Your Blanket Student Accident And Sickness Coverage Plan

Medical Expense Benefits in this Plan are underwritten by Aetna Life Insurance Company of Hartford, Connecticut (called Aetna). The benefits and main points of the group contract for persons covered under this Plan are set forth in this Booklet. They are effective only while you are covered under the Blanket contract.

If you become covered, this Booklet will become your Certificate of Coverage. It replaces and supersedes all Certificates issued to you by Aetna under the Blanket contract.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

This health plan satisfies **Minimum Creditable Coverage** requirement that is effective January 1, 2011 as part of the Massachusetts Health Care Reform Law. If you purchase this plan you **will satisfy** the individual mandate that you have health insurance. Please see page #1.1 for additional information.

Cert. Base: 1
Issue Date: August 10, 2012
Effective Date: August 15, 2012

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 plan is not intended to provide comprehensive health care coverage and **does not meet Minimum Creditable Coverage standards**, even if it does include services that are not available in the insured's other health plans.

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.

Table of Contents

1500,1505,1510

Physician Profiling

Physician profiling information is available from the Massachusetts Board of Registration in Medicine for physicians licensed to practice in Massachusetts.

1515

Interpreter and Translation Services

A **covered person** may contact Member Services at the toll-free telephone number listed on their I.D. card to receive information on interpreter and translation services related to administrative procedures. A TDD# for the hearing impaired is also available.

French

Services d'interprétation et de traduction

Vous pouvez contacter les services aux membres au numéro de téléphone sans frais indiqué sur votre carte d'identification pour recevoir de l'information sur les services d'interprétation et de traduction se rapportant aux procédures administratives. Les professionnels du service à la clientèle Aetna ont accès à des services de traduction par le biais des services linguistiques téléphoniques de AT&T. Un numéro de téléphone ATME est aussi disponible pour les malentendants.

Greek

Υπηρεσιες Μεταφρασεως

Για να λαβετε πληροφοριες οσον αφορα των υπηρεσιων μας μεταφρασεως σχετικα με την διαδικασια διοικητικη, μπορειτε να ερχοσαστε σε επαφη με την Υπηρεσια για τα Μελη στον αριθμο (χρωις διοδια) που βρισκεται επανω στην εξακριβωση σας ταυτοτητας. Οι επαγγελματικοι υπαλληλοι (του τμηματος της Αετνα το οποιο ανασχολειται με τους πελατες) μπορουν να χρησιμοποιουν την μεταφραστικη υπηρεσια της εταιρειας AT&T. Επισης υπαρχει και εξαιρετικος αριθμος ΤΔΔ για τους κουφους καθως και γι' εκεινους που εχουν προβληματα με το να ακουνε.

Italian

Servizi di traduzione e di interpretariato

Per ottenere informazioni sui servizi di traduzione e interpretariato connessi a procedure amministrative, potete rivolgervi al Servizio Membri chiamando il numero di linea verde indicato sulla vostra carta di ID. I professionisti del servizio clientela della Aetna hanno accesso ai servizio di traduzione della linea linguistica della AT&T. È anche disponibile un No TDD per i deboli di udito.

Portuguese

Serviços de Intérprete e de Tradução

Você poderá entrar em contato com os Serviços dos Associados ao telefone livre de tarifa indicado no seu cartão de identificação para obter informações sobre serviços de intérprete e de tradução com relação aos procedimentos administrativos. Os profissionais dos serviços aos clientes têm acesso aos serviços de tradução através da linha de idiomas da AT&T. Existe também uma linha TDD para quem tem dilficuldades com a audição.

Russian

Услуги по устному и письменному переводу

Чтобы получить информацию о предоставляемых услугах устного и письменного перевода, вы можете обращаться в отдел обслуживания членов программы по бесплатному номеру телефона, указанному на вашей членской карточке. Сотрудники Aetna по обслуживанию клиентов имеют доступ к переводческим услугами по языковой линии AT&T. Имеется также устройство связи для лиц с дефектами слуха (TDD).

Spanish

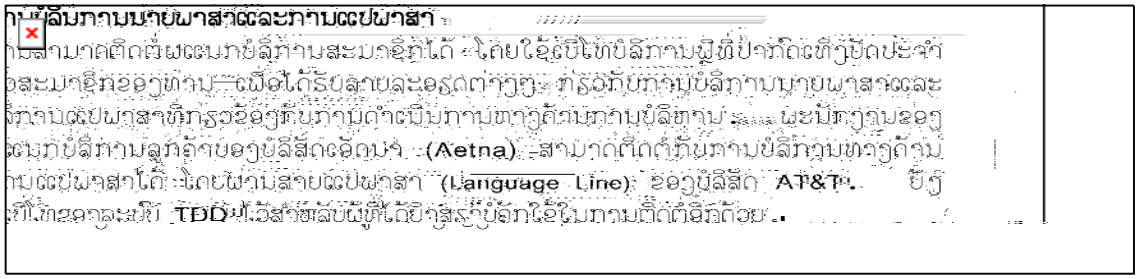
Servicio de Intérprete y Traducción

Usted puede ponerse en contacto con Servicios a Miembros, al número de teléfono gratis que aparece en su tarjeta de identificación para recibir información sobre servicios de intérprete y traducción relativo a los procedimientos administrativos. Los profesionales de servicio a clientes de Aetna tienen acceso a los servicios de traducción por medio de la linea de idiomas de AT&T. Además hay un número de TDD para las personas con impedimento de audición.

Interpreter and Translation Services (continued)

Haitian-Creole
Sèvis intèprèt ak tradiktè
Ou kapab pran kontak avèk Sèvis pou manm-yo si ou rele nimewo telefòn gratis ki sou kat I.D.-ou-a (idantifikasyon) pou ou jwenn ransèyman sou sèvis intèprèt ak tradiktè konsènan pwosedi administratif. Pwofesyonnèl nan sèvis kliyan “Aetna” gen mwayden jwenn sèvis tradiksyon nan “AT&T language line” (sèvis lang AT&T). Yon nimewo TDD disponnib tou pou moun ki pa tande byen.

Lao



Cambodian

;សេវាកម្មផ្តែកបកប្រែភាសា

អ្នកអាចទាក់ទងសេវាកម្មសមាជិក តាមរយៈលេខ ឥតគិតថ្លៃ ដែលចុះនៅលើកាតសំគាល់របស់

អ្នក ដើម្បីទទួលពត៌មាន អំពី សេវាកម្មផ្តែកបកប្រែភាសា ដែលទាក់ទងនឹងវិធីចាត់ចែងការ ។

អ្នកជំនាញការផ្តែកសេវាកម្មនៃអតិថិជនរបស់ Aetna មានមធ្យោបាយរកសេវាកម្មបកប្រែ

តាមរយៈខ្សែទូរស័ព្ទភាសា AT&T ។ លេខ TDD# សំរាប់មនុស្សគថ្លង់ ក៏មានផងដែរ ។

Chinese

口譯及筆譯服務

您可以通過撥打列在您會員卡上的免費電話號碼與會員服務處聯絡，以便獲取有關實施程序的口譯及筆譯服務的資訊。Aetna的專業用戶服務人員使用AT&T語言專線 (AT&T Language Line) 的翻譯服務。還有一個專門為聽力有障礙的用戶提供的TDD號碼。

Interpreter and Translation Services (continued)

Arabic

خدمات الترجمة الشفهية والكتابية
تستطيع الاتصال بدائرة خدمات الأعضاء على رقم الهاتف المجاني المدرج على بطاقة هويتا للحصول على معلومات حول خدمات الترجمة الشفهية والكتابية المتعلقة بالإجراءات الإدارية فموظفو دائرة خدمة الزبائن لدى شركة Aetna يستطيعون تلقي خدمات الترجمة عن طريق خط اللغات لشركة AT&T. ويتوفر للأصماء أيضاً رقم جهاز إتصالات الأصماء (TDD).

1515,1520,1525

STUDENT ACCIDENT AND SICKNESS INSURANCE

SECTION 1 - SCHEDULE OF BENEFITS

ELIGIBILITY

Undergraduates
Students taking 9 or more credits, Student in a degree program taking less than 9 credits are eligible

Graduates
Students taking 6 or more credits, Student in a degree program taking less than 6 credits are eligible. J1 Visa Students are eligible.

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

SCHEDULE OF ACCIDENT AND SICKNESS BENEFITS
PLAN LEVEL LIMITS

FOR COVERED STUDENTS ONLY

Aggregate Maximum Benefit Limit for all Accidents and **Sicknesses** $100,000

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

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

Should a **Preferred Care Provider** not be available within the **service area** in which the plan is offered, benefits rendered by **Non-Preferred Care Providers** will be paid at the **Preferred Care Provider** level.

Note: A referral is required except for; 1) Mental Health, including Substance Abuse, 2) Treatment of Emergency Medical Conditions, 3) OB/GYN Care, 4) The referral requirement is waived when students are traveling or vacationing, 25 miles or more outside of campus traveling, vacationing, etc. However, a prior referral is required for students that reside off-campus and commute to Emerson-Boston prior to seeking non-emergency medical evaluation or treatment in their local community. 5) No referral required for routine care

COVERAGE	BENEFIT AMOUNT	
PRE-ADMISSION TESTING EXPENSE	Payable as any other Condition	
HOSPITAL EXPENSE	**Preferred Care**	**Non-Preferred Care**
Covered Percentage **- Room and Board Expense**	80%	60%
Intensive Care Room and Board Expense	80%	60%
Miscellaneous **Hospital** Expense	80%	60%
SURGICAL EXPENSE		
Covered Percentage	80%	60%
Anesthesia Expense	80%	60%
Assistant Surgeon Expense	80%	60%
Nurse Anesthetist and Nurse Practitioners Expense	80%	60%

	Preferred Care	Non-Preferred Care
IN-HOSPITAL NON-SURGICAL PHYSICIAN'S FEES EXPENSE		
Covered Percentage	80%	60%
OUTPATIENT EXPENSE		
Therapy		
Covered Percentage	80%	60%
Copay/Deductible per visit	$20	$20
Outpatient Physician Office Visit (including specialists)		
Covered Percentage	80%	60%
Copay/Deductible per visit	$20	$20
Emergency Room Visit		
Covered Percentage	80%	80%
Copay/Deductible per visit	$75	$75
Hospital Outpatient Department Visit		
Covered Percentage	80%	60%
Walk-in Clinic Visit		
Covered Percentage	80%	60%
Copay/Deductible per visit	$ 35	$ 35
Ambulatory Surgical Expense		
Covered Percentage	80%	60%
Laboratory and X-Ray Expense		
Covered Percentage	80%	60%
Outpatient Physical Therapy		
Covered Percentage	80%	60%
Copay/Deductible per visit	$20	$20
Durable Medical and Surgical Equipment		
Covered Percentage	80%	60%
CONSULTANT EXPENSE		
Covered Percentage	80%	60%
Copay/Deductible per visit	$20	$20
AMBULANCE EXPENSE		
Covered Percentage	80% of the Actual Charge	80% of the Actual Charge
DENTAL EXPENSE FOR IMPACTED WISDOM TEETH		
Covered Percentage	80% of the Actual Charge	80% of the Actual Charge
DENTAL INJURY EXPENSE		
Covered Percentage	80% of the Actual Charge	80% of the Actual Charge
LICENSED NURSE EXPENSE		
Covered Percentage	80%	60%

	Preferred Care	Non-Preferred Care
SKILLED NURSING FACILITY EXPENSE		
Covered Percentage	80%	60%
REHABILITATION FACILITY EXPENSE		
Covered Percentage	80%	60%
PRESCRIBED MEDICINES EXPENSE		
Covered Percentage	100%	80%
Maximum Benefit per **Policy Year**	$100,000	
Copay/Deductible per **prescription**:		
Generic	$15	$15
Brand Name	$30	$30
ELECTIVE ABORTION EXPENSE		
Covered Percentage	80%	60%
SECOND SURGICAL OPINION EXPENSE		
Covered Percentage	80%	60%
Copay/Deductible per visit	$20	$20
CHLAMYDIA SCREENING TEST EXPENSE		
Covered Percentage	100%	80%
ROUTINE SCREENING FOR SEXUALLY TRANSMITTED DISEASE EXPENSE		
Covered Percentage	100%	80%
MATERNITY	See Description of Coverage	
HIGH COST PROCEDURES EXPENSE BENEFIT		
Covered Percentage	80%	60%
DIAGNOSTIC TESTING FOR LEARNING DISABILITIES		
Covered Percentage	80%	60%
CARDIAC REHABILITATION EXPENSE	**Covered Medical Expenses** are payable in accordance with type of expense incurred. Refer to the other sections of this Schedule of Benefits to determine what the plan pays, **including but not limited to**; Office Visit Expense, Therapy Expenses; Laboratory, X-ray and Consultation Expenses; Prescribed Medicines Expenses; and Mental Health Treatment.	
DERMATOLOGICAL EXPENSE	Payable as any other Condition	
ALLERGY TESTING AND TREATMENT	Payable as any other Condition	
ANTIGEN TESTING	**Covered Medical Expenses** are payable in accordance with type of expense incurred. Refer to the other sections of this Schedule of Benefits to determine what the plan pays, **including** Laboratory Expenses.	

