Your student health insurance coverage, offered by Aetna Student Health*, may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions for annual dollar limits for student health insurance coverage are $100,000 for policy years before September 23, 2012, and $500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014. Your student health insurance coverage includes an annual limit of $500,000 on all covered services including Essential Health Benefits. Other internal maximums (on Essential Health Benefits and certain other services) are described more fully in the benefits chart included inside this Plan summary. If you have any questions or concerns about this notice, contact 1-800-966-7772. Be advised that you may be eligible for coverage under a group health plan of a parent’s employer or under a parent’s individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent’s employer plan or the parent’s individual health insurance issuer for more information.

* Fully insured Aetna Student Health Insurance Plans are underwritten by Aetna Life Insurance Company (Aetna) and administered by Chickering Claims Administrators, Inc. Aetna Student Health is the brand name for products and services provided by these companies and their applicable affiliated companies.

Underwritten by:
Aetna Life Insurance Company (ALIC)
Policy Number 711110

This health plan meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance. Please see language below for additional information.
WHERE TO FIND HELP
In case of an emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility. For non-emergency situations please visit or call Boston University Student Health Services at (617) 353-3575 for medical care and (617) 353-3569 for mental health care.

For questions about:
- Insurance Benefits
- Enrollment
- Claims Processing
- Pre-Certification Requirements

Please contact:
Aetna Student Health
P.O. Box 981106
El Paso, TX 79998
(800) 966-7772

For questions about:
- ID Cards

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

For lost ID cards, contact:
Aetna Student Health at (800) 966-7772 or visit www.aetnastudenthealth.com/bu.

Once enrolled, you may print a temporary ID card online by registering on the Aetna Navigator\textsuperscript{®} at www.aetnanavigator.com.

For questions about:
- Dependent Enrollment
- Waiver Process
- Boston University Student Health Services Referrals (if applicable)

Please refer to:
- Boston University Student Link at www.bu.edu/studentlink
- Student Accounting Services at www.bu.edu/comp/saweb

For questions about:
- Pharmacy Claims or Benefits
- Excluded Drugs and Pre-Authorization

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

Aetna Prescription Drug claim forms are available at Boston University Student Health Services, 881 West Commonwealth Avenue, Boston, MA 02215 or may be downloaded from www.aetnastudenthealth.com/bu.

For questions about the prescription drug mail order program administered by Aetna Rx Home Delivery\textsuperscript{®} Program visit www.aetnarxhomedelivery.com.
For questions about:
• Provider Listings

Please contact:
Aetna Student Health at (800) 966-7772 or you can use Aetna’s DocFind® at www.aetnastudenthealth.com/bu.

For questions about:
• On Call International 24/7 Emergency Travel Assistance Services

Please contact:
On Call International at (866) 525-1956 (within U.S.) If outside the U.S., call collect by dialing the U.S. access code (001) plus (603) 328-1956. Please also visit www.aetnastudenthealth.com/bu.

IMPORTANT NOTE
Please keep this Brochure, as it provides a general summary of your coverage. A complete description of the benefits and full terms and conditions may be found in the Master Policy issued to Boston University. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits. The Master Policy may be viewed at the University’s Student Health Services or the Office of Risk Management during business hours. Please refer to the Certificate of Coverage on www.aetnastudenthealth.com/bu for a complete description of the benefits available.

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

The Boston University Student Health Services (SHS) is the University’s on-campus health facility and is staffed by doctors and nurse practitioners. Hours change seasonally, for the most up to date hours and information, please visit the web site at www.bu.edu/shs or call at (617) 353-3575 for medical care and (617) 353-3569 for mental health care.

You may use Student Health Services if you are:
- A full-time BU student, regardless of your insurance choice.
- A student who participates in at least 75% of the full-time curriculum.
- Any student with the Boston University Student Medical Insurance Plan.
- A summer student or a participant in one of the high school summer programs.

In the event of an emergency, calls should be directed to the Boston University Police Department at (617) 353-2121 (3-2121 from a campus phone) or to 911 emergency. Urgent, but non-emergency, questions can be directed to the on-call provider by calling Student Health Services at (617) 353-3575 (3-3575 from a campus phone).

The following services are provided at Student Health Service for members covered under the Student Medical Insurance Plan:
- Men’s Health Preventative Exams
- Women’s Health Preventive Exams
- Care for most acute medical conditions

Laboratory tests performed at Student Health Services are generally covered by the Aetna Student Health plan.

Please Note: For a description of other services performed at Student Health Services, please visit www.bu.edu/shs.

POLICY PROCEDURES

Students: Coverage for all insured students enrolled for the Fall Semester, will become effective at 12:01 a.m. on the effective date of the policy and will terminate at 11:59 p.m. on the termination date. Please see the Rates section below to determine which student category you belong to for exact Policy Period dates.

1. New Spring Semester students: Coverage for all insured students enrolled for the Spring Semester, will become effective at 12:01 a.m. on January 1, 2013, and will terminate at 11:59 p.m. on the termination date.

2. Insured dependents: Coverage will become effective on the same date the insured student’s coverage becomes effective, or the day after the qualifying life event for late enrollment. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Master Policy. Examples include, but are not limited to: the date the student’s coverage terminates, the date the dependent no longer meets the definition of a dependent.
RATES
Charles River Campus (CRC), School of Public Health (SPH) and Division of Graduate Medical Sciences (GMS)**

<table>
<thead>
<tr>
<th>Student Rates</th>
<th>Annual 8/23/12 to 8/22/13</th>
<th>Spring/Summer 1/1/13 to 8/22/13</th>
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<tbody>
<tr>
<td>Basic Plan</td>
<td>$1,989</td>
<td>$1,275</td>
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<tr>
<td>Plus Plan</td>
<td>$2,716</td>
<td>$1,740</td>
</tr>
<tr>
<td>Dependent Rates (Basic Plan ONLY) Spouse</td>
<td>$4,446</td>
<td>$2,851</td>
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<tr>
<td>Child(ren)</td>
<td>$2,428</td>
<td>$1,557</td>
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**PhD students in the Division of Graduate Medical Sciences will be enrolled in Plus plan. Student Basic is no longer available to GMS PhD students.

School of Medicine (MED) and Goldman School of Dental Medicine (SDM) Medical and Dental – Returning Students

<table>
<thead>
<tr>
<th></th>
<th>8/23/12 to 8/22/13</th>
<th>Annual</th>
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</thead>
<tbody>
<tr>
<td>Student Rate – Plus</td>
<td>$2,716</td>
<td></td>
</tr>
<tr>
<td>Dependent Rates (Basic Plan ONLY) Spouse Only</td>
<td>$4,446</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$2,428</td>
<td></td>
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</table>

Dental – Returning (Graduating in 2012/2013)

<table>
<thead>
<tr>
<th></th>
<th>8/23/12 to 8/31/13</th>
<th>Annual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Rate – Plus</td>
<td>$2,827</td>
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<tr>
<td>Dependent Rates (Basic Plan ONLY) Spouse Only</td>
<td>$4,554</td>
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<td></td>
<td>$2,489</td>
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Medical – New Students

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<tbody>
<tr>
<td>Student Rate – Plus</td>
<td>$2,871</td>
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<tr>
<td>Dependent Rates (Basic Plan ONLY) Spouse Only</td>
<td>$4,628</td>
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<td></td>
<td>$2,529</td>
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</table>

Dental – New Postdoctoral (Except Oral Biology)

<table>
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<tr>
<th></th>
<th>7/1/12 to 8/22/13</th>
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<tbody>
<tr>
<td>Student Rate – Plus</td>
<td>$3,111</td>
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<tr>
<td>Dependent Rates (Basic Plan ONLY) Spouse Only</td>
<td>$5,093</td>
<td></td>
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<tr>
<td></td>
<td>$2,783</td>
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### Dental – New General Dentist

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<tr>
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<tr>
<td>Student Rate – Plus</td>
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<td>$3,221</td>
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<tr>
<td>Dependent Rates <em>(Basic Plan ONLY)</em></td>
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<td></td>
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<tr>
<td>Spouse Only</td>
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<td>$5,202</td>
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<td>Child(ren)</td>
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<td>$2,844</td>
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### Dental – New Predoctoral

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<tr>
<td>Student Rate – Plus</td>
<td></td>
<td>$2,881</td>
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<td>Dependent Rates <em>(Basic Plan ONLY)</em></td>
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<tr>
<td>Spouse Only</td>
<td></td>
<td>$4,830</td>
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<td>Child(ren)</td>
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<td>$2,640</td>
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### Dental – New Postdoctoral Oral Biology and Perio 1

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<thead>
<tr>
<th></th>
<th>8/23/12 to 8/22/13</th>
<th>Annual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Rate – Plus</td>
<td></td>
<td>$2,716</td>
</tr>
<tr>
<td>Dependent Rates <em>(Basic Plan ONLY)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse Only</td>
<td></td>
<td>$4,446</td>
</tr>
<tr>
<td>Child(ren)</td>
<td></td>
<td>$2,428</td>
</tr>
</tbody>
</table>
BOSTON UNIVERSITY
STUDENT MEDICAL INSURANCE PLAN
This is a brief description of the Accident and Sickness Medical Expense benefits available for Boston University students and their eligible dependents. The Plan is underwritten by Aetna Life Insurance Company (called Aetna). The exact provisions governing this insurance are contained in the Master Policy issued to the University and may be viewed at Boston University Student Health Services or the Office of Risk Management during business hours or call Aetna Student Health at (800) 966-7772 or online at www.aetnastudenthealth.com/bu. Please refer to the Certificate of Coverage for a complete description of the benefits available.

STUDENT COVERAGE
ELIGIBILITY
Boston University requires that all full-time, three-quarter time, and international students (i.e., visa code F1, F2, J1, or J2) have adequate health insurance coverage. Full-time students are those registered for at least 12 credits a semester in the Fall and Spring Semesters for most schools within Boston University and graduate students registered below 12 credit-hours who have certified full-time status. Three-quarter time students are those certified as part-time, but registered for 75% or more of a full-time course load (nine or more credit hours for most schools within Boston University). Certified part-time students registered for fewer than nine credit hours may be eligible for coverage under the Plan. If it is discovered that this eligibility requirement has not been met, our only obligation is to refund premium, less any claims paid.

For all students: The guidelines for Comparable Coverage have been revised to provide greater clarity of the requirements necessary to waive insurance. The guidelines also include a few new rules. Please read the following carefully.

Students registered at least seventy-five percent of a full-time course load, or certified as full-time (regardless of where the student is studying) ARE REQUIRED TO BE ENROLLED IN THE BOSTON UNIVERSITY STUDENT MEDICAL INSURANCE PLAN unless the student is enrolled in a COMPARABLE health insurance plan and files a Medical Insurance Waiver by the Waiver deadline (this is an annual requirement).

IMPORTANT FOR ALL INTERNATIONAL AND EXCHANGE STUDENTS STUDYING IN THE UNITED STATES: NEW AS OF FALL 2012: Coverage in the Boston University Student Medical Insurance Plan (SMIP) for all International (F1*) and Exchange (J1*) students studying in the United States, both full and part-time, may be waived in limited cases only as explained in no. 11-13 below.

* F2 and J2 visa-holders who are also enrolled part-time for classes at Boston University are required to have health insurance, and are subject to the same comparable coverage guidelines described below.

Coverage comparable to the Boston University Student Medical Insurance Plan (SMIP) means:

1. The medical insurance plan must be provided by a U.S.-based carrier company or U.S.-based subsidiary. Foreign insurance plans (including foreign-based Embassy-sponsored plans except as noted above) are NOT acceptable. Neither a U.S.-based Third Party Administrator (TPA), nor a U.S. Satellite office of foreign company meets this requirement. The insurance carrier, itself, must be U.S.-based (unless the student is studying outside the United States).

2. Plans which provide coverage through a closed network of providers (such as Kaiser Permanente), not reasonably accessible in the area where the student attends school, are not acceptable. Plans must include coverage for preventative and primary care, chronic disease management, ambulatory patient services including non-emergency outpatient diagnostic and medical services, as well as hospitalization and surgery, and hospital based emergency services from providers in the Boston area (or in the area where the student is studying if outside the Boston area). Plans not meeting this requirement are not acceptable.
   • For this reason, Out-of-state Medicaid programs are not acceptable forms of coverage in lieu of the SMIP.
   • Massachusetts Health Safety Net is not medical insurance and may not be used to waive SMIP.
   • Commonwealth Care plans are not acceptable forms of coverage in lieu of the SMIP. This is the law in Massachusetts.
   • NOTE: Current MassHealth participants may lose eligibility for the program once they are a full time student, or when they turn age nineteen. If you are a current Mass Health participant, you are encouraged to consult with MassHealth before submitting a SMIP waiver.
3. The policy must have a minimum of $500,000 coverage per injury or sickness per policy (academic) year.

4. Mental health and substance abuse must be covered as any other illness or injury within the local Boston area or the area in which the student is studying (this means that both inpatient and outpatient treatment must be covered).

5. Injuries or illnesses that occur as a result of alcohol, illegal drugs or as the result of an attempt to commit suicide must be covered on the same basis as any other illness or injury.

6. Diagnosis and treatment for at risk evaluation of sexually transmitted disease must be covered by the policy.

7. Pregnancy must covered be as any other illness or injury.

8. There must be no limitations for the coverage of pre-existing medical conditions.

9. Prescription drug coverage must be included and have a minimum of $100,000 coverage per policy (academic) year. (The increase to a minimum level of $100,000 applies as of Fall 2012 semester).

10. If you will be studying outside your home country, emergency medical transportation if you become ill or injured must be included.
   
   a. Travel Insurance Policies for use outside the United States may not be used in lieu of a comprehensive medical insurance plan, but may be purchased to supplement the primary insurance plan. The combination of primary insurance plan and travel insurance plan must supply the student with all the requirements listed above (no. 2 – 9) and be fully accessible for all these services where the student is studying.
   
   b. Students studying outside the United States who supplement their coverage with a travel insurance plan must have an active comprehensive health insurance plan that covers the student in the home country (to protect the student in the event the student is med-evacuated to the home country).

11. **NEW!** Coverage in the Boston University Student Medical Insurance Plan (SMIP) for all International (F1) and Exchange (J1) students studying in the United States, both full and part-time, is required unless the student is covered by an employer-based plan (no. 12), or an Embassy-sponsored plan (no. 13) that provides the student with comprehensive U.S.-based coverage (as outlined 1-10 above).

12. International and Exchange students enrolled in an employer-based plan that provides comprehensive U.S. based coverage as described in 1 – 10 are eligible to waive. Neither foreign-based plans, nor a travel insurance plan combined with any foreign insurance policy are allowable. A Domestic Employer-based plan may be supplemented by a Travel Plan to provide the necessary Medical Evacuation coverage (see no.10 above).

13. Embassy-sponsored students for whom their Embassy provides comprehensive U.S. based coverage as described in 1 – 10 are eligible to waive, as indicated above.
   
   a. The University currently limits Embassy-sponsored plans as deemed comparable to SMIP to those which provide fully comprehensive and accessible domestic coverage. Examples of such plans are those provided to the sponsored students of the Saudi Arabian Cultural Mission, the Royal Thai Embassy, and the Kuwaiti Cultural Division.
   
   b. An Embassy-sponsored plan that requires the student to pay up-front for ambulatory or hospital services, and then seek reimbursement will not be accepted. An Embassy-sponsored plan that does not provide comprehensive coverage including chronic disease management, prescription drug coverage, mental health services, and substance abuse will also not be accepted.

14. The issuing insurance carrier must be a U.S. based carrier. Foreign-based coverage is not allowable for any student, foreign or domestic, who is studying in the United States.

**What makes an insurance carrier a U.S.-based carrier?**

A U.S.-based carrier means that the insurance carrier issuing the plan is a U.S. or domestic company, regardless of where the policy is purchased or where the claims are processed. Carriers outside of the U.S. means foreign or foreign-based insurance companies (i.e., non-domestic or non-U.S. companies), including those companies with satellite offices in the United States.

Some foreign insurance companies have numerous companies and subsidiaries worldwide. A foreign carrier may have a U.S. subsidiary, as well as subsidiaries in other countries. Policies purchased from the U.S. subsidiary qualify for a waiver, but policies purchased from foreign subsidiaries do not qualify for a waiver (unless the student is studying outside the United States).

Insurance carriers that are based in a foreign country, but have a U.S. satellite office are considered foreign or foreign-based insurance companies. Their health plans are ineligible for a waiver (unless the student is studying outside the United States).
15. All Professional Medical students (i.e., M.D. candidates), Graduate Medical Sciences (GMS) Ph.D. Level, Dermatology students and all Goldman School of Dental Medicine students have the following additional requirements:

- Essential services must pay at 100% for Preferred Care; and not less than 80% for Non-Preferred Care.
- Low Co-pays and low deductibles are allowed ($250, or less) High Deductible Plans are not allowed.
- The out-of-pocket maximums for Non-Preferred care may not be higher than $2,500.
- The aggregate maximum per Plan Year must be at least $500,000.
- In addition, the plan must meet all other criteria as listed above (1-14).

Late Enrollment
An eligible person may not be considered a late enrollee if the request for enrollment is made within 30 days after termination of coverage provided under another health insurance plan or arrangement where such coverage has ceased due to termination of the spouse’s employment or death of the spouse.

ENROLLMENT

Students required to carry health insurance will be automatically enrolled in this Plan, unless the completed online Waiver has been received by the University, by the specified enrollment/waiver deadline dates listed in the next section of this Brochure. Waivers are effective for this Plan period only. A new waiver is required each Academic Year at Boston University.

Charles River Campus (CRC), School of Public Health (SPH), Division of Graduate Medical Sciences (GMS M.A., M.S. and non-degree) and Extension Campuses

Eligible students will be enrolled in the Boston University Student Medical Insurance Plan – Basic Plan. Students may elect to upgrade to the Plus Plan.

Division of Graduate Medical Sciences –GMS PhD level

Eligible students will be automatically enrolled in the Boston University Student Medical Insurance Plan – Plus Plan.

School of Medicine (MED) and Goldman School of Dental Medicine (SDM)

Eligible students will be automatically enrolled in the Boston University Student Medical Insurance Plan – Plus Plan. Due to the clinical nature of their studies these Students do not have the option to opt into the Basic Plan.

Insurance Enrollment for Part-Time Students

Some part-time students may have their student account automatically assessed for medical insurance. If your student account was assessed for medical insurance, you will automatically be enrolled in the Student Medical Insurance Plan unless you actively decline (waive) enrollment by the Medical Insurance Waiver deadline.

Those part-time students whose student account is not automatically assessed for medical insurance for the 2012/2013 Policy Year may enroll by contacting Student Accounting Services in writing by September 30, 2012. Written requests for coverage may be faxed to Student Accounting Services at 617-353-3313. E-mail requests for insurance coverage may be sent to insmed@bu.edu. The student should include his or her BU ID number with the request and specify the level of coverage (Student Basic or Student Plus). The enrollment deadline for new students entering Boston University in the Spring 2013 semester is February 1, 2013.

Options for Confirming Enrollment or Changing Plan Selection:

Student link at www.bu.edu/studentlink. Starting at the main menu, select Money Matters, then Medical Insurance. A BU login name and Kerberos password is required to access the system.

- Contact Student Accounting Services at 881 Commonwealth Avenue, Boston, MA 02215 or call (617) 353-2264.

Note: Students who waive the coverage may later enroll up to September 30, 2012 (February 1, 2013 for newly enrolled Spring Semester students). Coverage will be effective on the first day of the semester.
**WAIVER PROCESS/PROCEDURE**

Students required to carry health insurance will be automatically be enrolled in this Plan, unless the completed online Waiver has been received by the University, by the specified enrollment/waiver deadline dates listed below. Waivers are effective for this Plan period only. A new waiver is required each Academic Year at Boston University.

<table>
<thead>
<tr>
<th>Category</th>
<th>Waiver Deadline Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students enrolling for the Annual Plan</td>
<td>09/30/12</td>
</tr>
<tr>
<td>New students enrolling for the Spring/Summer Semester</td>
<td>02/01/13*</td>
</tr>
</tbody>
</table>

*Also applies to Students who increase their part-time course load to 75% of the full course load (nine or more credit-hours) or who change to full-time status effective Spring Semester 2013.

**OPTIONS FOR WAIVING INSURANCE**

- Student link at [www.bu.edu/studentlink](http://www.bu.edu/studentlink). To file a Waiver electronically, select Money Matters from the main menu, then Medical Insurance. An Academic Computing System (ACS) account is required to access the system.
- Download Waiver Forms from the Student Accounting Services website at [www.bu.edu/studentaccountingservices](http://www.bu.edu/studentaccountingservices). Select Resources, then Medical Insurance. Or contact Student Accounting Services at 881 Commonwealth Avenue, Boston, MA 02215 or call (617) 353-2264.

**Note:** If the student is under the age of 18, the parent or guardian must cosign the Medical Insurance Waiver. Students under age 18 should use the paper Medical Insurance Waiver form (rather than the Student Link) which may be downloaded from the Student Accounting Services website at [www.bu.edu/studentaccountingservices](http://www.bu.edu/studentaccountingservices). Select Resources, then Medical Insurance.

Waiver submissions may be audited by Boston University, Aetna Student Health, and/or their contractors or representatives. You may be required to provide, upon request, any coverage documents and/or other records demonstrating that you meet the school’s requirements for waiving the Student Medical Insurance Plan. By submitting the Waiver request, you agree that your current insurance plan may be contacted for confirmation that your coverage is in force for the applicable Policy Year and that it meets the school’s waiver requirements.

**PREMIUM REFUND POLICY**

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

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

**INSURANCE ENROLLMENT FOR STUDENTS GRADUATING IN DECEMBER, 2012**

Insured students graduating in December, 2012 are eligible to request a Fall Semester Only student medical insurance premium. The annual premium rate will be charged until a student applies for and receives approval for the Fall Semester Only coverage option. A premium adjustment request must be made prior to January 1, 2013. Approval will not be given if a claim is received with a date of service after December 31, 2012. Students approved for an adjusted premium, who register for Spring 2013 or who do not graduate in December, 2012, will be responsible for the full annual premium.

Eligible students may contact Student Accounting Services at (617) 353-2264 to request a Medical Insurance Premium Adjustment Form or may download the form from the Student Accounting Services website at [www.bu.edu/studentaccountingservices](http://www.bu.edu/studentaccountingservices). Select Resources, then Medical Insurance.

**Please note:** Students approved for the Fall Semester Only adjusted coverage who also have dependent coverage through Aetna Student Health, must be aware that the dependent coverage will not continue beyond December 31, 2012. A pro-rated dependent premium will be refunded.
DEPENDENT COVERAGE

ELIGIBILITY
Students covered under the Boston University Student Medical Insurance Plan may also enroll their lawful spouse, and/or children under age 26.

- An eligible dependent will not be considered a late enrollee if a court order requires the covered student to provide coverage for his or her eligible dependent. Such coverage will become effective on the date of the court order.

ENROLLMENT
Insured students may enroll their eligible dependent(s) in the Basic Plan through the secure online enrollment system at www.aetnastudenthealth.com/bu. The Fall enrollment deadline is September 30, 2012. Dependent enrollment applications will not be accepted after September 30, 2012 unless there is a significant life change that directly affects their insurance coverage. (An example of a significant life change would be loss of health coverage under another health plan.) The Spring enrollment deadline is February 1, 2013 for eligible dependents. Premiums for dependent coverage are billed through Student Accounting Services and are added to your Boston University student account.

NEWBORN INFANT AND ADOPTED CHILD COVERAGE
A child born to a Covered Person shall be covered for Accident, Sickness, and congenital defects, for 31 days from the date of birth. At the end of this 31 day period, coverage will cease under the Boston University Student Medical Insurance Plan. To extend coverage for a newborn past the 31 days, the must: 1) enroll the child within 31 days of birth, and 2) pay the additional premium, if necessary, starting from the date of birth.

Coverage is provided for a child legally placed for adoption with a Covered Student for 31 days immediately from the date of the filing of a petition to adopt if the child has been residing in the home of the policyholder as a foster child, or, in all other cases, immediately from the date of placement of the child for purposes of adoption in the home of a policyholder. To extend coverage for an adopted child past the 31 days, the Covered Student must 1) enroll the child within 31 days of placement of such child, and 2) pay any additional premium, if necessary, starting from the date of placement.

