Policyholder No. 697443

Blanket Student Accident and Sickness Insurance Policy

a contract between

Aetna Life Insurance Company
(A Stock Company herein called Aetna)

and

Arizona State University
(Policyholder)

Policy Number: GP-697443
Date of issue: March 2, 2015
To take effect: August 16, 2014
Policy delivered in: Arizona

This Policy will be construed in line with the law of the jurisdiction in which it is delivered.

This Policy takes effect at 12:00 A.M. standard time at the Policyholder's address on August 16, 2014. The Policy Year starts on August 16, 2014 and ends at 11:59 P.M. on August 15, 2015.

Based on timely premium payments by the Policyholder, Aetna agrees with the Policyholder, to pay benefits in line with the Policy terms.

The duties and the rights of all persons will be based solely on Policy terms. This Policy is non-participating.
Signed at Aetna's Home Office in Hartford, Connecticut on the date of issue.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Registrar
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1500, 1505
ELIGIBILITY

Student
The following groups of students are eligible for coverage:

- Undergraduate students if they are enrolled in a program of study and a) taking at least seven units, b) have a consortium agreement to take courses at a qualified college with an overall credit hour total of at least seven units.
- Seniors may enroll with less than seven units if they are in their last semester to achieve their final graduation requirements and had the insurance coverage in the prior semester.
- Graduate students if they are enrolled in a graduate degree or certificate program and taking at least three units or one dissertation/thesis unit.
- Graduate non-degree students must have applied to a degree program and be taking at least six transferable units, be in a certificate program, or be a full-time student taking at least nine units.
- Graduate assistants or associates who are officially hired, with a signed and filed notice of appointment, and taking at least six units of graduate credit.
- Post-Doctoral Fellows, J1 Visiting Scholars or J1 Student Interns.
- International students on non-immigrant visas, regardless of his or her fitting into one of the above classifications and regardless of the number of units being taken, are automatically enrolled in the Plan.

If a student is eligible to enroll for student coverage they may not enroll as a dependent.

Dependents
Lawful Spouse, same and opposite sex domestic partner and dependent children up to age 26 are eligible to enroll.

Subject to the terms of this Policy, benefits are available for you and your eligible dependents only for the coverages listed below; and only up to the maximum amounts shown. The coverage sections of this Policy contain a complete description of the benefits available.

No person may be covered as both a covered student and as a dependent; and no person may be covered as a dependent of more than one covered student.

SCHEDULE OF ACCIDENT AND SICKNESS BENEFITS

PLAN LEVEL LIMITS

FOR COVERED STUDENTS AND DEPENDENTS

<table>
<thead>
<tr>
<th>Overall Aggregate Maximum Benefit Limit per Accident and Sickness:</th>
<th>Unlimited</th>
<th>Unlimited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td></td>
<td></td>
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<tr>
<td>Dependents</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Overall Aggregate Deductible Amount per Accident and Sickness:</th>
<th>Preferred Care</th>
<th>Non Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$ 500</td>
<td>$ 1,000</td>
</tr>
<tr>
<td>Dependents</td>
<td>$ 500</td>
<td>$ 1,000</td>
</tr>
<tr>
<td>Family</td>
<td>$ 1,500</td>
<td>$ 3,000</td>
</tr>
</tbody>
</table>

Preferred Care Deductible is waived for: Routine Physical Exam Office Visits, Pap Smear Screening, Mammogram, Routine Screening for Sexually Transmitted Disease, Routine Colorectal Cancer Screening, Routine Prostate Cancer Screening, Well Woman Preventive Visits Office Visits, Screening & Counseling Services Office Visits, Outpatient Routine Cancer Screenings, Prenatal Care Office Visits, Comprehensive Lactation Support and Counseling Services Facility or Office Visits, Breast Pumps & Supplies, Family Contraceptive Counseling Services Office Visits, Inpatient and Outpatient Female Voluntary Sterilization, Laboratory Services, Newborn Screening, Immunizations, Hypodermic Needles, Prostate Cancer Screening, Colorectal Cancer Screening, Mammography and Pap Smear, Hospice, Diabetic Supplies, Outpatient Diabetic Self-Management, Chlamydia Screening and Sexually Transmitted Disease, Preferred Care Pediatric Preventive Dental and Vision Services.
Annual Deductible is waived for services illustrated with a copay (office visits, emergency room visits, urgent care visits, mental health/substance abuse office visits, etc.). Additional services provided during the course of an office visit, emergency room, urgent care will be subject to the annual deductible (i.e. surgical procedures etc.)

Certification Requirements
The covered person must obtain certification for certain types of expenses to avoid a reduction in benefits paid for that care. The Basic Sickness Expense Benefits section of the Policy contains details of the types of care affected, how to get certification and the effect on benefits for failure to obtain certification.

Out-of-Pocket Limits

<table>
<thead>
<tr>
<th></th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Out-of-Pocket</td>
<td>$ 2,500</td>
<td>$ 3,000</td>
</tr>
<tr>
<td>Family Out-of-Pocket</td>
<td>$ 5,000</td>
<td>$ 6,000</td>
</tr>
</tbody>
</table>

Once the Individual or Family Out-of-Pocket Limit has been satisfied; Covered Medical Expenses will be payable at 100%; for the remainder of the Policy Year; up to any benefit maximum; that may apply.

Benefits Payable
After any applicable deductible, the Health Expense Benefits payable under this Policy in a Policy Year are paid at the Covered Percentage which applies to the type of Covered Medical Expense which is incurred. Benefits may vary depending upon whether a Preferred Care Provider is utilized. A Preferred Care Provider is a health care provider who has agreed to provide services or supplies at a "negotiated charge."

If any expense is covered under one type of Covered Medical Expense, it cannot be covered under any other type.

Note: A referral from the University of Arizona Campus Health Service is not necessary under the following:

- Treatment is for an Emergency Medical Condition (all follow-up treatment must be obtained through Campus Health Services);
- Urgent Care Expenses;
- Maternity Care;
- Obstetric and Gynecological Treatment;
- Annual Eye Exam;
- Injury to Sound, Natural teeth;
- Preventive/Routine Services (services considered preventive according to Health Care Reform and/or services rendered not to diagnosis or treat an Accident or Sickness);
- Pediatric Care;
- Care for Covered Dependents; and
- Vasectomies.

### COVERAGE

#### BENEFIT AMOUNT

**PRE-ADMISSION TESTING EXPENSE**

Payable on the same basis as any other Sickness.

<table>
<thead>
<tr>
<th></th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HOSPITAL EXPENSE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered Percentage</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Room and Board</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive Care</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Room and Board</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Hospital Expense</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SURGICAL EXPENSE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered Percentage</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Anesthesia Expense</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Expense</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IN-HOSPITAL NON-SURGICAL PHYSICIAN’S FEES EXPENSE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered Percentage</td>
<td>80%</td>
<td>50%</td>
</tr>
</tbody>
</table>
### OUTPATIENT EXPENSE

**Therapy (Physical, Occupational and Speech)**
- **Covered Percentage**: 100%
- **Non-Preferred Care**: 50%
- **Copay per visit**: $35

**Therapy (Cardiac and/or Pulmonary Rehabilitation)**
- **Covered Percentage**: 100%
- **Non-Preferred Care**: 50%
- **Copay per visit**: $35

**Therapy (Chiropractic Care)**
- **Covered Percentage**: 100%
- **Non-Preferred Care**: 50%
- **Copay per visit**: $35

**Therapy (Chemotherapy and Radiation Therapy)**
- **Covered Percentage**: 80%
- **Non-Preferred Care**: 50%

**Outpatient Physician Office Visit (including specialists)**
- **Covered Percentage**: 100%
- **Non-Preferred Care**: 50%
- **Copay per visit**: $35

**Emergency Room Visit**
- **Covered Percentage**: 100%
- **Non-Preferred Care**: 100% of the Actual Charge
- **Copay/Deductible per visit (waived if admitted)**: $200

**Hospital Outpatient Department Visit**
- **Covered Percentage**: 100%
- **Non-Preferred Care**: 50%

**Walk-in Clinic Visit**
- **Covered Percentage**: 100%
- **Non-Preferred Care**: 50%
- **Copay per visit**: $35

**Ambulatory Surgical Expense**
- **Covered Percentage**: 80%
- **Non-Preferred Care**: 50%

**Laboratory and X-Ray Expense**
- **Covered Percentage**: 100%
- **Non-Preferred Care**: 50%

**Outpatient Physical Therapy**
- **Covered Percentage**: 100%
- **Non-Preferred Care**: 50%
- **Copay per visit**: $35

**Durable Medical and Surgical Equipment**
- **Covered Percentage**: 80%
- **Non-Preferred Care**: 50%

**CONSULTANT EXPENSE**
- **Covered Percentage**: 100%
- **Non-Preferred Care**: 50%
- **Copay per visit**: $35

**AMBULANCE EXPENSE**
- **Covered Percentage**: 100% of the Actual Charge
- **Non-Preferred Care**: 100% of the Actual Charge

**DENTAL INJURY EXPENSE**
- **Covered Percentage**: 80% of the Actual Charge
- **Non-Preferred Care**: 80% of the Actual Charge

**LICENSED NURSE EXPENSE**
- **Covered Percentage**: 80%
- **Non-Preferred Care**: 50%
<table>
<thead>
<tr>
<th>Service Description</th>
<th>Preferred Care Covered Percentage</th>
<th>Non-Preferred Care Covered Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Facility Expense</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Rehabilitation Facility Expense</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Prescribed Medicines Expense</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formulary/Generic</td>
<td>80% of negotiated rate</td>
<td>80% of negotiated rate</td>
</tr>
<tr>
<td></td>
<td>60% of negotiated rate</td>
<td>60% of negotiated rate</td>
</tr>
<tr>
<td>Formulary/Brand Name</td>
<td>80% of negotiated rate</td>
<td>80% of negotiated rate</td>
</tr>
<tr>
<td>Non-Formulary/Generic</td>
<td>60% of negotiated rate</td>
<td>60% of negotiated rate</td>
</tr>
<tr>
<td>Non-Formulary/Name Brand</td>
<td>80% of negotiated rate</td>
<td>80% of negotiated rate</td>
</tr>
<tr>
<td>Formulary/Specialty Drugs</td>
<td>60% of specialty rate*</td>
<td>60% of specialty rate*</td>
</tr>
<tr>
<td>* up to $150 Copay per Prescription</td>
<td>$ 500</td>
<td>$ 500</td>
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<tr>
<td>Second Surgical Opinion Expense</td>
<td>Payable on the same basis as any other Sickness.</td>
<td></td>
</tr>
<tr>
<td>Chlamydia Screening Test Expense</td>
<td>100%</td>
<td>50%</td>
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<tr>
<td>Routine Screening for sexually transmitted disease Expense</td>
<td>100%</td>
<td>50%</td>
</tr>
<tr>
<td>Maternity</td>
<td>Payable on the same basis as any other Sickness.</td>
<td></td>
</tr>
<tr>
<td>High Cost Procedures Benefit</td>
<td>100%</td>
<td>50%</td>
</tr>
<tr>
<td>Diagnostic Testing for Learning Disabilities</td>
<td>Payable on the same basis as any other Sickness.</td>
<td></td>
</tr>
<tr>
<td>Temporomandibular Joint Dysfunction</td>
<td>Payable on the same basis as any other Sickness.</td>
<td></td>
</tr>
<tr>
<td>Dermatological Expense</td>
<td>Payable on the same basis as any other Sickness.</td>
<td></td>
</tr>
<tr>
<td>Weight-Loss Treatment Expense</td>
<td>Payable on the same basis as any other Sickness.</td>
<td></td>
</tr>
<tr>
<td>Allergy Testing and Treatment</td>
<td>Payable on the same basis as any other Sickness.</td>
<td></td>
</tr>
<tr>
<td>Well Newborn Nursery Care</td>
<td>100%</td>
<td>50%</td>
</tr>
<tr>
<td>Service</td>
<td>Preferred Care</td>
<td>Non-Preferred Care</td>
</tr>
<tr>
<td>----------------------------------------------</td>
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</tr>
<tr>
<td><strong>WELL BABY CARE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered Percentage</td>
<td>100%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>FAMILY PLANNING</strong></td>
<td>Preferred Care</td>
<td>Non-Preferred Care</td>
</tr>
<tr>
<td>Covered Percentage</td>
<td>100%</td>
<td>50%</td>
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<tr>
<td><strong>PROSTATE FUNCTION</strong></td>
<td></td>
<td></td>
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<tr>
<td>Covered Percentage</td>
<td>75% of the Actual Charge</td>
<td>75% of the Actual Charge</td>
</tr>
<tr>
<td><strong>PROSTHETIC DEVICE</strong></td>
<td>Preferred Care</td>
<td>Non-Preferred Care</td>
</tr>
<tr>
<td>Covered Percentage</td>
<td>80%</td>
<td>50%</td>
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<tr>
<td><strong>DIABETIC TESTING SUPPLIES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payable on the same basis as any other Sickness.</td>
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<tr>
<td><strong>OUTPATIENT DIABETIC SELF-MANAGEMENT</strong></td>
<td></td>
<td></td>
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<tr>
<td>Payable on the same basis as any other Sickness.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TRANSGENDER TREATMENT EXPENSE</strong></td>
<td></td>
<td></td>
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<tr>
<td>Payable on the same basis as any other Sickness.</td>
<td></td>
<td></td>
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<tr>
<td><strong>NON-PRESCRIPTION ENTERAL FORMULA</strong></td>
<td>Preferred Care</td>
<td>Non-Preferred Care</td>
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<tr>
<td>Covered Percentage</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>EOSINOPHILIC GASTROINTESTINAL DISORDER</strong></td>
<td>Preferred Care</td>
<td>Non-Preferred Care</td>
</tr>
<tr>
<td>Covered Percentage</td>
<td>75% of the Actual Charge</td>
<td>75% of the Actual Charge</td>
</tr>
<tr>
<td><strong>ROUTINE PHYSICAL EXAMS</strong></td>
<td>Preferred Care</td>
<td>Non-Preferred Care</td>
</tr>
<tr>
<td>Covered Percentage</td>
<td>100%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>ROUTINE COLORECTAL CANCER SCREENING</strong></td>
<td>Preferred Care</td>
<td>Non-Preferred Care</td>
</tr>
<tr>
<td>Covered Percentage</td>
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<td>50%</td>
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<tr>
<td><strong>ROUTINE PROSTATE CANCER SCREENING</strong></td>
<td>Preferred Care</td>
<td>Non-Preferred Care</td>
</tr>
<tr>
<td>Covered Percentage</td>
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<td>50%</td>
</tr>
<tr>
<td><strong>OUTPATIENT CONTRACEPTIVE DRUGS AND DEVICES</strong></td>
<td>Preferred Care</td>
<td>Non-Preferred Care</td>
</tr>
<tr>
<td>AND OUTPATIENT CONTRACEPTIVE SERVICES</td>
<td>100%</td>
<td>50%</td>
</tr>
<tr>
<td>Covered Percentage</td>
<td></td>
<td></td>
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<tr>
<td><strong>VISION CARE EXAM</strong></td>
<td>Preferred Care</td>
<td>Non-Preferred Care</td>
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<tr>
<td>Covered Percentage</td>
<td>100%</td>
<td>50%</td>
</tr>
<tr>
<td>Copay per visit</td>
<td>$ 35</td>
<td></td>
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<tr>
<td>Maximum number of Vision Care Exams per Policy Year</td>
<td>1</td>
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<tr>
<td><strong>ACUPUNCTURE IN LIEU OF ANESTHESIA</strong></td>
<td>Preferred Care</td>
<td>Non-Preferred Care</td>
</tr>
<tr>
<td>Covered Percentage</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>TRANSFUSION OR DIALYSIS OF BLOOD</strong></td>
<td></td>
<td></td>
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<tr>
<td>Payable on the same basis as any other Sickness.</td>
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</tbody>
</table>

