

2013-2014



**UNIVERSITY OF
NOTRE DAME**

Student Injury and Sickness Insurance Plan

Be advised that you may be eligible for Coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.

**Underwritten by:
Aetna Life Insurance Company
(ALIC)
Policy Number 474916**

aetnaSM

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 University Health Services at **(574) 631-7497**.

For questions about:

- Insurance Benefits
- Enrollment
- Waiver Process
- Claims Processing
- Pre-Certification Requirements
- Prescription Reimbursement

Please contact:

Aetna Student Health
P.O. Box 981106
El Paso, TX 79998
(888) 294-7406

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
(888) 294-7406

For questions about:

- Enrollment Forms
- Waiver Process
- University Health Services Referrals

Please contact:

The University of Notre Dame
(574) 631-7497

For questions about:

- Provider Listings

Please contact:

Aetna Student Health
(888) 294-7406

A complete list of providers can be found at the University Health Services Office, or you can use Aetna's **Doc Find**[®] Service at **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 the University of Notre Dame site for further information.

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 Notre Dame. 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 Health Services in the Assistant Director's 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?

NOTICE TO PLAN PARTICIPANTS

Please note the following information which is not a change from prior years.

The organization that sponsors your group health plan has certified that it qualifies for a temporary enforcement safe harbor with respect to the Federal requirement to cover contraceptive services without cost sharing. During this one-year period, Coverage under your group health plan will not include Coverage of contraceptive services

TABLE OF CONTENTS

	Page Numbers
University Health Services	5
Policy Period	5
Rates and Deductibles	5
Student Coverage – Eligibility	6
Continuously Insured	6
Waiver Process/Procedure	6
Refund Policy	7
Dependent Coverage	7
Referral Requirement	8
Pre-Certification Requirements	8
Pre-Existing Conditions	9
In-Patient Hospitalization Benefits	10
Surgical Benefits - Inpatient	11
Surgical Benefits – Inpatient	11
Outpatient Benefits	12
Mental Health & Substance Abuse Benefits	19
Maternity Benefits	19
Additional Benefits	20
General Provisions	27
Extension of Benefits	28
Termination of Insurance	28
Exclusions	30
Definitions	32
Appeals Procedure	42
Claim Procedure	42
Prescription Drug Claim Procedure	46
World Travel Assistance Services	47
Accidental Death & Dismemberment	47
Aetna Navigator	48
Notice	49

UNIVERSITY HEALTH SERVICES

University Health Services is the University’s on-campus health facility. Staffed by physicians and registered nurses, it is open 24/7 during the Fall and Spring semesters. Physicians hold clinic hours 9:00 a.m. – 5:00 p.m. Monday through Friday, and a physician is on call at all times for students in the inpatient observation unit.

For more information, call University Health Services at (574) 631-7497. In the event of an emergency, call 911 or the Campus Police at (574) 631-5555.

POLICY PERIOD

- **Early Start Students:** Coverage for all insured students enrolled for the Early Start Plan will become effective at 12:01 a.m. on **August 1, 2013**, and will terminate at 11:59 p.m. on **August 14, 2014**.
- **Students:** Coverage for all insured students enrolled for the Annual Plan will become effective at 12:01 a.m. on **August 15, 2013**, and will terminate at 11:59 p.m. on **August 14, 2014**.
- **Spring Semester Students:** Coverage for all insured students enrolled for the Spring Semester, will become effective at 12:01 a.m. on **January 1, 2014**, and will terminate at 11:59 p.m. on **August 14, 2014**.
- **Insured dependents:** Coverage will become effective on the same date 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 pages 28 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

2013-2014	Early Start Annual Rate 8/1/2013 – 8/14/2014	Annual Rate 8/15/2013 – /14/2014	Spring/Summer Rate 1/1/2014 – 8/14/2014	Summer Only Rate 5/15/2014 – 8/14/2014
Student Only	\$2,231	\$2,148	\$1,342	\$535
Spouse Only	\$5,578	\$5,372	\$3,348	\$1,342
Child Only	\$3,348	\$3,223	\$2,016	\$806
All Children	\$4,352	\$4,190	\$2,619	\$1,047

**THE UNIVERSITY OF NOTRE DAME/
STUDENT INJURY AND SICKNESS INSURANCE PLAN**

This is a brief description of the Accident and Sickness Medical Expense benefits available for University of Notre Dame 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 Health Services during business hours.

STUDENT COVERAGE/ ELIGIBILITY

All Registered International and all graduate nonresident and degree seeking students are automatically enrolled in this insurance plan upon registration. The premium for the Plan will be added to your tuition billing. If you are covered under another comparable plan, you may apply for a waiver. Proof of comparable Coverage must be in accordance with your school’s requirements.

Voluntary Enrollment:

- All registered Domestic undergraduate students taking 3 or more credit hours
- Non-degree seeking graduate students taking credit hours
- ROTC students taking credit hours
- Dependents – Spouse and Children

Eligible students who are enrolled at The University of Notre Dame must actively attend classes for at least the first 31 days, after the date when Coverage becomes effective.

Home study and correspondence 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/WAIVER

Eligible students will be automatically enrolled in this plan, unless the Waiver has been completed by the specified enrollment deadline dates listed in the next section of this Brochure.

This information can be submitted on-line via the waiver site below.

To complete the Online Waiver Form,

- Go to www.Aetnastudenthealth.com/schools/notredame
- Once on the University of Notre Dame Webpage, click on “Medical Enroll/Waive”.

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.

CONTINUOUSLY INSURED

“Continuously insured” means a person who was insured under prior Student Health Insurance policies issued to the school; and is now insured under this Policy. Persons who have remained continuously insured will be covered; except for expenses payable under prior policies in the absence of this Policy. Previously insured **dependents** and students must re-enroll for Coverage in order to avoid a break in Coverage for conditions which existed in prior Policy Years. Once a break in continuous insurance occurs; the definition of **injury** or **sickness** will apply in determining Coverage of any condition which existed during such break.

WAIVER PROCESS/PROCEDURE

Eligible students will automatically be enrolled in this plan, unless a Waiver is completed online by the specified deadline dates listed below:

Category	Waiver Open Date	Waiver Deadline Date
Students enrolling for the Fall Semester	7/17/2013	9/15/2014
Students enrolling for the Spring Semester	1/1/2014	2/15/2014
Students enrolling for the Summer Semester	5/15/2014	6/15/2014

Waiver submissions may be audited by The University of Notre Dame, Aetna Student Health, and/or their contractors or representatives. You may be required to provide, upon request, any Coverage documents and/or other records demonstrating that you meet the school’s requirements for waiving the student health insurance plan. By submitting the waiver request, you agree that your current insurance plan 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.

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, and children under age 26.

ENROLLMENT – Dependents and all other eligible students

to enroll the dependent(s) of a covered student, please complete the application on line at www.Aetnastudenthealth.com. Your application must be submitted before **October 1, 2013**, and then there will be no break in Coverage. The Fall enrollment deadline is **October 1, 2013**. Dependent enrollment applications will not be accepted after **October 1, 2013**, 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 February 15, 2014.**

Enrollment Instructions:

- Go to www.Aetnastudenthealth.com/schools/notredame
- Once in the University of Notre Dame section, click on “Medical Enroll/Waive”

NEWBORN INFANT AND ADOPTED CHILD COVERAGE

A child born to a **Covered person** shall be covered for Accident, Sickness, and congenital defects, for 31 days from the date of birth. At the end of this 31 day period, Coverage will cease under the University of Notre Dame 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 October 1, 2013 for the Fall Semester, and by February 15, 2014 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, (888) 294-7406.

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 Notre Dame 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 Notre Dame, Aetna Student Health, or Aetna. A complete listing of participating providers is available at the University of Notre Dame’s University Health Services.

You may also obtain information regarding Preferred Providers by contacting Aetna Student Health at (888) 294-7406 or through the Internet by accessing **DocFind** at www.Aetnastudenthealth.com/schools/notredame.

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.

REFERRAL REQUIRED FOR STUDENTS

Students' health care needs can best be satisfied when an organized system of health care providers at the University of Notre Dame's Health Services manages the treatment. If you do not obtain a referral from University Health Services, your benefits will be limited. If no referral is obtained, preferred care is reduced to non-preferred care. A referral is NOT needed for the services listed below.

- Treatment is for an Emergency Medical Condition.
- The student is more than 25 miles away from the campus.
- The University Health Services is closed during break or vacation.
- Medical care obtained when the student is no longer able to use the UHS due to a change in the student's status.
- Maternity.
- Mammogram.
- Wellness/Routine Exam.
- Dental Injury Expenses.
- Impacted Wisdom Teeth Expenses.
- Chiropractic Services
- High Cost Procedures and X-ray Services.
- Direct Access required for Obstetricians and Gynecologists.
- Treatment is for an Emergency Medical Condition,
- Obstetric and Gynecological Treatment,
- Pediatric Care

Dependent spouses and children are not eligible to use the services of the University Health Services and are therefore not subject to the referral requirements and penalties.

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's Managed Care Department at **(888) 294-7406**.

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.
- **If you do not secure pre-certification** for non-emergency inpatient admissions, or provide notification for emergency admissions, your **Covered Medical Expenses** will be subject to a **\$200** per admission penalty Deductible.