DEPENDENTS OF INTERNATIONAL STUDENTS
The United States Federal Government requires all J-2 Visa dependents to have insurance coverage under an approved insurance plan. Also, all F-2 Visa holders and other dependents are strongly recommended to have insurance coverage under an approved Plan. The Boston University Student Medical Insurance Plan described in this Brochure meets the State and Federal requirements.

For information or general questions on dependent enrollment, contact Aetna Student Health at (800) 966-7772.

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

To maximize your savings and reduce out-of-pocket expenses, select a Preferred Provider*. It is to your advantage because savings may be achieved from the Negotiated Charges these providers have agreed to accept as payment for their services.

You may obtain information regarding Preferred Providers by contacting Aetna Student Health at (800) 966-7772, or by accessing DocFind® at www.aetna.com/docfind/custom/studenthealth/index.html.

1. Click on “Enter DocFind”
2. Select zip code, city, or county
3. Enter criteria
4. Select Provider Category
5. Select Provider Type
6. Select Plan Type – Student Health Plans
7. Select “Start Search” or “More Options”
8. “More Options” enter criteria and “Search”
Preferred providers are independent contractors and are neither employees nor agents of Aetna Life Insurance Company, Chickering Claims Administrators, Inc. or their affiliates. Neither Aetna Life Insurance Company, Chickering Claims Administrators, Inc. nor their affiliates provide medical care or treatment and they are not responsible for outcomes. The availability of a particular provider(s) cannot be guaranteed and network composition is subject to change.

REFERRAL REQUIREMENT – CHARLES RIVER CAMPUS STUDENTS

When Student Health Services is available, all full-time and insured three-quarter time Charles River Campus students must first report to the Student Health Services for treatment. A referral for each condition is required from Student Health Services prior to receiving treatment in the community. If you do not obtain a referral from Student Health Services prior to receiving treatment, no benefits are payable. A new referral is required at the beginning of each Policy Year prior to obtaining treatment for ongoing conditions.

A referral is not required in the following circumstances:

- Treatment of an Emergency Medical Condition. (Note: A Student Health Service referral is also not required for follow-up treatment related to emergency care.)
- For services rendered outside the Route 128 area.
- All obstetrical and gynecological services including maternity care and treatment for an acute or emergency gynecological condition.
- Treatment of dental injuries.
- Extraction of impacted wisdom teeth.
- Part-Time students.
- Dependents.
- Routine Vision Exams.
- Services delivered in accordance with the healing practices of Christian Science.

While they have access to Student Health Services, students in the School of Public Health, the Division of Graduate Medical Sciences, the School of Medicine and the Goldman School of Dental Medicine do not have a referral requirement.

INPATIENT PRE-CERTIFICATION PROGRAM

Inpatient Pre-Certification simply means calling Aetna Student Health to obtain approval for a medical procedure or service prior to any Inpatient treatment. Pre-certification may be done by you, your doctor, a hospital administrator, or one of your relatives. All requests for pre-certification must be obtained by contacting Aetna Student Health at (800) 966-7772 (attention Managed Care Department).

Note: A referral from Student Health Services may also be required before treatment is obtained. Please see the Referral Requirements section of this brochure.

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

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

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

Pre-Certification does not guarantee the payment of benefits for your inpatient admission. Each claim is subject to medical policy review, in accordance with the exclusions and limitations contained in the Policy, as well as a review of eligibility, adherence to notification guidelines, and benefit coverage under the Boston University Student Medical Insurance Plan.
Pre-Certification of Non-Emergency Inpatient Admissions, Partial Hospitalization, Identified Outpatient Services and Home Health Services:
The patient, Physician or hospital must telephone at least **three (3) business days** prior to the planned admission or prior to the date the services are scheduled to begin. In the case of a maternity claim, notification is required **three days** prior to planned delivery or within two business days of a spontaneous delivery. Although pre-certification is not required for pre/post-natal care, it is beneficial for the **Covered Person** to notify Aetna Student Health at the time prenatal care begins.

**Notification of Emergency Admissions:**
The patient, patient’s representative, Physician or hospital must telephone within **two (2) business days** following inpatient (or partial hospitalization) admission.

**DESCRIPTION OF BENEFITS**
The Boston University Student Medical Insurance Plan may not cover all of your health care expenses. The Plan excludes coverage for certain services and contains limitations on the amounts it will pay. Please read the Boston University Student Medical Insurance Plan Brochure carefully before deciding whether this Plan is right for you. While this document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. If you want to look at the full Plan description, which is contained in the Master Policy issued to Boston University, you may view it at Boston University Student Health Services or the Office of Risk Management or you may contact Aetna Student Health at (800) 966-7772 or view it online at www.aetnastudenthealth.com/bu. Please refer to the Certificate of Coverage for a complete description of the benefits available.

This Plan will never pay more than $500,000 in a Policy Year. Additional Plan maximums may also apply. Some illnesses may cost more to treat and health care providers may bill you for what the Plan does not cover. Subject to the terms of the Policy, benefits are available for you and your eligible dependents only for the coverages listed below, and only up to the maximum amounts shown. Please refer to the Certificate of Coverage for a complete description of the benefits available. Please Note: While traveling abroad, charges incurred outside the United States would be covered at the Preferred Care benefit level of the actual charge. All insurance coverage is subject to the terms of the Master Policy and applicable state filings. Under health care reform legislation, student health plans may be required to eliminate or modify certain existing benefit plan provisions, including, but not limited to, exclusions and limitations. Aetna reserves the right to modify its products and services in response to federal and/or state legislation, regulation or requests of government authorities.

**MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:**
As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This health plan meets Minimum Creditable Coverage standards that are effective January 1, 2010 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards.

**THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2010. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.**

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.
SUMMARY OF BENEFITS CHART

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

<table>
<thead>
<tr>
<th>DEPARTMENT</th>
<th>BASIC PLAN BENEFITS</th>
<th>PLUS PLAN BENEFITS</th>
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</table>
| DEDUCTIBLES | The following deductibles are applied before **Covered Medical Expenses** for **Non-Preferred Care** are payable:  
  - Student: $250 per Policy Year  
  - Spouse: $250 per Policy Year  
  - Child: $250 per Policy Year  
  The Plan Deductible is waived for the following benefits: Ambulance Expense, Emergency Room Expense, and Prescribed Medicines Expense. In compliance with Massachusetts State Mandate(s), the Annual Deductible is also waived for Early Intervention Services Expense. | The following deductibles are applied before **Covered Medical Expenses** for **Non-Preferred Care** are payable:  
  - Student: $250 per Policy Year  
  - Spouse: $250 per Policy Year  
  - Child: $250 per Policy Year  
  The Plan Deductible is waived for the following benefits: Ambulance Expense, Emergency Room Expense, and Prescribed Medicines Expense. In compliance with Massachusetts State Mandate(s), the Annual Deductible is also waived for Early Intervention Services Expense. |
| COINSURANCE | **Covered Medical Expenses** are payable at the coinsurance percentage specified below, after any applicable deductible, up to a maximum benefit of **$500,000 per Policy Year**. | **Covered Medical Expenses** are payable at the coinsurance percentage specified below, after any applicable deductible, up to a maximum benefit of **$500,000 per Policy Year**. |
| OUT-OF-POCKET MAXIMUMS | **Preferred Care:** Individual Out-of-Pocket per **Covered Person:** $2,500  
**Non-Preferred Care:** Individual Out-of-Pocket per **Covered Person:** $2,500  
**Combined Preferred Care and Non-Preferred Care Individual Out-of-Pocket Maximum per Covered Person is $5,000.** | **Non-Preferred Care:** Individual Out-of-Pocket per **Covered Person:** $2,500 |

All coverage is based on Recognized Charges unless otherwise specified.

### Inpatient Hospitalization Benefits

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<tr>
<th>DEPARTMENT</th>
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<th>PLUS PLAN BENEFITS</th>
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</table>
| Room and Board Expense | **Covered Medical Expenses** are payable as follows:  
  **Preferred Care:** After a $100 copay per admission, 80% of the Negotiated Charge.  
  **Non-Preferred Care:** 60% of the Recognized Charge for a semi-private room. | **Covered Medical Expenses** are payable as follows:  
  **Preferred Care:** After a $100 copay per admission, 100% of the Negotiated Charge.  
  **Non-Preferred Care:** 80% of the Recognized Charge for a semi-private room. |
<table>
<thead>
<tr>
<th>Intensive Care Room and Board Expense</th>
<th>BASIC PLAN BENEFITS</th>
<th>PLUS PLAN BENEFITS</th>
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<td><strong>Covered Medical Expenses</strong> are payable as follows:</td>
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<td>Preferred Care: After a $100 copay per admission, 100% of the Negotiated Charge.</td>
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<tr>
<td>Non-Preferred Care: 60% of the Recognized Charge for the Intensive Care Room Rate for an overnight stay.</td>
<td>Non-Preferred Care: 80% of the Recognized Charge for the Intensive Care Room Rate for an overnight stay.</td>
<td>Non-Preferred Care: 80% of the Recognized Charge for the Intensive Care Room Rate for an overnight stay.</td>
</tr>
<tr>
<td>Miscellaneous Hospital Expense</td>
<td><strong>Covered Medical Expenses</strong> include, but are not limited to, laboratory tests, x-rays, surgical dressings, anesthesia, supplies and equipment use, and medicines.</td>
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<td>Non-Preferred Care: 60% of the Recognized Charge.</td>
<td>Non-Preferred Care: 80% of the Recognized Charge.</td>
<td>Non-Preferred Care: 80% of the Recognized Charge.</td>
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<tr>
<td>Non-Surgical Physicians Expense</td>
<td><strong>Covered Medical Expenses</strong> for charges for the non-surgical services of the attending Physician, or a consulting Physician, are payable as follows:</td>
<td><strong>Covered Medical Expenses</strong> for charges for the non-surgical services of the attending Physician, or a consulting Physician, are payable as follows:</td>
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<td>Preferred Care: 80% of the Negotiated Charge.</td>
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<td>Non-Preferred Care: 60% of the Recognized Charge.</td>
<td>Non-Preferred Care: 80% of the Recognized Charge.</td>
<td>Non-Preferred Care: 80% of the Recognized Charge.</td>
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<tr>
<td>Surgical Expense - Inpatient</td>
<td><strong>Covered Medical Expenses</strong> include charges incurred by a covered person for surgery provided by a hospital on an inpatient basis.</td>
<td><strong>Covered Medical Expenses</strong> include charges incurred by a covered person for surgery provided by a hospital on an inpatient basis.</td>
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<tr>
<td>Surgical Expense</td>
<td>If the physician performs both the surgical procedure and the anesthesia service, benefits for the anesthesia service will be reduced by 50%.</td>
<td>If the physician performs both the surgical procedure and the anesthesia service, benefits for the anesthesia service will be reduced by 50%.</td>
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<td><strong>Covered Medical Expenses</strong> are payable as follows:</td>
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<td>Preferred Care: After a $75 copay per admission, 80% of the Negotiated Charge.</td>
<td>Preferred Care: After a $50 copay per surgery, 100% of the Negotiated Charge.</td>
<td>Preferred Care: After a $50 copay per surgery, 100% of the Negotiated Charge.</td>
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<td>Non-Preferred Care: 60% of the Recognized Charge.</td>
<td>Non-Preferred Care: 80% of the Recognized Charge.</td>
<td>Non-Preferred Care: 80% of the Recognized Charge.</td>
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<tr>
<td>Assistant Surgeon Expense</td>
<td><strong>Covered Medical Expenses</strong> for the charges of an assistant surgeon, during a surgical procedure, are payable as follows:</td>
<td><strong>Covered Medical Expenses</strong> for the charges of an assistant surgeon, during a surgical procedure, are payable as follows:</td>
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<td>Preferred Care: 80% of the Negotiated Charge.</td>
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<tr>
<td>Non-Preferred Care: 60% of the Recognized Charge.</td>
<td>Non-Preferred Care: 80% of the Recognized Charge.</td>
<td>Non-Preferred Care: 80% of the Recognized Charge.</td>
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<tr>
<td>Nurse Anesthetist and Nurse Practitioners</td>
<td><strong>BASIC PLAN BENEFITS</strong></td>
<td><strong>PLUS PLAN BENEFITS</strong></td>
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<td><strong>Covered Medical Expenses</strong> include charges for services rendered by a certified registered nurse anesthetist or nurse practitioner, if,</td>
<td><strong>Covered Medical Expenses</strong> include charges for services rendered by a certified registered nurse anesthetist or nurse practitioner, if,</td>
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<td>• The service rendered is within the scope of the certified registered nurse anesthetist’s license or the nurse practitioner’s authorization to practice by the board or of registration in nursing, and</td>
<td>• The service rendered is within the scope of the certified registered nurse anesthetist’s license or the nurse practitioner’s authorization to practice by the board or of registration in nursing, and</td>
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<td>• The Policy currently provides benefits for identical services rendered by a provider of health care licensed by the commonwealth.</td>
<td>• The Policy currently provides benefits for identical services rendered by a provider of health care licensed by the commonwealth.</td>
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**Covered Medical Expenses** for the charges of a nurse anesthetist and Nurse Practitioners, during a surgical procedure, are payable as follows:

**Preferred Care**: 80% of the Negotiated Charge.  
**Non-Preferred Care**: 60% of the Recognized Charge.

**Surgical Expense - Outpatient**

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<thead>
<tr>
<th>Surgical Expense</th>
<th><strong>Covered Medical Expenses</strong> include charges incurred by a covered person for surgery provided by a hospital on an outpatient basis.</th>
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<tr>
<td><strong>Covered Medical Expenses</strong> are payable as follows:</td>
<td><strong>Covered Medical Expenses</strong> are payable as follows:</td>
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</table>
| **Preferred Care**: After a $75 copay per surgery, 80% of the Negotiated Charge.  
**Non-Preferred Care**: 60% of the Recognized Charge. | **Preferred Care**: After a $50 copay per surgery, 100% of the Negotiated Charge.  
**Non-Preferred Care**: 80% of the Recognized Charge. |  |
| If the physician performs both the surgical procedure and the anesthesia service, benefits for the anesthesia service will be reduced by 50%. | If the physician performs both the surgical procedure and the anesthesia service, benefits for the anesthesia service will be reduced by 50%. |  |
| 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. | 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. |  |

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<tr>
<th>Anesthesia Expense</th>
<th><strong>Covered Medical Expenses</strong> for the charges of anesthesia, during a surgical procedure, are payable as follows:</th>
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</table>
| **Preferred Care**: 80% of the Negotiated Charge.  
**Non-Preferred Care**: 60% of the Recognized Charge. | **Preferred Care**: 100% of the Negotiated Charge.  
**Non-Preferred Care**: 80% of the Recognized Charge. |  |
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<tr>
<th>Assistant Surgeon Expense</th>
<th><strong>BASIC PLAN BENEFITS</strong></th>
<th><strong>PLUS PLAN BENEFITS</strong></th>
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<td><strong>Covered Medical Expenses</strong> for the charges of an assistant surgeon, during a surgical procedure, are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 60% of the Recognized Charge.</td>
<td><strong>Covered Medical Expenses</strong> for the charges of an assistant surgeon, during a surgical procedure, are payable as follows: Preferred Care: 100% of the Negotiated Charge. Non-Preferred Care: 80% of the Recognized Charge.</td>
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| Ambulatory Surgical Expense | Benefits are payable for **Covered Medical Expenses** incurred by a covered person for expenses incurred for outpatient surgery performed in a hospital outpatient surgery department or in an ambulatory surgical center. **Covered Medical Expenses** must be incurred on the day of the surgery or within 48 hours after the surgery. Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 60% of the Recognized Charge. | Benefits are payable for **Covered Medical Expenses** incurred by a covered person for expenses incurred for outpatient surgery performed in a hospital outpatient surgery department or in an ambulatory surgical center. **Covered Medical Expenses** must be incurred on the day of the surgery or within 48 hours after the surgery. Preferred Care: 100% of the Negotiated Charge. Non-Preferred Care: 80% of the Recognized Charge. |

### Outpatient Benefits

**Covered Medical Expenses** include but are not limited to: Physician’s office visits, hospital or outpatient department or emergency room visits, durable medical equipment, clinical lab, or radiological facility.

Certain benefits are applicable to the overall outpatient maximum of 36 visits per condition per Policy Year, as noted below.

<p>| Hospital Outpatient Department Expense | <strong>Covered Medical Expenses</strong> includes treatment rendered in a Hospital Outpatient Department. <strong>Covered Medical Expenses</strong> 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. Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 60% of the Recognized Charge. | <strong>Covered Medical Expenses</strong> includes treatment rendered in a Hospital Outpatient Department. <strong>Covered Medical Expenses</strong> 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. Preferred Care: 100% of the Negotiated Charge. Non-Preferred Care: 80% of the Recognized Charge. |</p>
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<tr>
<th>Walk-in Clinic Visit Expense</th>
<th><strong>BASIC PLAN BENEFITS</strong></th>
<th><strong>PLUS PLAN BENEFITS</strong></th>
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<tr>
<td></td>
<td><strong>Covered Medical Expenses</strong> include services rendered in a walk-in clinic.</td>
<td><strong>Covered Medical Expenses</strong> include services rendered in a walk-in clinic.</td>
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<td></td>
<td><strong>Preferred Care:</strong> After a $25 copay per visit, 100% of the Negotiated Charge.<strong>Non-Preferred Care:</strong> 80% of the Recognized Charge.</td>
<td><strong>Preferred Care:</strong> After a $15 copay per visit, 100% of the Negotiated Charge.<strong>Non-Preferred Care:</strong> 80% of the Recognized Charge.</td>
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<td></td>
<td><strong>Covered Medical Expenses</strong> are applicable to the overall outpatient maximum of 36 visits per condition per Policy Year.</td>
<td><strong>Covered Medical Expenses</strong> are applicable to the overall outpatient maximum of 36 visits per condition per Policy Year.</td>
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<tr>
<td>Emergency Room Expense</td>
<td><strong>Covered Medical Expenses</strong> incurred for treatment of an Emergency Medical Condition are payable as follows:</td>
<td><strong>Covered Medical Expenses</strong> incurred for treatment of an Emergency Medical Condition are payable as follows:</td>
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<td><strong>Preferred Care:</strong> After a $50 copay per visit (waived if admitted), 80% of the Negotiated Charge.<strong>Non-Preferred Care:</strong> After a $50 deductible per visit (waived if admitted), 80% of the Recognized Charge.</td>
<td><strong>Preferred Care:</strong> After a $50 copay per visit (waived if admitted), 100% of the Negotiated Charge.<strong>Non-Preferred Care:</strong> After a $50 per visit deductible (waived if admitted), 100% of the Recognized Charge.</td>
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<tr>
<td></td>
<td><em>Please note, this per visit Deductible does not apply towards meeting the annual Deductible.</em></td>
<td><em>Please note, this per visit Deductible does not apply towards meeting the annual Deductible.</em></td>
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<tr>
<td></td>
<td><strong>Important Note:</strong> Please note that as Non-Preferred Care Providers do not have a contract with Aetna, the provider may not accept payment of your cost share (your deductible and coinsurance) as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. Please send Aetna the bill at the address listed on the back of your member ID card and Aetna will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.</td>
<td><strong>Important Note:</strong> Please note that as Non-Preferred Care Providers do not have a contract with Aetna, the provider may not accept payment of your cost share (your deductible and coinsurance) as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. Please send Aetna the bill at the address listed on the back of your member ID card and Aetna will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.</td>
</tr>
<tr>
<td>Therapy Expense</td>
<td><strong>BASIC PLAN BENEFITS</strong></td>
<td><strong>PLUS PLAN BENEFITS</strong></td>
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<td>-----------------</td>
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</tr>
</tbody>
</table>
| Covered Medical Expenses include charges incurred by a covered person for the following types of therapy provided on an outpatient basis:  
• Chiropractic Care,  
• 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.  
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 incurred are payable as follows:  
Preferred Care: After a $25 Copay,  
100% of the Negotiated Charge.  
Non-Preferred Care: 80% of the Recognized charge.  
Covered Medical Expenses also include charges incurred by a covered person for the following types of therapy provided on an outpatient basis:  
• Radiation therapy;  
• Chemotherapy; including anti-nausea drugs used in conjunction with the chemotherapy;  
• Dialysis; and  
• Respiratory therapy.  
Benefits for these types of therapies are payable as follows:  
Preferred Care: 80% of the Negotiated Charge.  
Non-Preferred Care: 60% of the Recognized Charge. | Covered Medical Expenses include charges incurred by a covered person for the following types of therapy provided on an outpatient basis:  
• Chiropractic Care,  
• 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.  
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 incurred are payable as follows:  
Preferred Care: After a $15 Copay,  
100% of the Negotiated Charge.  
Non-Preferred Care: 80% of the Recognized charge.  
Covered Medical Expenses also include charges incurred by a covered person for the following types of therapy provided on an outpatient basis:  
• Radiation therapy;  
• Chemotherapy; including anti-nausea drugs used in conjunction with the chemotherapy;  
• Dialysis; and  
• Respiratory therapy.  
Benefits for these types of therapies are payable as follows:  
Preferred Care: 100% of the Negotiated Charge.  
Non-Preferred Care: 80% of the Recognized Charge. |
<p>| Ambulance Expense | <strong>Covered Medical Expenses</strong> are payable as follows: 80% of the Actual Charge for the services of a professional ambulance to or from a hospital, when required due to the emergency nature of a covered Accident or Sickness. | <strong>Covered Medical Expenses</strong> are payable as follows: 100% of the Actual Charge for the services of a professional ambulance to or from a hospital, when required due to the emergency nature of a covered Accident or Sickness. |</p>
<table>
<thead>
<tr>
<th>Pre-Admission Testing Expense</th>
<th><strong>BASIC PLAN BENEFITS</strong></th>
<th><strong>PLUS PLAN BENEFITS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Covered Medical Expenses</strong> for Pre-Admission testing charges while an outpatient before scheduled surgery are payable as any other lab and X-ray expense. <strong>Covered Medical Expenses</strong> are payable on the same basis as any other Sickness.</td>
<td><strong>Covered Medical Expenses</strong> for Pre-Admission testing charges while an outpatient before scheduled surgery are payable as any other lab and X-ray expense. <strong>Covered Medical Expenses</strong> are payable on the same basis as any other Sickness.</td>
</tr>
</tbody>
</table>
| Physical Therapy Expense     | **Covered Medical Expenses** for physical therapy are payable as follows when provided by a licensed physical therapist:  
**Preferred Care:** After a $25 copay per visit, 100% of the Negotiated Charge.  
**Non-Preferred Care:** 80% of the Recognized Charge. | **Covered Medical Expenses** for physical therapy are payable as follows when provided by a licensed physical therapist:  
**Preferred Care:** After a $15 copay per visit, 100% of the Negotiated Charge.  
**Non-Preferred Care:** 80% of the Recognized Charge. |
| Physician’s Office Visit Expense  | 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. Coverage is also provided on a nondiscriminatory basis for covered services when delivered or arranged by a participating nurse practitioner with no annual or lifetime dollar or service limitation that is less than that for other preferred care providers. 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 sickness or accident condition or per Policy Year.  
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.  
**Covered Medical Expenses** are payable as follows:  
**Preferred Care:** After a $25 copay per visit, 100% of the Negotiated Charge.  
**Non-Preferred Care:** 80% of the Recognized Charge.  
**Covered Medical Expenses** are applicable to the overall outpatient maximum of 36 visits per condition per Policy Year.  
This benefit includes visits to specialists. | 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. Coverage is also provided on a nondiscriminatory basis for covered services when delivered or arranged by a participating nurse practitioner with no annual or lifetime dollar or service limitation that is less than that for other preferred care providers. 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 sickness or accident condition or per Policy Year.  
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.  
**Covered Medical Expenses** are payable as follows:  
**Preferred Care:** After a $15 copay per visit, 100% of the Negotiated Charge.  
**Non-Preferred Care:** 80% of the Recognized Charge.  
**Covered Medical Expenses** are applicable to the overall outpatient maximum of 36 visits per condition per Policy Year.  
This benefit includes visits to specialists. |
<table>
<thead>
<tr>
<th>Laboratory and X-Ray Expense</th>
<th><strong>BASIC PLAN BENEFITS</strong></th>
<th><strong>PLUS PLAN BENEFITS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Medical Expenses</strong> include expenses for diagnostic services, laboratory, and X-ray examinations.</td>
<td><strong>Covered Medical Expenses</strong> include expenses for diagnostic services, laboratory, and X-ray examinations.</td>
<td></td>
</tr>
<tr>
<td>Benefits are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 60% of the Recognized Charge.</td>
<td>Benefits are payable as follows: Preferred Care: 100% of the Negotiated Charge. Non-Preferred Care: 80% of the Recognized Charge.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>High Cost Procedures Expense</th>
<th><strong>Covered Medical Expenses</strong> 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:</th>
<th><strong>Covered Medical Expenses</strong> 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:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(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.</td>
<td>(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.</td>
<td></td>
</tr>
<tr>
<td><strong>Covered Medical Expenses</strong> for High Cost Procedures include charges for the following procedures and services:</td>
<td><strong>Covered Medical Expenses</strong> for High Cost Procedures include charges for the following procedures and services:</td>
<td></td>
</tr>
<tr>
<td>(a) C.A.T. Scan; (b) Magnetic Resonance Imaging; and (c) Contrast Materials for these tests.</td>
<td>(a) C.A.T. Scan; (b) Magnetic Resonance Imaging; and (c) Contrast Materials for these tests.</td>
<td></td>
</tr>
<tr>
<td><strong>Covered Medical Expenses</strong> include charges incurred by a covered person are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 60% of the Recognized Charge.</td>
<td><strong>Covered Medical Expenses</strong> include charges incurred by a covered person are payable as follows: Preferred Care: 100% of the Negotiated Charge. Non-Preferred Care: 80% of the Recognized Charge.</td>
<td></td>
</tr>
<tr>
<td>Durable Medical and Surgical Equipment Expense</td>
<td><strong>BASIC PLAN BENEFITS</strong></td>
<td><strong>PLUS PLAN BENEFITS</strong></td>
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<td>-----------------------------------------------</td>
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<tr>
<td></td>
<td>Covered Medical Expenses for Durable Medical Equipment (DME) are payable as follows:</td>
<td>Covered Medical Expenses for Durable Medical Equipment (DME) are payable as follows:</td>
</tr>
<tr>
<td></td>
<td>Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 60% of the Recognized Charge.</td>
<td>Preferred Care: 100% of the Negotiated Charge. Non-Preferred Care: 80% of the Recognized Charge.</td>
</tr>
<tr>
<td></td>
<td><strong>Breast Feeding Durable Medical Equipment</strong></td>
<td><strong>Breast Feeding Durable Medical Equipment</strong></td>
</tr>
<tr>
<td></td>
<td>Coverage includes the rental or purchase of breast feeding durable medical equipment for the purpose of lactation support (pumping and storage of breast milk) as follows.</td>
<td>Coverage includes the rental or purchase of breast feeding durable medical equipment for the purpose of lactation support (pumping and storage of breast milk) as follows.</td>
</tr>
<tr>
<td></td>
<td>Preferred Care: <strong>100%</strong> of the Negotiated Charge. Non-Preferred Care: 80% of the Recognized Charge.</td>
<td>Preferred Care: <strong>100%</strong> of the Negotiated Charge. Non-Preferred Care: 80% of the Recognized Charge.</td>
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<tr>
<td></td>
<td><strong>Breast Pump</strong></td>
<td><strong>Breast Pump</strong></td>
</tr>
<tr>
<td></td>
<td>Covered expenses include the following:</td>
<td>Covered expenses include the following:</td>
</tr>
<tr>
<td></td>
<td>• The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a hospital.</td>
<td>• The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a hospital.</td>
</tr>
<tr>
<td></td>
<td>• The purchase of:</td>
<td>• The purchase of:</td>
</tr>
<tr>
<td></td>
<td>- an electric breast pump (non-hospital grade), if requested within 30 days from the date of the birth of the child. A purchase will be covered once every five years following the date of the birth; or</td>
<td>- an electric breast pump (non-hospital grade), if requested within 30 days from the date of the birth of the child. A purchase will be covered once every five years following the date of the birth; or</td>
</tr>
<tr>
<td></td>
<td>- a manual breast pump, if requested within 6-12 months from the date of the birth of the child. A purchase will be covered once every five years following the date of the birth.</td>
<td>- a manual breast pump, if requested within 6-12 months from the date of the birth of the child. A purchase will be covered once every five years following the date of the birth; or</td>
</tr>
<tr>
<td></td>
<td>• If an electric breast pump was purchased within the previous one period, the purchase of an electric or manual breast pump will not be covered until a five year period has elapsed from the last purchase of an electric pump.</td>
<td>• If an electric breast pump was purchased within the previous one period, the purchase of an electric or manual breast pump will not be covered until a five year period has elapsed from the last purchase of an electric pump.</td>
</tr>
<tr>
<td></td>
<td><strong>Breast Pump Supplies</strong></td>
<td><strong>Breast Pump Supplies</strong></td>
</tr>
<tr>
<td></td>
<td>Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.</td>
<td>Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.</td>
</tr>
<tr>
<td>Durable Medical and Surgical Equipment Expense (continued)</td>
<td>BASIC PLAN BENEFITS</td>
<td>PLUS PLAN BENEFITS</td>
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<tr>
<td>---------------------------------------------------------</td>
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</tr>
<tr>
<td>Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. The covered person is responsible for the entire cost of any additional pieces of the same or similar equipment that he or she purchases or rents for personal convenience or mobility.</td>
<td>Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. The covered person is responsible for the entire cost of any additional pieces of the same or similar equipment that he or she purchases or rents for personal convenience or mobility.</td>
<td>Aetna reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of Aetna.</td>
</tr>
<tr>
<td><strong>Limitations:</strong></td>
<td></td>
<td><strong>Limitations:</strong></td>
</tr>
<tr>
<td>Unless specified above, not covered under this benefit are charges incurred for:</td>
<td></td>
<td>Unless specified above, not covered under this benefit are charges incurred for:</td>
</tr>
<tr>
<td>• Services which are covered to any extent under any other part of this Plan; and</td>
<td>• Services which are covered to any extent under any other part of this Plan; and</td>
<td>• Services and supplies furnished by a Non-Preferred Care Provider.</td>
</tr>
<tr>
<td>• Services and supplies furnished by a Non-Preferred Care Provider.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Dental Injury Expense</th>
<th>Covered Medical Expenses include dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition,</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Natural teeth damaged, lost, or removed, or</strong></td>
<td><strong>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.</strong></td>
</tr>
<tr>
<td><strong>Any such teeth must have been,</strong></td>
<td><strong>Any such teeth must have been,</strong></td>
</tr>
<tr>
<td>• Free from decay, or</td>
<td>• Free from decay, or</td>
</tr>
<tr>
<td>• In good repair, and</td>
<td>• In good repair, and</td>
</tr>
<tr>
<td>• Firmly attached to the jawbone at the time of the injury.</td>
<td>• Firmly attached to the jawbone at the time of the injury.</td>
</tr>
<tr>
<td>The treatment must be done in the calendar year of the accident or the next one.</td>
<td>The treatment must be done in the calendar year of the accident or the next one.</td>
</tr>
<tr>
<td>If,</td>
<td>If,</td>
</tr>
<tr>
<td>• Crowns (caps), or</td>
<td>• Crowns (caps), or</td>
</tr>
<tr>
<td>• Dentures (false teeth), or</td>
<td>• Dentures (false teeth), or</td>
</tr>
<tr>
<td>• Bridgework, or</td>
<td>• Bridgework, or</td>
</tr>
<tr>
<td>• In-mouth appliances,</td>
<td>• In-mouth appliances,</td>
</tr>
<tr>
<td>are installed due to such injury, <strong>Covered Medical Expenses</strong> include only charges for,**</td>
<td>are installed due to such injury, <strong>Covered Medical Expenses</strong> include only charges for,**</td>
</tr>
<tr>
<td>• The first denture or fixed bridgework to replace lost teeth,</td>
<td>• The first denture or fixed bridgework to replace lost teeth,</td>
</tr>
</tbody>
</table>
### Dental Injury Expense (continued)

