Your student health insurance coverage, offered by Aetna Student Health*, may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions for annual dollar limits for student health insurance coverage are $100,000 for policy years before September 23, 2012, and $500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014. Your student health insurance coverage includes an annual limit of $1,000,000 per Condition per Policy Year on all covered services including Essential Health Benefits. Other internal maximums (on Essential Health Benefits and certain other services) are described more fully in the benefits chart included inside this Plan summary. If you have any questions or concerns about this notice, contact (800) 558-8845. Be advised that you may be eligible for coverage under a group health plan of a parent’s employer or under a parent’s individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent’s employer plan or the parent’s individual health insurance issuer for more information.

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

In case of an emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.
For non-emergency situations, Arts & Sciences and Engineering students may visit or call Johns Hopkins University Student Health Services at (410) 516-8270. Students who are enrolled in Carey Business School, School of Education, AAP (Advanced Academic Programs), EP (Engineering for Professionals) and do not have access to a Health Center, please go to aetnastudenthealth.com to locate an In Network Provider through Docfind®.

For questions about:
• Enrollment Forms
• Waiver Process

Arts & Sciences and Engineering Students, please contact the Office of the Registrar: (410) 516-8079 or (410) 516-3328
Peabody Campus Students, please contact the Business Office: (410) 234-4544, ext. 3020
School of Advanced International Studies Students, please contact Student Accounts: (202) 663-5870
Carey Business School Students, please contact (410)-234-9240
School of Education Students, please contact: (410) 516-6027

For questions about:
• Insurance Benefits
• Claims Processing
• Inpatient Admission Pre-Certification
• Vision One® Discount Program
• Advantage Dental Program

Please contact:
Aetna Student Health
PO Box 981106
El Paso, TX 79998
(800) 558-8845 (Monday - Friday, 8:30 a.m. – 5:30 pm. EST)

For questions about:
• ID cards

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

For lost ID cards, contact:
Aetna Student Health
(800) 558-8845 or you may print a temporary ID by visiting our website @ aetnastudenthealth.com and visiting your appropriate JHU Campus site.

For questions about:
• Johns Hopkins University Student Health Services Referrals

Arts & Sciences and Engineering Students
Student Health and Wellness Center: (410) 516-8270
3003 North Charles Street, Suite N-200, Baltimore, MD 21218
Counseling Center: (410) 516-8278
Suite S-200
Peabody Students
Johns Hopkins Community Physicians, Inc: (410) 338-3052
Wyman Park Medical Center, 3100 Wyman Park Drive, Suite 300, Baltimore, MD 21211
Counseling Center: (410) 516-8278
Garland Hall, Third Floor

School of Advanced International Studies (SAIS) Students
Georgetown University Student Health Center: (202) 687-2200
Darnall Hall, Ground Floor 3800 Reservoir Rd. NW, Washington, DC 20007
Johns Hopkins Student Assistance Program, (866) 764-2317

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

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

For questions about:
- Provider Listings

Please contact:
Aetna Student Health
(800) 558-8845

A complete list of providers can be found using 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 Johns Hopkins 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 Health Center, during business hours.

This Student Plan fulfills the definition of Creditable Coverage explained in the Health Insurance Portability and
Accountability Act (HIPAA) of 1996. At any time should you wish to receive a certification of coverage, please call
the customer service number on your ID card.
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<th>Page Numbers</th>
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<td>Student Coverage</td>
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<td>Aetna’s Navigator®</td>
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JOHNS HOPKINS UNIVERSITY STUDENT HEALTH SERVICES

Student Health and Wellness Center or Counseling Center.

Arts and Sciences and Engineering STUDENTS ONLY
Student Health and Wellness Center: (410) 516-8270
3003 North Charles Street, Suite N-200, Baltimore, MD 21218
Counseling Center: (410) 516-8278
Suite S-200

POLICY PERIOD

1. **Students**: Coverage for all insured students enrolled for the Fall Semester, will become effective at 12:01 a.m. on **August 15, 2012**, and will terminate at 11:59 p.m. on **August 14, 2013**.

2. **New Spring Semester Students**: Coverage for all insured students enrolled for the Spring Semester, will become effective at 12:01 a.m. on **January 15, 2013**, and will terminate at 11:59 p.m. on **August 14, 2013**.

3. **Insured Dependents**: Coverage will become effective on the same date the insured student’s coverage becomes effective, or the day after the postmarked date when the completed application and premium are sent, if later. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Master Policy. For more information on Termination of Covered Dependents see page (34) of this Brochure. Examples include, but are not limited to: the date the student’s coverage terminates, the date the dependent no longer meets the definition of a dependent.

RATES

<table>
<thead>
<tr>
<th></th>
<th>Cost Undergraduates and Graduate Students</th>
<th>Annual</th>
<th>Spring Semester</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td></td>
<td>$1,848</td>
<td>$924</td>
</tr>
<tr>
<td>Spouse</td>
<td></td>
<td>$3,364</td>
<td>$1,682</td>
</tr>
<tr>
<td>Child</td>
<td></td>
<td>$1,582</td>
<td>$791</td>
</tr>
<tr>
<td>Child(ren)</td>
<td></td>
<td>$2,098</td>
<td>$1,049</td>
</tr>
</tbody>
</table>

The rates above include both premiums for the Student Health Plan underwritten by Aetna Life Insurance Company, as well as Johns Hopkins University’s administrative fee.

JOHNS HOPKINS UNIVERSITY

STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN

This is a brief description of the Accident and Sickness Medical Expense benefits available for Johns Hopkins 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 Johns Hopkins University Student Health Services during business hours.
STUDENT COVERAGE

ELIGIBILITY
All full-time registered domestic students are required to purchase the Insurance Plan unless proof of comparable coverage is furnished. All International students are required to enroll in the Student Health Insurance Plan. All students enrolled in part-time programs, non-resident Graduate students, and Graduate study abroad students are eligible to enroll in the Student Health Insurance Plan. The Enrollment/Waiver Form should be submitted prior to registration but no later than September 16, 2012. For Carey Business School and School of Advanced International Studies (SAIS) students, the Fall Semester waiver deadline is September 30, 2012.

To Enroll or Waive Online:
- Visit the “Find Your School” link at www.aetnastudenthealth.com.
- Select the appropriate Johns Hopkins University campus and click “Go”.
- Click on “Medical Plan: Enroll/Waive”.
- Click on “Enroll: Student Health Insurance Plan”.
- Simply follow the prompts on the screen by providing all information requested.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Part-time study, independent study, Internet classes, and television (TV) courses may not fulfill the eligibility requirements that the covered student actively attends classes. If the eligibility requirements are not met, Aetna’s only obligation is to refund the premium, less any claims paid.

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.
WAIVER PROCESS/PROCEDURE
Eligible students will automatically be enrolled in this Plan, unless a completed Waiver Form has been received by the Johns Hopkins University by the specified deadline dates listed below:

<table>
<thead>
<tr>
<th>Category</th>
<th>Waiver Deadline Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students enrolling for the Fall Semester</td>
<td>08/15/12*</td>
</tr>
<tr>
<td>Students enrolling for the Spring Semester</td>
<td>02/15/13</td>
</tr>
</tbody>
</table>

*Please note: For Carey Business School and School of Advanced International Studies (SAIS) students, the Fall Semester waiver deadline is September 30, 2012.

DEPENDENT COVERAGE

ELIGIBILITY
Covered students may also enroll their lawful spouse, and children under age 26.

At the request of the Plan sponsor school, the Plan shall provide that the same health insurance benefits and eligibility guidelines that apply to any covered dependent be available to a domestic partner or a child dependent of the domestic partner of the insured. Definition of a dependent child of a domestic partner is the same definition as dependent child of the insured except that the domestic partner child must live with the insured. See the definition of dependent child above for other criteria.

NOTE: If proof of domestic partner relationship is required then the proof requested must comply with MD regulation ADC 31.10.35-01 through 03. Domestic partner includes same and opposite sex per MD regulation.

ENROLLMENT
To Enroll:
- Visit the “Find Your School” link at www.aetnastudenthealth.com.
- Select the appropriate Johns Hopkins University campus and click “Go”.
- Click on “Medical Plan: Enroll/Waive”.
- Click on “Enroll: Student Health Insurance Plan”.
- Simply follow the prompts on the screen by providing all information requested.

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 Johns Hopkins 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 also provided for an adopted child who meets the definition of a dependent child as of the date the child is “placed for adoption” with the covered student (this means the assumption and retention of a legal obligation for total or partial support of the child in anticipation of adoption of the child), a grandchild that is placed in the covered student’s custody, or a child for whom guardianship is granted by a court or testamentary appointment, from the date the child is placed for adoption, the date of appointment or the date the grandchild is placed in custody for an initial period of 31 days. To continue the insurance beyond this initial 31 day period, the covered student must notify Aetna or its agent of the placement, adoption or custody of such child, and pay any additional premium required for the child’s insurance within the 31 day period.

Please Note: Previously Covered Persons must re-enroll for dependent coverage by September 2012 for the Fall Semester, and by January 2013 for the Spring Semester, in order to avoid a break in coverage for conditions which existed in prior Policy Years.
CONTINUOUSLY INSURED

Persons who have remained continuously insured under this Plan or other policies will be covered for any pre-existing condition, which 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, including dependent coverage, by September 2012, for the Fall Semester, and by January 2013, for the Spring Semester in order to avoid a break in coverage for conditions which existed in prior Policy Years. Once a break in continuous coverage occurs, the pre-existing conditions limitation will apply.

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 Johns Hopkins 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 Johns Hopkins University, Aetna Student Health, or Aetna. A complete listing of participating providers is available at the Johns Hopkins University Student Health Services.

You may also obtain information regarding Preferred Providers by contacting Aetna Student Health at (800) 558-8845, 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.

REFERRAL REQUIREMENTS

Students’ health care needs can best be satisfied when an organized system of health care providers at Johns Hopkins University Student Health Services manages the treatment. Student health care needs can best be satisfied and costs contained when an organized system of health care providers at the Johns Hopkins University Student Health Centers manages the treatment. If you are covered under the Student Health Insurance Plan, you should first seek treatment at the facilities listed as follows, except in the case of an Emergency Medical Condition or for obstetrical (including care related to pregnancy) and gynecological services. The Plan covers one well-woman visit per Policy Year which includes the office visit, Pap smear, and Chlamydia screening. (Please Note: The Student Health Centers offer comprehensive gynecological services including annual exams. Out-of-pocket expenses may be reduced by initiating care at the Student Health Center.) The health care providers can then refer you to an outside provider. Your Deductible will be reduced if you initiate treatment at these facilities. (Please see annual
Deductible section for details.) The Student Health Center will not issue a referral over the phone; the student must be seen by a provider onsite. Any treatment initiated while away from campus will be subject to the $250 annual Deductible. Full-Time Arts and Science and Engineering and Peabody students have access to the Counseling Center located on the Homewood Campus. Should the Counseling Center refer a student for additional treatment, the annual Deductible will be reduced to $75 per condition.

If you need continuing care from a specialist for one of these services, you may request that a “standing referral” be given for your continuing care for this treatment.

Please Note: The Counseling Center will not refer students who are not eligible for treatment at the Counseling Center. Dependents and students enrolled in the following divisions (Carey Business School and School of Education, Arts and Science Advanced Academic Programs (AAP), and Engineering and Applied Science Programs for Professionals (EPP)) are not eligible for services at the Student Health and Wellness Center or Counseling Center.

**Full-Time Arts & Sciences and Engineering Students**
- Student Health and Wellness Center: **(410) 516-8270**
  3400 North Charles Street, Baltimore, MD 21218
- Counseling Center: **(410) 516-8278**
  Garland Hall, Third Floor

**Peabody Students**
- Johns Hopkins Community Physicians, Inc: **(410) 338-3052**
  Wyman Park Medical Center, 3100 Wyman Park Drive, Suite 300, Baltimore, MD 21211
- Counseling Center: **(410) 516-8278**
  Garland Hall, Third Floor

**School of Advanced International Studies (SAIS) Students**
- Johns Hopkins Student Assistance Program: **(866) 764-2317**
  Washington, DC
- Georgetown University Student Health Center: **(202) 687-2200**
  Darnall Hall, Ground Floor 3800 Reservoir Rd. NW, Washington, DC 20007

Please be advised that students who are enrolled in Carey Business School, School of Education, AAP (Advanced Academic Programs), EP (Engineering for Professionals) and do not have access to a Health Center will be subject to the $250 Deductible. Please go to aetnastudenthealth.com to locate an In Network Provider through Docfind®.