Note: Tubal ligation will be paid in-network at 100% under preventive care.
<table>
<thead>
<tr>
<th>Service</th>
<th>Covered Percentage</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMMUNIZATIONS</td>
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<tr>
<td>CHILD IMMUNIZATIONS</td>
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<tr>
<td>HOSPICE EXPENSE</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>URGENT CARE EXPENSE</td>
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<td></td>
</tr>
<tr>
<td>HOME HEALTH CARE EXPENSE</td>
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</tr>
<tr>
<td>MAMMOGRAM EXPENSE BENEFIT</td>
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<td></td>
<td></td>
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<tr>
<td>PAP SMEAR SCREENING EXPENSE</td>
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</tr>
<tr>
<td>TREATMENT OF MENTAL AND NERVOUS DISORDERS EXPENSE</td>
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</tr>
<tr>
<td>Inpatient Benefits</td>
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<tr>
<td>Outpatient Benefits</td>
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<td></td>
<td></td>
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<tr>
<td>ALCOHOLISM AND DRUG ADDICTION TREATMENT EXPENSE</td>
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<tr>
<td>Inpatient Benefits</td>
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<tr>
<td>Outpatient Benefits</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>HYPODERMIC NEEDLES EXPENSE</td>
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<tr>
<td>AUTISM SPECTRUM DISORDERS</td>
<td></td>
<td></td>
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<tr>
<td>TOBACCO CESSATION EXPENSE</td>
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</tbody>
</table>

1510, 1510-A, 1515, 1520, 1520.1, 1525, 1530, 1535, 1540, 1545, 1550, 1555, 1560

Payable on the same basis as any other Sickness.
STUDENT ACCIDENT AND SICKNESS INSURANCE

SECTION 2 - DEFINITIONS

The following words and phrases when used in this Policy shall have, unless the context clearly indicates otherwise, the meaning given to them below:

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

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

Complications of Pregnancy: This Policy provides that when one of the following complications occurs, and such diagnoses are distinct from but are caused or affected by pregnancy, benefits are payable for expenses incurred in connection with the complication on the same basis as for a disease:

• 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 preeclampsia; and (d) similar conditions not medically distinct from a difficult pregnancy.

Complications of Pregnancy also include:

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

Copay: This is a fee charged to a person for Covered Medical Expenses. Prescribed Medicines Expense; the copay is payable directly to the pharmacy for each: prescription; kit; or refill; at the time it is dispensed. In no event will the copay be greater than the pharmacy’s charge per: prescription; kit; or refill.

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

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

Covered dependent: a covered student’s dependent who is insured under this Policy.

Covered Medical Expense: those charges for any treatment, service, or supplies covered by this Policy which are:

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

Covered person: a covered student and any covered dependent while coverage under this Policy in effect.

Covered student: a student of the Policyholder who is insured under this Policy.

Deductible: the amount of the Covered Medical Expenses that are paid by each covered person during the policy year before benefits are paid.
Dental consultant: a dentist who has agreed to provide consulting services in connection with the Dental Expense Benefit.

Dental provider: This is any dentist; group; organization; dental facility; or other institution; or person.

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

Dependent: (a) the covered student’s spouse residing with the covered student; or (b) the person identified as a domestic partner in the “Declaration of Domestic Partnership” which is completed and signed by the covered student; and (c) the covered student’s child under the age of 26 years.

The term “child” includes a covered student’s step-child; adopted child; and a child for whom a petition for adoption is pending.

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

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

Designated Care Provider: A pharmacy; that is affiliated; and has an agreement with the School Health Services to furnish services and supplies to students at a negotiated charge.

Durable Medical and Surgical Equipment: no more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

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

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

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; and
- treatment of infertility.

Emergency Admission: one where the physician admits the person to the hospital or residential treatment facility right after the sudden and at that time; unexpected onset of a change in a person’s physical or mental condition which:

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

Emergency Medical Condition: 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.
Home Health Agency:

- an agency licensed as a home health agency by the state in which home health care services are provided; or
- 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 a R.N., L.P.N., or L.V.N.; 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 for continued health care and treatment in a covered person's home. It must 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 hospice 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 care and treatment of injured and sick people; and
- it provides room and board services and nursing services 24 hours a day; and
- it has established facilities for diagnosis and major surgery; and
- it is run as a hospital under the laws of the jurisdiction which it is located.

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

Hospital Confinement: a stay of 18 or more hours in a row as a resident bed patient in a hospital.

Injury: bodily injury caused by an accident. This includes related conditions and recurrent symptoms of such injury.

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

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

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

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

- Be care or treatment which is likely to produce a significant positive outcome as any alternative service or supply; both as to the sickness or injury involved and the person’s overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply; both as to the sickness or injury involved and the person’s overall health condition
- Be a diagnostic procedure which is indicated by the health status of the person. It must be as likely to result in information that could affect the course of treatment as any alternative service or supply; both as to the sickness or injury involved and the person's overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply; both as to the sickness or injury involved and the person's overall health condition; and

- As to diagnosis; care; and treatment; be no more costly (taking into account all health expenses incurred in connection with the treatment; service; or supply;) than any alternative service or supply to meet the above tests.

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

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

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

Those that do not require the technical skills of a medical; a mental health; or a dental professional; or

Those furnished mainly for: the personal comfort; or convenience; of the person; any person who cares for him or her; or any person who is part of his or her family; any healthcare provider; or healthcare facility; or

Those furnished solely because the person is an inpatient on any day on which the person's sickness or injury could safely and adequately be diagnosed or treated while not confined; or

Those furnished solely because of the setting if the service or supply could safely and adequately be furnished; in a physician's or a dentist's office; or other less costly setting.

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

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 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; or
• a Preferred Care Provider that is furnishing services or supplies without the referral of a School Health Services.
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; or the covered student and their covered dependents; before Covered Medical Expenses will be payable at 100%; for the remainder of the Policy Year. The Preferred Care and Non-Preferred Care Out-of-Pocket limits accrue separately.

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

- expenses that are not Covered Medical Expenses;
- penalties; 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; (b) any other practitioner that must by law be recognized as a doctor legally qualified to render treatment; and (c) to the extent required by law, a practitioner who performs a service for which coverage is provided when it is performed by a physician.

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 primary care physician; or
- A health care provider that is not a Preferred Care Provider for an emergency medical condition when travel to a Preferred Care Provider; prior to treatment; is not feasible; or
- A Non-Preferred Urgent Care Provider when travel to a Preferred Urgent Care Provider for treatment is not feasible; and if authorized by Aetna.

Preferred Care Provider: a health care provider that has contracted to furnish services or supplies for a negotiated charge; but only if the provider is; with Aetna's consent; included in the directory as a Preferred Care Provider for:

- The service or supply involved; and
- The class of covered persons of which you are a member.

Preferred Pharmacy: a pharmacy; including a mail order pharmacy; which is party to a contract with Aetna, an affiliate, or a third party vendor, 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, an affiliate, or a third party vendor.
Preferred Prescription Drug Expense: an expense incurred for a prescription drug that:

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

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

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

Prescription Drug is a drug, biological, or compounded prescription which, by State or Federal Law, may be dispensed only by prescription and which is required by Federal Law to be labeled “Caution: Federal Law prohibits dispensing without prescription.” This includes an injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.

Prescription Drugs: any of the following:
- A drug, biological, or compounded prescription which; by law; may be dispensed only by prescription.
- Injectable insulin; disposable needles and syringes; when prescribed and purchased at the same time as insulin; and disposable diabetic supplies.

Primary Care Physician: This is the Preferred Care Provider who is:
- selected by a person from the list of Primary Care Physicians in the directory;
- responsible for the person's on-going health care; and
- shown on Aetna's records as the person's Primary Care Physician. For purposes of this definition, a Primary Care Physician also includes the School Health Services.

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

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

- The provider's usual charge for furnishing it; and
- The charge Aetna determines to be appropriate; based on factors such as the cost of providing the same or a similar service or supply; and the manner in which charges for the service or supply are made; and
- The charge Aetna determines to be the recognized charge percentage made for that service or supply.

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

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

- Unusual; or
- Not often provided in the area; or
- Provided by only a small number of providers in the area.

Aetna may take into account factors, such as:

- The complexity;
- The degree of skill needed;
- The type of specialty of the provider;
- The range of services or supplies provided by a facility; and
- The recognized charge in other areas.
Residential treatment facility: a treatment center for children and adolescents which provides residential care and treatment for emotionally disturbed individuals; and is licensed by the Department of Children and Youth Services; and is accredited as a residential treatment center by the Council on Accreditation or the Joint Commission on Accreditation of Health Organizations.

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

Room and Board: charges made by an institution for board and room and other necessary services and supplies. They must be regularly made at a daily or weekly rate.

School Health Services: any organization; facility; or clinic operated;, maintained; or supported by the school or other entity under contract to the school which provides health care services to enrolled students.

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

Service Area: the geographic area; as determined by Aetna; in which the Preferred Care Providers are located.

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

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

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

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

Surgery Center: a free standing ambulatory surgical facility that:

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

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a defibrillator; and

traheotomy set; and

ea 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**:

• 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 Care Provider**:

This is:

• A freestanding medical facility which:

  Provides unscheduled medical services to treat an urgent condition if the covered person’s physician is not reasonably available.

  Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.

  Makes charges.

  Is licensed and certified as required by any state or federal law or regulation.
Keeps a medical record on each patient.

Provides an ongoing quality assurance program. This includes reviews by physicians other than those who own or direct the facility.

Is run by a staff of physicians. At least one such physician must be on call at all times.

Has a full-time administrator who is a licensed physician.

- A physician’s office; but only one that:
  - has contracted with Aetna to provide urgent care; and
  - is; with Aetna’s consent; included in the Provider Directory as a Preferred Urgent Care Provider.

It is not the emergency room or outpatient department of a hospital.

**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.

**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.
STUDENT ACCIDENT AND SICKNESS INSURANCE

SECTION 3 - ELIGIBILITY, EFFECTIVE DATE OF INDIVIDUAL COVERAGE

**Eligible Persons**

**Students:** All classes of students are eligible except students in any class which is not listed in the Schedule of Benefits. A student is eligible only for the coverage shown in the Schedule of Benefits which applies to his or her class.

**Dependents:** dependents of a **covered student**; who meet the definition of a dependent; under this Policy; and are listed under the Schedule of Benefits.

**Effective Date of Insurance**

The coverage of each person who applies for coverage hereunder on or before the Effective Date hereof shall take effect on the Effective Date of this Policy; Coverage for each person applying for coverage hereunder after the Effective Date shall take effect on the published coverage effective date for the term during an open enrollment period he or she fails to submit a waiver form by any published deadlines.

**Dependent** insurance of a **covered student** becomes effective on the date the **covered student** becomes effective; or the date of the dependent’s enrollment; whichever is later. Otherwise the insurance becomes effective on the date the **covered student** acquires a dependent.

A child born to a Covered Person shall be covered for Preventive Services, **Accident, Sickness**, and congenital defects from the moment of birth; for an initial period of thirty-one days. To continue the insurance beyond this initial 31 day period; the **covered student** must notify Aetna; or its agent; of the birth; and pay any additional premium required for the child’s insurance within the 31 day period.