<table>
<thead>
<tr>
<th>BASIC PLAN BENEFITS</th>
<th>PLUS PLAN BENEFITS</th>
</tr>
</thead>
</table>
| • The first crown needed to repair each damaged tooth, and  
  • An in-mouth appliance used in the first course of orthodontic treatment after the injury.  
  Surgery needed to,  
  • Treat a fracture, dislocation, or wound.  
  • Cut out cysts, tumors, or other diseased tissues.  
  • Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement. Non-surgical treatment of infections or diseases. This does not include those of, or related to, the teeth.  
  **Covered Medical Expenses** are payable as follows: 100% of the Actual Charge.  
  Benefits are limited to a maximum of $300 per policy year. | • The first crown needed to repair each damaged tooth, and  
  • An in-mouth appliance used in the first course of orthodontic treatment after the injury.  
  Surgery needed to,  
  • Treat a fracture, dislocation, or wound.  
  • Cut out cysts, tumors, or other diseased tissues.  
  • Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement. Non-surgical treatment of infections or diseases. This does not include those of, or related to, the teeth.  
  **Covered Medical Expenses** are payable as follows: 100% of the Actual Charge.  
  Benefits are limited to a maximum of $300 per policy year. |

| Dental Expense for Impacted Wisdom Teeth | Covered Medical Expenses for removal of one or more impacted wisdom teeth are payable as follows: 100% of the Actual Charge. | Covered Medical Expenses for removal of one or more impacted wisdom teeth are payable as follows: 100% of the Actual Charge. |

| 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.  
**Covered Medical Expenses** are payable on the same basis as any other Sickness. | **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.  
**Covered Medical Expenses** are payable on the same basis as any other Sickness. |
<table>
<thead>
<tr>
<th>Diagnostic Testing For Learning Disabilities Expense</th>
<th><strong>BASIC PLAN BENEFITS</strong></th>
<th><strong>PLUS PLAN BENEFITS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Medical Expenses for diagnostic testing for:</td>
<td>Covered Medical Expenses for diagnostic testing for:</td>
<td>Covered Medical Expenses for diagnostic testing for:</td>
</tr>
<tr>
<td>• attention deficit disorder, or</td>
<td>• attention deficit disorder, or</td>
<td>• attention deficit disorder, or</td>
</tr>
<tr>
<td>• attention deficit hyperactive disorder.</td>
<td>• attention deficit hyperactive disorder.</td>
<td>• are payable on the same basis as any other Sickness.</td>
</tr>
<tr>
<td>• are payable on the same basis as any other Sickness.</td>
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</tr>
<tr>
<td>Once a covered person 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 this Plan.</td>
<td>Once a covered person 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 this Plan.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Routine Physical Exam Expense</th>
<th>Benefits include expenses for a routine physical exam performed by a physician. If charges for a routine physical exam given to a child who is a covered dependent are covered under any other benefit section, those charges will not be covered under this section.</th>
</tr>
</thead>
<tbody>
<tr>
<td>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:</td>
<td></td>
</tr>
<tr>
<td>• Routine vision and hearing screenings given as part of the routine physical exam.</td>
<td></td>
</tr>
<tr>
<td>• X-rays, lab, and other tests given in connection with the exam, and</td>
<td></td>
</tr>
<tr>
<td>• Materials for the administration of immunizations for infectious disease and testing for tuberculosis.</td>
<td></td>
</tr>
<tr>
<td>Preferred Care: visits are payable at 100% of the Negotiated Charge. Non-Preferred Care: visits are payable at 80% of the Recognized Charge.</td>
<td></td>
</tr>
<tr>
<td>In addition to any state regulations or guidelines regarding mandated Routine Physical Exam services, Covered Medical Expenses include services rendered in conjunction with,</td>
<td></td>
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<tr>
<td>• Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.</td>
<td></td>
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<tr>
<td>• For females, screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:</td>
<td></td>
</tr>
<tr>
<td>Benefits include expenses for a routine physical exam performed by a physician. If charges for a routine physical exam given to a child who is a covered dependent are covered under any other benefit section, those charges will not be covered under this section.</td>
<td></td>
</tr>
<tr>
<td>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:</td>
<td></td>
</tr>
<tr>
<td>• Routine vision and hearing screenings given as part of the routine physical exam.</td>
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</tr>
<tr>
<td>• X-rays, lab, and other tests given in connection with the exam, and</td>
<td></td>
</tr>
<tr>
<td>• Materials for the administration of immunizations for infectious disease and testing for tuberculosis.</td>
<td></td>
</tr>
<tr>
<td>Preferred Care: visits are payable at 100% of the Negotiated Charge. Non-Preferred Care: visits are payable at 80% of the Recognized Charge.</td>
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</tr>
<tr>
<td>In addition to any state regulations or guidelines regarding mandated Routine Physical Exam services, Covered Medical Expenses include services rendered in conjunction with,</td>
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<tr>
<td>• Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.</td>
<td></td>
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<tr>
<td>• For females, screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:</td>
<td></td>
</tr>
<tr>
<td>Routine Physical Exam Expense (continued)</td>
<td><strong>BASIC PLAN BENEFITS</strong></td>
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</tbody>
</table>
|  | - Screening and counseling services, such as:  
  Interpersonal and domestic violence;  
  Sexually transmitted diseases; and  
  Human Immune Deficiency Virus (HIV) infections.  
- Screening for gestational diabetes.  
- High risk Human Papillomavirus (HPV) DNA testing for women age 18 and older and limited to once every three years.  
• X-rays, lab and other tests given in connection with the exam.  
• Immunizations for infectious diseases and the materials for administration of immunizations that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.  
• If the plan includes dependent coverage, for covered newborns, an initial hospital check up.  
  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 over**, **Covered Medical Expenses will not include** charges for **more than** one exam in 12 months in a row.  
  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 12 months in a row.  
  **Covered Medical Expenses** incurred by a woman, are charges made by a physician for, one annual routine gynecological exam.  
  | Screening and counseling services, such as:  
  Interpersonal and domestic violence;  
  Sexually transmitted diseases; and  
  Human Immune Deficiency Virus (HIV) infections.  
- Screening for gestational diabetes.  
- High risk Human Papillomavirus (HPV) DNA testing for women age 18 and older and limited to once every three years.  
• X-rays, lab and other tests given in connection with the exam.  
• Immunizations for infectious diseases and the materials for administration of immunizations that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.  
If the plan includes dependent coverage, for covered newborns, an initial hospital check up.  
  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 over**, **Covered Medical Expenses will not include** charges for **more than** one exam in 12 months in a row.  
  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 12 months in a row.  
  **Covered Medical Expenses** incurred by a woman, are charges made by a physician for, one annual routine gynecological exam.  

<table>
<thead>
<tr>
<th>Routine Physical Exam Expense (continued)</th>
<th><strong>BASIC PLAN BENEFITS</strong></th>
<th><strong>PLUS PLAN BENEFITS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Screening and Counseling Services:</strong></td>
<td>Covered Medical Expenses include charges made by a <strong>physician</strong> in an individual or group setting for the following are covered at 100% of the Negotiated Charge when services are provided by a <strong>Preferred Care Provider:</strong></td>
<td>Covered Medical Expenses include charges made by a <strong>physician</strong> in an individual or group setting for the following are covered at 100% of the Negotiated Charge when services are provided by a <strong>Preferred Care Provider:</strong></td>
</tr>
<tr>
<td><strong>Obesity</strong></td>
<td>Screening and counseling services to aid in weight reduction due to obesity. Coverage includes: • Preventive counseling visits and/or risk factor reduction intervention; • Medical nutrition therapy; • Nutritional counseling; and • Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.</td>
<td></td>
</tr>
<tr>
<td><strong>Misuse of Alcohol and/or Drugs</strong></td>
<td>Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.</td>
<td>Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.</td>
</tr>
<tr>
<td><strong>Use of Tobacco Products</strong></td>
<td>Screening and counseling services to aid a covered person to stop the use of tobacco products. Coverage includes: • Preventive counseling visits; • Treatment visits; and • Class visits; to aid a covered person to stop the use of tobacco products.</td>
<td>Screening and counseling services to aid a covered person to stop the use of tobacco products. Coverage includes: • Preventive counseling visits; • Treatment visits; and • Class visits; to aid a covered person to stop the use of tobacco products.</td>
</tr>
<tr>
<td>Tobacco product means a substance containing tobacco or nicotine including: • cigarettes; • cigars; • smoking tobacco; • snuff; • smokeless tobacco; and • candy-like products that contain tobacco.</td>
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</tr>
<tr>
<td><strong>Limitations:</strong></td>
<td>Unless specified above, not covered under this Screening and Counseling Services benefit are charges incurred for: • Services which are covered to any extent under any other part of this Plan.</td>
<td>Unless specified above, not covered under this Screening and Counseling Services benefit are charges incurred for: • Services which are covered to any extent under any other part of this Plan.</td>
</tr>
<tr>
<td>Immunizations Expense</td>
<td><strong>BASIC PLAN BENEFITS</strong></td>
<td><strong>PLUS PLAN BENEFITS</strong></td>
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<td></td>
<td><strong>Covered Medical Expenses</strong> include:</td>
<td><strong>Covered Medical Expenses</strong> include:</td>
</tr>
<tr>
<td></td>
<td>• charges incurred by a covered student and dependent spouse for the materials for the administration of appropriate and <strong>medically necessary</strong> immunizations, and testing for tuberculosis, and</td>
<td>• charges incurred by a covered student and dependent spouse for the materials for the administration of appropriate and <strong>medically necessary</strong> immunizations, and testing for tuberculosis, and</td>
</tr>
<tr>
<td></td>
<td>• charges incurred by a covered dependent from age 6 for the materials for the administration of appropriate and <strong>medically necessary</strong> immunizations, when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics.</td>
<td>• charges incurred by a covered dependent from age 6 for the materials for the administration of appropriate and <strong>medically necessary</strong> immunizations, when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics.</td>
</tr>
<tr>
<td></td>
<td><strong>Preferred Care</strong>: 100% of the Negotiated Charge.</td>
<td><strong>Preferred Care</strong>: 100% of the Negotiated Charge.</td>
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<tr>
<td></td>
<td><strong>Non-Preferred Care</strong>: 80% of the Recognized Charge.</td>
<td><strong>Non-Preferred Care</strong>: 80% of the Recognized Charge.</td>
</tr>
<tr>
<td></td>
<td><strong>Covered Medical Expenses do not include</strong> a physician’s office visit in connection with immunization or testing for tuberculosis.</td>
<td><strong>Covered Medical Expenses do not include</strong> a physician’s office visit in connection with immunization or testing for tuberculosis.</td>
</tr>
</tbody>
</table>

<p>| Consultant Expense | <strong>Covered Medical Expenses</strong> include the expenses for the services of a consultant. The services must be requested by the attending physician for the purpose of confirming or determining a diagnosis. | <strong>Covered Medical Expenses</strong> include the expenses for the services of a consultant. The services must be requested by the attending physician for the purpose of confirming or determining a diagnosis. |
|                    | <strong>Covered Medical Expenses</strong> are covered as follows: | <strong>Covered Medical Expenses</strong> are covered as follows: |
|                    | <strong>Preferred Care</strong>: After a $25 copay per visit, 100% of the Negotiated Charge. | <strong>Preferred Care</strong>: After a $15 copay per visit, 100% of the Negotiated Charge. |
|                    | <strong>Non-Preferred Care</strong>: 80% of the Recognized Charge. | <strong>Non-Preferred Care</strong>: 80% of the Recognized Charge. |
|                    | <strong>Covered Medical Expenses are applicable to the overall outpatient maximum of 36 visits per condition per Policy Year.</strong> | <strong>Covered Medical Expenses are applicable to the overall outpatient maximum of 36 visits per condition per Policy Year.</strong> |</p>
<table>
<thead>
<tr>
<th>Qualified Clinical Trial Expense</th>
<th><strong>BASIC PLAN BENEFITS</strong></th>
<th><strong>PLUS PLAN BENEFITS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Clinical Trial Expenses are payable for <strong>Covered Medical Expenses</strong> incurred by each covered person. A qualified clinical trial is a clinical trial that meets the following conditions:</td>
<td></td>
<td>Qualified Clinical Trial Expenses are payable for <strong>Covered Medical Expenses</strong> incurred by each covered person. A qualified clinical trial is a clinical trial that meets the following conditions:</td>
</tr>
<tr>
<td>- The clinical trial is intended to treat cancer in a patient who has been so diagnosed,</td>
<td>- The clinical trial is intended to treat cancer in a patient who has been so diagnosed,</td>
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<tr>
<td>- The clinical trial has been peer reviewed, and is approved by one of the United States National Institutes of Health (NIH), a cooperative group or center of the NIH, a qualified non-governmental research entity identified in guidelines issued by the NIH for center support grants, the United States FDA pursuant to an investigational new drug exemption, the United States Departments of Defense or Veterans Affairs, or, with respect to Phase II, III and IV clinical trials only, a qualified institutional review board,</td>
<td>- The clinical trial has been peer reviewed, and is approved by one of the United States National Institutes of Health (NIH), a cooperative group or center of the NIH, a qualified non-governmental research entity identified in guidelines issued by the NIH for center support grants, the United States FDA pursuant to an investigational new drug exemption, the United States Departments of Defense or Veterans Affairs, or, with respect to Phase II, III and IV clinical trials only, a qualified institutional review board,</td>
<td></td>
</tr>
<tr>
<td>- The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training, and treat a sufficient volume of patients to maintain that expertise.</td>
<td>- The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training, and treat a sufficient volume of patients to maintain that expertise.</td>
<td></td>
</tr>
<tr>
<td>- With respect to phase I clinical trials, the facility shall be an academic medical center, or an affiliated facility, and the clinicians conducting the trial shall have staff privileges at said academic medical center.</td>
<td>- With respect to phase I clinical trials, the facility shall be an academic medical center, or an affiliated facility, and the clinicians conducting the trial shall have staff privileges at said academic medical center.</td>
<td></td>
</tr>
<tr>
<td>- The patient meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial.</td>
<td>- The patient meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial.</td>
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</tr>
<tr>
<td>- The patient has provided informed consent for participation in the clinical trial, in a manner that is consistent with current legal and ethical standards.</td>
<td>- The patient has provided informed consent for participation in the clinical trial, in a manner that is consistent with current legal and ethical standards.</td>
<td></td>
</tr>
<tr>
<td>- The available clinical or pre-clinical data provide a reasonable expectation that the patient’s participation in the clinical trial will provide a medical benefit, that is commensurate with the risks of participation in the clinical trial.</td>
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<tr>
<td>- The clinical trial does not unjustifiably duplicate existing studies.</td>
<td>- The clinical trial does not unjustifiably duplicate existing studies.</td>
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<tr>
<td>- The clinical trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the patient.</td>
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</table>