Dependents are not eligible to use the services of the Johns Hopkins University Student Health Services and are therefore not subject to the referral requirements and penalties.
PRE-CERTIFICATION REQUIREMENTS

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 (800) 558-8845 (attention: Managed Care Department).

- **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.
- **If you do not secure pre-certification** for partial hospitalizations, outpatient treatment of mental and nervous disorders and substance abuse, or home health care services, your **Covered Medical Expenses** will be subject to a **$200** Deductible.

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

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

**PRE-CERTIFICATION DOES NOT GUARANTEE THE PAYMENT OF BENEFITS FOR YOUR INPATIENT ADMISSION**

Each claim is subject to Medical Policy Review, in accordance with the exclusions and limitations contained in the Policy, as well as a review of eligibility, adherence to notification guidelines, and benefit coverage under the Student Accident and Sickness Plan.

**PRE-CERTIFICATION OF NON-EMERGENCY INPATIENT ADMISSIONS, PARTIAL HOSPITALIZATION, IDENTIFIED OUTPATIENT SERVICES AND HOME HEALTH SERVICES**

The patient, physician or hospital must telephone at least **three business days** prior to the planned admission or prior to the date the services are scheduled to begin.

**NOTIFICATION OF EMERGENCY ADMISSIONS**

The patient, patient’s representative, physician or hospital must telephone within **one business day** following inpatient (or partial hospitalization) admission.

**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 sought or received medical advice, treatment or services for that injury or disease or you took prescription drugs or medicines for that injury or disease during the **180 days** prior to your first day of coverage, that injury or disease will be considered a pre-existing condition.

**LIMITATION**

Pre-existing conditions are not covered during the first **365 days** that you are covered under this Plan. However, there is an important exception to this general rule if you have been Continuously Insured. This pre-existing limitation does not apply to Covered Persons under age 19.
CONTINUOUSLY INSURED
You have been continuously insured if you (i) had “creditable health insurance coverage” (such as COBRA, HMO, another group or individual policy, Medicare or Medicaid) prior to enrolling in this Plan; and (ii) the creditable coverage ended within 63 days of the date you enrolled under this Plan. If both of these tests are met, then the pre-existing limitation period under this Plan will be reduced (and possibly eliminated altogether) by the number of days of your prior creditable coverage. You will be asked to provide evidence of your prior creditable coverage.

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

Pre-existing condition will not apply to a pregnancy or insureds under the age of 19.

DESCRIPTION OF BENEFITS

Please Note:

THE JOHNS HOPKINS UNIVERSITY 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 Johns Hopkins University Plan Brochure carefully before deciding whether this Plan is right for you. While this document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. If you want to look at the full Plan description, which is contained in the Master Policy issued to Johns Hopkins University, you may view it at Health Center or you may contact Aetna Student Health at (800) 558-8845.

This Plan will never pay more than $1,000,000 Per Condition per Policy Year Additional Plan maximums may also apply. Some illnesses may cost more to treat and health care providers may bill you for what the Plan does not cover.

Subject to the terms of the Policy, benefits are available for you and your eligible dependents only for the coverages listed below, and only up to the maximum amounts shown. Please refer to the Certificate of Coverage for a complete description of the benefits available.

All insurance coverage is subject to the terms of the Master Policy and applicable state filings. Under health care reform legislation, student health plans may be required to eliminate or modify certain existing benefit plan provisions, including, but not limited to, exclusions and limitations. Aetna reserves the right to modify its products and services in response to federal and/or state legislation, regulation or requests of government authorities.
*Benefit descriptions have been added to this brochure to help illustrate new Health Care Reform (HCR) requirements. HCR requirements are currently being filed for support in individual states and will appear in policy contracts and certificates of coverage once approved.

**SUMMARY OF BENEFITS CHART**

<table>
<thead>
<tr>
<th>DEDUCTIBLES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The following Deductibles are applied before <strong>Covered Medical Expenses</strong> are payable:</td>
<td></td>
</tr>
<tr>
<td>Students: $250 per Policy Year, reduced to $75 with a referral from The Health Center.</td>
<td>Spouse: $250 Per Policy Year</td>
</tr>
<tr>
<td>Child: $250 Per Policy Year</td>
<td>Family: $500 Per Policy Year</td>
</tr>
</tbody>
</table>

**Waiver of Annual Deductible**

In compliance with Federal Health Care Reform legislation, the Annual Deductible is waived for Preferred Care **Covered Medical Expenses** (refer to specific benefit types for list of services) rendered as part of the following benefit types: Routine Physical Exam Expense (Office Visits), Pap Smear Screening Expense, Mammogram Expense, Routine Screening for Sexually Transmitted Disease Expense, Routine Colorectal Cancer Screening, Routine Prostate Cancer Screening Expense, Well Woman Preventive Visits (Office Visits), Screening & Counseling Services (Office Visits), Routine Cancer Screenings (Outpatient), Prenatal Care (Office Visits), Comprehensive Lactation Support and Counseling Services (Facility or Office Visits), Breast Pumps & Supplies, Family Contraceptive Counseling Services (Office Visits), Female Voluntary Sterilization (Inpatient and Outpatient).

**COINSURANCE**

**Covered Medical Expenses** are payable at the coinsurance percentage specified below, after any applicable Deductible, up to a maximum benefit of $1,000,000 per Condition per Policy Year.

**OUT OF POCKET MAXIMUMS**

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. Copays, Deductibles and Co-insurance all apply towards satisfying the Out-of-Pocket Maximum.

| Preferred Care Individual Out-of-Pocket: | $5,250 |
| Preferred Care Family Out-of-Pocket: | $4,500 if involved in same accident |
| Non-Preferred Care Individual Out-of-Pocket: | $7,750 |
| Non-Preferred Care Family Out-of-Pocket: | $4,500 if involved in same accident |

**Combined Out-of-Pocket Limit:** $13,000
All coverage is based on Recognized Charges unless otherwise specified.

<table>
<thead>
<tr>
<th>Inpatient Hospitalization Benefits</th>
<th>Covered Medical Expenses are payable as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and Board Expense</td>
<td>Preferred Care: 80% of the Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: 64% of the Recognized Charge for a semi-private room.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intensive Care Room and Board Expense</th>
<th>Covered Medical Expenses are payable as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Preferred Care: 80% of the Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: 64% of the Recognized Charge for the Intensive Care Room Rate for an overnight stay.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Miscellaneous Hospital Expense</th>
<th>Covered Medical Expenses include, but are not limited to: laboratory tests, x-rays, surgical dressings, anesthesia, supplies and equipment use, and medicines.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Benefits are payable as follows:</td>
</tr>
<tr>
<td></td>
<td>Preferred Care: 80% of the Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: 64% of the Recognized Charge.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-Surgical Physicians Expense</th>
<th>Covered Medical Expenses for charges for the non-surgical services of the attending Physician, or a consulting Physician, are payable as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Preferred Care: 80% of the Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: 64% of the Recognized Charge.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Surgical Expense - Inpatient</th>
<th>Covered Medical Expenses for charges for surgical services, performed by a Physician, are payable as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Expense</td>
<td>Preferred Care: 80% of the Negotiated Charge.</td>
</tr>
<tr>
<td>Anesthesia Expense</td>
<td>Non-Preferred Care: 64% of the Recognized Charge.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assistant Surgeon Expense</th>
<th>Covered Medical Expenses for the charges of an assistant surgeon, during a surgical procedure, are payable as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Preferred Care: 80% of the Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: 64% of the Recognized Charge.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Surgical Expense - Outpatient</th>
<th>Covered Medical Expenses for charges for surgical services, performed by a Physician, are payable as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Expense</td>
<td>Preferred Care: 80% of the Negotiated Charge.</td>
</tr>
<tr>
<td>Anesthesia Expense</td>
<td>Non-Preferred Care: 64% of the Recognized Charge.</td>
</tr>
</tbody>
</table>
| Assistant Surgeon Expense | **Covered Medical Expenses** for the charges of an assistant surgeon, during a surgical procedure, are payable as follows:

    Preferred Care: 80% of the Negotiated Charge.
    Non-Preferred Care: 64% 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: 80% of the Negotiated Charge.
    Non-Preferred Care: 64% of the Recognized Charge

    **Covered Medical Expenses** must be incurred on the day of the surgery or within 48 hours after the surgery. |

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

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

    Preferred Care: 80% of the Negotiated Charge
    Non-Preferred Care: 64% of the Recognized Charge. |

| Walk-in Clinic Visit Expense | **Covered Medical Expenses** include services rendered in a walk-in clinic.

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

    Preferred Care: 80% of the Negotiated Charge
    Non-Preferred Care: 64% of the Recognized Charge. |

| Emergency Room Expense | **Covered Medical Expenses** incurred for treatment of an Emergency Medical Condition are payable as follows:

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

    No referral required. When a student presents to the Emergency Room the Deductible is automatically reduced to **$75** for the ER charges only (facility, doctor. and ancillary charges). However, follow-up care should be co-coordinated through the Health Services, if a referral is not received for the follow-up care then the student will have to meet the balance of the **$250** Deductible. |

**Important Note**

Please note that as **Non-Preferred Care Providers** do not have a contract with **Aetna**, the provider may not accept payment of your cost share (your deductible and coinsurance) as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. Please send **Aetna** the bill at the address listed on the back of your member ID card and **Aetna** will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.
<table>
<thead>
<tr>
<th>Expense Type</th>
<th>Description</th>
</tr>
</thead>
</table>
| 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: 80% of the Negotiated Charge.  
Non-Preferred Care: 64% of the Recognized Charge. |
| Ambulance Expense           | **Covered Medical Expenses** are payable as follows: 80% of the Actual Charge for the services of a professional ambulance to or from a hospital, when required due to the emergency nature of a covered Accident or Sickness. |
| Pre-Admission Testing Expense | **Covered Medical Expenses** for Pre-Admission testing charges while an outpatient before scheduled surgery are payable on the same basis as any other Sickness. |
| Physician’s Office Visit Expense | **Covered Medical Expenses** are payable as follows:  
Preferred Care: 80% of the Negotiated Charge  
Non-Preferred Care: 64% of the Recognized Charge.  
This benefit includes visits to specialists. |
| Laboratory and X-ray Visit Expense | **Covered Medical Expenses** are payable as follows:  
Preferred Care: 80% of the Negotiated Charge.  
Non-Preferred Care: 64% of the Recognized Charge. |
| High Cost Procedures Expense | **Covered Medical Expenses** include charges incurred by a covered person for High Cost Procedures that are required as a result of injury or sickness. Expenses for High Cost Procedures; which must be provided on an outpatient basis; may be incurred in the following:  

a) A physician’s office; or  
b) Hospital outpatient department; or emergency room; or  
c) Clinical laboratory; or  
d) Radiological facility; or other similar facility; licensed by the applicable state; or the state in which the facility is located.  

**Covered Medical Expenses** for High Cost Procedures include charges for the following procedures and services:  
a) C.A.T. Scan;  
b) Magnetic Resonance Imaging; and  
c) Contrast Materials for these tests.  
Preferred Care: 80% of the Negotiated Charge.  
Non-Preferred Care: 64% of the Recognized Charge. |
| **Therapy Expense** | **Covered Medical Expenses** include charges incurred by a **covered person** for the following types of therapy provided on an outpatient basis:  
- Physical Therapy,  
- Chiropractic Care,  
- Speech Therapy,  
- Inhalation Therapy, or  
- Occupational Therapy.  

Expenses for Chiropractic Care are **Covered Medical Expenses**, if such care is related to neuromusculoskeletal conditions and conditions arising from: the lack of normal nerve, muscle, and/or joint function.  

Expenses for Speech and Occupational Therapies are **Covered Medical Expenses**, only if such therapies are a result of **injury** or **sickness**.  

**Covered Medical Expenses** are payable as follows:
- **Preferred Care**: 80% of the Negotiated Charge.
- **Non-Preferred Care**: 64% of the Recognized Charges.

**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**: 80% of the Negotiated Charge.
- **Non-Preferred Care**: 64% of the Recognized Charges.  

Coverage for orally administered anticancer medications, prescribed by a prescribing practitioner, and used to kill or slow the growth of cancerous cells, are payable on the same basis as intravenously administered anticancer medications.  

| **Durable Medical and Surgical Equipment Expense** | **Covered Medical Expenses** are payable as follows:
- **Preferred Care**: 80% of the Negotiated Charge.  
- **Non-Preferred Care**: 80% of the Recognized Charge.  

