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.

Generic Prescription Drug or Medicine

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

High-Cost Procedure

High-Cost Procedures include the following procedures and services:

- C.A.T. Scan,
- Magnetic Resonance Imaging,
- Laser treatment, which must be provided on an outpatient basis, and may be incurred in the following:
 - A physician’s office, or
 - Hospital outpatient department, or emergency room, or
 - Clinical laboratory, or
 - Radiological facility, or other similar facility, licensed by the applicable state, or the state in which the facility is located.

Home Health Agency

- an agency licensed as a home health agency by the state in which home health care services are provided, or
- an agency certified as such under Medicare, or
- an agency approved as such by Aetna.

Home Health Aide

A certified or trained professional who provides services through a home health agency which are not required to be performed by an RN, LPN, or LVN, primarily aid the covered person in performing the normal activities of daily living while recovering from an injury or sickness, and are described under the written Home Health Care Plan.

Home Health Care

Health services and supplies provided to a covered person on a part-time, intermittent, visiting basis. Such services and supplies must be provided in such person’s place of residence, while the person is confined as a result of injury or sickness. Also, a physician must certify that the use of such services and supplies is to treat a condition as an alternative to confinement in a hospital or skilled nursing facility.

Home Health Care Plan

A written plan of care established and approved in writing by a physician, for continued health care and treatment in a covered person’s home. It must either follow within 24 hours of and be for the same or related cause(s) as a period of hospital or skilled nursing confinement, or be in lieu of hospital or skilled nursing confinement.

Hospice

A facility or program providing a coordinated program of home and inpatient care which treats terminally ill patients. The program provides care to meet the special needs of the patient during the final stages of a terminal illness. Care is provided by a team made up of trained medical personnel, counselors, and volunteers. The team acts under an independent hospice administration and it helps the patient cope with physical, psychological, spiritual, social, and economic stresses. The hospital administration must meet the standards of the National Hospice Organization and any licensing requirements.

Hospice Benefit Period

A period that begins on the date the attending physician certifies that the covered person is a terminally ill patient who has less than 6 months to live. It ends after 6 months (or such later period for which treatment is certified) or on the death of the patient, if sooner.

Hospice Care Expenses

The reasonable and customary charges made by a hospice for the following services or supplies: charges for inpatient care, charges for drugs and medicines, charges for part-time nursing by an RN, LPN, or LVN, charges for physical and respiratory therapy in the home, charges for the use of medical equipment, charges for visits by licensed or trained social workers, psychologists or counselors, charges for bereavement counseling of the covered person's immediate family prior to, and within 3 months after, the covered person's death, and charges for respite care for up to 5 days in any 30 day period.

Hospital

A facility which meets all of these tests:

- it provides in-patient services for the care and treatment of injured and sick people, and
- it provides room and board services and nursing services 24 hours a day, and
- it has established facilities for diagnosis and major surgery, and
- it is run as a hospital under the laws of the jurisdiction which it is located.

Hospital does not include a place run mainly: a) for alcoholics or drug addicts, b) as a convalescent home, or c) as a nursing or rest home. The term "hospital" includes an alcohol and drug addiction treatment facility during any period in which it provides effective treatment of alcohol and drug addiction to the covered person.

Hospital Confinement

A stay of 18 or more hours in a row as a resident bed patient in a hospital.

Injury

Bodily injury caused by an accident. This includes related conditions and recurrent symptoms of such injury.

Intensive Care Unit

A designated ward, unit, or area within a hospital for which a specified extra daily surcharge is made and which is staffed and equipped to provide, on a continuous basis, specialized or intensive care or services, not regularly provided within such hospital.

Jaw Joint Disorder

This is a Temporomandibular Joint Dysfunction or any similar disorder in the relationship between the jaws or jaw joint, and the muscles, and nerves.

Mail Order Pharmacy

An establishment where prescription drugs are legally dispensed by mail.

Medically Necessary

A service or supply that is: necessary, and appropriate, for the diagnosis or treatment of a sickness, or injury, based on generally accepted current medical practice.

