2011 – 2012

Indiana University

Student Health Insurance Plan Brochure

For Indiana University Student Academic Appointees and Fellowship Recipients

Underwritten by:
Aetna Life Insurance Company
(ALIC)
Policy Number 812849
WHERE CAN I FIND HELP

In case of an emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

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

Please contact:
Aetna Student Health
P.O. Box 981106
El Paso, TX 79998
(877) 437-6512

For questions about:
ID Cards

ID cards will be issued as soon as possible to the address on file with the university. To ensure you receive your ID card, please provide address changes to the university. If you need medical attention before the ID card is received, benefits will be payable according to the Policy. You do not need an ID card to be eligible to receive benefits. Once you have received your ID card, present it to the provider to facilitate prompt payment of your claims.

For lost ID cards, contact:
Aetna Student Health
(877) 437-6512

For questions about:
- Enrollment Forms
- Premium Submission

Please contact:
Campus Student Insurance Coordinator
(812) 856-4650
studenhc@indiana.edu

For Questions at IUB About:
- Campus Health

Please contact:
Indiana University Student Health Center
600 N. Jordan Avenue at Tenth Street
(812) 855-4011

For Questions at IUPUI About:
- Campus Health

Please contact:
IUPUI Student Health Services
1140 West Michigan Street
Coleman Hall (1st Floor)
(317) 274-8214
For questions about:
- Status of Pharmacy Claim
- Pharmacy Claim Forms
- Excluded Drugs and Pre-Authorization

Please contact:
Aetna Pharmacy Management
(800) 238-6279 (Available 24 hours)

For questions about:
- Provider Listings

Please contact:
Aetna Student Health
(877) 437-6512

A complete list of providers can be found at the University Health Services Office, or you can use Aetna’s DocFind® Service at www.aetnastudenthealth.com.

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

Please contact:
On Call International at (866) 525-1956 (within U.S.).
If outside the U.S., call collect by dialing the U.S. access code plus (603) 328-1956. Please also visit www.aetnastudenthealth.com and visit your school-specific site for further information.

IMPORTANT NOTE
Please keep this Brochure, as it provides a general summary of your coverage. A complete description of the benefits and full terms and conditions may be found in the Master Policy issued to Indiana University. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits. The Master Policy may be viewed at the University’s Student Health Insurance Office during business hours.

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

This is a brief description of the Accident and Sickness Medical Expense benefits available for Indiana University students and their eligible dependents. The plan is underwritten by Aetna Life Insurance Company (called Aetna). The exact provisions governing this insurance are contained in the Master Policy issued to the University and may be viewed at the University’s Student Health Insurance Office during business hours.

UTILIZING UNIVERSITY STUDENT HEALTH CENTERS

Your health care needs may best be satisfied in a convenient, cost-effective manner by the health care providers at one of the Indiana University Student Health Centers. Plan Deductibles are waived for services rendered at the IUB Student Health Center and IUPUI Student Health Services. The health centers provide care for acute illnesses and certain ongoing conditions, such as asthma, as well as contraceptive counseling and immunizations. A referral is not required to be seen at the health centers. However, appointments are preferred, and can be made by calling the number located below.

BLOOMINGTON CAMPUS – IU STUDENT HEALTH CENTER

If you are insured under the Student Health Insurance Plan, you can minimize your out-of-pocket expenses by utilizing the IU Student Health Center at Bloomington. You are not required to pay the annual deductible for clinic visits. However, you may be required to pay a copay or certain charges for ancillary testing (e.g., lab test, X-ray). The IU Student Health Center, located at the corner of Tenth and Jordan (diagonally across from the Main Library), offers a wide range of services to IU students, spouses, and eligible dependents (12 years old and up). Minor dependents are not eligible to utilize the Student Health Center because there are no facilities for pediatric patients.

The Student Health Center is open from 8 a.m. to 4:30 p.m. Monday through Friday, with limited hours during the holidays and semester breaks. Appointments can be made up to one week in advance for general medical care and up to two weeks in advance for the Women’s Clinic. If you fail to cancel appointments at least two hours in advance, you will be charged a fee. If you fail to cancel a Counseling and Psychological Service (CAPS) appointment at least 24 hours in advance, you will also be charged a fee. The intent of these fees is to ensure access to students who need care, and you will be reminded of these fees when the appointment is made. The fee will not be waived except for emergencies. The number to dial to either make or cancel an appointment is (812) 855-7688. A walk-in clinic service is available for students who have urgent medical needs, although the walk-in clinic may also be used when appointment times are filled.

IUB Student Health Center
600 N. Jordan Avenue at Tenth Street

Phone Numbers:
Information, (812) 855-4011
Medical Questions, (812) 855-5001
Appointments, (812) 855-7688
Cancellations, (812) 855-9805
Billing and Registration, (812) 855-4030
Sexual Assault Crisis Service, 24-hour hotline, (812) 855-8900
Counseling and Psychological Services, (812) 855-5711

INDIANAPOLIS CAMPUS – IUPUI HEALTH SERVICES

IUPUI Health Services is the University’s on-campus health facility. When in Indianapolis, your health care needs may best be satisfied in a convenient, cost-effective manner by the health care providers at IUPUI Health Services. They provide care for acute conditions, immunizations and preventative health services. Please see http://www.health.iupui.edu/students for more information.
No referral is required to be seen at IUPUI Health Services but appointments are strongly preferred. For clinic visits at IUPUI Health Services, you are not required to pay the annual Deductible. You may be required to pay a copay or certain charges for ancillary testing. The only Insurance Plan that IUPUI Health Services will bill is the Student Health Insurance Plan. If you are covered by any other insurance plan you will be required to pay the charge for all services received at the time of service, and will be given a bill to submit to your insurance company for possible reimbursement.

IUPUI Health Services has two locations: Coleman Hall (1st Floor), 1140 West Michigan Street and a new location at Campus Center Student Health (Rm. 213 in the Campus Center). Call or see website at http://health.iupui.edu for hours.

Please note that not all services provided at IUPUI Health Services will be covered by the Student Health Insurance Plan. Please refer to this Brochure for coverage questions.

For more information, call IUPUI Health Services at (317) 274-8214. In the event of an emergency, call 911 or the Campus Police at (317) 247-7911.

**PREFERRED PROVIDER NETWORK**

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

To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider. It is to your advantage to use a Preferred Provider because savings may be achieved from the Negotiated Charges these providers have agreed to accept as payment for their services. Preferred Providers are independent contractors, and are neither employees nor agents of Indiana University, Aetna Student Health, or Aetna.

You may also obtain information regarding Preferred Providers by contacting Aetna Student Health at (877) 437-6512, or through the Internet by accessing DocFind at www.aetnastudenthealth.com.

1. Click on “Enter DocFind”
2. Select zip code, city, or county
3. Enter criteria
4. Select Provider Category
5. Select Provider Type
6. Select Plan Type – Student Health Plans
7. Select “Start Search” or “More Options”
8. “More Options” enter criteria and “Search”

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

**STUDENT COVERAGE**

**ELIGIBILITY**

All Student Academic Appointees (SAAs) appointed with 37.5% FTE or above for the corresponding semester, Fall and/or Spring, and all Fellowship recipients with an award of $3,328 or more per semester are automatically enrolled in this Insurance Plan which is fully subsidized by the University or external funding agency. All graduate students on an academic appointment at or above 37.5% FTE must enroll in six credit hours or G901 each semester on appointment (summer excluded). Fellowship recipients must be enrolled full time. A full-time course load is defined by each school, but will in no case be less than six credit hours per semester.

Participation in the Student Health Insurance Plan is mandatory for Indiana University Student Academic Appointees and Fellowship Recipients, unless proof of comparable coverage is presented, and a waiver is filed by the waiver deadline. The Waiver Deadlines are listed below.
WAIVER PROCESS/PROCEDURE
Waiver of this coverage will be authorized if the student presents evidence of other health insurance coverage under a plan which provides benefits equivalent to this Plan. Students must present the evidence of coverage and complete a waiver form and return it to the office indicated below by the waiver deadline dates shown below. The waiver form can be found online at http://hr.iu.edu/pubs/forms/StudentSAA-waiver.pdf.

Please note: SAAs and Fellowship Participants must complete a waiver form for each enrollment period (Fall and Spring/Summer).

Waiver Deadline Dates
Fall Semester: September 15, 2011
Spring/Summer Semester: January 31, 2012

Waiver Submission

<table>
<thead>
<tr>
<th>Campus</th>
<th>Student Type</th>
<th>Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bloomington</td>
<td>SAAs/Fellowship</td>
<td>Academic Policies &amp; Services – Bryan 016</td>
</tr>
<tr>
<td>Indianapolis</td>
<td>SAAs/Fellowship</td>
<td>Academic Affairs Office – A0 126</td>
</tr>
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</table>

DEPENDENT COVERAGE

ELIGIBILITY
If you are covered by the Student Health Insurance Plan for Indiana University Student Academic Appointees and Fellowship Recipients you may also enroll your spouse/same-sex domestic partner (residing with the insured student) and children under the age of 26. A financially child shall include (1) a son or daughter of the subscriber less than age 26 regardless of support and (2) a stepchild, child subject to legal guardianship, grandchild, or other blood relative less than age 26.

Please note: If you wish to enroll your same-sex domestic partner, please contact the Campus Student Insurance Coordinator at (812) 856-4650 for more information or to obtain enrollment forms.