**Breast Feeding Durable Medical Equipment**  
Coverage includes the rental or purchase of breast feeding **durable medical equipment** for the purpose of lactation support (pumping and storage of breast milk) as follows.  

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

**Breast Pump**  
**Covered expenses** include the following:  
- The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a **hospital**.  
- The purchase of:  
  - an electric breast pump (non-hospital grade), if requested within 30 days from the date of the birth of the child. A purchase will be covered once every five years following the date of the birth; or  
  - a manual breast pump, if requested within 6-12 months from the date of the birth of the child. A purchase will be covered once every five years following the date of the birth.  

| **Breast Pump**  
**Covered expenses** include the following:  
- The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a **hospital**.  
- The purchase of:  
  - an electric breast pump (non-hospital grade), if requested within 30 days from the date of the birth of the child. A purchase will be covered once every five years following the date of the birth; or  
  - a manual breast pump, if requested within 6-12 months from the date of the birth of the child. A purchase will be covered once every five years following the date of the birth.  

| **Breast Pump**  
**Covered expenses** include the following:  
- The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a **hospital**.  
- The purchase of:  
  - an electric breast pump (non-hospital grade), if requested within 30 days from the date of the birth of the child. A purchase will be covered once every five years following the date of the birth; or  
  - a manual breast pump, if requested within 6-12 months from the date of the birth of the child. A purchase will be covered once every five years following the date of the birth.
<table>
<thead>
<tr>
<th><strong>Durable Medical and Surgical Equipment Expense (continued)</strong></th>
<th>- If an electric breast pump was purchased within the previous one period, the purchase of an electric or manual breast pump will not be covered until a five year period has elapsed from the last purchase of an electric pump.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breast Pump Supplies</strong></td>
<td>Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.</td>
</tr>
<tr>
<td></td>
<td>Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. The covered person is responsible for the entire cost of any additional pieces of the same or similar equipment that he or she purchases or rents for personal convenience or mobility.</td>
</tr>
<tr>
<td></td>
<td><strong>Aetna</strong> reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of <strong>Aetna</strong>.</td>
</tr>
<tr>
<td><strong>Limitations:</strong></td>
<td>Unless specified above, not covered under this benefit are charges incurred for:</td>
</tr>
<tr>
<td></td>
<td>- Services which are covered to any extent under any other part of this Plan; and</td>
</tr>
<tr>
<td></td>
<td>- Services and supplies furnished by a <strong>Non-Preferred Care Provider</strong>.</td>
</tr>
<tr>
<td><strong>Prosthetic Devices Expense</strong></td>
<td><strong>Covered Medical Expenses</strong> include charges for: artificial limbs, or eyes, and other non-dental prosthetic devices, as a result of an accident or sickness, wigs required as a result of chemo or radiation therapy.</td>
</tr>
<tr>
<td></td>
<td><strong>Covered Medical Expenses</strong> do <strong>not</strong> include: eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet.</td>
</tr>
<tr>
<td></td>
<td>Benefits are payable as follows:</td>
</tr>
<tr>
<td></td>
<td><strong>Preferred Care</strong>: 80% of the Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td><strong>Non-Preferred Care</strong>: 80% of the Recognized Charge.</td>
</tr>
<tr>
<td><strong>Physical Therapy Expense</strong></td>
<td><strong>Covered Medical Expenses</strong> for physical therapy are payable as follows when provided by a licensed physical therapist:</td>
</tr>
<tr>
<td></td>
<td><strong>Preferred Care</strong>: 80% of the Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td><strong>Non-Preferred Care</strong>: 64% of the Recognized Charge.</td>
</tr>
<tr>
<td><strong>Dental Injury Expense</strong></td>
<td><strong>Covered</strong> Medical Expenses include dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition:</td>
</tr>
<tr>
<td></td>
<td>- Natural teeth damaged, lost, or removed, or</td>
</tr>
<tr>
<td></td>
<td>- 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.</td>
</tr>
<tr>
<td></td>
<td>- Non-surgical treatment of infections or diseases. This does not include those of, or related to, the teeth.</td>
</tr>
<tr>
<td></td>
<td>Any such teeth must have been:</td>
</tr>
<tr>
<td></td>
<td>- Free from decay, or</td>
</tr>
<tr>
<td></td>
<td>- In good repair, and</td>
</tr>
<tr>
<td></td>
<td>- Firmly attached to the jawbone at the time of the injury.</td>
</tr>
<tr>
<td></td>
<td>The treatment must be done in the calendar year of the accident or the next one.</td>
</tr>
</tbody>
</table>
### Dental Injury Expense (continued)

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.

**Covered Medical Expenses** are payable as follows:
- 80% of the Actual Charge.

### Allergy Testing and Treatment Expense

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

Covered dependents are not required to obtain a referral to be eligible for this benefit.

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

**Covered Medical Expenses** are payable as follows:
- Preferred Care: 80% of the Negotiated Charge.
- Non-Preferred Care: 64% of the Recognized Charges.

### Diagnostic Testing For Learning Disabilities Expense

**Covered Medical Expenses** for diagnostic testing for:
- attention deficit disorder
- attention deficit hyperactive disorder

are payable as follows:

- Preferred Care: 80% of the Negotiated Charge
- Non-Preferred Care: 64% of the Recognized Charge.

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

- Routine vision and hearing screenings given as part of the routine physical exam.
- X-rays, lab, and other tests given in connection with the exam, and
- Materials for the administration of immunizations for infectious disease and testing for tuberculosis.

Benefits for materials for the administration of immunizations are covered 100% for preferred and 84% for non-preferred.

Preferred Care: 100% of the Negotiated Charge
Non-Preferred Care: 84% of the Recognized Charge

In addition to any state regulations or guidelines regarding mandated Routine Physical Exam services, **Covered Medical Expenses** include services rendered in conjunction with,

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- For females, screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services, such as:
    - Interpersonal and domestic violence;
    - Sexually transmitted diseases; and
    - Human Immune Deficiency Virus (HIV) infections.
  - Screening for gestational diabetes.
  - High risk Human Papillomavirus (HPV) DNA testing for women age 18 and older and limited to once every three years.

- X-rays, lab and other tests given in connection with the exam.
- Immunizations for infectious diseases and the materials for administration of immunizations that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- If the plan includes dependent coverage, for covered newborns, an initial hospital check up.

For a **child** who is a covered dependent:

- The physical exam must **include at least:**
  - A review and written record of the patient’s complete medical history,
  - A check of all body systems, and
  - A review and discussion of the exam results with the patient or with the parent or guardian.

- For all exams given to a covered dependent from **age 2 up to age 6**, **Covered Medical Expenses** will **not include** charges for **more than** one exam in 12 months in a row.

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

- One exam in 12 months in a row.

Also included as **Covered Medical Expenses** are charges made by a physician for one annual routine gynecological exam.
## Routine Physical Exam Expense (continued)

### Screening and Counseling Services

**Covered Medical Expenses** include charges made by a **physician** in an individual or group setting for the following are covered at 100% of the Negotiated Charge when services are provided by a **Preferred Care Provider**:

**Obesity**

Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:

- Preventive counseling visits and/or risk factor reduction intervention;
- Medical nutrition therapy;
- Nutritional counseling; and
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

**Misuse of Alcohol and/or Drugs**

Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.

**Use of Tobacco Products**

Screening and counseling services to aid a covered person to stop the use of tobacco products.

Coverage includes:

- Preventive counseling visits;
- Treatment visits; and
- Class visits;
  - to aid a covered person to stop the use of tobacco products.

Tobacco product means a substance containing tobacco or nicotine including:

- cigarettes;
- cigars;
- smoking tobacco;
- snuff;
- smokeless tobacco; and
- candy-like products that contain tobacco.

### Limitations

Unless specified above, not covered under this Screening and Counseling Services benefit are charges incurred for:

- Services which are covered to any extent under any other part of this Plan; and
- Services and supplies furnished by a **Non-Preferred Care Provider**.

## Preventive Health Care Service Expense

**Covered Medical Expenses** include the charges described below for child wellness services, even though they are not incurred in connection with an **injury** or **disease**.

“Child wellness services” means preventive activities designed to protect children from morbidity and mortality and promote child development.

- All visits for and costs of childhood and adolescent immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control,
- Visits for the collection of adequate samples, the first of which is to be collected before two weeks of age, for hereditary and metabolic newborn screening and follow-up between birth and 4 weeks of age,
- Universal hearing screening of newborns provided by a hospital before discharge,
Preventive Health Care Service Expense (continued)

• All visits for and costs of age-appropriate screening tests for tuberculosis, anemia, lead toxicity, hearing, and vision as determined by the American Academy of Pediatrics,
• A physical examination, developmental assessment, and parental anticipatory guidance services at each of the visits required above, and
• Any laboratory tests considered necessary by the physician, as indicated by the services provided above.
• All visits for obesity evaluation and management, and
• All visits and costs for developmental screening as recommended by the American Academy of Pediatrics.

Not covered as Preventive Health Care Services Expenses are charges incurred for the following:
• services which are for diagnosis or treatment of a suspected or identified injury or disease,
• services not performed by a physician or under his or her direct supervision,
• medicines, drugs, appliances, equipment or supplies,
• dental exams,
• pre-marital exams.

Covered Medical Expenses are payable as follows:
Preferred Care: 100% of the Negotiated Charge.
Non-Preferred Care: 84% of the Recognized Charge.

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.

Benefits for materials for the administration of immunizations are covered 100% for preferred and 84% for non-preferred.

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

Covered Medical Expenses are payable as follows:
Preferred Care: 100% of the Negotiated Charge. Benefits are payable for scheduled visits in accordance with the prevailing clinical standards of the American Academy of Pediatrics.
Non-Preferred Care: 84% 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 19, for the materials for the administration of appropriate and medically necessary immunizations, when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics.

Preferred Care: 100% of the Negotiated Charge.
Non-Preferred Care: 84% of the Recognized Charge.
### Consultant Expense

**Covered Medical Expenses** include the expenses for the services of a consultant. The services must be requested by the attending physician for the purpose of confirming or determining a diagnosis.

**Covered Medical Expenses** are covered as follows:
- **Preferred Care:** 80% of the Negotiated Charge.
- **Non-Preferred Care:** 64% of the Recognized charge.

### Treatment Of Mental And Nervous Disorders Expense - General

<table>
<thead>
<tr>
<th>Expense</th>
<th><strong>Covered Medical Expenses</strong> for the diagnosis and inpatient treatment of mental illnesses and emotional disorders are payable on the same basis as any other sickness.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient</strong></td>
<td><strong>Covered Medical Expenses</strong> 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.</td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td><strong>Covered Medical Expenses</strong> for the diagnosis and treatment of biologically based mental illnesses and emotional disorders are payable as follows:</td>
</tr>
</tbody>
</table>
|                  | **Preferred Care:** 80% of the Negotiated Charge.  
                  | **Non-Preferred Care:** 65% of the Recognized charge.  
                  | Diagnostic Psychological and Neurological Testing is included. |

### Alcoholism And Drug Addiction Treatment Expense

<table>
<thead>
<tr>
<th>Expense</th>
<th><strong>Covered Medical Expenses</strong> 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><strong>Inpatient</strong></td>
<td><strong>Covered Medical Expenses</strong> 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.</td>
</tr>
<tr>
<td></td>
<td>Benefits include 60 days of partial hospitalization.</td>
</tr>
</tbody>
</table>
|                  | **Preferred Care:** 80% of the Negotiated Charge.  
                  | **Non-Preferred Care:** 64% of the Recognized Charge. |
**Outpatient Expense**

*Covered Medical Expenses* for outpatient treatment of a substance abuse condition are payable on the same basis as any other sickness.

Covered Medical Expenses include methadone treatment. The copayment for methadone maintenance treatment cannot be greater than 50% of the daily cost.

Benefits include Diagnostic Psychological and Neurological testing.

*Preferred Care: 100% of the Negotiated Charge for first 30 visits, thereafter 50%.*
*Non-Preferred Care: 100% of the Recognized charge for first 30 visits, thereafter 50%.*

## Maternity Benefits

**Maternity Expense**

*Covered Medical Expenses* are payable for pregnancy, complications of pregnancy, childbirth and other pregnancy-related expenses.

In the event of an inpatient confinement, such benefits will be payable for inpatient care of the covered person and any newborn child for: a minimum of 48 hours after an uncomplicated vaginal delivery, and a minimum of 96 hours after an uncomplicated cesarean delivery.