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

Any **injury; sickness;** or condition that was diagnosed or treated (including prescriptions); or would have caused a prudent person to seek diagnosis or treatment; within twelve months prior to the **covered person's** effective date of insurance.

Limitation

Expenses incurred by a **covered person** as a result of a **Pre-Existing Condition** will not be considered **Covered Medical Expense** unless (a) no charges are incurred or treatment rendered for the condition for a period of six months while covered under this Policy; or (b) the **covered person** has been covered under this Policy for twelve consecutive months; whichever happens first.

The pre-existing conditions clause of the University of Notre Dame Student Injury and Sickness Insurance Plan does not apply to International Students on the Plan, or to **Covered person** s to age 19.

Special Rules As To A Pre-Existing Condition

If a person had creditable Coverage; and such Coverage terminated within 63 days prior to the date he or she enrolled (or was enrolled) in this Plan; then any limitation as to a **Pre-Existing Condition** under this Plan will not apply for that person.

Pre-Existing Conditions will apply to students and their **covered dependents;** who elect Coverage more than 63 days after the date such person becomes eligible for Coverage under this Policy.

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

DESCRIPTION OF BENEFITS

Please Note:

The University of Notre Dame Student Injury and Sickness 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 Notre Dame's Student Injury and Sickness Insurance 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 Notre Dame, you may view it at University Health Services or you may contact Aetna Student Health at (888) 294-7406.

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.

All insurance Coverage is subject to the terms of the Master Policy and applicable state filings. Under health care reform legislation, student health plans may be required to eliminate or modify certain existing benefit plan provisions, including, but not limited to, exclusions and limitations. Aetna reserves the right to modify its products and services in response to federal and/or state legislation, regulation or requests of government authorities.

*Benefit descriptions have been added to this brochure to help illustrate new Health Care Reform (HCR) requirements. HCR requirements are currently being filed for support in individual states and will appear in policy contracts and certificates of Coverage once approved.

SUMMARY OF BENEFITS CHART

DEDUCTIBLES

The following Deductibles are applied before **Covered Medical Expenses** are payable:

- Students: **\$500 per Policy Year**
- Spouse: **\$500 per Policy Year**
- Child: **\$500 per Policy Year**

*The annual deductible is waived for expenses incurred at University Health Services, South Bend Medical Foundation, MIC (Medical Imaging Center), Rad, Inc. and McDonald Physical Therapy.

Waiver of Annual Deductible

In compliance with Federal Health Care Reform legislation, the Annual Deductible is waived for Preferred Care **Covered Medical Expenses** (refer to specific benefit types for list of services) rendered as part of the following benefit types: Routine Physical Exam Expense (Office Visits), Pap Smear Screening Expense, Mammogram Expense, Routine Screening for Sexually Transmitted Disease Expense, Routine Colorectal Cancer Screening, Routine Prostate Cancer Screening Expense, Preventive Care Immunizations (Facility or Office Visits) Well Woman Preventive Visits (Office Visits), Screening & Counseling Services (Office Visits) as illustrated under the Routine Physical Exam benefit type, Routine Cancer Screenings (Outpatient), Prenatal Care (Office Visits), Comprehensive Lactation Support and Counseling Services (Facility or Office Visits), and Breast Pumps & Supplies.

COINSURANCE

Covered Medical Expenses are payable at the coinsurance percentage specified below, after any applicable deductible, up to a maximum benefit of Unlimited.

OUT OF POCKET MAXIMUMS

Once the Individual or Family **Out-of-Pocket Limit** has been satisfied, **Covered Medical Expenses** will be payable at **100%** for the remainder of the Policy Year, up to any benefit maximum that may apply. Amounts supplied to the Out-of-Pocket Maximum would be the Annual Deductible and Coinsurance. Services not subject to the Out-of-Pocket Maximum are copays, prescription copays, pre-certification penalties, or charges for services rendered at University Health Services.

- Preferred Care and Non-Preferred Care: Individual Out-of-Pocket: **\$2,500**
- Preferred Care and Non-Preferred Care: Family Out-of-Pocket: **\$5,000**

All Coverage is based on Recognized charges unless otherwise specified.

Inpatient Hospitalization Benefits

Room and Board Expense	<p>Covered Medical Expenses are payable as follows:</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge.</p> <p><u>Non-Preferred Care:</u> 60% of the Recognized charge for a semi-private room.</p> <p>Benefits are limited to Non-Preferred Inpatient Hospital maximum of \$900 per day.</p>
Intensive Care Room and Board Expense	<p>Covered Medical Expenses are payable as follows:</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge.</p> <p><u>Non-Preferred Care:</u> 60% of the Recognized charge for the Intensive Care Room Rate for an overnight stay.</p> <p>Benefits are limited to Non-Preferred Inpatient Hospital maximum of \$900 per day.</p>

Miscellaneous Hospital Expense	<p>Covered Medical Expenses include, among others, expenses incurred during a hospital confinement for: Anesthesia and operating room, Laboratory tests and X rays, Oxygen tent, and Drugs, medicines, dressings.</p> <p>Covered Medical Expenses are payable as follows: <u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Recognized charge.</p> <p>Benefits are limited to Non-Preferred Inpatient Hospital maximum of \$900 per day.</p>
Non-Surgical Physicians Expense	<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:</u> 80% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Recognized charge.</p>
Surgical Benefits -Inpatient	
Inpatient Surgical Expense	<p>Covered Medical Expenses for charges for surgical services, performed by a Physician, are payable as follows: <u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Recognized charge.</p>
Anesthesia Expense	<p>Covered Medical Expenses for the charges of anesthesia, during a surgical procedure, are payable as follows: <u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Recognized charge.</p>
Assistant Surgeon Expense	<p>Covered Medical Expenses for the charges of an assistant surgeon, during a surgical procedure, are payable as follows: <u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Recognized charge.</p>
Surgical Benefits -Outpatient	
Outpatient Surgical Expense	<p>Covered Medical Expenses for charges for surgical services, performed by a Physician, are payable as follows: <u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Recognized charge.</p>
Anesthesia Expense	<p>Covered Medical Expenses for the charges of anesthesia, during a surgical procedure, are payable as follows: <u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Recognized charge.</p>
Assistant Surgeon Expense	<p>Covered Medical Expenses for the charges of an assistant surgeon, during a surgical procedure, are payable as follows: <u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Recognized charge.</p>

<p>Ambulatory Surgical Expense</p>	<p>Benefits are payable for Covered Medical Expenses incurred by a covered person for expenses incurred for outpatient surgery performed in a hospital outpatient surgery department or in an ambulatory surgical center.</p> <p>Covered Medical Expenses must be incurred on the day of the surgery or within 48 hours after the surgery.</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Recognized charge</p> <p>Benefits are limited to Non-Preferred: \$900 max per surgical procedure.</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>	
<p>Hospital Outpatient Department Expense</p>	<p>Covered Medical Expenses includes treatment rendered in a Hospital Outpatient Department. Covered Medical Expenses do not include Emergency Room/Urgent Care Treatment, Walk-in Clinic, Therapy Expenses, Chemotherapy and Radiation, and outpatient surgical services, including physician, anesthesia and facility charges, which are covered as outlined under the individual benefit types listed in this schedule of benefits.</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge <u>Non-Preferred Care:</u> 60% of the Recognized charge.</p> <p>Benefits are limited to Non-Preferred: \$600 per condition per policy year.</p>
<p>Walk-In Clinic Visit Expense</p>	<p>Covered Medical Expenses include services rendered in a walk-in clinic.</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge <u>Non-Preferred Care:</u> 60% of the Recognized charge.</p> <p>Benefits are limited to Non Preferred: \$50 max per day to a max of 16 visits per policy year.</p>
<p>Emergency Room Expense</p>	<p>Covered Medical Expenses incurred for treatment of an Emergency Medical Condition are payable as follows:</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred Care:</u> 80% of the Recognized charge.</p> <p>Important Note: Please note that as Non-Preferred Care Providers do not have a contract with Aetna, the provider may not accept payment of your cost share (your deductible and coinsurance) as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. Please send Aetna the bill at the address listed on the back of your member ID card and Aetna will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.</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 should <u>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:</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Recognized 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>Benefits are limited to Non-Preferred: \$600 per condition per policy year.</p>

Ambulance Expense	<p>Covered Medical Expenses are payable for the services of a professional ambulance to or from a hospital, when required due to the emergency nature of a covered Accident or Sickness.</p> <p>Covered Medical Expenses are payable as follows:</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge <u>Non-Preferred Care:</u> 80% of the Recognized Charge</p>
Pre-Admission Testing Expense	<p>Covered Medical Expenses for Pre-Admission testing charges while an outpatient before scheduled surgery are payable on the same basis as any other sickness.</p>
Physician's Office Visit Expense	<p>Covered Medical Expenses are payable as follows:</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge <u>Non-Preferred Care:</u> 60% of the Recognized charge.</p> <p>Benefits are limited to Non Preferred: \$50 per day maximum and 1 visit per day to a max of 16 visits per policy year.</p> <p>This benefit includes visits to specialists.</p>
Laboratory and X-Ray Expense	<p>Covered Medical Expenses are payable as follows:</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Recognized charge.</p> <p>Benefits are limited to Non-Preferred \$600 max per condition per policy year.</p>
High Cost Procedures Expense	<p>Covered Medical Expenses include charges incurred by a covered person for High Cost Procedures that are required as a result of injury or sickness. Expenses for High Cost Procedures; which must be provided on an outpatient basis; may be incurred in the following:</p> <p>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.</p> <p>Covered Medical Expenses for High Cost Procedures include charges for the following procedures and services:</p> <ul style="list-style-type: none"> • C.A.T. Scan; • Magnetic Resonance Imaging; and • Contrast Materials for these tests. <p>Covered Medical Expenses include charges incurred by a covered person are payable as follows:</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Recognized charge.</p>
Therapy Expense	<p>Covered Medical Expenses include charges incurred by a covered person for the following types of therapy provided on an outpatient basis:</p> <ul style="list-style-type: none"> • Physical Therapy, • Chiropractic Care, • Speech Therapy, • Inhalation Therapy, • Cardiac Rehabilitation, or • Occupational Therapy.

