

IMPORTANT NOTICE

To obtain information or make a complaint:
You may call **Aetna's** toll-free telephone number for information or to make a complaint at:

You may also write to **Aetna** at:

Aetna Inc.

2777 Stemmons Freeway, Dallas, TX 75207

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P. O. Box 149104

Austin, TX 78714-9104

Fax: (512) 475-1771

Web: <http://www.tdi.state.tx.us>

E-mail: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim you should contact the (agent) (company) (agent or the company) first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja: Usted puede llamar al numero de telefono gratis de (company)'s para informacion o para someter una queja al:

Usted tambien puede escribir a (company):

Aetna Inc.

2777 Stemmons Freeway, Dallas, TX 75207

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

P. O. Box 149104

Austin, TX 78714-9104

Fax: (512) 475-1771

Web: <http://www.tdi.state.tx.us>

E-mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el (agente) (la compania) (agente o la compania) primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

AETNA LIFE INSURANCE COMPANY

BLANKET SPORTS ACCIDENT INSURANCE POLICY

This Policy is entered into by and between

Aetna Life Insurance Company
(Aetna, We, Us, or Our)
and

Southern Methodist University
(the Policyholder)

Policy Number: GP-686199
Date of Issue: 03/30/2021
Effective Date: 08/01/2020

This Policy shall be effective on the Effective Date and shall continue in force until terminated as provided herein.

In consideration of the mutual promises hereunder and the payment of Premiums and fees when due, we will pay benefits in accordance with the terms, conditions, limitations, and exclusions set forth in this Policy. Benefits will be paid in accordance with the reasonable exercise of Our business judgment, consistent with applicable law. The duties and the rights of all persons will be based solely on the terms of this Policy.

Upon receipt of the Policyholder's signed Group Application, and upon receipt of the required initial Premium, this Policy shall be considered to be agreed to by the Policyholder and Us, and is fully enforceable in all respects against the Policyholder and Us.

Term of Policy: The Term shall be:
From 08/01/2020 through 07/31/2021.
The 12 consecutive month period beginning on the Effective Date.

Premium Due Dates: The Effective Date and each monthly anniversary of the Effective Date.

This Policy is non-participating.

Notice to Buyer:

THE GROUP INSURANCE POLICY UNDER WHICH THIS BOOKLET-CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR POLICYHOLDER TO DETERMINE WHETHER YOUR POLICYHOLDER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

THIS CERTIFICATE IS GOVERNED BY APPLICABLE FEDERAL LAW AND THE LAWS OF TEXAS.

This is an accident-only policy and it does not pay benefits for loss from sickness. Review your policy carefully.

This policy provides only selected benefits. Benefits provided are not intended to cover all medical expenses.

Additional Coverage may be available through another plan held by the Policyholder. Please check with the Policyholder about the availability of such coverage.

AETNA LIFE INSURANCE COMPANY

BLANKET SPORTS ACCIDENT INSURANCE POLICY

This Policy is governed by applicable federal law and the laws of Texas.

Signed at **Aetna's** Home Office 151 Farmington Avenue Hartford, Connecticut 06156 on the date of issue.

A handwritten signature in black ink, appearing to read 'Dan Finke', with a long horizontal flourish extending to the right.

Dan Finke
President

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**AETNA LIFE INSURANCE COMPANY
STUDENT SPORTS ACCIDENT INSURANCE
SECTION 1 - SCHEDULE OF BENEFITS**

ELIGIBILITY

All new eligible persons, after the effective date of this Policy, will automatically be considered a covered person, as defined under **you** or **your** in *Section 2 -Definitions* under this Policy. Please also refer to the definition of **covered activity** to see the listing of covered activities applicable to the Policyholder's intercollegiate sports athletic teams.

Change In Amounts

Covered Person

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

Aetna reserves the right to investigate and confirm that any person claiming benefits under this Policy is eligible for coverage under this Policy.

**AETNA LIFE INSURANCE COMPANY
STUDENT SPORTS ACCIDENT INSURANCE
SECTION 1 - SCHEDULE OF BENEFITS**

ACCIDENT MEDICAL EXPENSE BENEFITS

Benefits Payable

The Accident Medical Expense Benefits payable under this Policy in a **policy year** are paid at the Covered Percentage which applies to the type of **covered expense** which is incurred. Benefits may vary depending upon whether a **network provider** is utilized. A **network provider** is a health care provider who has agreed to provide services or supplies at a "**negotiated charge**."

If a covered service you need is not available from a **network provider** or facility, with preauthorization from **Aetna**, you may utilize an **out-of-network** provider. In this circumstance, services from **out-of-network providers** will be covered at the **network** level of benefits.

MAXIMUM NUMBER OF WEEKS PER INJURY	
<i>Class 1</i>	104

Preauthorization Penalty

The Policy contains a complete description of the **preauthorization** program. Refer to the "*Understanding Preauthorization*" section for a list of services and supplies that require **preauthorization**.

Failure to **preauthorize your covered expenses** when required will result in a benefits reduction as follows:

- A \$500 penalty will be applied separately to each type of expense.

**AETNA LIFE INSURANCE COMPANY
STUDENT SPORTS ACCIDENT INSURANCE
SECTION 1 - SCHEDULE OF BENEFITS**

ACCIDENT MEDICAL EXPENSE BENEFITS (continued)

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Hospital Expenses <i>Class 1</i>	100% per policy year	80% per policy year
Surgical Expenses <i>Class 1</i>	100% per policy year	80% per policy year
Physician Services Expenses <i>Class 1</i>	100% per policy year	80% per policy year

**AETNA LIFE INSURANCE COMPANY
STUDENT SPORTS ACCIDENT INSURANCE
SECTION 1 - SCHEDULE OF BENEFITS**

ACCIDENT MEDICAL EXPENSE BENEFITS (continued)

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Ambulance Expenses <i>Class 1</i>	 100% per policy year	If an Emergency , covered at the same level at Network benefits 100% per policy year
Laboratory and X-Ray Outpatient Expenses <i>Class 1</i>	 100% per policy year	 80% per policy year
Therapy Expenses <i>Class 1</i>	 100% per policy year	 80% per policy year

**AETNA LIFE INSURANCE COMPANY
STUDENT SPORTS ACCIDENT INSURANCE
SECTION 1 - SCHEDULE OF BENEFITS**

ACCIDENT MEDICAL EXPENSE BENEFITS (continued)

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Durable Medical and Surgical Equipment Expenses <i>Class 1</i>	100% per policy year	80% per policy year
Prosthetic Devices Expenses <i>Class 1</i>	100% per policy year	80% per policy year
Specialty Equipment Expenses <i>Class 1</i>	100% per policy year	80% per policy year

**AETNA LIFE INSURANCE COMPANY
STUDENT SPORTS ACCIDENT INSURANCE
SECTION 1 - SCHEDULE OF BENEFITS**

ACCIDENT MEDICAL EXPENSE BENEFITS (continued)