ENROLLMENT
To enroll the dependent(s) of covered Student Academic Appointees and Fellowship Recipients, please complete the Enrollment Form available online at www.aetnastudenthealth.com. Click on “Find Your School” and select Indiana University. A specific period of time will be allowed at the beginning of each year for enrolling in the Plan. The completed Dependent Enrollment Form should be submitted directly to Aetna Student Health.

Annual Policy/Fall Semester: If the Dependent Enrollment Form is submitted before September 15, 2011 coverage will be backdated to the beginning of the Policy Period. If the Enrollment Form is submitted after September 15, 2011, it will not be accepted in the absence of a significant life change, and the dependent will have to wait until the next open enrollment period to apply. The completed Dependent Enrollment Form and premium should be submitted directly to Aetna Student Health.

Spring/Summer Semester: Dependents will have an additional open enrollment period. If the completed Enrollment Form is submitted before January 31, 2012, coverage will be backdated to the beginning of the Policy Period. If the completed Enrollment Form is submitted after January 31, 2012, it will not be accepted in the absence of a significant life change, and the student will have to wait until the next open enrollment period to apply. The completed Dependent Enrollment Form and premium should be submitted directly to Aetna Student Health.
**Mid-Year Enrollment:** You may enroll your eligible dependents after the deadline date only if there has been a significant life change (i.e., marriage, birth, loss of prior coverage, arrival in the United States). If the completed Enrollment Form is submitted within 30 days of the qualifying event, coverage will be backdated to the date of the qualifying event. If the completed Enrollment Form is submitted after the 30 days of the qualifying event, it will not be accepted, and the dependent(s) will have to wait until the next annual open enrollment period to enroll. The completed Enrollment Form and premium should be submitted directly to Aetna Student Health along with required documentation.

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

Coverage is provided for a child legally placed for adoption with a Covered Student for 31 days from the moment of placement provided the child lives in the household of the Covered Student, and is dependent upon the Covered Student for support. To extend coverage for an adopted child past the 31 days, the Covered Student must 1) enroll the child within 31 days of placement of such child, and 2) pay any additional premium, if necessary, starting from the date of placement.

For information or general questions on dependent enrollment, contact Aetna Student Health at, (877) 437-6512.

**POLICY PERIOD**

1. **Students:** Coverage for all insured students enrolled for the Fall and Spring Semester, will become effective on **August 15, 2011**, and will terminate at 11:59 PM on **August 14, 2012**.

2. **Students:** Coverage for all insured students enrolled for the Fall Semester, will become effective on **August 15, 2011**, and will terminate at 11:59 PM on **December 31, 2011**.

3. **New Spring Semester Students:** Coverage for all insured students enrolled for the Spring Semester, will become effective on **January 1, 2012**, and will terminate at 11:59 PM on **August 14, 2012**.

4. **Insured Dependents:** Coverage will become effective on the same date the insured student’s coverage becomes effective. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Master Policy.

**RATES**

<table>
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<th>Student* (Medical Only)</th>
<th>Spouse (Medical Only)</th>
<th>Child(ren) (Medical Only)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual</strong></td>
<td>$2,214</td>
<td>$5,447</td>
<td>$4,133</td>
</tr>
<tr>
<td><strong>Fall</strong></td>
<td>$843</td>
<td>$2,074</td>
<td>$1,574</td>
</tr>
<tr>
<td><strong>Spring/Summer</strong></td>
<td>$1,371</td>
<td>$3,373</td>
<td>$2,559</td>
</tr>
</tbody>
</table>

*Qualifying SAAs and Fellowship Recipients will automatically be enrolled in the mandatory Plan which is fully subsidized by the University or an external granting agency and includes the premium for both the medical and dental coverage. Information on enrolling dependents can be found at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com).
REFUND POLICY
If you withdraw from school within the first 31 days of a coverage period, you will not be covered under the Policy and the full premium will be refunded, less any claims paid. After 31 days, you will be covered for the full period that you have paid the premium for, and no refund will be allowed. (This refund policy will not apply if you withdraw due to a covered Accident or Sickness.)

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

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

Preferred Care: $500 per covered person per policy year.
Non-Preferred Care: $1,000 per covered person per policy year.

PRE-CERTIFICATION PROGRAM
Pre-certification simply means calling Aetna Student Health prior to treatment to obtain approval for a medical procedure or service. Pre-certification may be done by you, your doctor, a hospital administrator, or one of your relatives. All requests for certification must be obtained by contacting Aetna Student Health at (877) 437-6512 (attention: Managed Care Department).

- All inpatient admissions, including length of stay, must be certified by contacting Aetna Student Health.
- If you do not secure Pre-Certification for non-emergency inpatient admissions or provide notification for emergency admissions, your Covered Medical Expenses will be subject to a $200 per admission penalty Deductible. (This is separate from the annual Plan Deductible.)
- The patient, Physician or hospital must telephone at least three (3) business days prior to the planned admission or prior to the date the services are scheduled to begin.

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

Notification of Emergency Admissions:
The patient, patient’s representative, Physician or hospital must telephone within one (1) business day following inpatient (or partial hospitalization) admission.

Aetna Student Health
(877) 437-6512
Hours: Monday through Friday, 8:30 a.m. to 5:30 p.m. (ET)
PRE-EXISTING CONDITIONS/
CONTINUOUSLY INSURED PROVISIONS

Pre-existing Condition
A pre-existing condition is an injury or disease that was present before your first day of coverage under a group health insurance plan. If you received treatment or services for that injury or disease or you took prescription drugs or medicines for that injury or disease during the six months prior to your first day of coverage, that injury or disease will be considered a pre-existing condition.

Limitation
Expenses incurred by a Covered Person as a result of a pre-existing condition will not be considered Covered Medical Expenses unless no charges are incurred, or treatment rendered, for the condition for a period of six months under the Policy, or, the Covered Person has been covered under the Policy for 12 consecutive months, whichever occurs first. Please note this limitation only applies to Covered Persons over age 19.

Special Rules For Pre-existing Conditions
If a Covered Person had creditable coverage and such coverage terminated within 63 days prior to the date he or she enrolled (or was enrolled) for coverage in the Policy, then any limitation as to a pre-existing condition under this Plan will not apply for that person. “Creditable coverage” is a person’s prior medical coverage as defined in HIPAA (Health Insurance Portability and Accountability Act of 1996). Such coverage includes coverage issued on a group or individual basis; Medicare; Medicaid; military-sponsored health care; a program of the Indiana Health Service; a state health benefits risk pool; the Federal Employee’s Health Benefit Plan (FEHBP); a public health plan as defined in the regulations; and any health benefit plan under Section 5(e) of the Peace Corps Act.

Continuously Insured
Persons who have remained Continuously Insured under the Policy and other prior health insurance policies will be covered for any pre-existing condition that manifests itself while Continuously Insured, except for expenses payable under prior policies in the absence of this Plan. Previously Covered Persons must re-enroll for coverage by the indicated enrollment deadlines in order to avoid a break in coverage for conditions that existed in the prior Policy Year.

Once a break in continuous coverage occurs for more than 63 days, the definition of pre-existing conditions will apply.

DESCRIPTION OF BENEFITS

Please Note:

THE INDIANA UNIVERSITY STUDENT HEALTH INSURANCE PLAN MAY NOT COVER ALL OF YOUR HEALTH CARE EXPENSES.

The Plan excludes coverage for certain services and contains limitations on the amounts it will pay. Please read the Indiana University Student Health Insurance Plan Brochure carefully. While this document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. If you want to look at the full plan description, which is contained in the Master Policy issued to the University you may view it at the University’s Student Health Insurance office.

This Plan will never pay more than $250,000 per Condition per Lifetime per student and $100,000 per Condition per Lifetime per dependent. Additional Plan maximums may also apply. Some illnesses may cost more to treat and health care providers may bill you for what the Plan does not cover.

Subject to the terms of the Policy, benefits are available for you and your eligible dependents only for the coverages listed on the next page, and only up to the maximum amounts shown. Please refer to the Policy for a complete description of the benefits available.
## SUMMARY OF BENEFITS CHART

### DEDUCTIBLES
The following Deductibles are applied before **Covered Medical Expenses** are payable:
- **Preferred Care**: $500 per covered person per policy year.
- **Non-Preferred Care**: $1,000 per covered person per policy year.

### COINSURANCE
Covered Medical Expenses are payable at the coinsurance percentage specified below, after any applicable deductible, up to a maximum benefit of:
- **Student Aggregate Maximum**: $250,000 per Condition per Lifetime.
- **Dependent Aggregate Maximum**: $100,000 per Condition per Lifetime.

### OUT-OF-POCKET MAXIMUMS (Includes the Deductible)
Once the Individual or Family **Out-of-Pocket Limit** has been satisfied, **Covered Medical Expenses** will be payable at 100% for the remainder of the Policy Year, up to any benefit maximum that may apply.

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

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

**Preferred Care**: Individual Out-of-Pocket: $1,000  
**Preferred Care**: Family Out-of-Pocket: $2,000  
**Non-Preferred Care**: Individual Out-of-Pocket: $5,000  
**Non-Preferred Care**: Family Out-of-Pocket: $10,000

All coverage is based on Recognized Charges unless otherwise specified.

