2013-2014

Student Health Insurance Plan

COLBY-SAWYER COLLEGE

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 846576

aetna℠

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 Colby-Sawyer College Health Services at **(603) 526-3621**.

For questions about:
- Insurance Benefits
- Enrollment
- Waiver Process
- Claims Processing

Please contact:
Gallagher Koster
500 Victory Rd
Quincy, MA 02171
(877) 320-4347

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
(800) 783-2573

For questions about:
- Enrollment Forms
- Waiver Process
- University Health Services Referrals

Please contact:
Colby-Sawyer College
(603) 526-3621

For questions about:
- Status of Pharmacy Claim
- Pharmacy Claim Forms
- Excluded Drugs and Pre-Authorization

Please contact:
Aetna Pharmacy Management
(888) RX-AETNA or **(888) 792-3862** (Available 24 hours)

For questions about:
- Provider Listings

Please contact:
Aetna Student Health
(800) 783-2573

A complete list of providers can be found at the Baird Health and Counseling Center, or you can use Aetna's **DocFind®** 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 your school-specific site for further information.

The Colby-Sawyer College Student Health Insurance Plan is underwritten by Aetna Life Insurance Company (ALIC) and administered by Chickering Claims Administrators, Inc. Aetna Student Health℠ is the brand name for products and services provided by these companies and their applicable affiliated companies.

IMPORTANT NOTE

Please keep this Brochure, as it provides a general summary of your coverage. A complete description of the benefits and full terms and conditions may be found in the Master Policy issued to Colby-Sawyer College. 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 College's Baird Health and Counseling Center during business hours.

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

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COLLEGE HEALTH SERVICES

The Baird Health and Counseling Center is the College's on-campus health facility. Staffed by nurse practitioners and registered nurses, it is open weekdays from 8:00 a.m. to 8:00 p.m. during the Fall and Spring semesters.

Please call the Baird Health & Counseling Center at **(603) 526-3621** to make an appointment.

New in 2013-2014:

- Hours are Monday - Thursday 9am to 5pm and Friday 9am to 3pm when classes are in session.
- A nominal **$10** fee will be charged for each office visit. Student smart-cards will be used for payment.
- Ten counseling visits per academic year are available for the nominal fee of **$10** each. Counseling visits in excess of 10/year will require payment of **$100**/hr due at the time of the visit. Students enrolled in the college health insurance plan will have charges billed directly to the provider. Other policy holders will receive a walk-out statement that they may process with their insurance provider for reimbursement.

For more information, call the Health Services at **(603) 526-3621**. In the event of an emergency, call **911** or the Campus Safety at **(603) 526-3675.**

Students are encouraged to establish an account at the local pharmacy – Colonial Pharmacy **(603) 526-2233**. If students have an account, requests can be made for medications to be delivered directly to Baird Health & Counseling Center for pick up at the student's convenience during normal hours of operation.

POLICY PERIOD

1. **Students:** Coverage for all insured students enrolled for the Fall Semester, will become effective at 12:01 AM on **August 15, 2013,** and will terminate at 11:59 PM on **August 14, 2014.**

2. **New Spring Semester students**: Coverage for all insured students enrolled for the Spring Semester, will become effective at 12:01 AM on **January 1, 2014,** and will terminate at 11:59 PM on **August 14, 2014.**

RATES

Rates Undergraduates and Graduate Students			
	Annual	**Spring Semester**	
Student	**$1500**	**$935**	

The rates above include both premium for the student health plan underwritten by Aetna Life Insurance Company as well as an administrative fee.

COLBY-SAWYER COLLEGE
STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN

This is a brief description of the Accident and Sickness Medical Expense benefits available for Colby-Sawyer College students. 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 College's Baird Health and Counseling Center during business hours.

STUDENT COVERAGE

ELIGIBILITY

All full-time taking 12 or more credit hours and qualifying part-time undergraduate and graduate students, who are enrolled at Colby-Sawyer College, and who actively attend classes for at least the first 31 days, after the date when coverage becomes effective.

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

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 upon written request received by Aetna within 90 days of withdrawal from school.

ENROLLMENT

To enroll online or obtain an enrollment form for voluntary coverage, log on to **www.gallagherkoster.com/Colby-Sawyer** and click on Student Enroll to complete the enrollment form.

WAIVER PROCESS/PROCEDURE

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

OR

To enroll online or obtain an enrollment form for voluntary coverage, log on to **www.aetnastudenthealth.com** and search for your school, then click on Enroll to download the appropriate form.

Category	Waiver Deadline Date
Students enrolling for the Fall Semester	**09/14/2013**
Students enrolling for the Spring Semester	**01/31/2014**

Waiver submissions may be audited by Colby-Sawyer College. 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.

Please make sure you understand your school’s credit hour and other requirements for enrolling in this plan. Aetna Student Health reserves the right to review, at any time, your eligibility to enroll in this plan. If it is determined that you did not meet the school's eligibility requirements for enrollment, your participation in the plan may be rescinded in accordance with its terms.

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 upon written request received by Aetna Student Health within 90 days of withdrawal from school.

DEPENDENT COVERAGE

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 Colby-Sawyer College Student Health Insurance Plan.

Coverage is provided for a child legally placed for adoption with a Covered Student for 31 days from the moment of placement.

For information, contact Aetna Student Health at **(800) 783-2573.**

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 Colby-Sawyer College 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. A listing of participating providers is available at the Colby-Sawyer College Health Services.

You may also obtain information regarding Preferred Providers by contacting Aetna Student Health at **(800) 783-2573**, or through the Internet by accessing DocFind at **www.aetnastudenthealth.com**.

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

PRE-CERTIFICATION PROGRAM

Pre-certification simply means calling Aetna Student Health prior to treatment to obtain approval for a medical procedure or service. Pre-certification may be done by you, your doctor, a hospital administrator, or one of your relatives. All requests for certification must be obtained by contacting Aetna Student Health's Managed Care Department at **(800) 783-2573**.

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

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

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

Pre-Certification of Non-Emergency Inpatient Admissions, Partial Hospitalization:
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.

DESCRIPTION OF BENEFITS*

Please Note:

THE COLBY-SAWYER COLLEGE STUDENT HEALTH 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 Colby-Sawyer College Student Health 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 Colby-Sawyer College, you may view it at the College's Baird Health and Counseling Center or you may contact Aetna Student Health at (800) 783-2573.