**Covered Medical Expenses** are payable on the same basis as any other condition.
<table>
<thead>
<tr>
<th>Mental Health Benefit</th>
<th>BASIC PLAN BENEFITS</th>
<th>PLUS PLAN BENEFITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of a Biologically-Based Mental Disorder</td>
<td>Covered Benefits include charges made for the treatment of mental disorders by behavioral health providers.</td>
<td>Covered Benefits include charges made for the treatment of mental disorders by behavioral health providers.</td>
</tr>
<tr>
<td></td>
<td>Covered Benefits include charges made by a Hospital, Psychiatric Hospital, Residential Treatment Facility or Behavioral Health Provider’s office for the treatment of Mental Disorders (including substance abuse).</td>
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</tr>
<tr>
<td></td>
<td>Benefits are payable as any other condition for the following:</td>
<td>Benefits are payable as any other condition for the following:</td>
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<tr>
<td></td>
<td>• Inpatient – Inpatient services may be provided in a general Hospital licensed to provide such services, in a facility under the direction and supervision of the department of mental health, in a private mental Hospital licensed by the department of mental health, or in a substance abuse facility licensed by the department of public health;</td>
<td>• Inpatient – Inpatient services may be provided in a general Hospital licensed to provide such services, in a facility under the direction and supervision of the department of mental health, in a private mental Hospital licensed by the department of mental health, or in a substance abuse facility licensed by the department of public health;</td>
</tr>
<tr>
<td></td>
<td>• Intermediate services – includes charges for a range of non-inpatient services that provide more intensive and extensive treatment interventions when outpatient services alone are not sufficient to meet the covered person’s needs. Intermediate services include, but are not limited to, the following:</td>
<td>• Intermediate services – includes charges for a range of non-inpatient services that provide more intensive and extensive treatment interventions when outpatient services alone are not sufficient to meet the covered person’s needs. Intermediate services include, but are not limited to, the following:</td>
</tr>
<tr>
<td></td>
<td>• Acute and other residential treatment – Mental health services provided in a 24-hour setting, with clinical staff and appropriately trained professional and paraprofessional staff to insure safety for the covered person while providing active treatment and reassessment.</td>
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</tr>
<tr>
<td></td>
<td>• Clinically managed detoxification services – 24 hour, seven days a week, clinically managed detoxification services in a licensed non-hospital setting that include 24 hour per day supervision, observation and support, and nursing care, seven days a week.</td>
<td>• Clinically managed detoxification services – 24 hour, seven days a week, clinically managed detoxification services in a licensed non-hospital setting that include 24 hour per day supervision, observation and support, and nursing care, seven days a week.</td>
</tr>
<tr>
<td></td>
<td>• Partial hospitalization – Short-term day/ evening mental health programming available five to seven days per week. These services consist of therapeutically intensive acute treatment within a therapeutic milieu and include daily psychiatric management.</td>
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</tr>
<tr>
<td></td>
<td>• Intensive Outpatient Programs (IOP) – Multimodal, inter-disciplinary, structured behavioral health treatment provided over the course of two to three</td>
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</tr>
<tr>
<td>Treatment of a Biologically-Based Mental Disorder (continued)</td>
<td>hours per day for multiple days per week in an outpatient setting. Includes, but is not limited to, diagnosis, evaluation and treatment of mental health and substance abuse disorders.</td>
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<tr>
<td><strong>Day treatment</strong> – Services based on a planned combination of diagnostic, treatment and rehabilitative approaches to a person with mental illness or substance abuse disorder who needs more active or intensive treatment. Day treatment programs encompass generally some portion of a day or week rather than a weekly visit to a mental health clinic, individual provider’s office or hospital outpatient department. The covered person does not need 24-hour hospitalization or partial hospitalization.</td>
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<tr>
<td><strong>Crisis stabilization</strong> – Short-term psychiatric treatment in structured, community-based therapeutic environments. Community Crisis Stabilization provides continuous 24-hour observation and supervision for individuals who do not require Inpatient Services.</td>
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<tr>
<td><strong>In-home therapy services</strong> – An intensive combination of diagnostic and treatment interventions delivered in the home and community to a youth and family designed to sustain the youth in his or her home and/or to prevent the youth’s admission to an inpatient hospital, psychiatric residential treatment facility, or other psychiatric treatment setting.</td>
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</table>

**The following services are not considered intermediate services:**

1. Programs in which the patient has a pre-defined duration of care without the health plan’s ability to conduct concurrent determinations of continued medical necessity for the covered person.
2. Programs that only provide meetings or activities that are not based on individualized treatment planning.
3. Programs that focus solely on improvement in interpersonal or other skills rather than treatment directed toward symptom reduction and functional recovery related to amelioration of specific psychiatric symptoms or syndromes.

| hours per day for multiple days per week in an outpatient setting. Includes, but is not limited to, diagnosis, evaluation and treatment of mental health and substance abuse disorders. |
|---|---|
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| **Crisis stabilization** – Short-term psychiatric treatment in structured, community-based therapeutic environments. Community Crisis Stabilization provides continuous 24-hour observation and supervision for individuals who do not require Inpatient Services. |
| **In-home therapy services** – An intensive combination of diagnostic and treatment interventions delivered in the home and community to a youth and family designed to sustain the youth in his or her home and/or to prevent the youth’s admission to an inpatient hospital, psychiatric residential treatment facility, or other psychiatric treatment setting. |

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3. Programs that focus solely on improvement in interpersonal or other skills rather than treatment directed toward symptom reduction and functional recovery related to amelioration of specific psychiatric symptoms or syndromes.
<table>
<thead>
<tr>
<th>4. Tuition-based programs that offer educational, vocational, recreational or personal development activities, such as a therapeutic school, camp or wilderness program. This policy must provide coverage for outpatient or intermediate services provided while the individual is in the program, subject to the terms of this Policy including any network requirements or Copayments provisions.</th>
<th>4. Tuition-based programs that offer educational, vocational, recreational or personal development activities, such as a therapeutic school, camp or wilderness program. This policy must provide coverage for outpatient or intermediate services provided while the individual is in the program, subject to the terms of this Policy including any network requirements or Copayments provisions.</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Programs that provide primarily custodial care services.</td>
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</tr>
</tbody>
</table>

- For outpatient treatment – provided in a licensed Hospital, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, a professional office, or home-based services, provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of their license.

- Rape Related Mental or Emotional Disorders - Coverage shall be provided for the diagnosis and treatment of rape related mental or emotional disorders if the covered person is a victim of a rape or victim of an assault with intent to commit rape under the same terms and conditions and which are no less extensive that coverage provided for any other type of health care for physical Illness.

- Children and Adolescents under the age of 19 - Benefits shall be covered under the same terms and conditions and which are not less extensive than coverage provided for an other health care for physical Illness, for children and adolescents under the age of 19 for the diagnosis and treatment of non-biologically-based mental, behavioral or emotional disorders, as described in the most recent edition of the DSM, which substantially interfere with or substantially limit the functioning and social interactions of such a child or adolescent; provided, that said interference or limitation is documented by and the referral for said diagnosis and treatment is made by the Primary Care Provider, primary pediatrician or a licensed mental health professional of such a child or adolescent or is evidenced by conduct, including but not limited to:
| Treatment of a Biologically-Based Mental Disorder (continued) | (1) an inability to attend school as a result of such a disorder;  
(2) the need to hospitalize the child or adolescent as a result of such a disorder;  
(3) a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others.  

This policy shall continue to provide such benefits to any adolescent who is engaged in an ongoing course of treatment beyond the adolescent’s nineteenth birthday until said course of treatment is completed and while the benefit contract under which such benefits first became available remains in effect, or subject to a subsequent benefits contract which is in effect.  
• Psychopharmacological Services/Neuropsychological Assessment Services - Coverage shall be provided for the diagnosis and treatment of psychopharmacological services/neuropsychological assessment services under the same term and conditions and which are no less extensive than coverage provided for any other type of health care for physical illness.  

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:  
• There is a written treatment plan prescribed and supervised by a Behavioral Health Provider.  
• The plan includes follow-up treatment.  

If the covered person requires ongoing care from a Behavioral Health Provider, the covered person may receive a standing referral to such Behavioral Health Provider. The Behavioral Health Provider agrees to a treatment plan and provides the primary care physician with all necessary clinical and administrative information on a regular basis. The health care services provided must be consistent with the terms of the Policy. | (1) an inability to attend school as a result of such a disorder;  
(2) the need to hospitalize the child or adolescent as a result of such a disorder;  
(3) a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others.  

This policy shall continue to provide such benefits to any adolescent who is engaged in an ongoing course of treatment beyond the adolescent’s nineteenth birthday until said course of treatment is completed and while the benefit contract under which such benefits first became available remains in effect, or subject to a subsequent benefits contract which is in effect.  
• Psychopharmacological Services/Neuropsychological Assessment Services - Coverage shall be provided for the diagnosis and treatment of psychopharmacological services/neuropsychological assessment services under the same term and conditions and which are no less extensive than coverage provided for any other type of health care for physical illness.  

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:  
• There is a written treatment plan prescribed and supervised by a Behavioral Health Provider.  
• The plan includes follow-up treatment.  

If the covered person requires ongoing care from a Behavioral Health Provider, the covered person may receive a standing referral to such Behavioral Health Provider. The Behavioral Health Provider agrees to a treatment plan and provides the primary care physician with all necessary clinical and administrative information on a regular basis. The health care services provided must be consistent with the terms of the Policy. |
<table>
<thead>
<tr>
<th>Non-Biologically Based Mental and Emotional Disorders - Inpatient Expense</th>
<th><strong>BASIC PLAN BENEFITS</strong></th>
<th><strong>PLUS PLAN BENEFITS</strong></th>
</tr>
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</table>
|  | **Covered Medical Expenses** for the treatment of a mental health while confined as an inpatient in a hospital or facility licensed for such treatment are payable as follows:  
Preferred Care: After a $100 Copay per admission, 80% of the Negotiated Charge.  
Non-Preferred Care: 60% of the Recognized Charge.  
**Covered Medical Expenses** also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission, whereby 2 days of partial hospitalization may be exchanged for 1 day of full hospitalization. | **Covered Medical Expenses** for the treatment of a mental health while confined as an inpatient in a hospital or facility licensed for such treatment are payable as follows:  
Preferred Care: After a $100 Copay per admission, 100% of the Negotiated Charge.  
Non-Preferred Care: 80% of the Recognized Charge.  
**Covered Medical Expenses** also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission, whereby 2 days of partial hospitalization may be exchanged for 1 day of full hospitalization. |
|  | **Covered Medical Expenses** for outpatient treatment of a mental health condition are payable as follows:  
Preferred Care: After a $10 copay per visit, 100% of the Negotiated Charge.  
Non-Preferred Care: 80% of the Recognized Charge.  
Benefits are limited to a maximum of 36 visits per condition per policy year. |  |
| Non-Biologically Based Mental and Emotional Disorders - Outpatient Expenses |  | **Covered Medical Expenses** for outpatient treatment of a mental health condition are payable as follows:  
Preferred Care: After a $10 copay per visit, 100% of the Negotiated Charge.  
Non-Preferred Care: 80% of the Recognized Charge.  
Benefits are limited to a maximum of 36 visits per condition per policy year. |
| Autism Spectrum Disorder Expense | **Covered Medical Expenses** include charges following care prescribed, provided or ordered for an individual diagnosed with one of the autism spectrum disorders by a licensed physician or a licensed psychologist who determines the care to be medically necessary:  
• Habilitative or Rehabilitative Care,  
• Pharmacy Care,  
• Psychiatric Care,  
• Psychological Care, and  
• Therapeutic Care.  
Applied Behavioral Analysis is the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior. | Covered expenses include charges following care prescribed, provided or ordered for an individual diagnosed with one of the autism spectrum disorders by a licensed physician or a licensed psychologist who determines the care to be medically necessary:  
• Habilitative or Rehabilitative Care,  
• Pharmacy Care,  
• Psychiatric Care,  
• Psychological Care, and  
• Therapeutic Care.  
Applied Behavioral Analysis is the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior. |
<table>
<thead>
<tr>
<th>Disorder Expense (continued)</th>
<th><strong>BASIC PLAN BENEFITS</strong></th>
<th><strong>PLUS PLAN BENEFITS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Autism Spectrum Disorder</td>
<td>Autism Spectrum Disorder means any of the pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, including,</td>
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<tr>
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<td>• Autistic Disorder,</td>
<td>• Autistic Disorder,</td>
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<td></td>
<td>• Rett’s Disorder,</td>
<td>• Rett’s Disorder,</td>
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<td></td>
<td>• Childhood Disintegrative Disorder,</td>
<td>• Childhood Disintegrative Disorder,</td>
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<td>• Asperger’s Syndrome, and</td>
<td>• Asperger’s Syndrome, and</td>
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<tr>
<td></td>
<td>• Pervasive Developmental Disorders – Not Otherwise Specified</td>
<td>• Pervasive Developmental Disorders – Not Otherwise Specified</td>
</tr>
<tr>
<td>Coverage for the diagnosis and treatment of Autism Spectrum Disorders is payable same as any other illness or injury.</td>
<td>Coverage for the diagnosis and treatment of Autism Spectrum Disorders is payable same as any other illness or injury.</td>
<td>Coverage for the diagnosis and treatment of Autism Spectrum Disorders is not subject to a limit on the number of visits an individual may make to an Autism Services Provider.</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Maternity Benefits</th>
<th><strong>BASIC PLAN BENEFITS</strong></th>
<th><strong>PLUS PLAN BENEFITS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity Expense</td>
<td><strong>Covered Medical Expenses</strong> include inpatient care of the covered person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery. Any decision to shorten such minimum coverages shall be made by the attending Physician in consultation with the mother. In such cases, covered services may include, home visits, parent education, and assistance and training in breast or bottle-feeding and the performance of any necessary and appropriate clinical tests, provided, however, that the first home visit be conducted by a registered nurse, physician, or certified nurse midwife, and provided that any subsequent home visits determined to be clinically necessary shall be provided by a licensed health care provider.</td>
<td><strong>Covered Medical Expenses</strong> include inpatient care of the covered person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery. Any decision to shorten such minimum coverages shall be made by the attending Physician in consultation with the mother. In such cases, covered services may include, home visits, parent education, and assistance and training in breast or bottle-feeding and the performance of any necessary and appropriate clinical tests, provided, however, that the first home visit be conducted by a registered nurse, physician, or certified nurse midwife, and provided that any subsequent home visits determined to be clinically necessary shall be provided by a licensed health care provider.</td>
</tr>
<tr>
<td></td>
<td><strong>Covered Medical Expenses</strong> include benefits for services of a certified nurse midwife, provided that expenses for such services are reimbursed when such services are performed by any other duly licensed practitioner. Complications of pregnancy, including spontaneous and non-elective abortions,</td>
<td><strong>Covered Medical Expenses</strong> include benefits for services of a certified nurse midwife, provided that expenses for such services are reimbursed when such services are performed by any other duly licensed practitioner. Complications of pregnancy, including spontaneous and non-elective abortions,</td>
</tr>
<tr>
<td>Maternity Expense (continued)</td>
<td>are considered a sickness, and are covered under this benefit. Voluntary or elective abortions are not covered. <strong>Covered Medical Expenses</strong> are payable on the same basis as any other sickness.</td>
<td>are considered a sickness, and are covered under this benefit. Voluntary or elective abortions are not covered. <strong>Covered Medical Expenses</strong> are payable on the same basis as any other sickness.</td>
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<tr>
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</tr>
<tr>
<td><strong>Prenatal Care</strong></td>
<td>Prenatal care will be covered at 100% of the Negotiated Charge* for services received by a pregnant female in a <strong>physician’s</strong>, obstetrician’s, or gynecologist’s office but only to the extent described below. Coverage for prenatal care under this benefit is limited to pregnancy-related <strong>physician</strong> office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).</td>
<td>Prenatal care will be covered at 100% of the Negotiated Charge* for services received by a pregnant female in a <strong>physician’s</strong>, obstetrician’s, or gynecologist’s office but only to the extent described below. Coverage for prenatal care under this benefit is limited to pregnancy-related <strong>physician</strong> office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).</td>
</tr>
<tr>
<td><strong>Comprehensive Lactation Support and Counseling Services</strong></td>
<td><strong>Covered Medical Expenses</strong> will be covered at 100% of the Negotiated Charge* and include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy and in the post partum period by a certified lactation support provider. The “post partum period” means the 60 day period directly following the child’s date of birth. <strong>Covered expenses</strong> incurred during the post partum period also include the rental or purchase of breast feeding equipment as described below. Lactation support and lactation counseling services are <strong>covered expenses</strong> when provided in either a group or individual setting.</td>
<td><strong>Covered Medical Expenses</strong> will be covered at 100% of the Negotiated Charge* and include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy and in the post partum period by a certified lactation support provider. The “post partum period” means the 60 day period directly following the child’s date of birth. <strong>Covered expenses</strong> incurred during the post partum period also include the rental or purchase of breast feeding equipment as described below. Lactation support and lactation counseling services are <strong>covered expenses</strong> when provided in either a group or individual setting.</td>
</tr>
<tr>
<td></td>
<td>*100% of the Negotiated Charge refers to Preferred Care only. Non-Preferred Care will be covered as any other Sickness.</td>
<td>*100% of the Negotiated Charge refers to Preferred Care only. Non-Preferred Care will be covered as any other Sickness.</td>
</tr>
<tr>
<td>Well Newborn Nursery Care Expense</td>
<td><strong>BASIC PLAN BENEFITS</strong></td>
<td><strong>PLUS PLAN BENEFITS</strong></td>
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<tr>
<td>Benefits include charges for routine care of a covered person’s newborn child as follows:</td>
<td>Benefits include charges for routine care of a covered person’s newborn child as follows:</td>
<td></td>
</tr>
<tr>
<td>• hospital charges for routine nursery care during the mother’s confinement, but for not more than four days</td>
<td>• hospital charges for routine nursery care during the mother’s confinement, but for not more than four days</td>
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</tr>
<tr>
<td>• physician’s charges for circumcision, and,</td>
<td>• physician’s charges for circumcision, and,</td>
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<tr>
<td>• physician’s charges for visits to the newborn child in the hospital and consultations, but for not more than 1 visit per day.</td>
<td>• physician’s charges for visits to the newborn child in the hospital and consultations, but for not more than 1 visit per day.</td>
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</tr>
</tbody>
</table>

**Covered Medical Expenses** are payable as follows:
- Preferred Care: 80% of the Negotiated Charge.
- Non-Preferred Care: 60% of the Recognized Charge.

**Covered Medical Expenses** are payable as follows:
- Preferred Care: 100% of the Negotiated Charge.
- Non-Preferred Care: 80% of the Recognized Charge.

**Additional Benefits**

<table>
<thead>
<tr>
<th>Prescribed Medicines Expense</th>
<th><strong>BASIC PLAN BENEFITS</strong></th>
<th><strong>PLUS PLAN BENEFITS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Drug Benefits are payable as follows:</td>
<td>Prescription Drug Benefits are payable as follows:</td>
<td></td>
</tr>
<tr>
<td>Preferred Care Pharmacy: 100% following a $10 copay for each Generic Prescription Drug or a $30 copay for each Preferred Brand Name Prescription Drug or a $45 copay for each Non-Preferred Brand Name Prescription Drug.</td>
<td>Preferred Care Pharmacy: 100% following a $10 copay for each Generic Prescription Drug or a $30 copay for each Preferred Brand Name Prescription Drug or a $45 copay for each Non-Preferred Brand Name Prescription Drug.</td>
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</tr>
<tr>
<td>Non-Preferred Care Pharmacy: 80% of the Recognized Charge per Prescription Drug.</td>
<td>Non-Preferred Care Pharmacy: 80% of the Recognized Charge per Prescription Drug.</td>
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</tr>
</tbody>
</table>

**Covered Medical Expenses** are payable to the maximum of $100,000 per Policy Year. (Maximum is combined Preferred Care and Non-Preferred Care.)

This Pharmacy benefit is provided to cover Medically Necessary Prescriptions associated with a covered Sickness or Accident occurring during the Policy Year. **Covered Medical Expenses** also include prescription smoking cessations aids. Please use your Aetna Student Health ID card when obtaining your prescriptions.

**Prescription drugs include:**
1) “Off-label” drugs for the HIV/AIDS treatment, provided such drugs (i) are prescribed by a Doctor for HIV/AIDS treatment, or medical condition arising from or related to HIV infection, and (ii) are prescribed or administered with the treatment protocol for coverage of “Off-label” drugs, determined in accordance with Massachusetts law.

Prescription drugs include:
1) “Off-label” drugs for the HIV/AIDS treatment, provided such drugs (i) are prescribed by a Doctor for HIV/AIDS treatment, or medical condition arising from or related to HIV infection, and (ii) are prescribed or administered with the treatment protocol for coverage of “Off-label” drugs, determined in accordance with Massachusetts law.

“Off-label” means a drug that has not been specifically approved by the Federal Food and Drug Administration.
Prescribed Medicines Expense (continued) | **BASIC PLAN BENEFITS** | **PLUS PLAN BENEFITS**
---|---|---
| “Off-label” means a drug that has not been specifically approved by the Federal Food and Drug Administration for HIV/AIDS treatment, but is a drug approved for other indications by the Federal Food and Drug Administration. | for HIV/AIDS treatment, but is a drug approved for other indications by the Federal Food and Drug Administration. |
| 2) “Off-label” drugs for cancer treatment, provided such drugs (i) are prescribed by a Doctor for cancer, and (ii) are prescribed or administered with the treatment protocol for coverage of “Off-label” drugs, determined in accordance with Massachusetts law. “Off-label” means a drug that has not been specifically approved by the Federal Food and Drug Administration for cancer treatment, but is a drug approved for other indications by the Federal Food and Drug Administration. | 2) “Off-label” drugs for cancer treatment, provided such drugs (i) are prescribed by a Doctor for cancer, and (ii) are prescribed or administered with the treatment protocol for coverage of “Off-label” drugs, determined in accordance with Massachusetts law. “Off-label” means a drug that has not been specifically approved by the Federal Food and Drug Administration for cancer treatment, but is a drug approved for other indications by the Federal Food and Drug Administration. |
| 3) Drugs and medicines which, by law, need a physician’s prescription. This includes those prescribed for the treatment of cancer or HIV/AIDS, even if the off-label use of the drug has not been approved by the FDA for that indication. However, such drug for the treatment of Cancer or HIV/AIDS must be recognized for treatment of such indication in one of the standard reference compendia, or in medical literature. The term “standard reference compendia” means: the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information. The term “medical literature” means published scientific studies appearing in any peer-reviewed national professional journal. | 3) Drugs and medicines which, by law, need a physician’s prescription. This includes those prescribed for the treatment of cancer or HIV/AIDS, even if the off-label use of the drug has not been approved by the FDA for that indication. However, such drug for the treatment of Cancer or HIV/AIDS must be recognized for treatment of such indication in one of the standard reference compendia, or in medical literature. The term “standard reference compendia” means: the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information. The term “medical literature” means published scientific studies appearing in any peer-reviewed national professional journal. |

Prior Authorization may be required for certain Prescription Drugs and some medications may not be covered under this Plan. For assistance and a complete list of excluded medications, or drugs requiring prior authorization, please contact Aetna Pharmacy Management at (888) 792-3862 (available 24 hours).