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Home Health Care Expenses <i>Class 1</i>	100% per policy year	80% per policy year
Oral and Maxillofacial Treatment <i>Class 1</i>	100% per policy year	80% per policy year

AGGREGATE MAXIMUM BENEFIT LIMIT PER COVERED PERSON PER ACCIDENT	
<i>Class 1</i>	\$10,000 per Accident per Policy Year

**AETNA LIFE INSURANCE COMPANY
STUDENT SPORTS ACCIDENT INSURANCE
SECTION 2 - DEFINITIONS**

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

Accident

This means a sudden external trauma that is unexpected; and unforeseen; and is an identifiable **occurrence** or event producing, at the time, objective symptoms of an external bodily **injury**. The **accident** must occur while the person is covered under this Policy and is participating in a **covered activity**. The **occurrence** or event must be definite as to time and place. It must not be due to, or contributed by, an **illness** or disease of any kind including a reaction to a condition that manifests within the human body or a reaction to a drug or medication regardless of the reason **you** have consumed the drug or medication.

Aggregate Maximum

The maximum benefit that will be paid under this Policy for all **covered expenses** incurred by **you** that accumulate from one **policy year** to the next.

Ambulance

A vehicle that is staffed with medical personnel and is equipped to transport an ill or injured person.

Covered Activity

This means the sports listed below for the Policyholder's intercollegiate sports athletic teams. A **covered activity** includes participation in: a scheduled game, official tournament game, scheduled training, scheduled exhibition game, scheduled tryout, scheduled workout session, scheduled team meeting, or other supervised and sponsored sports activity, or while **traveling** directly to or from such game, practice session, scheduled training, scheduled exhibition game, scheduled tryout, scheduled workout session, scheduled team meeting, **off-season conditioning**, or other **supervised and sponsored sports activity**.

Covered Expenses

Medical, or dental services and supplies shown as covered under this Policy.

Deductible

The part of **your covered expenses** that **you** pay before this plan starts to pay benefits. Additional information regarding **deductibles** and **deductible** amounts can be found in the *Schedule of Benefits*. This **deductible** needs to be satisfied separately. Other carrier **deductible/copayment** amounts or payments do not reduce this **deductible**.

Dental Consultant

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

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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**, or a **physician** licensed to do the dental work he or she performs.

Directory

A listing of all **network providers** serving the class of covered persons to which **you** belong. **Network provider** information is also available through Aetna's on-line provider directory, DocFind®.

Durable Medical and Surgical Equipment (DME)

Equipment, and the accessories needed to operate it, that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of an **injury**;
- Suited for use in the home;
- Not normally of use to people who do not have an **injury**;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Durable medical and surgical equipment does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids and telephone alert systems.

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Elective Treatment

A medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after **your** 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;
- Treatment of learning disabilities;
- Treatment of temporomandibular joint dysfunction (TMJ);
- Immunization;
- Treatment of infertility; and
- Routine physical examinations.

Emergency Admission

An admission to a **hospital** or treatment facility by a **physician** who admits **you** right after the sudden and, at that time, unexpected onset of an **emergency medical condition** which requires confinement right away as a full-time inpatient.

Emergency Medical Condition

A recent and severe medical condition, occurring as a result of participating in a **covered activity**, including (but not limited to) severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, or **injury** is of such a nature that failure to get immediate medical care could result in:

- placing **your** health in serious jeopardy; or
- serious impairment to bodily function; or
- serious dysfunction of a body part or organ;
- serious disfigurement; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

The cost of treatment for an **Emergency Medical Condition** rendered by an **out-of-network provider** will be covered at the **network service** benefit level, less **any coinsurance, copayments or deductible**, up to the time it is determined by the attending **physician** that you are medically able to travel or to be transported to a **network provider**.

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Formulary

A listing of **prescription drugs** established by Aetna or an affiliate, which includes both **brand name prescription drugs** and **generic prescription drugs**. This list is subject to periodic review and modification by Aetna or an affiliate. A copy of the **formulary** will be available upon your request or may be accessed on the Aetna website at www.Aetna.com/formulary.

Formulary Exclusions List

A list of **prescription drugs** in the **formulary** that are identified as excluded under the plan. This list is subject to periodic review and modification by Aetna.

Homebound

This means that you are confined to your place of residence:

- Due to an **injury** which makes leaving the home medically contraindicated; or
- Because the act of transport would be a serious risk to your life or health.

Situations where you would not be considered **homebound** include (but are not limited to) the following:

- You do not often **travel** from home because of feebleness or insecurity brought on by advanced age (or otherwise); or
- You are wheelchair bound but could safely be transported via wheelchair accessible transportation.

Home Health Care Agency

An agency that meets all of the following requirements:

- Mainly provides skilled nursing and other therapeutic services.
- Is associated with a professional group (of at least one **physician** and one **R.N.**) which makes policy.
- Has full-time supervision by a **physician** or an **R.N.**
- Keeps complete medical records on each person.
- Has an administrator.
- Meets licensing standards.

Home Health Aide

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

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Home Health Care Plan

This is a plan that provides for continued care and treatment of an **injury** after discharge from a **hospital**. The care and treatment must be:

- For the same or related condition that required the **hospital stay**; and
- Prescribed in writing by the attending **physician** within 7 days from the **hospital** discharge; and
- An alternative to a **hospital** or **skilled nursing facility stay**.

Hospital

An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physicians**;
- Provides twenty-four (24) hour-a-day **R.N.** service,
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations.

Hospitalization

Is necessary and continuous confinement as an inpatient in a **hospital** for which a **room and board** charge is made.

Illness

A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

Injury

An accidental bodily **injury** that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonably unforeseeable consequences of a voluntary act by the person.

The act or event must be definite as to time and place and occur while participating in a **covered activity**. An **injury** is not the direct result of **illness**.

With respect to the Accident Medical Expense Benefits, **injury** will also include the following:

- Heart or circulatory malfunction. This means a cardiovascular accident, stroke or other similar traumatic event.

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- Re-injury of prior **injury**. This means the re-injuring and/or aggravation of an **injury** which
 - Occurred prior to the effective date of **your** coverage under this Policy; or
 - Occurred during the policy year, and such **injury** was not fully rehabilitated at the timeSuch re-injuries will be eligible under the Accident Medical Expense Benefit only if the re-injury and/or aggravation occurs under circumstances which would have otherwise been covered under the Policy.
- Repetitive motion **injury**. This means stress fracture, strain, shin splint, Osgood-Schlatter Disease, Chondromalacia, tendonitis, bursitis, heat stroke or other similar event.
- Conditions which result from other than an accidental bodily **injury**, provided such conditions are:
 - A result of the practice and play of a **covered activity**; and
 - The student athlete, trainer, student trainer, manager, student manager and coach has been released to participate in practice or play by a legally qualified **physician**.