### Inpatient Hospitalization Benefits

<table>
<thead>
<tr>
<th>Expense Type</th>
<th>Covered Medical Expenses</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Room and Board</td>
<td></td>
<td>After a $200</td>
<td>100% of Negotiated Charge.</td>
</tr>
<tr>
<td>Expense</td>
<td></td>
<td>per Admission</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>copay,</td>
<td>50% of Recognized Charge for a semi-private room.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive Care Unit Expense</td>
<td>Covered Medical Expenses</td>
<td>After a $200</td>
<td>100% of Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>per Admission</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>copay,</td>
<td>50% of Recognized Charge for the Intensive Care Room Rate for an overnight stay.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Hospital Visit/</td>
<td>Covered Medical Expenses</td>
<td>For charges for the non-surgical services of the attending Physician, or a consulting Physician, are payable as follows:</td>
<td></td>
</tr>
<tr>
<td>Consultation Expenses</td>
<td></td>
<td>Preferred Care: 100% of Negotiated Charge.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-Preferred Care: 50% of Recognized Charge.</td>
<td></td>
</tr>
</tbody>
</table>
### Miscellaneous Hospital Expense

*Covered Medical Expenses* are payable as follows:
- **Preferred Care**: 100% of the Negotiated Charge.
- **Non-Preferred Care**: 50% of the Recognized Charge.

Non-Preferred Care benefits are limited to **$1,200** per day.

*Covered Medical Expenses* include, but are not limited to: laboratory tests, X-rays, surgical dressings, anesthesia, supplies and equipment use, and medicines.

### Surgical Benefits (Inpatient and Outpatient)

#### Surgical Expense

*Covered Medical Expenses* for charges for surgical services, performed by a Physician, are payable as follows:
- **Preferred Care**: After a **$100** per Inpatient Surgical procedure copay or **$50** per Outpatient Surgical procedure copay, 100% of the Negotiated Charge.
- **Non-Preferred Care**: 50% of the Recognized Charge.

#### Anesthesia Expense

*Covered Medical Expenses* for the charges of Anesthesia and an assistant surgeon, during a surgical procedure, are payable as follows:
- **Preferred Care**: 100% of the Negotiated Charge.
- **Non-Preferred Care**: 50% of the Recognized Charge.

#### Assistant Surgeon Expense

*Covered Medical Expenses* are payable as follows:
- **Preferred Care**: 50% of the Negotiated Charge.
- **Non-Preferred Care**: 50% of the Recognized Charge.

#### Ambulatory Surgical Expense

Benefits are payable for *Covered Medical Expenses* incurred by a covered person for expenses incurred for outpatient surgery performed in a hospital outpatient surgery department or in an ambulatory surgical center. *Covered Medical Expenses* must be incurred on the day of the surgery or within 48 hours after the surgery.
- **Preferred Care**: 100% of the Negotiated Charge.
- **Non-Preferred Care**: 50% of the Recognized Charge.

### Outpatient Benefits

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

#### Hospital Outpatient Department

*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.
- **Preferred Care**: After a **$25** per visit copay, 100% of the Negotiated Charge.
- **Non-Preferred Care**: 50% of the Recognized Charge.
| Walk-In Clinic Expense | **Covered Medical Expenses** incurred in a Walk-in Clinic are payable at:  
**Preferred Care**: After a $25 per visit copay, **100%** of the Negotiated Charge.  
**Non-Preferred Care**: **50%** of the Recognized Charge. |
|------------------------|---------------------------------------------------------------------------------------------------------------|
| Emergency Room Expense | **Covered Medical Expenses** incurred for treatment of an Emergency Medical Condition are payable as follows:  
**Preferred Care**: After a $100 per visit copay (waived if admitted), **100%** of the Negotiated Charge.  
**Non-Preferred Care**: After a $100 per visit deductible (waived if admitted), **100%** of the Recognized Charge.  
*Please note: this per visit Deductible does not apply towards meeting the annual Deductible.* |
| Urgent Care Expense | *Benefits include charges for treatment by an urgent care provider.*  
*Please note: A covered person should not seek medical care or treatment from an urgent care provider if their illness, injury, or condition, is an emergency condition. The covered person should go directly to the emergency room of a hospital or call 911 (or the local equivalent) for ambulance and medical assistance.*  
**Urgent Care**  
Benefits include charges for an urgent care provider to evaluate and treat an urgent condition.  
**Covered Medical Expenses** for urgent care treatment are payable as follows:  
**Preferred Care**: After a $25 per visit copay, **100%** of the Negotiated Charge.  
**Non-Preferred Care**: **50%** of the Recognized Charge.  
*No benefit will be paid under any other part of this Plan for charges made by an urgent care provider to treat a non-urgent condition.* |
| Ambulance Expense | **Covered Medical Expenses** are payable as follows:  
**100%** of the Actual Charge for the services of a professional ambulance to or from a hospital, when required due to the emergency nature of a covered Accident or Sickness.  
Benefits are limited to a maximum of $1,500 per trip for ground and air transportation. |
| Pre-Admission Testing Expense | **Covered Medical Expenses** for Pre-Admission testing charges while an outpatient before scheduled surgery are payable as any other expense. |
| Physician’s Office Visits | **Covered Medical Expenses** are payable as follows:  
**Preferred Care**: After a $25 per visit copay, **100%** of the Negotiated Charge  
**Non-Preferred Care**: **50%** of the Recognized Charge. |
| Laboratory Expense | **Covered Medical Expenses** are payable as follows:  
**Preferred Care**: After a $10 per visit copay, **100%** of the Negotiated Charge  
**Non-Preferred Care**: **50%** of the Recognized Charge. |
| X-ray Expense | **Covered Medical Expenses** are payable as follows:  
**Preferred Care**: After a $20 per visit copay, **100%** of the Negotiated Charge  
**Non-Preferred Care**: **50%** of the Recognized Charge. |
<table>
<thead>
<tr>
<th>Covered Medical Expenses</th>
<th>Covered Medical Expenses include charges incurred by a covered person are payable as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Cost Procedures Expense</strong></td>
<td>Preferred Care: After a $20 per visit copay, 100% of the Negotiated Charge. Non-Preferred Care: 50% of the Recognized Charge. For purposes of this benefit, “High Cost Procedure” means any outpatient procedure costing over $200.</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment Expense</strong></td>
<td>Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 80% of the Recognized Charge.</td>
</tr>
<tr>
<td><strong>Prosthetic Devices Expense</strong></td>
<td>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. Covered Medical expenses are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 80% of the Recognized Charge.</td>
</tr>
<tr>
<td><strong>Outpatient Physical Therapy Expense</strong></td>
<td>Covered Medical Expenses for physical therapy are payable as follows when provided by a licensed physical therapist and only when physical therapy begins within 6 months of the onset of symptoms: Preferred Care: After a $25 per visit copay, 100% of the Negotiated Charge. Non-Preferred Care: 50% of the Recognized Charge.</td>
</tr>
<tr>
<td><strong>Therapy Expense</strong></td>
<td>Covered Medical Expenses include charges incurred by a covered person for the following types of therapy provided on an outpatient basis:  • Chiropractic Care;  • Speech Therapy;  • Inhalation Therapy; or  • Occupational Therapy. Expenses for Chiropractic Care are Covered Medical Expenses; if such care is related to neromusculoskeletal conditions and conditions arising from: the lack of normal nerve; muscle; and/or joint function. Expenses for Speech and Occupational Therapies are Covered Medical Expenses; only if such therapies are a result of injury or sickness. Covered Medical Expenses are payable as follows: Preferred Care: After a $25 per visit copay, 100% of the Negotiated Charge. Non-Preferred Care: 50% of the Recognized Charge.</td>
</tr>
<tr>
<td><strong>Chemotherapy Expense</strong></td>
<td>Covered Medical Expenses also include charges incurred by a covered person for the following types of therapy provided on an outpatient basis:  • Radiation therapy;  • Chemotherapy; including anti-nausea drugs used in conjunction with the chemotherapy;  • Dialysis; and  • Respiratory therapy. Covered Medical Expenses are payable as follows: Preferred Care: After a $25 per visit copay, 100% of the Negotiated Charge. Non-Preferred Care: 50% of the Recognized Charge.</td>
</tr>
</tbody>
</table>
### Dental Injury Expense

**Covered Medical Expenses** include dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition:
- Natural teeth damaged, lost, or removed, or
- Other body tissues of the mouth fractured or cut due to injury. The accident causing the injury must occur while the person is covered under this Plan.

Any such teeth must have been:
- Free from decay, or
- In good repair, and
- Firmly attached to the jawbone at the time of the injury.

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

If:
- Crowns (caps), or
- Dentures (false teeth), or
- Bridgework, or
- In-mouth appliances, are installed due to such injury, **Covered Medical Expenses** include only charges for:
  - The first denture or fixed bridgework to replace lost teeth,
  - The first crown needed to repair each damaged tooth, and
  - An in-mouth appliance used in the first course of orthodontic treatment after the injury.

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

Non-surgical treatment of infections or diseases. This does not include those of, or related to, the teeth.

**Covered Medical Expenses** are payable at 100% of the Actual Charge for the treatment of an Injury to sound, natural teeth.

### Allergy Testing and Treatment Expense

Benefits include charges incurred for diagnostic testing and treatment of allergies and immunology services.

**Covered Medical Expenses** include, but are not limited to, charges for the following:
- laboratory tests,
- physician office visits, including visits to administer injections,
- prescribed medications for testing and treatment of the allergy, including any equipment used in the administration of prescribed medication, and
- other medically necessary supplies and services.