Additional Plan maximums may also apply. Some illnesses 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 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.

*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

AGGREGATE MAXIMUM None

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

	Preferred Care	**Non-Preferred Care**
Per Covered Person:	**$250**	**$500**

*Per visit/per admission deductibles do not apply towards satisfying the annual Deductible.

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, Well Woman Preventive Visits *(Office Visits),* Screening & Counseling Services *(Office Visits),* Routine Cancer Screenings *(Outpatient),* Prenatal Care *(Office Visits),* Comprehensive Lactation Support and Counseling Services *(Facility or Office Visits),* Breast Pumps & Supplies, Family Contraceptive Counseling Services *(Office Visits),* Female Voluntary Sterilization *(Inpatient and Outpatient).*

The Policy Year **Deductible** is not applicable to the following **covered expenses**:

- Female Generic Contraceptive Devices
- Female Generic Contraceptive Prescription Drugs
- Female Over-the-Counter Contraceptive Methods

In addition to legislative requirements, this plan also waives the **Preferred** and **Non-Preferred Care** Annual **Deductible** for **Covered Medical Expenses** for the following services: Physician Office Visit Expense, Outpatient Mental Health & Substance Abuse Office Visit Expenses, Consultant Expense, Walk-In Clinic Expense, Urgent Care Expense, Emergency Room Expense, Pediatric Preventative Care Expense, Pap Smear Screening Expense, and Mammogram Expense.

COINSURANCE
Covered Medical Expenses are payable at the coinsurance percentage specified below, after any applicable deductible.

OUT-OF-POCKET LIMIT*

	Preferred Care	**Non-Preferred Care**
Individual Out-of-Pocket:	**$5,000**	**$10,000**

Once the Individual **Out-of-Pocket Limit** has been satisfied, **Covered Medical Expenses** will be payable at **100%** for the remainder of the **Policy Year** up to the Aggregate Maximum.

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

- **deductibles;**
- **copays**;
- expenses that are not **Covered Medical Expenses**;
- penalties,
- expenses for prescription drugs; and
- other expenses not covered by this Policy.

*Out-of-Pocket accumulators are separate and do not apply towards satisfying each other.

All coverage is based on Recognized Charges unless otherwise specified.

Covered Medical Expenses include, but are not limited to testing, treatment, supplies and services for HIV/AIDS, Intractable Pain, Lyme Disease, Lymphedema, Osteoporosis, Port Wine Stains.	
Inpatient Hospitalization Benefits	
Room and Board Expense	**Covered Medical Expenses** include **Hospital Room and Board** Expenses incurred by a **covered person** for the period of confinement as an inpatient. **Covered Medical Expenses** include: • In-patient care for a minimum of 48 hours following a vaginal hysterectomy; or • In-patient care for a minimum of 23 hours following a laparoscopy-assisted vaginal hysterectomy. Any decision to shorten such minimum coverages shall be made by the attending **physician;** in consultation with the **covered person**. **Covered Medical Expenses** are payable as follows: Preferred Care: After a **$50** per admission Copay, **80%** of the Negotiated Charge. Non-Preferred Care: After a **$100** per admission Deductible, **60%** of the Recognized Charge.

Intensive Care Room and Board Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: After a **$50** per admission Copay, **80%** of the Negotiated Charge. Non-Preferred Care: After a **$100** per admission Deductible, **60%** of the Recognized Charge.
Miscellaneous Hospital Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: **80%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Non-Surgical Physicians Expense	**Covered Medical Expenses** for charges for the non-surgical services of the attending Physician, or a consulting Physician, are payable as follows: Preferred Care: **80%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Surgical Benefits (Inpatient and Outpatient)	
Surgical Expense	**Covered Medical Expenses** include charges for surgical services, performed by a Physician. **Covered Medical Expenses** include medically necessary surgical treatment for symptomatic varicose veins. **Covered Medical Expenses** are payable as follows: Preferred Care: **80%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Anesthesia Expense	**Covered Medical Expenses** for the charges of an anesthetist, during a surgical procedure. Anesthesia will be covered if a member is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental or medical reason as determined by the individual's physician or by the dentist providing the dental care. **Covered Medical Expenses** are payable as follows: Preferred Care: **80%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Assistant Surgeon Expense	**Covered Medical Expenses** for the charges of an assistant surgeon, during a surgical procedure, are payable as follows: Preferred Care: **80%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Ambulatory Surgical Expense	**Covered Medical Expenses** for outpatient surgery performed in an ambulatory surgical center are payable as follows: Preferred Care: **80%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge. **Covered Medical Expenses** must be incurred on the day of the surgery or within 48 hours after the surgery.

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.	
Hospital Outpatient Department Expense	**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. **Covered Medical Expenses** are payable as follows: Preferred Care: **80%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Walk-in Clinic Expense	**Covered Medical Expenses** includes treatment rendered in a Walk-in Clinic. **Covered Medical Expenses** are payable as follows: Preferred Care: After a **$25** per visit Copay, **100%** of the Negotiated Charge. Non-Preferred Care: After a **$40** per visit Deductible, **100%** of the Recognized Charge.
Emergency Room Expense	**Covered Medical Expenses** incurred for treatment of an Emergency Medical Condition are payable as follows: Preferred Care: After a **$100** per visit Copay*, **80%** of the Negotiated Charge. Non-Preferred Care: After a **$100** per visit Deductible*, **80%** of the Recognized Charge. *The per visit Copay/Deductible is waived if admitted as inpatient. **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.
Urgent Care Expense	Benefits include charges for treatment by an urgent care provider. **Please note: A covered person should not seek medical care or treatment from an urgent care provider if their illness, injury, or condition, is an emergency condition. 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.** **Urgent Care** Benefits include charges for an urgent care provider to evaluate and treat an urgent condition. **Covered Medical Expenses** for urgent care treatment are payable as follows: Preferred Care: After a **$50** per visit Copay, **80%** of the Negotiated Charge. Non-Preferred Care: After a **$75** per visit Deductible, **60%** of the Recognized Charge. 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.