L.P.N.

A licensed practical or vocational nurse.

Medically Necessary, Medical Necessity

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

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

For these purposes "generally accepted standards of medical or dental practice" means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community, or otherwise consistent with **physician** or dental specialty society recommendations and the views of **physicians** or **dentists** practicing in relevant clinical areas and any other relevant factors.

Negotiated Charge

As to health expense coverage, other than Prescription Drug Expense Coverage:

The **negotiated charge** is the maximum charge a **network provider** has agreed to make as to any service or supply for the purpose of the benefits under this plan.

As to Prescription Drug Expense Coverage:

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

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

Based on its overall drug purchasing, **Aetna** may receive rebates from the manufacturers of **prescription drugs** and may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not change the **negotiated charge** under this plan.

Network Provider

A health care provider, a **pharmacy** or **dental provider** who 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 **network provider** for:

- The service or supply involved; and
- The class of covered persons to which **you** belong.

Network Service(s) or Supply(ies)

Health care service or supply that is:

- Furnished by a **network provider**; or
- Furnished or arranged by **your PCP**.

Off-season Conditioning

This means a physical conditioning activity, which is not the play or practice of a **covered activity**, which is officially scheduled and authorized by a regularly employed coach or trainer.

Out-of-Network Provider

A health care provider, a **pharmacy** or **dental provider** who has not contracted with **Aetna** to furnish services or supplies at a **negotiated charge**.

Out-of-Network Service(s) and Supply(ies)

Health care service or supply that is:

- Furnished by an **out-of-network provider**; or
- Not furnished or arranged by **your PCP**.

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Physician

A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

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

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.

Preauthorization, Preauthorize

A process where **Aetna** is contacted before certain services are provided, such as **hospitalization** or outpatient **surgery**, or **prescription drugs** are prescribed to determine whether the services being recommended or the drugs prescribed are considered **covered expenses** under the plan. It is not a guarantee that benefits will be payable.

Pre-existing Condition

A **pre-existing condition** is an illness or injury for which, during the 6-month period immediately prior to your enrollment date:

- Medical treatment, services, or supplies were received or **prescription drugs** or medicines were taken.
- medical advice, diagnosis, care, or treatment was recommended or received.

The **pre-existing condition** limitation does not apply to

- Genetic information in the absence of a diagnosis of the condition related to that information.
- Pregnancy and its complications, if covered.

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Prescriber

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

Primary Care Physician (PCP)

This is the **network provider** who:

- Is optionally selected by a person from the list of **Primary Care Physicians** in the **directory**;
- Is allowed by **you** to supervise, coordinates and provide initial care and basic medical services to **you** as a general or family care practitioner, or in some cases, as an internist or a pediatrician;
- Initiates care and maintains continuity of patient care; and
- Is shown on Aetna's records as the **your PCP**.

Recognized Charge

The **covered expense** is only the part of a charge which is the **recognized charge**.

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

- What the provider bills or submits for that service or supply; and
- for professional services and other services or supplies not mentioned below:
 - 105% of the Medicare Allowable Rate;
- for inpatient charges of **hospitals** and other facilities:
 - 140% of the Medicare Allowable Rate;
- for outpatient charges of **hospitals** and other facilities:
 - 140% of the Medicare Allowable Rate;

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

- What the provider bills or submits for that service or supply; and
- 100% of the **Average Wholesale Price (AWP)** or other similar resource. **Average Wholesale Price (AWP)** is the current average wholesale price of a **prescription drug** listed in the Facts and Comparisons Medi-Span weekly price updates (or any other similar publication chosen by Aetna).

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

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

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

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

As used above, Geographic Area, Medicare Allowable Rates, Aetna Out-of-Network Rates (AONR), Aetna Facility Fee Schedule, and Prevailing Charge Rates are defined as follows:

Medicare Allowable Rates: Except as specified below, these are the rates established and periodically updated by The Centers for Medicare and Medicaid Services (CMS) for payment for services and supplies provided to Medicare enrollees. Aetna updates its systems with these revised rates within 90 days of receiving them from CMS. If Medicare does not have a rate for a particular service, the rate will be based on the same method that CMS uses to set Medicare rates.

Prevailing Charge Rates: These are rates reported by Ingenix, a United Health Group subsidiary, in the Prevailing Health Care Charges System (PHCS) database Medical Data Research (MDR) database, which is compiled from information that Aetna and other insurers submit to Ingenix. FAIR Health, a nonprofit company, in their database. Ingenix FAIR Health reviews and, if necessary, changes these rates periodically. Aetna updates its systems with these changes within 90 days after receiving them from Ingenix FAIR Health.

IMPORTANT NOTE:

Aetna periodically updates its systems with changes made to the Medicare Allowable Rates Prevailing Charge Rates

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

ADDITIONAL INFORMATION:

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

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R.N.

A registered nurse.

Room and Board

Charges made by an institution for **room and board** and other **medically necessary** services and supplies. The charges must be regularly made at a daily or weekly rate.

Semi-Private Room Rate

The **room and board** charge that an institution applies to the most beds in its semi-private rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Service Area

This is the geographic area, as determined by Aetna, in which **network providers** for this plan are located.

Skilled Nursing Facility

An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from **injury**:
 - Professional nursing care by an **R.N.**, or by an **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 severe mental illnesses.
- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
 - It is licensed or approved under state or local law.
 - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Qualifies as a **Skilled Nursing Facility** under Medicare or as an institution accredited by:
 - The Joint Commission on Accreditation of Health Care Organizations;
 - The Bureau of Hospitals of the American Osteopathic Association; or
 - The Commission on the Accreditation of Rehabilitative Facilities

Skilled Nursing Facilities also include Rehabilitation Hospitals (all levels of care, e.g. acute) and portions of a **hospital** designated for skilled or rehabilitation services.

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Skilled Nursing Facility does not include:

- Institutions which provide only:
 - Minimal care;
 - Custodial care services;
 - Ambulatory; or
 - Part-time care services.
- Institutions which primarily provide for the care and treatment of alcoholism, drug abuse, mental disorders or severe mental illnesses.

Stay

A full-time inpatient confinement for which a **room and board** charge is made.

Supervised and Sponsored Sports Activity

A **covered activity** that:

- Takes place:
 - On the Policyholder's premises during, before or after normal school hours; or
 - At another school or site at which the **covered activity** is scheduled; and
- Is supervised by a member of the faculty or staff of the Policyholder, or by another adult specifically assigned supervisory duties and authority for that **covered activity** by the Policyholder; or
- Is a regularly-scheduled sports tryout, practice, workout or training session, team meeting, game, exhibition play or competition of those sports shown on the *Schedule of Benefits* in which **you** are participating.