<p>Therapy Expense (continued)</p>	<p>Expenses for Chiropractic Care are Covered Medical Expenses, if such care is related to neuromusculoskeletal conditions and conditions arising from: the lack of normal nerve, muscle, and/or joint function.</p> <p>Expenses for Speech and Occupational Therapies are Covered Medical Expenses, only if such therapies are a result of injury or sickness.</p> <p>Covered Medical Expenses are payable as follows:</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Recognized Charge.</p> <p>Benefits are limited to a Non Preferred maximum of \$50 per day to a maximum of 16 visits per policy year for Chiropractic Care.</p> <p>Covered Medical Expenses for oral and intravenous chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy, radiation therapy, tests and procedures, physiotherapy (for rehabilitation only after a surgery), and expenses incurred at a radiological facility. Covered Medical Expenses also include expenses for the administration of chemotherapy and visits by a health care professional to administer the chemotherapy. Such expenses are payable as follows:</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge <u>Non-Preferred Care:</u> 60% of the Recognized Charge</p> <p>Benefits are limited to a Non-Preferred maximum of \$300 per condition per policy year</p>
<p>Durable Medical and Surgical Equipment Expense</p>	<p>Covered Medical Expenses are payable as follows:</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Recognized Charge.</p> <p>Benefits are limited to Non Preferred: maximum of \$2,000 per policy year.</p> <p>Breast Feeding Durable Medical Equipment Coverage includes the rental or purchase of breast feeding durable medical equipment for the purpose of lactation support (pumping and storage of breast milk) as follows.</p> <p><u>Preferred Care:</u> 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Recognized Charge.</p> <p><i>Breast Pump</i> Covered expenses include the following:</p> <ul style="list-style-type: none"> • The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a hospital. • The purchase of: <ul style="list-style-type: none"> • An electric breast pump (non-hospital grade), if requested within 30 days from the date of the birth of the child. A purchase will be covered once every five years following the date of the birth; or • A manual breast pump, if requested within 6-12 months from the date of the birth of the child. A purchase will be covered once every five years following the date of the birth. • If an electric breast pump was purchased within the previous one period, the purchase of an electric or manual breast pump will <u>not</u> be covered until a five year period has elapsed from the last purchase of an electric pump.

<p>Durable Medical and Surgical Equipment Expense (continued)</p>	<p><i>Breast Pump Supplies</i> Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.</p> <p>Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. The covered person is responsible for the entire cost of any additional pieces of the same or similar equipment that he or she purchases or rents for personal convenience or mobility.</p> <p>Aetna reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of Aetna.</p> <p>Limitations: Unless specified above, not covered under this benefit are charges incurred for: Services which are covered to any extent under any other part of this Plan.</p>
<p>Prosthetic Devices Expense</p>	<p>Benefits include charges for: artificial limbs, or eyes, and other non-dental prosthetic devices, as a result of an accident or sickness.</p> <p>Covered Medical Expenses will include wigs as required as a result of chemo or radiation therapy.</p> <p>Covered Medical Expenses do not include: eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet.</p> <p>Covered Medical Expenses are payable as follows:</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred care:</u> 60% of the Recognized Charge.</p> <p>Benefits are limited to a Non Preferred maximum of \$2,000 per policy year.</p>
<p>Physical Therapy Expense</p>	<p>Covered Medical Expenses for physical therapy are payable as follows when provided by a licensed physical therapist:</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred care:</u> 60% of the Recognized Charge.</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. • Non-surgical treatment of infections or diseases. This does not include those of, or related to, the teeth. <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.

<p>Dental Injury Expense (continued)</p>	<p>Surgery needed to:</p> <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. <p>Covered Medical Expenses are payable as follows:</p> <p>80% of the actual charge</p>
<p>Dental Expense for Impacted Wisdom Teeth</p>	<p>Covered Medical Expenses for removal of one or more impacted wisdom teeth are payable as follows 80% of the actual charge.</p>
<p>Diagnostic Testing for Learning Disabilities Expense</p>	<p>Covered Medical Expenses for diagnostic testing for:</p> <ul style="list-style-type: none"> • Attention deficit disorder, or • Attention deficit hyperactive disorder <p>Benefits are payable as follows:</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge <u>Non-Preferred Care:</u> 60% of the Recognized Charge.</p>
<p>Routine Physical Exam Expense</p>	<p>Benefits include expenses for a routine physical exam performed by a physician. If charges for a routine physical exam given to a child who is a covered dependent are covered under any other benefit section, those charges will not be covered under this section.</p> <p>A routine physical exam is a medical exam given by a physician, for a reason other than to diagnose or treat a suspected or identified injury or sickness.</p> <p>Included as a part of the exam are:</p> <p>Routine vision and hearing screenings given as part of the routine physical exam. 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> <p><u>Preferred Care:</u> 100% of the Negotiated Charge <u>Non-Preferred Care:</u> 60% of the Recognized charge.</p> <p>In addition to any state regulations or guidelines regarding mandated Routine Physical Exam services,</p> <p>Covered Medical Expenses include services rendered in conjunction with,</p> <ul style="list-style-type: none"> • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force. • For females, screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. • These services may include but are not limited to: <ul style="list-style-type: none"> • Screening and counseling services, such as: <ul style="list-style-type: none"> ○ Interpersonal and domestic violence; ○ Sexually transmitted diseases; and ○ Human Immune Deficiency Virus (HIV) infections. • Screening for gestational diabetes. • High risk Human Papillomavirus (HPV) DNA testing for women 10age 18 and older and limited to once every three years. <p>Sexually transmitted disease counseling expense is limited to two visits per Policy Year</p> <ul style="list-style-type: none"> • X-rays, lab and other tests given in connection with the exam. • Immunizations for infectious diseases and the materials for administration of immunizations that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. • If the plan includes dependent Coverage, for covered newborns, an initial hospital checkup.

<p>Routine Physical Exam Expense (continued)</p>	<p>For a child who is a covered dependent:</p> <ul style="list-style-type: none"> • The physical exam must include at least: • A review and written record of the patient's complete medical history, • A check of all body systems, and • A review and discussion of the exam results with the patient or with the parent or guardian. <p>For all exams given to covered dependent under age 2, Covered Medical Expenses will not include charges for the following:</p> <ul style="list-style-type: none"> • More than 6 exams performed during the first year of the child's life, • More than 2 exams performed during the second year of the child's life. <p>For all exams given to a covered student or a spouse who is a covered dependent, Covered Medical Expenses will not include charges for more than:</p> <p>For all exams given to a covered dependent from age 2 and over, Covered Medical Expenses will not include charges for more than one exam in 12 months in a row.</p> <ul style="list-style-type: none"> • One exam in 12 months in a row. <p>Covered Medical Expenses incurred by a woman, are charges made by a physician for, one annual routine gynecological exam.</p> <p>Screening and Counseling Services:</p> <p>Covered Medical Expenses include charges made by a physician in an individual or group setting for the following:</p> <p>Obesity</p> <p>Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:</p> <ul style="list-style-type: none"> • Preventive counseling visits and/or risk factor reduction intervention; • Medical nutrition therapy; • Nutritional counseling; and • Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease. <p>Misuse of Alcohol and/or Drugs</p> <p>Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.</p> <p>Use of Tobacco Products</p> <p>Screening and counseling services to aid a covered person to stop the use of tobacco products. Coverage includes:</p> <ul style="list-style-type: none"> • Preventive counseling visits; • Treatment visits; and • Class visits; <p>To aid a covered person to stop the use of tobacco products.</p> <p>Tobacco product means a substance containing tobacco or nicotine including:</p> <ul style="list-style-type: none"> • Cigarettes; • Cigars; • Smoking tobacco; • Snuff; • Smokeless tobacco; and • Candy-like products that contain tobacco.
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<p>Routine Physical Exam Expense (continued)</p>	<p>Limitations: Unless specified above, not covered under this Screening and Counseling Services benefit are charges incurred for:</p> <ul style="list-style-type: none"> • Services which are covered to any extent under any other part of this Plan
<p>Well Baby Care Expense</p>	<p>Benefits include charges for routine preventive and primary care services, rendered to a covered dependent child on an outpatient basis.</p> <p>Routine preventive and primary care services are services rendered to a covered dependent child, from the date of birth through the attainment of two (2) years of age. Services include: initial hospital check-ups, other hospital visits, physical examinations, including routine hearing and vision examinations, medical history, developmental assessments, and materials for the administration of appropriate and necessary immunizations and laboratory tests, when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics.</p> <p>Newborn examination Coverage will include for the detection of the following disorders: Phenylketonuria, Hypothyroidism, Hemoglobinopathies, including sickle cell anemia, Galactosemia, Maple Syrup urine disease, Homocystinuria, Inborn errors of metabolism that result in mental retardation and that are designated by the state department, congenital adrenal hyperplasia, biotinidase deficiency, Disorders detected by tandem mass spectrometry or other technologies with the same or greater detection capabilities as tandem mass spectrometry, if the state department determines that the technology is available for use by a designated laboratory.</p> <p>Newborn testing will also include testing for human immunodeficiency virus (HIV) or antibody or antigen to HIV. Payment to a hospital for this testing must be in an amount equal to the hospital's actual cost of performing the test.</p> <p>Newborn Coverage will also include a physiologic hearing screening examination at the earliest feasible time for the detection of hearing impairments.</p> <p>Covered Medical Expenses are payable as follows: <u>Preferred Care: 100% of the Negotiated Charge.</u> Benefits are payable for scheduled visits in accordance with the prevailing clinical standards of the American Academy of Pediatrics. <u>Non-Preferred Care: 60% of the Recognized Charge.</u> Benefits are payable for scheduled visits in accordance with the prevailing clinical standards of the American Academy of Pediatrics.</p> <p>Covered Medical Expenses for immunizations are covered as follows: <u>Preferred Care: 100% of the Negotiated Charge.</u> <u>Non-Preferred Care: 60% of the Recognized Charge.</u></p>
<p>Immunizations Expense</p>	<p>Covered Medical Expenses include:</p> <ul style="list-style-type: none"> • Charges incurred by a covered student and dependent spouse for the materials for the administration of appropriate and medically necessary immunizations, and testing for tuberculosis, and • Charges incurred by a covered dependent up to age 19, for the materials for the administration of appropriate and medically necessary immunizations, when given in accordance with the prevailing clinical standards of the American academy of pediatrics. <p>Covered Medical Expenses are covered as follows: <u>Preferred Care: 100% of the Negotiated Charge.</u> <u>Non-Preferred Care: 60% of the Recognized Charge.</u></p>