Aetna Specialty Pharmacy provides specialty medications and support to members living with chronic conditions. The medications offered may be injected, infused or taken by mouth. For additional information please go to www.AetnaSpecialtyRx.com.
<table>
<thead>
<tr>
<th>Diabetic Testing Supplies &amp; Outpatient Diabetic Self-Management Education Program</th>
<th><strong>BASIC PLAN BENEFITS</strong></th>
<th><strong>PLUS PLAN BENEFITS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Medical Expenses for a 90-day supply of drugs ordered through the Aetna Rx Home Delivery Program are covered at 100% after a $20 copay for each Generic Prescription Drug or a $60 copay for each Preferred Brand Name Prescription Drug or a $90 copay for each Non-Preferred Brand Name Prescription Drug.</td>
<td>Covered Medical Expenses for a 90-day supply of drugs ordered through the Aetna Rx Home Delivery Program are covered at 100% after a $20 copay for each Generic Prescription Drug or a $60 copay for each Preferred Brand Name Prescription Drug or a $90 copay for each Non-Preferred Brand Name Prescription Drug. For assistance, or for a complete list of excluded medications or drugs available with prior authorization, please contact (888) 792-3862.</td>
<td>Covered Medical Expenses include charges for the following services, supplies, equipment and training for the treatment of insulin- and non-insulin-dependent diabetes and elevated blood glucose levels during pregnancy: • Insulin and Insulin preparations, • External insulin pumps, • Syringes, • Injections aids for the blind, • Test strips and tablets, including blood glucose monitoring strips, urine glucose strips, ketone strips, • Blood glucose monitors without special features unless required due to blindness, • Lancets, • Prescribed oral medications whose primary purpose is to influence blood sugar, • Alcohol swabs, • Injectable gluca gens, • Glucagon emergency kits, • Foot care to minimize the risk of infection, • All lab tests and urinary profiles, • Voice synthesizers and visual magnifying aids, • Therapeutic/molded shoes and shoe inserts, • Insulin pump supplies, • Insulin pens, and • Oral medications. <strong>Covered Medical Expenses</strong> include charges incurred by a covered student for testing material used to detect the presence of sugar in the person’s urine or blood for monitoring glycemic control. Diabetic Testing Supplies are limited to • Lancet devices, • glucose monitors, and • test strips.</td>
</tr>
<tr>
<td>Diabetic Testing Supplies &amp; Outpatient Diabetic Self-Management Education Program (continued)</td>
<td><strong>BASIC PLAN BENEFITS</strong></td>
<td><strong>PLUS PLAN BENEFITS</strong></td>
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<td></td>
<td>Syringes, insulin, or other items, used in the treatment of diabetes, are not <strong>Covered Medical Expenses</strong>.</td>
<td>Syringes, insulin, or other items, used in the treatment of diabetes, are not <strong>Covered Medical Expenses</strong>.</td>
</tr>
<tr>
<td><strong>Covered Medical Expenses</strong> include charges incurred by a covered student for outpatient diabetic self-management education programs.</td>
<td><strong>Covered Medical Expenses</strong> include charges incurred by a covered student for outpatient diabetic self-management education programs.</td>
<td><strong>Covered Medical Expenses</strong> include charges incurred by a covered student for outpatient diabetic self-management education programs.</td>
</tr>
<tr>
<td>Such charges must be made by:</td>
<td>Such charges must be made by:</td>
<td>Such charges must be made by:</td>
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<tr>
<td>• a physician, nurse practitioner, clinical nurse specialist, or</td>
<td>• a physician, nurse practitioner, clinical nurse specialist, or</td>
<td>• a physician, nurse practitioner, clinical nurse specialist, or</td>
</tr>
<tr>
<td>• a pharmacist, or dietitian (as to residents of Massachusetts, the provider must be legally qualified by the Commonwealth of Massachusetts, to provide diabetic management education),</td>
<td>• a pharmacist, or dietitian (as to residents of Massachusetts, the provider must be legally qualified by the Commonwealth of Massachusetts, to provide diabetic management education),</td>
<td>• a pharmacist, or dietitian (as to residents of Massachusetts, the provider must be legally qualified by the Commonwealth of Massachusetts, to provide diabetic management education),</td>
</tr>
<tr>
<td>Charges incurred for the following are not <strong>Covered Medical Expenses</strong>:</td>
<td>Charges incurred for the following are not <strong>Covered Medical Expenses</strong>:</td>
<td>Charges incurred for the following are not <strong>Covered Medical Expenses</strong>:</td>
</tr>
<tr>
<td>• a diabetic education program whose only purpose is weight control, or which is available to the public at no cost, or</td>
<td>• a diabetic education program whose only purpose is weight control, or which is available to the public at no cost, or</td>
<td>• a diabetic education program whose only purpose is weight control, or which is available to the public at no cost, or</td>
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<tr>
<td>• a general program not just for diabetics, or</td>
<td>• a general program not just for diabetics, or</td>
<td>• a general program not just for diabetics, or</td>
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<tr>
<td>• a program made up of services not generally accepted as necessary for the management of diabetes.</td>
<td>• a program made up of services not generally accepted as necessary for the management of diabetes.</td>
<td>• a program made up of services not generally accepted as necessary for the management of diabetes.</td>
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<tr>
<td>Benefits are payable as any Sickness.</td>
<td>Benefits are payable as any Sickness.</td>
<td>Benefits are payable as any Sickness.</td>
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<tr>
<td><em>As used in this section, a “Physician certified in diabetes health care” means a licensed health care professional with expertise in diabetes, a registered dietician or a health care provider certified by the National Certification Board of Diabetes Educators as a certified diabetes educator.</em></td>
<td><em>As used in this section, a “Physician certified in diabetes health care” means a licensed health care professional with expertise in diabetes, a registered dietician or a health care provider certified by the National Certification Board of Diabetes Educators as a certified diabetes educator.</em></td>
<td><em>As used in this section, a “Physician certified in diabetes health care” means a licensed health care professional with expertise in diabetes, a registered dietician or a health care provider certified by the National Certification Board of Diabetes Educators as a certified diabetes educator.</em></td>
</tr>
<tr>
<td>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.</td>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>Hypodermic Needles Expense</td>
<td><strong>BASIC PLAN BENEFITS</strong></td>
<td><strong>PLUS PLAN BENEFITS</strong></td>
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<tr>
<td><strong>Covered Medical Expenses</strong> include expenses incurred by a covered person for medically necessary hypodermic needles and syringes. Benefits are payable on the same basis as any other condition.</td>
<td><strong>Covered Medical Expenses</strong> include expenses incurred by a covered person for medically necessary hypodermic needles and syringes. Benefits are payable on the same basis as any other condition.</td>
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| Non Prescription Enteral Formula Expense | **Covered Medical Expenses** include Non Prescription Enteral formulas for which a physician has issued a written order. Such formulas must be medically necessary 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 expenses** for inherited diseases of amino acids and organic acids will include food products modified to be low protein in an amount not to exceed **$5,000 per Policy Year** for any covered person. | **Covered Medical Expenses** include Non Prescription Enteral formulas for which a physician has issued a written order. Such formulas must be medically necessary 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 expenses** for inherited diseases of amino acids and organic acids will include food products modified to be low protein in an amount not to exceed **$5,000 per Policy Year** for any covered person. |

<p>| Special Medical Formula Expense | Special Medical Formula Expense Benefits are payable for newly born infants and adoptive children for those special medical formulas. These formulas must be approved by the Commissioner of the Department of Public Health, must be prescribed by a physician and must be medically necessary for the treatment of: • phenylketonuria, • tyrosinemia, • homocystinuria, • maple syrup urine disease, • propionic acidemia, and • methylmalonic acidemia, • in infants and children, medically necessary to protect the unborn fetuses of pregnant women with phenylketonuria, and screening for lead poisoning. <strong>Covered Medical Expenses</strong> are payable on the same basis as any other condition. | Special Medical Formula Expense Benefits are payable for newly born infants and adoptive children for those special medical formulas. These formulas must be approved by the Commissioner of the Department of Public Health, must be prescribed by a physician and must be medically necessary for the treatment of: • phenylketonuria, • tyrosinemia, • homocystinuria, • maple syrup urine disease, • propionic acidemia, and • methylmalonic acidemia, • in infants and children, medically necessary to protect the unborn fetuses of pregnant women with phenylketonuria, and screening for lead poisoning. <strong>Covered Medical Expenses</strong> are payable on the same basis as any other condition. |</p>
<table>
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<tr>
<th>BASIC PLAN BENEFITS</th>
<th>PLUS PLAN BENEFITS</th>
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</table>
| **Cytologic Screening Expense** | **Covered Medical Expenses** include charges incurred by a covered person for an annual Cytologic screening for women 18 years of age and older.  
**Covered Medical Expenses** are payable as follows:  
Preferred Care: 100% of the Negotiated Charge.  
Non-Preferred Care: 80% of the Recognized Charge. | **Covered Medical Expenses** include charges incurred by a covered person for an annual Cytologic screening for women 18 years of age and older.  
**Covered Medical Expenses** are payable as follows:  
Preferred Care: 100% of the Negotiated Charge.  
Non-Preferred Care: 80% of the Recognized Charge. |
| **Mammogram Expense** | **Covered Medical Expenses** include one baseline mammogram for women between age 35 and 40. Coverage is also provided for one routine annual mammogram for women age 40 and older, as well as when medically indicated for women with risk factors who are under age 40. Risk factors for women under 40 are,  
• Prior personal history of breast cancer  
• Positive Genetic Testing  
• Family history of breast cancer, or  
• Other risk factors  
Mammogram screenings coverage must also include comprehensive ultrasound screening for the entire breast or breasts if a mammogram demonstrates heterogenous or dense breast tissue and when determined to be medically necessary by a licensed physician.  
**Covered Medical Expenses** are payable as follows:  
Preferred Care: 100% of the Negotiated Charge.  
Non-Preferred Care: 80% of the Recognized Charge. | **Covered Medical Expenses** include one baseline mammogram for women between age 35 and 40. Coverage is also provided for one routine annual mammogram for women age 40 and older, as well as when medically indicated for women with risk factors who are under age 40. Risk factors for women under 40 are,  
• Prior personal history of breast cancer  
• Positive Genetic Testing  
• Family history of breast cancer, or  
• Other risk factors  
Mammogram screenings coverage must also include comprehensive ultrasound screening for the entire breast or breasts if a mammogram demonstrates heterogenous or dense breast tissue and when determined to be medically necessary by a licensed physician.  
**Covered Medical Expenses** are payable as follows:  
Preferred Care: 100% of the Negotiated Charge.  
Non-Preferred Care: 80% of the Recognized Charge. |
| **Elective Abortion Expense** | **Covered Medical Expenses** for Elective Abortion Expense are covered as follows,  
Preferred Care: 80% of the Negotiated Charge.  
Non-Preferred Care: 60% of the Recognized Charge.  
This benefit is in lieu of any other Policy benefits.  
Benefits are limited to a maximum of $200 per occurrence. | **Covered Medical Expenses** for Elective Abortion Expense are covered as follows,  
Preferred Care: 100% of the Negotiated Charge.  
Non-Preferred Care: 80% of the Recognized Charge.  
This benefit is in lieu of any other Policy benefits.  
Benefits are limited to a maximum of $200 per occurrence. |
<table>
<thead>
<tr>
<th>Family Planning Expense</th>
<th><strong>BASIC PLAN BENEFITS</strong></th>
<th><strong>PLUS PLAN BENEFITS</strong></th>
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<tr>
<td></td>
<td>For females with reproductive capacity, <strong>Covered Medical Expenses</strong> include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this benefit must be approved by the Food and Drug Administration (FDA).</td>
<td>For females with reproductive capacity, <strong>Covered Medical Expenses</strong> include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this benefit must be approved by the Food and Drug Administration (FDA).</td>
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<tr>
<td></td>
<td>Coverage includes counseling services on contraceptive methods provided by a <strong>physician</strong>, obstetrician or gynecologist. Such counseling services are <strong>Covered Medical Expenses</strong> when provided in either a group or individual setting. The following contraceptive methods are <strong>covered expenses</strong> under this benefit:</td>
<td>Coverage includes counseling services on contraceptive methods provided by a <strong>physician</strong>, obstetrician or gynecologist. Such counseling services are <strong>Covered Medical Expenses</strong> when provided in either a group or individual setting. The following contraceptive methods are <strong>covered expenses</strong> under this benefit:</td>
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<td><strong>Voluntary Sterilization</strong> <strong>Covered expenses</strong> include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.</td>
<td><strong>Voluntary Sterilization</strong> <strong>Covered expenses</strong> include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.</td>
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<tr>
<td></td>
<td><strong>Covered expenses</strong> under this <strong>Preventive Care</strong> benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.</td>
<td><strong>Covered expenses</strong> under this <strong>Preventive Care</strong> benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.</td>
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<td></td>
<td><strong>Contraceptives</strong> <strong>Covered expenses</strong> include charges made by a <strong>physician</strong> or <strong>pharmacy</strong> for:</td>
<td><strong>Contraceptives</strong> <strong>Covered expenses</strong> include charges made by a <strong>physician</strong> or <strong>pharmacy</strong> for:</td>
</tr>
<tr>
<td></td>
<td>• female contraceptives that are <strong>generic prescription drugs</strong>. The prescription must be submitted to the pharmacist for processing. <strong>This contraceptives benefit covers only generic prescription drugs.</strong></td>
<td>• female contraceptives that are <strong>generic prescription drugs</strong>. The prescription must be submitted to the pharmacist for processing. <strong>This contraceptives benefit covers only generic prescription drugs.</strong></td>
</tr>
<tr>
<td></td>
<td>• female contraceptive devices and related services and supplies that are generic prescription devices when prescribed in writing by a <strong>physician</strong>. <strong>This contraceptives benefit covers only those devices that are generic prescription devices.</strong></td>
<td>• female contraceptive devices and related services and supplies that are generic prescription devices when prescribed in writing by a <strong>physician</strong>. <strong>This contraceptives benefit covers only those devices that are generic prescription devices.</strong></td>
</tr>
<tr>
<td></td>
<td>• FDA-approved female over-the-counter contraceptive methods that are prescribed by your <strong>physician</strong>. The <strong>prescription</strong> must be submitted to the pharmacist for processing. These items are limited to one per day and a 30 day supply per <strong>prescription</strong>.</td>
<td>• FDA-approved female over-the-counter contraceptive methods that are prescribed by your <strong>physician</strong>. The <strong>prescription</strong> must be submitted to the pharmacist for processing. These items are limited to one per day and a 30 day supply per <strong>prescription</strong>.</td>
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<tr>
<td>FAMILY BENEFITS</td>
<td>PLUS PLAN BENEFITS</td>
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<tr>
<td><strong>Family Planning Expense (continued)</strong></td>
<td><strong>Limitations:</strong> Unless specified above, not covered under this benefit are charges for:</td>
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<td></td>
<td>• Services which are covered to any extent under any other part of this Plan;</td>
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<td></td>
<td>• Services and supplies incurred for an abortion;</td>
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<td></td>
<td>• Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care;</td>
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<tr>
<td></td>
<td>• Services which are for the treatment of an identified illness or injury;</td>
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<td></td>
<td>• Services that are not given by a physician or under his or her direction;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Psychiatric, psychological, personality or emotional testing or exams;</td>
<td></td>
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<tr>
<td></td>
<td>• Any contraceptive methods that are only “reviewed” by the FDA and not “approved” by the FDA;</td>
<td></td>
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<tr>
<td></td>
<td>• Male contraceptive methods, sterilization procedures or devices;</td>
<td></td>
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<tr>
<td></td>
<td>• The reversal of voluntary sterilization procedures, including any related follow-up care.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Covered Medical Expenses</strong> are payable as follows:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred Care: 100% of the Negotiated Charge.</td>
<td></td>
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<tr>
<td></td>
<td>Non-Preferred Care: 80% of the Recognized Charge.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Important note:</strong> Brand-Name Prescription Drug or Devices will be covered at 100% of the Negotiated Charge, including waiver of Annual Deductible if a Generic Prescription Drug or Device is not available in the same therapeutic drug class or the prescriber specifies Dispense as Written.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Limitations:</strong> Unless specified above, not covered under this benefit are charges for:</td>
<td></td>
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<tr>
<td></td>
<td>• Services which are covered to any extent under any other part of this Plan;</td>
<td></td>
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<tr>
<td></td>
<td>• Services and supplies incurred for an abortion;</td>
<td></td>
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<tr>
<td></td>
<td>• Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care;</td>
<td></td>
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<tr>
<td></td>
<td>• Services which are for the treatment of an identified illness or injury;</td>
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<td></td>
<td>• Services that are not given by a physician or under his or her direction;</td>
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<td></td>
<td>• Psychiatric, psychological, personality or emotional testing or exams;</td>
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<td></td>
<td>• Any contraceptive methods that are only “reviewed” by the FDA and not “approved” by the FDA;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Male contraceptive methods, sterilization procedures or devices;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The reversal of voluntary sterilization procedures, including any related follow-up care.</td>
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<tr>
<td></td>
<td><strong>Covered Medical Expenses</strong> are payable as follows:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred Care: 100% of the Negotiated Charge.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: 80% of the Recognized Charge.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Important note:</strong> Brand-Name Prescription Drug or Devices will be covered at 100% of the Negotiated Charge, including waiver of Annual Deductible if a Generic Prescription Drug or Device is not available in the same therapeutic drug class or the prescriber specifies Dispense as Written.</td>
<td></td>
</tr>
<tr>
<td>BASIC PLAN BENEFITS</td>
<td>PLUS PLAN BENEFITS</td>
<td></td>
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<tr>
<td>----------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td><strong>Chlamydia Screening Test Expense</strong></td>
<td><strong>Chlamydia Screening Test Expense</strong></td>
<td></td>
</tr>
<tr>
<td>Benefits include charges incurred for an annual Chlamydia screening test.</td>
<td>Benefits include charges incurred for an annual Chlamydia screening test.</td>
<td></td>
</tr>
<tr>
<td>Benefits will be paid for Chlamydia screening expenses incurred for:</td>
<td>Benefits will be paid for Chlamydia screening expenses incurred for:</td>
<td></td>
</tr>
<tr>
<td>• Women who are:</td>
<td>• Women who are:</td>
<td></td>
</tr>
<tr>
<td>- under the age of 20 if they are sexually active, and</td>
<td>- under the age of 20 if they are sexually active, and</td>
<td></td>
</tr>
<tr>
<td>- at least 20 years old if they have multiple risk factors.</td>
<td>- at least 20 years old if they have multiple risk factors.</td>
<td></td>
</tr>
<tr>
<td>• Men who have multiple risk factors.</td>
<td>• Men who have multiple risk factors.</td>
<td></td>
</tr>
<tr>
<td><strong>Covered Medical Expenses</strong> are payable as follows:</td>
<td><strong>Covered Medical Expenses</strong> are payable as follows:</td>
<td></td>
</tr>
<tr>
<td>Preferred Care: 100% of the Negotiated Charge.</td>
<td>Preferred Care: 100% of the Negotiated Charge.</td>
<td></td>
</tr>
<tr>
<td>Non-Preferred Care: 80% of the Recognized Charge.</td>
<td>Non-Preferred Care: 80% of the Recognized Charge.</td>
<td></td>
</tr>
<tr>
<td><strong>Routine Screening for Sexually Transmitted Disease Expense</strong></td>
<td><strong>Covered Medical Expenses</strong> include charges for covered persons who are at least 18 years old and who are sexually active for annual routine screening for sexually transmitted diseases.</td>
<td></td>
</tr>
<tr>
<td>Refer to Routine Physical Exam for benefits required by Health Care Reform for Sexually Transmitted Disease testing.</td>
<td>Benefits are payable as follows: Preferred Care: 100% of the Negotiated Charge. Non-Preferred Care: 80% of the Recognized Charge.</td>
<td></td>
</tr>
<tr>
<td><strong>Routine Colorectal Cancer Screening Expense</strong></td>
<td><strong>Routine Colorectal Cancer Screening Expense</strong></td>
<td></td>
</tr>
<tr>
<td>Even though not incurred in connection with a sickness or injury, benefits include charges for colorectal cancer examination and laboratory tests, for any nonsymptomatic person age 50 or more, or a symptomatic person under age 50, for the following:</td>
<td>Even though not incurred in connection with a sickness or injury, benefits include charges for colorectal cancer examination and laboratory tests, for any nonsymptomatic person age 50 or more, or a symptomatic person under age 50, for the following:</td>
<td></td>
</tr>
<tr>
<td>• One fecal occult blood test every 12 months in a row</td>
<td>• One fecal occult blood test every 12 months in a row</td>
<td></td>
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<tr>
<td>• A Sigmoidoscopy at age 50 and every 3 years thereafter</td>
<td>• A Sigmoidoscopy at age 50 and every 3 years thereafter</td>
<td></td>
</tr>
<tr>
<td>• One digital rectal exam every 12 months in a row</td>
<td>• One digital rectal exam every 12 months in a row</td>
<td></td>
</tr>
<tr>
<td>• A double contrast barium enema, once every 5 years</td>
<td>• A double contrast barium enema, once every 5 years</td>
<td></td>
</tr>
<tr>
<td>• A colonoscopy, once every 10 years</td>
<td>• A colonoscopy, once every 10 years</td>
<td></td>
</tr>
<tr>
<td>• Virtual colonoscopy</td>
<td>• Virtual colonoscopy</td>
<td></td>
</tr>
<tr>
<td>• Stool DNA.</td>
<td>• Stool DNA.</td>
<td></td>
</tr>
<tr>
<td>Benefits are payable as follows: Preferred Care: 100% of the Negotiated Charge.</td>
<td>Benefits are payable as follows: Preferred Care: 100% of the Negotiated Charge.</td>
<td></td>
</tr>
<tr>
<td>Non-Preferred Care: 80% of the Recognized Charge.</td>
<td>Non-Preferred Care: 80% of the Recognized Charge.</td>
<td></td>
</tr>
</tbody>
</table>

Routi

**Sexually Transmitted Disease Expense**

**Covered Medical Expenses** include charges for covered persons who are at least 18 years old and who are sexually active for annual routine screening for sexually transmitted diseases.

Benefits are payable as follows:

**Routine Screening for Sexually Transmitted Disease Expense**

Refer to Routine Physical Exam for benefits required by Health Care Reform for Sexually Transmitted Disease testing.

**Covered Medical Expenses** are payable as follows:

Preferred Care: 100% of the Negotiated Charge.

Non-Preferred Care: 80% of the Recognized Charge.
<table>
<thead>
<tr>
<th>Routine Prostate Cancer Screening Expense</th>
<th><strong>BASIC PLAN BENEFITS</strong></th>
<th><strong>PLUS PLAN BENEFITS</strong></th>
</tr>
</thead>
</table>
| 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.  
Benefits are payable as follows:  
Preferred Care: 100% of the Negotiated Charge.  
Non-Preferred Care: 80% of the Recognized Charge. | 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.  
Benefits are payable as follows:  
Preferred Care: 100% of the Negotiated Charge.  
Non-Preferred Care: 80% of the Recognized Charge. |
| Second Surgical Opinion Expense | **Covered Medical Expenses** will include a second opinion consultation by a specialist on the need for non-emergency elective surgery which has been recommended by the covered person’s physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed.  
Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation.  
Benefits are payable as follows,  
Preferred Care: 100% of the Negotiated Charge.  
Non-Preferred Care: 100% of the Recognized Charge.  
Benefits are limited to a maximum of $100 per surgery. | Covered Medical Expenses will include a second opinion consultation by a specialist on the need for non-emergency elective surgery which has been recommended by the covered person’s physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed.  
Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation.  
Benefits are payable as follows,  
Preferred Care: 100% of the Negotiated Charge.  
Non-Preferred Care: 100% of the Recognized Charge.  
Benefits are limited to a maximum of $100 per surgery. |
| Acupuncture In Lieu Of Anesthesia | **Covered Medical Expenses** include acupuncture therapy, when acupuncture is used in lieu of other anesthesia, for a surgical or dental procedure covered under this Plan.  
The acupuncture must be administered by a health care provider who is a legally qualified physician, practicing within the scope of their license.  
Preferred Care: 80% of the Negotiated Charge.  
Non-Preferred Care: 60% of the Recognized Charge. | Covered Medical Expenses include acupuncture therapy, when acupuncture is used in lieu of other anesthesia, for a surgical or dental procedure covered under this Plan.  
The acupuncture must be administered by a health care provider who is a legally qualified physician, practicing within the scope of their license.  
Preferred Care: 100% of the Negotiated Charge.  
Non-Preferred Care: 80% of the Recognized Charge. |
<table>
<thead>
<tr>
<th>Dermatological Expense</th>
<th><strong>BASIC PLAN BENEFITS</strong></th>
<th><strong>PLUS PLAN BENEFITS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Medical Expenses</strong> include charges for the diagnosis and treatment of skin disorders, excluding laboratory fees. Related laboratory expenses are covered under the Outpatient Expense Benefit.</td>
<td><strong>Covered Medical Expenses</strong> include charges for the diagnosis and treatment of skin disorders, excluding laboratory fees. Related laboratory expenses are covered under the Outpatient Expense Benefit.</td>
<td><strong>Covered Medical Expenses</strong> are payable on the same basis as any other condition. <strong>Covered Medical Expenses</strong> do not include cosmetic treatment and procedures.</td>
</tr>
<tr>
<td><strong>Covered Medical Expenses</strong> are payable on the same basis as any other condition. <strong>Covered Medical Expenses</strong> do not include cosmetic treatment and procedures.</td>
<td><strong>Covered Medical Expenses</strong> are payable on the same basis as any other condition. <strong>Covered Medical Expenses</strong> do not include cosmetic treatment and procedures.</td>
<td></td>
</tr>
<tr>
<td>Podiatric Expense</td>
<td><strong>Covered Medical Expenses</strong> include charges for podiatric services, provided on an outpatient basis following an injury.</td>
<td><strong>Covered Medical Expenses</strong> include charges for podiatric services, provided on an outpatient basis following an injury.</td>
</tr>
<tr>
<td></td>
<td><strong>Covered Medical Expenses</strong> are payable on the same basis as any other Sickness. Expenses for routine foot care, such as trimming of corns, calluses, and nails, are not <strong>Covered Medical Expenses</strong>.</td>
<td><strong>Covered Medical Expenses</strong> are payable on the same basis as any other Sickness. Expenses for routine foot care, such as trimming of corns, calluses, and nails, are not <strong>Covered Medical Expenses</strong>.</td>
</tr>
</tbody>
</table>
Home Health Care Expenses

**Covered Medical Expenses** include charges incurred by a covered person for home health care services made by a home health agency pursuant to a home health care plan, but only if,

1) The services are furnished by, or under arrangements made by, a licensed home health agency.
2) 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.
3) 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.

**Covered Medical Expenses** also include the use of durable medical equipment and supplies to the extent such additional services are determined to be a medically necessary component of said nursing and physical therapy.

**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 an R.N. if the services of an R. N. are not available,
2) Part time or intermittent home health aide services, that consist primarily of care of a medical or therapeutic nature by other than an R.N.,
3) Physical, occupational, speech therapy, or respiratory therapy,
4) Medical supplies, drugs and medicines, and laboratory services. However, these items are covered only to the extent they would be covered if the patient was confined to a hospital,
5) Medical social services by licensed or trained social workers,
6) Nutritional counseling.