Surgery or Surgical Procedure

The diagnosis and treatment of **injury** by manual and instrumental means, such as cutting, abrading, suturing, destruction, ablation, removal, lasering, introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy), correction of fracture, reduction of dislocation, application of plaster casts, injection into a joint, injection of sclerosing solution or otherwise physically changing body tissues and organs.

Surgery Center

A freestanding ambulatory surgical facility that meets all of the following requirements:

- Meets facility licensing standards as ambulatory surgical facility.
- Is set up, equipped and run to provide general **surgery**.
- Charges for its services.
- 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** requiring general or spinal anesthesia is performed and during the recovery period.

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- Extends surgical staff privileges to:
 - **Physicians** who practice **surgery** in an area **hospital**; and
 - **Dentists** who perform oral **surgery**.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic X-ray and lab services needed in connection with **surgery**.
- Does not have a place for patients to **stay** overnight.
- Provides, in the operating and recovery rooms, full-time **skilled nursing services** directed by an **R.N.**
- Is equipped and has trained staff to handle **emergency medical conditions**.

It must have all of the following:

- A **physician** trained in cardiopulmonary resuscitation; and
- A defibrillator; and
- A tracheotomy set; and
- A blood volume expander; and
- Has a written agreement with a **hospital** in the area for immediate emergency transfer of patients; and
- Written procedures for such a transfer must be displayed and the staff must be aware of them, and
- **Physicians** who do not own or direct the facility, and
- Keeps a medical record on each patient.

Travel

Includes **travel**, only within or outside the United States:

- Between home or the Policyholder's location and a **covered activity**;
- Between home or the Policyholder's location and another meeting place designated by the Policyholder for participation in a **covered activity**;
- Between home or the Policyholder's location and another school or site designated by the Policyholder, where a **covered activity** is scheduled.
- When **your** participation in, or attendance at it, requires **you** to be away from **your** normal residence for a stay of one or more nights.

Travel means transportation on a common carrier, the Policyholder's bus or Private Passenger Automobile driven by a member of the faculty or staff of the Policyholder, **your** parent, or other adult with a valid drivers' license. It will also include **travel** by foot or non-motorized bicycle between **your** home or the Policyholder's location to a **covered activity**.

Urgent Admission

A **hospital** admission by a **physician** due to an **injury**:

The condition, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.

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Urgent Care Provider

This is:

- A freestanding medical facility that meets all of the following requirements.
 - Provides unscheduled medical services to treat an **urgent condition** if **your physician** is not reasonably available.
 - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
 - Makes charges.
 - Is licensed and certified as required by any state or federal law or regulation.
 - Keeps a medical record on each patient.
 - Provides an ongoing quality assurance program. This includes reviews by **physicians** other than those who own or direct the facility.
 - Is run by a staff of **physicians**. At least one **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 **directory** as a network **urgent care provider**.
- It is not the emergency room or outpatient department of a **hospital**.

Urgent Condition

This means a sudden **injury**, or condition that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of **your** health;
- Includes a condition which would subject **you** 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 **your physician** becomes reasonably available.

You or Your

The term **you** or **your**, includes a covered person in any of the following classes:

Class 1 Intercollegiate student athletes, trainers, student trainers, managers, student managers and coaches

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TERMINATION OF INSURANCE

Your insurance will end on the first of these to occur:

- The date this Policy terminates;
- The last day for which any required premium has been paid;
- The date **you** are no longer in an eligible class.

Termination does not affect a claim for an **injury** that occurs before the termination date. However, in no instance will benefits extend beyond the earlier of:

- The end of the Benefit Period; or
- The date benefits equal any applicable plan level limit or benefit limit, as shown in the *Schedule of Benefits*, have been paid.

Extension of Coverage After Termination

Coverage will be available while you are totally disabled, but only for the condition that caused the disability, for up to the earlier of 90 days or the end of the disability.

Special Circumstances

If, at the time the coverage would otherwise terminate, the covered person has “special circumstances” such as a disability, acute condition, or life-threatening illness and is receiving treatment from a provider and the provider reasonably believes that discontinuing care could cause harm to the covered person, coverage may be continued.

A "special circumstances" situation must be identified by the treating provider and the provider must request that the covered person be permitted to continue treatment under the provider’s care. The provider must also agree to continue to accept the terms of the coverage as they existed at the time coverage would have terminated.

Coverage may be continued:

- Up to 90 days if the covered person has a disability, acute condition or life threatening illness; or
- Up to 9 months, if the covered person has been diagnosed with a terminal illness.

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General Conditions for Coverage

To be covered by the plan, services and supplies must meet all of the following requirements:

1. The service or supply must be **covered by the plan**. For a service or supply or **prescription drug** to be covered, it must:
 - Be included as a **covered expense** in this Policy;
 - **Not** be an excluded expense under this Policy. Refer to the *Exclusions and Limitations* section of this Policy for a list of services and supplies that are excluded;
 - **Not** exceed the maximums and limitations outlined in this Policy. Refer to the *Schedule of Benefits* for information about certain expense limits; and
 - Be obtained in accordance with all the terms, policies and procedures outlined in this Policy.
2. The service or supply must be provided while **coverage is in effect**. See the *Eligibility* and the *Termination of Insurance* sections for details on when coverage begins and ends.
3. The service or supply must be **medically necessary**. To meet this requirement, the health care or dental services, supply must be provided by a **physician** or **dental provider**, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an **injury**. The provision of the service or supply must be:
 - In accordance with generally accepted standards of medical dental practice;
 - Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness, injury** or disease;
 - Not primarily for the convenience of the patient, **physician** or **dental provider**; and
 - And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **injury**.

For these purposes "generally accepted standards of medical dental practice" means standards that are based on credible scientific evidence published in peer-reviewed medical dental literature generally recognized by the relevant medical dental community, or otherwise consistent with **physician** dental specialty society recommendations and the views of **physicians dentists** practicing in relevant clinical areas and any other relevant factors.

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

Certain services such as inpatient **stays** require **preauthorization**. Refer to the section *Understanding Preauthorization* for details about **preauthorization**.

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WHAT THE PLAN COVERS

HOSPITAL EXPENSES

Room and Board

Covered expenses include charges for **room and board** provided at a **hospital** during your **stay**. Private room charges that exceed the **hospital's semi-private room rate** are not covered.

Room and board charges also include:

- Services of the **hospital's** nursing staff;
- Admission and other fees;
- General and special diets; and
- Sundries and supplies.

Other Hospital Services and Supplies

Covered expenses include charges made by a **hospital** for services and supplies furnished to **you** in connection with your **stay**.

Covered expenses include **hospital** charges for other services and supplies provided, such as:

- **Ambulance** services
- **Physicians** and surgeons.
- Operating and recovery rooms.
- Intensive or special care facilities.
- Administration of blood and blood derivatives, but not the cost of the blood or blood product.
- Radiation therapy.
- Speech therapy, physical therapy and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services.
- Medications.
- Intravenous (IV) preparations.
- Discharge planning.