<p>Consultant Expense</p>	<p>Covered Medical Expenses include the expenses for the services of a consultant. The services must be requested by the attending physician for the purpose of confirming or determining a diagnosis.</p> <p>Covered Medical Expenses are covered as follows:</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Recognized Charge.</p> <p>Benefits are limited to Non Preferred: \$50 max per day to a max of 16 visits per policy year</p>
<p>Treatment of Mental and Nervous Disorders</p>	
<p>Inpatient Expense</p>	<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:</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Recognized Charge.</p>
<p>Outpatient Expense</p>	<p>Covered Medical Expenses for outpatient treatment of a mental health condition are payable as follows:</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Recognized Charge.</p> <p>Benefits are limited to max of 1 visit per day, up to \$50 per day, up to a 16 day maximum.</p> <p>Charges for marriage and family therapies are not Covered Medical Expenses.</p>
<p>Alcoholism and Drug Addiction Treatment Expense</p>	
<p>Inpatient Expense</p>	<p>Covered Medical Expenses for the treatment of a substance abuse condition while confined as an inpatient in a hospital or facility licensed for such treatment are payable as follows:</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Recognized Charge.</p>
<p>Maternity Benefits</p>	
<p>Maternity Expense</p>	<p>Covered Medical Expenses include inpatient care of the covered person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery.</p> <p>If a person is discharged earlier, benefits will be payable for one (1) at-home post-delivery care visit by a health care provider. The at-home post-delivery care visit shall be conducted not later than forty-eight (48) hours following the discharge of the woman and her newborn child from a licensed hospital. However, at the mother's discretion, the visit may occur at the facility of the provider subject to the terms of the policy or group contract.</p> <p>As used in this benefit, "at-home post-delivery care" refers to health care provided to a woman at her residence by a physician, registered nurse, or advance practice nurse, whose scope of practice includes providing postpartum care in the area of maternal and child health care. The health care services provided must include, at a minimum:</p> <ul style="list-style-type: none"> • Parent education, • Assistance and training in breast or bottle feeding, and • Performance of any maternal and neonatal test routinely performed during the usual course of inpatient care for the woman or her newborn child, including the collections of an adequate sample for the hereditary and metabolic newborn screening. <p>Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other sickness.</p>

<p>Maternity Expense (continued)</p>	<p>Prenatal Care</p> <p>Prenatal care will be covered for services received by a pregnant female in a physician's, obstetricians, or gynecologist's office but only to the extent described below.</p> <p>Coverage for prenatal care under this benefit is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).</p> <p>Comprehensive Lactation Support and Counseling Services</p> <p>Covered Medical Expenses will include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy and in the post-partum period by a certified lactation support provider. The "post-partum period" means the 60 day period directly following the child's date of birth. Covered expenses incurred during the post-partum period also include the rental or purchase of breast feeding equipment as described below.</p> <p>Lactation support and lactation counseling services are covered expenses when provided in either a group or individual setting.</p> <p>Covered Medical Expenses for Prenatal Care and Comprehensive Lactation Support and Counseling Services are payable as follows:</p> <p><u>Preferred Care:</u> 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Recognized Charge.</p>
<p>Well Newborn Nursery Care Expense</p>	<ul style="list-style-type: none"> • Benefits include charges for routine care of a covered person 's newborn child as follows: • Hospital charges for routine nursery care during the mother's confinement, but for not more than four days, • 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 follows:</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge <u>Non-Preferred Care:</u> 60% of the Recognized Charge</p>
<p>Additional Benefits</p>	
<p>Prescribed Medicines Expense</p>	<p>Prescription Drug Benefits* are payable as follows:</p> <p><u>Preferred Care Pharmacy:</u> 80% of the Negotiated Charge for each Generic Prescription Drug or 60% of the Negotiated Charge for each Brand Name Prescription Drug. <u>Non-Preferred Care Pharmacy:</u> 80% of the Recognized Charge for each Generic Prescription Drug, or 60% of the Recognized Charge for each Brand Name Prescription Drug.</p> <p>At University Health Services Prescription Drug Benefits* are payable as follows: <u>Preferred Care Pharmacy:</u> 100% of the Negotiated Charge, following \$5 Copay for each Generic Prescription Drugs, and \$25 Copay for each Brand Name Prescription Drug.</p> <p>This Pharmacy benefit is provided to cover Medically Necessary Prescriptions associated with a covered Sickness or Accident occurring during the Policy Year. Covered Medical Expenses also include prescription smoking cessations aids. Please use your Aetna Student Health ID card when obtaining your prescriptions.</p> <p>Prior Authorization may be required for certain Prescription Drugs and some medications may not be covered under this Plan. For assistance and a complete list of excluded medications, or drugs requiring prior authorization, please contact Aetna Pharmacy Management at 888 RX-AETNA (available 24 hours).</p>

<p>Prescribed Medicines Expense (continued)</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>*Contraceptive Drugs and Device benefits are illustrated under the Family Planning Benefit of this Policy.</p>
<p>Diabetic Treatment, Supplies and Outpatient Self-Management Expense</p> <p>Per approved filing, will “always be included.”</p>	<p>Covered Medical Expense includes expenses incurred for the diagnosis and treatment of diabetes, including those for drugs and diabetic supplies, equipment and an outpatient diabetic self-management education program prescribed as part of a treatment plan. Benefits are payable on the same basis as any other sickness.</p> <p>Charges for a diabetic self-management education program are covered but only if: The training is medically necessary, ordered in writing by physician or podiatrist, and provided by a health care professional who is licensed, registered, or certified, and has specialized training in the management of diabetes, The covered person is a diabetic who is covered under this plan and is not confined in a hospital or skilled nursing facility as a full-time inpatient, or The person is covered under this plan and cares for or helps care for a diabetic who is covered under this plan and is not confined in a hospital or skilled nursing facility as a full-time inpatient.</p> <p>Covered Medical Expenses include: One visit after receiving a diagnosis that represents a significant change in the insured’s symptoms or condition. One visit for re-education or refresher training.</p> <p>Not covered are: Program expenses incurred for a diabetic education program whose only purpose is weight control. Program expenses incurred for a diabetic education program that is available to the public at no cost.</p> <p>Covered Medical Expenses are payable on the same basis as any other sickness.</p>
<p>Hypodermic Needles Expense</p>	<p>Covered Medical Expenses for hypodermic needles and syringes used in the treatment of diabetes are payable on the same basis as any other sickness.</p>
<p>Non-Prescription Enteral Formula Expense</p>	<p>Benefits include charges incurred by a covered person for non-prescription enteral formulas, for which a physician has issued a written order, and are for the treatment of malabsorption caused by:</p> <ul style="list-style-type: none"> • Crohn’s disease, • Ulcerative colitis, • Gastroesophageal reflux, • Gastrointestinal motility, • Chronic intestinal pseudoobstruction, • Inherited diseases that may result in mental or physical retardation or death; • Phenylketonuria (an inherited condition that may cause severe mental retardation if not treated); and • Inherited diseases of amino acids and organic acids. <p>Covered Medical Expenses for inherited diseases of amino acids and organic acids, will also include food products modified to be low protein.</p> <p>Covered Medical Expenses are payable as follows: <u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Recognized charge.</p>