Ambulance Expense	**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. Benefits include coverage to professional ambulance services of a newly born to the nearest available hospital/special care unit for treatment of illnesses, congenital defects or complications of birth. Ambulances services will also be provided to the mother, if needed. **Covered Medical Expenses** are payable as follows: Preferred Care: After a **$100** per trip Copay, **100%** of the Negotiated Charge. Non-Preferred Care: After a **$100** per trip Deductible, **100%** of the Recognized Charge.
Physician's Office Visits Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: After a **$25** per visit Copay, **100%** of the Negotiated Charge. Non-Preferred Care: After a **$40** per visit Deductible, **100%** of the Recognized Charge. This benefit includes visits to specialists. **Covered Medical Expenses** includes coverage for telemedicine when services are rendered by a heath care provider without person-to-person contact with the provider. "Telemedicine" means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Neither a telephone conversation nor an electronic mail message between a health care practitioner and patient constitutes "telemedicine." **Covered Medical Expenses** include the expenses incurred by **covered person** in connection with the services performed by a qualified interpreter/transliterator, other than a family member of the **covered person**, when such services are used by the **covered person** in connection with medical treatment or diagnostic consultations performed by a **physician or dental provider**. Such medical treatment or consultation must be covered under this **Policy** and the services must be required due to the **covered person's** hearing impairment or his/her failure to understand or otherwise communicate in spoken language.
Consultant Expense	**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. **Covered Medical Expenses** are payable as follows: Preferred Care: After a **$25** per visit Copay, **100%** of the Negotiated Charge. Non-Preferred Care: After a **$40** per visit Deductible, **100%** of the Recognized Charge.
Laboratory and X-Ray Expense	**Covered Medical Expenses** include outpatient charges for lab and X-ray services, including but not limited to human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation. **Covered Medical Expenses** are payable as follows: Preferred Care: **80%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.

Therapy Expense	**Covered Medical Expenses** include charges incurred by a **covered person** for the following types of therapy provided on an outpatient basis: • Physical Therapy, • Chiropractic Care, • Speech Therapy, • Inhalation Therapy, or • Occupational Therapy. 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. Expenses for Speech and Occupational Therapies are **Covered Medical Expenses,** only if such therapies are a result of **injury** or **sickness**. All therapy must be provided by a therapist who is licensed in accordance with state law; and practicing within the scope of their license. **Covered Medical Expenses** are payable as follows: Preferred Care: **80%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge. **Covered Medical Expenses** also include charges incurred by a **covered person** for the following types of therapy provided on an outpatient basis: • Radiation therapy, • Chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy, • Orally administered anticancer drugs prescribed to kill or slow the growth of cancerous cells. • Administration of high dose chemotherapy with autologous bone marrow transplantation or stem cell transplantation for the treatment of breast cancer, • Dialysis, • Cardiac Rehabilitation and • Respiratory therapy. **Covered Medical Expenses** include expenses incurred by a covered person for: cognitive rehabilitation therapy, cognitive speech/communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services or community reintegration services, if such services are necessary as a result of and related to an acquired brain injury. **Covered Medical Expenses** are payable as follows: Preferred Care: **80%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Durable Medical Equipment Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: **80%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge. **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. Preferred Care: **100%** of the Negotiated Charge.

Durable Medical Equipment Expense (continued)	Non-Preferred Care: **80%** of the Recognized Charge.
	
	Breast Pump
	C**overed expenses** include the following:
	• The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a **hospital**.
	• The purchase of:
	  • an electric breast pump (non-hospital grade), if requested within 60 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 not be covered until a five year period has elapsed from the last purchase of an electric pump.
	
	Breast Pump Supplies
	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.
	
	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.
	
	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**.
	
	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.

Dental Injury Expense	**Covered Medical Expenses** include dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition: • Natural teeth damaged, lost, or removed, or • Other body tissues of the mouth fractured or cut due to injury. The accident causing the injury must occur while the person is covered under this Plan. Any such teeth must have been: • Free from decay, or • In good repair, and • Firmly attached to the jawbone at the time of the injury. **The treatment must be done in the calendar year of the accident or the next one**. If: • Crowns (caps), or • Dentures (false teeth), or • Bridgework, or • In-mouth appliances, are installed due to such injury, **Covered Medical Expenses** include only charges for: • The first denture or fixed bridgework to replace lost teeth, • The first crown needed to repair each damaged tooth, and • An in-mouth appliance used in the first course of orthodontic treatment after the injury. • Surgery needed to:

Dental Injury Expense (continued)	• Treat a fracture, dislocation, or wound. • Cut out cysts, tumors, or other diseased tissues. • Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement. • Non-surgical treatment of infections or diseases. This does not include those of, or related to, the teeth. **Covered Medical Expenses** are payable at **80%** of the Actual Charge.
Allergy Testing and Treatment Expense	Benefits include charges incurred for diagnostic testing and treatment of allergies and immunology services. **Covered Medical Expenses** include, but are not limited to, charges for the following: • Laboratory tests, • Physician office visits, including visits to administer injections, • Prescribed medications for testing and treatment of the allergy, including any equipment used in the administration of prescribed medication, and • Other medically necessary supplies and services. **Covered Medical Expenses** are payable on the same basis as any other Sickness.
Additional Benefits	
Mental and Emotional Disorders Inpatient Expense	**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: Preferred Care: After a **$50** per admission Copay, **80%** of the Negotiated Charge. Non-Preferred Care: After a **$100** per admission Deductible, **60%** of the Recognized Charge. **Covered Medical Expenses** also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health.
Mental and Emotional Disorders Outpatient Expense	**Covered Medical Expenses** for outpatient treatment of a mental health condition are payable as follows: Preferred Care: After a **$25** per visit Copay, **100%** of the Negotiated Charge. Non-Preferred Care: After a **$40** per visit Deductible, **100%** of the Recognized Charge. **Covered Medical Expenses** include diagnosis, assessment and services (including treatment that is educational or habilitative in nature) for Covered Persons for Autism Spectrum Disorder (ASD). For purposes of this benefit, ASD means Autistic Disorder, Asperger syndrome, pervasive development disorder not otherwise specified.
Substance Abuse Inpatient Expense	**Covered Medical Expenses** for the treatment of a substance abuse condition while confined as a inpatient in a hospital or facility licensed for such treatment are payable as follows: Preferred Care: After a **$50** per admission Copay, **80%** of the Negotiated Charge. Non-Preferred Care: After a **$100** per admission Deductible, **60%** of the Recognized Charge. **Covered Medical Expenses** also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health.