HOSPITAL OUTPATIENT EXPENSES

Hospital Outpatient Department

Covered expenses include charges made by a **hospital** for covered services and supplies provided by the outpatient department of a **hospital**.

LABORATORY AND X-RAY EXPENSES

Benefits are payable for **covered expenses** made by a **physician, hospital**, or licensed radiological facility or lab for diagnostic X-rays and laboratory services incurred on an outpatient basis.

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SURGICAL EXPENSES

Covered expenses include charges made by a **physician** or **surgery center** for surgical, assistant surgical and anesthesia services.

This Plan will pay for the following surgical services performed by a **physician** during an operation. For purposes of this Plan, an “operation” is one or more surgical procedures performed during the same operating period, while under one continuous period of anesthesia.

Surgery, if it is:

- Incision or excision of any part of the body;
- Electrocauterization of any part of the body;
- Manipulative reduction of a fracture or dislocation;
- Manipulation of a joint under a general anesthetic, including application of a cast or traction;
- Suturing a wound;
- Endoscopic removal of a stone or foreign object from the larynx, bronchus, trachea, esophagus, stomach, urinary bladder, or ureter;
- The diagnostic exam by endoscopic means of those organs shown the above item.

Related preoperative care.

Administration of an anesthetic.

Related postoperative care provided during the same **hospital stay** as the **surgery**, or in the 14 days following the **surgery**, whichever is longer.

IMPORTANT NOTE:

More than one surgical procedure may be performed during one operation through the same incision or natural body orifice, or in the same operative field. When this happens, this Plan covers only one procedure. This Plan will pay for the most expensive procedure as shown in the *Schedule of Surgical Procedures*.

When two or more surgical or bilateral procedures are performed during one operation in separate operative fields, this Plan will pay for the full cost of the most expensive procedure, up to the maximum shown in the *Schedule of Surgical Procedures*; and 50% of the scheduled amount for each of the other procedures.

Surgical Assistance Services

Surgical assistance services include **physician** services giving technical assistance to an operating **physician**. This Plan will pay for these services if provided during your **hospital stay** for covered **surgery**.

This Plan does **not** cover routine services given by an intern, resident **physician** or house officer of the **hospital**.

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Anesthesia Services

This Plan pays for the charges of a **physician** to administer a general anesthetic during covered **surgery**. This Plan will also pay for related pre- and postoperative care. This Plan does **not** cover:

- Anesthesia administered by your operating **physician**;
- Anesthesia administered by your operating **physician's** assistant; or
- Local anesthetics.

This Plan will pay for the services of a **physician** to administer a general or local anesthetic during covered **surgery**. This Plan will also pay for related pre- and postoperative care.

The maximum payable for a procedure is determined by units of anesthesia time, which is the number of minutes that elapse between:

- The time that anesthesia is first administered; and
- The time when the patient can be safely placed under post-operative care.

Fifteen minutes of anesthesia time equals one unit. To calculate the anesthesia maximum for a surgical procedure, multiply by the anesthesia dollar factor shown in the *Schedule of Benefits*.

If the operating **physician** or surgical assistant administers the anesthesia, this Plan will pay no more than 50% of the amount determined above.

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AMBULANCE EXPENSES

Covered expenses include charges made by a professional **ambulance**, as follows:

Ground Ambulance

Covered expenses include charges for transportation:

- To the first **hospital** where treatment is given in a medical emergency.
- From one **hospital** to another **hospital** in a medical emergency when the first **hospital** does not have the required services or facilities to treat **your** condition.
- From **hospital** to home or to another facility when other means of transportation would be considered unsafe due to **your** medical condition.
- From home to **hospital** for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to **your** medical condition. Transport is limited to 100 miles
- During a covered inpatient **stay** at a **hospital, skilled nursing facility**, or acute rehabilitation hospital, to transport **you** for inpatient or outpatient **medically necessary** treatment when an **ambulance** is required to safely and adequately transport **you**.

Air or Water Ambulance

Covered expenses include charges for transportation to a **hospital** by air or water **ambulance** when:

- Ground **ambulance** transportation is not available;
- **Your** condition is unstable, and requires medical supervision and rapid transport; and
- From one **hospital** to another **hospital** in a medical emergency when the first **hospital** does not have the required services or facilities to treat **your** condition; and the two conditions above are met.

Limitations

Not covered under this benefit are charges incurred to transport **you**:

- If an **ambulance** service is not required for **your** physical condition; or
- If the type of **ambulance** service provided is not required for **your** physical condition; or
- By any form of transportation other than a professional **ambulance** service.

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HOME HEALTH CARE EXPENSES

Covered expenses include charges made by a **home health care agency** for home health care, and the care:

- Is given under a **home health care plan**;
- Is given to you in your home while you are **homebound** and
- Starts within 7 days after discharge from a **stay** in a **hospital** or other inpatient facility; and
- Is for the same or related condition that caused the **stay** in a **hospital** or other inpatient facility.

Home health care expenses include charges for:

- Part-time or intermittent care by an **R.N.** or by an **L.P.N.** if an **R.N.** is not available.
- Part-time or intermittent home health aid services provided in conjunction with and in direct support of care by an **R.N.** or an **L.P.N.**
- Physical, occupational, and speech therapy.
- Part-time or intermittent medical social services by a social worker when provided in conjunction with, and in direct support of care by an **R.N.** or an **L.P.N.**
- Medical supplies, **prescription drugs** and lab services by, or for, a **home health care agency** to the extent they would have been covered under this Plan if you had continued your **hospital stay**.

Covered expenses will not include:

- Services by a person who resides in **your** home, or is a member of **your** immediate family;
- Homemaker or housekeeper services;
- Maintenance therapy;
- Dialysis treatment;
- Purchase or rental of dialysis equipment; or
- Food or home delivered services.

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THERAPY EXPENSES

Covered expenses included charges for short-term therapy services when prescribed by a **physician** as described below. The services have to be performed by:

- A licensed or certified physical, occupational, or speech therapist;
- A **hospital**, or **skilled nursing facility**;
- A **home health care agency**; or
- A **physician**.

Charges for the following short term rehabilitation expenses are covered:

- Physical therapy including spinal manipulation is covered for **injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an **injury**. Physical therapy does not include educational training or services designed to develop physical function.
- Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for **injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an **injury**, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function.
- Speech therapy is covered for **injuries** and expected to restore the speech function or correct a speech impairment resulting from **injury**. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration; and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.
- If you are **homebound**, therapy services may be provided in your home.

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DURABLE MEDICAL AND SURGICAL EQUIPMENT (DME) EXPENSES

Covered expenses include charges by a **DME** supplier for the rental of equipment or, in lieu of rental:

The initial purchase of **DME** if:

- Long term care is planned; and
- The equipment cannot be rented or is likely to cost less to purchase than to rent.

Repair of purchased equipment. Maintenance and repairs needed due to misuse or abuse are not covered.

This Plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. **You** are responsible for the entire cost of any additional pieces of the same or similar equipment **you** purchase or rent for personal convenience or mobility.

Replacement of purchased equipment if:

- The replacement is needed because of a change in **your** physical condition; and
- It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

Covered **durable medical equipment** includes those items covered by Medicare unless excluded in the *Exclusions* section of this Policy. Aetna reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of Aetna.

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PROSTHETIC DEVICES EXPENSES

Covered expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by **injury**. **Covered expenses** also include instruction and incidental supplies needed to use a covered prosthetic device.

This Plan covers the first prosthesis **you** need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of **injury** as described in the list of covered devices below for an:

- Internal body part or organ; or
- External body part.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in **your** physical condition; or **your** normal growth, or the device's wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:

- An artificial arm, leg, hip, knee, or eye;
- Eye lens;
- Ostomy supplies, urinary catheters, and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made for and fitted for **you**.

This Plan will not cover expenses and charges for, or expenses related to:

- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless prescribed by a **physician**; or
- Trusses, corsets, and other support items or
- Any item listed in the *Exclusions* section.

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PHYSICIAN SERVICES EXPENSES

Covered expenses include inpatient and outpatient charges incurred by **you** for the treatment of an **injury**; which occurred while **you** were participating in a **covered activity**; requiring services provided by a **physician**.

SPECIALTY EQUIPMENT EXPENSES

Aetna will pay benefits for specialty equipment expenses to accommodate **your** physical disability, such as residence or automobile modification, when the need for such specialty equipment is a direct result of an **injury** which occurred while **you** were participating in a **covered activity**.

You must present satisfactory evidence to Aetna that participation in a **covered activity** precipitated the necessity of the specialty equipment.

ORAL AND MAXILLOFACIAL TREATMENT (Mouth, Jaws and Teeth)

Covered expenses include charges made by a **physician**, a **dentist** and **hospital** for services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues, (this includes bones, muscles, and nerves), for surgery needed to:

- Treat a fracture, dislocation, or wound.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Hospital services and supplies received for a **stay** required because of your condition.

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

- Natural teeth damaged, lost, or removed; or
- Other body tissues of the mouth fractured or cut;

due to **injury**.

Any such teeth must have been free from decay or in good repair, and are firmly attached to the jaw bone at the time of the **injury**.

If crowns, dentures, bridges, or in-mouth appliances are installed due to **injury**, **covered expenses** only include 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**.

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Covered expenses include charges made for limited services and supplies related to the treatment of teeth, gums, and jaws and their supporting structures, muscles and nerves as follows:

- Accidental **injuries** and other trauma. This Plan covers oral surgery and related dental services to return sound natural teeth to their pre-trauma functional state, but only if the services take place within the maximum number of weeks per **injury** as reflected in the *Schedule of Benefits*.

Sound natural teeth are teeth that were stable, functional, and free from decay and advanced periodontal disease at the time of the trauma.

IMPORTANT NOTE:

Trauma which occurs solely as a result of biting or chewing is **not** considered accidental **injury**, even if it is unplanned or unexpected.

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UNDERSTANDING PREAUTHORIZATION

Preauthorization or Preauthorized

Certain services, such as inpatient **stays** require **preauthorization** by Aetna. **Preauthorization** is a process that helps **you** and **your physician** determine whether the services being recommended are **covered expenses** under the plan. It also allows Aetna to help **your** provider coordinate **your** transition from an inpatient setting to an outpatient setting (called discharge planning), and to register **you** for specialized programs or case management when appropriate.

You do not need to **preauthorize** services provided by a **network provider**. **Network providers** will be responsible for obtaining necessary **preauthorization** for **you**. Since **preauthorization** is the provider's responsibility, there is no additional out-of-pocket cost to **you** as a result of a **network provider's** failure to **preauthorize** services.

When **you** go to an **out-of-network provider**, it is **your** responsibility to obtain **preauthorization** from Aetna for any services or supplies on the **preauthorization** list below. If **you** do not **preauthorize your** benefits may be reduced.

As part of **preauthorization**, **you** may be required to get a second or third opinion through an independent medical exam. If the plan requires **you** to obtain a second or third opinion, the plan will fully cover the second or third opinion with no **deductible**.

IMPORTANT NOTE:

Please read the following sections in their entirety for important information on the **preauthorization** process, and any impact it may have on **your** coverage.

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The Preauthorization Process

Prior to being **hospitalized** or receiving certain other medical services or supplies there are certain **preauthorization** procedures that must be followed.

You are responsible for obtaining **preauthorization**. **You** or a member of **your** family, a **hospital** staff member, or the attending **physician**, must notify Aetna to **preauthorize** the admission or medical services and expenses prior to receiving any of the services or supplies that require **preauthorization** pursuant to this Booklet-Certificate in accordance with the following timelines:

Preauthorization should be secured within the timeframes specified below. To obtain **preauthorization**, call Aetna at the telephone number listed on **your** ID card. This call must be made:

For non-emergency admissions:	It is your responsibility to call and request preauthorization at least 14 days before the date you are scheduled to be admitted.
For an emergency outpatient medical condition: **	You or your physician should call prior to the outpatient care, treatment or procedure if possible; or as soon as reasonably possible.
For an emergency admission : **	You, your physician or the facility must call within 24 hours or as soon as reasonably possible after you have been admitted.
For an urgent admission :	You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness ; the diagnosis of an illness ; or an injury .
For outpatient non-emergency medical services requiring preauthorization ,	You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

Aetna will provide a written notification to **you** and **your physician** of the **preauthorization** decision. If **your preauthorized** expenses are approved the approval is good for 30 days as long as **you** remain enrolled in the plan.

When **you** have an inpatient admission to a facility, Aetna will notify **you, your physician** and the facility about **your preauthorized** length of **stay**. If **your physician** recommends that **your** stay be extended, additional days will need to be authorized. **You, your physician**, or the facility will need to call Aetna at the number on **your** ID card as soon as reasonably possible, but no later than the final authorized day. Aetna will review and process the request for an extended **stay**. **You** and **your physician** will receive a notification of an approval or denial.

If **preauthorization** determines that the **stay** or services and supplies are not **covered expenses**, the notification will explain why and how Aetna’s decision can be appealed.

** The cost of treatment for an **Emergency Medical Condition** rendered by an **out-of-network provider** will be covered at the **network service** benefit level, less **any coinsurance, copayments or deductible**, up to the time it is determined by the attending **physician** that you are medically able to travel or to be transported to a **network provider**.

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Services and Supplies Which Require Preauthorization:

Preauthorization is required for the following types of medical expenses:

Inpatient and Outpatient Care

- **Stays in a hospital**
- **Stays in a skilled nursing facility**
- **Home health care**

How Failure to Preauthorize Affects Your Benefits

A **preauthorization** penalty will be applied to the benefits paid if **you** fail to obtain a required **preauthorization** prior to incurring medical expenses. This means Aetna will reduce the amount paid towards **your** coverage. **You** will be responsible for the unpaid balance of the bills.