In order for a treatment, service, or supply to be considered medically necessary, the service or supply must:

- Be care or treatment which is likely to produce as significant positive outcome as any alternative service or supply, both as to the sickness or injury involved and the person's overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply, both as to the sickness or injury involved and the person's overall health condition
- Be a diagnostic procedure which is indicated by the health status of the person. It must be as likely to result in information that could affect the course of treatment as any alternative service or supply, both as to the sickness or injury involved and the person's overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply, both as to the sickness or injury involved and the person's overall health condition, and
- As to diagnosis, care, and treatment, be no more costly (taking into account all health expenses incurred in connection with the treatment, service, or supply,) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- information relating to the affected person's health status,
- reports in peer reviewed medical literature,
- reports and guidelines published by nationally recognized health care organizations that include supporting scientific data,
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment,
- the opinion of health professionals in the generally recognized health specialty involved, and
- any other relevant information brought to Aetna's attention.

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

- 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, or 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 sickness or injury could safely and adequately be diagnosed or treated while not confined, or
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished, in a physician's or a dentist's office, or other less costly setting.

Medication Formulary

A listing of prescription drugs which have been evaluated and selected by Aetna clinical pharmacists, for their therapeutic equivalency and efficacy. This listing includes both brand name and generic prescription drugs. This listing is subject to periodic review, and modification by Aetna.

Member Dental Provider

Any dental provider who has entered in to a written agreement to provide to covered students the dental care described under the Dental Expense Benefit.

A covered student's member dental provider is a member dental provider currently chosen, in writing by the covered student, to provide dental care to the covered student.

A member dental provider chosen by a covered student takes effect as the covered student's member dental provider on the effective date of that covered student's coverage.

Member Dental Provider Service Area

The area within a 50 mile radius of the covered student's member dental provider.

Negotiated Charge

The maximum charge a Preferred Care Provider or Designated Provider has agreed to make as to any service or supply for the purpose of the benefits under this Policy.

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 covered student:

- 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

A health care service or supply furnished by a health care provider that is not a Designated Care Provider, or that is not a Preferred Care Provider, if, as determined by Aetna:

- 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

- 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 School Health Services.

Non-Preferred Pharmacy

A pharmacy not party to a contract with Aetna, or a pharmacy who is party to such a contract but who does not dispense prescription drugs in accordance with its terms.

Non-Preferred Prescription Drug Expense

An expense incurred for a prescription drug that is not a preferred prescription drug expense.

One Sickness

A sickness and all recurrences and related conditions which are sustained by a covered person.

Orthodontic Treatment

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
- surgical procedure to correct malocclusion.

Out-of-Area Emergency Dental Care

Medically necessary care or treatment for an emergency medical condition, that is rendered outside a 50 mile radius of the covered student's member dental provider. Such care is subject to specific limitations set forth in this Policy.

Out-of-Pocket Limit

The amount that must be paid, by the covered student, or the covered student and their covered dependents, before Covered Medical Expenses will be payable at 100% for the remainder of the Policy Year. The Out-of-Pocket Limit applies only to Covered Medical Expenses for preferred care, which are payable at a rate greater than 50%.

The following expenses do not apply toward meeting the Out-of-Pocket Limit:

- deductibles,
- copays,
- expenses that are not Covered Medical Expenses,
- expenses for designated care or non-preferred care,
- penalties,
- expenses for prescription drugs, and
- other expenses not covered by this Policy.

Outpatient Diabetic Self-Management Education Program

A scheduled program on a regular basis, which is designed to instruct a covered person in the self-management of diabetes. It is a day care program of educational services and self-care training, (including medical nutritional therapy). The program must be under the supervision of an appropriately licensed, registered, or certified health care professional whose scope of practice includes diabetic education or management.

Partial Hospitalization

Continuous treatment consisting of not less than four hours and not more than twelve hours in any twenty-four hour period under a program based in a hospital.