Substance Abuse Outpatient Expense	**Covered Medical Expenses** for outpatient treatment of a substance abuse condition are payable as follows: Preferred Care: After a **$25** per visit Copay, **100%** of the Negotiated Charge. Non-Preferred Care: After a **$40** per visit Deductible, **100%** of the Recognized Charge.
Maternity Expense	**Prenatal Care:** **Covered Medical Expenses** include the following Prenatal Care services and supplies provided in connection with a pregnancy of the covered person: • Risk assessment, • Serial surveillance, • Prenatal education, • Use of specialized skills and technology: such as, pregnancy tests, prenatal work ups, prescription vitamins, sonograms, genetic counseling and amniocentesis. Benefits are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **100%** of the Recognized Charge. **Labor, delivery or postpartum care:** **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. Any decision to shorten such minimum coverages shall be made by the attending Physician in consultation with the mother. If a covered person is discharged earlier, benefits will be payable for 2 post-delivery home visits by a health care provider. The first such visit shall occur within 48 hours of discharge. In such cases, covered services may include: home visits, parent education, and assistance and training in breast or bottle-feeding. The home care visit will not be subject to any deductible, copay or insurance. **Covered Medical Expenses** include services of a licensed midwife unless those services duplicate the services already provided by the covered person's physician. **Covered Medical Expenses** for childbirth, and complications of pregnancy are payable on the same basis as any other sickness. **Prenatal Care** Prenatal care will be covered for services received by a pregnant female in a **physician's**, obstetrician's, or gynecologist's office but only to the extent described below. 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). **Comprehensive Lactation Support and Counseling Services** **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.

Maternity Expense (continued)	Lactation support and lactation counseling services are **covered expenses** when provided in either a group or individual setting. **Covered Medical Expenses** for Prenatal Care and Comprehensive Lactation Support and Counseling Services are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **100%** of the Recognized Charge.
Well Newborn Nursery Care Expense	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. **Covered Medical Expenses** are payable as follows: Preferred Care: **80%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Prescription Drug Benefit	Prescribed Drug Annual Deductible: None After the Annual Deductible, Prescription Drug Benefits are payable as follows: Preferred Care Pharmacy: **100%** of the Negotiated Charge, following: Non-Formulary Generic Drug Copay: **$15** per prescription Non-Formulary Brand Name Drug Copay: **$75** per prescription Formulary Generic Drug Copay: **$15** per prescription Formulary Brand Name Drug Copay: **$45** per prescription Non-Preferred Care Pharmacy: **80%** of the Recognized Charge. This Pharmacy benefit is provided to cover Medically Necessary Prescriptions associated with a covered Sickness or Accident occurring during the Policy Year. Please use your Aetna Student Health ID card when obtaining your prescriptions. 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** or **(888) 792-3862** (available 24 hours). *Contraceptive Drugs and Device benefits are illustrated under the Family Planning Benefit of this Policy.
Home Health Care Expenses	**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: • 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,

Home Health Care Expenses (continued)	• 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. **Home Health Care Services** • Part-time or intermittent nursing care by: a registered nurse (R. N.), a licensed Practical nurse (L.P.N.), or under the supervision of 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. **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. **Covered Medical Expenses** include charges incurred by a covered person for expenses incurred in connection with the treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. The benefits to be provided shall include coverage for the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders when the home treatment program is under the supervision of the state-approved hemophilia treatment center. **Covered Medical Expenses** are payable as follows: Preferred Care: **80%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Hospice Benefit	**Covered Medical Expenses** include charges for hospice care provided for a terminally ill covered person during a hospice benefit period. **Covered Medical Expenses** are payable as follows: Preferred Care: **80%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Licensed Nurse Expense	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. **Covered Medical Expenses** are payable as follows: Preferred Care: **80%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.

Skilled Nursing Facility Expense	**Covered Medical Expenses** include charges incurred by a covered person for confinement in a skilled nursing facility for treatment rendered: • in lieu of confinement in a hospital as a full time inpatient, or • within 24 hours following a hospital confinement and for the same or related cause(s) as such hospital confinement. **Covered Medical Expenses** are payable as follows: Preferred Care: After a **$50** per admission Copay, **80%** of the Negotiated Charge. Non-Preferred Care: After a **$100** per admission Deductible, **60%** of the Recognized Charge.
Rehabilitation Facility Expense	**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. **Covered Medical Expenses** are payable as follows: Preferred Care: **80%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Convalescent Facility Expense	Benefits include charges for room and board, during a period of convalescent care and confinement. **Covered Medical Expenses** are payable as follows: Preferred Care: After a **$50** per admission Copay, **80%** of the Negotiated Charge. Non-Preferred Care: After a **$100** per admission Deductible, **60%** of the Recognized Charge.
Acupuncture Expense	Acupuncture is a **Covered Medical Expense** when it is administered for the following indications by a health care provider, who is a legally qualified physician, who is practicing within the scope of their license: • Adult postoperative and chemotherapy nausea and vomiting • Nausea of pregnancy • Postoperative dental pain • Fibromyalgia/myofacial pain • Chronic low back pain secondary to osteoarthritis. **Covered Medical Expenses** are payable as follows: Preferred Care: **80%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Acupuncture in Lieu of Anesthesia Expense	**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. The acupuncture must be administered by a health care provider who is a legally qualified physician, practicing within the scope of their license. **Covered Medical Expenses** are payable on the same basis as any other Sickness.