<p>Pap Smear Screening Expense</p>	<p>Covered Medical Expenses include one annual routine pap smear screening for women age 18 and older.</p> <p>Covered Medical Expenses are payable as follows:</p> <p><u>Preferred Care:</u> 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Recognized Charge.</p>
<p>Mammogram Expense</p>	<p>Covered Medical Expenses include one baseline mammogram for women between age 35 and 40. Coverage is also provided for one routine annual mammogram for women age 40 and older, as well as when medically indicated for women with risk factors who are under age 40. Risk factors for women under 40 are:</p> <ul style="list-style-type: none"> • A woman who has a personal history of breast cancer. • A woman who has a personal history of breast disease that was proven benign by biopsy. • A woman whose mother, sister, or daughter has had breast cancer. • A woman who is at least thirty (30) years of age and has not given birth. <p>Mammogram screenings Coverage must also include comprehensive ultrasound screening for the entire breast or breasts if a mammogram demonstrates heterogenous or dense breast tissue and when determined to be medically necessary by a licensed physician.</p> <p>Covered Medical Expenses are payable as follows:</p> <p><u>Preferred Care:</u> 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Recognized Charge.</p>
<p>Mastectomy and Prosthetic Devices Expense</p>	<p>Coverage will be provided to a covered person who is receiving benefits for a necessary mastectomy and who elects breast reconstruction after the mastectomy for:</p> <ul style="list-style-type: none"> • Reconstruction of the breast on which a mastectomy has been performed, • Surgery and reconstruction of the other breast to produce a symmetrical appearance, • Prostheses, • Treatment of physical complications of all stages of mastectomy, including lymphedemas, and • Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction. This is subject to the approval of the attending physician. <p>Covered Medical Expenses are payable on the same basis as any other Sickness.</p> <p>This Coverage will be provided in consultation with the attending physician and the patient. It will be subject to the same annual deductibles and coinsurance provisions that apply to the mastectomy.</p>
<p>Chlamydia Screening Test Expense</p>	<p>Benefits include charges incurred for an annual Chlamydia screening test.</p> <p>Benefits will be paid for Chlamydia screening expenses incurred for:</p> <ul style="list-style-type: none"> • Women who are: <ul style="list-style-type: none"> • Under the age of 20 if they are sexually active, and • At least 20 years old if they have multiple risk factors. • Men who have multiple risk factors. <p>Covered Medical Expenses are payable as follows:</p> <p><u>Preferred Care:</u> 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Recognized Charge.</p>

<p>Routine Colorectal Cancer Screening Expense</p>	<p>Even though not incurred in connection with a sickness or injury, benefits include charges for colorectal cancer examination and laboratory tests, for any nonsymptomatic person age 50 or more, or a high risk or 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>Covered Medical Expenses are payable as follows:</p> <p><u>Preferred Care:</u> 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Recognized Charge.</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 50 or over, one digital rectal exam and one prostate specific antigen test each Policy Year. <p>Covered Medical Expenses are payable as follows:</p> <p><u>Preferred Care:</u> 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Recognized Charge.</p>
<p>Second Surgical Opinion Expense</p>	<p>Covered Medical Expenses will include 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>Covered Medical Expenses are payable on the same basis as any other sickness.</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>Covered Medical Expenses are payable on the same basis as any other sickness.</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.</p> <p>Covered Medical Expenses are payable on the same basis as any other Sickness.</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.</p> <p>Covered Medical Expenses are payable on the same basis as any other Sickness.</p> <p>Expenses for routine foot care, such as trimming of corns, calluses, and nails, are not Covered Medical Expenses.</p>

<p>Alternative Health Care Expense</p>	<p>Benefits include charges for alternative health care, when prescribed by a health care provider who is a legally qualified physician, practicing within the scope of their license. For purposes of this benefit, “alternative health care” means aromatherapy.</p> <p>Covered Medical Expenses are payable as follows:</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the recognized charge.</p>
<p>Home Health Care Expense Home</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"> • The services are furnished by, or under arrangements made by, a licensed home health agency • 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 • 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 • The care starts within 7 days after discharge from a hospital as an inpatient, and • 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"> • 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, • 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., • Physical, occupational. speech therapy, or respiratory therapy, • 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, • Medical social services by licensed or trained social workers, • 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 follows:</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Recognized charge.</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>Covered Medical Expenses are payable on the same basis as any other Sickness.</p>
<p>Hospice Expense</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 follows:</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred care:</u> 60% of the Recognized charge.</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 Expenses for a Licensed Nurse are covered as follows:</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge.</p> <p><u>Non-Preferred Care:</u> 60% of the Recognized 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> <p>In lieu of confinement in a hospital as a full time inpatient, or</p> <p>Within 24 hours following a hospital confinement and for the same or related cause(s) as such hospital confinement.</p> <p>Covered Medical Expenses are payable as follows:</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge for the semi-private room rate.</p> <p><u>Non-Preferred Care:</u> 60% of the Recognized charge for the semi-private room rate.</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:</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge for the rehabilitation facility's daily room and board maximum for semi-private accommodations</p> <p><u>Non-Preferred Care:</u> 60% of the Recognized charge for the rehabilitation facility's daily room and board maximum for semi-private accommodations.</p>
<p>Routine Care Costs for Cancer Clinical Trials Expense</p>	<p>Covered Medical Expenses include Coverage for routine care costs incurred in the course of a clinical trial if the same costs would be covered in a non-trial procedure/setting/benefit.</p> <p>Covered Medical Expenses are payable on the same basis as any other sickness.</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 and are not insurance. Please note that these programs are subject to change. To learn more about these additional services and search for providers visit, www.Aetnastudenthealth.com.

Aetna Book^s discount program: Access to discounts on books and other items from the American Cancer Society Bookstore, the MayoClinic.com Bookstore and Pranayama.

Aetna FitnessSM discount program: Access to preferred rates on gym memberships and discounts on at-home weight loss programs, home fitness options and one-on-one health coaching services through GlobalFitTM.

Aetna HearingSM discount program: Offers members and their families savings on hearing exams, hearing aids and other hearing services. Members can choose between two great offers at no additional premium cost, Hearing Care Solutions and HearPO®.

Aetna Natural Products and ServicesSM discount program: Access to savings on complementary health care products and services, including online consultations, not traditionally covered by their health benefits plan. All products and services are provided through the ChooseHealthy® program* and Vital Health Network (VHN).

*The Choose Healthy program is made available through American Specialty Health Networks, Inc. (ASH Networks) and Healthy roads, Inc. subsidiaries of American Specialty Health Incorporated (ASH). Choose Healthy is a federally registered trademark of ASH and used with permission herein.

Aetna VisionSM discount program: Access to discounts on vision exams, lenses and frames when a member utilizes a provider participating in the EyeMed Select Network.

Aetna Weight ManagementSM discount program: Access to discounts on the CalorieKing® Program and products, eDiets® diet plans and products, Jenny® weight loss programs and Nutrisystem® weight loss meal plans. **Oral Health Care discount program:** Access to discounts on oral health care products. Save on xylitol mints, mouth rinses, gum, candies and toothpaste from Epic. Additionally, receive exclusive savings on Waterpik® dental water jets and sonic toothbrushes.

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.

Beginning Right® Maternity Program: Make healthy choices for you and your baby. Learn what decisions are good ones for you and your baby. Our Beginning Right maternity program helps prepare you for the exciting changes pregnancy brings.

Vital Savings by Aetna® on Dental* is a dental discount program helping you and your dependents save. In most instances, savings range from 15-50 percent on services from general dentistry and cleanings to root canals, crowns, and orthodontia (braces). No claims to file. Enroll online at www.Aetnastudenthealth.com.

2013/2014 Vital Savings on Dental	Annual Rates 9/1/13-8/31/14 Deadline: 5/31/14
Student Only	\$25
Student + One Dependent	\$44
Student + Two or more Dependents	\$63

Actual costs and savings vary by provider and geographic area.

The Vital Savings by Aetna® program (the “Program”) is not insurance. The Program does not meet the Minimum Creditable Coverage requirements in Massachusetts. It provides Members with access to discounted fees according to schedules negotiated by Aetna Life Insurance Company for the Vital Savings by Aetna discount program. The range of discounts provided under the Program will vary depending on the type of provider and type of service received. The Program does not make payments directly to the participating providers. Each Member must 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 may receive a percentage of the fee you pay to the discount vendor. Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, CT 06156, 1-888-BeVital, is the Discount Medical Plan Organization.

Aetna Student Health Voluntary Group Term Life Insurance Coverage*:

- The University Of Notre Dame will offer a Group Term Life Insurance product as an option for students to purchase on a voluntary basis. The coverage amount is **\$10,000**.
- The availability of Life Insurance will be included on the Aetna Student Health/University of Notre Dame web page. This plan can be purchased only during the Fall 2012 open enrollment period of the Student Sickness and Accident plan. Students do not need to be enrolled in the Student Sickness and Accident plan in order to enroll for the Group Term Life Insurance coverage.
- Voluntary Group Term Life Insurance Coverage: Student: **\$15** (direct)

*The applicable Life Insurance plan documents are in the process of being filed and/or reviewed by the appropriate state agencies. Rates, plan benefits and other plan documents are subject to, and contingent upon, state approval prior to issuance and the required number of plan sponsors to join the Aetna Voluntary Student Discretionary Group Trust.