**PLUS PLAN BENEFITS**

**Covered Medical Expenses** include charges incurred by a covered person for home health care services made by a home health agency pursuant to a home health care plan, but only if,

1) The services are furnished by, or under arrangements made by, a licensed home health agency.
2) 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.
3) 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.

**Covered Medical Expenses** also include the use of durable medical equipment and supplies to the extent such additional services are determined to be a medically necessary component of said nursing and physical therapy.

**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 an R.N. if the services of an R. N. are not available,
2) Part time or intermittent home health aide services, that consist primarily of care of a medical or therapeutic nature by other than an R.N.,
3) Physical, occupational, speech therapy, or respiratory therapy,
4) Medical supplies, drugs and medicines, and laboratory services. However, these items are covered only to the extent they would be covered if the patient was confined to a hospital,
5) Medical social services by licensed or trained social workers,
6) Nutritional counseling.
### Home Health Care Expenses (continued)

<table>
<thead>
<tr>
<th>BASIC PLAN BENEFITS</th>
<th>PLUS PLAN BENEFITS</th>
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</thead>
<tbody>
<tr>
<td><strong>Covered Medical Expenses</strong> will not include:</td>
<td><strong>Covered Medical Expenses</strong> will not include:</td>
</tr>
<tr>
<td>1) services by a person who resides in the covered person’s home, or is a member of the covered person’s immediate family,</td>
<td>1) services by a person who resides in the covered person’s home, or is a member of the covered person’s immediate family,</td>
</tr>
<tr>
<td>2) homemaker or housekeeper services,</td>
<td>2) homemaker or housekeeper services,</td>
</tr>
<tr>
<td>3) maintenance therapy,</td>
<td>3) maintenance therapy,</td>
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<tr>
<td>4) dialysis treatment,</td>
<td>4) dialysis treatment,</td>
</tr>
<tr>
<td>5) purchase or rental of dialysis equipment, or</td>
<td>5) purchase or rental of dialysis equipment, or</td>
</tr>
<tr>
<td>6) food or home delivered services.</td>
<td>6) food or home delivered services.</td>
</tr>
<tr>
<td><strong>Preferred Care</strong>: 100% of the Negotiated Charge.</td>
<td><strong>Preferred Care</strong>: 100% of the Negotiated Charge.</td>
</tr>
<tr>
<td><strong>Non-Preferred Care</strong>: 100% of the Recognized Charge.</td>
<td><strong>Non-Preferred Care</strong>: 100% of the Recognized Charge.</td>
</tr>
</tbody>
</table>

### Hospice Expenses

<p>| 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 recognized charges and customary charges made by a hospice for the following services or supplies: | 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 recognized charges and customary charges made by a hospice for the following services or supplies: |
| a) charges for inpatient care; | a) charges for inpatient care; |
| b) charges for drugs and medicines; | b) charges for drugs and medicines; |
| c) charges for part-time nursing by an RN; LPN; or LVN for up to 8 hours in one day; | c) charges for part-time nursing by an RN; LPN; or LVN for up to 8 hours in one day; |
| d) charges for physical and respiratory therapy in the home; | d) charges for physical and respiratory therapy in the home; |
| e) charges for the use of medical equipment; | e) charges for the use of medical equipment; |
| f) charges for medical social services under the direction of a physician; including assessment of the person’s social; emotional; and medical needs and of the home and family situation; identification of the community resources that are available to the person; and assistance in obtaining the resources needed to meet the person’s assessed needs; | f) charges for medical social services under the direction of a physician; including assessment of the person’s social; emotional; and medical needs and of the home and family situation; identification of the community resources that are available to the person; and assistance in obtaining the resources needed to meet the person’s assessed needs; |
| g) charges for psychological and dietary counseling; and visits by licensed or trained social workers and counselors; | g) charges for psychological and dietary counseling; and visits by licensed or trained social workers and counselors; |
| h) charges for bereavement counseling of the covered person’s immediate family; prior to; and within 3 months after; the covered person’s death; and | h) charges for bereavement counseling of the covered person’s immediate family; prior to; and within 3 months after; the covered person’s death; and |
| i) charges for respite care for up to 5 days in any 30 day period. | i) charges for respite care for up to 5 days in any 30 day period. |</p>
<table>
<thead>
<tr>
<th>Hospice Expenses (continued)</th>
<th><strong>BASIC PLAN BENEFITS</strong></th>
<th><strong>PLUS PLAN BENEFITS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Medical Expenses</strong></td>
<td>are payable as follows:</td>
<td><strong>Covered Medical Expenses</strong> are payable as follows:</td>
</tr>
<tr>
<td>Preferred Care: 80% of the Negotiated Charge</td>
<td>Preferred Care: 100% of the Negotiated Charge</td>
<td></td>
</tr>
<tr>
<td>Non-Preferred Care: 60% of the Recognized Charge</td>
<td>Non-Preferred Care: 80% of the Recognized Charge</td>
<td></td>
</tr>
<tr>
<td><strong>EXCLUSIONS</strong></td>
<td><strong>EXCLUSIONS</strong></td>
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</tr>
<tr>
<td>The following are not considered hospice care:</td>
<td>The following are not considered hospice care:</td>
<td></td>
</tr>
<tr>
<td>a) funeral arrangements; b) financial or legal counseling; c) homemaker or caretaker services; not related solely to the care of the covered person.</td>
<td>a) funeral arrangements; b) financial or legal counseling; c) homemaker or caretaker services; not related solely to the care of the covered person.</td>
<td></td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Transfusion or Dialysis of Blood Expense</th>
<th><strong>Covered Medical Expenses</strong> include charges for the transfusion or dialysis of blood, including the cost of whole blood, blood components, and the administration thereof.</th>
<th><strong>Covered Medical Expenses</strong> include charges for the transfusion or dialysis of blood, including the cost of whole blood, blood components, and the administration thereof.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Medical Expenses</strong> are payable on the same basis as any other Sickness.</td>
<td><strong>Covered Medical Expenses</strong> are payable on the same basis as any other Sickness.</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Licensed Nurse Expense</th>
<th>Benefits include charges incurred by a covered person who is confined in a hospital as a resident bed-patient, and requires the services of a registered nurse or licensed practical nurse.</th>
<th>Benefits include charges incurred by a covered person who is confined in a hospital as a resident bed-patient, and requires the services of a registered nurse or licensed practical nurse.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Expenses</strong> for a Licensed Nurse are covered as follows:</td>
<td><strong>Covered Expenses</strong> for a Licensed Nurse are covered as follows:</td>
<td></td>
</tr>
<tr>
<td>Preferred Care: 80% of the Negotiated Charge.</td>
<td>Preferred Care: 100% of the Negotiated Charge.</td>
<td></td>
</tr>
<tr>
<td>Non-Preferred Care: 60% of the Recognized Charge.</td>
<td>Non-Preferred Care: 80% of the Recognized Charge.</td>
<td></td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Skilled Nursing Facility Expense</th>
<th><strong>Covered Medical Expenses</strong> include charges incurred by a covered person for confinement in a skilled nursing facility for treatment rendered in lieu of confinement in a hospital as a full time inpatient, or within 24 hours following a hospital confinement and for the same or related cause(s) as such hospital confinement.</th>
<th><strong>Covered Medical Expenses</strong> include charges incurred by a covered person for confinement in a skilled nursing facility for treatment rendered in lieu of confinement in a hospital as a full time inpatient, or within 24 hours following a hospital confinement and for the same or related cause(s) as such hospital confinement.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Medical Expenses</strong> are payable as follows:</td>
<td><strong>Covered Medical Expenses</strong> are payable as follows:</td>
<td></td>
</tr>
<tr>
<td>Preferred Care: 80% of the Negotiated Charge for the semi-private room rate.</td>
<td>Preferred Care: After a $100 copay per admission, 100% of the Negotiated Charge for the semi-private room rate.</td>
<td></td>
</tr>
<tr>
<td>Non-Preferred Care: 60% of the Recognized Charge for the semi-private room rate.</td>
<td>Non-Preferred Care: 80% of the Recognized Charge for the semi-private room rate.</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation Facility Expense</td>
<td><strong>BASIC PLAN BENEFITS</strong></td>
<td><strong>PLUS PLAN BENEFITS</strong></td>
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<tr>
<td><strong>Covered Medical Expenses</strong> 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. <strong>Covered Medical Expenses</strong> for Rehabilitation Facility Expense are covered as follows: <strong>Preferred Care:</strong> 80% of the Negotiated Charge for the rehabilitation facility’s daily room and board maximum for semi-private accommodations. <strong>Non-Preferred Care:</strong> 60% of the Recognized Charge for the rehabilitation facility’s daily room and board maximum for semi-private accommodations.</td>
<td><strong>Covered Medical Expenses</strong> 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. <strong>Covered Medical Expenses</strong> for Rehabilitation Facility Expense are covered as follows: <strong>Preferred Care:</strong> After a $100 copay per admission, 100% of the Negotiated Charge for the rehabilitation facility’s daily room and board maximum for semi-private accommodations. <strong>Non-Preferred Care:</strong> 80% of the Recognized Charge for the rehabilitation facility’s daily room and board maximum for semi-private accommodations.</td>
<td>Benefits include charges for any service shown below, which is furnished by a legally qualified ophthalmologist or optometrist. <strong>Routine Eye Exam Expenses:</strong> Charges for a complete eye exam that includes refraction. A routine eye exam does not include charges for a contact lens exam. Benefits are limited to one routine eye exam per Policy Year. <strong>Covered Medical Expenses</strong> will be payable as follows: <strong>Preferred Care:</strong> After a $15 Copay, 100% of the Negotiated Charge. <strong>Non-Preferred Care:</strong> 80% of the Recognized Charge. 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 Plan, 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 lay or any other law of like purpose. • For special procedures. This means things such as orthoptics or vision training.</td>
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</table>

<p>| Vision Care Exam Expense | Not a covered benefit. | Not a covered benefit. |</p>
<table>
<thead>
<tr>
<th>Vision Care Exam Expense (continued)</th>
<th><strong>BASIC PLAN BENEFITS</strong></th>
<th><strong>PLUS PLAN BENEFITS</strong></th>
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<tbody>
<tr>
<td><strong>Bone Marrow Transplants for Breast Cancer Expense</strong></td>
<td>Benefits are payable for expenses incurred by a covered person who has been diagnosed with breast cancer that has progressed to metastatic disease as follows: a) referral to and participation in clinical trails when an oncologist recommends participation on the grounds that the proposed procedure shows promise as a useful treatment for that covered person and the proposed procedure is likely to be at least as effective as conventional treatment for that covered person, and b) a bone marrow transplant, provided that the covered person has been found to meet eligibility criteria established for enrollment in a clinical trial even if the covered person is not formally enrolled in that clinical trial, and c) coverage for a bone marrow transplant to the extent that benefits generally are provided for other medical procedures. The clinical trial will be conducted: a) at a licensed health facility which is located at the principal site of an academic medical center which participates in National Cancer Institute (NCI) sponsored or approved research in any cancer specialty area, or b) at a licensed health facility which has a formal affiliation agreement with an academic medical center to provide bone marrow transplantation as part of a NCI sponsored or approved research protocol.</td>
<td>Benefits are payable for expenses incurred by a covered person who has been diagnosed with breast cancer that has progressed to metastatic disease as follows: a) referral to and participation in clinical trails when an oncologist recommends participation on the grounds that the proposed procedure shows promise as a useful treatment for that covered person and the proposed procedure is likely to be at least as effective as conventional treatment for that covered person, and b) a bone marrow transplant, provided that the covered person has been found to meet eligibility criteria established for enrollment in a clinical trial even if the covered person is not formally enrolled in that clinical trial, and c) coverage for a bone marrow transplant to the extent that benefits generally are provided for other medical procedures. The clinical trial will be conducted: a) at a licensed health facility which is located at the principal site of an academic medical center which participates in National Cancer Institute (NCI) sponsored or approved research in any cancer specialty area, or b) at a licensed health facility which has a formal affiliation agreement with an academic medical center to provide bone marrow transplantation as part of a NCI sponsored or approved research protocol.</td>
</tr>
<tr>
<td>Bone Marrow Transplants for Breast Cancer Expense (continued)</td>
<td><strong>BASIC PLAN BENEFITS</strong></td>
<td><strong>PLUS PLAN BENEFITS</strong></td>
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<tr>
<td>DEFINITIONS</td>
<td>DEFINITIONS</td>
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<tr>
<td>“Bone marrow transplant” means use of high dose chemotherapy and radiation in conjunction with transplantation of autologous bone marrow or peripheral blood stem cells which originate in the bone marrow.</td>
<td>“Bone marrow transplant” means use of high dose chemotherapy and radiation in conjunction with transplantation of autologous bone marrow or peripheral blood stem cells which originate in the bone marrow.</td>
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<tr>
<td>“Metastatic disease” means Stage III and Stage IV breast cancer, as well as Stage II breast cancer which has spread to ten or more lymph nodes, as defined by the American College of Surgeons.</td>
<td>“Metastatic disease” means Stage III and Stage IV breast cancer, as well as Stage II breast cancer which has spread to ten or more lymph nodes, as defined by the American College of Surgeons.</td>
<td></td>
</tr>
<tr>
<td>Benefits are payable on the same basis as any Sickness.</td>
<td>Benefits are payable on the same basis as any Sickness.</td>
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<tr>
<td>Cardiac Rehabilitation Expense</td>
<td><strong>Covered Medical Expenses</strong> include cardiac rehabilitation treatment in connection with documented cardiovascular disease.</td>
<td><strong>Covered Medical Expenses</strong> include cardiac rehabilitation treatment in connection with documented cardiovascular disease.</td>
</tr>
<tr>
<td>Such treatment shall include, but not be limited to, outpatient treatment which is to be initiated within 26 weeks after the diagnosis of such disease.</td>
<td>Such treatment shall include, but not be limited to, outpatient treatment which is to be initiated within 26 weeks after the diagnosis of such disease.</td>
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<tr>
<td>DEFINITIONS</td>
<td>DEFINITIONS</td>
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<tr>
<td>“Cardiac Rehabilitation” means multidisciplinary, medically necessary treatment of persons with documented cardiovascular disease, which shall be provided in either a hospital or other setting and which shall meet standards promulgated by the Commissioner of Public Health.</td>
<td>“Cardiac Rehabilitation” means multidisciplinary, medically necessary treatment of persons with documented cardiovascular disease, which shall be provided in either a hospital or other setting and which shall meet standards promulgated by the Commissioner of Public Health.</td>
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<tr>
<td>“Cardiac Rehabilitation Program” is a program operated by a duly licensed clinic or hospital which treats cardiovascular disease through cardiac rehabilitation treatment.</td>
<td>“Cardiac Rehabilitation Program” is a program operated by a duly licensed clinic or hospital which treats cardiovascular disease through cardiac rehabilitation treatment.</td>
<td></td>
</tr>
<tr>
<td>“Cardiac Rehabilitation Treatment” means treatment of cardiovascular disease by a cardiovascular rehabilitation program that teaches and monitors the following: a) risk reduction, b) lifestyle adjustment to such disease, c) therapeutic exercise, d) proper diet, e) use of proper prescription drugs, f) self-assessment skills, and g) self-help skills.</td>
<td>“Cardiac Rehabilitation Treatment” means treatment of cardiovascular disease by a cardiovascular rehabilitation program that teaches and monitors the following: a) risk reduction, b) lifestyle adjustment to such disease, c) therapeutic exercise, d) proper diet, e) use of proper prescription drugs, f) self-assessment skills, and g) self-help skills.</td>
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<tr>
<td>Benefits are payable as any Sickness.</td>
<td>Benefits are payable as any Sickness.</td>
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<tr>
<td>Speech, Hearing and Language Disorders Expense</td>
<td>BASIC PLAN BENEFITS</td>
<td>PLUS PLAN BENEFITS</td>
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<tr>
<td><strong>Covered Medical Expenses</strong> include charges incurred by a covered person for medically necessary diagnosis or treatment of speech; hearing; and language disorders as any other sickness; but only if the charges are made for:</td>
<td></td>
<td><strong>Covered Medical Expenses</strong> include charges incurred by a covered person for medically necessary diagnosis or treatment of speech; hearing; and language disorders as any other sickness; but only if the charges are made for:</td>
</tr>
<tr>
<td>• Diagnostic services rendered to find out if; and to what extent; a covered person’s ability to speak or hear is lost or impaired.</td>
<td></td>
<td>• Diagnostic services rendered to find out if; and to what extent; a covered person’s ability to speak or hear is lost or impaired.</td>
</tr>
<tr>
<td>• Rehabilitative services rendered that are expected to restore or improve a covered person’s ability to speak or hear.</td>
<td></td>
<td>• Rehabilitative services rendered that are expected to restore or improve a covered person’s ability to speak or hear.</td>
</tr>
<tr>
<td>The services must be performed by:</td>
<td></td>
<td>The services must be performed by:</td>
</tr>
<tr>
<td>• A physician certified as an otolaryngologist or otologist;</td>
<td></td>
<td>• A physician certified as an otolaryngologist or otologist;</td>
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<tr>
<td>• or</td>
<td></td>
<td>• or</td>
</tr>
<tr>
<td>• An audiologist who either:</td>
<td></td>
<td>• An audiologist who either:</td>
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<tr>
<td>• Is legally qualified in audiology;</td>
<td></td>
<td>• Is legally qualified in audiology;</td>
</tr>
<tr>
<td>Or</td>
<td></td>
<td>Or</td>
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<tr>
<td>• Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements; and</td>
<td></td>
<td>• Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements; and</td>
</tr>
<tr>
<td>• Who performs the exam at the written direction of a legally qualified otolaryngologist or otologist;</td>
<td></td>
<td>• Who performs the exam at the written direction of a legally qualified otolaryngologist or otologist;</td>
</tr>
<tr>
<td>or</td>
<td></td>
<td>or</td>
</tr>
<tr>
<td>• A speech-language pathologist.</td>
<td></td>
<td>• A speech-language pathologist.</td>
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<tr>
<td><strong>Covered Medical Expenses</strong> will not include charges for more than one hearing exam per Policy Year.</td>
<td></td>
<td><strong>Covered Medical Expenses</strong> will not include charges for more than one hearing exam per Policy Year.</td>
</tr>
<tr>
<td>The maximum number of Routine Hearing exams is 1 per Policy Year.</td>
<td></td>
<td>The maximum number of Routine Hearing exams is 1 per Policy Year.</td>
</tr>
<tr>
<td>Pediatric Preventive Care Expense</td>
<td><strong>BASIC PLAN BENEFITS</strong></td>
<td><strong>PLUS PLAN BENEFITS</strong></td>
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| **Covered Medical Expenses** include services rendered to a dependent child of a Covered Person from the moment of birth through the attainment of six years. This shall include physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and development screening, and assessment at the following intervals, | - Birth to under age 1 6 exams per year  
- Age 1 to under age 2 3 exams per year  
- Age 2 to under age 6 1 exam per year | - Birth to under age 1 6 exams per year  
- Age 1 to under age 2 3 exams per year  
- Age 2 to under age 6 1 exam per year |
| Services shall include hereditary and metabolic screening at birth, appropriate immunization and tuberculin tests, hematocrit, hemoglobin, or other appropriate blood tests, and urinalysis as recommended by the doctor. | Benefits are payable as follows:  
**Preferred Care:** 100% of the Negotiated Charge.  
**Non-Preferred Care:** 80% of the Recognized Charge. | Benefits are payable as follows:  
**Preferred Care:** 100% of the Negotiated Charge.  
**Non-Preferred Care:** 80% of the Recognized Charge. |