Diagnostic Testing for Attention Disorders and Learning Disabilities Expense	**Covered Medical Expense** includes coverage for the diagnosis and treatment of attention deficit disorder and attention deficit hyperactivity disorder (ADHD). **Covered Medical Expenses** are payable on the same basis as any other Sickness.
Second Surgical Opinion Expense	To the extent that this Policy provides coverage for surgery; this Policy shall provide coverage for expenses incurred for a second opinion consultation by a specialist on the need for non-elective surgery or cancer consultation 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. **Covered Medical Expenses** are payable on the same basis as any Sickness.
Outpatient Contraceptive Drugs And Devices And Outpatient Contraceptive Services Expense	**Covered Medical Expenses** include charges incurred for (a) any type of drug or device for contraception; (b) any type of hormone replacement therapy, which is lawfully prescribed or ordered and which has been approved by the FDA, and (c) any health care service related to contraceptives or hormone replacement therapy. Related outpatient contraceptive services include; a) Prescription contraceptive drugs; b) Voluntary sterilization procedures; c) Hormone injections for contraception; and d) Emergency contraception; e) Intrauterine devices (IUDs), subdermal implants and the insertion, management and removal of such devices. **Covered Medical Expenses** do not include; a) The drugs RU-486, mifepristone, or any other drug or device that induces a medical abortion are not defined as contraceptives or emergency contraceptives and therefore are not required to be covered under the contraceptive benefit; b) charges for services which are covered to any extent; under any other part of this Plan; or under any other group plan; c) charges incurred for contraceptive services; while confined as an inpatient; and d) charges incurred for duplicate; lost; stolen; or damaged contraceptive devices. **Covered Medical Expenses** are payable as any other Sickness.
Diabetic Testing Supplies and Equipment Expense	**Covered Medical Expenses** include equipment, supplies and prescription drugs medically necessary to manage and treat diabetes. Diabetic Testing Supplies and Equipment benefits include: • Blood glucose monitors and blood glucose testing strips, • Blood glucose monitors designed to assist the visually impaired, • Insulin pumps and all related and necessary supplies, • Ketone urine test strips, • Lancets and lancet puncture devices, • Pen delivery systems for the administration of insulin, • Podiatric devices to prevent or treat diabetes-related complications, • Insulin syringes, • Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin, • Insulin, • Prescriptive medications for the treatment of diabetes, • Glucogan. **Covered Medical Expenses** are payable on the same basis as any other Sickness.

Diabetic Daycare Self-Management Education Programs	**Covered Medical Expenses** for Diabetic Daycare Self-Management Education Programs include: Programs directed and supervised by a licensed physician who is board certified in internal medicine or pediatrics. Diabetic daycare self-management and education programs will be provided by health care professionals including, but not limited to, physicians, registered nurses, registered pharmacists, and registered dieticians who are knowledgeable about the disease process of diabetes and the treatment of diabetic patients. As used in this section, diabetic daycare self-management education programs means instruction which will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy thereby avoiding frequent hospitalizations and complications. These programs do not include programs whose sole or primary purpose is weight reduction. **Covered Medical Expenses** are payable on the same basis as any other Sickness.
Family Planning Expense	Benefits include charges incurred for the following, although they are not incurred in connection with the diagnosis or treatment of a sickness or injury: For females with reproductive capacity, **Covered Medical Expenses** include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this benefit must be approved by the Food and Drug Administration (FDA). Coverage includes counseling services on contraceptive methods provided by a **physician**, obstetrician or gynecologist. Such counseling services are **Covered Medical Expenses** when provided in either a group or individual setting. The following contraceptive methods are **covered expenses** under this benefit: *Voluntary Sterilization* **Covered expenses** include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants. **Covered expenses** under this *Preventive Care* benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement. *Contraceptives* **Covered expenses** include charges made by a **physician** or **pharmacy** for: • Female contraceptives that are **generic prescription drugs**. The prescription must be submitted to the pharmacist for processing. *This contraceptives benefit covers only **generic prescription drugs**.* • Female contraceptive devices and related services and supplies that are generic prescription devices when prescribed in writing by a **physician**. *This contraceptives benefit covers only those devices that are generic prescription devices.* • FDA-approved female over-the-counter contraceptive methods that are prescribed by your **physician**. The **prescription** must be submitted to the pharmacist for processing. These items are limited to one per day and a 30 day supply per **prescription**. **Limitations:** Unless specified above, not covered under this benefit are charges for: • Services which are covered to any extent under any other part of this Plan;

Family Planning Expense (continued)	• Services and supplies incurred for an abortion; • Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care; • Services which are for the treatment of an identified **illness** or **injury**; • Services that are not given by a **physician** or under his or her direction; • Psychiatric, psychological, personality or emotional testing or exams; • Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA; **Covered Medical Expenses** are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **80%** of the Recognized Charge. **Important note:** Brand-Name Prescription Drug or Devices will be covered at 100% of the Negotiated Charge, including waiver of Annual Deductible if a Generic Prescription Drug or Device is not available in the same therapeutic drug class or the prescriber specifies Dispense as Written.
Non Prescription Enteral Formula Expense	**Covered Medical Expenses** include charges incurred for special dietary treatment, both tube-fed and oral, when medically necessary and physician recommended. **Covered Medical Expenses** are payable as follows: Preferred Care: **80%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Prosthetic Devices Expense	**Covered Medical Expenses** include charges for prosthetic and orthotic devices that are medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that are not solely for comfort or convenience. **Covered Medical expenses** will include all services and supplies medically necessary for the effective use of a prosthetic or orthotic device, including formulating its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments, and instructing the patient in the use of the device. As used in this section: Orthotic device means a rigid or semirigid device supporting a weak or deformed leg, foot, arm, hand, back or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck. Prosthetic device means an artificial limb device or appliance designed to replace in whole or in part an arm or a leg. Benefits are payable at the lesser of: **80%** of Actual Charges or **100%** of Medicare Allowable The initial purchase and installation of a prosthetic device is not subject to any copay or deductible. Repair and replacement of such prosthetic devices are covered provided that such repair or replacement is not due to loss or misuse of the device. These repair/replacement benefits are subject to copay and/or deductible.

Prosthetic Devices Expense (continued)	**Covered Medical Expenses** also include charges for a scalp hair prosthesis worn for hair loss as a result of alopecia areta, alopecia totalis, alopecia medicamentosa resulting from the treatment of any form of cancer or leukemia, or permanent loss of scalp hair due to injury. **Covered Medical Expenses** include the professional services associated with the practice of fitting, dispensing, servicing, or sale of hearing instruments or hearing aids by a hearing instrument dispenser or other hearing care professional. Hearing Aids Expenses are limited to one hearing aid for each ear every three years.
Temporomandibular Joint Dysfunction (TMJ) Expense	**Covered Medical Expenses** include charges incurred by a covered person for the diagnosis and surgical treatment involving any bone or joint of the head, neck, face or jaw if the treatment is required due to a medical condition or injury which prevents normal function of the bone or joint. **Covered Medical Expenses** are payable on the same basis as any other sickness.
Podiatric Expense	**Covered Medical Expenses** include orthotic and prosthetic devices prescribed by surgeons or doctors of podiatric medicine. Any coverage for prosthetic devices shall include original and replacement devices, as prescribed by a physician and surgeon or doctor of podiatric medicine acting within the scope of his or her license. **Covered Medical Expenses** include special footwear needed by persons who suffer from foot disfigurement. As used in this section, foot disfigurement shall include, but not be limited to, disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes, and foot disfigurement caused by accident or developmental disability. **Covered Medical Expenses** are payable on the same basis as any other Sickness.
Preventive Treatment	

Routine Physical Exam Expense	Benefits include expenses for a routine physical exam performed by a physician.
	