**Covered Medical Expenses** are payable on the same basis as any other expense.
| Diagnostic Testing for Attention Disorders and Learning Disabilities Expense | **Covered Medical Expenses** for diagnostic testing for:  
- attention deficit disorder, or  
- attention deficit hyperactive disorder  

are payable as follows:  
**Preferred Care**: After a **$10** per visit copay, **100%** of the Negotiated Charge.  
**Non-Preferred Care**: **50%** of the Recognized Charge.  

Benefits are limited to diagnostic testing covered only; treatment is not a covered benefit. |
|---|---|
| Routine Physical Exam Expense | Benefits include expenses for a routine physical exam performed by a physician. If charges for a routine physical exam given to a child who is a covered dependent are covered under any other benefit section, those charges will not be covered under this section.  

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.  

**Preferred Care**: **100%** of the Negotiated Charge.  
**Non-Preferred Care**: **50%** of the Recognized Charge.  

For all exams given to a covered student or a spouse who is a covered dependent, **Covered Medical Expenses** will **not include** charges for **more than**:  
- One exam in 24 months in a row, if the person is under age 65, and  
- One exam in 12 months in a row, if the person is age 65 or over.  

Also included as **Covered Medical Expenses** are charges made by a physician for one annual routine gynecological exam. |
| Well Baby Care Expense | Benefits include charges for routine preventive and primary care services, rendered to a covered dependent child on an outpatient basis.  

**Routine preventive and primary care** services are services rendered to a covered dependent child, from the date of birth through the attainment of **two (2)** years of age. Services include: initial hospital check-ups, other hospital visits, physical examinations, including routine hearing and vision examinations, medical history, developmental assessments, and materials for the administration of appropriate and necessary immunizations and laboratory tests, when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics.  

Newborn examination coverage will include for the detection of the following disorders: Phenyketonuria, Hypothyroidism, Hemoglobinopathies, including sickle cell anemia, Galactosemia, Maple Syrup urine disease, Homocystinuria, Inborn errors of metabolism that result in mental retardation and that are designated by the state department, congenital adrenal hyperplasia, biotinidase deficiency, Disorders detected by tandem mass spectrometry or other technologies with the same or greater detection capabilities as tandem mass spectrometry, if the state department determines that the technology is available for use by a designated laboratory.  

Newborn testing will also include testing for human immunodeficiency virus (HIV) or antibody or antigen to HIV. Newborn coverage will also include a physiologic hearing screening examination at the earliest feasible time for the detection of hearing impairments. |
### Covered Medical Expenses

**Well Baby Care Expense**

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

- **Preferred Care**: 100% of the Negotiated Charge.
- **Non-Preferred Care**: 50% of the Recognized Charge.

Benefits are payable for scheduled visits in accordance with the prevailing clinical standards of the American Academy of Pediatrics.

### Immunizations Expense

**Covered Medical Expenses** include:

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

- **Preferred Care**: 100% of the Negotiated Charge.
- **Non-Preferred Care**: 50% of the Recognized Charge.

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

### Consultant or Specialist Expense

**Covered Medical Expenses** include the expenses for the services of a consultant or specialist, when referred by the School Health Services. 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 covered as follows:
  - **Preferred Care**: After a $25 per visit copay, 100% of the Negotiated Charge.
  - **Non-Preferred Care**: 50% of the Recognized Charge.

### Mental Health Benefits

#### Mental and Emotional Disorders Inpatient Expense

**Covered Medical Expenses** for the treatment of a mental health condition while confined as an inpatient in a hospital or facility licensed for such treatment are payable as follows:

- **Preferred Care**: After a $200 per Admission copay, 100% of the Negotiated Charge.
- **Non-Preferred Care**: 50% of the Recognized Charge.

Non-Preferred Care benefits are limited to $1,200 per Day.

**Covered Medical Expenses** also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission, whereby 2 days of partial hospitalization may be exchanged for 1 day of full hospitalization.

#### Mental and Emotional Disorders Outpatient Expense

**Covered Medical Expenses** for outpatient treatment of a mental health condition are payable as follows:

- **Preferred Care**: After a $25 copay 100% of the Negotiated Charge.
- **Non-Preferred Care**: 50% of the Recognized Charge.

Charges for marriage and family therapies are not **Covered Medical Expenses**.
### Substance Abuse Benefits

<table>
<thead>
<tr>
<th>Inpatient Expense</th>
<th>Covered Medical Expenses</th>
<th>for the treatment of a substance abuse condition while confined as an inpatient in a hospital or facility licensed for such treatment are payable on the same basis as any other sickness.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Preferred Care:</strong> After a $200 per admission copay, 100% of the Negotiated Charge.</td>
<td></td>
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<tr>
<td></td>
<td><strong>Non-Preferred Care:</strong> 50% of the Recognized Charge.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care benefits are limited to $1,200 per day.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient Expense</th>
<th>Covered Medical Expenses</th>
<th>for outpatient treatment of a substance abuse condition are payable as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Preferred Care:</strong> After a $25 per visit copay, 100% of the Negotiated Charge.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Non-Preferred Care:</strong> 50% of the Recognized Charge.</td>
<td></td>
</tr>
</tbody>
</table>

### Maternity Benefits

<table>
<thead>
<tr>
<th>Maternity Expense</th>
<th>Covered Medical Expenses</th>
<th>include inpatient care of the covered person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If a person is discharged earlier, benefits will be payable for one at-home post-delivery care visit by a health care provider. The at-home post-delivery care visit shall be conducted not later than forty-eight (48) hours following the discharge of the woman and her newborn child from a licensed hospital. However, at the mother’s discretion, the visit may occur at the facility of the provider subject to the terms of the policy or group contract.</td>
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<td></td>
<td>As used in this benefit, “at-home post-delivery care” refers to health care provided to a woman at her residence by a physician, registered nurse, or advance practice nurse, whose scope of practice includes providing postpartum care in the area of maternal and child health care. The health care services provided must include, at a minimum:</td>
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<tr>
<td></td>
<td>• parent education;</td>
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<tr>
<td></td>
<td>• assistance and training in breast or bottle feeding; and</td>
<td></td>
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<tr>
<td></td>
<td>• performance of any maternal and neonatal test routinely performed during the usual course of inpatient care for the woman or her newborn child, including the collections of an adequate sample for the hereditary and metabolic newborn screening.</td>
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<tr>
<td></td>
<td><strong>Covered Medical Expenses</strong> for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other sickness.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Well Newborn Nursery Care Expense</th>
<th>Benefits include charges for routine care of a covered person’s newborn child as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• hospital charges for routine nursery care during the mother’s confinement, but for not more than four days for a normal delivery,</td>
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<tr>
<td></td>
<td>• physician’s charges for circumcision, and</td>
</tr>
<tr>
<td></td>
<td>• physician’s charges for visits to the newborn child in the hospital and consultations, but for not more than 1 visit per day.</td>
</tr>
<tr>
<td></td>
<td><strong>Covered Medical Expenses</strong> are payable as follows:</td>
</tr>
<tr>
<td></td>
<td><strong>Preferred Care:</strong> 100% of the Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td><strong>Non-Preferred Care:</strong> 50% of the Recognized Charge.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care benefits are limited to $1,200 per Day.</td>
</tr>
</tbody>
</table>
### Additional Benefits

<table>
<thead>
<tr>
<th>Prescription Drug Benefit</th>
<th>Prescription Drug Benefits are payable as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Preferred Care Pharmacy: <strong>100%</strong> of the Negotiated Charge after a;</td>
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<tr>
<td></td>
<td>$10 copay for Generic Prescription Drugs,</td>
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<td></td>
<td>$30 copay for Brand Name Formulary Prescription Drugs,</td>
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<tr>
<td></td>
<td>$50 copay for Brand Name Non-Formulary Prescription Drugs.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care Pharmacy: Not covered.</td>
</tr>
</tbody>
</table>

This Pharmacy benefit is provided to cover Medically Necessary Prescriptions associated with a covered Sickness or Accident occurring during the Policy Year. Please use your Aetna Student Health ID card when obtaining your prescriptions.

Prior Authorization is required for certain Prescription Drugs, including Imitrex, certain stimulants, growth hormones and for any Prescription quantities larger than a 30-day supply. *(This is only a partial list.)*

Medications not covered by this benefit include, but are not limited to: allergy sera (see Allergy Testing and Treatment coverage), inhalers, all acne medications, drugs whose sole purpose is to promote or to stimulate hair growth, appetite suppressants, smoking deterrents, immunization agents and vaccines, and non-self injectables. *(This is only a partial list.)*

For assistance or for a complete list of excluded medications, or drugs requiring prior authorization, please contact Aetna Pharmacy Management at (800) 238-6279 (available 24 hours).

**Aetna Specialty Pharmacy** provides specialty medications and support to members living with chronic conditions. The medications offered may be injected, infused or taken by mouth. For additional information please go to [www.AetnaSpecialtyRx.com](http://www.AetnaSpecialtyRx.com).

**Aetna Rx Home Delivery** is the prescription mail service for Aetna pharmacy benefit members. You can order your maintenance medications through Aetna Rx Home Delivery. Maintenance medications treat chronic conditions such as arthritis, asthma, diabetes, high cholesterol, heart conditions, hypertension and others.