<table>
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<tr>
<th>Early Intervention Services Expenses</th>
<th><strong>Covered Medical Expenses</strong> include medically necessary services and supplies provided by early intervention specialists who are working in early intervention programs certified by the department of public health for dependents from birth until thirty-six (36) months of age including, but not limited to,</th>
<th><strong>Covered Medical Expenses</strong> include medically necessary services and supplies provided by early intervention specialists who are working in early intervention programs certified by the department of public health for dependents from birth until thirty-six (36) months of age including, but not limited to,</th>
</tr>
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</table>
| - Speech therapy given in connection with a speech impairment resulting from a congenital abnormality, disease or injury, | - Speech therapy given in connection with a speech impairment resulting from a congenital abnormality, disease or injury,  
- Occupational or physical therapy expected to result in significant improvement of a body function, impaired by a congenital abnormality, disease or injury,  
- Clinical psychological tests, or treatment,  
- Skilled nursing services, on a part-time or intermittent basis, given by a R.N. or by a L.P.N. | - Occupational or physical therapy expected to result in significant improvement of a body function, impaired by a congenital abnormality, disease or injury,  
- Clinical psychological tests, or treatment,  
- Skilled nursing services, on a part-time or intermittent basis, given by a R.N. or by a L.P.N. |
| Benefits are payable as follows:  
**Preferred Care:** 100% of the Negotiated Charge.  
**Non-Preferred Care:** 100% of the Recognized Charge. | Benefits are payable as follows:  
**Preferred Care:** 100% of the Negotiated Charge.  
**Non-Preferred Care:** 100% of the Recognized Charge. | Benefits are payable as follows:  
**Preferred Care:** 100% of the Negotiated Charge.  
**Non-Preferred Care:** 100% of the Recognized Charge. |
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<th>BASIC PLAN BENEFITS</th>
<th>PLUS PLAN BENEFITS</th>
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<tr>
<td><strong>Infertility Expense</strong></td>
<td><strong>Covered Medical Expenses</strong> include medically necessary expenses for the diagnosis and treatment of infertility. Benefits are payable for non-experimental infertility procedures including, a) artificial insemination (AI), b) In Vitro Fertilization and Embryo Placement (IVF), c) gamete intrafallopian transfer (GIFT), d) sperm, egg and/or inseminated egg procurement, processing, and banking to the extent such costs are not covered by the donor’s insurer, if any, e) intracytoplasmic sperm injection (ICSI) for treatment of male factor infertility, and f) zygote intrafallopian transfer (ZIFT).</td>
</tr>
<tr>
<td><strong>DEFINITIONS</strong></td>
<td><strong>DEFINITIONS</strong></td>
</tr>
<tr>
<td>“<strong>Infertility</strong>” means the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year.</td>
<td>“<strong>Infertility</strong>” means the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year.</td>
</tr>
<tr>
<td><strong>“Non-experimental infertility procedure”</strong> means a procedure recognized as generally accepted as non-experimental by, (a) the American Fertility Society, (b) the American College of Obstetrics and Gynecology, or (c) a fertility expert recognized by the Insurance Commissioner.</td>
<td><strong>“Non-experimental infertility procedure”</strong> means a procedure recognized as generally accepted as non-experimental by, (a) the American Fertility Society, (b) the American College of Obstetrics and Gynecology, or (c) a fertility expert recognized by the Insurance Commissioner.</td>
</tr>
<tr>
<td><strong>EXCLUSIONS</strong> The following services do not qualify as non-experimental procedures, a) any experimental infertility procedure, until the procedure becomes recognized as non-experimental and is so recognized by the Commissioner, b) surrogacy, c) reversal of voluntary sterilization, and d) cryopreservation of eggs. Benefits are payable on the same basis as any pregnancy-related procedure.</td>
<td><strong>EXCLUSIONS</strong> The following services do not qualify as non-experimental procedures, a) any experimental infertility procedure, until the procedure becomes recognized as non-experimental and is so recognized by the Commissioner, b) surrogacy, c) reversal of voluntary sterilization, and d) cryopreservation of eggs. Benefits are payable on the same basis as any pregnancy-related procedure.</td>
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<td>Plan</td>
<td>BASIC PLAN BENEFITS</td>
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<tr>
<td>Hormone Replacement</td>
<td><strong>Covered Medical Expenses</strong> include charges for outpatient services and supplies</td>
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<tr>
<td>Therapy Expense</td>
<td>incurred, in connection with hormone replacement therapy, for peri and post menopausal</td>
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<tr>
<td></td>
<td>women, under the same terms and conditions as for such other outpatient services.</td>
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<td></td>
<td><strong>Covered Medical Expenses</strong> include charges for outpatient prescription drugs or</td>
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<td></td>
<td>devices for hormone replacement therapy, for peri and post menopausal women, under</td>
</tr>
<tr>
<td></td>
<td>the same terms and conditions as other prescription drugs or devices covered by this</td>
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<td></td>
<td>Policy.</td>
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<td></td>
<td><strong>Covered Medical Expenses</strong> are payable on the same basis as any other condition.</td>
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<tr>
<td>Prosthetic Devices</td>
<td><strong>Covered Medical Expenses</strong> include charges incurred by a covered person for:</td>
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<tr>
<td>Expense</td>
<td>artificial limbs or eyes, and other non-dental prosthetic devices, as a result of an</td>
</tr>
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<td></td>
<td>accident or sickness.</td>
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<td></td>
<td><strong>Covered Medical Expenses</strong> do not include: eye exams, eyeglasses, vision aids,</td>
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<td></td>
<td>hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other</td>
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<td></td>
<td>devices to support the feet are not <strong>Covered Medical Expenses</strong> unless such devices</td>
</tr>
<tr>
<td></td>
<td>are necessary to prevent complications from diabetes.</td>
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<td></td>
<td>Benefits are payable as follows, <strong>Preferred Care</strong>: 80% of the Negotiated Charge.</td>
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<td></td>
<td><strong>Non-Preferred Care</strong>: 60% of the Recognized Charge.</td>
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<tr>
<td>Scalp Hair Prosthesis</td>
<td>Coverage is provided for expenses for scalp hair prostheses worn for hair loss</td>
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<tr>
<td>Expense</td>
<td>suffered as a result of the treatment of any form of cancer or leukemia, provided,</td>
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<td></td>
<td>however, that such coverage shall be subject to a written statement by the treating</td>
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<td></td>
<td>Physician that the scalp hair prosthesis is Medically Necessary.</td>
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<td></td>
<td>Benefits are payable on the same basis as any other prostheses.</td>
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<td>BASIC PLAN BENEFITS</td>
<td>PLUS PLAN BENEFITS</td>
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| **Hearing Screening for Newborns Expense** | Hearing Screening for newborns means services rendered to a dependent child of a Covered person, for hearing tests performed before the newborn infant is discharged from the hospital or birthing center.  
*Covered Medical Expenses* are payable on the same basis as any other condition. |
| **Transplants Expense** | Charges for services or supplies furnished in connection with organ and bone marrow transplants, which are non-experimental and non-investigative, are considered *Covered Medical Expenses*.  
The following types of transplants are covered:  
- Cornea, heart, lung, heart and lung, liver, kidney, pancreas, kidneys and pancreas, and bone marrow.  
- Covered bone marrow transplants include transplants for persons who have been diagnosed with breast cancer that has progressed to metastatic disease.  
*Covered Medical Expenses* for Transplant expenses are payable on the same basis as any other sickness. |
| **Christian Science Expense** | *Covered Medical Expenses* include charges incurred by a covered person for the healing practices of Christian Science.  
Benefits are payable as follows:  
After a $20 Copay per visit, 80% of the Actual Charge. |
| **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. |
| **Covered Medical Expenses** are payable on the same basis as any other condition.  
Charges for services or supplies furnished in connection with organ and bone marrow transplants, which are non-experimental and non-investigative, are considered *Covered Medical Expenses*.  
The following types of transplants are covered:  
- Cornea, heart, lung, heart and lung, liver, kidney, pancreas, kidneys and pancreas, and bone marrow.  
- Covered bone marrow transplants include transplants for persons who have been diagnosed with breast cancer that has progressed to metastatic disease.  
*Covered Medical Expenses* for Transplant expenses are payable on the same basis as any other sickness. |
| **Covered Medical Expenses** include charges incurred by a covered person for the healing practices of Christian Science.  
Benefits are payable as follows:  
After a $20 Copay per visit, 100% of the Actual Charge. |
| **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. |
<table>
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<tr>
<th>Urgent Care Expense (continued)</th>
<th><strong>BASIC PLAN BENEFITS</strong></th>
<th><strong>PLUS PLAN BENEFITS</strong></th>
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</table>
| Should it not be reasonable to reach a Preferred Provider, payment for care related to the emergency shall be made at the same level and in the same manner as if the covered person had been treated by a Preferred Provider. | Should it not be reasonable to reach a Preferred Provider, payment for care related to the emergency shall be made at the same level and in the same manner as if the covered person had been treated by a Preferred Provider. | **Emergency Services** Use of 911  
A covered person has the option of calling the local pre-hospital emergency medical service system by dialing the emergency telephone access number 911; or its local equivalent; whenever he or she is confronted by an emergency medical condition. A covered person will not be discouraged from using this emergency telephone access number; or be denied coverage; for any **Covered Medical Expenses** incurred for medical and ambulance services as a result of such an emergency medical condition.  
Preferred Care: After a $25 copay per visit, 100% of the Negotiated Charge.  
Non-Preferred Care: 80% of the Recognized Charge. | **Preferred Care**: After a $15 copay per visit, 100% of the Negotiated Charge.  
**Non-Preferred Care**: 80% of the Recognized Charge. |
| **Antigen Testing Expense** | **Covered Medical Expenses** include human leukocyte antigen or histocompatibility locus antigen testing that is medically necessary to establish bone marrow transplant suitability. Antigen testing expenses are payable on the same basis as any other sickness. Also included is testing for A; B; or DR antigens; or any combination thereof. As to residents of Massachusetts; the testing must be consistent with rules; regulations; and criteria established by the Massachusetts Department of Public Health.  
Such **Covered Medical Expenses** are payable on the same basis as any other illness. | **Covered Medical Expenses** include human leukocyte antigen or histocompatibility locus antigen testing that is medically necessary to establish bone marrow transplant suitability. Antigen testing expenses are payable on the same basis as any other sickness. Also included is testing for A; B; or DR antigens; or any combination thereof. As to residents of Massachusetts; the testing must be consistent with rules; regulations; and criteria established by the Massachusetts Department of Public Health.  
Such **Covered Medical Expenses** are payable on the same basis as any other illness. |
ADDITIONAL SERVICES AND DISCOUNTS

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

**Aetna BookSM discount program,** Access to discounts on books and other items from the American Cancer Society Bookstore, the MayoClinic.com Bookstore and Pranamaya.

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

**Aetna HearingSM discount program,** Access to discounts on hearing aids and hearing tests from HearPO. Guaranteed lowest pricing* on over 1000 models from seven leading manufacturers.

*Competitor copy required for verification of price and model. Limited to manufacturers offered through the HearPO program. Local provider quotes only will be matched, no internet quotes.

**Aetna Natural Products and ServicesSM discount program,** Access to reduced rates on services from participating providers for acupuncture, chiropractic care, massage therapy and dietetic counseling. Also, access to discounts on over-the-counter vitamins, herbal and nutritional supplements and natural products. All products and services are provided through American Specialty Health Incorporated (ASH) and its subsidiaries.

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

**Aetna Weight ManagementSM discount program,** Access to discounts on eDiets® diet plans and products, Jenny Craig® weight loss programs and products, and Nutrisystem® weight loss meal plans.

**Oral Health Care discount program,** Access to discounts on oral health care products. Save on xylitol mints, mouth rinses, gum, candies and toothpaste from Epic. Additionally, receive exclusive savings on Waterpik® dental water jets and sonic toothbrushes.

**Zagat discounts,** Discount off a one-year online membership to ZAGAT.com, with access to ratings and reviews of over 40,000 restaurants, hotels and more in hundreds of cities worldwide.

**At Home Products discount program,** Access to discounts on health care products that members can use in the privacy and comfort of their home.

**Aetna Specialty Pharmacy,** provides specialty medications and support to members living with chronic conditions and illnesses. These medications are usually injected or infused, or some may be taken by mouth. Custom compounded doses and forms are also available. For additional information please go to www.AetnaSpecialtyRx.com.

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

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

These services, programs or benefits are offered by vendors who are independent contractors and not employees or agents of Chickering Claims Administrators, Inc., Aetna Life Insurance Company or their affiliates. Discount programs and other programs above provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Discount programs may be offered by vendors who are independent contractors and not employees or agents of Aetna. Aetna may receive a percentage of the fee you pay to the discount vendor.
Aetna’s Informed Health® Line*,
Call toll free 1-800-556-1555 24 hours a day, 7 days a week.
Get health answers 24/7. When you have an Aetna health benefits and health insurance plan, you have instant access to the information you need. Our tools and resources can help you,

- Make more informed decisions about your care.
- Communicate better with your doctors.
- Save time and money, by showing you how to get the right care at the right time.

When you call our Informed Health Line*, you can talk directly to a registered nurse. Our nurses can discuss a wide variety of health and wellness topics.

* While only your doctor can diagnose, prescribe or give medical advice, the Informed Health Line nurses can provide information on more than 5,000 health topics. Contact your doctor first with any questions or concerns regarding your health care needs.

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

* Not all topics in the audio health service are covered expenses under your plan.

Use the Healthwise® Knowledgebase to find out more about a health condition you have or medications you take. It explains things in terms that are easy to understand.
Get to it through your secure Aetna Navigator® member website, at www.aetnastudenthealth.com.

GENERAL PROVISIONS
STATE MANDATED BENEFITS

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

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

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

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

The Covered Person shall do nothing to prejudice Aetna’s subrogation and reimbursement rights. The Covered Person shall, when requested, fully cooperate with Aetna’s efforts to recover its benefits paid. It is the duty of the Covered Person to notify Aetna within 45 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim, to recover damages, due to injuries sustained by the Covered Person.
The **Covered Person** acknowledges that this Plan’s subrogation and reimbursement rights are a first priority claim against all potential responsible parties, and are to be paid to Aetna before any other claim for the **Covered Person**’s damages. This Plan shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the Plan will result in a recovery to the **Covered Person**, which is insufficient to make the **Covered Person** whole, or to compensate the **Covered Person** in part or in whole for the damages sustained. This Plan is not required to participate in or pay attorney fees to the attorney hired by the **Covered Person** to pursue the **Covered Person**’s damage claim. In addition, this Plan shall be responsible for the payment of attorney fees for any attorney hired or retained by this Plan. The **Covered Person** shall be responsible for the payment of all attorney fees for any attorney hired or retained by the **Covered Person** or for the benefit of the **Covered Person**.

The terms of this entire subrogation and reimbursement provision shall apply. This Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party, and regardless of whether the settlement or judgment received by the **Covered Person** identifies the medical benefits this Plan provided. This Plan is entitled to recover from any and all settlements or judgments, even those designated as “pain and suffering” or “non-economic damages” only.

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

**EXCESS PROVISION**

This Plan is an excess only Plan. As an excess only Plan, this Plan pays its Covered Medical Expenses after any other medical coverage. This Plan’s liability will be determined without consideration to any limitation clause or clauses regarding other coverage contained in any other medical coverage. Benefits Payable under this Plan shall be limited to the Plan’s Covered Medical Expense and reduced by the amount paid or payable by any other medical coverage.

For the purposes of calculating a benefit under this Plan, the liability of the other medical coverage shall be considered and shall not depend upon whether timely application for benefits from other medical coverage is made by you or on your behalf. If any other medical coverage provides benefits on an excess only basis, the coverage for the **Covered Member** which has been in effect the longest shall pay benefits first.

“Other medical coverage” means any reimbursement for or recovery of any element of incurred covered charges available from any other source whatsoever whether through an insurance policy or other type of coverage, except gifts and donations, including but not limited to the following,

- Any group, accident-only, blanket, individual, or franchise policy of accident, disability, health, or accident and sickness insurance.
- Any arrangement of benefits for members of a group, whether insured or uninsured.
- Any prepaid service arrangement such as Blue Cross or Blue Shield, individual or group practice plans or health maintenance organizations.
- Any amount payable as a benefit for accidental bodily injury arising out of a motor vehicle accident to the extent such benefits are payable under the medical expense payment provision (or, by whatever terminology used to include such benefits mandated by law) of any motor vehicle insurance policy.
- Any amounts payable for injuries related to your job to the extent that he or she actually received benefits under a Workers’ Compensation Law.
- Social Security Disability Benefits, except that Other Medical Insurance shall not include any increase in Social Security Disability Benefits payable to you after you become disabled while insured hereunder.
- Any benefits payable under any program provided or sponsored solely or primarily by any governmental agency or subdivision or through operation of law or regulation.

HMO/PPO Provision – In the event that covered expenses are denied under a Health Maintenance Organization, Preferred Provider Organization (PPO) or other group medical plan the member has in force, and such denial is because care or treatment was received outside of the network’s geographic area, benefits will be payable under this coverage, provided the expense is a covered expense.
EXTENSION OF BENEFITS
If a Covered Person is confined to a hospital on the date his or her coverage terminates, charges incurred during the continuation of that hospital confinement shall also be included in the term “Expense”, but only while they are incurred during the 90 day period following such termination of insurance.

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

TERMINATION OF STUDENT COVERAGE
Insurance for a Covered Student will end on the first of these to occur:
- the date this Plan terminates,
- the date on which the Covered Student withdraws from the school because of entering the armed forces of any country. Premiums will be refunded on a pro-rata basis when application is made within 90 days from withdrawal,
- the date the Covered Student is no longer in an eligible class.
- If withdrawal from school is for other than entering the armed forces, no premium refund will be made. Students will be covered for the Policy term for which they are enrolled, and for which premium has been paid.

TERMINATION OF DEPENDENT COVERAGE
Insurance for a covered student’s dependent will end when insurance for the covered student ends. Before then, coverage will end:
- a) For a child, on the last day of the Policy Period following the child’s 26th birthday.
- b) For the spouse, the date the marriage ends in divorce or annulment.
- c) The date dependent coverage is deleted from this Plan.

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

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

Due proof of the child’s incapacity and dependency must be furnished to Aetna by the Covered Student within 31 days after the date insurance would otherwise cease. Such child will be considered a covered dependent, so long as the Covered Student submits proof to Aetna at reasonable intervals during the two (2) years following the child’s attainment of the limiting age and each year thereafter, that the child remains physically or mentally unable to earn his own living. The premium due for the child’s insurance will be the same as for a child who is not so incapacitated.

The child’s insurance under this provision will end on the earlier of:
- the date specified under the provision entitled Termination of Dependent Coverage, or
- the date the child is no longer incapacitated and dependent on the Covered student for support.
EXCLUSIONS

This Plan does not cover nor provide benefits for:

1. Expense incurred as a result of dental treatment, except for treatment resulting from injury to sound, natural teeth or for extraction of impacted wisdom teeth as provided elsewhere in this Policy.
2. Expense incurred for services normally provided without charge by the Policyholder’s Health Service, Infirmary or Hospital, or by health care providers employed by the Policyholder.
3. Expense incurred for eye refractions, vision therapy, radial keratotomy, eyeglasses, contact lenses (except when required after cataract surgery), or other vision or hearing aids, or prescriptions, or examinations except as required for repair caused by a covered injury or as provided elsewhere in this plan.
4. 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.
5. 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.
6. 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.
7. 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.
8. Expense incurred for treatment provided in a governmental hospital unless there is a legal obligation to pay such charges in the absence of insurance.
9. Expense incurred for elective treatment or elective surgery except as specifically provided elsewhere in this Policy and performed while this Policy is in effect.
10. 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: (a) 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 a direct result of disease; or (b) surgery performed to treat a disease or injury or to 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. Facings on molar crowns and pontics will always be considered cosmetic.
11. Expense covered by any other valid and collectible medical, health, or accident insurance to the extent that benefits are payable under other valid and collectible insurance whether or not a claim is made for such benefits.
12. Expense incurred as a result of commission of a felony.
13. Expense incurred after the date insurance terminates for a covered person except as may be specifically provided in the Extension of Benefits Provision.
14. Expense incurred for services normally provided without charge by the school and covered by the school fee for services.
15. 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.
16. Expense incurred for injury resulting from the play or practice of intercollegiate sports, including collegiate or intercollegiate club sports.
18. Treatment for injury to the extent benefits are payable under any state no-fault automobile coverage; first party medical benefits payable under any other mandatory no-fault law.
19. Expense for elective sterilization or its reversal or elective abortion unless specifically provided for in this Policy.
20. Expenses for treatment of injury or sickness to the extent that payment is made, as a judgment or settlement, by any person deemed responsible for the injury or sickness (or their insurers).
21. Expense incurred for which no member of the covered person’s immediate family has any legal obligation for payment.

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

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

24. Expenses incurred for or in connection with procedures, services, or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational (a) if there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or (b) if required by the FDA, approval has not been granted for marketing; or (c) a recognized national medical or dental society or regulatory agency has determined in writing that it is experimental, investigational, or for research purposes; or (d) the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment, states that it is experimental, investigational, or for research purposes. However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease if Aetna determines that: (a) The disease can be expected to cause death within one year in the absence of effective treatment; and (b) The care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination, Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved. Also, this exclusion will not apply with respect to drugs that: (a) Have been granted treatment investigational new drug (IND), or Group c/treatment IND status; or (b) Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or (c) If Aetna determines that available; scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease; or (d) to the extent coverage for such drug or medicine is specifically provided in the Policy.

25. Expenses incurred for gastric bypass; and any restrictive procedures; for weight loss.


27. Expenses incurred for gynecomastia (male breasts).

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

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

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

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

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

33. Expense incurred for hearing aids; the fitting; or prescription of hearing aids.

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

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

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

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

38. Expenses incurred for massage therapy.

39. Expense incurred for; or related to; sex change surgery; or to any treatment of gender identity disorder.
40. 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.

41. 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.

42. Expenses for routine physical exams; including expenses in connection with well newborn care; routine vision exams; routine dental exams; routine hearing exams; immunizations; or other preventive services and supplies; except to the extent coverage of such exams; immunizations; services; or supplies is specifically provided in the Policy.

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

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

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

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

Adverse Benefit Determination
A determination by Aetna that an admission, availability of care, continued stay, or other health care service, has been reviewed and, based upon the information provided, does not meet Aetna’s requirements for, medical necessity, appropriateness, health care setting, level of care, or effectiveness. The requested service or supply is therefore denied, reduced, or terminated.

Aggregate Maximum
The maximum benefit that will be paid under this Policy for all Covered Medical Expenses incurred by a covered person that accumulate in one Policy Year.

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

Appeal
A request (grievance) for review of a decision which has been denied, in whole or in part, for, claim payment, certification, eligibility, referral, etc. This will be done after consideration of any relevant information.

Autism Services Provider
A person, entity or group that provides treatment of autism spectrum disorders.

Autism Spectrum Disorders
Any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, Asperger’s disorder and pervasive developmental disorders not otherwise specified.
**Behavioral Health Provider**

A licensed facility, organization or other health care provider furnishing diagnostic and therapeutic services for treatment of alcoholism, drug abuse, **Mental Disorders** or acting within the scope of the applicable license. This includes,

- Hospitals,
- Psychiatric Hospitals,
- Residential Treatment Facilities,
- Psychiatric Physicians,
- Psychologists,
- Social workers,
- Psychiatric nurses,
- Addictionologists,
- Substance abuse facility licensed by the department of mental health,
- Level III community-based detoxification, acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the department of public health or the department of mental health,
- Mental health or substance abuse clinic licensed by the department of public health,
- A public community mental health center,
- Professional office or home-based services,
- Licensed independent clinical social worker,
- Licensed mental health counselor,
- Licensed nurse mental health clinical specialist,
- Other alcoholism, drug abuse and mental health providers or groups, involved in the delivery of health care or ancillary services, or
- Facility under the direction and supervision of the department of mental health,
- Private mental hospital licensed by the department of mental health,
- Substance abuse facility licensed by the department of public health,
- Clinically managed detoxification services,
- Intensive Outpatient Programs (IOP), and
- In-home therapy services.

**Biologically-Based Mental Illness**

This means the following biologically-based mental illnesses, as defined in the most recent edition of the American Psychiatric Association’s “*Diagnostic and Statistical Manual of Mental Disorders*”,

- Schizophrenia,
- Schizoaffective Disorder,
- Major depressive Disorder,
- Bipolar Disorder,
- Paranoia and other Psychotic Disorders,
- Obsessive-Compulsive Disorder,
- Panic Disorder,
- Delirium and Dementia,
- Affective Disorders,
- Eating Disorders,
- Post Traumatic Stress Disorders,
- Substance Abuse Disorders,
- Pervasive Developmental Disorder (Autism).

Treatment is generally provided by, or under the direction of, a physician or mental health professional, such as a psychiatrist, a psychologist, or a licensed independent clinical social worker, a licensed mental health counselor, or a licensed nurse mental health clinical specialist.

**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 and 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, 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.

Board Certified Behavior Analyst
A behavior analyst credentialed by the behavior analyst certification board as a board certified behavior analyst.

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

Complications of Pregnancy
Conditions which require hospital stays before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy. These conditions are,
• acute nephritis or nephrosis, or
• cardiac decompensation or missed abortion, or
• similar conditions as severe as these.

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

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

Convalescent Facility
This is an institution that,
• Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury,
  - professional nursing care by a R.N., or by a L.P.N, directed by a full-time R.N., and
  - physical restoration services to help patients to meet a goal of self-care in daily living activities.
• Provides 24 hour a day nursing care by licensed nurses directed by a full-time R.N.
• Is supervised full-time by a physician or R.N.
• Keeps a complete medical record on each patient.
• Has a utilization review plan.
• Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
• Makes charges.
Copay
This is a fee charged to a person for Covered Medical Expenses. For Prescribed Medicines Expense, the copay is payable directly to the pharmacy for each prescription, kit, or refill, at the time it is dispensed. In no event will the copay be greater than the pharmacy’s charge per prescription, kit, or refill.

Covered Dental Expenses
Those charges for any treatment, service, or supplies, covered by this Plan which are,
• not in excess of the recognized charges, or
• not in excess of the charges that would have been made in the absence of this coverage,
• and incurred while this Plan is in force as to the covered person.

Covered Dependent
A covered student’s dependent who is insured under this Plan.

Covered Medical Expense
Those charges for any treatment, service or supplies covered by this Policy which are,
• not in excess of the recognized charges, or
• not in excess of the charges that would have been made in the absence of this coverage, and
• incurred while this Policy is in force as to the covered person except with respect to any expenses payable under the Extension of Benefit Provisions.

Covered Person
A covered student and any covered dependent including newborn infants of a covered person while coverage under this Plan is in effect.

Covered Student
A student of the Policyholder who is insured under this Plan.

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

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

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

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

Dependent
(a) the covered student’s spouse residing with the covered student, or (b) the covered student’s child, from the moment of birth, and under the age of 26. Coverage includes newborn infants of a covered person.

The child will continue to be eligible until the earlier of, (a) the child’s attainment of age 26, or (b) the date two (2) years after the end of the calendar year in which such persons last qualify as a dependent under 26 U.S.C. 106, whichever occurs first.

The term “child” includes, a covered student’s biological child, step-child, adopted child, and a child for whom a petition for adoption is pending, and who is residing with the covered student, and who is chiefly dependent on the covered student for his or her full support.

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

Designated Care
Care provided by a Designated Care Provider upon referral from the School Health Services.
**Designated Care Provider**
A health care provider [or pharmacy,] that is affiliated with, and has an agreement with, the School Health Services to furnish services and supplies at a negotiated charge.

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

**Durable Medical and Surgical Equipment**
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 shall also include:
- hormone replacement therapy prescription devices for peri and post menopausal women;
- outpatient prescription contraceptive devices which have been approved by the United States Food and Drug Administration on the same basis as any other illness; and
- blood glucose monitors, voice-synthesizers and visual magnifying aids for the diagnosis and treatment of insulin-dependent, insulin-using, gestational and non-insulin-dependent diabetes.

The use of durable medical equipment as part of a physician approved home health care plan is covered under the Home Health Care Expense section.

Coverage for such items includes the fitting; adjustment; and repair of such devices.

All equipment and supplies must be prescribed by a physician.

Any Durable Medical Equipment benefit maximum applicable under the Plan will not apply to any durable medical equipment expenses incurred under this benefit that have been prescribed by a physician; as part of a home health care plan.

**Elective Treatment**
Medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the covered person’s effective date of coverage. Elective treatment includes, but is not limited to,
- tubal ligation,
- vasectomy,
- breast reduction,
- sexual reassignment surgery,
- submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis,
- treatment for weight reduction,
- learning disabilities,
- temporomandibular joint dysfunction (TMJ),
- routine physical examinations.
Emergency Admission
One where the physician admits the person to the hospital or residential treatment facility right after the sudden and 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,
- placing the person’s health or that of another person in serious jeopardy, or
- serious impairment to bodily function, or
- serious dysfunction of any body part or organ, or
- on the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Dental Care
Medically necessary care or treatment for an emergency medical condition. Such care is subject to specific limitations set forth in this Plan.