	A routine physical exam is a medical exam given by a physician, for a reason other than to diagnose or treat a suspected or identified injury or sickness. Included as a part of the exam are:
	• 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.
	
	Preferred Care **visits** are payable at **100%** of the Negotiated Charge.
	Preferred Care **immunizations** are payable at **100%** of the Negotiated Charge.
	
	Non-Preferred Care **visits** are payable at **100%** of the Recognized Charge.
	Non-Preferred Care **immunizations** are payable at **100%** of the Recognized Charge.
	
	In addition to any state regulations or guidelines regarding mandated Routine Physical Exam services, **Covered Medical Expenses** include services rendered in conjunction with,
	• 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:
	  • Screening and counseling services, such as:
	  o Interpersonal and domestic violence;
	  o Sexually transmitted diseases; and
	  o Human Immune Deficiency Virus (HIV) infections.
	  • Screening for gestational diabetes.

Routine Physical Exam Expense (continued)	• High risk Human Papillomavirus (HPV) DNA testing for women age 18 and older and limited to once every three years. *Sexually transmitted disease counseling expense is limited to two counseling visits per Policy Year. • 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** check up. **Important Note:** ***For details on the frequency and age limits that apply to Routine Physical Exams and Routine Cancer Screenings, a covered person may contact his or her physician or Member Services by logging onto the Aetna website www.aetna.com or calling the toll-free number on the back of the ID card.*** For all exams given to a covered student, **Covered Medical Expenses** will **not include** charges for **more than**: • One exam in 12 months in a row. **Covered Medical Expenses** incurred by a woman, are charges made by a physician for, one annual routine gynecological exam. **Screening and Counseling Services:** **Covered Medical Expenses** include charges made by a **physician** in an individual or group setting for the following: **Depression Screening** This service is limited to once per year. **Obesity** Screening and counseling services to aid in weight reduction due to obesity. Coverage includes: • 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. Services in this category are subject to a combined limit of 26 individual or group visits by any recognized provider per Policy Year. The 10 Healthy Diet Counseling visits will be counted toward the total number of visits allowed for Obesity counseling. **Misuse of Alcohol and/or Drugs** 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. Services in this category are subject to a combined limit of 5 individual or group visits by any recognized provider per Policy Year. **Use of Tobacco Products** Screening and counseling services to aid a covered person to stop the use of tobacco products.

Routine Physical Exam Expense (continued)	Coverage includes: • Preventive counseling visits; • Treatment visits; and • Class visits; To aid a covered person to stop the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including: • cigarettes; • cigars; • smoking tobacco; • snuff; • smokeless tobacco; and • candy-like products that contain tobacco. Services in this category are subject to a combined limit of 8 individual or group visits by any recognized provider per Policy Year. **Limitations:** Unless specified above, not covered under this Screening and Counseling Services benefit are charges incurred for: • Services which are covered to any extent under any other part of this Plan Screening and Counseling Services are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **100%** of the Recognized Charge.
Pap Smear Screening Expense	**Covered Medical Expenses** include one routine annual Pap smear screening (or an alternative cervical cancer screening test when recommended by a physician or a health care provider), and an FDA approved human papillomavirus screening test for women age 18 and older. **Covered Medical Expenses** are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **100%** of the Recognized Charge.
Mammogram Expense	**Covered Medical Expenses** include coverage for mammograms for screening or diagnostic purposes upon referral of a nurse practitioner, certified nurse-midwife, physician assistant, or physician. **Covered Medical Expenses** are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **100%** of the Recognized Charge.
Routine Screening for Sexually Transmitted Disease Expense	**Covered Medical Expenses** include charges for covered persons who are at least 18 years old and who are sexually active for annual routine screening for sexually transmitted diseases. **Covered Medical Expenses** are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **100%** of the Recognized Charge.

Routine Colorectal Cancer Screening Expense	**Covered Medical Expenses** include colorectal cancer screenings, examinations and laboratory tests in accordance with the most recently published guidelines and recommendations established by the American Cancer Society. **Covered Medical Expenses** are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **100%** of the Recognized Charge.
Routine Prostate Cancer Screening Expense	**Covered Medical Expenses** include charges incurred by a covered person for the screening of cancer in accordance with the latest screening guidelines issued by the American Cancer Society for the ages, family histories and frequencies referenced in such guidelines. Plans cover routine annual (or more frequently if recommended by a physician) digital rectal exams and PSA tests. **Covered Medical Expenses** are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **100%** of the Recognized Charge.
Hypodermic Needles Expense	**Covered Medical Expenses** for hypodermic needles and syringes used in the treatment of diabetes are payable on the same basis as any other Sickness.
Pre-Admission Testing Expense	**Covered Medical Expenses** for Pre-Admission testing charges while an Outpatient before scheduled surgery are payable on the same basis as any other Sickness.
Transfusion or Dialysis of Blood Expense	Covered Medical Expenses include charges for the transfusion or dialysis of blood, including the cost of: whole blood, blood components, and the administration thereof. **Covered Medical Expenses** are payable on the same basis as any other Sickness.

Chlamydia Screening Test Expense	**Covered Medical Expenses** include charges incurred by a covered person for an annual chlamydia screening test.
	As used above, "chlamydia screening test" means any laboratory test of the urogenital tract that specifically detects for infection by one or more agents of chlamydia trachomatis; and which test is approved for such purposes by the FDA. Benefits will be paid for chlamydia screening expenses incurred for:
	
	• Women who are:
	  • 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.
	
	Covered Medical Expenses are payable as follows:
	Preferred Care: **100%** of the Negotiated Charge.
	Non-Preferred Care: **100%** of the Recognized Charge.

Dermatological Expense	**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. **Covered Medical Expenses** are payable on the same basis as any other Sickness. **Covered Medical Expenses** do not include treatment for acne, or cosmetic treatment and procedures.

High Cost Procedures Expense	**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: • 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. **Covered Medical Expenses** for High Cost Procedures include charges for the following procedures and services: • C.A.T. Scan; • Magnetic Resonance Imaging; and • Contrast Materials for these tests. **Covered Medical Expenses** are payable as follows: Preferred Care: **80%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Physical Therapy Expense	**Covered Medical Expenses** for physical therapy are payable as follows when provided by a licensed physical therapist: Preferred Care: **80%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.