	Preferred Care	Non-Preferred Care
WELL NEWBORN NURSERY CARE		
Covered Percentage	80%	60%
FAMILY PLANNING		
Covered Percentage	100%	80%
PROSTHETIC DEVICES		
Covered Percentage	80%	60%
PODIATRIC EXPENSE	Payable as any other Condition	
DIABETIC EQUIPMENT AND SELF-MANAGEMENT EDUCATION EXPENSE	**Covered Medical Expenses** are payable in accordance with type of expense incurred. Refer to the other sections of this Schedule of Benefits to determine what the plan pays, **including but not limited to**; Office Visit Expense and Durable Medical Equipment Expense.	
NON-PRESCRIPTION ENTERAL FORMULA		
Covered Percentage	80%	60%
Maximum Benefit per **Policy Year**	$5,000	
SPECIAL MEDICAL FORMULA EXPENSE		
Covered Percentage	80%	60%
Maximum Benefit per **Policy Year**	$5,000	
ROUTINE PHYSICAL EXAMS		
Covered Percentage	100%	80%
Deductible per visit		$20
ROUTINE COLORECTAL CANCER SCREENING		
Covered Percentage	100%	80%
ROUTINE PROSTATE CANCER SCREENING		
Covered Percentage	100%	80%
BONE MARROW TRANSPLANTS FOR BREAST CANCER	**Covered Medical Expenses** are payable in accordance with type of expense incurred. Refer to the other sections of this Schedule of Benefits to determine what the plan pays, **including but not limited to;** Office Visit Expense, Inpatient or Outpatient Surgical Expenses; Laboratory, X-ray and Consultation Expenses; Prescribed Medicines Expenses; and Clinical Trials.	
TRANSPLANTS	Payable as any other condition	
SCALP HAIR PROSTHESES		
Covered percentage	80%	60%
QUALIFIED CLINICAL TRIALS	**Covered Medical Expenses** are payable in accordance with type of expense incurred. Refer to the other sections of this Schedule of Benefits to determine what the plan pays, **including but not limited to**; Office Visit Expense, Laboratory, X-ray and Consultation Expenses; and Prescribed Medicines Expenses.	

	Preferred Care	Non-Preferred Care
OUTPATIENT CONTRACEPTIVE DRUGS AND DEVICES AND OUTPATIENT CONTRACEPTIVE SERVICES		
Covered percentage	100%	80%
INFERTILITY	Payable as any other Condition	
SPEECH, HEARING AND LANGUAGE EXPENSES	**Covered Medical Expenses** are payable in accordance with type of expense incurred. Refer to the other sections of this Schedule of Benefits to determine what the plan pays, **including but not limited to**; Office Visit Expense, Therapy Expenses; Laboratory, X-ray and Consultation Expenses; Prescribed Medicines Expenses.	
CHRISTIAN SCIENCES		
Covered Percentage	80% of the Actual Charge	80% of the Actual Charge
Copay/Deductible per visit	$20	$20
ACUPUNCTURE IN LIEU OF ANESTHESIA		
Covered Percentage	80%	60%
TRANSFUSION OR DIALYSIS OF BLOOD	Payable as any other Condition	
IMMUNIZATIONS		
Covered Percentage	100%	80%
Deductible per visit		$20
HOSPICE EXPENSE	Payable as any other Condition	
URGENT CARE EXPENSE		
Covered Percentage	80%	60%
Copay/Deductible per visit	$35	$35
HOME HEALTH CARE EXPENSE		
Coverage Percentage	80%	60%
MAMMOGRAM EXPENSE BENEFIT		
Covered Percentage	100%	80%
CYTOLOGIC SCREENING EXPENSE		
Covered Percentage	100%	80%
HORMONE REPLACEMENT THERAPY EXPENSE	Payable as any other Condition	
TREATMENT OF MENTAL AND NERVOUS DISORDERS EXPENSE Biologically-Based Mental Disorders (including substance abuse), Rape Related Mental or Emotional Disorders and Mental Health for Children and adolescents under the age or 19.		
Inpatient Benefits		
Covered Percentage	80%	80%
Outpatient Benefits		
Covered Percentage	80%	80%
Copay/Deductible per visit	$20	$20

	Preferred Care	Non-Preferred Care
Non Biologically-Based Mental Disorders for other than Biologically-Based Mental Disorders, Rape Related Mental or Emotional Disorders, and Mental Health for children and adolescents under the age of 19.		
Inpatient Benefits (the inpatient number of days for all non-biologically Based mental disorders will never be less than 60 days).		
Covered Percentage	80%	80%
Inpatient Maximum Days per Policy Year	60	
Outpatient Benefits		
Covered Percentage	80%	80%
Copay/Deductible per visit	$20	$20
Maximum Number of Outpatient Visits per Policy Year	24	
Autism Spectrum Disorders	**Covered Medical Expenses** are payable in accordance with type of expense incurred. Refer to the other sections of this Schedule of Benefits to determine what the plan pays, **including but not limited to**; Office Visit Expense, Therapy Expenses; Laboratory, X-ray and Consultation Expenses; Prescribed Medicines Expenses; and Mental Health Treatment.	
HYPODERMIC NEEDLES EXPENSE	Payable as any other Condition	

NOTE: If a covered person needs emergency care and cannot reasonably reach a **Preferred Care Provide**r, payment related to the emergency care will be made at the same level and in the same manner as if the covered person had been treated by a **Preferred Care Provider**.

1530,1535,1540,1545,1550,1555,1560,1565,1571,1570,1580,1590,1595,1600,1605,1610

SECTION 2 - DEFINITIONS

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

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

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

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

Aggregate 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 **Aggregate Out-of-Pocket Limit** applies to **Covered Medical Expenses;** which are payable at a rate greater than 50%.

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

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

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.

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 Disorder**s or acting within the scope of the applicable license. This includes:

- **Hospital**s;
- **Psychiatric Hospital**s;
- **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, delivery and the immediate postpartum period, full-time skilled nursing services directed by a R.N., or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
- Is equipped and has trained staff to handle medical emergencies and provide immediate support measures to sustain life if complications arise during labor and if a child is born with an abnormality which impairs function or threatens life.
- Accepts only patients with low risk pregnancies.
- Has a written agreement with a **hospital** in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. This includes reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient and child.

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

Complications of Pregnancy also include:

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

Copay/Copayment: 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 Medical Expense: those charges for any treatment; service; or supplies covered by this Policy which are:

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

Covered person: a **covered student** while coverage under this Policy is in effect.

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

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

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

Designated Care Provider: a health care provider or **pharmacy**; that is affiliated; and has an agreement with the **School Health Services** to furnish services and supplies at a **negotiated charge**.

Directory: a listing of **Preferred Care Providers** in the **service area** covered under this Policy; which is given to the Policyholder.

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); and
- routine physical examinations.

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

- requires confinement right away as a full-time inpatient; and
- if immediate inpatient care was not given could, as determined by Aetna, reasonably be expected to result in:

  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
  in the case of a pregnant woman, serious jeopardy to the health of the fetus

Emergency Condition: this is any traumatic injury or condition which:

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

Emergency Medical Condition: 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 a R.N.; L.P.N.; or L.V.N.; primarily aid the **covered person** in performing the normal activities of daily living; while recovering from an **injury** or **sickness**; and are described under the written **Home Health Care Plan**.

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

Home Health Care Plan: a written plan 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.

Hospital: a facility which meets all of these tests:

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

Mail Order Pharmacy: an establishment where **prescription drugs** are legally dispensed by mail.

Medically Necessary: health care or dental services, and supplies or **prescription drug**s 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 **dentist**s 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 800-238-6279 or the list may be accessed at www.aetna.com.

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-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 Care 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 **Non-Preferred Care Out-of-Pocket Limit** applies only to **Covered Medical Expenses** for **Non-Preferred Care preferred care**; which are payable at a rate greater than 50%.

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

- **deductibles**;
- **copays**;
- expenses that are not **Covered Medical Expenses**;
- expenses for **designated care** or **preferred care**;
- penalties;
- expenses for prescription drugs; and

other expenses not covered by this Policy.

Non-Preferred Pharmacy: a **pharmacy** not party to a contract with Aetna, an affiliate, or a third party vendor; 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.

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

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

- **deductibles**;
- **copays**;
- expenses that are not **Covered Medical Expenses**;
- expenses for **non-preferred care**;
- penalties;
- expenses for prescription drugs; and

other expenses not covered by this Policy.

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
- when 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 if an **emergency medical condition**; 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 Provider; 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:

(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 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.

(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.

Primary Care Provider:

This is the **Preferred Care Provider** who is:

- selected by a person from the list of **Primary Care Providers** in the **directory**;
- responsible for the person's on-going health care; and
- shown on Aetna's records as the person's **Primary Care Provider**.

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

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.

- **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 Physician**s 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: The **covered expense** is only the part of a charge which is the **recognized charge**.

As to medical expenses, the **recognized charge** for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and

- for professional services and other services or supplies not mentioned below:

  - the 80th percentile of the Prevailing Charge Rate;
    for the Geographic Area where the service is furnished.

- for inpatient charges **of hospitals** and other facilities:

  - 80% of the Aetna Facility Fee Schedule;
    for the Geographic Area where the service is furnished.

- for outpatient charges of **hospitals** and other facilities:

  - 80% of the Aetna Facility Fee Schedule;
    for the Geographic Area where the service is furnished.

As to prescription drug expenses, the **recognized charge** for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- 110% of the **Average Wholesale Price (AWP)** or other similar resource. **Average Wholesale Price (AWP)** is the current average wholesale price of a **prescription drug** listed in the Medi-Span weekly price updates (or any other similar publication chosen by Aetna).

If Aetna has an agreement with a provider (directly or through a third party) which sets the rate that Aetna will pay for a service or supply, then the **recognized charge** is the rate established in such agreement.

Aetna may also reduce the **recognized charge** by applying Aetna Reimbursement Policies. Aetna Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- The duration and complexity of a service;
- Whether multiple procedures are billed at the same time, but no additional overhead is required;
- Whether an assistant surgeon is involved and necessary for the service;
- If follow up care is included;
- Whether there are any other characteristics that may modify or make a particular service unique; and
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

Aetna Reimbursement Policies are based on Aetna**'s** review of: the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with physician or dental specialty society recommendations; and the views of physicians and dentists practicing in the relevant clinical areas. Aetna uses a commercial software package to administer some of these policies.

As used above, Geographic Area, Aetna Facility Fee Schedule, and Prevailing Charge Rates are defined as follows:

Geographic Area: This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.

Prevailing Charge Rates: These are rates reported by Ingenix, a United Health Group subsidiary, in the Prevailing Health Care Charges System (PHCS) database, which is compiled from information that Aetna and other insurers submit to Ingenix. Ingenix reviews and, if necessary, changes these rates periodically. Aetna updates its systems with these changes within 180 days after receiving them from Ingenix.

Aetna Facility Fee Schedule: The schedule of rates developed by Aetna using Aetna data or experience for out-of-network facility services and supplies provided in the Geographic Area in which **you** receive the service or supply.