You are responsible for obtaining the necessary **preauthorization** from Aetna prior to receiving services from an **out-of-network provider**. **Your** provider may **preauthorize your** treatment for **you**; however **you** should verify with Aetna prior to the procedure, that the provider has obtained **preauthorization** from Aetna. If your treatment is not **preauthorized** by **you** or **your** provider, the benefit payable may be significantly reduced.

How Your Hospital Inpatient Benefits Are Affected

If your **stay** has not been recommended by your **PCP** or another **network provider** treating **physician**, your benefits may be reduced if the necessary **preauthorization** is not obtained, as illustrated in the chart below.

If preauthorization is:	and Aetna determines that the stay , or any day of the stay is:	then room and board expenses are:	and all other inpatient facility expenses are:
requested and approved	approved,	covered;	covered.
requested and denied	denied	not covered; may be appealed	covered.
not requested	would have been approved if requested,	covered after a benefit reduction is applied*;	covered.
not requested	would have been denied if requested,	not covered; may be appealed	covered after a benefit reduction is applied*.

*Refer to the *Summary of Benefits* section for the amount of **preauthorization** benefit reduction that applies to your plan.

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SECTION 4 - COVERAGE**

How Your Benefits for Inpatient and Outpatient Care are Affected

The chart below illustrates the effect on your benefits if necessary **preauthorization** for outpatient or inpatient services is not obtained.

If preauthorization is:	then the expenses are:
<ul style="list-style-type: none">• requested and approved by Aetna	<ul style="list-style-type: none">• covered.

*Refer to the *Summary of Benefits* section for the amount of **preauthorization** benefit reduction that applies to your plan.

It is important to remember that any additional out-of-pocket expenses incurred because your **preauthorization** requirement was not met will not count toward your **deductible** or **coinsurance** or **coinsurance limit**.

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SECTION 5 – EXCLUSIONS AND LIMITATIONS**

Exclusions

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What The Plan Covers* section or by amendment attached to this Policy.

IMPORTANT NOTE:

This coverage is only for losses caused by **accidents**. No benefits are payable for **Sickness**, disease or **illness** expenses.

Acupuncture, acupressure and acupuncture therapy, except as a form of anesthesia in connection with covered **surgery**.

Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this Policy.

Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain medical services, **prescription drugs**, or supplies, even if otherwise covered in this Policy, or such drugs or supplies are unavailable or illegal in the United States, or the purchase of such **prescription drugs** or supplies outside the United States is considered illegal.

Artificial organs: Any device intended to perform the function of a body organ.

Behavioral Health Services:

- Alcoholism or drug abuse Substance Abuse rehabilitation treatment on an inpatient or outpatient basis.
- Non-serious; Non biologically based and Serious; Biologically based Mental health services, inpatient and outpatient;
- Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of their training in that field.
- Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use.
- Treatment of antisocial personality disorder.
- Treatment in wilderness programs or other similar programs.

Blood, blood plasma, synthetic blood, blood derivatives or substitutes, including but not limited to, the provision of blood, other than blood derived clotting factors. Any related services including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are not covered. For autologous blood donations, only administration and processing costs are covered.

Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the plan.

Charges submitted for services by an unlicensed **hospital**, **physician** or other provider or not within the scope of the provider's license.

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SECTION 5 – EXCLUSIONS AND LIMITATIONS

Cosmetic services and plastic surgery: any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons including:

- Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures;
- Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
- Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin; and
- Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when **medically necessary**
- Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy);
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
- Surgery to correct Gynecomastia;
- Breast augmentation;
- Otoplasty.

Covered expenses for cheerleading activities which include but are not limited to: camps, clinics, national competitions, conference competitions, and any events not conducted by the member institution. This exclusion does not apply to:

- A **covered activity** that takes place at a team competition, scheduled by the member institution. This includes but is not limited to cheering at a football or basketball game.
- Practice sessions and pep rallies that are authorized, organized, and directly supervised by a safety-certified official coach or advisor of the member institution in preparation for a team competition. The coach or advisor must have current safety certification by a nationally recognized formal credentialing program for safety certification. The coach or advisor cannot be a full-time undergraduate student, student-coach, or member of the squad.

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:

- Who prescribed the custodial care; or
- Who recommended the custodial care; or
- Who performed the custodial care.

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Dental Services: except as specifically described in the *What the Plan Covers* section any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of **injuries** and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:

- Services of **dentists**, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, removal of bony impacted teeth, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
- Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth;
- Non-surgical and surgical treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment;

This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors and orthodontogenic cysts.

Disposable outpatient supplies: Any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses, and other devices not intended for reuse by another patient.

Drugs, medications and supplies:

- Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a **prescription** including vitamins;
- Any services related to the dispensing, injection or application of a drug;
- Any **prescription drug** purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
- Immunizations related to travel;
- Needles, syringes and other injectable aids;
- Drugs related to the treatment of non-covered expenses;
- Performance enhancing steroids;
- Implantable drugs and associated devices;
- Injectable drugs if an alternative oral drug is available;
- Outpatient **prescription drugs**;
- Self- injectable **prescription drugs** and medications;
- Any **prescription drugs**, injectibles, or medications or supplies provided by the policyholder or through a third party vendor contract with the policyholder.
- Any expenses for **prescription drugs**, and supplies covered under an Aetna Managed Prescription Plan will not be covered under this medical expense plan; **Prescription drug** exclusions that apply to the Aetna Managed Prescription Plan will apply to the medical expense coverage;
- Charges for any **prescription drug** for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

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Durable medical and surgical equipment including purchase, rental, replacement or repair, except as specifically provided in the *What the Plan Covers* section.

Educational services:

- Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
- Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause; and
- Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.

Examinations:

Any health examinations:

- Required by a third party;
- Required by any law of a government, securing insurance or school admissions, or professional or other licenses;
- Required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
- Any special medical reports not directly related to treatment except when provided as part of a covered service.
- Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *What the Plan Covers* section.

Expenses incurred as a result of suicide; attempted suicide or intentionally self inflicted **injury** whether sane or not.

Expenses incurred for **injury** resulting from declared or undeclared war or any act thereof. Declared or undeclared war does not include acts of terrorism.

Expenses incurred as a result of **injury** due to participation in a riot. "Participation in a riot" means taking part in a riot in any way; including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense; so long as they are not taken against persons who are trying to restore law and order.

Expenses incurred as a result of preventive medicines; serums; vaccines or oral contraceptive.

Expenses incurred beyond 104 weeks from the date of the **accident**.

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

Expenses incurred by a covered person who is not a United States citizen, for services performed within the covered person's home country; if the covered person's home country has a socialized medicine program.