GENERAL PROVISIONS

STATE MANDATED BENEFITS

The Plan will pay benefits in accordance with any applicable New Hampshire 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.

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

TERMINATION OF INSURANCE

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

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

- the date this 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.

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 or as provided elsewhere in this plan.

3. Expense incurred as a result of injury due to participation in a riot. "Participation in a riot" means taking part in a riot in any way, including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense so long as they are not taken against persons who are trying to restore law and order.

4. Expense incurred as a result of an accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.

5. Expense incurred as a result of an injury or sickness due to working for wage or profit or for which benefits are payable under any Workers' Compensation or Occupational Disease Law.

6. Expense incurred as a result of an injury sustained or sickness contracted while in the service of the Armed Forces of any country. Upon the covered person entering the Armed Forces of any country, the unearned pro-rata premium will be refunded to the Policyholder.

7. Expense incurred for treatment provided in a governmental hospital unless there is a legal obligation to pay such charges in the absence of insurance.

8. Expense incurred for elective treatment or elective surgery except as specifically provided elsewhere in this Policy and performed while this Policy is in effect.

9. Expense incurred for cosmetic surgery, reconstructive surgery, or other services and supplies which improve, alter, or enhance appearance whether or not for psychological or emotional reasons, to the extent needed to improve the function of a part of the body that: (a) is 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 (c) to the extent needed to repair an injury 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. For reconstructive breast surgery following a mastectomy, including (1) all stages of reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas, in a manner determined by the attending physician and patient to be appropriate.

10. Expense covered by any other valid and collectible medical, health, or accident insurance to the extent that benefits are payable under other valid and collectible insurance whether or not a claim is made for such benefits.

11. Expense incurred as a result of commission of a felony.

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 injury resulting from the play or practice of collegiate or intercollegiate sports, excluding collegiate or intercollegiate club sports and intermurals.

16. 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.

17. 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).

18. Expense incurred for which no member of the covered person's immediate family has any legal obligation for payment.

19. Expense incurred for custodial care. Custodial care means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes room and board and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to by whom they are prescribed, by whom they are recommended, or by whom or by which they are performed.

20. 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.

21. Expenses incurred for blood or blood plasma, except charges by a hospital for the processing or administration of blood.

22. Expenses incurred for or in connection with procedures, services, or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational (a) if there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or (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. (c) The covered person has been accepted into a phase I, II, III, or IV approved cancer clinical trial and the attending physician recommended the program. Also, this exclusion will not apply with respect to drugs that: (a) Have been granted treatment investigational new drug (IND), or Group c/treatment IND status; or (b) Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or (c) If Aetna determines that available; scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

23. Expense for services or supplies provided for the treatment of obesity and/or weight control, except morbid obesity through gastric bypass surgery or such other methods as recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity.

24. Expenses incurred for gynecomastia (male breasts).

25. Expenses incurred for any sinus surgery except for acute purulent sinusitis.

26. Expenses incurred for care, treatment, services, or supplies for or related to obstructive sleep apnea and sleep disorders, including CPAP and UPP.

27. Expense incurred by a covered person not a United States citizen for services performed within the covered person’s home country if the covered person’s home country has a socialized medicine program.

28. Expense incurred for or related to services, treatment, testing, educational testing, training, or medication for Learning Disabilities or other developmental delays.

29. Expense incurred for alternative holistic medicine and/or therapy, including but not limited to yoga and hypnotherapy.

30. Expense for: (a) care of flat feet; (b) supportive devices for the foot; (c) care of corns, bunions, or calluses; (d) care of toenails; and (e) care of fallen arches, weak feet, or chronic foot strain except that (c) and (d) are not excluded when medically necessary because the covered person is diabetic or suffers from circulatory problems.

31. Expense for injuries sustained as the result of a motor vehicle accident to the extent that benefits are payable under other valid and collectible insurance whether or not claim is made for such benefits. The Policy will only pay for those losses which are not payable under the automobile medical payment insurance Policy.

32. Expense incurred when the person or individual is acting beyond the scope of his/her/its legal authority.

33. Expenses incurred for hearing exams not performed in conjunction with a routine physical exam.

34. Expense for services or supplies used to treat conditions related to hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation, or senile deterioration beyond the period necessary to diagnose the condition.

35. Expense for care or services to the extent the charge would have been covered under Medicare Part A or Part B even though the covered person is eligible but did not enroll in Part B.

36. Expense for telephone consultations (except telemedicine), charges for failure to keep a scheduled visit, or charges for completion of a claim form.

37. Expense for personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment even if such items are prescribed by a physician.

38. Expense for services or supplies provided for the treatment of obesity and/or weight control.

39. Expense for incidental surgeries and standby charges of a physician.

40. Expense for services and supplies in connection with psychological testing or neuropsychological testing.

41. Expense incurred as a result of dental treatment, including extraction of wisdom teeth, except for treatment resulting from injury to sound natural teeth as provided elsewhere in this Policy.

42. Expense for contraceptive methods, devices, or aids and charges for services and supplies for or related to gamete intrafallopian transfer, artificial insemination, in-vitro fertilization (except as required by the state law) or embryo transfer procedures, elective sterilization or its reversal, or elective abortion unless specifically provided for in this Policy.

43. Expenses incurred for massage therapy.

44. Expense incurred for or related to sex change surgery.

45. 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.

46. 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.

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: (a) information relating to the affected person's health status; (b) reports in peer reviewed medical literature; (c) reports and guidelines published by nationally recognized health care organizations that include supporting scientific data; (d) generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment; (e) the opinion of health professionals in the generally recognized health specialty involved; and (f) 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 (d) 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.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by a R.N.
- Is equipped and has trained staff to handle medical emergencies.
- It must have: a physician trained in cardiopulmonary resuscitation; and a defibrillator; and a tracheotomy set; and a blood volume expander.
- Has a written agreement with a **hospital** in the area for immediate emergency transfer of patients. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. The program must include reviews by physicians who do not own or direct the facility.
- Keeps a medical record on each patient.