Aetna reviews and, if necessary, adjusts this schedule periodically. This schedule is the same for all facilities within the state. It is based on state-wide data reflecting payments made by Aetna. The schedule is adjusted from time to time in Aetna's discretion.

IMPORTANT NOTE:

Aetna periodically updates its systems with changes made to the Prevailing Charge Rates and Aetna Facility Fee Schedule.

*What this means to **you*** is that the **recognized charge** is based on the version of the schedule rates that is in use by Aetna on the date that the service or supply was provided.

ADDITIONAL INFORMATION:

Aetna's website www.aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to Aetna Navigator to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools, or contact our Customer Service Department for assistance.

Residential treatment facility (Mental Disorders): 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 ; in which the **Preferred Care Providers** are located.

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

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

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

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

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 Care Provider: this is:

- A freestanding medical facility which:

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

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

  Makes charges.

  Is licensed and certified as required by any state; or federal law; or regulation.

  Keeps a medical record on each patient.

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

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

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

- A **physician's** office; but only one that:

  Has contracted with Aetna to provide urgent care; and
  Is, with Aetna's consent; included in the Provider **Directory** as a Preferred Urgent Care Provider.

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

Urgent Condition: this means a sudden illness; **injury**; or condition; that:

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

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

1620,1625,1630,1635,1640,,1645,1650,1655,1660,1665,1670,1675,1680,1685,1690,1695,1700,1705,17101715,1720,1725,

1730,1735,1740,1745,1750,1755,1760,1765,1770

STUDENT ACCIDENT AND SICKNESS INSURANCE

SECTION 3 - ELIGIBILITY, EFFECTIVE DATE OF INDIVIDUAL COVERAGE

Eligible Persons

Students: all classes of students are eligible except students in any class which is not listed in the Schedule of Benefits. A student is eligible only for the coverages shown in the Schedule of Benefits which applies to his or her class.
Students must actively attend classes for at least the first 31 days after the date when coverage becomes effective. Home study; correspondence; Internet classes and television (TV) courses; do not fulfill the eligibility requirements that the student actively attend classes. If Aetna discovers that this eligibility requirement has not been met; its only obligation is to refund premium; less any claims paid.

Effective Date of Insurance
The coverage of each person who applies for coverage hereunder on or before the Effective Date hereof shall take effect on the Effective date of this Policy.

Coverage for each person applying for coverage hereunder after the Effective Date shall take effect on the date he or she submits a completed application or fails to submit a waiver form and pays the premium for the insurance.

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

An eligible 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.

An eligible student may not enroll for coverage under this Policy if he is not enrolled in the health service plan provided by the Policyholder. Once an eligible student makes a coverage selection under this Policy; he may not change his election.

The Policyholder agrees to submit to Aetna within 20 days after the effective date of each **covered person**'s insurance: (1) the name of each person who applied for coverage hereunder; (2) the effective date of insurance; and (3) the premium paid as to each such **covered person**. The insurance of those **covered person**s whose names and premiums were received more than 20 days after the date the insurance would have become effective will take effect on the date such name and premium is received by Aetna or an agent of Aetna except as may otherwise be provided above.

Change In Amounts
Covered student

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

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

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

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

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

1775,1780,1785,1790

STUDENT ACCIDENT AND SICKNESS INSURANCE

SECTION 4 - TERMINATION OF COVERAGE, EXTENSION OF BENEFITS

TERMINATION OF STUDENT COVERAGE

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

(a) the date this Policy terminates;

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

(c) the date on which the **covered student** withdraws from the school because of entering the armed forces of any country. Premiums will be refunded on a pro-rata basis when application is made within 90 days from withdrawal.

(d) 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.

ADMINISTRATIVE DISENROLLMENTS

Aetna has the right to:

cancel;
refuse to renew; or
refuse to continue;

a **covered person's** coverage only in the following circumstances:

- failure to make payments as required under the Group Policy;
- the **covered person** commits significant misrepresentations of fraud against Aetna;
- the **covered person** commits an act of physical or verbal abuse which poses a threat to a **Preferred Care Provider** or other **covered person**. The commission of the act of physical or verbal abuse must be unrelated to the **covered person's** physical or mental condition;
- the **covered person's** place of residence is no longer within the Service Area covered under this Plan;
- non-renewal or cancellation of the Group Policy; or
- failure to meet the eligibility requirements of the Group Policy.

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 30 day period following such termination of insurance.

1795,1800,1810

STUDENT ACCIDENT AND SICKNESS INSURANCE

SECTION 5 - GENERAL PROVISIONS

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

POLICY CHANGES. This Policy may be changed at any time; by written agreement between Aetna and the Policyholder. The consent of any insured or other person is not needed. All agreements made by Aetna are signed by one of its executive officers. No other person can change or waive any of the policy terms; or make any agreement binding Aetna. The Policyholder will not have to give written approval of a change in the policy if:

The Policyholder has asked for the change; and Aetna has agreed to it.

The change is needed so that the policy will conform to any law; regulation; or ruling of:
a jurisdiction that affects a person covered under the policy; or
the federal government.

In addition; Aetna will notify the Policyholder of any "material modifications" made to covered services; or to clinical review criteria; at least 60 days before the effective date of such changes. Such notice will:

- contain any premium renewal rate adjustments;
- describe any changes to a **covered person's** out-of-pocket expenses including; but not limited to; **;** payment percentages; coinsurance; **deductibles**; and
- describe in detail the effect of the changes on the plan of benefits.

A "material modification"; in accordance with Federal Regulation 29 CFR Part 2520; is any:
modification to the plan of benefits; or
change in the information required to be included in the Policy;
that in**dependent**ly; or in conjunction with other modifications or changes; would be considered to be a significant:
reduction in covered services; or benefits under the plan; or
change to the conditions or requirements to obtain services or benefits under the plan.
CERTIFICATES. **Aetna will issue to the Policyholder; as needed; the individual Certificates; amendments; riders and any other materials that describe or change the benefits and provisions; that apply to the plan of benefits. The Policyholder is responsible for delivering such materials to** covered persons**.**

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

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

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

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

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

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

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

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

They will be refigured using:

- the ages of the covered students;
- the amounts of insurance in force;
- the premium rates; and
- any other pertinent factors.

All facts will be taken as of the date of the refiguring.

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

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

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

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

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

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

This applies even if the premium was paid in error.

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

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

GRACE PERIOD. The premium due date will be negotiated by Aetna and the Policyholder. Unless Aetna has given notice of its intention to terminate the Policy as provided in the "Discontinuance of Policy" section; a grace period of 31 days will be granted for the payment of each premium falling due after the first premium. During that period, this Policy shall continue in force. The Policyholder shall be liable to Aetna for the payment of the premium for the period this Policy continues in force. If premiums are not paid by the end of the Grace Period; the policy will automatically terminate at the end of the Grace Period.

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

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

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

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

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

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

a) the **covered student's** parents or legal guardian, if a minor;
b) otherwise to the **covered student's** estate.

Claims will be paid within 45 days after receipt. If a claim is not paid within such 45 days, Aetna will notify you and explain the reason for non-payment, including the need for any further documentation. Aetna will pay interest at the rate of 1 ½% per month (up to 18% per annum) for any amount not paid within the 45 day period. But this provision will not apply to any claim which Aetna is investigating because of suspected fraud.

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

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

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

PHYSICAL EXAMINATION. Aetna will have the right and opportunity to have a **physician**; or dentist; of its choice examine any **covered person**:

- for whom certification or benefits have been requested; or
- who is under investigation by Aetna:

    for significant misrepresentation; or fraud; with regards to a claim for benefits; or

    because the **covered person** committed an act of physical or verbal abuse which posed a threat to a **Preferred Care Provider;** or other **covered person;** and Aetna must determine if the commission of the act was related to the **covered person's** physical or mental condition.

This exam will be done at all reasonable times while the:

- certification;
- claim for benefits; or
- the investigation;

is pending or under review. This will be done at Aetna's expense.

Aetna will have the right and opportunity to have a **physician**; or dentist; of its choice examine any **covered person**:

- for whom certification or benefits have been requested; or
- who is under investigation by Aetna:

    for significant misrepresentation; or fraud; with regards to a claim for benefits; or

    because the **covered person** committed an act of physical or verbal abuse which posed a threat to a **Preferred Care Provider;** or other **covered person;** and Aetna must determine if the commission of the act was related to the **covered person's** physical or mental condition.

This exam will be done at all reasonable times while the:

- certification;
- claim for benefits; or
- the investigation;

is pending or under review. This will be done at Aetna's expense.

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

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

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

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

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

REIMBURSEMENT AND SUBROGATION. When a **covered person's injury** appears to be someone else's fault; benefits otherwise payable under this Policy for **Covered Medical Expenses** incurred as a result of that **injury** will not be paid unless the **covered person** or his legal representative agrees:

(a) to repay Aetna for such benefits to the extent they are for losses for which compensation is paid to the **covered person** by or on behalf of the person at fault;

(b) to allow Aetna a lien on such compensation and to hold such compensation in trust for Aetna; and

(c) to execute and give to Aetna any instruments needed to secure the rights under (a) and (b).

Further; when Aetna has paid benefits to or on behalf of the injured **covered person**; Aetna will be subrogated to all rights or recovery that the **covered person** has against the person at fault. These subrogation rights will extend only to recovery of the amount Aetna has paid. The **covered person** must execute and deliver any instruments needed and do whatever else is necessary to secure those rights to Aetna.

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 for 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 judgement 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.

This Policy terminates as to any of the students of a Policyholder; and Premiums have not been paid for the period this Policy was in force for those students;

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

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

Aetna has the right to terminate this Policy as to any or all coverage of all or any class of students at any time after the end of the grace period (as stated in the Policy) if the premium; fee; charge; or rate for the student's coverage has not been paid. Written notice of the termination date must be given by Aetna. This right is subject to the terms of any laws or regulations.

A **covered person** will receive written notice of the termination of this Policy at their last known home address. Such notice will contain:

- the date of termination; and
- the reason for termination.

Such termination of coverage shall become effective at least 3 days after the date on which the notice was mailed. Any claims incurred for Covered medical expenses prior to the effective date of termination will be paid.

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

If:

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

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

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

Experimental and Investigational Criteria

Aetna's Clinical Policy Bulletins describe Aetna's determinations regarding whether certain services or supplies are experimental and investigational in nature. Aetna makes these policy determinations based upon a review of currently available clinical information, including:

- Clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology;
- Evidence-based guidelines of public health and health research agencies;
- Evidence-based guidelines and positions of leading national health professional organizations;
- Views of physicians practicing in relevant clinical areas; and
- Other relevant factors.

1830,1835,1840,1845,1850,1855,1860,1865,1866

SECTION 6 - COVERAGE

MEDICAL EXPENSE BENEFITS

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

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

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

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

CONTINUITY OF CARE

In the event a **covered person's Primary Care Provider** is disenrolled from the plan; Aetna will notify a **covered person** at least 30 days before the disenrollment of his or her **Primary Care Provider**. If this occurs:

- The **covered person** may continue to be covered for health services provided by the **Primary Care Provider** for at least 30 days after the **physician** is disenrolled (this does not apply for disenrollment due to quality-related reasons or for fraud). The covered health care services will be consistent with the terms of this Policy. The **Primary Care Provider** must agree to abide by all of the terms and conditions of the Primary Care **Provider** Agreement (between Aetna and the **physician**); that was in effect prior to the notice of disenrollment. Such terms and conditions include; but are not limited to: compensation; quality assurance and utilization management standards; and any other rules; policies; and procedures.
- The **covered person** may change the **Primary Care Provider** at any time by:

  calling the Member Services toll-free telephone number listed on his or her I.D. card; or
  written or electronic submission of a change form. The **covered person** may contact Aetna to request a change form; or for assistance in completing that form.

The change will become effective upon Aetna's receipt and approval of the request.