Aetna's Informed Health® Line*:

Call our toll-free number to talk to registered nurses. They can share information on a range of healthy topics*. The nurses can help you:

- Learn about medical procedures and treatment options.
- Improve how you talk with your doctor and other health care providers.
- Find out how to describe your symptoms better.
- Ask the right questions.
- Tell your doctor about your eating, exercise and lifestyle habits.

Call anytime. (United States only). Nurses are available 24-hours a day.

To reach a nurse, call **1-800-556-1555**.

TDD for hearing and speech-impaired people only: **1-800-270-2386**.

Or reach them through e-mail.

You can send an e-mail to **IHL2@Aetna.com** for links to health information about your questions. Nurses reply within 24 hours. **Note:** Due to security reasons, the Informed Healthline will not open any attachments sent by e-mail.

Or listen to the Audio Health Library**. It explains thousands of health conditions in English and Spanish. Transfer easily to a registered nurse at any time during the call.

* While only your doctor can diagnose, prescribe or give medical advice, the Informed Health Line nurses can provide information on more than **5,000** health topics. Contact your doctor first with any questions or concerns regarding your health care needs. Information is believed to be accurate as of the production date; however, it is subject to change.

** Not all topics may be covered expenses under your plan.

Use the Health wise® Knowledgebase to find out more about a health condition you have or medications you take. It explains things in terms that are easy to understand.

Get to it through your secure Aetna Navigator® member website, at **www.Aetnastudenthealth.com**.

Health programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health/dental care professional. The availability and terms of specific discount programs and wellness services are subject to change without notice. Not all programs are available in all states.

Discount programs and other programs above provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Discount programs may be offered by vendors who are independent contractors and not employees or agents of Aetna. Aetna may receive a percentage of the fee you pay to the discount vendor. These services, programs or benefits may be offered by vendors who are independent contractors and not employees or agents of Chickering Claims Administrators, Inc., Aetna Life Insurance Company or their affiliates.

GENERAL PROVISIONS

STATE MANDATED BENEFITS

The Plan will pay benefits in accordance with any applicable Indiana 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.

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 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 90 day period, following such termination of insurance.

TERMINATION OF INSURANCE

Benefits are payable under this Plan 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 Plan 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 last day of the Policy Period following the child's 26th 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 Plan.

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 120 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 at reasonable intervals during the two (2) years following the child's attainment of the limiting age and each year thereafter, 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:

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

EXCLUSIONS

This Plan does not cover nor provide benefits for:

1. Expense incurred for services normally provided without charge by the Policyholder's Health Service, Infirmary or Hospital, or by health care providers employed by the Policyholder.
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 elective treatment or elective surgery except as specifically provided elsewhere in this Policy and performed while this Policy is in effect.
8. Expense incurred for cosmetic surgery, reconstructive surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons, except to the extent needed to: Improve the function of a part of the body that is (a) not a tooth or structure that supports the teeth, and (b) 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. 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. This exclusion does not apply to reconstructive surgery or prosthetic devices for a **covered person** who has undergone a mastectomy.
9. Expense incurred as a result of preventive medicines, serums, vaccines or oral contraceptive.
10. Expense incurred as a result of commission of a felony.
11. Expense incurred for voluntary or elective abortions unless otherwise provided in this Policy.
12. Expense incurred after the date insurance terminates for a **covered person** except as may be specifically provided in the Extension of Benefits Provision.
13. Expense incurred for services normally provided without charge by the school and covered by the school fee for services.
14. Expense incurred for any services rendered by a member of the **covered person's** immediate family or a person who lives in the **covered person's** home.
15. Expense incurred for treatment of temporomandibular joint dysfunction and associated myofascial pain.
16. Expense incurred for the treatment of alcoholism or drug addiction unless otherwise provided in this Policy
17. Expense for allergy serums and injections.
18. Treatment for injury to the extent benefits are payable under any state no-fault automobile Coverage, first party medical benefits payable under any other mandatory No-fault law.
19. Expense for the contraceptive methods, devices or aids, and charges for or related to artificial insemination, in-vitro fertilization, or embryo transfer procedures, elective sterilization or its reversal or elective abortion unless specifically provided for in this Policy.
20. Expenses for treatment of injury or sickness to the extent that payment is made, as a judgment or settlement, by any person deemed responsible for the injury or sickness (or their insurers).
21. Expense incurred for which no member of the **covered person's** immediate family has any legal obligation for payment.
22. 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 : (a) by whom they are prescribed, or (b) by whom they are recommended, or (c) by whom or by which they are performed.
23. 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.
24. Expenses incurred for the repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices.
25. Expenses incurred for or in connection with: procedures, services, or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if: a) There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature, to substantiate its safety and effectiveness, for the disease or injury involved, or b) If required by the FDA, approval has not been granted for marketing, or c) A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes, or d) The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility, or by another facility studying the same drug, device, procedure, or treatment, states that it is experimental, investigational, or for research purposes. However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease, if Aetna determines that: a) The disease can be expected to

cause death within one year, in the absence of effective treatment, and b) The care or treatment is effective for that disease, or shows promise of being effective for that disease, as demonstrated by scientific data. In making this determination, Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved. Also, this exclusion will not apply with respect to drugs that: a) Have been granted treatment investigational new drug (IND), or b) Group c/treatment IND status, or c) Are being studied at the Phase III level in a national clinical trial, sponsored by the National Cancer Institute, d) If Aetna determines that available, scientific evidence demonstrates that the drug is effective, or shows promise of being effective, for the disease.

26. Expenses incurred for gastric bypass, and any restrictive procedures, for weight loss.
27. Expenses incurred for breast reduction/mammoplasty.
28. Expenses incurred for gynecomastia (male breasts).
29. Expense incurred as a result of dental treatment, except for treatment resulting from injury to sound natural teeth, dental abscesses, or for removal of wisdom teeth, as provided elsewhere in this Policy.
30. Expense incurred for; or related to; services; treatment; testing; educational testing; or training for Attention Deficit Disorder; Attention Deficit Hyperactive Disorder; or Learning Disabilities; or other developmental delays, except Pervasive Developmental Disorder, unless otherwise provided in the policy.
31. Expense incurred for acupuncture, unless services are rendered for anesthetic purposes.
32. Expense incurred for alternative, holistic medicine, and/or therapy, including but not limited to, yoga and hypnotherapy.
33. Expense incurred when the person or individual is acting beyond the scope of his/her/its legal authority.
34. 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.
35. Expense for telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
36. 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.
37. Expense for services or supplies provided for the treatment of obesity and/or weight control, unless otherwise provided in the policy.
38. Expense for incidental surgeries, and standby charges of a physician.
39. Expense for treatment and supplies for programs involving cessation of tobacco use, unless otherwise provided in the policy.
40. Expense incurred for injury resulting from the play or practice of intercollegiate sports (participating in sports clubs, or intramural athletic activities, is not excluded).
41. Expenses incurred for massage therapy.
42. Expense incurred for, or related to, sex change surgery.
43. 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.
44. 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.
45. Expenses arising from a Pre-Existing Condition, unless (a) no charges are incurred or treatment rendered for the condition for a period of six months while covered under this Policy, or (b) the **covered person** has been covered under this Policy for 12 consecutive months, whichever happens first?
46. 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.
47. Expense incurred for a treatment, service, or supply, which is not medically necessary, as determined by Aetna, for the diagnosis care or treatment of the sickness or injury involved. This applies even if they are prescribed, recommended, or approved, by the person's attending physician, or dentist. In order for a treatment, service, or supply, to be considered medically necessary, the service or supply must: a) be care, or treatment, which is likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the sickness or injury involved, and the person's overall health condition, b) be a diagnostic procedure which is indicated by the health status of the person, and be as likely to result in information that could

affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the sickness or injury involved, and the person's overall health condition, and c) as to diagnosis, care, and treatment, be no more costly (taking into account all health expenses incurred in connection with the treatment, service, or supply), than any alternative service or supply to meet the above tests. In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration: information relating to the affected person's health status, reports in peer reviewed medical literature, reports and guidelines published by nationally recognized health care organizations that include supporting scientific data, generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment, the opinion of health professionals in the generally recognized health specialty involved, and any other relevant information brought to Aetna's attention. In no event will the following services or supplies be considered to be medically necessary: a) those that do not require the technical skills of a medical, a mental health, or a dental professional, or b) those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, or any persons who is part of his or her family, any healthcare provider, or healthcare facility, or c) those furnished solely because the person is an inpatient on any day on which the person's sickness or injury could safely, and adequately, be diagnosed, or treated, while not confined, or those furnished solely because of the setting, if the service or supply could safely and adequately be furnished in a physician's or a dentist's office, or other less costly setting.

48. 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 in one Policy Year.

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.
- Have 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.

Birth 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 is a **prescription drug** with a proprietary name assigned to it by the manufacturer or distributor and so indicated by Medispan or any other similar publication designated by Aetna, an affiliate or third party vendor.

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)

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 recognized 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.

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, and (c) the covered student's unmarried child under the age of 26. The term "child" includes a covered student's step-child, adopted child, and a child for whom a petition for adoption is pending. The term dependent does not include a person who is: (a) an eligible student, or (b) a member of the armed forces.

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, and has an agreement with the School Health Services to furnish services and supplies at a negotiated charge.

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:

- 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), and
- Treatment of infertility.