If after childbirth, the covered person is required for medical reasons to remain confined as an inpatient, and requests that the newborn remain confined, *Covered Medical Expenses* for the newborn will be payable up to a maximum of 4 additional inpatient confinement days.

Benefits are payable on the same basis as any other Sickness.

Upon discharge, benefits will be payable for 1 post-delivery home visit by a health care provider, if the visit is prescribed by the attending physician. If a person is discharged earlier, benefits will be payable for 1 post-delivery home visit by a health care provider within 24 hours of the discharge and, if prescribed by the attending physician, 1 additional home visit. Charges for such visits will be paid at 100% and will not be subject to any deductible.

**Prenatal Care**

Prenatal care will be covered at 100% of the Negotiated Charge* for services received by a pregnant female in a physician’s, obstetrician’s, or gynecologist’s office but only to the extent described below.

Coverage for prenatal care under this benefit is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).

**Comprehensive Lactation Support and Counseling Services**

*Covered Medical Expenses* will be covered at 100% of the Negotiated Charge* and include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy and in the postpartum period by a certified lactation support provider. The “postpartum period” means the 60 day period directly following the child’s date of birth. *Covered expenses* incurred during the postpartum period also include the rental or purchase of breast feeding equipment as described below.

Lactation support and lactation counseling services are *covered expenses* when provided in either a group or individual setting.

*100% of the Negotiated Charge refers to Preferred Care only. Non-Preferred Care will be covered as any other Sickness.*
Well Newborn Nursery Care Expense

Benefits include charges for routine care of a covered person’s newborn child as follows:

- hospital charges for routine nursery care during the mother’s confinement, but for not more than four days [for a normal delivery],
- physician’s charges for circumcision, and
- physician’s charges for visits to the newborn child in the hospital and consultations, but for not more than 1 visit per day.

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

- **Preferred Care**: 80% of the Negotiated Charge.
- **Non-Preferred Care**: 64% of the Recognized Charge.

<table>
<thead>
<tr>
<th>Additional Benefits</th>
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<td>Prescribed Medicines Expense</td>
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<tr>
<td>Prescription Drug Benefits are payable as follows:</td>
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<tr>
<td><strong>Preferred Care Pharmacy</strong>: 100% of the Negotiated Charge, following a $25 Copay for each Brand Name Prescription Drug or a $15 Copay for each Generic Prescription Drug.</td>
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A benefit will be paid at the Preferred level of coverage for a prescription drug dispensed by a Non-Preferred pharmacy only:

- For an Emergency Condition, or
- On Referral of a person’s Primary Care Physician.

**Non-Preferred Care Pharmacy**: 100% of the Recognized Charges, following a $25 Deductible for each Brand Name Prescription or a $15 Deductible for each Generic Prescription Drug. You must pay out-of-pocket for prescriptions at a Non-Preferred pharmacy and then submit the receipt with a Prescription Claim Form for reimbursement.

This pharmacy benefit is provided to cover medically necessary prescriptions associated with a covered sickness or accident occurring during the Policy Year. Please use your Aetna Student Health ID card when obtaining your prescriptions.

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

**Covered Medical Expenses** include prescription drugs approved by the FDA as an aid for the cessation of the use of tobacco products and 2 90-day courses of nicotine replacement therapy per year.

**Please Note**: Covered Medical Expenses for prescribed supplies for the treatment of diabetes will not be subject to the listed per Policy Year Prescription Drug limit.
Diabetic Equipment and Self-Management Education Expense

**Covered Medical Expenses** include charges incurred by a covered person for diabetes equipment, supplies and outpatient self-management training and educational services, including nutrition therapy, that the covered person's attending physician, or other appropriately licensed health care provider, or a physician that specializes in the treatment of diabetes, certifies as necessary for the treatment of:

- Insulin-using diabetes;
- Non-insulin-using diabetes; or
- Elevated blood glucose levels induced by pregnancy.

Diabetic self-management training and educational services, including medical nutrition, must be provided through a program supervised by an appropriately licensed, registered or certified health care provider, whose scope of practice includes diabetes education or management.

Diabetic Equipment and Self-Management Education Expenses are payable as follows:
- Preferred Care: 80% of the Negotiated Charge.
- Non-Preferred Care: 64% of the Recognized Charge.

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Hypodermic Needles Expense

**Covered Medical Expenses** include expenses incurred by a covered person for hypodermic needles and syringes used in the treatment of diabetes.

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

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Non-Prescription Enteral Formula Expense

**Covered Medical Expenses** include charges incurred by a covered person for non-prescription enteral formulas for which a physician has issued a written order, and are for the treatment of malabsorption caused by the following, to the extent not provided under another part of this Policy:

- 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.

**Coverage** for this benefit is obtained by paying for the formula out-of-pocket and submitting the receipt and documentation that the formula was prescribed by a PCP (or as a result of a PCP authorized referral to a specialist) for reimbursement.

Please contact: **Aetna Pharmacy Management 888 RX-AETNA** (Available 24 hours) for more information on Aetna’s Prescription Drug Claim Forms and Procedures.

Benefits are payable as follows:
-Preferred Care: 80% of the Negotiated Charge.
-Non-Preferred Care: 64% of the Recognized Charge.

Benefits are limited to a maximum of $200 per Policy Year.
| Medical Foods and Modified Food Products | **Covered Medical Expenses** include charges incurred by a **covered person** for medical foods and low protein modified food products for the treatment of inherited metabolic disease when authorized by, and administered under the direction of, a **physician**. Benefits are payable as follows:  
Preferred Care: 80% of the Negotiated Charge.  
Non-Preferred Care: 64% of the Recognized Charges. |
|---|---|
| Outpatient Contraceptive Drugs And Devices And Outpatient Contraceptive Services Expense | **Covered Medical Expenses** for contraceptive drugs and outpatient services include:  
• Charges incurred for contraceptive drugs and devices that by law need a **physician’s prescription** and that have been approved by the FDA.  
• Related outpatient contraceptive services such as:  
  - Consultations,  
  - Exams,  
  - Procedures, and  
  - Other medical services and supplies.  
Expenses for contraceptive devices and outpatient contraceptive services are payable as follows:  
Preferred Care: 100% of the Negotiated Charge.  
Non-Preferred Care: 84% of the Recognized Charges.  
A referral is not required for this benefit. |
| Pap Smear Screening Expense | **Covered Medical Expenses** include one annual routine pap smear screening for women age 18 and older, including FDA approved screening tests for Human Papilloma Virus at the testing intervals outlined in the recommendations for cervical cytology screening by the American College of Obstetricians and Gynecologists.  
**Covered Medical Expenses** are payable as follows:  
Preferred Care: 100% of the Negotiated Charge.  
Non-Preferred Care: 100% of the Recognized Charge. |
| Mammogram Expense | **Covered Medical Expenses** include the following:  
• A baseline mammogram for women between the ages of 35 to 39, and  
• A mammogram every two years, or more frequently based on the recommendation of the women’s physician for women ages 40 to 49,  
• A mammogram on an annual basis for women 50 years of age and older.  
Mammogram screenings coverage must also include comprehensive ultrasound screening for the entire breast or breasts if a mammogram demonstrates heterogenous or dense breast tissue and when determined to be medically necessary by a licensed physician.  
**Covered Medical Expenses** are payable as follows:  
Preferred Care: 100% of the Negotiated Charge.  
Non-Preferred Care: 100% of the Recognized Charge. |
| Reconstructive Breast Surgery Expense | **Covered Medical Expenses** include charges incurred for reconstructive breast surgery performed on a covered person including:  
- Reconstructive breast surgery, including coverage for all stages of reconstructive breast surgery performed on a nondiseased breast to establish symmetry with the diseased breast when reconstructive breast surgery is performed on the diseased breast; and  
- Physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.  
“Mastectomy” means the surgical removal of all or part of a breast.  
“Reconstructive breast surgery” means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts and includes augmentation mammoplasty, reduction mammoplasty and mastopexy.  
**Covered Medical Expenses** also include a prosthesis that has been prescribed by a physician for a covered person who has undergone a mastectomy and has not had a breast reconstruction.  
**Covered Medical Expenses** are payable as follows:  
Preferred Care: 80% of the Negotiated Charge.  
Non-Preferred Care: 64% of the Recognized Charge.  
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. |
| --- | --- |
| Mastectomy - Prosthetic Devices Expense | **Covered Medical Expenses** include a prosthes that has been prescribed by a physician for a covered person who has undergone a mastectomy and has not had a breast reconstruction.  
“Mastectomy” means the removal of all or part of a breast as a result of breast cancer.  
**Covered Medical Expenses** are payable on the same basis as any other Sickness. |
| Post-Hospitalization Mastectomy Expense | **Covered Medical Expenses** include the following minimum-length-of-stay coverage for anyone having a mastectomy or the surgical removal of a testicle on an outpatient or inpatient basis.  
If the hospital stay is less than 48 hours, or the surgery is done on an outpatient basis, benefits will include coverage for the following care:  
- Home visit within 24 hours of discharge, and  
- Additional home visit if prescribed by the patient’s attending physician.  
**Covered Medical Expenses** are payable as follows:  
Preferred Care: 80% of the Negotiated Charge.  
Non-Preferred Care: 64% of the Recognized Charges |
| Family Planning Expense | For females with reproductive capacity, **Covered Medical Expenses** include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this benefit must be approved by the Food and Drug Administration (FDA).

Coverage includes counseling services on contraceptive methods provided by a **physician**, obstetrician or gynecologist. Such counseling services are **Covered Medical Expenses** when provided in either a group or individual setting.

The following contraceptive methods are **covered expenses** under this benefit:

**Voluntary Sterilization**

**Covered expenses** include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.

**Covered expenses** under this **Preventive Care** benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.

**Contraceptives**

**Covered expenses** include charges made by a **physician** or **pharmacy** for:
- Female contraceptives that are **generic prescription drugs**. The prescription must be submitted to the pharmacist for processing. *This contraceptives benefit covers only generic prescription drugs.*
- Female contraceptive devices and related services and supplies that are generic prescription devices when prescribed in writing by a **physician**. *This contraceptives benefit covers only those devices that are generic prescription devices.*
- FDA-approved female over-the-counter contraceptive methods that are prescribed by your **physician**. The **prescription** must be submitted to the pharmacist for processing. These items are limited to one per day and a 30 day supply per **prescription**.

**Limitations**

Unless specified above, not covered under this benefit are charges for:
- Services which are covered to any extent under any other part of this Plan;
- Services and supplies incurred for an abortion;
- Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care;
- Services which are for the treatment of an identified **illness** or **injury**;
- Services that are not given by a **physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams;
- Any contraceptive methods that are only “reviewed” by the FDA and not “approved” by the FDA;
- Male contraceptive methods, sterilization procedures or devices;
- The reversal of voluntary sterilization procedures, including any related follow-up care; and
- Services and supplies furnished by a **Non-Preferred Care Provider**.

**Covered Medical Expenses** are payable as follows:
- **Preferred Care**: 100% of the Negotiated Charge.
- **Non-Preferred Care**: 84% of the Recognized Charge.

**Important note**: Brand-Name Prescription Drug or Devices will be covered at 100% of the Negotiated Charge, including waiver of Annual Deductible if a Generic Prescription Drug or Device is not available in the same therapeutic drug class or the prescriber specifies Dispense as Written.
| 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**: 84% of the Recognized Charge. |

| Routine Screening For Sexually Transmitted Disease Expense | Benefits include charges for covered persons who are at least 18 years old and who are sexually active for an annual routine screening for sexually transmitted diseases.

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

- **Preferred Care**: 80% of the Negotiated Charge.
- **Non-Preferred Care**: 64% of the Recognized Charge. |

| Colorectal Cancer Screening Expense | Even though not incurred in connection with a sickness or injury, benefits include charges for colorectal cancer examination and laboratory tests, for any nonsymptomatic person age 50 or more, or a symptomatic person under age 50, for the following:

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

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

- **Preferred Care**: 100% of the Negotiated Charge.
- **Non-Preferred Care**: 84% of the Recognized Charge. |

| Routine Prostate Cancer Screening Expense | **Covered Medical Expenses** include a medically recognized diagnostic examination, which will include a digital rectal exam and a prostate specific antigen (PSA) test, as follows:

- For men who are between 40 and 75 years of age,
- When used for the purpose of guiding patient management in monitoring response to prostate cancer treatment,
- When used for staging in determining the need for a bone scan in patients with prostate cancer, or
- When used for male patients who are at high risk for prostate cancer.