Birthing Center: a freestanding facility that:

- Meets licensing standards.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
- Makes charges.
- Is directed by at least one physician who is a specialist in obstetrics and gynecology.
- Has a **physician** or certified nurse midwife present at all births and during the immediate postpartum period.
- Extends staff privileges to physicians who practice obstetrics and gynecology in an area **hospital.**
- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.
- Provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by a R.N. or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
- Is equipped and has trained staff to handle medical emergencies and provide immediate support measures to sustain life if complications arise during labor and if a child is born with an abnormality which impairs function or threatens life.
- Accepts only patients with low risk pregnancies.
- Has a written agreement with a hospital in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. This includes reviews by physicians who do not own or direct the facility.
- Keeps a medical record on each patient and child.

Brand Name Prescription Drug or Medicine: a **prescription drug** which is protected by trademark registration.

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

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

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

Complications of Pregnancy also include:

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

Convalescent Facility: This is an institution that:

- Is approved pursuant to law;
- Is approved for payment of Medicare benefits or is qualified to receive approval for payment of Medicare benefits, if so requested;
- Is primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;
- Provides 24 hour a day nursing by or under the supervision of a registered nurse;
- Maintains a complete medical record on each patient.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Makes charges.

Copay: this is a fee charged to a person for **Covered Medical Expenses**.

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

Covered Dental Expenses: those charges for any treatment; service; or supplies; covered by this Policy which are:

- not in excess of the **recognized charge**; 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 Medical Expense: those charges for any treatment, service or supplies covered by this Policy which are:

- not in excess of the **recognized charge**; 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** 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 Provider: This is any **dentist**; group; organization; dental facility; or other institution; or person legally qualified to furnish dental services or supplies.

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

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:

- breast reduction unless **medically necessary**;
- sexual reassignment surgery;
- submucous resection and/or other surgical correction for deviated nasal septum, other than **medically necessary** treatment of covered acute purulent sinusitis;
- treatment for weight reduction;
- learning disabilities, except when provided in connection with the treatment of biologically- based mental illness; 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 reasonably be expected to result in:
  - serious jeopardy to the patient's health;
  - serious impairment to bodily functions; or'
  - serious dysfunction of any bodily organ or part.

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

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

Generic Prescription Drug or Medicine. a **prescription drug** which is not protected by trademark registration; but is produced and sold under the chemical formulation name.

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.**

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.

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. A service or supply will not be considered as **medically necessary** if:

- It is provided only as a convenience to the **covered person** or provider; or
- it is not the appropriate treatment for the **covered person**'s diagnosis or symptoms; or
- it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment.

The fact that any particular **physician** may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply medically necessary.

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

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

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-Pocket Limit: The amount that must be paid by the **covered student** 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** which are payable at a rate greater than **50%**.
The following expenses do not apply toward meeting the **Out-of-Pocket Limit:**

- **deductibles;**
- **copays;**
- expenses that are not C**overed 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.

Preferred Care: care provided by

- a **covered person's preferred care provider;** or
- a health care provider that is not a **Preferred Care Provider** for an **emergency medical condition** when

travel to a **Preferred Care Provider** is not feasible; or
- a **Non-Preferred Urgent Care Provider** when travel to a **Preferred Urgent Care Provider** for treatment is not feasible; and if authorized by Aetna.

Preferred Care Provider: a health care provider that has contracted to furnish services or supplies for a **negotiated charge**; but only if the provider is; with Aetna's consent; included in the directory as a **Preferred Care Provider** for:
- the service or supply involved; and
- the class of **covered persons** of which you are member.

Preferred Pharmacy: a **pharmacy** 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 **Preferred Care Provider**; or
  - a **Non-Preferred Care Provider**; but only for an **emergency condition;** or
  - a **dentist** who is a **Non-Preferred Care Provider**; but only one who is not of a type that falls into one or more of the categories of providers listed in the directory of **Preferred Care Providers**.

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

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

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

Primary Care Physician:
This is the **Preferred Care Provider** who is:
- selected by a person from the list of **Primary Care Physician**s 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**.

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.

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: This is an institution that:

- Is approved pursuant to law;
- Is approved for payment of Medicare benefits or is qualified to receive approval for payment of Medicare benefits, if so requested;
- Is primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;
- Provides 24 hour a day nursing by or under the supervision of a registered nurse;
- Maintains a complete medical record on each patient.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Makes charges.

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

Surgery Center: a free standing ambulatory surgical facility that:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Makes charges.
- Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery which requires general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to: **physicians** who practice surgery in an area **hospital**; and **dentists** who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by a registered nurse.
- Is equipped and has trained staff to handle medical emergencies.
- It must have:
    - a **physician** trained in cardiopulmonary resuscitation; and
    - a tracheotomy set; and and a defibrillator; 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.**

Also, 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

1. Bills must be submitted within 90 days from the date of treatment.
2. Payment for **Covered Medical Expenses** will be made directly to the hospital or physician concerned, unless bill receipts and proof of payment are submitted.
3. 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.
4. 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

Definitions

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 New Hampshire Department of Insurance to request an investigation of a **complaint** or **appeal**, or
- File a complaint or **appeal** with the New Hampshire 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 ID card to a Preferred Pharmacy, along with your applicable copay. The pharmacy will bill Aetna for the cost of the drug, plus a dispensing fee, less the copay amount.

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

WORLDWIDE TRAVEL ASSISTANCE SERVICES

On Call International
Chickering Claims Administrators, Inc. (CCA) has contracted with On Call International (On Call) to provide **Covered Persons** with access to certain accidental death and dismemberment benefits, worldwide emergency 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 Persons**, 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 Persons** 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 (800) 783-2573.

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 Persons when they enroll in the Plan: Toll Free at **(866) 525-1956** or Collect at **(603) 328-1956**. All Covered Persons 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's Navigator®
As an Aetna Student Health insurance member, you have access to Aetna Navigator®, your secure member website, packed with personalized claims and health information. You can take full advantage of our interactive website to complete a variety of self-service transactions online. **By logging into Aetna Navigator, you can:**

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

How do I register?

- Go to **www.aetnastudenthealth.com**

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. 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
El Paso, TX 79998
(800) 783-2573
www.aetnastudenthealth.com

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

Policy No. **846576**

The Colby-Sawyer College Student Health Insurance Plan is underwritten by Aetna Life Insurance Company (ALIC) and administered by Chickering Claims Administrators, Inc. Aetna Student Health℠ is the brand name for products and services provided by these companies and their applicable affiliated companies.