Emergency Medical Condition
A medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected, by a prudent layperson possessing an average knowledge of medicine and health, to 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.

A covered person has the option of calling the local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent, whenever he or she is confronted by an emergency medical condition. A covered person will not be discouraged from using this emergency telephone access number or be denied coverage for any Covered Medical Expenses incurred for medical and ambulance services as a result of such an emergency medical condition.

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

Habilitative or Rehabilitative Care
Professional, counseling and guidance services and treatment programs, including, but not limited to, applied behavior analysis supervised by a board certified behavior analyst, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of an individual.

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

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

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

Home Health Care Plan
A written plan of care established and approved in writing by a physician, for continued health care and treatment in a covered person’s home. It must either follow within 24 hours of and be for the same or related cause(s) as a period of hospital or skilled nursing confinement, or be in lieu of hospital or skilled nursing confinement.
Hospice
A facility, or program, providing a coordinated program of home and inpatient care, which treats terminally ill patients. The program provides care to meet the special needs of the patient during the final stages of a terminal illness. Care is provided by a team made up of trained medical personnel, counselors, and volunteers. The team acts under an independent hospice administration, and it helps the patient cope with physical, psychological, spiritual, social, and economic stresses. The 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 case and treatment of injured and sick people, and
- it provides room and board services and nursing services 24 hours a day, and
- it has established facilities for diagnosis and major surgery, and
- it is run as a hospital under the laws of the jurisdiction which it is located.

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

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

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

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

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

Mail Order Pharmacy
An establishment where prescription drugs are legally dispensed by mail.

Medically Necessary
Health care or dental services, and supplies or prescription drugs that a physician, other health care provider or dental provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that provision of the service, supply or prescription drug is:

a) In accordance with generally accepted standards of medical or dental practice;
b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
c) Not primarily for the convenience of the patient, physician, other health care or dental provider; and
d) And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury, or disease.

For these purposes “generally accepted standards of medical or dental practice” means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community, or otherwise consistent with physician or dental specialty society recommendations and the views of physicians or dentists practicing in relevant clinical areas and any other relevant factors. For services and interventions not in widespread use, it is based on scientific evidence.
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. A copy of the Medication Formulary will be available upon request by calling (888) 792-3862 or the list may be accessed at www.aetna.com.

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

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

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

Mental Disorder
An illness commonly understood to be a Mental Disorder, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a Behavioral Health Provider such as a Psychiatric Physician, a psychologist, a psychiatric social worker, a licensed independent clinical social worker, a licensed mental health counselor, or a licensed nurse mental health clinical specialist.

Any one of the following conditions is a Mental Disorder under this plan,
• Anorexia/Bulimia Nervosa.
• Bipolar disorder.
• Major depressive disorder.
• Obsessive compulsive disorder.
• Panic disorder.
• Pervasive Mental Developmental Disorder (including Autism).
• Psychotic Disorders/Delusional Disorder.
• Schizoaffective Disorder.
• Schizophrenia.
• Paranoia and other psychotic disorders.
• Delirium and dementia.
• Affective disorders.
• Eating disorders.
• Post traumatic stress disorders.
• Substance Abuse
• All other mental disorders not otherwise identified and which are described in the most recent edition of the diagnostic and statistical Manual of Mental Disorders (DSM).

Negotiated Charge
As to Health Expense Coverage, other than Prescription Drug Expense Coverage,
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.

As to Prescription Drug Expense Coverage,
The negotiated charge is the amount Aetna has established for each prescription drug obtained from a preferred pharmacy under this Policy. This negotiated charge may reflect amounts Aetna has agreed to pay directly to the preferred pharmacy or to a third party vendor for the prescription drug, and may include an additional service or risk charge set by Aetna.

The negotiated charge does not include or reflect any amount Aetna, an affiliate, or a third party vendor, may receive under a rebate arrangement between Aetna, an affiliate or a third party vendor and a drug manufacturer for any prescription drug, including prescription drugs on the medication formulary.

Based on its overall drug purchasing, Aetna may receive rebates from the manufacturers of prescription drugs and may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not change the negotiated charge under this Policy.
Non-Biologically Based Mental Disorder
A mental disorder that is not defined as a Biologically-Based Mental Illness or disorder in this Policy.

Non-Occupational Disease
A non-occupational disease is a disease that does not,
- arise out of (or in the course of) any work for pay or profit, or
- result in any way from a disease that does.

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the covered student,
- is covered under any type of workers’ compensation law, and
- is not covered for that disease under such law.

Non-Occupational Injury
A non-occupational injury is an accidental bodily injury that does not,
- arise out of (or in the course of) any work for pay or profit, or
- result in any way from an injury which does.

Non-Preferred Care
A health care service or supply furnished by a health care provider that is not a Designated Care Provider, or that is not a Preferred Care Provider, if, as determined by Aetna,
- the service or supply could have been provided by a Preferred Care Provider, and
- the provider is of a type that falls into one or more of the categories of providers listed in the directory.

Non-Preferred Care Provider
- a health care provider that has not contracted to furnish services or supplies at a negotiated charge, or
- a Preferred Care Provider that is furnishing services or supplies without the referral of a School Health Services.

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

Non-Preferred Prescription Drug Expense
An expense incurred for a prescription drug that is not a preferred prescription drug expense.

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

Orthodontic Treatment
Any
- medical service or supply, or
- dental service or supply,
  furnished to prevent or to diagnose or to correct a misalignment,
  - of the teeth, or
  - of the bite, or
  - of the jaws or jaw joint relationship,
- whether or not for the purpose of relieving pain. Not included is,
  - the installation of a space maintainer, or
  - surgical procedure to correct malocclusion.

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

The following expenses do not apply toward meeting the Out-of-Pocket Limit:
- deductibles,
- copays,
- expenses that are not Covered Medical Expenses,
• expenses for designated care or non-preferred care,
• penalties,
• expenses for prescription drugs, and
• other expenses not covered by this Plan.

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.

Pharmacy Care
Medications prescribed by a licensed physician and health-related services deemed medically necessary to determine the need or effectiveness of the medications, to the same extent that pharmacy care is provided by the contract for other medical conditions.

Physician
A duly licensed member of a medical profession who,
• Has an M.D. or D.O. degree,
• Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices, and
• Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who,
• Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices,
• Provides medical services which are within the scope of his or her license or certificate,
• Under applicable insurance law, is considered a “physician” for purposes of this coverage,
• Has the medical training and clinical expertise suitable to treat your condition, and
• Specializes in psychiatry, if your illness or injury is caused, to any extent, by alcohol abuse, drug abuse, or non biologically-based mental disorders or biologically-based mental disorders.
• is a physician other than you and not related to you.

Also, to the extent required by law, a practitioner who performs a service which coverage is provided when it is performed by a physician. These include, but may not be limited to the following,
• Podiatrist,
• Chiropractors,
• Optometrists,
• Certified Registered Nurse Anesthetists,
• Certified Nurse Midwives,
• Nurse Practitioners.
• Christian Science Practitioner

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
A health care service or supply that is provided by,
• a covered person’s primary care physician, or a preferred care provider on the referral of the primary care physician, 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], or
• a health care provider that is not a preferred care provider for the following situations,
  - for an emergency medical condition when travel to a preferred care provider, [or referral by a
covered person’s primary care physician, prior to treatment] is not feasible, or
  - for treatment or services furnished by a physician that has a type of practice that is not listed in the Directory, but whose services are required to be covered by law, or
- for treatment or services furnished by a **physician**, within a geographic area covered in the Directory, but only if a **preferred care provider** is not reasonably available, provided you contact Aetna, and Aetna confirms that a **preferred care provider** is not reasonably available.

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

**Preferred Pharmacy**
A **pharmacy**, including a **mail order pharmacy**, which is party to a contract with Aetna, 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 medical condition only, by a non-preferred pharmacy, and
- is dispensed upon the Prescription of a Prescriber who is,
  - a **Designated Care Provider**, or
  - a **Preferred Care Provider**, or
  - a **Non-Preferred Care Provider**, but only for an **emergency condition**, or on referral of a person’s Primary Care Physician, or
  - a **Dentist** who is a **Non-Preferred Care Provider**, but only one who is not of a type that falls into one or more of the categories of providers listed in the **directory** of **Preferred Care Providers**.

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

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

**Prescription 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**.

Prescription drugs include,
- “Off-label” drugs for the HIV/AIDS treatment, provided such drugs (i) are prescribed by a Doctor for HIV/AIDS treatment, or medical condition arising from or related to HIV infection, and (ii) are prescribed or administered with the treatment protocol for coverage of “Off-label” drugs, determined in accordance with Massachusetts law. “Off-label” means a drug that has not been specifically approved by the Federal Food and Drug Administration for HIV/AIDS treatment, but is a drug approved for other indications by the Federal Food and Drug Administration.
- “Off-label” drugs for cancer treatment, provided such drugs (i) are prescribed by a Doctor for cancer, and (ii) are prescribed or administered with the treatment protocol for coverage of “Off-label” drugs, determined in accordance with Massachusetts law. “Off-label” means a drug that has not been specifically approved by the Federal Food and Drug Administration for cancer treatment, but is a drug approved for other indications by the Federal Food and Drug Administration.
• Drugs and medicines which, by law, need a physician’s prescription. This includes those prescribed for the treatment of cancer or HIV/AIDS, even if the off-label use of the drug has not been approved by the FDA for that indication. However, such drug for the treatment of Cancer or HIV/AIDS must be recognized for treatment of such indication in one of the standard reference compendia, or in medical literature. The term “standard reference compendia” means, the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information. The term “medical literature” means published scientific studies appearing in any peer-reviewed national professional journal.

Prosthetic Device
An artificial limb device to replace, in whole or in part, an arm or leg.

Psychiatric Care
Direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

Psychiatric Hospital
This is an institution that meets all of the following requirements.
• Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, drug abuse, Mental Disorders or Biologically-Based Mental Disorders.
• Is not mainly a school or a custodial, recreational or training institution.
• Provides infirmary-level medical services. Also, it provides, or arranges with a Hospital in the area for, any other medical service that may be required.
• Is supervised full-time by a Psychiatric Physician who is responsible for patient care and is there regularly.
• Is staffed by Psychiatric Physicians involved in care and treatment.
• Has a Psychiatric Physician present during the whole treatment day.
• Provides, at all times, psychiatric social work and nursing services.
• Provides, at all times, Skilled Nursing Services by licensed nurses who are supervised by a full-time R.N.
• Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a Psychiatric Physician.
• Makes charges.
• Meets licensing standards.

Psychiatric Physician
This is a Physician who,
• Specializes in psychiatry, or
• Has the training or experience to do the required evaluation and treatment of alcoholism, drug abuse, Mental Disorders, or Biologically-Based Mental Illnesses or Disorders.

Psychological Care
Direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

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
This is an institution that meets all of the following requirements,

• On-site licensed Behavioral Health Provider 24 hours per day/7 days a week.
• Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
• Is admitted by a Physician.
• Has access to necessary medical services 24 hours per day/7 days a week.
• Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
• Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
• Has the ability to involve family/support systems in therapy (required for children and adolescents, encouraged for adults).
• Provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy.
• Has peer oriented activities.
• Services are managed by a licensed Behavioral Health Provider who, while not needing to be individually contracted, needs to (1) meet the Aetna credentialing criteria as an individual practitioner, and (2) function under the direction/ supervision of a licensed psychiatrist (Medical Director).
• Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
• Provides a level of skilled intervention consistent with patient risk.
• Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
• Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

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

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

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

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

Service Area
The geographic area, as approved by the Massachusetts Division of Insurance as determined by Aetna, in which the Preferred Care Providers are located.

Sickness
Disease or illness including related conditions and recurrent symptoms of the sickness. Sickness also includes pregnancy, and complications of pregnancy. All injuries or sickness due to the same or a related cause are considered one injury or sickness.
Skilled Nursing Facility
A lawfully operating institution engaged mainly in providing treatment for people convalescing from injury or sickness. It must have,
- Organized facilities for medical services,
- 24 hours nursing service by RNs,
- A capacity of six or more beds,
- A daily medical records for each patient, and
- A physician available at all times.

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

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

  - Has a written agreement with a hospital in the area for immediate emergency transfer of patients. Written procedures for such a transfer must be displayed, and the staff must be aware of them.
  - Provides an ongoing quality assurance program. The program must include reviews by physicians who do not own or direct the facility.
  - Keeps a medical record on each patient.

Surgical Assistant
A medical professional trained to assist in surgery in both the preoperative and postoperative periods under the supervision of a physician.

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.

**Therapeutic Care**
Services provided by licensed or certified speech therapists, occupational therapists, physical therapists or social workers.

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

**Urgent Admission**
One where the **physician** admits the person to the **hospital** due to,
• the onset of or change in a disease, or
• the diagnosis of a disease, or
• an **injury** caused by an **accident**, which, while not needing an emergency admission, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.

**Urgent Condition**
This means a sudden illness, **injury**, or condition, that,
• is severe enough to require prompt medical attention to avoid serious deterioration of the **covered person**’s health,
• includes a condition which would subject the **covered person** to severe pain that could not be adequately managed without urgent care or treatment,
• does not require the level of care provided in the emergency room of a **hospital**, and
• requires immediate outpatient medical care that cannot be postponed until the **covered person**’s **physician** becomes reasonably available.

**Urgent Care Provider**
This is,
• A freestanding medical facility which,
  - Provides unscheduled medical services to treat an **urgent condition** if the **covered person**’s **physician** is not reasonably available.
  - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
  - Makes charges.
  - Is licensed and certified as required by any state or federal law or regulation.
  - Keeps a medical record on each patient.
  - Provides an ongoing quality assurance program. This includes reviews by **physicians** other than those who own or direct the facility.
  - Is run by a staff of **physicians**. At least one such **physician** must be on call at all times.
  - Has a full-time administrator who is a licensed **physician**.

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

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

**Walk-in Clinic**
A clinic with a group of **physicians**, which is not affiliated with a **hospital**, that provides, diagnostic services, observation, treatment, and rehabilitation on an outpatient basis.
CLAIM PROCEDURE

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

Customer Service Representatives are available 8:30 a.m. to 5:30 p.m., Monday through Friday, ET for any questions.

1. Bills must be submitted within **90 days** from the date of treatment.
2. Payment for **Covered Medical Expenses** will be made directly to the hospital or physician concerned, unless bill receipts and proof of payment are submitted.
3. If itemized medical bills are available at the time the claim form is submitted, attach them to the claim form. Subsequent medical bills should be mailed promptly to the above address.
4. You will receive an “Explanation of Benefits” when your claims are processed. The Explanation of Benefits will explain how your claim was processed, according to the benefits of your Student Accident and Sickness Insurance Plan.

HOW TO APPEAL A CLAIM

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

Aetna Student Health
P.O. Box 14464
Lexington, KY 40512

INQUIRIES

The Inquiry process is a process prior to the Appeal process during which Aetna may attempt to answer questions and/or resolve concerns communicated on behalf of the claimant to their satisfaction within three (3) business days. This process shall not be used for review of an Adverse Determination, which must be reviewed through the Appeal process.

COMPLAINTS

If an inquiry is not resolved in three (3) **business days** or if you are dissatisfied with the service you receive from the Plan or want to complain about a participating provider you must call Aetna Customer Service within **30 calendar days** of the incident. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written response within **30 calendar days** of the receipt of the complaint, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

APEALS OF ADVERSE BENEFIT DETERMINATIONS

You may submit an Appeal if Aetna gives notice about a Complaint or an Adverse Benefit Determination. this Plan provides for two levels of Appeal. It will also provide an option to request an external review of the Adverse Benefit Determination.

You have **180 calendar days** with respect to Health claims (and **60 calendar days** with respect to all other claims) following the receipt of notice about a Complaint or an Adverse Benefit Determination to request your level one Appeal. Your appeal must be made by telephone, in person, by mail, or by electronic means and should include:

- Your name,
- Your school’s name,
- A copy of Aetna’s notice of an Adverse Benefit Determination,
- Your reasons for making the appeal, and
- Any other information you would like to have considered.

A claimant may contact Member Services at the toll-free telephone number on their ID card for assistance in resolving Appeals. A claimant may also contact the Office of Patient Protection at their toll-free number **(800) 436-7757**, facsimile **(617) 624-5046** or via the internet site [www.state.ma.us/dph/opp](http://www.state.ma.us/dph/opp) regarding an external appeal.
You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to Aetna. All rights of the claimant also extend to the claimant’s authorized representative, which includes a claimant’s guardian, conservator, holder of a power of attorney, health care agent designated pursuant to the law, family member, or another person authorized by the claimant in writing or by law with respect to a specific Appeal or external review, provided that if the claimant is unable to designate a representative, where such designation would otherwise be required, a conservator, holder of a power of attorney, or family member in that order or priority may be the claimant’s representative or appoint another responsible party to serve as the claimant’s authorized representative. If the authorized representative is a health care provider, the claimant must specify a named individual who will act on behalf of the authorized representative and a telephone number for that individual.

**EXPEDITED APPEALS REVIEW PROCESS**

In the event the claimant is a hospital inpatient, the claimant shall receive a written resolution of an expedited review of the Appeal prior to hospital discharge and the opportunity to request continuation of services. In the event the Appeal is of an emergent or urgent nature where the physician believes that denial of coverage for a medically necessary service would cause serious harm to the claimant, an Aetna Medical Director shall review the matter as soon as possible or within 48 hours and communicate a decision to the claimant by telephone. In addition, Aetna will provide the claimant with a written resolution which shall include identification of the specific information considered and an explanation of the basis for the decision. The written resolution shall include a substantive clinical justification therefore that is consistent with generally accepted principles of professional medical practice.

**EXTERNAL REVIEW**

A claimant, who remains aggrieved by an Adverse Determination and has exhausted at least one level of Appeal, may seek further review of the Appeal by filing a request in writing with the Office of Patient Protection. The request for an external review must be made within 45 days of receipt of the Aetna determination. For the purposes of this provision, an Adverse Determination is based upon a review of information provided by Aetna to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other health care services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care or effectiveness.

Please review your Certificate of Coverage for additional information concerning your appeal rights.
PRESCRIPTION DRUG CLAIM PROCEDURE

PREFERRED CARE
When obtaining a covered Prescription, please present your Aetna ID card to Preferred Pharmacy along with your applicable copay. The Pharmacy will submit a claim to Aetna for the drug.

When you need to fill a Prescription and do not have your ID card with you, you may obtain your Prescription from an Aetna Preferred Pharmacy and be reimbursed by submitting a completed Aetna Prescription Drug claim form. A claim form is available at Student Health Services or by calling (888) 792-3862. You will be reimbursed for covered medications directly by Aetna.

Please note: In addition to your copay, you may be required to pay the difference between the retail price you paid for the prescription drug and the amount Aetna would have paid if you had presented your ID card and the Pharmacy had billed Aetna directly.

Information regarding Preferred Care Pharmacy locations is available by accessing the Internet at: www.aetnastudenthealth.com. From the “Find Your School” drop down menu, select “Boston University”.

NON-PREFERRED CARE
You may obtain your Prescription from a Non-Preferred Pharmacy and be reimbursed by submitting a completed Aetna Prescription Drug claim form. You will be reimbursed for covered medications at the Recognized Charge allowance, less any applicable Deductible, directly by Aetna. You will be responsible for any amount in excess of the Recognized Charge.

Please note: You will be required to pay in full at the time of service for all Prescriptions dispensed at a Non-Participating Pharmacy.

Claim forms, Pharmacy locations, and claims status information can be obtained by contacting Aetna Pharmacy Management at (888) 792-3862. When submitting a claim, please include all Prescription receipts, indicate that you attend Boston University, and include your name, address, and student identification number.

WORLDWIDE TRAVEL ASSISTANCE SERVICES
On Call International
Chickering Claims Administrators, Inc. (CCA) has contracted with On Call International (On Call) to provide Covered Persons with access to certain accidental death and dismemberment benefits, worldwide emergency travel assistance services and other benefits.

A brief description of these benefits is outlined below.

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

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

• Unlimited Emergency Medical Evacuation
• Unlimited Medically Supervised Repatriation
• Unlimited Return of Mortal Remains
• Return of Traveling Companion
• $2,500 Emergency Return Home in the event of death or life-threatening illness of a parent or sibling

Natural Disaster and Political Evacuation Services (NDPE)
The following benefits are underwritten by US Fire Insurance Company (USFIC) with medical, travel and security assistance services provided by On Call.

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

If the Covered Person is delayed at the safe haven, On Call shall arrange and pay for reasonable lodging expenses up to $100 per day, for a maximum of three days.
(Economy airfare and lodging costs shall not exceed a combined single limit of $5,000 USD per Covered Person.)
Subject to a maximum benefit of $100,000 per Covered Person, per Event.
Worldwide Emergency Travel Assistance (WETA) Services. On Call provides the following travel assistance services:

- 24/7 Emergency Travel Arrangements
- Translation Assistance
- Emergency Travel Funds Assistance
- Lost Luggage and Travel Documents Assistance
- Assistance with Replacement of Credit Card/Travelers Checks
- Medical/Dental/Pharmacy Referral Service
- Hospital Deposit Arrangements
- Dispatch of Physician
- Emergency Medical Record Assistance
- Legal Referral
- Bail Bonds Assistance

The On Call International Global Response Center can be reached 24 hours a day, 365 days a year.
The information contained above is a just summary of the ADD, MER, WETA, and NDPE benefits and services available through On Call, USFIC, and VSC. For a copy of the plan documents applicable to the ADD, MER, WETA and NDPE coverage, including a full description of coverage, exclusions and limitations, please contact Aetna Student Health at www.aetnastudenthealth.com or (800) 966-7772.

NOTE: In order to obtain coverage, all MER, WETA and NDPE services must be provided and arranged through On Call. Reimbursement will not be provided for any services not provided and arranged through On Call. Although certain emergency medical services may be covered under the terms of the Covered Person’s student health insurance plan (the “Plan”), neither OnCall, USFIC, nor VSC provide coverage for emergency medical treatment rendered by doctors, hospitals, pharmacies or other health care providers. Coverage for such services will be provided in accordance with the terms of the Plan and exclusions, limitations and benefit maximums may apply. Neither CCA, nor Aetna Life Insurance Company, nor their affiliates provide medical care or treatment and they are not responsible for outcomes.

To file a claim for ADD benefits, or to obtain MER, WETA or NDPE benefits/services, or for any questions related to those benefits/services, please call On Call International at the following numbers listed on the On Call ID card provided to Covered Persons when they enroll in the Plan: Toll Free at (866) 525-1956 or Collect at (603) 328-1956.

All Covered Persons should carry their On Call ID card when traveling.

Aetna Student Health provides access to certain Accidental Death and Dismemberment (AD&D); Medical Evacuation/Repatriation (MER); Natural Disaster and Political Evacuation (NDPE); and Worldwide Emergency Travel Assistance (WETA) coverages and services through a contractual relationship with On Call International, LLC (On Call). AD&D coverage and NDPE coverage are underwritten by United States Fire Insurance Company (USFIC). MER coverage is underwritten by Virginia Surety Company (VSC). These services, programs or benefits are offered by vendors who are independent contractors and not employees or agents of Aetna Student Health. This material is for information only. Plans and programs provided through On Call contain exclusions and limitations. Information is believed to be accurate as of the production date; however, it is subject to change. Policy forms issued in OK include: GR-96134. Aetna Student Health is the brand name for products and services provided by Aetna Life Insurance Company, Chicckering Claims Administrators, Inc. and their applicable affiliated companies. Premiums/fees for benefits/services provided through On Call, USFIC and VSC are included in the Rates outlined in this brochure.

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

**AETNA NAVIGATOR®**

**Got Questions? Get Answers with Aetna’s Navigator®**

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

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

**How do I register?**

Need help with registering onto Aetna Navigator? Registration assistance is available toll free, Monday through Friday, from 7 a.m. to 9 p.m. Eastern Time at (800) 225-3375.
NOTICE

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

Administered by:
Aetna Student Health
P.O. Box 981106
El Paso, TX 79998 (800) 966-7772
www.aetnastudenthealth.com

Underwritten by:
Aetna Life Insurance Company (ALIC)
151 Farmington Avenue
Hartford, CT 06156
(860) 273-0123
Policy No. 711110

The Boston University Student Medical Insurance Plan (Group Number 711110) is underwritten by Aetna Life Insurance Company (ALIC) and administered by Chickering Claims Administrators, Inc. Aetna Student HealthSM is the brand name for products and services provided by these companies and their applicable affiliated companies.