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 Medical Condition: The sudden and, at that time, unexpected onset of a change in a person's physical or mental condition requiring immediate medical, surgical, or psychiatric care, which if not performed right away 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. It does include an accident or serious illness such as heart attack, stroke, poisoning, loss of consciousness or respiration, and convulsions. It does not include elective care, routine care, care for a non-emergency illness, or care required as a result of circumstances which would have been foreseen prior to the covered student's departure from the college area.

Generic Prescription Drug is a **prescription drug**, whether identified by its chemical, proprietary, or non-proprietary name that is accepted by the U.S. Food and Drug Administration (FDA) as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by Medispan or any other publication designated by Aetna, an affiliate or third party vendor.

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.

Hospital: A facility which meets all of these tests:

- It provides in-patient services for the case 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.

Injectable Drug(s) are **prescription drugs** when an oral alternative drug is not available, unless specifically excluded as described in the Exclusion section of this Policy.

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 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.

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 Drug is a **brand-name prescription drug** or **generic prescription drug** that does not appear on the **preferred drug list**.

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:

- Copays,
- Expenses that are not **Covered Medical Expenses**,
- Penalties,
- Expenses for prescription drugs, and
- Other expenses not covered by this Policy.

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.

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.

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-Existing Condition: Any injury, sickness, or condition that was diagnosed or treated, or would have caused a prudent person to seek diagnosis or treatment, within six 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 on the referral of the primary care physician, or
- Health care provider that is not a Preferred Care Provider for an emergency medical condition when travel to a Preferred Care Provider, or referral by a **covered person** 's primary care physician prior to treatment, is 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 person** s 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 on referral 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 Drug is a drug, biological, or compounded **prescription** which, by State or Federal Law, may be dispensed only by **prescription** and which is required by Federal Law to be labeled "Caution: Federal Law prohibits dispensing without **prescription**." This includes an injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.

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.

Provider is any recognized health care professional, **pharmacy** or facility providing services with the scope of their license.

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.

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 and their dependents.

Self-injectable Drug(s) are **prescription drugs** that are intended to be [self] administered by injection to a specific part of the body to treat certain chronic medical conditions.

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 runs,
- 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.
- Have 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.

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:

This includes but is not limited to:

- 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 8:30 a.m. to 5:30 p.m., Monday through Friday, for any questions.

Please send claims to:
Aetna Student Health
PO Box 981106
El Paso, TX 79998

- 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.

APPEALS PROCEDURE

Adverse Benefit Determination (Decision): A denial; reduction; termination of; or failure to; provide or make payment (in whole or in part) for a service, supply or benefit.

Such **adverse benefit determination** may be based on:

- Your eligibility for Coverage.
- Coverage determinations, including plan limitations or exclusions.
- The results of any Utilization Review activities.
- A decision that the service or supply is **experimental or investigational**.
- A decision that the service or supply is not **medically necessary**.

As to medical and **prescription drug** claims, an **adverse benefit determination** also means the termination of a **covered person’s** Coverage back to the original effective date (rescission) as it applies under any rescission provision appearing in the Policy.

Appeal: An oral or written request to Aetna to reconsider an **adverse benefit determination**.

Complaint: Any oral or written expression of dissatisfaction about quality of care or the operation of the Plan.

Concurrent Care Claim Extension: A request to extend a course of treatment that was previously approved.

Concurrent Care Claim Reduction or Termination: A decision to reduce or terminate a course of treatment that was previously approved.

External Review: A review of an **adverse benefit determination** or a **final adverse benefit determination** by an Independent Review Organization/External Review Organization (ERO) assigned by the State Insurance Commissioner Aetna or the U.S. Office of Personnel Management, as determined by Aetna and made up of **physicians** or other appropriate health care **providers**. The ERO must have expertise in the problem or question involved.

Final Adverse Benefit Determination: An **adverse benefit determination** that has been upheld by Aetna at the exhaustion of the appeals process.

Pre-service Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

Post-Service Claim: Any claim that is not a “Pre-Service Claim.”

Urgent Care Claim: Any claim for medical care or treatment in which a delay in treatment could:

- Seriously jeopardize your life or health;
- Jeopardize your ability to regain maximum function;
- Cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- In the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

Full and Fair Review of Claim Determinations and Appeals

As to medical and **prescription drug** claims and **appeals** only, Aetna will provide you with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue. This will be provided to you in advance of the date on which the notice of the **final adverse benefit determination** is required to be provided so that you may respond prior to that date.

Prior to issuing a **final adverse benefit determination** based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of **final adverse determination** is required.

Claim Determinations – Health Coverage

Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below. As to medical and **prescription drug** claims only, if Aetna makes an **adverse benefit determination**, written notice will be provided to you, or in the case of a concurrent care claim, to your **provider**.

Urgent Care Claims

Aetna will notify you of an **urgent care** claim decision as soon as possible, but not later than 72 hours after the claim is made.

If more information is needed to make an **urgent care claim** decision, Aetna will notify the claimant within 72 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide Aetna with the additional information. Aetna will notify the claimant within 48 hours of the earlier to occur:

- The receipt of the additional information; or
- The end of the 48 hour period given the **physician** to provide Aetna with the information.

Pre-Service Claims

Aetna will notify you of a **pre-service** claim decision as soon as possible, but not later than 15 calendar days after the claim is made. Aetna may determine that due to matters beyond its control an extension of this 15 calendar day claim decision period is required. Such an extension, of no longer than 15 additional calendar days, will be allowed if Aetna notifies you within the first 15 calendar day period. If this extension is needed because Aetna needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Post-Service Claims

Aetna will notify you of a **post-service** claim decision as soon as possible, but not later than 30 calendar days after the claim is made. Aetna may determine that due to matters beyond its control an extension of this 30 calendar day claim decision period is required. Such an extension, of no longer than 15 additional calendar days, will be allowed if Aetna notifies you within the first 30 calendar day period. If this extension is needed because Aetna needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Concurrent Care Claim Extension

Following a request for a **concurrent care claim extension**, Aetna will notify you of a claim decision for **urgent care** as soon as possible but not later than 24 hours, provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. A decision will be provided not later than 15 calendar days with respect to all other care, following a request for a **concurrent care claim extension**.

Concurrent Care Claim Reduction or Termination

Aetna will notify you of a claim decision to reduce or terminate a previously approved course of treatment with enough time for you to file an **appeal**.

As to medical and **prescription drug** claims only, if you file an **appeal**, Coverage under the plan will continue for the previously approved course of treatment until a final **appeal** decision is rendered. During this continuation period, you are responsible for any **copayments; coinsurance; and deductibles**; that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under **appeal**. If Aetna's initial claim decision is upheld in the final **appeal** decision, you will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.

Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a **network provider** you must call or write Member Services. The complaint must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written response within 30 calendar days of the receipt of the **complaint**, unless more information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations

You may submit an **appeal** if Aetna gives notice of an **adverse benefit determination**. This Plan provides for one level of **appeal**. As to medical and **prescription drug** claims only, a **final adverse benefit determination** notice may also provide an option to request an **External Review** (*if available*).

You have 180 calendar days with respect to Health Claims following the receipt of notice of an **adverse benefit determination** to request your Level One **appeal**. Your **appeal** may be submitted orally or must be submitted in writing and must include:

- Your name.
- The school's name.
- A copy of Aetna's notice of an **adverse benefit determination**.
- Your reasons for making the **appeal**.
- Any other information you would like to have considered.

Send your written **appeal** to the address shown on the notice of **adverse benefit determination**, or you may call in your **appeal** using the telephone number listed on the notice.

You may also choose to have another person (an authorized representative) make the **appeal** on your behalf. You must provide written consent to Aetna.

As to medical and **prescription drug** claims only, you may be allowed to provide evidence or testimony during the appeal process in accordance with the guidelines established by the Federal Department of Health and Human Services.

Appeal – Medical and Prescription Drug Claims

A review of an **Appeal** of an **adverse benefit determination** shall be provided by Aetna personnel. They shall not have been involved in making the **adverse benefit determination**.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)

Aetna shall issue a decision within 72 hours of receipt of the request for an **appeal**.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)

Aetna shall issue a decision within 30 calendar days of receipt of the request for an **appeal**.

Post-Service Claims

Aetna shall issue a decision within 60 calendar days of receipt of the request for an Appeal.

Exhaustion of Process

You must exhaust the applicable Level One processes of the Appeal Procedure before you:

- Contact the Indiana Department of Insurance to request an investigation of a **complaint** or **appeal**; or
- File a complaint or **appeal** with the Indiana Department of Insurance; or
- Establish any:
 - Litigation;
 - Arbitration; or
 - Administrative proceeding;

Regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the Appeals Procedure

As to medical and **prescription drug** claims only, under certain circumstances you may seek simultaneous review through the internal Appeals Procedure and **External Review** processes—these include **Urgent Care Claims** and situations where you are receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.

Important Note:

As to medical and **prescription drug** claims only, if Aetna does not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services, you are considered to have exhausted the **appeal** requirements and may proceed with **External Review** or any of the actions mentioned above. There are limits, though, on what sends a claim or an **appeal** straight to an **External Review**. Your claim or internal **appeal** *will not* go straight to **External Review** if:

- A rule violation was minor and isn't likely to influence a decision or harm you;
- It was for a good cause or was beyond Aetna's control; and
- It was part of an ongoing, good faith exchange between you and Aetna.