Aetna Rx Home Delivery offers you:

- **Savings** - You can save money by using Aetna Rx Home Delivery, and standard shipping is always free.
- **Privacy** - Confidential shipping of your prescriptions right to your home, workplace or any other location you choose.
- **Convenience** - Reorder only once every three months.
- **Peace of mind** - Registered pharmacists check orders for accuracy and are available 24 hours a day, seven days a week in case of emergency.

Please see the order form on your Student Connection website for more information and to enroll.

<table>
<thead>
<tr>
<th>Prescription Contraceptive Devices</th>
<th>Covered Medical Expenses include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charges incurred for contraceptive drugs and devices that by law need a physician's prescription and that have been approved by the FDA.</td>
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</tr>
<tr>
<td>Related outpatient contraceptive services such as:</td>
<td></td>
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<tr>
<td>- Consultations,</td>
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<tr>
<td>- Exams,</td>
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<tr>
<td>- Procedures, and</td>
<td></td>
</tr>
<tr>
<td>- Other medical services and supplies</td>
<td></td>
</tr>
<tr>
<td>Benefits for contraceptive devices and outpatient contraceptive services are payable as follows:</td>
<td></td>
</tr>
<tr>
<td>Preferred Care: Payable as any other Condition.</td>
<td></td>
</tr>
<tr>
<td>Non-Preferred Care: Payable as any other Condition.</td>
<td></td>
</tr>
</tbody>
</table>
**Diabetic Treatment, Supplies and Outpatient Self-Management Expense**

**Covered Medical Expense** includes expenses incurred for the diagnosis and treatment of diabetes, including those for drugs and diabetic supplies, equipment and an outpatient diabetic self-management education program prescribed as part of a treatment plan. Benefits are payable on the same basis as any other sickness.

Charges for a diabetic self-management education program are covered but only if:

- the training is medically necessary, ordered in writing by physician or podiatrist, and provided by a health care professional who is licensed, registered, or certified, and has specialized training in the management of diabetes;
- the **covered person** is a diabetic who is covered under this Plan and is not confined in a **hospital** or **skilled nursing facility** as a full-time inpatient; or
- the person is covered under this Plan and cares for or helps care for a diabetic who is covered under this Plan and is not confined in a **hospital** or **skilled nursing facility** as a full-time inpatient.

**Covered Medical Expenses** include:

- one visit after receiving a diagnosis that represents a significant change in the insured’s symptoms or condition.
- One visit for re-education or refresher training.

Not covered are:

- Program expenses incurred for a diabetic education program whose only purpose is weight control.
- Program expenses incurred for a diabetic education program that is available to the public at no cost.

**Preferred Care**: After a $10 per visit copay, **100%** of the Negotiated Charge.

**Non-Preferred Care**: **50%** of the Recognized Charge.

**Hypodermic Needles Expense**

**Covered Medical Expenses** for hypodermic needles and syringes used in the treatment of diabetes are payable as follows:

- Preferred Care: Payable as any other Condition.
- Non-Preferred Care: Payable as any other Condition.

**Benefits are subject to the policy year maximum.**

**Non Prescription Enteral Formula Expense**

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

- Crohn’s Disease,
- ulcerative colitis,
- gastroesophageal reflux,
- gastrointestinal motility,
- chronic intestinal pseudoobstruction, and
- inherited diseases of amino acids and organic acids.

**Covered Medical Expenses** for inherited diseases of amino acids and organic acids, will also include food products modified to be low protein.

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

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

**Covered Medical Expenses** are covered up to a maximum of **$10,000 per Lifetime**.
| Pap Smear Expense | **Covered Medical Expenses** include one annual routine pap smear screening for women age 18 and older.  
Benefits are payable as follows:  
Preferred Care: **100%** of the Negotiated Charge.  
Non-Preferred Care: **50%** of the Recognized Charge. |
|-------------------|--------------------------------------------------------------------------------------------------|
| Mammography Expense | **Covered Medical Expenses** include one baseline mammogram for women between age 35 and 40. Coverage is also provided for one routine annual mammogram for women age 40 and older, as well as when medically indicated for women with risk factors who are under age 40. Risk factors for women under 40 are:  
- A woman who has a personal history of breast cancer.  
- A woman who has a personal history of breast disease that was proven benign by biopsy.  
- A woman whose mother, sister, or daughter has had breast cancer.  
- A woman who is at least thirty (30) years of age and has not given birth.  
Mammogram screenings coverage must also include comprehensive ultrasound screening for the entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue and when determined to be medically necessary by a licensed physician.  
Benefits are payable as follows:  
Preferred Care: **100%** of the Negotiated Charge.  
Non-Preferred Care: **50%** of the Recognized Charge. |
| Mastectomy and Breast Reconstruction Expense Benefit | Coverage will be provided to a covered person who is receiving benefits for a necessary mastectomy and who elects breast reconstruction after the mastectomy for:  
- reconstruction of the breast on which a mastectomy has been performed,  
- surgery and reconstruction of the other breast to produce a symmetrical appearance,  
- prostheses,  
- treatment of physical complications of all stages of mastectomy, including lymphedemas, and  
- reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction. This is subject to the approval of the attending physician.  
**Covered Medical Expenses** are payable on the same basis as any other expense.  
This coverage will be provided in consultation with the attending physician and the patient. It will be subject to the same annual deductibles and coinsurance provisions that apply to the mastectomy. |
| Chlamydia Screening Test Expense | Benefits include charges incurred for an annual Chlamydia screening test.  
Benefits will be paid for Chlamydia screening expenses incurred for:  
- Women who are:  
  - under the age of 20 if they are sexually active, and  
  - at least 20 years old if they have multiple risk factors.  
- Men who have multiple risk factors.  
**Covered Medical Expenses** are payable as follows:  
Preferred Care: **100%** of the Negotiated Charge.  
Non-Preferred Care: **50%** of the Recognized Charge. |
| Routine Screening for Sexually Transmitted Disease Expense | **Covered Medical Expenses** include charges for covered persons who are at least 18 years old and who are sexually active for annual routine screening for sexually transmitted diseases. Benefits are payable as follows:  
**Preferred Care**: 100% of the Negotiated Charge.  
**Non-Preferred Care**: 50% of the Recognized Charge. |
|---|---|
| Elective Surgical Second Opinion Expense | **Covered Medical Expenses** will include a second opinion consultation by a specialist on the need for non-emergency elective surgery which has been recommended by the covered person’s physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation. Benefits are payable as follows:  
**Preferred Care**: After a $10 per visit copay 100% of the Negotiated Charge.  
**Non-Preferred Care**: 50% of the Recognized Charge. |
| Acupuncture in Lieu of Anesthesia Expense | **Covered Medical Expenses** include acupuncture therapy, when acupuncture is used in lieu of other anesthesia, for a surgical or dental procedure covered under this Plan. The acupuncture must be administered by a health care provider who is a legally qualified physician, practicing within the scope of their license.  
**Preferred Care**: 100% of the Negotiated Charge.  
**Non-Preferred Care**: 50% of the Recognized Charge. |
| Dermatological Expense | **Covered Medical Expenses** include charges for the diagnosis and treatment of skin disorders, excluding laboratory fees. Related laboratory expenses are covered under the Outpatient Expense Benefit. Benefits are payable as any other sickness.  
**Covered Medical Expenses** do not include cosmetic treatment and procedures. |
| Home Health Care Expenses | **Covered Medical Expenses** include charges incurred by a covered person for home health care services made by a home health agency pursuant to a home health care plan, but only if:  
(a) The services are furnished by, or under arrangements made by, a licensed home health agency  
(b) The services are given under a home care plan. This plan must be established pursuant to the written order of a physician, and the physician must renew that plan every 60 days. Such physician must certify that the proper treatment of the condition would require inpatient confinement in a hospital or skilled nursing facility if the services and supplies were not provided under the home health care plan. The physician must examine the covered person at least once a month  
(c) Except as specifically provided in the home health care services, the services are delivered in the patient’s place of residence on a part-time, intermittent visiting basis while the patient is confined  
(d) The care starts within 7 days after discharge from a hospital as an inpatient, and  
(e) The care is for the same condition that caused the hospital confinement, or one related to it.  
**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 |
| Home Health Care Expenses (continued) | 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. 

Home Health Care Expense benefits are payable as follows:

**Preferred Care:** 100% of the Negotiated Charge.

**Non-Preferred Care:** 100% of the Recognized Charge.

- A visit means a maximum of 4 continuous hours of home health service. 
Benefits are limited to 40 visits per Policy Year.

| Transfusion or Dialysis of Blood Expense | Covered Medical Expenses include charges for the transfusion or dialysis of blood, including the cost of: whole blood, blood components, and the administration thereof. 
Benefits are payable as follows:

**Preferred Care:** After a $10 per visit copay, 100% of the Negotiated Charge.

**Non-Preferred Care:** 50% of the Recognized Charge.

| Hospice Benefit | Covered Medical Expenses include charges for hospice care provided for a terminally ill covered person during a hospice benefit period. 
Benefits are payable as follows:

**Preferred Care:** After a $15 per visit copay, 100% of the Negotiated Charge.

**Non-Preferred Care:** 50% of the Recognized Charge.

Please see definition on page 40 for more information on Hospice Care Expenses.

| Licensed Nurse Expense | Benefits include charges incurred by a covered person who is confined in a hospital as a resident bed-patient, and requires the services of a registered nurse or licensed practical nurse. 