Benefits are payable as follows:

- **Preferred Care**: 100% of the Negotiated Charge.
- **Non-Preferred Care**: 84% of the Recognized Charge. |
Second Surgical Opinion Expense

**Covered Medical Expenses** include a second opinion consultation by a specialist on the need for 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 for Surgical Second Opinion Expense are covered as follows:
- **Preferred Care:** 100% of the Negotiated Charge.
- **Non-Preferred Care:** 100% of the Recognized Charge.

Acupuncture In Lieu Of Anesthesia Expense

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

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

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

- **Preferred Care:** 80% of the Negotiated Charge.
- **Non-Preferred Care:** 64% of the Recognized Charge.

Dermatological Expense

Benefits include charges for the diagnosis and treatment of skin disorders, excluding laboratory fees. Related laboratory expenses are covered under the Outpatient Expense Benefit.

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

*Covered Medical Expenses do not include or cosmetic treatment and procedures.*

Podiatric Expense

Benefits include charges for podiatric services, provided on an outpatient basis following an injury.

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

Expenses for routine foot care, such as trimming of corns, calluses, and nails, are **not Covered Medical Expenses**.

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

**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**: 80% of the Actual Charge.  
**Non-Preferred Care**: 80% of the Actual Charge.  
Benefits are limited to 100 visits per policy year.  

| **Transfusion or Dialysis of Blood Expense** | Benefits include charges for the transfusion or dialysis of blood, including the cost of: whole blood, blood components, and the administration thereof.  

**Covered Medical Expenses** are payable as follows:  
**Preferred Care**: 80% of the Actual Charge.  
**Non-Preferred Care**: 64% of the Actual Charge.  

| **Hospice Expense** | Benefits include charges for respite care provided for a terminally ill covered person during a hospice benefit period.  

**Covered Medical Expenses** are payable as follows:  
**Preferred Care**: 80% of the Negotiated Charge.  
**Non-Preferred Care**: 64% of the Recognized Charge.  

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

**Covered Expenses** for a Licensed Nurse are covered as follows:  
**Preferred Care**: 80% of the Negotiated Charge.  
**Non-Preferred Care**: 64% 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**: 80% of the Negotiated Charge for the semi-private room rate.
- **Non-Preferred Care**: 64% of the Recognized Charge for the semi-private room rate. |
| --- | --- |
| 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**: 80% of the Negotiated Charge for the rehabilitation facility’s daily room and board maximum for semi-private accommodations.
- **Non-Preferred Care**: 64% of the Recognized Charge for the rehabilitation facility’s daily room and board maximum for semi-private accommodations. |
| Alzheimer’s Disease Expense | **Covered Medical Expenses** include care for Alzheimer’s disease including nursing home care for intermediate and custodial levels of care.  

**Covered Medical Expenses** are payable as follows:
- **Preferred Care**: 80% of the Negotiated Charge.
- **Non-Preferred Care**: 64% of the Recognized Charge |
| Coverage for Bones of Face, Neck & Head Expense | **Covered Medical Expenses** include charges for a diagnostic or surgical procedure involving a bone or joint of the face, neck or head if, under accepted standards of the profession of the health care provider rendering the service, the procedure is medically necessary to treat a condition caused by a congenital deformity, disease or injury.  

**Note**: Intraoral prosthetic devices are not covered by this benefit.  

**Covered Medical Expenses** are payable as follows:
- **Preferred Care**: 80% of the Negotiated Charge.
- **Non-Preferred Care**: 64% of the Recognized Charge |
| Cleft Lip/Cleft Palate Treatment Expense | **Covered Medical Expenses** include inpatient and outpatient charges incurred for a congenital cleft lip or cleft palate or both. Such charges are included to the extent they would have been so included if incurred for treatment of a disease.  

Covered treatment means any of the services or supplies listed below given for the management of the birth defect known as cleft lip or cleft palate or both.

- Inpatient and outpatient orthodontics
- Oral surgery. This includes pre-operative and postoperative care performed by a physician.
- Otologic treatment.
- Audiological treatment
- Speech/language treatment  

**Covered Medical Expenses** are payable as follows:
- **Preferred Care**: 80% of the Negotiated Charge.
- **Non-Preferred Care**: 64% of the Recognized Charge. |
| Clinical Trial Costs Expense | **Covered Medical Expenses** include charges for medically necessary patient costs for participation in a clinical trial as a result of (a) treatment provided for a life-threatening condition, or (b) prevention, early detection and treatment studies on cancer, if:
  - The treatment is provided or the studies are being conducted in a Phase I, Phase II, Phase III or Phase IV clinical trial for cancer, or
  - The treatment is being provided in a Phase I, Phase II, Phase III or Phase IV clinical trial for any other life-threatening disease.
  
  **Please see definition on page 46 for more detailed information on Clinical Trials as intended for the purposes of this benefit.**
  
  Coverage includes costs incurred for drugs and devices that have been approved for sale by the FDA, whether or not the FDA has approved the drug or device for use in treating the patient’s particular condition, to the extent that the drug or device is not paid for by the manufacturer, distributor or provider of that drug or device.
  
  “Patient costs” means: the cost of a medically necessary health care service that is incurred as a result of the treatment being provided to the member for the purposes of the clinical trial. It does not include:
  - The cost of an investigational new drug or device,
  - The cost of non-health care services that a patient may be required to receive as a result of the treatment being provided for purposes of the clinical trial,
  - Costs associated with managing the research associated with the clinical trial, or
  - Costs that would not be covered under this Policy for non-investigational treatments.

| Habilitative Services Expense | **Covered Medical Expenses** include charges incurred for rehabilitative services provided to children from birth to age 19.

  “Rehabilitative Services” means services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child’s ability to function.

  “Congenital or genetic birth defect” means a defect existing at or from birth, including a hereditary defect, and includes, but is not limited to:
  - Autism or an autism spectrum disorder, and
  - Cerebral palsy.

  This Plan does not provide coverage for any rehabilitative services given through early intervention and school services.

  **Covered Medical Expenses** will be payable as follows:
  Preferred Care: 80% of the Negotiated Charge.
  Non-Preferred Care: 64% of the Recognized Charge

  There are no limits on the number of annual visits for physical, speech or occupational therapy services received in connection with this benefit. |
| Hair Prosthesis Expense | **Covered Medical Expenses** include charges for one hair prosthesis for loss of hair as a result of chemotherapy or radiation treatment for cancer. The hair prosthesis must be prescribed in writing by the attending oncologist.  

Benefits will be payable as follows:  
**Preferred Care:** 80% of the Negotiated Charge.  
**Non-Preferred Care:** 64% of the Recognized Charge. |
|---|---|
| Hearing Aid Expense | **Covered Medical Expenses** include charges for hearing aids for a child less than 18 years of age when prescribed, fitted and dispensed by a licensed audiologist. “Hearing aid” means:  
- a device that is (a) of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children, and (b) non-disposable.  
This benefit is limited to $1,400 for each hearing aid, for each impaired ear, every 36 months.  

Benefits will be payable as follows:  
**Preferred Care:** 80% of the Negotiated Charge.  
**Non-Preferred Care:** 64% of the Recognized Charge. |
| Outpatient In Vitro Fertilization Expense | Even though not incurred for treatment of a sickness or injury, **Covered Medical Expenses** will include expenses incurred:  
- by a female student, or  
- by the dependent wife of a male student,  
for outpatient in vitro fertilization procedures. They will be included on the same basis as for **sickness**, but only if all these tests are met:  

The procedures are performed while she is not confined in a hospital or any other facility as an inpatient.  
Her oocytes are fertilized with her husband’s sperm.  
She and her husband have a history of infertility. It must have lasted at least 2 years, or the infertility is associated with one or more of these conditions:  
- Endometriosis.  
- Exposure in utero to diethylstilbestrol, known as DES.  
- Blockage of one or both fallopian tubes.  
- Surgical removal of, one or both fallopian tubes, known as lateral or bilateral salpingectomy.  
- Abnormal male factors, including oligospermia, contributing to the infertility.  
- She has been unable to attain a successful pregnancy through any less costly treatments for which coverage is available under this plan.  
- The in vitro fertilization procedures are performed at a medical facility that:  
  - meets the guidelines for in vitro clinics set by the American College of Obstetricians and Gynecologists, or meets the American Family Fertility Society’s minimal standards for programs of in vitro fertilization.  
Not more than three (3) in vitro fertilization attempts per live birth are covered. |
| Treatment of Morbid Obesity Expense | **Covered Medical Expenses** include charges incurred by a **covered person** for the treatment of morbid obesity through gastric bypass surgery or other surgical method, that is:
- Recognized by the national institutes of health as effective for the long-term reversal of morbid obesity, and
- Consistent with the criteria approved by the national institutes of health.

“Morbid obesity” means: a body mass index that is:
- Greater than 40 kilograms per meter squared, or
- Equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

“Body mass index” means: a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Benefits will be payable as follows:
Preferred Care: **80%** of the Negotiated Charge.
Non-Preferred Care: **64%** of the Recognized Charges. |
| --- | --- |
| Mastectomy – Prosthetic Devices Expense | **Covered Medical Expenses** include a prothesis that has been prescribed by a physician for a covered person who had undergone a mastectomy and has not had a breast reconstruction.

“Mastectomy” means the removal of all or part of a breast as a result of breast cancer.

**Covered Medical Expenses** are payable on the same basis as any other condition. |
| --- | --- |
| Osteoporosis Prevention and Treatment Expense | **Covered Medical Expenses** include bone mass measurements for the prevention, diagnosis and treatment of osteoporosis when the bone mass measurement is prescribed by a physician for a qualified individual.

“Qualified individual” means:
- An estrogen deficient individual at clinical risk for osteoporosis,
- An individual with a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease,
- An individual receiving long-term glucocorticoid (steroid) therapy,
- An individual with primary hyperparathyroidism, or
- An individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

“Bone mass measurement” means: a radiologic or radioisotopic procedure or other scientifically proven technology performed on a qualified individual for the purpose of identifying bone mass or detecting bone loss.

Benefits will be payable as follows:
Preferred Care: **80%** of the Negotiated Charge.
Non-Preferred Care: **64%** of the Recognized Charges. |
| Covered Medical Expenses will include expenses incurred by a person for residential crisis services.

“Residential crisis services” means: intensive mental health and support services that are:

- Provided to a child or adult with a mental illness who is experiencing or is at risk of a psychiatric crisis that would impair their ability to function in the community,
- Designed to prevent psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, or shorten the length of the inpatient stay,
- Provided out of the individual’s residence on a short term basis in a community based residential setting, and
- Provided by entities that are licensed by the Department of Health and Mental Hygiene to provide residential crisis services.

Benefits will be payable as follows:

- Preferred Care: 80% of the Negotiated Charge.
- Non-Preferred Care: 64% of the Recognized Charges.

| Covered Medical Expenses include prosthetic devices, components of prosthetic devices, and the repair of prosthetic devices.

Benefits will be payable as follows:

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

| Covered Medical Expenses general anesthesia and associated hospital or ambulatory facility charges for dental care provided if the covered person is:

- 7 years of age or younger or is developmentally disabled.
- An individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition; and
- An individual for whom a superior result can be expected from dental care provided under general anesthesia; or
- An extremely uncooperative, fearful or uncommunicative child who is 17 years of age or younger with dental needs of such magnitude that treatment should not be delayed or deferred; and
- An individual for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth or other increased oral or dental morbidity.

Benefits will be payable as follows:

- Preferred Care: 80% of the Negotiated Charge.
- Non-Preferred Care: 64% of the Recognized Charges.
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. The member is responsible for the full cost of the discounted services. Please note that these programs are subject to change without notice. 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: Offers members and their families savings on hearing exams, hearing aids and other hearing services. Members can choose between two great offers at no additional premium cost, Hearing Care Solutions and HearPO®.

Aetna Natural Products and ServicesSM discount program: Access to savings on complementary health care products and services, including online consultations, not traditionally covered by their health benefits plan. All products and services are provided through the ChooseHealthy® program* and Vital Health Network (VHN).

*Athe ChooseHealthy program is made available through American Specialty Health Networks, Inc. (ASH Networks) and Healthyroads, Inc. subsidiaries of American Specialty Health Incorporated (ASH). ChooseHealthy is a federally registered trademark of ASH and used with permission herein.