Coverage is provided for a child legally placed for adoption with a **covered student** from the moment of placement; for an initial period of thirty-one days; provided the child lives in the household of the **covered student**; and is dependent upon the **covered student** for support. Notification of placement of such child and payment of any additional premium; if necessary; is required within 31 days from placement. To continue the insurance beyond this initial 31 day period; the **covered student** must notify Aetna or its agent of the placement of such child; and pay any additional premium required for the child’s insurance; within the 31 day period.

If this Policy provides coverage for maternity expenses, this Policy will also provide coverage for expenses incurred with the birth of any child legally adopted by the **covered student** provided that all of the following conditions have been met:

- The **covered student** requests that coverage be provided.
- The child is adopted within one year of birth.
- The **covered student** is legally obligated to pay the costs of the birth.
- All limitations, terms and conditions of the Policy have been met by the **covered student**.

Benefits will only be payable for expenses incurred in connection with the delivery of the child. They will be payable on the same basis as benefits would have been payable if the birth mother was a dependent. No benefits will be payable for expenses incurred after the birth mother is discharged from the facility where the child is born.

**Late Enrollment**

If an application and premium payment for insurance are made more than 30 days following the date the Eligible Person or dependent become eligible; then his or her insurance will become effective only if and when Aetna gives its written consent or, if such enrollment occurs during a late enrollment period established by the Plan Sponsor; or, if such enrollment occurs due to the loss of prior comparable coverage; for any reason.

An eligible dependent will not be considered a late enrollee if the **covered student** is required to provide coverage for his eligible dependent as a result of a court order; and written request for such coverage is made within 31 days of the court order. Such coverage will become effective on the date of the court order. If request for coverage is not made within 31 days of the court order; the dependent’s coverage will be subject to all of the terms of this Policy.

Once an eligible student makes a coverage selection under this Policy; he may not change his election after the enrollment period closes as defined by the policyholder.
The Policyholder agrees to submit to Aetna within 20 days after the effective date of each covered person’s insurance: (1) the name of each person who applied for coverage hereunder; (2) the effective date of insurance; and (3) the premium paid as to each such covered person. The insurance of those covered persons, whose names and premiums were received more than 20 days after the date the insurance would have become effective will take effect on the date such name and premium is received by Aetna or an agent of Aetna except as may otherwise be provided above.

Change In Amounts
Covered Student
Status Change – If at any time; the covered student’s status changes so as to warrant an amount of coverage other than that for which the covered student is then covered; the amount of his or her coverage will be changed as follows:

An increase will be effective on the date of the status change.

Schedule or Benefit Level Change - If, at any time; any schedule or the level of any benefit is changed so as to warrant an amount of coverage other than that for which the covered student is then covered; the amount of coverage will be changed to the new amount.

All Changes - A retroactive change in a covered student’s status will not result in a retroactive change in coverage. Any change in coverage will be effective on the date the change in status is made.

Covered Dependent
Status, Schedule, or Benefit Level Change - If for any reason and at any time; a dependent's status; any schedule; or the level of any benefit for a dependent is changed so as to warrant an amount of coverage for a dependent other than that then in force; the amount of a dependent's coverage will be changed to the new amount.
TERMINATION OF STUDENT COVERAGE

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

(a) the date this Policy terminates;

(b) the last day for which any required premium has been paid;

(c) 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;

If withdrawal from classes is before the end of the open enrollment or is for entering the armed forces a full refund will be made. If withdrawal is after the last day of the open enrollment no premium refund will be made and students will be covered for the Policy term for which they are enrolled.

However, if covered student withdraw from classes for a second consecutive semester, coverage for you and your covered dependents will terminate on the date of the second withdrawal and a pro-rated premium refund will be made.

TERMINATION OF DEPENDENT COVERAGE

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

(a) For a child, on the first premium due date following the first to occur of the child’s 26th birthday

(b) The date the covered student fails to pay any required premium.

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

INCAPACITATED DEPENDENT CHILDREN

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

Due proof of the child's incapacity and dependency must be furnished to Aetna by the covered student within 31 days after the date insurance would otherwise cease. Aetna will have the right to require proof of the continuation of the handicap. Aetna also has the right to examine the child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date the child reached the maximum age. The premium due for the child's insurance will be the same as for a child who is not so incapacitated.

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

(a) the date specified under the provision entitled Termination of Dependent Coverage; or

(b) the date the child is no longer incapacitated and dependent on the covered student for support; or

(c) the date the policy terminates.

EXTENSION OF BENEFITS

If a covered person is confined to a hospital or under treatment for a covered condition on the date his or her Basic Sickness; Supplemental Sickness Expense, or Major Medical Expense coverage terminates; charges incurred during the continuation of that hospital confinement or for that treatment of the covered condition shall also be included in the term “Expense”; but only while they are incurred during the 90 day period following such termination of insurance.
If Major Medical Expense Benefits for a **covered person** ends while he or she 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 twelve months from the date coverage ends.

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ENTIRE CONTRACT CHANGES. The entire contract is made up of: (i) this Policy; including the Policyholder’s application; and (ii) the individual applications; if any; of covered persons. Statements made by the Policyholder; or a covered person; shall be deemed to be representations and not warranties. No such statement may be used in any contest of this insurance; unless the statements: (1) are contained in writing and signed by the applicant; and (2) a copy has been given to such person; or to his or her beneficiary. Further; no statement by a covered person; except a fraudulent statement; will be used in defense to a claim for loss incurred after the coverage under which claim is made has been in effect for 2 years. This Policy may be changed at any time by written agreement between Aetna and the Policyholder. The consent of any student or other person is not needed. All agreements made by Aetna are signed by one of its executive officers. No other person can change or waive any of the Policy terms or make any agreement binding Aetna. The Policyholder will not have to give written approval of a change in the Policy if: (1) The Policyholder has asked for the change and Aetna has agreed to it; or (2) the change is needed so that the Policy will conform to any law; regulation; or ruling of a jurisdiction; that affects a person covered under this Policy or the federal government.

BROCHURES. Aetna will issue to the Policyholder individual brochures. These should be delivered to each covered student. The main points of the insurance in force will be set forth. Statements as to whom benefits are payable will appear.

PREMIUMS. Aetna sets the premiums that apply to the coverage provided under this Policy. Those premiums are shown in a notice given to the Policyholder with or prior to delivery of this Policy. Aetna has the right to adjust the premium rate on each anniversary date of this Policy; or when the terms of this Policy are changed. The Policyholder will be given notice of such premium adjustment at least 60 days before the date it is to take effect unless the change in Policy terms is to take effect before the 60 days.

PREMIUMS DUE - EXPERIENCE RATING. The premium due under this Policy on any premium due date will be the sum of the premium charges for the coverages then provided under this Policy.

If premiums are payable monthly; any insurance becoming effective will be charged for from the first day of the Policy month on or right after the date the insurance takes effect. Premium charges for insurance which terminates will cease as of the first day of the Policy month on or right after the date the insurance terminates. If premiums are payable less often than monthly; premium charges or credits for a fraction of a premium-paying period will be made on a pro rata basis; for the number of Policy months between the date premium charges start or cease; and the end of the premium-paying period. If this Policy is changed to provide more coverage to take effect on a date other than the first day of a premium-paying period; a pro rata premium for the coverage will be due and payable on that date. It will cover the period then starting and ending right before the start of the next premium-paying period.

Aetna may change premium charges due to experience or a change in factors bearing on the risk assumed. Each change shall be made by written notice to the Policyholder by Aetna; or its agent.

No experience reduction or increase in premium rates shall become effective less than 12 months after the effective date of the policy. As used here; “policy” shall be deemed to include any policy previously issued by Aetna that has been replaced in whole or in part by this Policy.

The premium charges for any coverage under this Policy may be refigured as of any premium due date, only:

By reason of a change in factors bearing on the risk assumed. This must be requested by Aetna.

Once during any continuous 12 month period. The Policyholder must request this. Advance notice of 60 days must be given to Aetna.

They will be refigured using:

• the ages of the covered students;
• the amounts of insurance in force;
• the premium rates; and
• any other pertinent factors.
All facts will be taken as of the date of the refiguring.

At the end of a Policy Year; Aetna may declare an experience credit. The amount of each credit Aetna declares will be returned to the Policyholder. Upon request by the Policyholder; part or all of it will be applied against the payment of premiums or in any other manner as may be agreed to by the Policyholder and Aetna.

If the sum of student contributions which have been made for group insurance exceeds the sum of premiums which have been paid for group insurance (after giving effect to any experience credits), the excess will be applied by the Policyholder for the sole benefit of students. Aetna will not have to see to the use of such excess.

Instead of figuring premiums as described above; premiums may be figured in any way approved by Aetna that comes up with about the same amount of premiums.

Aetna will not have to refund any premium for a period prior to:

The first day of the Policy Year in which Aetna receives proof that the refund should be made; or

The date 3 months before Aetna receives proof, if this produces a larger refund.

This applies even if the premium was paid in error.

**PAYMENT OF PREMIUMS.** The Policyholder will pay premiums in advance. They may be paid at Aetna's Home Office; or to its authorized agent. A premium is due to be paid on the first day of each Policy month; or a mutually agreed upon alternate. The Policyholder may change the number of premium payments as of a premium due date. This needs Aetna's written consent.

**RENEWAL OF POLICY.** With Aetna’s consent; this Policy may be renewed for like periods by payment of the renewal premium at the premium rate in effect at that time. This renewal premium must be paid within the grace period. Aetna also has the right to refuse to renew this Policy.

**GRACE PERIOD.** The premium due date will be negotiated by Aetna and the Policyholder. The grace period of 31 days will be granted for the payment of each premium falling due after the first premium. During that period; this Policy shall continue in force. The Policyholder shall be liable to Aetna for the payment of the premium for the period this Policy continues in force.

**NOTICE OF CLAIM.** Written notice of claim must be given to Aetna within 30 days after the occurrence or commencement of any loss covered by this Policy; or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant or the beneficiary to Aetna at its Home Office in Hartford, Connecticut or to its authorized agent; with information sufficient to identify the covered person; shall be deemed notice to Aetna.

**CLAIM FORMS.** Upon receipt of a written notice of claim; Aetna or its authorized agent will give the claimant such forms as are usually given for filing proofs of loss. If such forms are not given within 15 days after the receipt of such notice; the claimant can fulfill the terms of this Policy as to proof of loss by giving written proof of: (i) the occurrence of the loss; and (ii) the nature of the loss; and (iii) the extent of the loss.

**REINSTATEMENT.** If any renewal premium is not paid within the time granted the Policyholder for payment; a subsequent acceptance of premium by Aetna or by any agent duly authorized by Aetna to accept such premium; without requiring in connection therewith an application for reinstatement; shall reinstate the Policy. Provided; however; that if Aetna or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered; the Policy will be reinstated upon approval of such application by Aetna or; lacking such approval; upon the forty-fifth day following the date of such conditional receipt unless Aetna has previously notified the Policyholder in writing of its disapproval of such application. The reinstated Policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects; the Policyholder and Aetna shall have the same rights thereunder as they had under the Policy immediately before the due date of the defaulted premium; subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with the reinstatement shall be applied to a period for which premium has not been previously paid; but not to any period for more than 60 days prior to the date of reinstatement.

**PROOFS OF LOSS.** Written proof of loss must be given to Aetna at Aetna's Home Office within 90 days after the date of such loss. Failure to give such proof within the time required shall not invalidate nor reduce any claim if it was not
reasonably possible to give proof within such time. However, proof must be given as soon as reasonably possible and in no event, except in the absence of legal capacity; later than 1 year after the deadline. Otherwise; late claims will not be covered.

**TIME OF PAYMENT OF CLAIMS.** Benefits payable under this Policy will be paid as they accrue and as soon as due written proof of such loss has been received by Aetna or its authorized agent.

**PAYMENT OF CLAIMS.** All benefits will be paid to the covered student. All or a portion of the benefits; if any; provided by this Policy may be paid directly to the hospital or person upon whose charges the claim is based or to the person who made payment on behalf of the covered student. The covered person must make a written request to Aetna before Aetna can do this. Aetna must receive the request no later than the time for filing proof of loss. If the covered student dies; Aetna will pay any accrued benefits at the time of death to the beneficiary or; if no beneficiary is designated and surviving the covered student, then as follows:

a) the covered student’s parents or legal guardian; if a minor;

b) otherwise to the covered student’s estate.

**RECOVERY OF OVERPAYMENT.** If a benefit payment is made by Aetna; to or on behalf of any covered person; which exceeds the benefit amount such covered person is entitled to receive in accordance with the terms of the contract; Aetna has the right:

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

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

**PHYSICAL EXAMINATION.** At Aetna's expense ;Aetna has the right to have a physician examine a covered person when and so often as Aetna deems reasonably necessary; while there is a claim pending under this Policy.

**LEGAL ACTIONS.** No one may sue Aetna for payment of claim: (i) less than 60 days after due proof of claim is furnished; or (ii) more than 3 years after the date proof of claim is required by this Policy.

**RECORDS MAINTAINED.** The Policyholder shall maintain records of each person covered. The records shall show all data that is needed to administer this Policy.

**EXAMINATION AND AUDIT.** Aetna shall be allowed to examine and audit the Policyholder's books and records which pertain to this Policy at reasonable times. Aetna must also be allowed to do this within 3 years after the later of: (i) the date this Policy terminates; or (ii) until final settlement of all claims hereunder.