Coverage is provided for any **covered person** who is in the second or third trimester of pregnancy and whose **Preferred Care Provider**; in connection with the pregnancy; is involuntarily disenrolled. This does not apply for disenrollment due to quality-related reasons; or for fraud. The covered person may continue treatment with the **Preferred Care Provider**; consistent with the terms of this Policy; for the period up to; and including; the first postpartum visit.

Coverage is provided for a **covered person** who is terminally ill; and whose **Preferred Care Provider**; in connection with the **illness**; is involuntarily disenrolled. This does not apply for disenrollment due to quality-related reasons or for fraud. The **covered person** may continue treatment with the disenrolled **Preferred Care Provider**; consistent with the terms of this Policy; until the **covered person's** death.

Coverage is provided for a new **covered person;** for up to 30 days from the effective date of coverage; for services rendered by a **Non-Preferred Care** provider; if:

- the Policyholder only offers **covered persons** a choice of carriers in which the **physician** is not a **Preferred Care Provider**; and
- the **physician** is providing a **covered person** with an ongoing course of treatment; or is the **covered person's primary care provider**.

With respect to a **covered person** in the second or third trimester of a pregnancy; this provision will apply to services rendered through the first postpartum visit. With respect to a **covered person** with a terminal illness; this provision will apply to services rendered until death.

BASIC ACCIDENT EXPENSE BENEFITS

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

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

Covered Medical Expenses incurred for services and supplies:

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

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

The total amount payable for dental treatment, services, and supplies needed for repair of **injury** to **sound, natural teeth** will not exceed the Dental **Injury** Maximum per **accident** shown on the Schedule of Benefits.

No more than the **aggregate maximum** benefit limit will be paid for all **Covered Medical Expenses** incurred for any one **accident**.

The **Deductible Amount** will be applied separately to each **accident**.

BASIC SICKNESS EXPENSE BENEFITS

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

Covered Medical Expenses incurred for services and supplies:

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

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

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

BASIC EXPENSE BENEFITS

HOSPITAL EXPENSE

Hospital Room and Board Expense

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

Miscellaneous Hospital Expense

"Miscellaneous **Hospital** Expense" includes; among others; expenses incurred during a **hospital confinement** for:

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

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

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

SURGICAL EXPENSE

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

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.

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

Anesthetic Expense

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

Nurse Anesthetists and Nurse Practitioners

Covered medical expenses include charges for services rendered by a certified registered nurse anesthetist or nurse practitioner; if:

(1) 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

(2) The Policy currently provides benefits for identical services rendered by a provider of health care licensed by the commonwealth.

The maximum benefit for Nurse Anesthetists and Nurse Practitioners is shown on the Schedule of Benefits.

Assistant Surgeon Expense
If, in connection with such operation, the **covered person** requires the services of an Assistant Surgeon, the expenses incurred will be **Covered Medical Expenses**. The maximum benefit for Assistant Surgeon Expense is shown on the Schedule of Benefits.

IN-HOSPITAL NON-SURGICAL PHYSICIAN'S FEES EXPENSE

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

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

OUTPATIENT EXPENSE

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

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

Outpatient Physician Office Visit Expense (including specialists)

Subject to the Exception below:
If a **covered person** requires the services of a **physician** in the **physician's** office while not confined as an inpatient in a **hospital**; **Covered Medical Expenses** include the charges made by the **physician**. 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**.

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

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

Emergency Room Visit Expense

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

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

Hospital Outpatient Department Expense

Covered Medical Expenses includes treatment rendered in a Hospital Outpatient Department. **Covered Medical Expenses** do not include Emergency Room/Urgent Care Treatment, Walk-in Clinic, Therapy Expenses, Chemotherapy and Radiation, and outpatient surgical services, including physician, anesthesia and facility charges, which are covered as outlined under the individual benefit types listed in this schedule of benefits.
Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

Walk-In Clinic Visit Expense

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

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

Ambulatory Surgical Expense

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

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

Laboratory and **X-Ray Expense**

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

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

Outpatient Physical Therapy Expense

Benefits are payable for **Covered Medical Expenses** incurred by a **covered person** for physical therapy when provided by a licensed physical therapist and only when physical therapy begins within 6 months of the onset of symptoms.

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

Durable Medical and Surgical Equipment Expense

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

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

Durable medical and surgical equipment would include:

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

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**.

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

AMBULANCE EXPENSE

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

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

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

EXPENSE FOR IMPACTED WISDOM TEETH OR ACCIDENTAL INJURY TO SOUND NATURAL TEETH

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

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

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

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

Dental work; surgery; and **orthodontic treatment** needed to remove; repair; replace; restore; or reposition:

- Natural teeth damaged; lost; or removed; or
- Other body tissues of the mouth fractured or cut due to **injury**. The **accident** causing the **injury** must occur while the person is covered under this Plan.

Any such teeth must have been:

- Free from decay; or
- In good repair; and
- Firmly attached to the jawbone at the time of the **injury**.

The treatment must be done in the calendar year of the **accident** or the next one.

If:

- Crowns (caps); or
- Dentures (false teeth); or
- Bridgework; or
- In-mouth appliances;

are installed due to such **injury**; **Covered Medical Expenses** include only charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of **orthodontic treatment** after the **injury**.

Not included are charges:

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

    muscle training therapy; or
    training to correct or control harmful habits.

Surgery needed to:

- Treat a fracture; dislocation; or wound.
- Cut out cysts; tumors; or other diseased tissues.
- Alter the jaw; jaw joints; or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Non-surgical treatment of infections or diseases. This does not include those of; or related to; the teeth.
Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

PRESCRIBED MEDICINES EXPENSE

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

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

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

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

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

- there is no generic equivalent to the **brand name drug**;
- the **pharmacy** is unable to supply the **generic drug** at the time the **prescription** is presented; or
- the **prescriber** indicates that the **generic drug** should not be dispensed.

Limitations
No benefits are paid under this section:

- For a device of any type unless specifically included as a **prescription drug**.
- For any drug entirely consumed at the time and place it is prescribed.
- For more than a 30 day supply per **prescription** or refill.
- For the administration or injection of any drug, except for medically necessary services associated with the administration of off-label use of drugs to treat cancer or HIV/AIDS.
- For any injectable drug.
- For any refill of a drug if it is more than the number of refills specified by the **prescriber**. Before recognizing charges; Aetna may require a new **prescription** or evidence as to need:
  if the **prescriber** has not specified the number of refills; or
  if the frequency or number of **prescriptions** or refills appears excessive under accepted medical practice standards.
- For any refill of a drug dispensed more than one year after the latest **prescription** for it or as permitted by the law of the jurisdiction in which the drug is dispensed.
- For any drug provided on an inpatient or outpatient basis in any health care facility to the extent benefits are paid for it under any other part of this **policy** or under any other medical or **prescription drug** expense benefit plan carried or sponsored by the Policyholder.
- For immunization agents and vaccines.
- For biological sera and blood products.
- For vitamins.
- For nutritional supplements.
- For any smoking cessation aids or drugs.
- For appetite suppressants.

- For any medication prescribed for a **pre-existing condition**.
- For any drug that is available from the **School Health Services**.
- topical acne treatment (i.e. Retin A).
- Inhalers.

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

Expenses incurred will be payable as follows:

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

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

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

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

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

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

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

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

Certification for Certain Prescription Drugs
Under the Precertification Program:

- Certification of more than a 30 day supply of a **prescription** or refill; and certification of the medical necessity of certain **prescription drugs**; is required prior to the time the drug is dispensed; in order for the charge made by the **pharmacy** to be considered a **Covered Medical Expense**.
- Certification is required prior to the time the following drugs are dispensed:
  Growth hormones;
  Drugs which are used for the treatment of malaria.
- Refer to the Precertification List on the **Medication Formulary** Guide to determine which **prescription drugs** require certification. The Precertification List is subject to periodic review and modification by Aetna.

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

Benefits will be paid at the applicable Covered Percentage.

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

No benefits will be payable.

If the drug is not **medically necessary**:

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

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

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

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

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

SKILLED NURSING FACILITY EXPENSE

Covered Medical Expenses include charges incurred by a **covered person** for confinement in a **skilled nursing** facility for treatment rendered:

- in lieu of confinement in a **hospital** as a full time inpatient; or
- within 24 hours following a **hospital** confinement and for the same or related cause(s) as such **hospital** confinement.

Covered Medical Expenses will not include any charge in excess of the **skilled nursing facility's** daily **room and board** maximum for semi-private accommodations or expenses for confinement in excess of the maximum number of days of confinement.
Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

Benefits for Skilled Nursing require pre-certification.

REHABILITATION FACILITY EXPENSE

Covered Medical Expenses include charges incurred by a **covered person** for confinement as a full time inpatient in a rehabilitation facility. Not more than the maximum days of confinement will be covered.

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

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

Benefits for Rehabilitation Facility expenses require pre-certification.

SECOND SURGICAL OPINION EXPENSE

To the extent that this Policy provides coverage for surgery; this Policy shall provide coverage for expenses incurred for a second opinion consultation by a specialist on the need for non-elective surgery which has been recommended by the **covered person's physician**. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Not more than the Maximum Benefit will be paid per **Policy Year**. Aetna must receive a written report on the second opinion consultation.

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

MAMMOGRAM EXPENSE BENEFIT

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

Benefits will be paid for Expenses incurred for the following:

(1) A baseline mammogram for women between the ages of 35 to 40; and

(2) A mammogram every two years; or more frequently based on the recommendation of the women's **physician** for women 40 years of age and older.

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

CYTOLOGIC SCREENING EXPENSE

Covered Medical Expenses include charges incurred by a **covered person** for a Cytologic screening; for women 18 years of age and older.

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

HORMONE REPLACEMENT THERAPY EXPENSE

Covered medical expenses include charges for outpatient services and supplies incurred; in connection with hormone replacement therapy; for peri and post menopausal women; under the same terms and conditions as for such other outpatient services.

Covered medical expenses include charges for outpatient prescription drugs or devices for hormone replacement therapy; for peri and post menopausal women; under the same terms and conditions as other prescription drugs or devices covered by this Policy.

CHLAMYDIA SCREENING TEST EXPENSE

Covered Medical Expenses include charges incurred by a **covered person** for an annual chlamydia screening test. The screening must occur at **School Health Services.**

As used above, "chlamydia screening test" means any laboratory test of the urogenital tract that specifically detects for infection by one or more agents of chlamydia trachomatis; and which test is approved for such purposes by the FDA. Benefits will be paid for chlamydia screening expenses incurred for:

- Women who are:
- under the age of 20 if they are sexually active; and
- at least 20 years old if they have multiple risk factors.
- Men who have multiple risk factors.

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

ROUTINE SCREENING FOR SEXUALLY TRANSMITTED DISEASE EXPENSE

Covered Medical Expenses include charges incurred by a **covered person;** for annual routine screening for sexually transmitted diseases. The screening must occur at **School Health Services.**

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

- gonorrhea;
- syphilis;
- hepatitis;
- HIV; and
- genital herpes; and

which test is approved for such purposes by the FDA.

Benefits will be paid for routine screening for sexually transmitted disease expenses; incurred by **covered persons**; who are at least 18 years old and who are sexually active.

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

HYPODERMIC NEEDLES EXPENSE

Covered Medical Expenses include expenses incurred by a **covered person** for **medically necessary** hypodermic needles and syringes.

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

DIAGNOSTIC TESTING FOR LEARNING DISABILITIES EXPENSE

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

- attention deficit disorder; or
- attention deficit hyperactive disorder.

No benefits are payable under this benefit for the treatment of these disorders.

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

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

DERMATOLOGICAL EXPENSE

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

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

Covered Medical Expenses do not include cosmetic treatment and procedures.

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 as outlined in the Schedule of Benefits of this Policy.

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.

Covered Medical Expenses include charges incurred by a **covered person** for alternative health care; when prescribed by a health care provider who is a legally qualified **physician**; practicing within the scope of their license. For purposes of this benefit; “alternative health care” means aromatherapy.

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

WELL NEWBORN NURSERY CARE EXPENSE

Covered Medical Expenses include charges incurred by a **covered person;** for routine care of a **covered person’s** newborn child as follows:

- **hospital** charges for routine nursery care during the mother’s confinement; but for not more than four days;
- **physician’s** charges for circumcision; and
- **physician’s** charges for visits to the newborn child in the **hospita**l and consultations; but for not more than 1 visit per day.