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 Management discount program: Access to discounts on the CalorieKing® Program and products, eDiets® diet plans and products, Jenny® weight loss programs 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® discount: Zagat® offers a free 60-day Premium Membership to ZAGAT.com and a discount when you purchase a one-year, full-access ZAGAT.com Premium Membership. With your membership, you can access Zagat’s trusted Ratings & Reviews for restaurants worldwide, receive discounts on purchases from the online Zagat Survey Shop and access Zagat Ratings & Reviews on the go with ZAGAT.com from your mobile device.

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. For compounded medications, Aetna Specialty Pharmacy will coordinate getting your prescription to the compounding pharmacy that will be able to fill your prescription. For additional information please go to www.AetnaSpecialtyRx.com.

Quit Tobacco Cessation Program: Say good-bye to tobacco and hello to a healthier future! The one-year Quit Tobacco program is provided by Healthyroads, a leading provider of tobacco cessation programs. You’ll get personal attention from health professionals that can help find what works for you.
Beginning Right® Maternity Program: Make healthy choices for you and your baby. Learn what decisions are good ones for you and your baby. Our Beginning Right maternity program helps prepare you for the exciting changes pregnancy brings.

Vital Savings by Aetna® on Dental* is a dental discount program helping you [and your dependents] save – with one low annual fee. In most instances, savings range from 15-50 percent on services from general dentistry and cleanings to root canals, crowns, and orthodontia (braces) No claims to file. Enroll online at www.aetnastudenthealth.com.

$25 – Student only  
$44 Student + one dependent only  
$63 Student + 2 or more dependents only  
*Actual costs and savings vary by provider and geographic area.

The Vital Savings by Aetna® program (the “Program”) is not insurance. The Program does not meet the Minimum Creditable Coverage requirements in Massachusetts. It provides Members with access to discounted fees according to schedules negotiated by Aetna Life Insurance Company for the Vital Savings by Aetna discount program. The range of discounts provided under the Program will vary depending on the type of provider and type of service received. The Program does not make payments directly to the participating providers. Each Member must pay for all services or products but will receive a discount from the providers who have contracted with the Discount Medical Plan Organization to participate in the Program. Aetna may receive a percentage of the fee you pay to the discount vendor. Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, CT 06156, 1-888-BeVital, is the Discount Medical Plan Organization.

Aetna Dental® PPO
For all states except for Texas
Under our PPO insurance plan you may visit any licensed dentist. However you will generally save when you visit a participating provider. Enroll and search dentists online at www.aetnastudenthealth.com.

$447.00  Student only  
$453.89  Spouse only  
$516.27  Child(ren) only  
*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. Policy form numbers in Oklahoma include: GR-9 and/or GR-9N, GR-23, GR-29 and/or GR-29N.

With our Aetna Advantage™ Dental benefits and insurance plan, you select a primary care dentist (PCD) and have most of your preventive and restorative services covered by a copayment or reduced fee for each visit. Enroll online at www.aetnastudenthealth.com.

$220.00 Student only  
$705.00 Student and family  

Aetna Advantage™ Dental are underwritten by Aetna Dental Inc., Aetna Dental of California Inc., Aetna Health Inc. and/or Aetna Life Insurance Company, and in Texas by Aetna Dental Inc., and in Florida by Aetna Health Inc. and/or Aetna Life Insurance Company (Aetna). Each insurer has sole financial responsibility for its own products.

Aetna’s Informed Health® Line*
Call our toll-free number to talk to registered nurses. They can share information on a range of healthy topics*. The nurses can help you:

- Learn about medical procedures and treatment options.  
- Improve how you talk with your doctor and other health care providers.  
- Find out how to describe your symptoms better.  
- Ask the right questions.  
- Tell your doctor about your eating, exercise and lifestyle habits.
Call anytime. (United States only). Nurses are available 24-hours a day.
To reach a nurse, call **800 556-1555**.
TDD for hearing and speech-impaired people only: **800 270-2386**.
Or reach them through e-mail.
You can send an e-mail to **IHL2@aetna.com** for links to health information about your questions. Nurses reply within 24 hours. **Note:** Due to security reasons, the Informed Healthline will not open any attachments sent by e-mail.

Or 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.

* 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. Information is believed to be accurate as of the production date; however, it is subject to change.
** Not all topics may be 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**.

*Health programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health/dental care professional. The availability and terms of specific discount programs and wellness services are subject to change without notice. Not all programs are available in all states.*

Discount programs and other programs above provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Discount programs may be offered by vendors who are independent contractors and not employees or agents of Aetna. Aetna may receive a percentage of the fee you pay to the discount vendor. These services, programs or benefits may be offered by vendors who are independent contractors and not employees or agents of Chickering Claims Administrators, Inc., Aetna Life Insurance Company or their affiliates.
GENERAL PROVISIONS

STATE MANDATED BENEFITS
The Plan will pay benefits in accordance with any applicable Maryland State Insurance Law(s).

RECOVERY OF BENEFITS PAID
When a Covered Person’s injury appears to be someone else’s fault, benefits otherwise payable under this Plan for Covered Medical Expenses incurred as a result of that injury will not be paid unless the Covered Person or his/her legal representative agrees:

a) that Aetna shall have the right to recover such benefits to the extent they are for losses for which compensation is paid to the Covered Person by or on behalf of the person at fault. The amount that can be recovered for health care benefits will be reduced by the percentage of the total recovery payable by the Covered Person for attorney fees, not to exceed one third of the total recovery.

b) to allow Aetna a lien on such compensation and to hold such compensation in trust for Aetna, and
c) to execute and give to Aetna any instruments needed to secure the rights under (a) and (b).

Further, when Aetna has paid benefits to or on behalf of the injured Covered Person, Aetna will be subrogated to all rights or recovery that the Covered Person has against the person at fault. These subrogation rights will extend only to recovery of the amount Aetna has paid. The Covered Person must execute and deliver any instruments needed and do whatever else is necessary to secure those rights to Aetna. This provision does not apply to automobile reparations (No fault) insurance.

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 (excluding Personal Injury Protection/no-fault insurance), Workers’ Compensation, Medicare, or other coverage. The Plan pays in accordance with the rules set forth in the Policy.

EXTENSION OF BENEFITS
If Basic Sickness Expense, Supplemental Sickness Expense coverage for a covered person ends while he is totally disabled, benefits will continue to be available for expenses incurred for that person, only while the covered person continues to be totally disabled until the earlier of:

- the date the individual ceases to be totally disabled, or
- 12 months after the date coverage terminates.

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, until the earlier of:

- the date the individual is discharged from the hospital, or
- 12 months after the date coverage terminates.

TERMINATION OF INSURANCE
Benefits are payable under this Plan only for those Covered Medical 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 premium date coinciding with or next following 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, as applicable.

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 will not prejudice any claim beginning before the date coverage ends for a Covered Medical Expense.

**TERMINATION OF DEPENDENT COVERAGE**

Insurance for a covered student’s dependent will end when insurance for the covered student ends. Coverage will continue during scholastic vacations if the student was insured on the day before such vacation began. Before then, coverage will end:

a) For a child, on the last day of the Policy Period 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 Policy.
e) For a domestic partner, the earlier to occur of:
   - the date this Policy no longer allows coverage for domestic partners, and
   - on the premium due date 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) On the premium due date the date the dependent ceases to be in an eligible class.

Termination will not prejudice any claim beginning before the date coverage ends for a Covered Medical Expense.

**INCAPACITATED DEPENDENT CHILDREN**

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

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

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

a) the date specified under the provision entitled Termination of Dependent Coverage, or
b) the end of the term for which premium has been paid on or after the date the child is no longer incapacitated and dependent on the covered student for support.

**CONVERSION**

All persons covered under this Policy for at least 3 months whose coverage was not terminated for failure to pay the required premium or contribution have the right to convert to an individual policy when this student policy terminates. Covered persons have up to 45 days to apply for a converted policy. Please contact Aetna Student Health at (877) 437-6535 for more information.
EXCLUSIONS

This Policy does not cover nor provide benefits for:

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

2. Expense incurred for services normally provided without charge by the Policyholder’s Health Service; Infirmary or Hospital; or by health care providers employed by the Policyholder.

3. Expense incurred for eye refractions, vision therapy, radial keratotomy, eyeglasses, contact lenses (except when required after cataract surgery), or other vision or hearing aids, or prescriptions or examinations except as required for repair caused by a covered injury or as provided elsewhere in this plan.

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

5. Expense incurred for injury or sickness resulting from declared or undeclared war or any act thereof.

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 federal 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 which is not necessitated by a pathological change in the function or structure in any part of the body. 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, treatment for learning disabilities, temporomandibular joint dysfunction (TMJ), immunizations unless otherwise covered under the Policy, and vaccines unless otherwise covered under the Policy.

10. Expense incurred for cosmetic surgery, reconstructive surgery, or other services and supplies which improve, alter, or enhance appearance whether or not for psychological or emotional reasons, except to the extent needed to: (a) 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. (b) Repair an injury (including reconstructive surgery or a prosthetic device for a covered person who has undergone a mastectomy) which occurs while the covered person is covered under this Policy. Surgery must be performed in the calendar year of the accident which causes the injury or in the next calendar year.

11. Expense incurred as a result of preventive medicines; serums or vaccines, except as otherwise provided by this Policy.

12. Expense incurred for voluntary or elective abortions, unless otherwise provided in this Policy.

13. Expense incurred after the date insurance terminates for a covered person except as may be specifically provided in the Extension of Benefits provision of this Booklet-Certificate.

14. Expense incurred for services normally provided without charge by the school and covered by the school fee for services.
15. Expense incurred for any services rendered by a member of the covered person’s immediate family or a person who lives in the covered person’s home. “Immediate family” means the parents, children and siblings of the covered person, and corresponding in-laws.

16. Expenses for charges for or related to artificial insemination, elective sterilization or its reversal or elective abortion unless specifically provided for in this Policy.

17. Expense incurred for which no member of the covered person’s immediate family has any legal obligation for payment. However, this does not exclude charges made by hospitals and other institutions of the Maryland state or local governments.

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

19. Expenses incurred for gynecomastia (male breasts), except for reconstructive breast surgery, including coverage for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with the diseased breast when reconstructive surgery is performed on the diseased breast.

20. Expense incurred for acupuncture, except as otherwise specifically provided under this policy.

21. Expenses incurred for hearing exams not performed in conjunction with a routine physical exam, except as otherwise specifically covered under this policy.

22. 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.

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

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

25. Expense for services or supplies provided for the treatment of obesity and/or weight control, except as otherwise provided in this Policy.

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

27. Expenses incurred for massage therapy.

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

29. Expenses 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.

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

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

32. 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: (a) There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or (b) If required by the FDA, approval has not been granted for marketing; or (c) A recognized national medical or dental society or regulatory agency has determined in writing that it is experimental, investigational, or for research purposes; or (d) The written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment, states that it is experimental, investigational, or for research purposes. However, this exclusion will not apply with respect to (a) patient costs (as described elsewhere in this Policy) incurred by a covered person for participating in a clinical trial; and (b) Services or supplies (other than drugs) received in connection with a disease if Aetna determines that: (a) The disease can be expected to cause death within one year in the absence of effective treatment; and (b) The care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination, Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved. Also, this exclusion will not apply with respect to drugs that: (a) Have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or (b) Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or (c) Are recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following reference compendia: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, The United States Pharmacopeia Drug Information; or (d) Recommended by review article or editorial comment in a major peer reviewed professional journal; or (e) If Aetna determines that available; scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

33. Those for any bills or other demands or requests for payment for services and supplies furnished as a result of a referral prohibited by section 1-302 of the Health Services Occupations Article, Maryland Statutes.

34. Expenses arising from a pre-existing condition.

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.

Administrative Complaint
An oral or written contact from the Covered Person which expresses dissatisfaction regarding:
- the direct provision or quality of care by a Preferred Health Care Provider,
- the quality of administrative service provided by a Preferred Health Care Provider, or
- the quality of administrative service provided by Aetna.

Adverse Decision
A utilization review determination by a private review agent, a carrier, or a health care provider acting on behalf of a carrier, that:
- a proposed or delivered health care service, which would otherwise be covered under the Policy, is not, or was not, medically necessary, appropriate, or efficient, and
- may result in non-coverage of the health care service.

An adverse decision does not include a decision concerning a person’s status as a Covered Person.

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.

Alzheimer’s Disease
A progressive brain disease diagnosed as Alzheimer’s disease by the Covered Person’s physician and confirmed by a second opinion of another physician who is not associated with or in practice with the Covered Person’s physician.