External Review

As to medical and **prescription drug** claims only, you may receive an **adverse benefit determination** or **final adverse benefit determination** because Aetna determines that:

- The claim involves medical judgment;
- The care is not **necessary** or appropriate;
- A service, supply or treatment is **experimental or investigational** in nature.

In these situations, you may request an **External Review** if you or your provider disagrees with Aetna's decision.

To request an **External Review**, any of the following requirements must be met:

- You have received an **adverse benefit determination** notice by Aetna, and Aetna did not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services.
- You have received a **final adverse benefit determination** notice of the denial of a claim by Aetna.
- Your claim was denied because Aetna determined that the care was not **necessary** or appropriate or was **experimental or investigational**.
- You qualify for a faster review as explained below.

The notice of **adverse benefit determination** or **final adverse benefit determination** that you receive from Aetna will describe the process to follow if you wish to pursue an **External Review**, and include a copy of the *Request for External Review Form*.

You must submit the *Request for External Review Form* to the U.S. Office of Personnel Management within 123 calendar days of the date you received the **adverse benefit determination** or **final adverse benefit determination** notice. You also must include a copy of the notice and all other pertinent information that supports your request.

The U.S. Office of Personnel Management will contact the ERO that will conduct the review of your claim. The ERO will select one or more independent clinical reviewers with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the *Request for External Review Form*, and will follow Aetna's contractual documents and plan criteria governing the benefits. You will be notified of the decision of the ERO usually within 45 calendar days of Aetna's receipt of your request form and all the necessary information.

A faster review is possible if your **physician** certifies (by telephone or on a separate *Request for External Review Form*) that a delay in receiving the service would:

- Seriously jeopardize your life or health; or
- Jeopardize your ability to regain maximum function; or
- If the **adverse benefit determination** relates to **experimental or investigational** treatment, if the **physician** certifies that the recommended or requested health care service, supply or treatment would be significantly less effective if not promptly initiated.

You may also receive a faster review if the **final adverse benefit determination** relates to an admission; availability of care; continued **stay**; or health service for which you received **emergency care**, but have not been discharged from a facility.

Faster reviews are decided within 72 hours after Aetna receives the request.

Aetna will abide by the decision of the ERO, except where Aetna can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the ERO to Aetna. Aetna is responsible for the cost of sending this information to the ERO and for the cost of the external review.

For more information about the Appeals Procedure or **External Review** processes, call the Member Services telephone number shown on your ID card.

PRESCRIPTION DRUG CLAIM PROCEDURE

When obtaining a covered Prescription, please present your Aetna ID card to an Aetna Preferred Pharmacy along with your applicable deductible. The Pharmacy will submit a claim to Aetna for the drug. Claim Forms, Pharmacy locations, and claims status information can be obtained by contacting Aetna Pharmacy Management at **(800) 238-6279**. Additionally, a listing of Pharmacy locations may be obtained by accessing the Internet at: **www.Aetnastudenthealth.com**.

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 Care Pharmacy and be reimbursed by submitting a completed Aetna Prescription Drug claim form. You will be reimbursed for covered medications directly by Aetna Pharmacy Management. Please note, in addition to your deductible, you may be required to pay the difference between the retail price you paid for the drug and the amount Aetna would have paid if you had presented your ID card and the Pharmacy had billed Aetna Pharmacy Management directly. When submitting a claim, please include all Prescription receipts, indicate that you attend University of Notre Dame, and include your name, address, and student identification number.

Please note that Prescriptions filled at Non-Preferred Care Pharmacies will be reimbursed directly by Aetna Pharmacy Management. Students must pay in full for the Prescription and then file for reimbursement through Aetna Student Health. The applicable deductible will apply for each Prescription until your deductible has been reached.

To file a claim, simply forward all Non-Preferred Care Pharmacy receipts to the address below. Please indicate that you attend University of Notre Dame and include your name, address, and Aetna ID Number. A claim form is not necessary.

Aetna Pharmacy Management

Attn: Claims Processing
P. O. Box 14024
Lexington, KY 40512-4024

WORLDWIDE TRAVEL ASSISTANCE SERVICES

On Call International

Chickering Claims Administrators, Inc. (CCA) has contracted with On Call International (On Call) to provide **Covered person s** with access to certain accidental death and dismemberment benefits, worldwide emergency medical, travel and security assistance services and other benefits.

Services rendered without On Call International's coordination and approval are not covered. No claims for reimbursement will be accepted. If the Member is able to leave the Member's host country by normal means, On Call International will assist the Member in rebooking flights or other transportation. Expenses for non-emergency transportation are the Member's responsibility.

On Call phone number: 1-866-525-1956 or collect 1-603-328-1956

A brief description of these benefits is outlined below.

Accidental Death and Dismemberment (ADD) Benefits

These benefits are underwritten by United States Fire Insurance Company (USFIC) and include the following:
Benefits are payable for the Accidental Death and Dismemberment of **Covered person s**, up to a maximum of **\$10,000**.

Medical Evacuation and Repatriation (MER) Benefits

The following benefits are underwritten by United States Fire Insurance Company (USFIC) with medical and travel assistance services provided by On Call. These benefits are designed to assist **Covered person s** when traveling more than 100 miles from home, anywhere in the world.

- Unlimited Emergency Medical Evacuation
- Unlimited Medically Supervised Repatriation
- Unlimited Return of Deceased Remains
- Unlimited Family Reunion (airfare only)
- **\$2,500** Return of Traveling Companion
- **\$2,500** Return of Dependent Children
- **\$2,500** Bereavement Reunion - in the event of a **Covered person**'s death, On Call will fly a family member to identify the remains and accompany the remains back to the deceased's home country
- **\$2,500** Emergency Return Home in the event of death or life-threatening illness of a parent, sibling or spouse
- **\$1,000** Return of Personal Belongings

Natural Disaster and Political Evacuation Services (NDPE)

The following benefits are underwritten by United States Fire Insurance Company (USFIC) with medical, travel, and security assistance services provided by On Call.

If a **Covered person requires** emergency evacuation due to governmental or social upheaval, which places him/her in imminent bodily harm (as determined by On Call security personnel in accordance with local and U.S. authorities), On Call will arrange and pay for his/her transportation to the nearest safe location, and then a one-way economy class airline ticket to his/her home country.

If a **Covered person** requires emergency evacuation due to a natural disaster, which makes his/her location Uninhabitable, On Call will arrange and pay for his/her evacuation from a safe departure point to the nearest safe haven, and then home.

If the **Covered person is** delayed at the safe haven, On Call shall arrange and pay for reasonable lodging expenses up to **\$100** per day for a maximum of three days. (Economy airfare and lodging costs shall not exceed a combined single limit of **\$5,000** USD per **Covered person**).

Subject to a maximum benefit of **\$100,000** per **Covered person** per Event.

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
- Medical/Dental/Pharmacy Referral Service
- Hospital Deposit Arrangements
- Dispatch of **Physician**
- Emergency Medical Record Assistance
- Legal Consultation and Referral
- Bail Bonds Assistance

The On Call International Global Response Center can be reached 24 hours a day, 365 days a year.

The information contained above is a just summary of the ADD, MER, WETA, and NDPE benefits and services available through On Call. For a copy of the plan documents applicable to the ADD, MER, WETA and NDPE Coverage, including a full description of Coverage, exclusions and limitations, please contact Aetna Student Health at www.Aetnastudenthealth.com or (888) 294-7406

NOTE: In order to obtain Coverage, all MER, WETA and NDPE services must be provided and arranged through On Call. Reimbursement will not be provided for any services not provided and arranged through On Call. Although certain emergency medical services may be covered under the terms of the **Covered person**'s student health insurance plan (the "Plan"), neither On Call nor its contracted insurance providers provide Coverage for emergency 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, limitations and benefit maximums may apply. Neither CCA, nor Aetna Life Insurance Company, nor their affiliates provide medical care or treatment and they are not responsible for outcomes.

To file a claim for ADD benefits, or to obtain MER, WETA or NDPE 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 person s** when they enroll in the Plan: Toll Free at (866) 525-1956 or Collect at (603) 328-1956. All **Covered person s** should carry their On Call ID card when traveling.

Chickering Claims Administrators, Inc. (CCA) provides access to certain Accidental Death and Dismemberment (AD&D); Medical Evacuation/Repatriation (MER); Natural Disaster and Political Evacuation (NDPE); and Worldwide Emergency Travel Assistance (WETA) Coverages and services through a contractual relationship with On Call International, LLC (On Call). AD&D Coverage is underwritten by Fairmont Specialty dba United States Fire Insurance Company (USFIC). MER, NDPE and WETA membership services are administered by On Call.

CCA and On Call are independent contractors and not employees or agents of the each other. Neither CCA nor any of its affiliates provides or administers ADD, MER, NPDE and WETA benefits/services and neither CCA nor any of its affiliates is responsible in any way for the benefits/services provided by or through On Call.

These services, programs or benefits are offered by vendors who are independent contractors and not employees or agents of Aetna.

AETNA NAVIGATOR®

Got Questions? Get Answers with Aetna 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 that 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/schools/notredame

Need help with registering onto Aetna Navigator?

Registration assistance is available toll free, Monday through Friday, from 7 a.m. to 9 p.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 981106
(888) 294-7406
www.Aetnastudenthealth.com

Underwritten by:

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

Policy No. **474916**



The University of Notre Dame 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.