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

FAMILY PLANNING EXPENSE

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

Charges by a **physician** or **hospital** for a tubal ligation for voluntary sterilization; and

Covered Medical Expenses do not include the reversal of a sterilization procedure.
Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

PODIATRIC EXPENSE

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

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

MATERNITY EXPENSE BENEFITS

Covered Medical Expenses include charges incurred by a **covered person** for a normal childbirth; while insured; as a result of a pregnancy commencing while insured under this Policy. Benefits are payable for **Covered Medical Expenses** on the same basis as any other **sickness**.

Covered Medical Expenses include:

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

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

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

Covered medical expenses 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.

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

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

ROUTINE PHYSICAL EXAMS EXPENSE

Covered Medical Expenses include the expenses incurred by a **covered student** for a routine physical exam performed by a **physician**. A routine physical exam is a medical exam given by a **physician;** for a reason other than to diagnose or treat a suspected or identified **injury** or **sickness**. Included as a part of the exam are:

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

For all exams given to a **covered student**; **Covered Medical Expenses** will not include charges for more than:

- One exam in 24 months in a row; if the person is under age 65; and
- One exam in 12 months in a row; if the person is age 65 or over.

Not covered are charges for:

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

- Premarital exams.
- Vision; hearing; or dental exams.
- A **physician's** office visit in connection with immunizations or testing for tuberculosis.

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

ROUTINE COLORECTAL CANCER SCREENING EXPENSE

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

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

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

ROUTINE PROSTATE CANCER SCREENING EXPENSE

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

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

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

TRANSPLANT 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**. Transplant expenses are payable on the same basis as any other **sickness**.

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 are payable as outlined in the Schedule of Benefits of this Policy.

SCALP HAIR PROSTHESES EXPENSE

Covered medical expenses include charges incurred by a **covered person** for scalp hair prostheses worn for hair loss; as a result of the treatment of any form of cancer or leukemia; provided there is a written statement by the treating **physician**; that the scalp hair prosthesis is **medically necessary**.

QUALIFIED CLINICAL TRIAL EXPENSE

Qualified Clinical Trial Expenses are payable for **Covered medical expenses** incurred by each **covered person**. A qualified clinical trial is a clinical trial that meets the following conditions:

- The clinical trial is intended to treat cancer in a patient who has been so diagnosed;
- 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;
- 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.
- 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.
- The patient meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial.
- The patient has provided informed consent for participation in the clinical trial; in a manner that is consistent with current legal and ethical standards.
- 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.
- The clinical trial does not unjustifiably duplicate existing studies.
- The clinical trial must have a therapeutic intent and must; to some extent; assess the effect of the intervention on the patient.

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

CHRISTIAN SCIENCE

Covered Medical Expenses include charges incurred by a **covered person** for the healing practices of Christian Science.

ACUPUNCTURE IN LIEU OF ANESTHESIA EXPENSE

Covered Medical Expenses include charges incurred by a **covered person** for acupuncture therapy; when acupuncture is used in lieu of other anesthesia; for a surgical or dental procedure covered under this Plan.

The acupuncture must be administered by a health care provider who is a legally qualified **physician**; practicing within the scope of their license.

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

Acupuncture is a **Covered Medical Expense** when it is administered for the following indications by a health care provider; who i a legally qualified **physician;** who is practicing within the scope of their license:

- Adult postoperative and chemotherapy nausea and vomiting
- Nausea of pregnancy
- Postoperative dental pain
- Fibromyalgia/myofacial pain
- Chronic low back pain secondary to osteoarthritis.

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

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

TRANSFUSION OR DIALYSIS OF BLOOD EXPENSE

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

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

IMMUNIZATIONS EXPENSE

Covered Medical Expenses include:

- charges incurred by a **covered student** for the materials for the administration of appropriate and **medically necessary** immunizations; and testing for tuberculosis; and
- charges incurred by a **covered dependent** from age 6 up to age 19; for the materials for the administration of appropriate and **medically necessary** immunizations; when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics.

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

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

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** for urgent care treatment are covered at

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.

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

Non-urgent care includes; but is not limited to; the following:

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

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**.

CERTIFICATION REQUIREMENTS

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

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

If notification is not provided for emergency inpatient care or partial hospitalization; or if pre-certification is not obtained for non-emergency inpatient care; partial hospitalization; or home health care; Covered Medical Expenses will be subject to a $ 100 copay/deductible.

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

Following is a description of the certification requirements:

CERTIFICATION FOR:

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

If:

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

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

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

  If certification has been requested and denied:
  No benefits will be paid for **hospital**; **convalescent facility**; **skilled nursing facility**; facility established primarily for the treatment of alcohol and drug addiction; and **residential treatment facility**; expenses incurred for board and room.

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

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

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

  Expenses; up to the certification **deductible** amount; will not be deemed to be **Covered Medical Expenses**.

  Expenses for such expenses in excess of the certification **copay/deductible** amount will be paid at the Covered Percentage.

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

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

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

- As to other **Covered Medical Expenses**:

  Benefits will be paid at the Covered Percentage.

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

  Certification of days of confinement can be obtained as follows:

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

This must be done:

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

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

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

CERTIFICATION FOR ALL PARTIAL HOSPITALIZATIONS IN A HOSPITAL; RESIDENTIAL TREATMENT FACILITY; OR A FACILITY ESTABLISHED PRIMARILY FOR THE TREATMENT OF ALCOHOL AND DRUG ADDICTION

If:

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

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

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

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

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

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

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

This must be done:

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

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

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

1880,1885,1890,1895,1900,1905,1910,1915,1920,1925,1930,1935,1940,1945,1950,1970,1975,1980,1985,1990,1995,2000,2005,2010,2015,2020,2025,2030,2035,2040,2045,2050,2055,2060,2065,2070,2075,2080,2085,2090,2095,2100,2105,2110,2115,2120,2125,2130,2135,2140,2145,2150,2155,2160,2165,2170,2175,2180,2185,2190,2195,2200,2205,2210,2215,2220,2225,2230,2235,2240,2245,2250,2255,2260,2265,2270,2275,2280,2285,2290,2295,2300,2305,2310,2315,2320,2325,2330,2335,2340,2345

SECTION 6 - COVERAGE (Continued)

BASIC EXPENSE BENEFIT

PRE-ADMISSION TESTING EXPENSE

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

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

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

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

CONSULTANT EXPENSE

Covered Medical Expenses include the expenses incurred by **covered person** in connection with the services of a consultant. The services must be requested by the attending **physician** for the purpose of confirming or determining to confirm or determine a diagnosis.

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

ELECTIVE ABORTION EXPENSE

A **covered person** incurs expenses in connection with an elective abortion, a benefit is payable; but not more than the Maximum Benefit shown on the Schedule of Benefits per occurrence for all **Covered Medical Expenses** with respect to such **covered person**.

This benefit is in lieu of any other Policy benefits.

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

HOME HEALTH CARE EXPENSE

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:

(a) The services are furnished by, or under arrangements made by, a licensed **Home Health Agency**.
(b) The services are given under a home care plan. This plan must be established pursuant to the written order of a **physician** and the **physician** must renew that plan every 60 days. Such physician must certify that the proper treatment of the condition would require inpatient confinement in a **hospital**, **skilled nursing** or **rehabilitation facility** if the services and supplies were not provided under the home health care plan. The physician must examine the covered person at least once a month.
(c) Except as specifically provided in the List of Covered **Home 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 on an R.N. if the services of an R. N. are not available;

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

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

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

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

(6) Nutritional counseling.

Covered Medical Expenses will not include: 1) services by a person who resides in the **covered person's** home; or is a member of the **covered person's** immediate family; 2) homemaker or housekeeper services; 3) maintenance therapy; 4) dialysis treatment; 5) purchase or rental of dialysis equipment; or 6) food or home delivered services.

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

1910,1975,1980,2020,2025,2045,2395,2400

TREATMENT OF MENTAL AND NERVOUS DISORDERS

Covered Benefits include charges made for the treatment of **mental disorders** by **behavioral health providers**.

Treatment of a Biologically-Based Mental Disorder

Covered expenses include charges made by a **hospital**, **psychiatric hospital**, **residential treatment facility** or by **behavioral health providers** for the treatment of **biologically-based mental disorders** (including substance abuse). Coverage shall be provided for **biologically-based mental disorders** under the same terms and conditions and which are no less extensive than coverage provided for any other type of health care for physical illness. This includes the same copayments, coinsurance, deductibles, and/or annual lifetime maximums.

Benefits are payable for the following:

- 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;

- 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 your needs. Intermediate services include, but are not limited to, the following:

    - *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 you while providing active treatment and reassessment.

    - *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.

    - *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.

    - *Intensive Outpatient Programs (IOP)* – Multimodal, inter-disciplinary, structured behavioral health treatment provided over the course of two to three 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.

    - *Day treatment* - 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. You do not need 24-hour hospitalization or partial hospitalization.

    - *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.

The following services are not considered intermediate services:

- 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 you.

- Programs that only provide meetings or activities that are not based on individualized treatment planning.

- 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.

- Tuition-based programs that offer educational, vocational, recreational or personal development activities, such as a therapeutic school, camp or wilderness program. **Aetna** must provide coverage for outpatient or intermediate services provided while the individual is in the program, subject to the terms of this Booklet-Certificate including any network requirements or co-payments/coinsurance provisions.

- Programs that provide primarily custodial care services.

- 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 you are 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 **physician**, primary pediatrician or a licensed mental health professional of such a child or adolescent or is evidenced by conduct, including but not limited to:

  (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.

Treatment of a Non-Biologically-Based Mental Disorder

Covered Benefits include charges made by a hospital, **Psychiatric Hospital**, **Residential Treatment Facility** or **Behavioral Health Provider's** office for the treatment of **Non-Biologically-Based Mental Disorders.** Coverage will be provided for outpatient and inpatient treatment for the diagnosis and treatment of all other covered **Mental Disorders** subject to the maximum number of visits and days, if any shown on the *Schedule of Benefits*. The inpatient maximum number of days for all **Non-Biologically Based Mental Disorders** will never be less than 60 days. In addition to meeting all other conditions for coverage, the treatment plan must include follow-up treatment.

Benefits are payable for the following:

- 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;

- 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 your needs. Intermediate services include, but are not limited to, the following:

    - *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 you while providing active treatment and reassessment.

    - *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.

    - *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.

    - *Intensive Outpatient Programs (IOP)* – Multimodal, inter-disciplinary, structured behavioral health treatment provided over the course of two to three 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.

    - *Day treatment* - 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. You do not need 24-hour hospitalization or partial hospitalization.

    - *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.

The following services are not considered intermediate services:

- 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 you.

- Programs that only provide meetings or activities that are not based on individualized treatment planning.

- 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.

- Tuition-based programs that offer educational, vocational, recreational or personal development activities, such as a therapeutic school, camp or wilderness program. **Aetna** must provide coverage for outpatient or intermediate services provided while the individual is in the program, subject to the terms of this Booklet-Certificate including any network requirements or co-payments/coinsurance provisions.

- Programs that provide primarily custodial care services.

- 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.

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 Provider** 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.

This policy may require consent to the disclosure of information regarding services for mental disorders only to the same or similar extent in which this policy requires consent for the disclosure of information for other medical conditions.

2080,2085,2090,2095

HIGH COST PROCEDURES EXPENSE BENEFIT

Covered Medical Expenses include charges incurred by a **covered person** for High Cost Procedures that are required as a result of **injury** or **sickness**. Expenses for High Cost Procedures; which must be provided on an outpatient basis; may be incurred in the following:

(a) A **physician's** office; or

(b) **Hospital** outpatient department; or emergency room; or

(c) Clinical laboratory; or

(d) Radiological facility; or other similar facility; licensed by the applicable state; or the state in which the facility is located.

Covered Medical Expenses for High Cost Procedures include charges for the following procedures and services:

(a) C.A.T. Scan;

(b) Magnetic Resonance Imaging;

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

BONE MARROW TRANSPLANTS FOR BREAST CANCER

Expenses incurred for bone marrow transplants for breast cancer are payable on the same basis as any other **sickness**.