**POLICYHOLDER ERROR.** Clerical errors will not affect coverage in any way.

**NOT IN LIEU OF WORKERS COMPENSATION.** This Policy is not a Worker's Compensation Policy. It does not provide Worker's Compensation benefits.

**DISCONTINUANCE OF POLICY.** The Policyholder may terminate this Policy as to any or all coverage of all or any class of students. Aetna must be given written notice. The notice must state when such termination shall occur. It must be a date after the notice. It shall not be effective during a period for which a premium has been paid to Aetna as to the coverage.

Aetna has the right to terminate this Policy as to all or any class of students of a Policyholder at any time after the end of the grace period if the premium for student coverage has not been paid. Written notice of the termination date must be given by Aetna. This right is subject to the terms of any laws or regulations.

Aetna may also terminate this Policy in its entirety or as to any or all coverage of all or any class of students by giving the Policyholder advance written notice of when it will terminate. The date shall not be earlier than 31 days after the date of the notice unless it is agreed to by the Policyholder and Aetna.
If:

This Policy terminates as to any of the students of a Policyholder; and

Premiums have not been paid for the period this Policy was in force for those students;

Then the Policyholder shall be liable to Aetna for the unpaid premiums.

DISCOUNT ARRANGEMENTS

From time to time, Aetna may offer, provide, or arrange for discount arrangements or special rates from certain service providers such as pharmacies, optometrists, dentists, alternative medicine, wellness and healthy living providers to the Covered Person. Some of these arrangements may be made available through third parties who may make payments to Aetna in exchange for making these services available.

The third party service providers are independent contractors and are solely responsible to the Covered Person for the provision of any such goods and/or services. Aetna reserves the right to modify or discontinue such arrangements at any time. These discount arrangements are not insurance. There are no benefits payable to the Covered Person nor does Aetna compensate providers for services they may render.

INCENTIVES

In order to encourage the Covered Person to access certain medical services when deemed appropriate by the Covered Person in consultation with his or her physician or other service provider, Aetna may, from time to time, offer to waive or reduce a Covered Person’s copayment, coinsurance, and/or a deductible otherwise required under the Plan or offer coupons or other financial incentives.

Aetna has the right to determine the amount and duration of any waiver, reduction, coupon, or financial incentive and to limit the Covered Person to whom these arrangements are available.

2060, 2065, 2070, 2075, 2080, 2092, 2093
STUDENT ACCIDENT AND SICKNESS INSURANCE

SECTION 6 - COVERAGE

MEDICAL EXPENSE BENEFITS

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

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

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

The Schedule of Benefits shows the deductible; covered percentages; and maximum benefits that apply to Covered Medical Expenses described in this Section.

BASIC ACCIDENT EXPENSE BENEFITS

Accident Expense Benefits are payable for Covered Medical Expenses incurred by each covered person. Such expense must be incurred as a result of accidental injury.

Covered Medical Expenses include expenses for: hospital; surgical; or medical treatment; services or supplies incurred by a covered person by reason of injury. The benefits will be provided to the same extent that benefits are provided under this Policy for expenses incurred on account of sickness. An expense is incurred: on the date the service is performed; or the supply is purchased.

Covered Medical Expense incurred for services and supplies:

(a) must be medically necessary;
(b) must be prescribed or ordered by the attending physician; and
(c) will not include amounts in excess of the reasonable and customary charge.

All Accident Expense Benefits are subject to all of the terms of this Policy.

BASIC SICKNESS EXPENSE BENEFITS

Covered Medical Expenses include the Basic Sickness Expense Benefit Provisions which follow, when expenses are incurred by a covered person by reason of sickness.

Covered Medical Expense incurred for services and supplies:

(a) must be medically necessary;
(b) must be prescribed or ordered by the attending physician; and
(c) will not include amounts in excess of the reasonable and customary charge.

All Sickness Expense Benefits are subject to all of the terms of this Policy.

The Aggregate Maximum Benefit Limit and Copay/Deductible are shown in the Schedule of Benefits.
HOSPITAL EXPENSE

Hospital Room and Board Expense

Covered Medical Expenses include Hospital Room and Board Expense incurred by a covered person for the period of confinement as an inpatient; including: expense for an intensive care unit; and for a birthing center for treatment in connection with pregnancy. However, the covered room and board expense does not include any charge in excess of the Daily Room and Board Maximum.

Benefits are payable for pregnancy-related and maternity expenses of covered females and dependents on the same basis as for a disease. In the event of an inpatient confinement, such benefits will be payable for inpatient care of the covered person and any newborn child for a minimum of 48 hours following a vaginal delivery and a minimum of 96 hours following a cesarean delivery.

If this Policy provides coverage for maternity expenses, this Policy will also provide coverage for expenses incurred with the birth of any child legally adopted by the covered student provided that all of the following conditions have been met:

• The covered student requests that coverage be provided.
• The child is adopted within one year of birth.
• The covered student is legally obligated to pay the costs of the birth.
• All terms and conditions of the Policy have been met by the covered student.

Benefits will only be payable for expenses incurred in connection with the delivery of the child. They will be payable on the same basis as benefits would have been payable if the birth mother was a dependent. No benefits will be payable for expenses incurred after the birth mother is discharged from the facility where the child is born.

Miscellaneous Hospital Expense

“Miscellaneous Hospital Expense” includes; among others; expenses incurred during a hospital confinement for:

- Anesthesia and operating room;
- Laboratory tests and X-rays;
- Oxygen tent; and
- Drugs; medicines; dressings.

The Covered Percentage Daily Room and Board: Daily Room and Board Maximum; Daily Room and Board Intensive Care; Room and Board Intensive Care Benefit Maximum per Policy Year; Maximum Number of Days of Confinement; Copay/Deductible per covered person, per Injury or Sickness; Copay/Deductible Amount per covered person per Policy Year; and the Miscellaneous Hospital Expense Maximum per condition are shown on the Schedule of Benefits.

Inpatient benefits for Hospital Room and Board require pre-certification.

SURGICAL EXPENSE

Covered Medical Expenses include charges incurred by a covered person for surgery provided by a hospital on an inpatient or outpatient basis.

The Covered Percentage; Copay/Deductible per covered person; Surgical Maximum per Operation; and Surgical Maximum per Condition are shown on the Schedule of Benefits.

When surgery is performed in the outpatient department of a hospital, Covered Medical Expenses include hospital services provided within 24 hours of the covered surgical procedure.

Anesthetic Expense

If, in connection with such operation, the covered person requires the services of an anesthetist who is not employed or retained by the hospital in which the operation is performed, the expenses incurred will be Covered Medical Expenses. The maximum benefit for Anesthetic Expense is shown on the Schedule of Benefits.

Assistant Surgeon Expense

If, in connection with such operation, the covered person requires the services of an Assistant Surgeon, the expenses incurred will be Covered Medical Expenses. The maximum benefit for Assistant Surgeon Expense is shown on the Schedule of Benefits.
IN-HOSPITAL NON-SURGICAL PHYSICIAN’S FEES EXPENSE

Covered Medical Expenses include charges incurred by a covered person who is confined as an inpatient in a hospital for a surgical procedure for the services of a physician who is not the physician who may have performed surgery on the covered person.

The Covered Percentage; Maximum Benefit per Visit; Maximum Benefit per Day; Maximum Number of Days; Maximum Number of Visits per day; Maximum Number of Visits per Policy Year; Copay/Deductible per Injury or Sickness; Copay/Deductible per visit; and the Benefit Maximum per condition, per Policy Year are shown on the Schedule of Benefits.

OUTPATIENT EXPENSE

Covered Medical Expenses include charges incurred by a covered person for the use of: diagnostic X-ray; laboratory services; Consultant or Specialist Expense; durable medical and surgical equipment; or an emergency or operating room. These include expenses incurred for: an ambulatory surgical center; hospital outpatient department; outpatient physician’s office visit; and walk-in clinic visit.

The Maximum Benefit per Policy Year; Maximum Benefit per Visit; Maximum Number of Visits per Injury or Sickness; and Copay/Deductible per Injury or Sickness; Copay/Deductible per Visit; and Copay/Deductible per Policy Year are shown on the Schedule of Benefits.

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 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;
• Dialysis; and
• Respiratory therapy.

Benefits for these types of therapies are payable for Covered Medical Expenses on the same basis as any other sickness.

The Covered Percentage; Copay/Deductible per visit; Maximum Number of Visits per Policy Year; Visit Maximum; and the Maximum Benefit per Policy Year are shown on the Schedule of Benefits.

Outpatient Physician Office Visit Expense (including specialists)

Subject to the Exception below:

If a covered person requires the services of a physician in the physician’s office while not confined as an inpatient in a hospital; Covered Medical Expenses include the charges made by the physician. Not more than the Visit Maximum will be paid for any visit; and not more than the Maximum Number of Visits will be covered per condition or per Policy Year.
The Covered Percentage; **Copay/Deductible** per visit; Number of Visits to which the **Copay/Deductible** applies; Maximum Number of Visits per Condition; Maximum Number of Visits per **Policy Year**; Maximum Benefit per Visit; and the Maximum Benefit per Condition are shown on the Schedule of Benefits.

**Exception:** If the services are in connection with surgery and the physician is the surgeon who performed the surgery; no benefits are payable under this provision.

**Emergency Room Visit Expense**
Benefits are payable for **Covered Medical Expenses** incurred by a **covered person** for:
Services received in the emergency room of a hospital while the **covered person** is not a full-time inpatient of the hospital. The treatment received must be for emergency care for an **emergency medical condition**. There is no coverage for elective treatment; routine care; or care for a non-emergency illness.

The Covered Percentage; **Copay/Deductible** per visit; and Maximum Benefit per condition are shown on the Schedule of Benefits.

**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.

The Covered Percentage; **Copay/Deductible** per visit; and Maximum Benefit per condition are shown on the Schedule of Benefits.

**Walk-In Clinic Visit Expense**
**Covered Medical Expenses** for services rendered in a Walk-in Clinic expenses are payable as outline in the Schedule of Benefits.

Not more than the applicable Maximum Amount will be paid for all outpatient expenses in a **Policy Year**.

**Ambulatory Surgical Expense**
Benefits are payable for **Covered Medical Expenses** incurred by a **covered person** for expense incurred for outpatient surgery performed in an **ambulatory surgical center**. **Covered Medical Expenses** must be incurred on the day of the surgery or within 48 hours after the surgery.

The Maximum Benefit per **Policy Year**; Covered Percentage; and **Copay/Deductible** per visit are shown on the Schedule of Benefits.

**Laboratory and X-Ray Expense**
Benefits are payable for **Covered Medical Expenses** incurred by a **covered person** for: diagnostic X-rays and laboratory services; and incurred on an outpatient basis.

The Covered Percentage; **Copay/Deductible** per visit; Maximum Number of Visits per Condition; Maximum Number of Visits per **Policy Year**; and the Maximum Benefit per condition are shown on the Schedule of Benefits.

**Outpatient Physical Therapy Expense**
Benefits are payable for **Covered Medical Expenses** incurred by a **covered person** for physical therapy when provided by a licensed physical therapist.

The Covered Percentage; **Copay/Deductible** per visit; Maximum number of Visits per **Policy Year**; Visit Maximum and Maximum Benefit per **Policy Year** are shown on the Schedule of Benefits.

**Durable Medical And Surgical Equipment Expense**
Benefits are payable for **Covered Medical Expenses** incurred by a **covered person** as a result of renting **durable medical and surgical equipment**. In lieu of rental; the following may be covered:

- The initial purchase of such equipment if Aetna is shown that: long term care is planned; and that such equipment either cannot be rented or is likely to cost less to purchase than to rent;
- Repair of purchased equipment;
• Replacement of purchased equipment if Aetna is shown that it is needed due to a change in the person’s physical condition; or it is likely to cost less to purchase a replacement than to repair existing equipment or to rent like equipment; or;
• The purchase of orthopedic appliances and braces or non-dental prosthetic devices to replace natural body parts.

**Durable medical and surgical equipment** would include:

- artificial arms and legs; including accessories;
- leg braces; including attached shoes (but not corrective shoes)
- arm braces;
- back braces;
- neck braces;
- surgical supports; and

scalp hair prostheses required as the result of hair loss due to injury; disease; or treatment of disease; and

head halters.

Coverage for such items includes the fitting; adjustment; and repair of such devices. All equipment and supplies must be prescribed by a physician.

The Covered Percentage; Maximum Benefit per Policy Year; and the Copay/Deductible per Injury or Sickness are shown on the Schedule of Benefits.

**AMBULANCE EXPENSE**

When a covered person requires the use of a professional ambulance in an emergency; this Policy will pay for the charges incurred. Covered Medical Expenses for the service are limited to charges for ground transportation to the nearest hospital equipped to render treatment for the condition. Air transportation is covered only when medically necessary. Subject to the Ambulance Copay/Deductible; not more than the applicable Maximum Amount per sickness will be paid.

The Covered Percentage, Copay/Deductible per trip; Maximum Benefit per trip; Maximum Benefit per Injury or Sickness; and Maximum Benefit per Policy Year are shown in the Schedule of Benefits.

Benefits for expenses for non-emergent transportation by ambulance or medical van; and all transfers via air ambulance require pre-certification.

**PRESCRIBED MEDICINES EXPENSE**

If a covered person requires medicines; and if a prescription drug is dispensed by a pharmacy to a person for treatment of a sickness or injury; a benefit will be paid; determined from the Benefit Amount subsection; but only if the pharmacy’s charge for the drug is more than the copay or deductible amount per prescription or refill.