Pervasive Developmental Disorder

A neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Pharmacy

An establishment where prescription drugs are legally dispensed.

Physician

a) legally qualified physician licensed by the state in which he or she practices, and b) any other practitioner that must by law be recognized as a doctor legally qualified to render treatment, including a dentist and podiatrist.

Policy Year

The period of time from anniversary date to anniversary date except in the first year when it is the period of time from the effective date to the first anniversary date.

Pre-Admission Testing

Tests done by a hospital, surgery center, licensed diagnostic lab facility, or physician, in its own behalf, to test a person while an outpatient before scheduled surgery if:

- the tests are related to the scheduled surgery,
- the tests are done within the 7 days prior to the scheduled surgery,
- the person undergoes the scheduled surgery in a hospital or surgery center, this does not apply if the tests show that surgery should not be done because of his physical condition,
- the charge for the surgery is a Covered Medical Expense under this Plan,
- the tests are done while the person is not confined as an inpatient in a hospital,
- the charges for the tests would have been covered if the person was confined as an inpatient in a hospital,
- the test results appear in the person's medical record kept by the hospital or surgery center where the surgery is to be done, and
- the tests are not repeated in or by the hospital or surgery center where the surgery is done.

If the person cancels the scheduled surgery, benefits are paid at the Covered Percentage that would have applied in the absence of this benefit.

Pre-Existing Condition

Any injury, sickness, or condition that was diagnosed or treated, within twelve months prior to the covered person's effective date of insurance.

Preferred Care

Care provided by:

- a covered person's primary care physician, or a preferred care provider of the primary care physician, or
- a health care provider that is not a Preferred Care Provider for an emergency medical condition when travel to a Preferred Care Provider, not feasible, or
- a Non-Preferred Urgent Care Provider when travel to a Preferred Urgent Care Provider for treatment is not feasible, and if authorized by Aetna.

Preferred Care Provider

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 covered persons of which you are member.

Preferred Pharmacy

A pharmacy, including a mail order pharmacy, which is party to a contract with Aetna to dispense drugs to persons covered under this Policy, but only:

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

Preferred Prescription Drug Expense

An expense incurred for a prescription drug that:

- is dispensed by a Preferred Pharmacy, or for an emergency medical condition only, by a non-preferred pharmacy, and
- is dispensed upon the Prescription of a Prescriber who is:
 - a Designated Care Provider, or
 - a Preferred Care Provider, or
 - a Non-Preferred Care Provider, but only for an emergency condition, or of a person's Primary Care Physician, or
 - a dentist who is a Non-Preferred Care Provider, but only one who is not of a type that falls into one or more of the categories of providers listed in the directory of Preferred Care Providers.

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 be promptly put in writing by the pharmacy.

Prescription Drugs

Any of the following:

- A drug, biological, or compounded prescription, which, by Federal law, may be dispensed only by prescription and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription",
- Injectable insulin, disposable needles, and syringes, when prescribed and purchased at the same time as insulin, and disposable diabetic supplies.

Primary Care Physician

This is the Preferred Care Provider who is:

- selected by a person from the list of Primary Care Physicians in the directory,
- responsible for the person's on-going health care, and
- shown on Aetna's records as the person's Primary Care Physician.

For purposes of this definition, a Primary Care Physician also includes the School Health Services.

Reasonable and Customary

The charge which is the smallest of:

- the actual charge,
- the charge usually made for a covered service by the provider who furnishes it, and
- the prevailing charge made for a covered service in the geographic area by those of similar professional standing.

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 Aetna 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 Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In some circumstances, Aetna may have an agreement, either directly or indirectly through a third party, with a provider which sets the rate that Aetna 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.

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.

Aetna may take into account factors, such as:

- 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.

Recognized Charge

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

- The provider's usual charge for furnishing it, and
- The charge Aetna 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 Aetna determines to be the recognized charge percentage made for that service or supply.

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

In determining the recognized 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.