**Covered Expenses** for a Licensed Nurse are covered as follows:

**Preferred Care:** 100% of the Negotiated Charge.

**Non-Preferred Care:** 50% of the Recognized Charge.

| Skilled Nursing Facility Expense | Covered Medical Expenses include charges incurred by a covered person for confinement in a skilled nursing facility for treatment rendered:

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

Covered Medical Expenses are payable as follows:

**Preferred Care:** After a $200 per confinement, copay 100% of the Negotiated Charge for the semi-private room rate.

**Non-Preferred Care:** 50% of the Recognized Charge for the semi-private room rate.

Non-Preferred Care benefits are limited to $1,200 per Day.
Clinical Cancer Trials Expense

**Covered Medical Expenses** include coverage for routine care costs incurred in the course of a clinical trial if the same costs would be covered in a non-trial procedure/setting/benefit.

**Covered Medical Expenses** are payable on the same basis as any other condition.

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Rehabilitation Facility Expense

**Covered Medical Expenses** include charges incurred by a covered person for confinement as a full time inpatient in a rehabilitation facility. Confinement in the rehabilitation facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of hospital or skilled nursing facility confinement.

**Covered Medical Expenses** for Rehabilitation Facility Expense are covered as follows:

- **Preferred Care:** After a $200 per confinement copay, 100% of the Negotiated Charge for the rehabilitation facility’s daily room and board maximum for semi-private accommodations.
- **Non-Preferred Care:** 50% of the Recognized Charge for the rehabilitation facility’s daily room and board maximum for semi-private accommodations.

Non-Preferred Care benefits are limited to $1,200 per Day.
AETNA DENTAL® PPO

With our Aetna Dental® PPO insurance plan, participating dentists have agreed to provide services at a negotiated rate for covered services, as well as reduced fees for certain non-covered services such as cosmetic tooth whitening, so you generally pay less out of pocket. Enroll and search dentists online at www.aetnastudenthealth.com.

With our Aetna Dental® PPO insurance plan, you can choose to visit a participating or non-participating dentist for care.

Plan Description
- Approximately 124,996* available participating dental practice locations nationwide
- Pay less for care when you visit a participating dentist
- No referrals
- No need to choose a primary care dentist
- Affordable coverage for cleanings, X-rays, restorative work and more!

*Aetna Enterprise Provider Database, 1/1/11.

What the Plan Offers
- Preventive care – exams, cleanings, X-rays and more
- Basic care – fillings, simple extractions, root canals, basic restorative work and more
- Major services – bridges, crowns, and more

Premium Cost

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*Qualifying SAAs and Fellowship Recipients will automatically be enrolled in the mandatory Plan which is fully subsidized by the University or an external granting agency and includes the premium for both the medical and dental coverage. Information on enrolling dependents can be found at www.aetnastudenthealth.com.

In Texas, the Preferred Provider Organization (PPO) plan is known as the Participating Dental Network (PDN).*Discounts for non-covered services may not be available in all states. The Aetna Dental PPO insurance plan is underwritten by Aetna Life Insurance Company.
ADDITIONAL SERVICES AND DISCOUNTS

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

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

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

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

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

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

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

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

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

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

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

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

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

**Beginning Right® Maternity Program:** Make healthy choices for you and your baby. Learn what decisions are good ones for you and your baby. Our Beginning Right maternity program helps prepare you for the exciting changes pregnancy brings.
Aetna Student Assistance Program (SAP) 1-800-556-1555 provides resources to help you balance the challenges of college life with assistance 24 hours a day, seven days a week, by telephone or interactive web resources. All calls are confidential. As a complement to on-campus student health and counseling services available at your school, the Aetna Student Assistance Program offers you these services:

- 24-Hour Telephone Access: You can talk to a licensed mental health professional toll free, 24 hours a day, about any issue. All calls are confidential.
- Interactive Web Resources: With our easy-to-use web resources, you can search for information on relationships, stress, academics, finances, and other issues of special interest…comfortably and privately.

Visit www.aetnastudenthealth.com for full program details. The SAP is administered by Aetna Behavioral Health, LLC and Aetna Life Insurance Company (Aetna). All SAP calls are confidential, except as required by law (i.e., when a person’s emotional condition is a threat to himself/herself or others, or there is suspected abuse of a minor child, and in some areas, spousal or elder abuse).

Aetna’s Informed Health® Line*:
Call toll free 1-800-556-1555 24 hours a day, 7 days a week. Get health answers 24/7. When you have an Aetna health benefits and health insurance plan, you have instant access to the information you need. Our tools and resources can help you:

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

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

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

Listen to the Audio Health Library:*It explains thousands of health conditions in English and Spanish. Transfer easily to a registered nurse at any time during the call.
* Not all topics in the audio health service are covered expenses under your plan.

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

Get to it through your secure Aetna Navigator® member website, at www.aetnastudenthealth.com.
GENERAL PROVISIONS

STATE MANDATED BENEFITS

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

SUBROGATION/REIMBURSEMENT

RIGHT OF RECOVERY PROVISION

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

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

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

The Covered Person shall do nothing to prejudice Aetna’s subrogation and reimbursement rights. The Covered Person shall, when requested, fully cooperate with Aetna’s efforts to recover its benefits paid. It is the duty of the Covered Person to notify Aetna within 45 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim, to recover damages, due to injuries sustained by the Covered Person.

The Covered Person acknowledges that this Plan’s subrogation and reimbursement rights are a first priority claim against all potential responsible parties, and are to be paid to Aetna before any other claim for the Covered Person’s damages. This Plan shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the Plan will result in a recovery to the Covered Person, which is insufficient to make the Covered Person whole, or to compensate the Covered Person in part or in whole for the damages sustained. This Plan is not required to participate in or pay attorney fees to the attorney hired by the Covered Person to pursue the Covered Person’s damage claim. In addition, this Plan shall be responsible for the payment of attorney fees for any attorney hired or retained by this Plan. The Covered Person shall be responsible for the payment of all attorney fees for any attorney hired or retained by the Covered Person or for the benefit of the Covered Person.

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

In the event any claim is made that any part of this subrogation and reimbursement provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Covered Person and this Plan agree that Aetna shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.
COORDINATION OF BENEFITS
If the Covered Person is insured under more than one group health plan, the benefits of the plan that covers the insured student will be used before those of a plan that provides coverage as a dependent. When both parents have group health plans that provide coverage as a dependent, the benefits of the plan of the parent whose birth date falls earlier in the year will be used first. The benefits available under this Plan may be coordinated with other benefits available to the Covered Person under any auto insurance, Workers’ Compensation, Medicare, or other coverage. The Plan pays in accordance with the rules set forth in the Policy.

EXTENSION OF BENEFITS
If a Covered Person is confined to a hospital on the date his or her insurance terminates, expenses incurred after the termination date and during the continuance of that hospital confinement, shall be payable in accordance with the policy, but only while they are incurred during the 90 day period, following such termination of insurance.

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

TERMINATION OF STUDENT COVERAGE
Insurance for a covered student will end on the first of these to occur:
(a) the date this Plan 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.

TERMINATION OF DEPENDENT COVERAGE
Insurance for a covered student’s dependent will end when insurance for the covered student ends. Before then, coverage will end:
(a) For a child, on the first premium due date following the child’s 26th birthday,
(b) The date the covered student fails to pay any required premium.
(c) For the spouse, the date the marriage ends in divorce or annulment.
(d) The date dependent coverage is deleted from this Plan.
(e) For a domestic partner, the earlier to occur of:
1. the date this Plan no longer allows coverage for domestic partners, and
2. the date of termination of the domestic partnership. In that event, a completed and signed declaration of Termination of Domestic Partnership must be provided to the Policyholder.
(f) The date the dependent ceases to be in an eligible class.

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

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

CONTINUATION OF COVERAGE
A covered student who has graduated or is otherwise ineligible for coverage under this Plan, and has been continuously insured under the plan offered by the Policyholder (regular student plan), may be covered for up to 7 1/2 consecutive months provided that: (1) a written request for continuation has been forwarded to Aetna 30 days after the termination of coverage, and (2) premium payment has been made. Coverage under this provision ceases on the date this Plan terminates.
EXCLUSIONS
This Plan does not cover nor provide benefits for:

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

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.

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 Plan and performed while this Plan 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 extend needed to:
   • Improve the function of a part of the body that:
     • is not a tooth or structure that supports the teeth, and
     • is malformed.
   • as a result of a severe birth defect, including harelip, webbed fingers, or toes, or
   • as direct result of:
     • disease, or
     • surgery performed to treat a disease or injury.

   Repair an injury (including reconstructive surgery for prosthetic device for a covered person who has undergone a mastectomy,) which occurs while the covered person is covered under this Plan. Surgery must be performed:
   • in the calendar year of the accident which causes the injury, or
   • in the next calendar year.

   This exclusion does not apply to reconstructive surgery or prosthetic devices for a covered person who has undergone a mastectomy.

11. Expense incurred as a result of preventive medicines, serums, or vaccines.
12. Expense incurred as a result of commission of a felony.

13. Expense incurred for voluntary or elective abortions unless otherwise provided in this Plan.

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

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

16. Expense incurred for any services rendered by a member of the covered person's immediate family or a person who lives in the covered person's home.

17. Expense incurred for injury resulting from the play or practice of collegiate or intercollegiate sports, including collegiate or intercollegiate club sports and intramurals.