The benefit amount for each covered prescription drug or refill prescribed by a Preferred Care Provider or School Health Services Physician and dispensed by a preferred pharmacy will be an amount equal to the Covered Percentage of the total charges less any applicable copays. The total charge is determined by:

- the preferred pharmacy; and
- Aetna, an affiliate, or a third party vendor.

Any amount so determined will be paid to the preferred pharmacy on the covered person’s behalf.

In figuring the benefit amount; a Separate Brand Name Fee applies to brand name drugs in addition to any applicable copay or deductible. The amount of the Separate Brand Name Fee will be equal to the difference between the cost of the brand name drug and the generic equivalent. The Separate Brand Name Fee will apply to any brand name drug dispensed unless:

- there is no generic equivalent to the brand name drug;
- the pharmacy is unable to supply the generic drug at the time the prescription is presented; or
- the prescriber indicates that the generic drug should not be dispensed.
Limitations
No benefits are paid under this section:

• For a device of any type unless specifically included as a prescription drug.
• For any drug entirely consumed at the time and place it is prescribed.
• For more than a 30 day supply per prescription or refill.
• For the administration or injection of any drug.
• For any injectable drug.
• For any refill of a drug if it is more than the number of refills specified by the prescriber. Before recognizing charges; Aetna may require a new prescription or evidence as to need:
  if the prescriber has not specified the number of refills; or
  if the frequency or number of prescriptions or refills appears excessive under accepted medical practice standards.
• For any refill of a drug dispensed more than one year after the latest prescription for it or as permitted by the law of the jurisdiction in which the drug is dispensed.
• For any drug provided on an inpatient or outpatient basis to the extent benefits are paid for it under any other part of this policy or under any other medical or prescription drug expense benefit plan carried or sponsored by the Policyholder.
• For immunization agents and vaccines.
• For biological sera and blood products.
• For vitamins.
• For nutritional supplements.
• For any fertility drugs.
• For appetite suppressants.
• For any drug that is available from the School Health Services.
• Inhalers.

Certification For Certain Prescription Drugs
Certification of more than a 30 day supply of a prescription or refill; and of the medical necessity of certain prescription drugs is required before the drug is dispensed by a pharmacy.

Expenses incurred will be payable as follows:

• If certification has been requested and the drug is medically necessary; benefits will be payable at the applicable Covered Percentage.
• If certification has not been requested and the drug is medically necessary; no benefits will be payable.
• If the drug is not medically necessary; no benefits will be payable whether or not certification has been requested.

Certification Procedures
It is the covered person’s responsibility to arrange for the prescriber of the drug to call to request certification. This call must be made as soon as reasonably possible before the drug is to be dispensed. Copies of laboratory and/or medical records may be requested. If such information is requested; it must be provided in order to certify the medical necessity of the drug.

Written notice of the certification decision will be sent promptly to the covered person. This notice will show:

• the approved period of certification; during which time any authorized refills of the drug may be dispensed; or
• when certification is denied; the procedure to follow to appeal the decision.

If the drug is to be dispensed after the certification period ends; certification must again be requested; as described above.

List of Prescription Drugs
The following prescription drugs require certification before the drug is dispensed:

• CNS Stimulants (except Ritalin and Cylert)
• Erythroid Stimulants including Epoetin.
• Myeloid Stimulants including Filgrastim
• Imitrex
• Interferon alfa.
• Interferon beta.
• Leuprolide.
• Retin-A
• Quantities larger than 30 days.

This benefit is provided to cover prescription expenses associated with sickness or injury occurring during the Policy Year. If, by reason of similar benefit provisions elsewhere contained; this Policy provides for reimbursement for the same charges; no benefits shall be payable under those provisions. These benefits are in place of all other benefits of this Policy. Not more than Maximum Annual Benefit will be paid during any one Policy Year.

Certification For Certain Prescription Drugs
Under the Precertification Program:

• Certification of more than a 30 day supply of a prescription or refill; and certification of the medical necessity of certain prescription drugs; is required prior to the time the drug is dispensed; in order for the charge made by the pharmacy to be considered a Covered Medical Expense.
• Certification is required prior to the time the following drugs are dispensed:
  - Growth hormones;
  - Drugs which are used for the treatment of malaria.

• Refer to the Precertification List on the Medication Formulary Guide to determine which prescription drugs require certification. The Precertification List is subject to periodic review and modification by Aetna.

When one of the prescription drugs requiring certification is dispensed; expenses incurred will be payable as follows:
If certification has been requested and the drug is medically necessary:

Benefits will be paid at the applicable Covered Percentage.

If certification has not been requested; and the drug is medically necessary:

No benefits will be payable.

If the drug is not medically necessary:

No benefits will be payable whether or not certification has been requested.

Under a different form of precertification called the StepTherapy Program:

• The use of one or more prerequisite therapy drugs is required; prior to the time a Step Therapy drug is dispensed; in order for a Step Therapy drug to be considered a Covered Medical Expense.
• No benefits will be payable for a Step Therapy drug; unless the corresponding prerequisite therapy drug(s) are used first. However; if it is medically necessary for the covered person to be initially treated with a Step Therapy drug; the prescriber of the drug may request a medical exception by following the Certification Procedures section below.
• Refer to the Step Therapy List on the Medication Formulary Guide to determine which prescription drugs require the use of prerequisite therapy drugs. The Step Therapy List is subject to periodic review; and modification by Aetna.

Certification Procedures
It is the covered person’s responsibility to arrange for the prescriber of the drug to call to request certification. This call must be made as soon as reasonably possible; before the drug is to be dispensed. Copies of laboratory and medical records may be requested. If such information is requested; it must be provided in order to certify the medical necessity of the drug.

Written notice of the certification decision will be sent to the covered person. This notice will show:

• the approved period of certification; during which time any authorized refills of the drug may be dispensed; or
• when certification is denied; the specific reasons for denial; and the procedure to follow to appeal the decision.

If the drug is to be dispensed after the certification period ends; certification must again be requested; as described above.
MAMMOGRAM EXPENSE BENEFIT

Benefits are payable for charges for mammograms. The charges must be incurred while a covered person is insured for these benefits.

Benefits will be paid for Expenses incurred for the following:

1. A baseline mammogram for women between the ages of 35 to 40; and
2. A mammogram every two years; or more frequently based on the recommendation of the woman's physician for women ages 40 to 50;
3. A mammogram on an annual basis for women 50 years of age and older.

The Covered Percentage; Copay/Deductible per screening; and the Maximum Benefit per Policy Year are shown on the Schedule of Benefits.

If, by reason of similar benefits provisions elsewhere contained, this Policy provides for reimbursement for the same charges, no benefits shall be payable under those provisions. These benefits are in place of all other benefits of this Policy.

MASTECTOMY DEVICES EXPENSE BENEFITS

Covered Medical Expenses include expenses incurred by a covered person for the following devices which are required due to a mastectomy performed on a person: an internal breast prosthesis; the first external breast prosthesis; the first replacement of a breast prosthesis, if replacement is not available under the manufacturer’s warranty; and the first bra designed for use with a prosthesis.

PAP SMEAR SCREENING EXPENSE

Covered Medical Expenses include charges incurred by a covered person for an annual Pap smear screening; for women 18 years of age and older.

The Covered Percentage; Copay/Deductible per screening; and the Maximum Benefit per Policy Year are shown on the Schedule of Benefits.

If, by reason of similar benefits provisions elsewhere contained, this Policy provides for reimbursement for the same charges, no benefits shall be payable under those provisions. These benefits are in place of all other benefits of this Policy.

DIABETIC TESTING AND SUPPLIES EXPENSE

Covered Medical Expenses include expenses incurred by a covered person for the following medically necessary outpatient diabetic treatment equipment and supplies including:

- blood glucose monitors;
- blood glucose monitors for the legally blind;
- test strips for glucose monitors and visual reading and urine testing strips;
- insulin preparations and glucagon;
- insulin cartridges;
- drawing up devices and monitors for the visually impaired;
- injection aids;
- insulin cartridges for the legally blind;
- syringes and lancets including automatic lancing devices;
- orthopedic shoes, foot orthotics or other devices to support the feet provided that they are medically necessary to prevent complications of diabetes.

HYPODERMIC NEEDLES EXPENSE

Covered Medical Expenses include expenses incurred by a covered person for hypodermic needles used in the treatment of diabetes.
The Covered Percentage; Maximum Benefit per Policy Year; and the Copay/Deductible per accident or sickness are shown on the Schedule of Benefits.

OUTPATIENT DIABETIC SELF-MANAGEMENT EDUCATION PROGRAM EXPENSE

Covered Medical Expenses include charges incurred by a covered student for outpatient diabetic self-management education programs.

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

Charges incurred for the following are not Covered Medical Expenses:

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

The Covered Percentage; Copay/Deductible per visit; and the Maximum Benefit per Policy Year are shown on the Schedule of Benefits.

MATERNITY EXPENSE BENEFITS

Covered Medical Expenses include charges incurred by a covered person for a normal childbirth; while insured. Benefits are payable for Covered Medical Expenses on the same basis as any other sickness.

Covered Medical Expenses include:

(a) In-patient care for a minimum of 48 hours following vaginal delivery for the mother and her newly born child; or
(b) In-patient care for a minimum of 96 hours following cesarean section for the mother and her newly born child.

During the initial 48 or 96 hours; no pre-certification is required for the mother or her newly born child. Pre-certification is required after the 48 or 96 hours.

Any decision to shorten such minimum coverages shall be made by the attending physician; in consultation with the mother. In such cases; covered services may include: home visits; parent education; and assistance and training in breast or bottle-feeding.

Complications of pregnancy; including spontaneous and non-elective abortions; are considered a sickness; and are covered under this benefit. Voluntary or elective abortions are not covered.

TRANSGENDER RELATED EXPENSE

Covered Medical Expenses include charges incurred by a covered person for medically necessary surgery, mental health services, prescription drugs, and other related services that are Covered Medical Expenses under this plan. Benefits are payable for Covered Medical Expenses on the same basis as any other sickness.

NON-PRESCRIPTION ENTERAL FORMULA EXPENSE

Covered Medical Expenses include charges incurred by a covered person; for non-prescription enteral formulas for which a physician has issued a written order; and are for the treatment of malabsorption caused by:

- Crohn’s Disease;
- ulcerative colitis;
- gastroesophageal reflux;
- gastrointestinal motility;
- chronic intestinal pseudoobstruction; and
- inherited diseases of amino acids and organic acids.
Covered Medical Expenses for inherited diseases of: amino acids; and organic acids; will also include food products modified to be low protein.

The Covered Percentage; Maximum Benefit per Policy Year; and the Copay/Deductible per formula are shown on the Schedule of Benefits.

EOSINOPHILIC GASTROINTESTINAL DISORDER EXPENSE

Covered Medical Expenses include charges incurred by a covered person for amino acid-based formulas necessary for the treatment of eosinophilic gastrointestinal disorder, when prescribed or ordered by a physician.

The Covered Percentage, Annual Maximum Benefit, Copay, and Deductible are shown in the Schedule of Benefits.

CERTIFICATION REQUIREMENTS

The covered person must obtain certification for certain types of expenses to avoid a reduction in benefits paid for that care. Certification is required for the following:

- All inpatient admissions and partial hospitalizations to: a hospital; convalescent facility; skilled nursing facility; facility established primarily for the treatment of alcohol and drug addiction; or residential treatment facility.
- All inpatient maternity care after the initial 48 hours for a vaginal delivery; or the initial 96 hours for a cesarean delivery.
- All partial hospitalizations in a hospital or residential treatment facility for the treatment of mental and nervous disorders.
- All partial hospitalizations for the treatment of alcohol and drug addiction; in a facility established primarily for the treatment of alcohol and drug addiction.

Pre-certification does not guarantee the payment of benefits. Each claim is subject to medical policy review in accordance with the exclusions and limitations contained in this Policy; as well as a review of eligibility; adherence to notification guidelines; and benefit coverage; under this Policy.

Following is a description of the certification requirements:

CERTIFICATION FOR:

- ALL INPATIENT ADMISSIONS TO A HOSPITAL; CONVALESCENT FACILITY; SKILLED NURSING FACILITY; FACILITY ESTABLISHED PRIMARILY FOR THE TREATMENT OF ALCOHOL AND DRUG ADDICTION; OR RESIDENTIAL TREATMENT FACILITY; AND
- ALL INPATIENT MATERNITY CARE AFTER THE INITIAL 48-96 HOURS

If:

- a covered person becomes confined as a full-time inpatient in: a hospital; convalescent facility; skilled nursing facility; facility established primarily for the treatment of alcohol and drug addiction; or residential treatment facility; and
- it has not been certified that such confinement (or any day of such confinement) is medically necessary; and
- the confinement has not been ordered and prescribed by a physician who is a preferred care provider;
- the confinement has not been ordered and prescribed by:

A provider.

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

- As to hospital; convalescent facility; skilled nursing facility; facility established primarily for the treatment of alcohol and drug addiction; and residential treatment facility; expenses incurred during the confinement:

If certification has been requested and denied:

No benefits will be paid for hospital; convalescent facility; skilled nursing facility; facility established primarily for the treatment of alcohol and drug addiction; and residential treatment facility; expenses incurred for board and room.
Benefits for all other hospital; convalescent facility; skilled nursing facility; facility established primarily for the treatment of alcohol and drug addiction; and residential treatment facility expenses will be paid at the Covered Percentage.