Aetna may take into account factors, such as:

- 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 recognized charge in other areas.

Residential Treatment Facility

A treatment center for children and adolescents, which provides residential care and treatment for emotionally disturbed individuals, and is licensed by the department of children and youth services, and is accredited as a residential treatment center by the council on accreditation or the joint commission on accreditation of health organizations.

Respite Care

Care provided to give temporary relief to the family or other care givers in emergencies and from the daily demands for caring for a terminally ill covered person.

Room and Board

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.

Routine Screening for Sexually Transmitted Disease

This is any laboratory test approved for such purposes by the FDA that specifically detects for infection by one or more agents of:

- Gonorrhea,
- Syphilis,
- Hepatitis,
- HIV, and
- Genital Herpes

School Health Services

Any organization, facility, or clinic operated, maintained, or supported by the school or other entity under contract to the school which provides health care services to enrolled students.

Semi-Private Rate

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

Service Area

The geographic area, as determined by Aetna, in which the Preferred Care Providers are located.

Sickness

Disease or illness including related conditions and recurrent symptoms of the sickness. Sickness also includes pregnancy, and complications of pregnancy. All injuries or sickness due to the same or a related cause are considered one injury or sickness.

Skilled Nursing Facility

A lawfully operating institution engaged mainly in providing treatment for people convalescing from injury or sickness. It must have:

- organized facilities for medical services,
- 24 hours nursing service by RNs,
- a capacity of six or more beds,
- a daily medical records for each patient, and
- a physician available at all times.

Sound Natural Teeth

Natural teeth, the major portion of the individual tooth which is present regardless of fillings and is not carious, abscessed, or defective. Sound natural teeth shall not include capped teeth.

Surgery Center

A free standing ambulatory surgical facility that:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Makes charges.
- Is directed by a staff of physicians. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery which requires general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
 - physicians who practice surgery in an area hospital, and
 - dentists who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by a registered nurse.
- Is equipped and has trained staff to handle medical emergencies.
- It must have:
 - a physician trained in cardiopulmonary resuscitation, and
 - a defibrillator, and
 - a tracheotomy set, and
 - a blood volume expander.
- Has a written agreement with a hospital in the area for immediate emergency transfer of patients. Written procedures for such a transfer must be displayed, and the staff must be aware of them.
- Provides an ongoing quality assurance program. The program must include reviews by physicians who do not own or direct the facility.
- Keeps a medical record on each patient.

Surgical Assistant

A medical professional trained to assist in surgery in both the preoperative and postoperative periods under the supervision of a physician. This includes a registered nurse who performs first assistant functions and services that are within the scope and practice of a registered nurse.

Surgical Expense

Charges by a physician for,

- a surgical procedure,
- a necessary preoperative treatment during a hospital stay in connection with such procedure, and
- usual postoperative treatment.

Surgical Procedure

- a cutting procedure,
- suturing of a wound,
- treatment of a fracture,
- reduction of a dislocation,
- radiotherapy (excluding radioactive isotope therapy), if used in lieu of a cutting operation for removal of a tumor,
- electrocauterization,
- diagnostic and therapeutic endoscopic procedures,
- injection treatment of hemorrhoids and varicose veins,
- an operation by means of laser beam,
- cryosurgery.

Totally Disabled

Due to disease or injury, the covered person is not able to engage in most of the normal activities of a person of like age and sex in good health.

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.

Urgent Care Provider

This is:

- A freestanding medical facility which:
 - Provides unscheduled medical services to treat an urgent condition if the covered person's physician is not reasonably available.
 - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
 - Makes charges.
 - Is licensed and certified as required by any state or federal law or regulation.
 - 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.
 - Has a full-time administrator who is a licensed physician.
- A physician's office, but only one that:
 - has contracted with Aetna to provide urgent care, and
 - is, with Aetna's consent, included in the Provider Directory as a Preferred Urgent Care Provider.
 - It is not the emergency room or outpatient department of a hospital.