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 two operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic X-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by a R.N.
- Is equipped and has trained staff to handle medical emergencies.
- It must have:
  - a physician trained in cardiopulmonary resuscitation, and
  - a defibrillator, and
  - a tracheotomy set, and
  - a blood volume expander.
• Has a written agreement with a hospital in the area for immediate emergency transfer of patients. Written procedures for such a transfer must be displayed and the staff must be aware of them.
• Provides an ongoing quality assurance program. The program must include reviews by physicians who do not own or direct the facility.
• Keeps a medical record on each patient.

**Appeal**
A protest filed by a Covered Person or a health care provider with Aetna under Aetna’s internal appeal process regarding a coverage decision concerning a Covered Person.

**Appeal Decision**
A final determination by Aetna that arises from an appeal filed with Aetna of a coverage decision concerning a Covered Person.

**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 two beds or two 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.

**Clinical Trial**
For the purposes of the Clinical Trials Expense Benefit, the treatment must be provided in a clinical trial approved by:
• One of the National Institutes of Health (NIH),
• An NIH cooperative group or an NIH center (“Cooperative group” means a formal network of facilities that collaborate on research projects and have an established NIH-approved Peer Review Program operating within the group, and includes: the National Cancer Institute Clinical Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research on Aids),
• The Federal Food and Drug Administration (FDA) in the form of an investigational new drug application,
• The Federal Department of Veterans Affairs, or
An institutional review board of an institution in the State which has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NIH. “Multiple project assurance contract” means: a contract between an institution and the Federal Department of Health and Human Services that defines the relationship of the institution to the Federal Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training and volume of patients treated to maintain expertise. There is no clearly superior, non-investigational treatment alternative, and the available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the non-investigative alternative.

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

Complaint
A protest filed by a Covered Person with the Maryland Insurance Commissioner. It involves a coverage decision, adverse decision, or grievance decision. The address for filing a complaint is:

Maryland Insurance Administration
Appeal and Grievance Unit
525 St. Paul Place
Baltimore, Maryland 21202-2272
Fax: (410) 468-2270
Phone: (410) 468-2000 or (800) 492-6116 (toll free)
TDD Users: (800) 735-2258 (toll free)

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.
Condition
An injury or sickness.

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.

Coverage Decision
An initial determination by Aetna that results in non-coverage of a health care service. A coverage decision includes non-payment of all or any part of a claim. It does not include an adverse decision.

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 Policy.

Covered Medical 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 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/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 biological children, adopted children, children placed with the covered student for adoption, minor children for whom the covered student is granted guardianship by court or testamentary appointment (other than temporary guardianship of less than twelve months), grandchildren for whom the covered student is granted custody by a court, a child for whom the covered student or his/her spouse is required, under a Medical Court Order, to provide health coverage, stepchildren, any other child whom the covered student supports and lives with in a parent-child relationship. This will not operate to exclude a child because such child:

- Was born out of wedlock,
- Is not claimed as a dependent on the covered student’s federal income tax return,
- Does not reside with the covered student, or
- Is receiving benefits or is eligible to receive benefits under the Maryland Medical Assistance Program.

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 Johns Hopkins University Student Health Services.

**Designated Care Provider**
A health care provider, or pharmacy, that is affiliated with, and has an agreement with, the Johns Hopkins University Student 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, 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.

**The following are not considered Diabetic Self-Management Education Courses for the purposes of this Plan:**
- A Diabetic Education program whose only purpose is weight control, or which is available to the public at no cost, or
- A general program not just for Diabetics, or
- A program made up of services not generally accepted as necessary for the management of Diabetes.

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

**Diseases of the Elderly**
Any sickness, injury or other medical condition which has caused the Covered Person to become functionally impaired or disabled so as to require home nursing care and which has been confirmed by a second opinion of another physician who is no associated or in practice with the Covered Person’s physician.

**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, over-bed tables, elevators, communication aids, vision aids, and telephone alert systems.
Elderly
A person who is 65 years or older.

Elective Treatment
Medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Covered Person’s effective date of coverage. Elective treatment includes, but is not limited to:
- tubal ligation,
- vasectomy,
- breast reduction,
- sexual reassignment surgery,
- submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis,
- treatment for weight reduction,
- learning disabilities,
- temporomandibular joint dysfunction (TMJ),
- 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 at that time, unexpected onset of a change in a person’s physical or mental condition which:
- requires confinement right away as a full-time inpatient, and
- if immediate inpatient care was not given could, as determined by Aetna, reasonably be expected to result in:
  - loss of life or limb, or
  - significant impairment to bodily function, or
  - permanent dysfunction of a body part.

Emergency Case
A case involving an adverse decision for which an expedited review is requested.

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/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 disfigurement, or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Filing Date
The earlier of:
- five days after the date of mailing, or
- the date of receipt.

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.
Grievance
A protest filed by a Covered Person, or health care provider on behalf of a Covered Person, with a carrier. It must be filed through the carrier’s internal grievance process for adverse decisions applicable to Covered Persons.

Grievance Decision
A final determination by Aetna or Magellan that arises from a grievance filed by a Covered Person under Aetna’s internal grievance process for adverse decisions applicable to Covered Persons.

Health Advocacy Unit
Means the Health Education and Advocacy Unit. It is part of the Maryland Division of Consumer Protection, Office of the Attorney General. The address is:

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, Maryland 21202
Fax: (410) 576-6571
Phone: (410) 528-1840 or (877) 261-8807 (toll free)
E-mail: heau@oag.state.md.us

Health Care Provider
• A person who is licensed, or otherwise authorized in Maryland, to provide health care services in the ordinary course of business or practice of a profession and is a treating health care provider of a Covered Person, or
• a hospital.

Health Care Service
A health or medical care procedure, or service, rendered by a health care provider that:
• provides testing, diagnosis, or treatment, on a human disease or dysfunction, or
• dispenses drugs, medical devices, medical appliances, or medical goods, for the treatment of a human disease or dysfunction.

Home Health Agency
• a hospital which is located in the jurisdiction where the contract is delivered, and which is certified to provide home health care services.
• an agency licensed as a home health agency by the state in which home health care services are provided, or
• an agency certified as such under Medicare, or
• an agency approved as such by Aetna.

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

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

Home Health Care Plan
A program for continued health care and treatment in a Covered Person’s home which is:
• prescribed in writing by the Covered Person’s attending physician, and
• an alternative to inpatient care in a hospital or skilled nursing facility.
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 six months to live. It ends after six 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 a 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 three months after, the Covered Person’s death, and charges for respite care for up to five days in any 30 day period.

Hospital
A facility which meets all of these tests:
• it provides inpatient 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, 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/her, or any person who is part of his/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 in to 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.

**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 from Johns Hopkins University Student Health Services.

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

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

**One Sickness**
A **sickness** and all recurrences and related conditions which are sustained by a **Covered Person**.

**Orthodontic Treatment**
Any:
- medical service or supply, or
- dental service or supply,

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

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

**Out-of-Pocket Limit (Preferred Care and Non-Preferred Care)**
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**, up to any benefit maximum that may apply.

The following expenses do not apply toward meeting the **Preferred Care/Non-Preferred Care Out-of-Pocket Limit**:
- 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 24 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/she practices, and (b) any other practitioner that must by law be recognized as a doctor legally qualified to render treatment (this includes a licensed certified social worker).

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 **seven 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/her physical condition,
- the charge for the surgery is a **Covered Medical Expense** under this Plan,
- the tests are done while the person is not confined as an inpatient in a **hospital**,
- the charges for the tests would have been covered if the person was confined as an inpatient in a **hospital**,
- the test results appear in the person’s medical record kept by the **hospital** or **surgery center** where the surgery is to be done, and
- the tests are not repeated in or by the **hospital** or **surgery center** where the surgery is done.

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

Pre-Existing Condition
Any **injury**, **sickness**, or condition (other than pregnancy) for which the **Covered Person** received medical treatment during the **six months** before the effective date of insurance.

Preferred Care
Care provided by a **hospital** or **physician** that is a **Preferred Care Provider**. It also includes a health care service or supply furnished by a **hospital** or **physician** that is not a **Preferred Care Provider**:
- For an **emergency condition** when travel to a **Preferred Care Provider** is not feasible.
- Within or outside of the geographic area covered in the **Directory**, on a written referral from a **Preferred Care Provider**.
• Within the geographic area covered in the Directory, but only if:
  - Preferred Care Provider is not reasonably available, provided you contact Aetna, and Aetna confirms that a Preferred Care Provider is not reasonably available, or
  - The physician furnishing the service has a type of practice that is not listed in the Directory.
• Outside of the geographic area covered in the Directory, but only if:
  - You contact Aetna with an explanation of the person’s illness or injury and the reasons that such person requires a health care service or supply to be furnished outside of such service area, or
  - Aetna determines that it is not medically practical or reasonable for such person to return to such area in order to receive such service or supply.

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.

A Covered Person will not be required to pay more than applicable copayments, visit fees, Deductibles and out-of-pocket expense for services or supplies provided at a Negotiated Charge for Covered Medical Expenses that are necessary.

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 Medical Condition, or on referral of a person’s Primary Care Physician, or
    - a dentist who is a Non-Preferred Care Provider, but only one who is not of a type that falls into one or more of the categories of providers listed in the directory of Preferred Care Providers.

Prescriber
Any person, while acting within the scope of his/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 Johns Hopkins University Student Health Services.

Recognized Charges
Only that part of a charge which is reasonable is covered. The Recognized Charges for a service or supply is the lowest of:
• The provider’s usual charge for furnishing it,
• 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 prevailing charge level made for it in the geographic area where it is furnished.

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 Charges is the rate established in such agreement.

In determining the Recognized Charges 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 prevailing charge in other areas.

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**
Means temporary care provided to the terminally ill insured to relieve the family caregiver from the daily care of the insured.

**Retrospective Denial**
A coverage decision made after the health care service has been rendered to the 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.

**Johns Hopkins University Student 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 semi-private rooms with two 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 two 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:
  - 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 Expenses
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 two 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 Medical Condition
A medical condition, including a physical condition, a mental condition or a dental condition, where the absence of medical attention within **72 hours** could reasonably be expected by an individual, acting on behalf of Aetna, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:
• placing the **Covered Person**’s life or health in serious jeopardy,
• the inability of the **Covered Person** to regain maximum function,
• serious impairment to bodily function,
• serious dysfunction of any bodily organ or part,
• the **Covered Person** remaining seriously mentally ill with symptoms that cause the **Covered Person** to be a danger to self or others, or
• a medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within **72 hours** in the opinion of a health care provider with knowledge of the **Covered Person**’s medical condition, would subject the **Covered Person** to severe pain that cannot be adequately managed without the care or treatment that is the subject of a coverage decision.
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 eight 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.

Please send claims to:
Aetna Student Health
PO Box 981106
El Paso, TX 79998

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

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 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

Aetna Life Insurance Company has established a procedure for resolving complaints by Covered Persons. If a Covered Person has a complaint, he/she must follow this procedure.

CLAIMS DETERMINATION

Claims Involving Urgent Medical Conditions
Aetna will make notification of a claim involving an Urgent Medical Condition as soon as possible, but not more that 72 hours after the claim is made.

If more information is needed to make a claim determination involving an Urgent Medical Condition, Aetna will notify the Covered Person within 24 hours of receipt of the claim. The Covered Person has 48 hours after receiving such notice to provide Aetna with the additional information. Aetna will notify the Covered Person within 48 hours of the earlier of the receipt of the additional information or the end of the 48 hour period given the health care provider to provide Aetna with the information.

If the Covered Person fails to follow plan procedures for filing a claim, Aetna will notify the Covered Person within 24 hours following the failure to comply.
Pre-Service Claims
Aetna will make notification of a claim determination as soon as possible but not later than 15 calendar days after the pre-service claim is made. Aetna may determine that due to matters beyond its control an extension of this 15 calendar day claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies the Covered Person within the first 15 calendar day period. If this extension is needed because Aetna needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. The Covered Person will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Post-Service Claims
Aetna will make notification of a claim determination as soon as possible but not later than 30 calendar days after the post-service claim is made. Aetna may determine that due to matters beyond its control an extension of this 30 calendar day claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies the Covered Person within the first 30 calendar day period. If this extension is needed because Aetna needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. The Covered Person will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Concurrent Care Claim Extension
Following a request for a Concurrent Care Claim Extension, Aetna will make notification of a claim determination for emergency or urgent care as soon as possible but not later than 24 hours, with respect to emergency or urgent care provided the request is received at least 24 hours prior to the expiration of the approved course of treatment, and 15 calendar days with respect to all other care, following a request for a Concurrent Care Claim Extension.