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

No benefits will be paid for hospital; convalescent facility; skilled nursing facility; facility established primarily for the treatment of alcohol and drug addiction; or residential treatment facility expenses incurred for board and room.

As to all other hospital; convalescent facility; skilled nursing facility; facility established primarily for the treatment of alcohol and drug addiction; or residential treatment facility expenses.

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

Hospital; convalescent facility; skilled nursing facility; facility established primarily for the treatment of alcohol and drug addiction; and residential treatment facility expenses; up to the certification copay/deductible amount; will not be deemed to be Covered Medical Expenses.

Benefits for all other hospital; convalescent facility; skilled nursing facility; facility established primarily for the treatment of alcohol and drug addiction; and residential treatment facility expenses will be payable at the Covered Percentage.

• As to other Covered Medical Expenses:

Benefits will be paid at the Covered Percentage.

Whether or not a day of confinement is certified; no benefit will be paid for expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Policy; except that; if certification has been given for a day of confinement; the exclusion of services and supplies; because they are not medically necessary; will not be applied to expenses for hospital; convalescent facility; skilled nursing facility; facility established primarily for the treatment of alcohol and drug addiction; or residential treatment facility board and room.

Certification of days of confinement can be obtained as follows:

If the admission is a non-urgent admission; the covered person must get the days certified by calling Aetna. This must be done at least 3 days before the date the covered person is scheduled to be confined as a full-time inpatient. If the admission is an emergency or an urgent admission; the covered person; the covered person’s physician; or the hospital; convalescent facility; skilled nursing facility; facility established primarily for the treatment of alcohol and drug addiction; or residential treatment facility must get the days certified by calling Aetna.

This must be done:

• before the start of a confinement as a full-time inpatient which requires an urgent admission; or
• not later than 1 day following the start of a confinement as a full-time inpatient; which requires an emergency admission; unless it is not possible for the physician to request certification within that time. In that case; it must be done as soon as reasonably possible.

If; in the opinion of the covered person’s physician; it is necessary for the covered person to be confined for a longer time than already certified; the covered person; the physician; or the hospital; convalescent facility; skilled nursing facility; facility established primarily for the treatment of alcohol and drug addiction; or residential treatment facility may request that more days be certified by calling Aetna. This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent to the hospital; convalescent facility; skilled nursing facility; facility established primarily for the treatment of alcohol and drug addiction; or residential treatment facility. A copy will be sent to the covered person and to the physician.
CERTIFICATION FOR ALL PARTIAL HOSPITALIZATIONS IN A HOSPITAL; RESIDENTIAL TREATMENT FACILITY; OR A FACILITY ESTABLISHED PRIMARILY FOR THE TREATMENT OF ALCOHOL AND DRUG ADDICTION

If:

- a covered person is partially hospitalized in a hospital; residential treatment facility; or a facility established primarily for the treatment of alcohol and drug addiction; and
- it has not been certified that such partial hospitalization is medically necessary; and
- the partial hospitalization has not been ordered and prescribed by a physician who is a preferred care provider; and
- the partial hospitalization has not been ordered and prescribed by:

A.

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

If certification has been requested and denied no benefits will be paid.

If certification has not been requested and the partial hospitalization is not medically necessary; no benefits will be paid.

If certification has not been requested and the partial hospitalization is medically necessary; partial hospitalization expenses will not be deemed to be Covered Medical Expenses; and no benefits will be paid.

Certification of days of partial hospitalization can be obtained as follows:

If the partial hospitalization is done on a non-urgent basis; the covered person must get the days certified by calling Aetna. This must be done at least 3 days before the date the covered person is scheduled for partial hospitalization. If the partial hospitalization is done on an emergency or an urgent basis; the covered person; the covered person’s physician; or the hospital; residential treatment facility; or the facility established primarily for the treatment of alcohol and drug addiction must get the days certified by calling Aetna. This must be done:

- before the start of partial hospitalization which is done on an urgent basis; or
- not later than 1 business day following the start of partial hospitalization done on an emergency basis; unless it is not possible for the physician to request certification within that time. In that case, it must be done as soon as reasonably possible.

If, in the opinion of the covered person’s physician; it is necessary for the covered person to have partial hospitalization for a longer time than already certified; the covered person; the physician; or the hospital; facility established primarily for the treatment of alcohol and drug addiction; or residential treatment facility may request that more days be certified by calling Aetna. This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent to the hospital; residential treatment facility; or facility established primarily for the treatment of alcohol and drug addiction. A copy will be sent to the covered person and to the physician.

TREATMENT OF AUTISM SPECTRUM DISORDERS

Covered Medical Expenses include charges incurred in connection with services and supplies for the treatment of autism spectrum disorders. Treatment includes diagnosis, assessment and services, including behavioral therapy services provided or supervised by a physician. Unless otherwise indicated, autism spectrum disorders will be treated like and at the same level of benefits as any other illness.

Autism spectrum disorders means one of the three following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

- Autistic Disorder.
- Asperger’s Syndrome.
- Pervasive Development Disorder – Not otherwise specified.
Behavioral therapy means interactive therapies derived from evidence based research, including applied behavioral analysis, which includes discrete trial training, pivotal response training, intensive intervention programs and early behavioral interventions.

The Covered Percentage and Maximum per Policy Year are shown on the Schedule of Benefits.

TOBACCO CESSATION EXPENSE

Covered Medical Expenses include charges incurred by a covered person for medically necessary tobacco cessation counseling and tobacco cessation medications, along with other related services that are Covered Medical Expenses under this plan. Benefits are payable for Covered Medical Expenses on the same basis as any other sickness.
PRE-ADMISSION TESTING EXPENSE

Covered Medical Expenses include expenses incurred by a covered person for pre-admission testing charges made by a hospital, surgery center, licensed diagnostic lab facility, or physician, in its own behalf, to test a person while an outpatient before scheduled surgery if:

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

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

The Copay/Deductible Amount; Covered Percentage; and Maximum Benefit per Policy Year are shown in the Schedule of Benefits.

DENTAL INJURY EXPENSE

Covered Medical Expenses include charges incurred by a covered person for services of a dentist or dental surgeon for removal of one or more impacted wisdom teeth as a result of an injury.

The Plan will pay for the charges made by the dentist or dental surgeon. Not more than the Maximum Benefit will be paid.

Covered Medical Expenses also include expenses for the treatment of: the mouth; teeth; and jaws; but only those for services rendered and supplies needed for the following treatment of; or related to conditions; of the:

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

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 jaw bone 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.

Not included are charges:

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

Surgery needed to:

- 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.

The Covered Percentage; Maximum Benefit per **Policy Year**; Maximum Benefit per Tooth; and the **Copay/Deductible** per visit are shown on the Schedule of Benefits.

**SECOND 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-emergency surgery which has been recommended by the **covered person's physician**. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Not more than the Maximum Benefit will be paid per **Policy Year**.

The Covered Percentage; **Copay/Deductible** per visit; and the Maximum Benefit per **Policy Year** are shown on the Schedule of Benefits.

**CONSULTANT EXPENSE**

**Covered Medical Expenses** include the expenses incurred by a **covered person** in connection with the services of a consultant. No more that the Maximum Benefit shown on the Schedule of Benefits will be paid per **Policy Year**. The services must be requested by the attending **physician** for the purpose of confirming or determining to confirm or determine a diagnosis.

Coverage may be extended to include treatment by the consultant; if so stated in the Schedule of Benefits.

The Covered Percentage; **Copay/Deductible** per visit; and Maximum Benefit per **Policy Year** are shown on the Schedule of Benefits.

**LICENSED NURSE EXPENSE**

**Covered Medical Expenses** 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 a licensed practical nurse.

The Covered Percentage, Daily Maximum Benefit; Maximum Benefit per Day; Maximum Benefit per condition, per **Policy Year**; Maximum Benefit per **Policy Year**; and the Maximum Number of Visits per **Policy Year** are shown on the Schedule of Benefits.

Not more than the Daily Maximum Benefit per shift will be paid. For purposes of determining this maximum; a shift means 8 consecutive hours.
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 causes(s) as such hospital confinement.

Covered Medical Expenses will not include any charge in excess of the skilled nursing facility’s daily room and board maximum for semi-private accommodations or expenses for confinement in excess of the maximum number of days of confinement.

The Covered Percentage; Daily Room and Board Maximum Benefit; Maximum Number of Days of Confinement – per injury or sickness; and the Copay/Deductible per visit are shown on the Schedule of Benefits.

Benefits for Skilled Nursing require pre-certification.

REHABILITATION FACILITY EXPENSES

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. Not more than the maximum days of confinement will be covered.

Covered Medical Expenses will not include any charge in excess of the rehabilitation facility’s daily room and board maximum for semi-private accommodations or expenses for confinement in excess of the maximum number of days of confinement.

The Covered Percentage; Daily Room and Board Maximum Benefit; Maximum Number of Days of Confinement per Policy Year; and the Copay/Deductible per days of confinement are shown on the Schedule of Benefits.

Benefits for Rehabilitation Facility expenses require pre-certification.

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 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. Not more than the Maximum Benefit will be paid per Policy Year. Aetna must receive a written report on the second opinion consultation.

Covered Medical Expenses will not include any charge in excess of the daily room and board maximum for semi-private accommodations.

The Covered Percentage; Daily Room and Board Maximum Benefit; Maximum Number of Days of Confinement per Injury or Sickness; Maximum Benefit per Injury or Sickness; and Copay/Deductible per Visit are shown on the Schedule of Benefits.

HOME HEALTH CARE EXPENSE

Covered Medical Expenses include expenses 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:

(a) The services are furnished by; or under arrangements made by; a licensed Home Health Agency.
(b) The services are given under a home care plan. This plan must be established pursuant to the written order of a physician; and the physician must renew that plan every 60 days. Such physician must certify that the proper treatment of the condition would require inpatient confinement in a hospital or skilled nursing facility if the services and supplies were not provided under the home health care plan. The physician must examine the covered person at least once a month.
(c) Except as specifically provided in the **home health care** services; the services are delivered in the patient's place of residence on a part-time; intermittent; visiting basis while the patient is confined.

**HOME HEALTH CARE SERVICES**

(1) Part-time or intermittent nursing care by: a registered nurse (R.N.); a licensed Practical nurse (L.P.N.); or under the supervision of a R.N. if the services of a R.N. are not available;

(2) Part time or intermittent **home health aide** services; that consist primarily of care of a medical or therapeutic nature by other than a R.N.;

(3) Physical; occupational; speech therapy; or respiratory therapy;

(4) Medical supplies; drugs and medicines; and laboratory services. However; these items are covered only to the extent they would be covered if the patient was confined to a **hospital**;

(5) Medical social services by licensed or trained social workers;

(6) Nutritional counseling.

**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 housekeeping services; 3) maintenance therapy; 4) dialysis treatment; 5) purchase or rental of dialysis equipment; or 6) food or home delivered services.

The Covered Percentage; and **Copay/Deductible per Policy Year** are shown on the Schedule of Benefits. A visit means a maximum of 4 continuous hours of home health service.

**Home health care** requires pre-certification.

**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.

The Covered Percentage; **Copay/Deductible per screening**; and the **Maximum Benefit per Policy Year** are shown on the Schedule of Benefits.

**ROUTINE SCREENING FOR SEXUALLY TRANSMITTED DISEASE EXPENSE**

**Covered Medical Expenses** include charges incurred by a **covered person**; for annual routine screening for sexually transmitted diseases.

As used above; “routine screening for sexually transmitted disease” means any laboratory test that specifically detects for infection by one or more agents of:

- gonorrhea;
- syphilis;
- hepatitis;
- HIV; and
- genital herpes; and
- which test is approved for such purposes by the FDA.
Benefits will be paid for routine screening for sexually transmitted disease expenses; incurred by covered persons; who are at least 18 years old and who are sexually active.

The Covered Percentage, Copay/Deductible per screening; and the Maximum Benefit per Policy Year are shown on the Schedule of Benefits.

**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) A physician’s office; or
(b) Hospital outpatient department; or emergency room; or
(c) Clinical laboratory; or
(d) 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:

(a) C.A.T. Scan;
(b) Magnetic Resonance Imaging;
(c) Laser treatment;

For purposes of this benefit, “High Cost Procedure” means any outpatient procedure costing over $200.

The Covered Percentage; Maximum Benefit per Policy Year; and Copay/Deductible per visit are shown on the Schedule of Benefits.

**DIAGNOSTIC TESTING FOR LEARNING DISABILITIES EXPENSE**

Covered Medical Expenses include charges incurred by a covered student for diagnostic testing for:

- attention deficit disorder; or
- attention deficit hyperactive disorder

The Covered Percentage; Copay/Deductible per visit; and the Maximum Benefit per covered student; per Policy Year are shown on the Schedule of Benefits.

Once a covered student has been diagnosed with one of these conditions; medical treatment will be payable as detailed under the outpatient Treatment of Mental and Nervous Disorders portion of the Policy.

**TEMPOROMANDIBULAR JOINT DYSFUNCTION EXPENSE**

Covered Medical Expenses include charges incurred by a covered person for non-surgical treatment of Temporomandibular Joint (TMJ) Dysfunction.

The Covered Percentage; Copay/Deductible per visit; and the Maximum Benefit per lifetime are shown on the Schedule of Benefits.

**DERMATOLOGICAL EXPENSE**

Covered Medical Expenses include charges incurred by a covered person for diagnosis and treatment of skin disorders; excluding laboratory fees. Related laboratory expenses are covered under the Outpatient Expense Benefit.