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.

DEFINITIONS

"Bone marrow transplant" means use of high dose chemotherapy and radiation; in conjunction with transplantation of autologuous bone marrow or peripheral blood stem cells; which originate in the bone marrow.

"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.

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

CARDIAC REHABILITATION EXPENSE BENEFITS

Cardiac Rehabilitation Expense Benefits are payable on the same basis as any other **sickness;** for a **covered medical expense;** incurred by a **covered person;** for cardiac rehabilitation treatment in connection with documented cardiovascular disease.

Such treatment shall include; but not be limited to; outpatient treatment which is to be initiated within twenty-six (26) weeks after the diagnosis of such disease.
DEFINITIONS

"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.

"Cardiac Rehabilitation Program" is a program operated by a duly licensed clinic; or **hospital**; which treats cardiovascular disease through cardiac rehabilitation treatment.

"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.

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

INFERTILITY EXPENSE BENEFITS

Covered medical expenses include **medically necessary** expenses for the diagnosis and treatment of infertility. Such **Covered medical expenses** are payable on the same basis as any other pregnancy-related procedures.

Covered expenses include expenses incurred 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).

DEFINITIONS

"Infertility" means the condition of an individual who is presumably healthy covered person who is unable to conceive or produce conception after:

- *For a* woman *who is under 35 years of age*: 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination; or
- *For a* woman *who is 35 years of age or older*: 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination.

If a female conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the one year or 6 month period, as applicable.

"Non-experimental infertility procedure" 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.

EXCLUSIONS

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.

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

SPECIAL MEDICAL FORMULA EXPENSE BENEFITS

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 or **medically necessary** to protect the unborn fetuses of pregnant women with phenylketonuria; and screening for lead poisoning.

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

NON PRESCRIPTION ENTERAL FORMULA EXPENSE BENEFITS

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

Crohn's Disease;
ulcerative colitis;
gastroesophageal reflux;
gastrointestinal motility;
chronic intestinal pseudo obstruction; and
inherited diseases of amino acids and organic acids.

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

HOSPICE CARE EXPENSE BENEFITS

Covered Medical Expenses include charges incurred by a **covered person** for **hospice** care provided for a terminally ill **covered person** during a **hospice benefit period**. Hospice Care Expenses are the **reasonable** and recognized **charges** made by a **hospice** for the following services or supplies:

(a) charges for inpatient care;
(b) charges for drugs and medicines;
(c) charges for part-time or intermittent charges for nursing by a **R.N.**; **L.P.N.** or **L.V.N.** for up to 8 hours in any one day;
(d) charges for physical and respiratory therapy in the home;
(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;

(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;
(i) charges for **respite care**

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

EXCLUSIONS

The following are not considered **hospice** care:

(a) Funeral arrangements;

(b) Financial or legal counseling;

(c) Homemaker or caretaker services not related solely to the care of the **covered person.**

Benefits for Hospice expenses require pre-certification.

DIABETIC EQUIPMENT AND SELF-MANAGEMENT EDUCATION EXPENSES

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

A "diabetic self-management education program" is a scheduled program on a regular basis, which is designed to instruct a person in the self-management of diabetes. It is a day care program of educational services and self-care training, (including medical nutrition 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.

Such charges must be made by:

- a **physician**; nurse practitioner; clinical nurse specialist; or
- 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);

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

SPEECH, HEARING AND LANGUAGE EXPENSES

Covered Medical Expenses include charges incurred by a **covered person** for medically necessary diagnosis or treatment of speech; hearing; and language disorders; but only if the charges are made for:

- Diagnostic services rendered to find out if; and to what extent; a **covered person's** ability to speak or hear is lost or impaired.
- Rehabilitative services rendered that are expected to restore or improve a **covered person's** ability to speak or hear.

The services must be performed by:

- A **physician** certified as an otolaryngologist or otologist;
  or
- An audiologist who either:
  Is legally qualified in audiology;
  or
  Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements; and
  Who performs the exam at the written direction of a legally qualified otolaryngologist or otologist;
  or
- A speech-language pathologist.

Covered medical expenses will not include charges for more than one hearing exam per **Policy Year**.

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

Limitations

No benefits will be payable for a charge which is:

- For any ear or hearing exam; to diagnose or treat a disease or **injury**;
- For drugs or medicines;
- For any hearing care service or supply; which is a covered expense in whole or in part; under any other part of this Policy; or under any other group plan;
- For any hearing care service or supply; for which a benefit is provided under any workers' compensation law; or any other law of like purpose; whether benefits are payable as to all; or only part of the charges;
- For any hearing care service or supply; which does not meet professionally accepted standards;
- For any diagnostic or rehabilitative services; rendered before the **covered person** becomes eligible for coverage; or any supply received while the person is not covered;
- For hearing aids; hearing aid evaluation tests; hearing aid batteries; and the fitting or prescription of hearing aids;
- For any exam which:
  Is required by an employer as a condition of employment; or
  An employer is required to provide under a labor agreement; or
  Is required by any law of a government;
- For special education (including lessons in sign language) to instruct a **covered person**; whose ability to speak or hear is lost or impaired; to function without that ability;
- For diagnostic or rehabilitative services for treatment of speech; hearing; and language disorders:
  that any school system; by law; must provide; or
  as to speech therapy; to the extent such coverage is already provided for under Early Intervention and Home Health Care Services;
- For any services unless they are provided in accordance with a specific treatment plan;
  which details the treatment to be rendered and the frequency and duration of the treatment; and
  provides for on going services; and is renewed only if such treatment is still **medically necessary**.

PROSTHETIC DEVICE EXPENSES

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

Covered Medical Expenses do not include: eye exams; eyeglasses; vision aids; hearing aids; communication aids; and orthopedic shoes; foot orthotics; or other devices to support the feet are not covered medical expenses unless such devices are necessary to prevent complications from diabetes.

Covered Medical Expenses are payable as outlined in the Schedule of Benefits of this Policy.

OUTPATIENT CONTRACEPTIVE DRUGS AND DEVICES AND OUTPATIENT CONTRACEPTIVE SERVICES EXPENSE

Covered medical expenses include:

- Charges incurred for contraceptive drugs and devices that by law need a **physician's prescription**; and that have been approved by the FDA.
- Related outpatient contraceptive services such as:

  Consultations;
  Exams;
  Procedures; and
  Other medical services and supplies.

Covered medical expenses for contraceptive drugs and devices are covered at the same level; and subject to the same terms and conditions; as any other such **prescription drugs** and devices.

Covered medical expenses do not include:

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

2055,2060,2065,2070,2110,2135,2180,2195,2210,2215,2260,2265,2285,2315

STUDENT ACCIDENT AND SICKNESS INSURANCE

SECTION 7 - EXCLUSIONS AND LIMITATIONS

This Policy does not cover nor provide benefits for:

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

2. Expense incurred for 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 to the extent needed to:

    Improve the function of a part of the body that:

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

    is malformed:

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

    as direct result of:

    disease; or

    surgery performed to treat a disease or **injury**.

Repair an **injury** (including reconstructive surgery to implant a **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 incurred as a result of commission of a felony.

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

13. Expense incurred for services normally provided without charge by the school and covered by the school fee for services.

14. Expense incurred for treatment of temporomandibular joint dysfunction and associated myofascial pain.

15. Expense for allergy serums and injections unless otherwise provided in the policy.

16. Treatment for **injury** to the extent benefits are payable under any state no-fault automobile coverage; first party medical benefits payable under any other mandatory no-fault law.

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

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

19. Expense incurred for the removal of an organ from a **covered person** for the purpose of donating or selling the organ to any person or organization. This limitation does not apply to a donation by a **covered person** to a spouse; child; brother; sister; or parent.

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

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

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

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

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

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

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

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

Also; this exclusion will not apply with respect to:

drugs and medicines that have been granted treatment investigational new drug (IND) or Group c/treatment IND status or are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute if Aetna determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease; or to the extent coverage for such drug and medicine is specifically provided in the Policy.

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

22. Expenses incurred for breast reduction/mammoplasty.

23. Expenses incurred for gynecomastia (male breasts).

24. Expenses incurred for any sinus surgery; except for acute purulent sinusitis.

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

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

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

28. 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.

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

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

31. Expenses incurred for hearing exams not performed in conjunction with a routine physical exam. This exclusion does not apply to a newborn hearing screening test to be performed before the newborn infant is discharged from the hospital or birthing center to care of the parent or guardian.

32. Expense for transplants; other than cornea, bone marrow transplants or transplants for persons who have been diagnosed with breast cancer that has progressed to metastatic disease; and kidney.

33. 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.

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

35. 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**.

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

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

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

39. 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.

40. 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.

41. Expenses for routine physical exams; including expenses in connection with 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.

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

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

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

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

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

    - those that do not require the technical skills of a medical; a mental health; or a dental professional; or
    - those furnished mainly for the personal comfort or convenience of the person; any person who cares for him or her; or any person who is part of his or her family; any healthcare provider; or healthcare facility; or
    - those furnished solely because the person is an inpatient on any day on which the person's **sickness** or **injury** could safely; and adequately; be diagnosed; or treated; while not confined; or those furnished solely because of the setting; if the service or supply could safely and adequately be furnished in a **physician's** or a **dentist**'s office; or other less costly setting.

Any exclusion above will not apply to the extent that coverage is specifically provided by name in this Policy; or coverage of the charges is required under any law that applies to the coverage.

2440,2445,2450,2455,2460,2465,2470,2475

STUDENT ACCIDENT AND SICKNESS INSURANCE

SECTION 7 - EXCLUSIONS AND LIMITATIONS

Preexisting Condition

This Policy does not contain a preexisting conditions limitation.

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**.

2490,2521

STUDENT ACCIDENT AND SICKNESS INSURANCE

SECTION 8 – CUSTOMER SERVICES

Customer Services
Customer Services representatives are trained to assist you (or your authorized representative) in using your plan properly and efficiently. They are also trained to answer questions or inquiries about your Plan. Please call the Customer Services toll-free number on your I.D. card to:

- notify Aetna of changes in your name, address or telephone number;
- change your Primary Care Physician or dentist (if applicable); or
- obtain information about how to file a complaint or an Appeal.

You may also contact Customer Services if:

you have an inquiry about; or
to attempt to resolve a concern regarding:

benefits;
administrative services;
a claim;
the scope of coverage for health services including denials; cancellations; terminations; or
the quality of services provided.

Customer Services will attempt to answer your inquiry or resolve your concern as quickly as possible. However, Customer Services cannot resolve complaints regarding an adverse determination, which must be reviewed through the Appeals Procedure. (An "adverse determination" is 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.)

If you are a resident of Massachusetts, Customer Services will attempt to answer your inquiry or resolve your concern as quickly as possible but not later than 3 business days from the date you contact Customer Services. If you advise Customer Services that the inquiry or concern has not been resolved to your satisfaction, Customer Services will provide you with a written notice of your right to file the inquiry or concern as a complaint through the Appeals Procedure as required by Massachusetts law. Aetna will keep the records of any inquiry or concern for at least 2 years.

2525

STUDENT ACCIDENT AND SICKNESS INSURANCE

SECTION 9 – APPEALS PROCEDURE

DEFINITIONS

"You" or "your" means you and/or your authorized representative acting on your behalf.

Adverse Benefit Determination: A determination, based upon a review of information provided by Aetna or its designated utilization review organization, 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.

The written notice of an Adverse Benefit Determination shall include a substantive clinical justification that is consistent with generally accepted principal of professional medical practice and shall, at a minimum, also provide the following important information that will assist you in making an **Appeal** of the Adverse Benefit Determination, if you wish to do so:

(a) identify the specific information upon which the Adverse Benefit Determination was based;

(b) discuss the presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria;

(c) specify any alternative treatment options covered by Aetna, if any;

(d) reference and include applicable clinical practice guidelines and review criteria; and

(e) a clear, concise and complete description of Aetna's formal internal **Appeal** process and the procedures for obtaining external review, including the procedure to request an expedited external review.