18. Expenses for treatment of injury or sickness to the extent that payment is made; as a judgment or settlement; by any person deemed responsible for the injury or sickness (or their insurers).

19. Expenses for treatment of injury or sickness to the extent that payment is made; as a judgment or settlement; by any person deemed responsible for the injury or sickness (or their insurers).

20. Expenses for treatment of injury or sickness to the extent that payment is made; as a judgment or settlement; by any person deemed responsible for the injury or sickness (or their insurers).

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

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

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

24. Expenses incurred for the repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices.

25. Expenses incurred for or in connection with: procedures, services, or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:
   • There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature, to substantiate its safety and effectiveness, for the disease or injury involved, or
   • If required by the FDA, approval has not been granted for marketing, or
   • A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes, or
   • The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility, or by another facility studying the same drug, device, procedure, or treatment, states that it is experimental, investigational, or for research purposes.
However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease, if Aetna determines that:

- The disease can be expected to cause death within one year, in the absence of effective treatment, and
- The care or treatment is effective for that disease, or shows promise of being effective for that disease, as demonstrated by scientific data. In making this determination, Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

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

- Have been granted treatment investigational new drug (IND), or Group c/treatment IND status, or
- Are being studied at the Phase III level in a national clinical trial, sponsored by the National Cancer Institute, or
- Are recognized for treatment of the indication of at least one (1) standard reference compendium, or
- Are recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.

If Aetna determines that available, scientific evidence demonstrates that the drug is effective, or shows promise of being effective, for the disease.

26. Expenses incurred for gastric bypass, and any restrictive procedures, for weight loss.

27. Expenses incurred for breast reduction/mammoplasty.

28. Expenses incurred for gynecomastia (male breasts).

29. Expense incurred 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.

30. Expense incurred for, or related to, services, treatment, testing, educational testing, training, or medication for Attention Deficit Disorder, Attention Deficit Hyperactive Disorder, or Learning Disabilities, or other developmental delays, except Pervasive Developmental Disorder.

31. Expense incurred for acupuncture, unless services are rendered for anesthetic purposes.

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

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

34. Expense incurred for hearing aids, the fitting, or prescription of hearing aids.

35. Expenses incurred for hearing exams.

36. 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.

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

38. 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.
39. Expense for incidental surgeries, and standby charges of a physician.

40. Expense for treatment and supplies for programs involving cessation of tobacco use.

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

42. Expenses incurred for massage therapy.

43. Expense incurred for, or related to, sex change surgery, or to any treatment of gender identity disorder.

44. 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.

45. 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.

46. Expenses arising from a Pre-Existing Condition, unless (a) no charges are incurred or treatment rendered for the condition for a period of six months while covered under this Plan, or (b) the covered person has been covered under this Plan for 12 consecutive months, whichever happens first.

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

48. 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 persons 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 of the charges is required under any law that applies to the coverage.
DEFINITIONS

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

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

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

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

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

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

Chlamydia Screening Test
This is 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.

Coinsurance
The percentage of Covered Medical Expenses payable by Aetna under this Accident and Sickness Insurance Plan.

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

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

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

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

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

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

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

Covered Person
A covered student and any covered dependent while coverage under this Plan is in effect.

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

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

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

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

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

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

The term “child” includes a covered student’s step-child, adopted child whose coverage is effective upon the earlier of the date of placement for the purpose of adoption, or the date of the entry of an order granting the adoptive parent custody of the child for purposes of adoption.

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

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

Diabetic Self-Management Education Course
A scheduled program on a regular basis which is designed to instruct a covered person in the self-management of diabetes. It is a day care program of educational services and self-care training. All of the following requirements must be met:

- A physician must direct and supervise the program.
- The program’s services and training must be rendered by health care professionals who are familiar with diabetes and its treatment. This includes physicians, R.N.s, registered pharmacists, registered dietitians and licensed social workers.
- The program must include:
  - An assessment of the diabetic’s needs and skills. This must be done by the health care professionals who render the service and before the program starts and after it ends.
  - An education plan designed for the diabetic’s condition and skills.
  - At least a total of 5 hours of one-on-one or group instructions.
  - At least one dietary counseling session for the diabetic and the persons who help in his or her care.
  - A discussion of the history of diabetes, psycho-social factors which affect the diabetic and his or her family, complications and related symptoms and special general health care concerns. (These include hygiene and pregnancy care if appropriate.)
  - Training in dietary and nutritional planning, procedures for testing and monitoring of blood sugars and adjusting medications or diet to correspond to activities and exercises done.
  - Provision for at least one follow-up evaluation. This is done after the person completes the program.

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

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

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

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

Elective Treatment
Medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the covered person’s effective date of coverage. Elective treatment includes, but is not limited to:

- 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,
- immunization,
- treatment of infertility, 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 unexpected onset of a change in a person's physical or mental condition which:

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

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

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

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

High Cost Procedure
High Cost Procedures include the following procedures and services:

- C.A.T. Scan,
- Magnetic Resonance Imaging,
- Laser treatment, which must be provided on an outpatient basis, and 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.

Home Health Agency

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

Home Health Aide
A certified or trained professional who provides services through a home health agency which are not required to be performed by an 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 hospital administration must meet the standards of the National Hospice Organization and any licensing requirements.

Hospice Benefit Period
A period that begins on the date the attending **physician** certifies that the **covered person** is a terminally ill patient who has less than 6 months to live. It ends after 6 months (or such later period for which treatment is certified) or on the death of the patient, if sooner.

Hospice Care Expenses
The recognized charges made by a hospice for the following services or supplies: charges for inpatient care, charges for drugs and medicines, charges for part-time nursing by an R.N., L.P.N., or L.V.N., charges for physical and respiratory therapy in the home, charges for the use of medical equipment, charges for visits by licensed or trained social workers, psychologists or counselors, charges for bereavement counseling of the covered person’s immediate family prior to, and within 3 months after, the covered person’s death, and charges for respite care for up to 5 days in any 30 day period.

Hospital
A facility which meets all of these tests:
- it provides in-patient services for the case and treatment of injured and sick people, and
- it provides room and board services and nursing services 24 hours a day, and
- it has established facilities for diagnosis and major surgery, and
- it is run as a **hospital** under the laws of the jurisdiction which it is located.

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

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

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

Intensive Care Unit
A designated ward, unit, or area within a **hospital** for which a specified extra daily surcharge is made and which is staffed and equipped to provide, on a continuous basis, specialized or intensive care or services, not regularly provided within such **hospital**.
Jaw Joint Disorder
This is a Temporomandibular Joint Dysfunction or any similar disorder in the relationship between the jaws or jaw joint, and the muscles, and nerves.

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

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

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

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

In no event will the following services or supplies be considered to be medically necessary:
• Those that do not require the technical skills of a medical, a mental health, or a dental professional, or
• Those furnished mainly for: the personal comfort, or convenience, of the person, any person who cares for him or her, or any person who is part of his or her family, any healthcare provider, or healthcare facility, or
• Those furnished solely because the person is an inpatient on any day on which the person’s sickness or injury could safely and adequately be diagnosed or treated while not confined, or
• Those furnished solely because of the setting if the service or supply could safely and adequately be furnished, in a physician’s or a dentist’s office, or other less costly setting.

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

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

A covered student’s member dental provider is a member dental provider currently chosen, in writing by the covered student, to provide dental care to the covered student.
A member dental provider chosen by a covered student takes effect as the covered student’s member dental provider on the effective date of that covered student’s coverage.

Member Dental Provider Service Area
The area within a 30 mile radius of the covered student’s member dental provider.

Mental Illness
Mental Illness means the psychiatric illnesses as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association.

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

Non-Occupational Disease
A non-occupational disease is a disease that does not:

• arise out of (or in the course of) any work for pay or profit, or
• result in any way from a disease that does.

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the covered student:

• is covered under any type of workers’ compensation law, and
• is not covered for that disease under such law.

Non-Occupational Injury
A non-occupational injury is an accidental bodily injury that does not:

• arise out of (or in the course of) any work for pay or profit, or
• result in any way from an injury which does.

Non-Preferred Care
A health care service or supply furnished by a health care provider that is not a Designated Care Provider, or that is not a Preferred Care Provider, if, as determined by Aetna:

• the service or supply could have been provided by a Preferred Care Provider, and
• the provider is of a type that falls into one or more of the categories of providers listed in the directory.

Non-Preferred Care Provider

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

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

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

One Sickness
A sickness and all recurrences and related conditions which are sustained by a covered person.
Orthodontic Treatment
Any
• medical service or supply, or
• dental service or supply,

furnished to prevent or to diagnose or to correct a misalignment:
• of the teeth, or
• of the bite, or
• of the jaws or jaw joint relationship,

whether or not for the purpose of relieving pain. Not included is:
• the installation of a space maintainer, or
• surgical procedure to correct malocclusion.

Out-of-Area Emergency Dental Care
Medically necessary care or treatment for an emergency medical condition, that is rendered outside a 30 mile radius of the covered student’s member dental provider. Such care is subject to specific limitations set forth in this Plan.

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

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

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

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.

Pervasive Developmental Disorder
A neurological condition, including Asperger’s syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Pharmacy
An establishment where prescription drugs are legally dispensed.

Physician
(a) legally qualified physician licensed by the state in which he or she practices, and (b) any other practitioner that must by law be recognized as a doctor legally qualified to render treatment.