Covered Medical Expenses do not include cosmetic treatment and procedures.

The Covered Percentage; Maximum Benefit per Policy Year; and the Copay/Deductible per visit are shown on the Schedule of Benefits.
WEIGHT-LOSS TREATMENT EXPENSE

Covered Medical Expenses include charges incurred by a covered person for medically necessary nutritional counseling, weight-loss medications and surgery, along with other related services that are Covered Medical Expenses under this plan. Benefits are payable for Covered Medical Expenses on the same basis as any other sickness.

ALLERGY TESTING AND TREATMENT EXPENSE

Covered Medical Expenses include charges incurred by a covered person 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;

The Covered Percentage; Copay/Deductible per visit; the Maximum Benefit per Policy Year; and the Maximum Benefit for injections and serums per Policy Year are shown on the Schedule of Benefits.

WELL NEWBORN NURSERY CARE EXPENSE

Covered Medical Expenses include charges incurred by a covered person; 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 for a normal delivery
• physician’s charges for circumcision; and
• physician’s charges for visits to the newborn child in the hospital and consultations; but for not more than 1 visit per day.

The Covered Percentage; and the Maximum Benefit per confinement are shown on the Schedule of Benefits.

WELL BABY CARE EXPENSE

Covered Medical Expenses include charges incurred by a covered person for Well Baby Care. Well Baby Care includes routine preventive and primary care services; rendered to a covered dependent child on an outpatient basis.

Routine preventive and primary care services are services rendered to a covered dependent child of a covered person. Services include: initial hospital check-ups; other hospital visits; physical examinations; including routine hearing and vision examinations; medical history; developmental assessments; and materials for the administration of appropriate and necessary immunizations and laboratory tests; when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics.

Coverage for such services shall be provided only to the extent that such services are provided by; or under the supervision of a physician; or other licensed professional.

The Covered Percentage; Copay/Deductible per visit; Copay/Deductible per immunization; Visit Maximum; Maximum Benefit per visit; Immunization Covered Percentage; Maximum per Immunization; and the Immunization Benefit Maximum per Policy Year are shown on the Schedule of Benefits.

FAMILY PLANNING EXPENSE

Covered Medical Expenses include charges incurred by a covered student for the following; although they are not incurred in connection with the diagnosis or treatment of a sickness or injury:

Charges by a physician or hospital for:

• a vasectomy for voluntary sterilization; and
• a tubal ligation for voluntary sterilization.
Covered Medical Expenses do not include the reversal of a sterilization procedure.

The Covered Percentage; Maximum Benefit per Policy Year; and the Copay/Deductible per visit are shown on the Schedule of Benefits.

PROSTHETIC DEVICES EXPENSE

Covered Medical Expenses include charges incurred by a covered person for: artificial limbs; or eyes; and other non-dental prosthetic devices; as a result of an accident or sickness.

Covered Medical Expenses do not include: eye exams; eyeglasses; vision aids; hearing aids; communication aids; and orthopedic shoes; foot orthotics; or other devices to support the feet.

The Covered Percentage; Copay/Deductible per visit; Maximum Benefit per Injury or Sickness; and the Maximum Benefit per Policy Year are shown on the Schedule of Benefits.

PODIATRIC EXPENSE

Covered Medical Expenses include charges incurred by a covered person for podiatric services; provided on an outpatient basis following an injury.

The Covered Percentage; Copay/Deductible per visit; and Maximum Benefit per Policy Year are shown on the Schedule of Benefits.

ROUTINE PHYSICAL EXAMS

Covered Medical Expenses include the expenses incurred by a covered student or a covered dependent for a routine physical exam performed by a physician. If charges made by a physician in connection with a routine physical exam given to a child; who is a covered dependent; are Covered Medical Expenses under any other benefit section; no charges in connection with that physical exam will be considered Covered Medical Expenses under this section. A routine physical exam is a medical exam given by a physician; for a reason other than to diagnose or treat a suspected or identified injury or sickness. Included as a part of the exam are:

• X-rays; lab; and other tests given in connection with the exam; and
• Materials for the administration of immunizations for infectious disease and testing for tuberculosis.

For a child who is a covered dependent:

• The physical exam must include at least:
  
  A review and written record of the patient's complete medical history;

  A check of all body systems; and

  A review and discussion of the exam results with the patient or with the parent or guardian.

• For all exams given to covered dependent under age 2; Covered Medical Expenses will not include charges for the following:
  
  More than 6 exams performed during the first year of the child's life;

  More than 2 exams performed during the second year of the child's life.

• For all exams given to a covered dependent from age 2 and above; Covered Medical Expenses will not include charges for more than one exam per Policy Year.

• For all exams given to a covered student or a spouse who is a covered dependent; Covered Medical Expenses will not include charges for more than:

  • One exam in 24 months in a row; if the person is under age 65; and
  • One exam in 12 months in a row; if the person is age 65 or over.
Also included as **Covered Medical Expenses** are charges made by a **physician** for one annual routine gynecological exam.

Not covered are charges for:

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

The Routine Physical Exam Maximum Benefit per **Policy Year**; **Copay/Deductible** per visit; **Copay/Deductible** per immunization; Immunization Covered Percentage; Maximum per Immunization; and the Immunization Benefit Maximum per **Policy Year** are shown on the Schedule of Benefits.

**ROUTINE COLORECTAL CANCER SCREENING EXPENSE**

Even though not incurred in connection with a **sickness** or **injury**; **Covered Medical Expenses** include charges incurred by a **covered person** for colorectal cancer examination and laboratory tests; for any nonsymptomatic person age 50 or more; or a symptomatic person under age 50; for the following:

- One fecal occult blood test every 12 months in a row
- A Sigmoidoscopy at age 50 and every 3 years thereafter
- One digital rectal exam every 12 months in a row
- A double contrast barium enema; once every 5 years
- A colonoscopy; once every 10 years.

The Covered Percentage; **Copay/Deductible** per visit; and the Maximum Benefit per **Policy Year** are shown on the Schedule of Benefits.

**ROUTINE PROSTATE CANCER SCREENING EXPENSE**

Although not incurred in connection with a **sickness** or **injury**; **Covered Medical Expenses** include charges incurred by a **covered person** for the screening of cancer as follows:

- for a male age 50 or over; one digital rectal exam and one prostate specific antigen test each **Policy Year**.

The Covered Percentage; **Copay/Deductible** per visit; and the Maximum Benefit per **Policy Year** are shown on the Schedule of Benefits.

**OUTPATIENT CONTRACEPTIVE DRUGS AND DEVICES AND OUTPATIENT CONTRACEPTIVE SERVICES EXPENSE**

**Covered Medical Expenses** include:

- Charges incurred for contraceptive drugs and devices that by law need a **physician’s prescription**; and that have been approved by the FDA.
- Related outpatient contraceptive services such as:
  - Consultations;
  - Exams;
  - Procedures; and
  - Other medical services and supplies.

**Covered Medical Expenses** do not include:

- charges for services which are covered to any extent; under any other part of this Plan; or under any other group plan; and
• charges incurred for contraceptive services; while confined as an inpatient; and
• charges incurred for duplicate; lost; stolen; or damaged; contraceptive devices.

The Covered Percentage; Copay/Deductible; and Maximum Benefit per Policy Year are shown on the Schedule of Benefits.

VISION CARE EXAM EXPENSE

Covered Medical Expenses include charges incurred by a covered person for any service shown below; which is furnished by a legally qualified ophthalmologist or optometrist.

Routine Eye Exam Expenses: Charges for a complete eye exam that includes refraction. A routine eye exam does not include charges for a contact lens exam.

Contact Lens Exam Expenses: Charges for an eye exam performed for the sole purpose of the fitting of contact lenses.

Limitations

The following limitations apply.

No benefits will be payable for a charge which is:

• For any eye exam to diagnose or treat a disease or injury.
• For drugs or medicines.
• For a vision care service that is a Covered Medical Expense in whole or in part; under any other part of this Policy; or under any other group plan.
• For a vision care service for which a benefit is provided in whole or in part; under any workers’ compensation law or any other law of like purpose.
• For special procedures. This means things such as orthoptics or vision training.
• For any vision care supply.
• For an eye exam which:
  Is required by an employer as a condition of employment; or
  An employer is required to provide under a labor agreement; or
  Is required by any law of a government.
• For a service received while the person is not a covered person.
• For a service which does not meet professionally accepted standards.
• For any exams given while the person is confined in a hospital or other facility for medical care.

The Covered Percentage; Copay/Deductible per visit; Maximum Benefit per Policy Year; and Maximum number of Vision Care Exams per Policy Year are shown on the Schedule of Benefits.

ACUPUNCTURE IN LIEU OF ANESTHESIA EXPENSE

Covered Medical Expenses include charges incurred by a covered person for 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.

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.
Acupuncture is not a **Covered Medical Expense** when it is administered for any of the following conditions:

- Acute low back pain
- Addiction
- AIDS
- Allergic rhinitis
- Asthma
- Carpal tunnel syndrome
- Chronic pain syndrome (e.g., RSD)
- Fibrotic contractures
- Headache (migraine; tension)
- Hypertension
- Menstrual cramps
- Neck pain/cervical spondylosis
- Obesity
- Painful neuropathies
- Phantom leg pain
- Psychiatric disorders
- Raynaud’s disease pain
- Rheumatoid arthritis
- Sensorineural deafness
- Shoulder pain (e.g., bursitis)
- Smoking cessation
- Stroke rehabilitation
- Tennis elbow/epicondylitis
- Tinnitus
- Whiplash.

The Covered Percentage; Maximum Number of Sessions per **Policy Year**; and Maximum Benefit per **Policy Year** are shown on the Schedule of Benefits.

**TRANSFUSION OR DIALYSIS OF BLOOD EXPENSE**

**Covered Medical Expenses** include charges incurred by a **covered person** for the transfusion or dialysis of blood; including the cost of: whole blood; blood components; and the administration thereof.

The Covered Percentage; Maximum Benefit per **Policy Year**; and **Copay/Deductible** per visit are shown on the Schedule of Benefits.

**IMMUNIZATIONS EXPENSE**

**Covered Medical Expenses** include:

- charges incurred by a **covered student** and **dependent** spouse for the materials for the administration of appropriate and **medically necessary** immunizations; and testing for tuberculosis.

The Covered Percentage; Maximum per Immunization; Immunization Benefit Maximum per **Policy Year**; and the **Copay/Deductible** per Immunization are shown on the Schedule of Benefits.

**Covered Medical Expenses** do not include a **physician’s** office visit in connection with immunization or testing for tuberculosis.

**CHILD IMMUNIZATIONS EXPENSE**

**Covered Medical Expenses** include:

- charges incurred by a **covered dependent** up to age 26; for the materials for the administration of appropriate and **medically necessary** immunizations; when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics.

The Covered Percentage; Maximum per Immunization; Immunization Benefit Maximum per **Policy Year**; and the **Copay/Deductible** per Immunization are shown on the Schedule of Benefits.

**Covered Medical Expenses** do not include a **physician’s** office visit in connection with immunization or testing for tuberculosis.

**HOSPICE EXPENSE**

**Covered Medical Expenses** include charges incurred by a **covered person** for **hospice** care provided for a **terminally ill covered person** during a **hospice benefit period**. Hospice Care Expenses are the **reasonable and customary** charges made by a **hospice** for the following services or supplies: charges for inpatient care; charges for drugs and medicines; charges for part-time nursing by an RN; LPN; or LVN; charges for physical and respiratory therapy in the home; charges for the use of
medical equipment; charges for visits by licensed or trained social workers; psychologists or counselors; charges for bereavement counseling of the covered person’s immediate family prior to.

The Covered Percentage; Maximum Number of Days Inpatient Confinement; Maximum Benefit; Maximum Benefit for Bereavement Counseling; and Maximum Number of Days Respite Care per 30-day Period are shown on the Schedule of Benefits.

Benefits for Hospice expenses require pre-certification.

**URGENT CARE EXPENSE**

**Covered Medical Expenses** include charges incurred by a covered person for treatment by an urgent care provider. 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**

**Covered Medical Expenses** include charges incurred by a covered person for an urgent care provider to evaluate and treat an urgent condition.

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

A separate preferred urgent care copay/deductible applies to each visit for urgent care by a covered person to a preferred urgent care provider. This does not apply if the covered person is admitted to a hospital as an inpatient right after a visit to an urgent care provider.

The Covered Percentage; Copay/Deductible per visit; and Maximum Benefit per Visit or Condition are shown on the Schedule of Benefits.

2125,2175,2180,2185,2225,2230,2235,2240,2245,2250,2270,2275,2295,2300,2305,2310,2315,2320,2325,2330,2335,2340,2350,2355,2360,2365,2390,2395,2400,2405,2410,2415,2420,2425,2430,2435,2440,2445,2450,2460,2461,2462
TREATMENT OF MENTAL AND NERVOUS DISORDERS EXPENSE

Inpatient Benefits

Covered Medical Expenses include expenses incurred by a covered person; during partial hospitalization or while the covered person is confined as a full-time inpatient in a hospital or residential treatment facility for the treatment of mental and nervous disorders.

The Covered Percentage Daily Room and Board; Daily Room and Board Maximum; Covered Percentage Miscellaneous Expense; Copay/Deductible per covered person, per Injury or Sickness; Copay/Deductible per covered person, per Policy Year; Inpatient Maximum Days per Condition; Inpatient Maximum Days per Policy Year; the Partial Hospitalization Maximum Days per Condition; and Partial Hospitalization Maximum Days per Policy Year are shown on the Schedule of Benefits.