Appeal: An oral or written request to Aetna to reconsider a **Complaint** or an **Adverse Benefit Determination**.

Complaint: Any oral or written **inquiry** that has not been explained or resolved to the claimant**'**s satisfaction within three (3) business days of the **Inquiry** or any matter concerning an **Adverse Benefit Determination**.

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

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

Inquiry: any communication that has not been subject to an **Adverse Benefit Determination** and that request redress or an action, omission or policy of Aetna.

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

Post-Service Claim: Any claim that is not a "**Pre-Service Claim**."

Urgent Care Claim: Any claim for medical care or treatment in which a delay in treatment could:
- jeopardize the life of the **covered person**;
- jeopardize the ability of the **covered person** to regain maximum function;
- cause the **covered person** to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

CLAIM DETERMINATIONS – Health Coverage

Urgent Care Claims

Aetna will make notification of an **urgent care claim** determination as soon as possible but not more than 72 hours after the claim is made. Aetna shall make an initial determination regarding a proposed admission, procedure or service that requires such a determination within 2 (two) working days of obtaining all necessary information. Necessary information shall include the results of any face-to-face clinical evaluation or second opinion that may be required. In the case of a determination to approve an admission, procedure or service, Aetna shall notify the provider rendering the service by telephone within 24 hours, and shall provide written or electronic confirmation of the telephone notification to the claimant and the provider within two (2) working days thereafter. In the case of an **Adverse Benefit Determination** for a utilization review decision, Aetna will notify the provider within 24 hours and then send written or electronic confirmation of the telephone notification to the claimant and the provider within one (1) working day thereafter.

If more information is needed to make an urgent claim determination, Aetna will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide Aetna with the additional information. Aetna will notify the claimant within 48 hours of the earlier of the receipt of the additional information or the end of the 48 hour period given the **physician** to provide Aetna with the information.

If the claimant fails to follow plan procedures for filing a claim, Aetna will notify the claimant within 24 hours following the failure to comply.

Pre-Service Claims-Utilization Review

Aetna will make notification of a claim determination as soon as possible but not later than within 24 hours of obtaining all necessary information after the **pre-service claim** is made. Aetna will notify the **physician** within 24 hours and then send written or electronic confirmation of the telephone notification to the claimant and the **physician** within one (1) working day thereafter. Necessary information shall include the results of any face-to-face clinical evaluations or second opinions that may be required. The claimant may contact Member Services at the toll-free telephone number on your ID card to determine the status or outcome of utilization review decisions.

Post-service Claims

Aetna will make notification of a claim determination as soon as possible but not later than 30 calendar days after the **post-service claim** is made. Aetna may determine that due to matters beyond its control an extension of this 30 calendar day claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies the **covered person** within the first 30 calendar day period. If this extension is needed because Aetna needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. The claimant will have 45 calendar days, from the date of the notice, to provide Aetna with the required information. Within 45 days from receipt of notice of a claim, if payment is not made, Aetna shall notify the claimant in writing specifying the reasons for the nonpayment or whatever further documentation is necessary for payment of said claim, within the terms of the policy. If Aetna fails to provide this information, Aetna shall pay, in addition to any benefits, interest on such benefits, which shall accrue beginning 45 days after Aetna's receipt of notice of claim at the rate of 1½% per month, not to exceed 18% per year.

Concurrent Care Claim Extension-Utilization Review

Following a request for a **Concurrent Care Claim Extension**, Aetna will make notification of a claim determination for emergency or urgent care as soon as possible but not later than 24 hours and within one (1) working day of obtaining all necessary information with respect to all other care, following a request for a **Concurrent Care Claim Extension**.

With respect to all other care, following a request for a **Concurrent Care Claim Extension**:

a) in the case of a determination to approve a **Concurrent Care Claim Extension**, Aetna shall notify the **physician** rendering the service by telephone within one (1) working day and shall provide written or electronic confirmation to the claimant and the **physician** within one (1) working day thereafter. The written or electronic notification shall include the number of extended days or the next review date, the new total number of days or services approved and the date of admission or initiation of services.

b) in the case of an **Adverse Benefit Determination** for a utilization review decision, Aetna will notify the **physician** within 24 hours and then send written or electronic confirmation of the telephone notification to the claimant and the **physician** within one (1) working day thereafter. In the case of inpatient care, the claimant will be notified in writing of the **Adverse Benefit Determination** prior to discharge. The service shall be continued without liability to the claimant until notified of the determination.

The claimant may contact Member Services at the toll-free telephone number to determine the status or outcome of utilization review decisions.

Concurrent Care Claim Reduction or Termination
Aetna will make notification of a claim determination to reduce or terminate a previously approved course of treatment with enough time for the **covered person** to file an **Appeal**. In the case of an **Adverse Benefit Determination** for a utilization review decision, Aetna will notify the **physician** within 24 hours and then send written or electronic confirmation of the telephone notification to the claimant and the **physician** within one (1) working day thereafter. The service shall be continued without the liability until the claimant has been notified of the determination.

Utilization Review Reconsideration Process
Aetna shall give a **physician** an opportunity to seek reconsideration of a utilization review **Adverse Benefit Determination** from a clinical peer reviewer in any case involving an initial determination or a concurrent review determination. The reconsideration process shall occur within one (1) working day of the receipt of the request and shall be conducted between the **physician** rendering the service and the clinical peer reviewer or a clinical peer designated by the clinical peer reviewer if the reviewer cannot be available within one (1) working day. If the reconsideration process does not reverse the utilization review **Adverse Benefit Determination**, the claimant or the **physician**, on behalf of the claimant, may pursue the **Appeal** process. The reconsideration process shall not be a prerequisite to the **Appeal** process or an expedited **Appeal**.

CLAIM DETERMINATIONS – All Other Coverage (not applicable to any dental coverage that may be available under this plan)
Aetna will make notification of a claim determination as soon as possible but not later than 90 calendar days after the claim is made. Aetna may determine that due to matters beyond its control an extension of this 90 calendar day claim determination period is required. Such an extension, of not longer than 90 additional calendar days, will be allowed if Aetna notifies the **covered person** within the first 90 calendar day period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which a decision can be expected.

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 Benefit Determination**, which must be reviewed through the **Appeal** process.

Aetna will address any **Inquiries** as expeditiously as possible, and provide a call back within 24 hours. A claimant whose **Inquiry** has not been explained or resolved to their satisfaction within three (3) business days of the **Inquiry**, has the right to have the **Inquiry** processed as a **Complaint** at their option, including reduction of an oral **Inquiry** to writing by Aetna, written acknowledgement and written resolution of the **Complaint**.

Aetna maintains records of each **Inquiry** communicated by a claimant or on their behalf, and each response thereto, for a minimum period of two (2) years. These records are subject to inspection by the Commissioner of Insurance and the Department of Public Health.

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 or write 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.

Appeals of Adverse Benefit Determinations

Please refer to the Expedited **Appeal** Process section for information regarding certain types of claims that may be eligible for an expedited **Appeal** process.

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.

Oral **Appeals** made by a claimant, or the authorized representative, shall be reduced to writing by Aetna and a copy thereof forwarded to the claimant, or authorized representative, by Aetna within 48 hours of receipt, except where this time limit is waived or extended by mutual written agreement of the claimant or the claimant's authorized representative and Aetna.

A written acknowledgement of the receipt of an **Appeal** shall be sent to the claimant or the claimant's authorized representative, if any, within 15 business days of said receipt, except where an oral **Appeal** has been reduced to writing by Aetna or this time period is waived or extended by mutual written agreement of the claimant or the claimant's authorized representative and Aetna.

Send in your **Appeal** to Customer Service at the address shown on your ID Card., or call in your **Appeal** to Customer Service using the toll-free telephone number shown on your ID Card.

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 (1-800-436-7757), facsimile (617-624-5046) or via the internet site (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.

The described two-level **Appeal** process will be completed within 30 business days, regardless of the number of levels in the process. When an **Appeal** requires the review of medical records, the 30 business day period will not begin to run until the claimant, or the claimant's authorized representative, submits a signed authorization for release of medical records and treatment information. In the event the signed authorization is not provided by the claimant, or the claimant's authorized representative, if any, within 30 business days of the receipt of the **Appeal**, Aetna may, in its discretion, issue a resolution of the **Appeal** without review of some or all of the medical records.

Appeals shall be reviewed by an individual or individuals who are knowledgeable about the matters at issue with the **Appeal**.

Appeals shall be reviewed with the participation of an individual or individuals who did not participate in any of Aetna's prior decisions of the **Appeal**. In at least one level of review of an **Appeal**, the **Appeal** shall be reviewed with the participation of an individual who is an actively practicing health care professional in the same or similar specialty that typically treats the medical condition, performs the procedure or provides the treatment that is the subject of the **Appeal**.

Any second level of **Appeal** is strictly voluntary and not a prerequisite to filing an external **Appeal** to the Office of Patient Protection.

Level One Appeal –Health Claims
A level one **Appeal** of an **Adverse Benefit Determination** shall be provided by Aetna personnel not involved in making the **Complaint** or **Adverse Benefit Determination**.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 36 hours of receipt of the request for an **Appeal**.

Aetna shall issue a concurrent review decision within one working day of obtaining all necessary information.

In the case of a decision to reverse an **Adverse Benefit Determination** to approve an extended stay or additional services, Aetna shall notify by telephone the provider rendering the service within one working day, and shall provide written or electronic confirmation to the claimant and the provider within one working day thereafter. A written or electronic notification shall include the number of extended days or the next review date, and the new total number of days or services approved, and the date of admission or initiation of services.

In the case of a decision to uphold an **Adverse Benefit Determination** for an extended stay or additional services, Aetna shall notify by telephone the provider rendering the service within 24 hours, and shall provide written or electronic notification to the claimant and the provider within one working day thereafter. The service shall be continued without liability to the claimant until the claimant has been notified of the decision.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 15 calendar days of receipt of the request for an **Appeal**.

Aetna shall issue a concurrent review decision within one working day of obtaining all necessary information.

In the case of a decision to reverse an **Adverse Benefit Determination** to approve an extended stay or additional services, Aetna shall notify by telephone the provider rendering the service within one working day, and shall provide written or electronic confirmation to the claimant and the provider within one working day thereafter. A written or electronic notification shall include the number of extended days or the next review date, and the new total number of days or services approved, and the date of admission or initiation of services.

In the case of a decision to uphold an **Adverse Benefit Determination** for an extended stay or additional services, Aetna shall notify by telephone the provider rendering the service within 24 hours, and shall provide written or electronic notification to the claimant and the provider within one working day thereafter. The service shall be continued without liability to the claimant until the claimant has been notified of the decision.

Post-Service Claims
Aetna shall issue a both a level one and level two decision within 30 business days of receipt of the request for an **Appeal**.

The time limits stated above may be waived or extended by mutual written agreement of the claimant or the claimant's authorized representative, and Aetna. Any such agreement shall state the additional time limits, which shall not exceed 30 business days from the date of the agreement. If additional information is required and the claimant does not agree to an extension, Aetna shall make a decision based on the information available.

If Aetna fails to reduce an oral **Appeal** to writing and forward a copy to the claimant within 48 hours, fails to provide written acknowledgement of the receipt of an **Appeal** to the claimant within 15 business days or fails to complete the two-level **Appeal** process within 30 business days, an **Appeal** shall be deemed resolved in favor of the claimant. Time limits include any extensions made by mutual written agreement of the claimant, or the claimant's authorized representative, if any, and Aetna.

A written notice stating the results of the **Appeal** of the **Adverse Benefit Determination** shall include a substantive clinical justification that is consistent with generally accepted principals of professional medical practice that shall at a minimum:

(a) identify the specific information upon which the **Complaint** or **Adverse Benefit Determination** was based;

(b) discuss the claimant**'s** presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria;

(c) specify alternative treatment options covered by Aetna, if any;

(d) reference and include applicable clinical practice guidelines and review criteria; and

(e) notify the claimant or the claimant's authorized representative of the procedures for requesting external review, including the procedure to request an expedited external review.