Policy Year
The period of time from anniversary date to anniversary date except in the first year when it is the period of time from the effective date to the first anniversary date.
Pre-Admission Testing
Tests done 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 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.

Pre-Existing Condition
Any injury, sickness, or condition that was diagnosed or treated, or would have caused a prudent person to seek diagnosis or treatment, within six months prior to the covered person’s effective date of insurance.

Preferred Care
Care provided by

- a covered person’s primary care physician, or a preferred care provider of the primary care physician, or
- a health care provider that is not a Preferred Care Provider for an emergency medical condition when travel to a Preferred Care Provider, is not feasible, or
- a Non-Preferred Urgent Care Provider when travel to a Preferred Urgent Care Provider for treatment is not feasible, and if authorized by Aetna.

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

- the service or supply involved, and
- the class of covered persons of which you are member.

Preferred Pharmacy
A pharmacy, including a mail order pharmacy, which is party to a contract with Aetna to dispense drugs to persons covered under this Plan, but only:

- while the contract remains in effect, and
- while such a pharmacy dispenses a prescription drug, under the terms of its contract with Aetna.

Preferred Prescription Drug Expense
An expense incurred for a prescription drug that:

- is dispensed by a Preferred Pharmacy, or for an emergency medical condition only, by a non-preferred pharmacy, and
- is dispensed upon the Prescription of a Prescriber who is:
  - a Designated Care Provider, or
  - a Preferred Care Provider, or
  - a Non-Preferred Care Provider, but only for an emergency condition, or of a person’s Primary Care Physician, or
  - a dentist who is a Non-Preferred Care Provider, but only one who is not of a type that falls into one or more of the categories of providers listed in the directory of Preferred Care Providers.
Prescriber
Any person, while acting within the scope of his or her license, who has the legal authority to write an order for a prescription drug.

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

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

This is the Preferred Care Provider who is:
- selected by a person from the list of Primary Care Physicians in the directory,
- responsible for the person’s on-going health care, and
- shown on Aetna’s records as the person’s Primary Care Physician.

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

Recognized Charge
Only that part of a charge which is recognized is covered. The recognized charge for a service or supply is the lowest of:
- The provider’s usual charge for furnishing it, and
- The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply, and the manner in which charges for the service or supply are made, and
- The charge Aetna determines to be the recognized charge percentage made for that service or supply.

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

In determining the recognized charge for a service or supply that is:
- Unusual, or
- Not often provided in the area, or
- Provided by only a small number of providers in the area.

Aetna may take into account factors, such as:
- The complexity,
- The degree of skill needed,
- The type of specialty of the provider,
- The range of services or supplies provided by a facility, and
- The recognized charge in other areas.

Residential Treatment Facility
A treatment center for children and adolescents, which provides residential care and treatment for emotionally disturbed individuals, and is licensed by the department of children and youth services, and is accredited as a residential treatment center by the council on accreditation or the joint commission on accreditation of health organizations.

Respite Care
Care provided to give temporary relief to the family or other care givers in emergencies and from the daily demands for caring for a terminally ill covered person.
Room and Board
Charges made by an institution for board and room and other necessary services and supplies. They must be regularly made at a daily or weekly rate.

Routine Screening for Sexually Transmitted Disease
This is any laboratory test approved for such purposes by the FDA that specifically detects for infection by one or more agents of:
- Gonorrhea,
- Syphilis,
- Hepatitis,
- HIV, and
- Genital Herpes

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

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

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

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

Skilled Nursing Facility
A lawfully operating institution engaged mainly in providing treatment for people convalescing from injury or sickness. It must have:
- organized facilities for medical services,
- 24 hours nursing service by R.N.s,
- a capacity of six or more beds,
- a daily medical records for each patient, and
- a physician available at all times.

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

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

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

**Surgical Expense**
Charges by a physician for,
• a surgical procedure,
• a necessary preoperative treatment during a hospital stay in connection with such procedure, and
• usual postoperative treatment.

**Surgical Procedure**
• a cutting procedure,
• suturing of a wound,
• treatment of a fracture,
• reduction of a dislocation,
• radiotherapy (excluding radioactive isotope therapy), if used in lieu of a cutting operation for removal of a tumor,
• electrocauterization,
• diagnostic and therapeutic endoscopic procedures,
• injection treatment of hemorrhoids and varicose veins,
• an operation by means of laser beam,
• cryosurgery.

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

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

**Urgent Condition**
This means a sudden illness, injury, or condition, that:
is severe enough to require prompt medical attention to avoid serious deterioration of the covered person’s health,

includes a condition which would subject the covered person to severe pain that could not be adequately managed without urgent care or treatment,

does not require the level of care provided in the emergency room of a hospital, and

requires immediate outpatient medical care that cannot be postponed until the covered person’s physician becomes reasonably available.

Urgent Care Provider
This is:

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

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

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

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

On occasion, the claims investigation process will require additional information in order to properly adjudicate the claim. This investigation will be handled directly by Aetna. Customer Service Representatives are available 8:30 a.m. to 5:30 p.m., Monday through Friday, ET for any questions.

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

Please send claims to:
Aetna Student Health
PO Box 981106
El Paso, TX 79999
(877) 437-6512

How to Appeal a Claim

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

Aetna Student Health
P.O. Box 14464
Lexington, KY 40512 4

If you (a) need assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer, you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: (800) 622-4461; (317) 232-2395
Complaints can be filed electronically at www.in.gov/idoi.

PRESCRIPTION DRUG CLAIM PROCEDURE

When obtaining a covered prescription, please present your ID card to a Preferred Pharmacy, along with your applicable copay. The pharmacy will bill Aetna for the cost of the drug, plus a dispensing fee, less the copay amount.

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

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

A brief description of these benefits is outlined below.

Accidental Death and Dismemberment (ADD) Benefits

These benefits are underwritten by United States Fire Insurance Company (USFIC) and include the following:

Benefits are payable for the Accidental Death and Dismemberment of Covered Persons, up to a maximum of $10,000.

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

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

Natural Disaster and Political Evacuation Services (NDPE)

The following benefits are underwritten by an insurer contracted with On Call, with medical and travel assistance services provided by On Call. If a Covered Person requires emergency evacuation due to governmental or social upheaval, which places him/her in imminent bodily harm (as determined by On Call security personnel in accordance with local and U.S. authorities), On Call will arrange and pay for his/her transportation to the nearest safe location, and then to the his/her home country. If a Covered Person requires emergency evacuation due to a natural disaster, which makes his/her location uninhabitable, On Call will arrange and pay for his/her evacuation from a safe departure point. Benefits are payable up to $100,000 per event per person.

Worldwide Emergency Travel Assistance (WETA) Services. On Call provides the following travel assistance services:

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

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

The information contained above is a just summary of the ADD, MER, WETA, and NDPE benefits and services available through On Call, USFIC, VSC and CV. For a copy of the plan documents applicable to the ADD, MER, WETA and NDPE coverage, including a full description of coverage, exclusions and limitations, please contact Aetna Student Health at www.aetnastudenthealth.com or (800) 966-7772.

NOTE: In order to obtain coverage, all MER, WETA and NDPE services must be provided and arranged through On Call. Reimbursement will not be provided for any services not provided and arranged through On Call. Although certain emergency medical services may be covered under the terms of the Covered Person’s student health insurance plan (the “Plan”), neither OnCall, USFIC, VSC nor CV provide coverage for emergency medical treatment rendered by doctors, hospitals, pharmacies or other health care providers. Coverage for such services will be provided in accordance with the terms of the Plan and exclusions, limitations and benefit maximums may apply. Neither CCA, nor Aetna Life Insurance Company, nor their affiliates provide medical care or treatment and they are not responsible for outcomes.
To file a claim for ADD benefits, or to obtain MER, WETA or NDPE benefits/services, or for any questions related to those benefits/services, please call On Call International at the following numbers listed on the On Call ID card provided to Covered Persons when they enroll in the Plan: Toll Free at (866) 525-1956 or Collect at (603) 328-1956.

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

CCA and On Call are independent contractors and not employees or agents of the other. CCA provides access to ADD, MER, WETA and NDPE benefits/services through a contractual arrangement with On Call. However, neither CCA nor any of its affiliates provides or administers ADD, MER, WETA or NDPE benefits/services and neither CCA nor any of its affiliates is responsible in any way for the benefits/services provided by or through On Call, USFIC, VSC or CV. Premiums/fees for benefits/services provided through On Call, USFIC, VSC and CV are included in the Rates outlined in this brochure.

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

AETNA NAVIGATOR®

GOT QUESTIONS? GET ANSWERS WITH AETNA NAVIGATOR®

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

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

HOW DO I REGISTER?

- Go to www.aetnastudenthealth.com
- Click on “Find Your School.”
- Enter your school name and then click on “Search.”
- Click on Aetna Navigator and then the “Access Navigator” link.
- Follow the instructions for First Time User by clicking on the “Register Now” link.
- Select a user name, password and security phrase.

Your registration is now complete, and you can begin accessing your personalized information!

NEED HELP WITH REGISTERING ONTO AETNA NAVIGATOR?

Registration assistance is available toll free, Monday through Friday, from 7 a.m. to 9 p.m. Eastern Time at (800) 225-3375.
NOTICE

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

Administered by:
Aetna Student Health
P.O. Box 981106
El Paso, TX 79998
(877) 437-6512
www.aetnastudenthealth.com

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

Policy No. 812849

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