Outpatient Benefits

Covered Medical Expenses include charges for treatment of mental and nervous disorders; while the covered person is not confined as a full-time inpatient in a hospital.

The Covered Percentage; Copay/Deductible per Visit; Copay/Deductible per Policy Year; Maximum Outpatient Benefit per visit; the Maximum Number of Outpatient Visits per Policy Year; and the Outpatient Daily Visit Maximum are shown on the Schedule of Benefits.

Partial hospitalization: inpatient for Treatment of Mental and Nervous Disorders require pre-certification.

TREATMENT OF ALCOHOL AND DRUG ADDICTION EXPENSE

Inpatient Benefits

Covered Medical Expenses include expenses incurred by a covered person; during partial hospitalization or while the covered person is confined as a full-time inpatient in a facility established primarily for the treatment of alcohol and drug addiction.

The Covered Percentage Daily Room and Board; Daily Room and Board Maximum; Covered Percentage Miscellaneous Expense; Copay/Deductible per covered person, per Injury or Sickness; Copay/Deductible per covered person, per Policy Year; Inpatient Maximum Days per Condition; Inpatient Maximum Days per Policy Year; the Daily Room and Board Maximum; the Partial Hospitalization Maximum Days per Condition; and Partial Hospitalization Maximum Days per Policy Year are shown on the Schedule of Benefits.

Outpatient Benefits

Covered Medical Expense include charges for treatment of alcoholism and drug addiction; while the covered person is not confined as a full-time inpatient in a hospital.

The Covered Percentage; Copay/Deductible per Visit; Copay/Deductible per Policy Year; the Maximum Number of Outpatient Visits per Policy Year; and the Outpatient Daily Visit Maximum are shown on the Schedule of Benefits.

Partial hospitalization: inpatient and outpatient benefits for Treatment of Alcohol and Drug Addiction require pre-certification.
This Policy 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 vision therapy; radial keratotomy; eyeglasses; contact lenses (except when required after cataract surgery); or other vision 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; except to the extent needed to:

   Improve the function of a part of the body that:

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

   is malformed:

   as a result of a severe birth defect; including harelip; webbed fingers; or toes; or

   as direct result of:

   disease; or

   surgery performed to treat a disease or injury.

Repair an injury (including reconstructive surgery for prosthetic device for a covered person who has undergone a mastectomy;) which occurs while the covered person is covered under this Policy. Surgery must be performed:

   in the calendar year of the accident which causes the injury; or

   in the next calendar year.
10. Expense incurred for voluntary or elective abortions unless otherwise provided in this Policy.

11. Expense incurred after the date insurance terminates for a covered person except as may be specifically provided in the Extension of Benefits Provision.

12. 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.

13. 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.

14. 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).

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

16. Expense incurred for custodial care. Custodial care means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes room and board and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:

   • by whom they are prescribed; or
   • by whom they are recommended; or
   • by whom or by which they are performed.

17. Expenses incurred for or in connection with: procedures; services; or supplies that are; as determined by Aetna; to be experimental or investigational. A drug; a device; a procedure; or treatment will be determined to be experimental or investigational if:

   There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature; to substantiate its safety and effectiveness; for the disease or injury involved; or

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

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

   The written protocol or protocols used by the treating facility; or the protocol or protocols of any other facility studying substantially the same drug; device; procedure; or treatment; or the written informed consent used by the treating facility; or by another facility studying the same drug; device; procedure; or treatment; states that it is experimental; investigational; or for research purposes.

   However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease; if Aetna determines that:

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

   The care or treatment is effective for that disease; or shows promise of being effective for that disease; as demonstrated by scientific data. In making this determination; Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

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

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

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

   If Aetna determines that available; scientific evidence demonstrates that the drug is effective; or shows promise of being effective; for the disease.
Insurers are required to cover patient costs associated with cancer clinical trials. Applies to routine patient costs incurred by a participant in a Phase I, II, III, or IV cancer clinical trial if the costs would be covered for non-investigational treatment.

18. Expenses incurred for breast reduction/mammoplasty; except as required for reconstructive surgery of the breast following mastectomy.

19. Expenses incurred for gynecomastia (male breasts).

20. Expense incurred for acupuncture; unless services are rendered for anesthetic purposes.

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

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

23. Expense for telephone consultations; charges for failure to keep a scheduled visit; or charges for completion of a claim form.

24. 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.

25. Expense for incidental surgeries; and standby charges of a physician.

26. 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.

27. Expense incurred for injury resulting from the play or practice of intercollegiate sports; (participating in sports clubs; or intramural athletic activities; is not excluded).

28. Expense 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.

29. Expenses incurred for massage therapy.

30. 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.

31. 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.

32. Expense incurred for a treatment; service; or supply; which is not medically necessary; as determined by Aetna; for the diagnosis, care or treatment of the sickness or injury involved. This applies even if they are prescribed; recommended; or approved; by the person’s attending physician; or dentist.

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

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

In determining if a service or supply is appropriate under the circumstances; Aetna will take into consideration: information relating to the affected person's health status; reports in peer reviewed medical literature; reports and guidelines published by nationally recognized health care organizations that include supporting scientific data; generally
recognized professional standards of safety and effectiveness in the United States for diagnosis; care; or treatment; the opinion of health professionals in the generally recognized health specialty involved; and any other relevant information brought to Aetna's attention.

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

• those that do not require the technical skills of a medical; a mental health; or a dental professional; or

• those furnished mainly for the personal comfort or convenience of the person; any person who cares for him or her; or any person who is part of his or her family; any healthcare provider; or healthcare facility; or

• those furnished solely because the person is an inpatient on any day on which the person's sickness or injury could safely; and adequately; be diagnosed; or treated; while not confined; or those furnished solely because of the setting; if the service or supply could safely and adequately be furnished in a physician's or a dentist's office; or other less costly setting.

Any exclusion above will not apply to the extent that coverage is specifically provided by name in this Policy; or coverage of the charges is required under any law that applies to the coverage.
Benefits Subject To This Provision: This Coordination of Benefits (COB) provision applies to This Plan when a covered student or the covered dependent has medical and/or dental coverage under more than one Plan. "Plan" and "This Plan" are defined herein.

The Order of Benefit Determination Rules below determines which plan will pay as the primary plan. The primary plan pays first; without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan; and may reduce the benefits it pays; so that payments from all group plans do not exceed 100% of the total allowable expense.

Definitions. When used in this provision; the following words and phrases have the meaning explained herein.

Allowable Expense means a health care service or expense; including deductibles; coinsurance; and copayments; that is covered; at least in part; by any of the Plans covering the person. When a Plan provides benefits in the form of services (for example an HMO); the reasonable cash value of each service will be considered an allowable expense; and a benefit paid. An expense or service that is not covered by any of the Plans; is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

1. If a covered person is confined in a private hospital room; the difference between the cost of a semi-private room in the hospital; and the private room (unless the patient’s stay in the private hospital room is medically necessary in terms of generally accepted medical practice; or one of the Plans routinely provides coverage of hospital private rooms); is not an allowable expense.

2. If a covered person is covered by 2 or more Plans that compute their benefit payments on the basis of reasonable and customary charges; any amount in excess of the highest of the reasonable and customary charges for a specific benefit is not an allowable expense.

3. If a covered person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated charges; an amount in excess of the highest of the negotiated charges is not an allowable expense; unless the secondary plan’s provider’s contract prohibits any billing in excess of the provider’s agreed upon rates.

4. If a covered person is covered by one Plan that calculates its benefits or services on the basis of reasonable and customary charges; and another Plan that provides its benefits or services on the basis of negotiated charges; the primary Plan’s payment arrangements shall be the allowable expense for all the Plans.

5. The amount a benefit is reduced by the primary Plan because a covered person does not comply with the Plan provisions. Examples of these provisions are: second surgical opinions; precertification of admissions; and preferred provider arrangements.

When a plan provides benefits in the form of services; the reasonable cash value of each service rendered shall be deemed an allowable expense and a benefit paid.

Claim Determination Period means the Calendar Year.

Closed Panel Plan. A plan that provides health benefits to covered persons; primarily in the form of services through a panel of providers that have contracted with or are employed by the plan; and that limits or excludes benefits for services provided by other providers; except in cases of emergency or referral by a panel member.

Custodial Parent. A parent awarded custody by a court decree. In the absence of a court decree; it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Plan. Any Plan providing benefits or services by reason of medical or dental care or treatment; which benefits or services are provided by one of the following:

A. Group; blanket; or franchise health insurance policies issued by insurers; including health care service contractors;
B. Other prepaid coverage under service plan contracts; or under group or individual practice;
C. Uninsured arrangements of group; or group-type coverage;
D. Labor-management trustee plans; labor organization plans; employer organization plans; or employee benefit organization plans;
E. Medical benefits coverage in a group; group-type; and individual automobile “no-fault” and traditional automobile “fault” type contracts;
F. Medicare; or other governmental benefits;
G. Other group-type contracts. Group type contracts are those which are not available to the general public; and can be obtained and maintained only because of membership in; or connection with; a particular organization or group.

If the contract includes both medical and dental coverage; those coverages will be considered separate plans. The Medical/Pharmacy coverage will be coordinated with other Medical/Pharmacy plans. In turn; the dental coverage will be coordinated with other dental plans.

This Plan is any part of the policy that provides benefits for health care expenses.

Primary Plan/Secondary Plan. The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a Primary Plan; its benefits are determined before those of the other Plan; and without considering the other Plan’s benefits.

When This Plan is a Secondary Plan; its benefits are determined after those of the other Plan; and may be reduced because of the other Plan’s benefits.

When there are more than two Plans covering the person; This Plan may be a Primary Plan as to one or more other Plans; and may be a Secondary Plan as to a different Plan or Plans.

Order Of Benefit Determination.

When two or more plans pay benefits; the rules for determining the order of payment are as follows:

A. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

B. A plan that does not contain a coordination of benefits provision; that is consistent with this provision; is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits; may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits; and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A plan may consider the benefits paid or provided by another plan in determining its benefits; only when it is secondary to that other plan.

D. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

1. Non-Dependent or Dependent. The plan that covers the person other than as a dependent; for example; as an employee; member; subscriber; or retiree is primary; and the plan that covers the person as a dependent is secondary. However; if the person is a Medicare beneficiary and; as a result of federal law; Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee; member; subscriber; or retiree is secondary; and the other plan is primary.

2. Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one plan is:

(a) The primary plan is the plan of the parent whose birthday is earlier in the year; if:

- The parents are married;
- The parents are not separated (whether or not they ever have been married); or
- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday; the plan that covered either of the parents longer is primary.
(b) If the specific terms of a court decree state that one of the parents is responsible for the child’s health care expenses or health care coverage; and the plan of that parent has actual knowledge of those terms; that plan is primary. This rule applies to claim determination periods; or plan years; commencing after the plan is given notice of the court decree.

(c) If the parents are not married; or are separated (whether or not they ever have been married) or are divorced; the order of benefits is:
- The plan of the custodial parent;
- The plan of the spouse of the custodial parent;
- The plan of the noncustodial parent; and then
- The plan of the spouse of the noncustodial parent.

3. **Continuation Coverage**. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan; the plan covering the person as an employee; member; subscriber; or retiree (or as that person’s dependent) is primary; and the continuation coverage is secondary. If the other plan does not have this rule; and if; as a result; the plans do not agree on the order of benefits; this rule is ignored.

4. **Longer or Shorter Length of Coverage**. The plan that covered the person as an employee; member; or subscriber longer is primary.

5. **If the preceding rules do not determine the primary plan**: the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition; this plan will not pay more than it would have paid had it been primary.

**Effect On Benefits Of This Plan.**

A. When this plan is secondary; it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total allowable expenses. The difference between the benefit payments that this plan would have paid had it been the primary plan; and the benefit payments that it actually paid or provided; shall be recorded as a benefit reserve for the covered person; and used by this plan to pay any allowable expenses; not otherwise paid during the claim determination period. As each claim is submitted; this plan will:

(1) Determine its obligation to pay or provide benefits under its contract;

(2) Determine whether a benefit reserve has been recorded for the covered person; and

(3) Determine whether there are any unpaid allowable expenses during that claims determination period.

B. If a covered person is enrolled in two or more closed panel plans and if; for any reason; including the provision of service by a non-panel provider; benefits are not payable by one closed panel plan; COB shall not apply between that plan and other closed panel plans.

**Multiple Coverage Under This Plan.**

If a person is covered under this Plan both as a covered student and a covered dependent; or as a dependent of 2 covered students; the following will also apply:

- The person’s coverage in each capacity under this Plan will be set up as a separate “Plan”.
- The order in which various plans will pay benefits will apply to the “Plans” set up above and to all other plans.
- This provision will not apply more than once to figure the total benefits payable to the person for each claim under this Plan.
Right To Receive And Release Needed Information.

Certain facts about health care coverage and services are needed to apply these COB rules; and to determine benefits under this plan and other plans. Aetna has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility Of Payment.

Any payment made under another Plan may include an amount which should have been paid under This Plan. If so; Aetna may pay that amount to the organization; which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. Aetna will not have to pay that amount again. The term “payment made” means reasonable cash value of the benefits provided in the form of services.

Right of Recovery.

If the amount of the payments made by Aetna is more than it should have paid under this COB provision; it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Other Plan

This means any other plan of health expense coverage under:

- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.

2995, 3000, 3005, 3010, 3015, 3020