Walk-in Clinic

A clinic with a group of physicians, which is not affiliated with a hospital, that provides: diagnostic services, observation, treatment, and rehabilitation on an outpatient basis.

CLAIM PROCEDURE

On occasion, the claims investigation process will require additional information in order to properly adjudicate the claim. This investigation will be handled directly by Aetna.

Customer Service Representatives are available 8:30a.m. to 5:30p.m., Monday through Friday, ET for any questions. Bills must be submitted within 90 days from the date of treatment.

Payment for Covered Medical Expenses will be made directly to the hospital or physician concerned, unless bill receipts and proof of payment are submitted.

If itemized medical bills are available at the time the claim form is submitted, attach them to the claim form. Subsequent medical bills should be mailed promptly to the above address.

You will receive an "Explanation of Benefits" when your claims are processed. The Explanation of Benefits will explain how your claim was processed, according to the benefits of your Student Accident and Sickness Insurance Plan.

HOW TO APPEAL A CLAIM

In the event a Covered Person disagrees with how a claim was processed, he/she may request a review of the decision. The Covered Person's requests must be made in writing within one hundred eighty (180) days of receipt of the Explanation of Benefits (EOB). The Covered Person's request must include why he/she disagrees with the way the claim was processed. The request must also include any additional information that supports the claim (e.g., medical records, Physician's office notes, operative reports, Physician's letter of medical necessity, etc.). Please submit all requests to:

Aetna Student Health
P.O. Box 15717
Boston, MA 02215-0014

PRESCRIPTION DRUG CLAIM PROCEDURE

When obtaining a covered prescription, please present your ID card to a Preferred Pharmacy, along with your applicable copay. The pharmacy will bill Aetna for the cost of the drug, plus a dispensing fee, less the copay amount.

When you need to fill a prescription, and do not have your ID card with you, you may obtain your prescription from an Aetna Preferred Pharmacy, and be reimbursed by submitting a completed Aetna Prescription Drug claim form. You will be reimbursed for covered medications, less your copay.

ON CALL INTERNATIONAL

Chickering Claims Administrators, Inc. (CCA) has contracted with On Call International (On Call) to provide Covered Persons with access to certain accidental death and dismemberment benefits, worldwide emergency travel assistance services and other benefits. A brief description of these benefits is outlined below.

Accidental Death and Dismemberment (ADD) Benefits

Benefits are payable for the Accidental Death and Dismemberment of Covered Persons, up to a maximum of Ten Thousand Dollars (\$10,000).

NOTE: For most school plans, ADD benefits are provided by Aetna Life Insurance Company (ALIC). However, in some states, ADD benefits may be provided through a contractual relationship between Chickering Claims Administrators, Inc. (CCA) and On Call International (On Call). ADD coverage provided through On Call is underwritten by United States Fire Insurance Company (USFIC). Please refer to your school's policy to determine whether ALIC or USFIC underwrites ADD benefits for your specific Plan. Should you have questions or need to file a claim please contact 888-407-0445.

MEDICAL EVACUATION AND REPATRIATION (MER) AND WORLDWIDE EMERGENCY TRAVEL ASSISTANCE (WETA) SERVICES PROVIDED THROUGH ON CALL INTERNATIONAL, INC.

Chickering Claims Administrators, Inc. (CCA) has contracted with On Call International, Inc. (On Call) to provide Covered Persons with access to certain Medical Evacuation and Repatriation (MER) and Worldwide Emergency Travel Assistance (WETA) benefits and/or services.

Medical Evacuation and Repatriation (MER) Benefits. The following benefits are underwritten by Virginia Surety Company (VSC), with medical and travel assistance services provided by On Call. These benefits are designed to assist Covered Persons when traveling more than 100 miles from home, anywhere in the world.