Concurrent Care Claim Reduction or Termination
Aetna will make notification of a claim determination to reduce or terminate a previously approved course of treatment with enough time for the Covered Person to file an appeal.

ADMINISTRATIVE COMPLAINTS
If you have an administrative complaint, please contact Aetna either verbally or in writing. The address and telephone number are listed in your Brochure. Administrative complaints will be resolved within 30 days of their receipt.

COVERAGE DECISIONS
INITIAL DECISIONS
Notice of a Coverage Decision
If Aetna renders a coverage decision, Aetna will, within 30 calendar days of the date of the coverage decision, send a written notice to the Covered Person and health care provider on behalf of the Covered Person. The notice will include:

- The specific factual basis for the decision stated in detail in clear, understandable language.
- A statement advising the Covered Person or health care provider on behalf of the Covered Person that they have the right to file an appeal of the coverage decision with Aetna.
- A statement advising the Covered Person or health care provider that they may file a complaint with the Maryland Insurance Commissioner without first exhausting Aetna’s internal appeals process if the decision involves an urgent medical condition for which care has not been rendered.
- The Commissioner’s address, telephone number and facsimile number.
- A statement advising the Covered Person or health care provider acting on behalf of the Covered Person that the Health Advocacy Unit is available to assist the Covered Person in both mediating and filing an appeal under the Aetna’s internal appeal process. The Covered Person will be provided with the address, telephone number facsimile number and e-mail address for the Health Advocacy Unit, as listed in the “Definitions” section.


APPEAL OF A COVERAGE DECISION

Coverage Decisions

If, after reviewing the information provided by Aetna concerning the coverage decision, the Covered Person wishes to have the decision reconsidered, the Covered Person or the health care provider acting on behalf of the Covered Person can file an appeal of the coverage decision. An appeal of a coverage decision may be filed orally or in writing. The appeal should contain sufficient information for Aetna to investigate and render a decision.

Appeals of coverage decisions will be handled as described below. Aetna will review and render an appeal decision and will forward a written notice stating the results of the review to the Covered Person or the health care provider acting on behalf of the Covered Person. This will occur within 30 calendar days of the filing date. This notice will include:

- The specific factual basis for the decision stated in detail in clear, understandable language.
- A statement advising the Covered Person or health care provider acting on behalf of the Covered Person that they have the right to file a complaint with the Maryland Insurance Commissioner within 60 working days after receipt of the appeal decision. The Commissioner’s address is listed in the “Definitions” section.

ADVERSE DECISIONS

INITIAL DECISIONS

Notice of Adverse Decision

If Aetna renders an adverse decision on a non-emergency case, Aetna will orally communicate the adverse decision to the Covered Person or health care provider on behalf of the Covered Person. Aetna also will, within five working days of the date of the adverse decision, send a written notice to the Covered Person or health care provider acting on behalf of the Covered Person. The notice will include:

- The specific factual basis for the decision stated in detail in clear, understandable language.
- A reference to the specific criteria and standards, including interpretive guidelines, on which the adverse decision was based, and not solely use generalized terms such as “experimental procedure not covered,” “cosmetic procedure not covered,” “services included under another procedure” or “not medically necessary.”
- The name, business address and business telephone number of the medical director that made the adverse decision as follows:
  Medical Director
  1301 McCormick Drive
  Largo, Maryland 20774

- The details of the internal grievance process and procedures.
- A statement advising the Covered Person or health care provider that they may, within 30 working days of receiving a grievance decision, file a complaint with the Maryland Insurance Commissioner. The Commissioner’s address is listed in the “Definitions” section.
- A statement advising the Covered Person or health care provider that they may file a complaint with the Maryland Insurance Commissioner without first filing a grievance, if it can be demonstrated that there is a compelling reason to do so. The “compelling reason” must show that the potential delay in receiving the health care service until after the Covered Person, or health care provider on behalf of the Covered Person, has exhausted the Aetna’s internal grievance process and obtained a final decision, could result in:
  - loss of life;
  - serious impairment to a bodily function;
  - serious dysfunction of a bodily organ; or
  - the Covered Person remaining seriously mentally ill with symptoms that cause the Covered Person to be a danger to him/herself or others.

To file a complaint with the Maryland Insurance Commissioner, please use the address listed in the “Definitions” section.

- A statement advising the Covered Person, or health care provider on behalf of the Covered Person, that the Health Advocacy Unit:
  - is available to help the Covered Person with filing a grievance under the carrier’s internal grievance process;
- is not available to represent or accompany the Covered Person during the procedures of the internal grievance process; and
- can help the Covered Person in mediating a resolution of the adverse decision with the carrier, but that any time during the mediation, the Covered Person or health care provider on behalf of the Covered Person, may file a grievance.

The address for the Health Advocacy Unit is listed in the “Definitions” section.

If, after reviewing the information provided by Aetna, the Covered Person, or a health care provider acting on behalf of the Covered Person, wishes to have the adverse decision reconsidered, the Covered Person or health care provider can file a grievance within the next 180 calendar days. A grievance may be filed orally or in writing as follows:
Regional Grievance Unit
1301 McCormick Drive
Largo, Maryland 20774

The grievance should contain sufficient information for Aetna to investigate and render a decision. All grievances will be handled as described below.

The appropriate entity’s Grievance Unit will review all of the information submitted. It will gather any additional information necessary to prepare and render a decision about the grievance. If there is insufficient information available to make a decision, the Grievance Unit will notify the Covered Person or health care provider on behalf of the Covered Person, of the need for additional information. This will occur within five working days of the filing date of the grievance. The Grievance Unit will help the Covered Person or health care provider to obtain the information without further delay. If necessary for the review, it also will send an “authorization for release” form to the Covered Person for the purpose of obtaining medical records or other information.

Except for an emergency case (please see “Expedited Review of Adverse Decisions Involving an Emergency Case”), Aetna’s Grievance Unit will review and render a grievance decision within:
- 36 hours of receipt of the request with respect to a claim involving an urgent medical condition;
- 15 calendar days of receipt of the request with respect to a pre-service claim;
- 30 calendar days of receipt of the request with respect to post-service claims.

It will orally communicate this grievance decision to the Covered Person or the health care provider who filed the grievance on behalf of the Covered Person. A written notice stating the results of the review by the appropriate Grievance Unit will be forwarded to the Covered Person or health care provider. This will occur within five working days of the date of the decision. This notice will include:
- The specific factual basis for the decision stated in detail in clear, understandable language.
- A reference to the specific criteria and standards, including interpretive guidelines, on which the grievance decision was based and not solely use, generalized terms such as “experimental procedure not covered,” “cosmetic procedure not covered,” “services included under another procedure” or “not medically necessary.”
- The name, business address and business telephone number of the medical director that made the grievance decision as follows:
  Medical Director
  1301 McCormick Drive
  Largo, Maryland 20774

A statement advising the Covered Person or health care provider that they have the right to file a complaint with the Maryland Insurance Commissioner: Within 30 working days after receipt of the grievance decision. If a grievance decision for a pending health care service appeal is not received within 30 working days after filing. If a grievance decision for a retrospective denial of services appeal is not received within 45 working days after filing. Without first exhausting the grievance process, if there is a compelling reason to do so.

The Commissioner’s address is listed in the “Definitions” section.
EXPEDITED REVIEW OF ADVERSE DECISIONS INVOLVING AN EMERGENCY CASE

The Covered Person, or health care provider acting on behalf of the Covered Person, may request an expedited review when an adverse decision is rendered for health care services that are: (a) proposed but have not been delivered; and (b) necessary to treat a condition or illness that, without immediate medical attention, would:

- seriously jeopardize the life or health of the Covered Person or the Covered Person’s ability to regain maximum function; or
- cause the Covered Person to be a danger to him/herself or others.

Aetna’s Medical Director will determine whether an emergency exists. The Covered Person and health care provider will be notified immediately if Aetna does not have sufficient information to complete the expedited review and Aetna will help the Covered Person or health care provider in gathering the necessary information without further delay.

Expedited reviews will be completed and a decision rendered within 24 hours of the time the Covered Person or health care provider files the request. A Covered Person may file a complaint with the Maryland Insurance Commissioner if a decision has not been received within 24 hours of the filing of the request.

Within one day after a decision has been orally communicated to the Covered Person or health care provider acting on behalf of the Covered Person, a written notice will be sent to the Covered Person and health care provider. The notice will include:

- The specific factual basis for the decision stated in detail in clear, understandable language.
- A reference to the specific criteria and standards (including interpretive guidelines) on which the expedited review was based, and not solely use generalized terms such as “experimental procedure not covered,” “cosmetic procedure not covered,” “services included under another procedure” or “not medically necessary.”
- Give details of the internal grievance process and procedures.
- The name, business address and business telephone number of the medical director that performed the expedited review and rendered the decision.
- A statement informing the Covered Person, or health care provider acting on behalf of the Covered Person, that they have the right to file a complaint with the Maryland Insurance Commissioner within 30 working days of receipt of the grievance decision. The Commissioner’s address is listed in the “Definitions” section.
- A statement advising the Covered Person or health care provider acting on behalf of the Covered Person that the Health Advocacy Unit is available to assist the Covered Person in both mediating and filing an appeal under the Aetna’s internal appeal process. The Covered Person will be provided with the address, telephone number facsimile number and e-mail address for the Health Advocacy Unit, as listed in the “Definitions” section.

If the expedited review is a concurrent review determination, the service should be continued without liability to the Covered Person until the Covered Person or health care provider is notified of the decision. This does not apply if the service is related to an initial unauthorized admission.

Expedited reviews for retrospective non-certifications are not required.

EXHAUSTION OF PROCESS

The Covered Person must exhaust the internal appeals process before the establishing of any litigation or arbitration or any administrative proceeding regarding either an alleged breach of the group contract by Aetna Life Insurance Company, or any matter within the scope of the appeals process.

RECORD RETENTION

Records of all administrative complaints and grievances will be retained for a period of at least seven years.

FEES AND COSTS

Nothing herein will be construed to require Aetna to pay counsel fees or any other fees or costs incurred by a Covered Person in pursuing a grievance or administrative complaint.
PRESCRIPTION DRUG CLAIM PROCEDURE

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

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

WORLDWIDE TRAVEL ASSISTANCE SERVICES

On Call International
Chickering Claims Administrators, Inc. (CCA) has contracted with On Call International (On Call) to provide Covered Persons with access to certain accidental death and dismemberment benefits, worldwide emergency medical, travel and security assistance services and other benefits.
A brief description of these benefits is outlined below.

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

Medical Evacuation and Repatriation (MER) Benefits. The following benefits are underwritten by United States Fire Insurance Company (USFIC) with medical and travel assistance services provided by On Call. These benefits are designed to assist Covered Persons when traveling more than 100 miles from home, anywhere in the world.
• Unlimited Emergency Medical Evacuation
• Unlimited Medically Supervised Repatriation
• Unlimited Return of Deceased Remains
• Unlimited Family Reunion
• $2,500 Return of Traveling Companion
• $2,500 Bereavement Reunion - in the event of a Covered Person’s death, On Call will fly a family member to identify the remains and accompany the remains back to the deceased’s home country
• $2,500 Emergency Return Home in the event of death or life-threatening illness of a parent, sibling or spouse

Natural Disaster and Political Evacuation Services (NDPE)
The following benefits are underwritten by United States Fire Insurance Company (USFIC), with security assistance services provided by On Call. If a Covered Person requires emergency evacuation due to governmental or social upheaval, which places him/her in imminent bodily harm (as determined by On Call security personnel in accordance with local and U.S. authorities), On Call will arrange and pay for his/her transportation to the nearest safe location, and then 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 to the nearest safe haven, and then home. 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 Consultation and Referral
• Bail Bonds Assistance
The On Call International Global Response Center can be reached 24 hours a day, 365 days a year.

The information contained above is a just summary of the ADD, MER, WETA, and NDPE benefits and services available through On Call. For a copy of the plan documents applicable to the ADD, MER, WETA and NDPE coverage, including a full description of coverage, exclusions and limitations, please contact Aetna Student Health at www.aetnastudenthealth.com or (800) 558-8845.

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

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

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.
GOT QUESTIONS? GET ANSWERS WITH AETNA'S NAVIGATOR®

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

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

HOW DO I REGISTER?

- Go to www.aetnastudenthealth.com.
- 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
PO Box 981106
El Paso, TX 79998
(800) 558-8845
www.aetnastudenthealth.com

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

Policy Number 100111

The Johns Hopkins University 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.