Aetna will furnish the claimant with a copy of the form prescribed by the Department for filing the request for an external review (see External Review). If an **Appeal** is filed concerning the termination of ongoing coverage or treatment, the disputed coverage or treatment shall remain in effect at Aetna'**s** expense through completion of the internal **Appeal** process, regardless of the original internal **Appeal** decision, provided the **Appeal** is filed on a timely basis, based on the course of treatment. Ongoing coverage or treatment include only that medical care that, at the time it was initiated, was authorized by Aetna and does not include medical care that was terminated pursuant to a specific time or episode-related exclusion from the claimant's contract for benefits.

Level One Appeal – All Other Claims
Aetna shall issue a decision within 60 calendar days of receipt of the request for an **Appeal**. If Aetna determines that due to special circumstances an extension of time for claim processing is required, such an extension, of not longer than 60 additional calendar days, will be allowed if Aetna notifies the **covered person** within the first 60 calendar day period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which a decision can be expected.

Level Two Appeal -- Health Claims
If Aetna upholds an **Adverse Benefit Determination** at the first level of **Appeal**, and the reason for the **Adverse Benefit Determination** was based on medical necessity or experimental or investigational reasons, you or your authorized representative have the right to file a level two **Appeal**. The **Appeal** must be submitted within 60 calendar days following the receipt of notice of a level one **Appeal**.

A level two **Appeal** of an **Adverse Benefit Determination** of an **Urgent Care Claim** shall be provided by Aetna personnel not involved in making the **Adverse Benefit Determination**. A level two **Appeal** of an **Adverse Benefit Determination** of a **Pre-Service Claim** or a **Post-Service claim** will be reviewed by the Aetna **Appeal**s Committee.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 36 hours of receipt of the request for a level two **Appeal**.

Aetna shall issue a concurrent review decision within one working day of obtaining all necessary information.

In the case of a decision to reverse an **Adverse Benefit Determination** to approve an extended stay or additional services, **Aetna** shall notify by telephone the provider rendering the service within one working day, and shall provide written or electronic confirmation to the claimant and the provider within one working day thereafter. A written or electronic notification shall include the number of extended days or the next review date, and the new total number of days or services approved, and the date of admission or initiation of services.

In the case of a decision to uphold an **Adverse Benefit Determination** for an extended stay or additional services, Aetna shall notify by telephone the provider rendering the service within 24 hours, and shall provide written or electronic notification to the claimant and the provider within one working day thereafter. The service shall be continued without liability to the claimant until the claimant has been notified of the decision.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 15 calendar days of receipt of the request for level two **Appeal**.

Aetna shall issue a concurrent review decision within one working day of obtaining all necessary information.

In the case of a decision to reverse an **Adverse Benefit Determination** to approve an extended stay or additional services, Aetna shall notify by telephone the provider rendering the service within one working day, and shall provide written or electronic confirmation to the claimant and the provider within one working day thereafter. A written or electronic notification shall include the number of extended days or the next review date, and the new total number of days or services approved, and the date of admission or initiation of services.

In the case of a decision to uphold an **Adverse Benefit Determination** for an extended stay or additional services, Aetna shall notify by telephone the provider rendering the service within 24 hours, and shall provide written or electronic notification to the claimant and the provider within one working day thereafter. The service shall be continued without liability to the claimant until the claim has been notified of the decision.

Post-Service Claims
Aetna shall issue both a level one and level two decision within 30 business days of receipt of the request for an **Appeal**.

The time limits stated above may be waived or extended by mutual written agreement of the claimant or the claimant's authorized representative, and Aetna. Any such agreement shall state the additional time limits, which shall not exceed 30 business days from the date of the agreement. If additional information is required and the claimant does not agree to an extension, Aetna shall make a decision based on the information available.

If Aetna fails to reduce an oral **Appeal** to writing and forward a copy to the claimant within 48 hours, fails to provide written acknowledgement of the receipt of an **Appeal** to the claimant within 15 business days or fails to complete the two-level **Appeal** process within 30 business days, an **Appeal** shall be deemed resolved in favor of the claimant. Time limits include any extensions made by mutual written agreement of the claimant, or the claimant's authorized representative, if any, and Aetna.

A written notice stating the results of the **Appeal** of the **Adverse Benefit Determination** shall include a substantive clinical justification that is consistent with generally accepted principals of professional medical practice that shall at a minimum:

(a) identify the specific information upon which the **Complaint** or **Adverse Benefit Determination** was based;

(b) discuss the claimant**'s** presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria;

(c) specify alternative treatment options covered by Aetna, if any;

(d) reference and include applicable clinical practice guidelines and review criteria; and

(e) notify the claimant or the claimant's authorized representative of the procedures for requesting external review, including the procedure to request an expedited external review.

Aetna will furnish the claimant with a copy of the form prescribed by the Department for filing the request for an external review (see External Review).

If an **Appeal** is filed concerning the termination of ongoing coverage or treatment, the disputed coverage or treatment shall remain in effect at Aetna**'s** expense through completion of the internal **Appeal** process, regardless of the original internal **Appeal** decision, provided the **Appeal** is filed on a timely basis, based on the course of treatment. Ongoing coverage or treatment include only that medical care that, at the time it was initiated, was authorized by Aetna and does not include medical care that was terminated pursuant to a specific time or episode-related exclusion from the claimant's contract for benefits.

Expedited Appeals Review Process

1. In the event the claimant is a **hospital i**npatient, 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. If the expedited review results in an **Adverse Benefit Determination** regarding the continuation of inpatient care, the written resolution must inform the claimant or the claimant's authorized representative of the opportunity to request an expedited external review if the treating **physician** certifies in writing, that delay in the continuation of inpatient services would pose a serious and immediate threat to the health of the claimant. While the claimant is a **hospital** inpatient, a health care provider or a representative of the **hospital** may act as the claimant's representative without the need for a written authorization from the claimant.

2. In the event the **Appeal** is of an emergency or urgent nature where the **physician** believes that denial of coverage for **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.

3. Within 48 hours of receipt of certification by the **physician** responsible for treatment or proposed treatment that is the subject of the **Appeal** that, in the **physicia**n's opinion:

    a. the service is **medically necessary**;

    b. a denial of coverage for such services would create a substantial risk of serious harm to the claimant; and

    c. such risk of serious harm is so immediate that the provision of such services should not wait the outcome of the normal **Appeal** process.

4. Within less than 48 hours of receipt of certification by the **physician** who ordered any **durable medical equipment** that is subject to **Appeal**, Aetna will provide the claimant with a written resolution when such **physician**:

    a. certifies that the use of the **durable medical equipment** is medically necessary;

    b. certifies that a denial of coverage for such **durable medical equipment** would create a substantial risk of serious harm to the patient;

    c. certifies that such risk of such serious harm is so immediate that the provision of such **durable medical equipment** should not await the outcome of the normal **Appeal**s process;

    d. describes the specific, immediate and severe harm that will result to the patient absent action within the 48 hours; and

    e. specifies a reasonable time period in which Aetna must provide a response.

5. If the expedited review process set forth in 3 or 4 above results in an **Adverse Benefit Determination**, the written resolution will inform the claimant, or the claimant's representative, of the opportunity to request an expedited external review, and if the review involves the termination of ongoing services, the opportunity to request continuation of services during the period the review is pending. Any such continuation shall be at Aetna**'s** expense, regardless of the final external review determination.

6. In the event the claimant has a terminal illness, a resolution shall be provided to the claimant or authorized representative within five (5) days from the receipt of the **Appeal**.

   If the expedited review process affirms the denial of coverage to a claimant with a terminal illness, Aetna shall provide the claimant, within five (5) business days of the decision:

   a. a statement setting forth the specific medical and scientific reasons for denying coverage;

   b. a description of alternative treatment, services or supplies covered by Aetna, if any; and

   c. the procedure the claimant should use to request a conference.

   Aetna shall schedule such conferences within ten (10) days of receiving the request for a conference from the claimant. At the conference the information provided to the claimant pursuant to provisions (1) and (2) above shall be reviewed by the claimant and a representative of Aetna who has authority to determine the disposition of the **Appeal**. Aetna shall permit attendance at the conference of the claimant, a designee of the claimant or both, or, if the claimant is a minor or incompetent, the parent guardian or conservator of the claimant as appropriate. The conference shall be held within five (5) business days if the treating **physician** determines, after consultation with Aetna's Medical Director or designee, and based on standard medical practice, that the effectiveness of either the proposed treatment, services or supplies or any alternative treatment, services or supplies covered by Aetna, would be materially reduced if not provided at the earliest possible date.

External Review

A claimant**,** who remains aggrieved by an **Adverse Benefit 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 Benefit 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.

A claimant or the claimant's authorized representative, if any, may request to have their request for review processed as an expedited external review.

1. Any request for an expedited external review shall contain a certification, in writing, from a **physician**, that delay in the providing or continuation of health care services that are the subject of a final **Adverse Benefit Determination**, would pose a serious and immediate threat to the health of the claimant.

2. Upon finding that a serious and immediate threat to the claimant exists, the Office of Patient Protection shall qualify such request as eligible for an expedited external review.

3. A claimant seeking a review shall pay a fee of $25.00, to the Office of Patient Protection, which shall accompany the request for a review. The fee may be waived by said office if it determines that the payment of the fee would result in an extreme hardship to the claimant.

4. The remainder of the cost for an external review shall be borne by Aetna. Upon completion of the external review, the Office of Patient Protection shall bill Aetna the amount established pursuant to a contract between the Department and the assigned external review agency minus the $25.00 fee, which is the claimant's responsibility.

5. In connection with any request for an external review, Aetna shall assure that the claimant, and where applicable the claimant's authorized representative, have access to any medical information and records relating to the claimant in possession of Aetna or under Aetna**'s** control.

6. Request for a review submitted by the claimant or the claimant's authorized representative shall:

   a) Be on a form prescribed by the Department;

   b) Include the signature of the claimant or the claimant's authorized representative consenting to the release of medical information;

   c) Include a copy of the written final **Adverse Benefit Determination** issued by Aetna; and

   d) Include the required $25.00 fee.

7. If the subject matter of the external review involves the termination of ongoing services, the claimant may **Appeal** to the external review agency to seek the continuation of coverage for the terminated service during the period the review is pending. Any such request must be made before the end of the second business day following receipt of the final **Adverse Benefit Determination**. The external review agency may order the continuation of coverage or treatment where it determines that substantial harm to the claimant's health may result absent such continuation or for such other good cause as the external review agency shall determine. Any such continuation of coverage shall be at Aetna's expenses regardless of the final external review determination.

8. The decision of the external review agency shall be binding.

If the external review agency overturns Aetna**'s** decision in whole or in part, **Aetna** shall issue a written notice to the claimant within five (5) business days of receipt of the written decision from the external review agency. Such notice shall:

(1) acknowledge the decision of the review agency;
(2) advise the claimant of any additional procedures for obtaining the requested coverage of services;
(3) advise the claimant of the date by which the payment will be made or the authorization for services will be issued by Aetna; and
(4) advise the claimant of the name and phone number of the person within Aetna who will assist the claimant with final resolution of the **Appeal**.

The Office of Patient Protection, established by the Department of Public Health, is responsible for the administration and enforcement of certain Massachusetts Managed Care requirements. A claimant may contact the Office of Patient Protection to obtain a report detailing, for the previous calendar year, the total number:

a) a list of sources of independently published information assessing insureds' satisfaction and evaluating the quality of health care services offered by Aetna.

b) the percentage of **physicians** who voluntarily and involuntarily terminated participation contracts with the carrier during the previous calendar year for which such data has been compiled and the three most common reasons for voluntary and involuntary **physician** disenrollment.

c) the percentage of premium revenue expended by the carrier for health care services provided to insureds for the most recent year for which information is available; and

d) a report detailing, for the previous calendar year, the total number of:

   1. filed **Appeals**, **Appeals** that were approved internally, **Appeals** that were denied internally and **Appeals** that were withdrawn before resolution; and

   2. external **Appeals** pursued after exhausting the internal **Appeals** process and the resolution of all such **Appeals**.

2530,2535,2540,2545,2550,2555,2560,2565,2570,2575,2580,2585,2590,2595