- Unlimited Emergency Medical Evacuation
- Unlimited Medically Supervised Repatriation (while traveling or on campus)
- Unlimited Return of Mortal Remains (while traveling or on campus)
- Return of Traveling Companion
- \$2,500 Emergency Return Home in the event of death or life-threatening illness of a parent or sibling

Worldwide Emergency Travel Assistance (WETA) Services. On Call provides the following travel assistance services:

- 24/7 Emergency Travel Arrangements
- Translation Assistance
- Emergency Travel Funds Assistance
- Lost Luggage and Travel Documents Assistance
- Assistance with Replacement of Credit Card/Travelers Checks
- 24/7 U.S. Nurse Help Line
- Medical/Dental/Pharmacy Referral Service
- Hospital Deposit Arrangements
- Dispatch of Physician
- Emergency Medical Record Assistance

NOTE: In order to obtain coverage, all MER and WETA services must be provided and arranged through On Call. Reimbursement will NOT be provided for any such services not provided and arranged through On Call. Although certain medical services may be covered under the terms of the Covered Person's student health insurance plan (the "Plan"), On Call does not provide coverage for medical treatment rendered by doctors, hospitals, pharmacies or other health care providers. Coverage for such services will be provided in accordance with the terms of the Plan and exclusions and limitations may apply.

To obtain MER and WETA benefits/services, or for any questions related to those benefits/services, please call On Call International at the following numbers listed on the On Call ID card provided to Covered Persons when they enroll in the Plan: Toll Free 1-866-525-1956 or collect 1-603-328-1956. All Covered Persons should carry their On Call ID cards when traveling.

CCA and On Call are independent contractors and not employees or agents of the other. CCA provides access to certain ADD, MER and WETA benefits/services through a contractual arrangement with On Call. However, neither CCA nor any of its affiliates underwrites or administers any MER or WETA benefits/services. Neither CCA nor any of its affiliates underwrites or administers any ADD benefits that are provided through On Call. Neither CCA nor any of its affiliates is responsible in any way for the benefits/services provided by or through On Call, USFIC or VSC. Premiums/fees for benefits/services provided through On Call, USFIC and VSC are included in the Rates outlined in this brochure.

Got Questions? Get Answers with Aetna's Navigator®

As an Aetna Student Health insurance member, you have access to Aetna Navigator®, your secure member website, packed with personalized claims and health information. You can take full advantage of our interactive website to complete a variety of self-service transactions online. **By logging into Aetna Navigator, you can:**

- Review who is covered under your plan.
- Request member ID cards.
- View Claim Explanation of Benefits (EOB) statements.
- Estimate the cost of common health care services and procedures to better plan your expenses.
- Research the price of a drug and learn if there are alternatives.
- Find health care professionals and facilities that participate in your plan.
- Send an e-mail to Aetna Student Health Customer Service at your convenience.
- View the latest health information and news, and more!

How do I register?

- Go to **www.aetnastudenthealth.com**
- Find your school in the School Directory
- Click on Aetna Navigator® Member Website and then the “Register for Aetna Navigator” link.
- Follow the instructions for the registration process, including selecting a user name, password and security phrase.

Need help with registering onto Aetna Navigator?

Registration assistance is available toll free, Monday through Friday, from 7:00a.m. to 9:00p.m. Eastern Time at **800-225-3375**.

NOTICE

Aetna considers nonpublic personal member information confidential and has policies and procedures in place to protect the information against unlawful use and disclosure. When necessary for your care or treatment, the operation of your health Plan, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals, and other caregivers), vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. Participating Network/Preferred Providers are also required to give you access to your medical records within a reasonable amount of time after you make a request. By enrolling in the Plan, you permit us to use and disclose this information as described above on behalf of yourself and your dependents. To obtain a copy of our Notice of Privacy Practices describing in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Customer Services number on your ID card or visit www.aetnastudenthealth.com.

Administered by:

Aetna Student Health.
P.O. Box 15708
Boston, MA 02215-0014
1-888-407-0445

www.aetnastudenthealth.com



Underwritten by:

Aetna Life Insurance Company (ALIC)
151 Farmington Avenue
Hartford, CT 06156
860-273-0123

Policy No. 474922

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