Expenses incurred for the use of orthotics; unless used exclusively to promote healing.

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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.

Expenses incurred for which no member of **your** immediate family has any legal obligation for payment.

Expenses incurred as a result of an **injury** sustained while in the service of the Armed Forces of any country. When you enter the Armed Forces of any country; the unearned pro-rata premium will be refunded to the Policyholder.

Expenses incurred for treatment provided in a governmental **hospital** if that facility regularly and customarily demands and collects payment from non-indigent persons care received, unless there is a legal obligation to pay such charges in the absence of insurance.

Expenses incurred for **elective treatment** or elective **surgery**.

Expenses incurred for pregnancy, childbirth or miscarriage.

Experimental or investigational drugs, devices, treatments or procedures and expenses for; or in connection with; services or supplies that are; as determined by Aetna; to be experimental or investigational. A drug; a device; a procedure; or treatment; will be determined to be experimental or investigational if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the **injury** involved; or
- If required by the FDA; approval has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined; in writing; that it is experimental; investigational; or for research purposes; or
- The written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying substantially the same drug; device; procedure; or treatment; or the written informed consent used by the treating facility or by another facility studying the same drug; device; procedure; or treatment states that it is experimental; or for research purposes.

Facility charges for care, services or supplies provided in:

- Rest homes;
- Assisted living facilities;
- Similar institutions serving as an individuals primary residence or providing primarily custodial or rest care;
- Health resorts;
- Spas, sanitariums; or
- Infirmaries at schools, colleges, or camps.

Food and nutritional items: Any food item, nutritional supplements, vitamins, including prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition.

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Foot care: Except as specifically covered for diabetics, any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including:

- treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes; and
- Shoes (including orthopedic shoes), orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an **illness or injury**.

Hearing:

- Any hearing service or supply that does not meet professionally accepted standards;
- Hearing exams given during a **stay** in a **hospital** or other facility;
- Any tests, appliances, and devices for the improvement of hearing, including aids, hearing aids and amplifiers, or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech;
- Routine hearing exams.

Home and mobility: Except as specifically provided in the *What the Plan Covers* section, any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, including:

- Bathroom equipment such as bathtub seats, benches, rails, and lifts;
- Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds and swimming pools;
- Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, massage devices or over-bed tables;
- Equipment or supplies to aid sleeping or sitting, including electric beds, water beds, air beds, pillows, sheets, blankets, warming or cooling devices, elevating chairs, bed tables and reclining chairs;
- Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;
- Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;
- Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your **injury**;
- Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.

Maintenance care: This is care made up of services and supplies that:

- Are furnished mainly to maintain, rather than to improve, a level of physical, or mental function; and
- Provide a surrounding free from exposures that can worsen the person's physical or mental condition.

Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.

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Miscellaneous charges for services or supplies including:

- Annual or other charges to be in a **physician's** practice;
- Charges to have preferred access to a **physician's** services such as boutique or concierge **physician** practices;
- Cancelled or missed appointment charges or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
 - Care in charitable institutions;
 - Care for conditions related to current or previous military service;
 - Care while in the custody of a governmental authority;
 - Any care a public **hospital** or other facility is required to provide; or
 - Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.

Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).

Non-**medically necessary** services, including but not limited to, those treatments, services, **prescription drugs** and supplies which are not **medically necessary**, as determined by Aetna, for the diagnosis and treatment of **illness, injury**, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including: Telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy. Also excluded are items; such as air conditioners; humidifiers; hot tubs; whirlpools; or physical exercise equipment; even if such items are prescribed by a **physician**

Private duty nursing during your **stay** in a **hospital**, and outpatient private duty nursing services. Skilled nursing care is covered as specifically described in the *What the Plan Covers* section in accordance with a home health treatment plan approved by Aetna.

Prosthetics or prosthetic devices unless specifically covered under *What the Plan Covers* section.

Repair or replacement of existing artificial limbs; prosthetic appliances, rental of existing **Durable Medical Surgical Equipment**, orthopedic braces; or orthotic devices, unless the purpose of modifying the item is due to **injury** while participating in a **covered activity** that has caused further impairment in the underlying bodily condition.

Routine physical exam expenses; routine vision exams; routine dental exams; routine hearing exams; immunizations; or other preventive services and supplies; except to the extent coverage of such exams; immunizations; services; or supplies is specifically provided in the Policy.

Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law or any household member. This exclusion does not apply with regard to the choice of a **dentist** for coverage of services under the plan.

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Services of a resident **physician** or intern rendered in that capacity.

Services provided where there is no evidence of pathology or dysfunction.

Sexual dysfunction/enhancement: Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and
- Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.

Services rendered before the effective date or after the termination of coverage.

Services that are not covered under this Policy.

Services and supplies provided in connection with treatment or care that is not covered under the plan.

Spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine including manipulation of the spine treatment, except as specifically provided in the *What the Plan Covers* section.

Strength and performance: Services, devices and supplies to enhance strength, physical condition, endurance or physical performance including:

- Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching;
- Drugs or preparations to enhance strength, performance, or endurance; and
- Treatments, services and supplies to treat **injuries** or disabilities related to the use of performance-enhancing drugs or preparations.

Therapies and tests: Any of the following treatments or procedures:

- Aromatherapy;
- Bio-feedback and bioenergetic therapy;
- Carbon dioxide therapy;
- Chelation therapy (except for heavy metal poisoning);
- Chiropractic Care.
- Computer-aided tomography (CAT) scanning of the entire body;
- Cost of supplies used in the performance of any occupational therapy.
- Educational therapy;
- Full body CT scans;
- Gastric irrigation;
- Hair analysis;
- Holistic medicine and/or therapy; including but not limited to yoga and hypnotherapy
- Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
- Hypnosis, and hypnotherapy, except when performed by a **physician** as a form of anesthesia in connection with covered surgery;
- Lovaas therapy;

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- Massage therapy;
- Megavitamin therapy;
- Primal therapy;
- Psychodrama;
- Purging;
- Recreational therapy;
- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy;
- Thermograms and thermography.

Transportation costs, including **ambulance** services for routine transportation to receive outpatient or inpatient services except as described in the *What the Plan Covers* section.

Treatment of conditions not related to an **accident**.

Treatment required for condition caused by repetitive motion **injuries** and not a result of a **covered activity** including, but not limited to: stress fracture, strain, shin splint, Osgood-Schlatter Disease, Chondromalacia, tendonitis, bursitis or heat stroke.

Unauthorized services, including any service obtained by or on behalf of you without **Preauthorization** by Aetna when required. This exclusion does not apply in a Medical Emergency or in an Urgent Care situation.

Vision-related services and supplies. The plan does not cover:

- Anti-reflective coatings;
- Special supplies such as non-**prescription** sunglasses and subnormal vision aids;
- Vision services or supplies which do not meet professionally accepted standards;
- Tinting of eyeglass lenses;
- Special vision procedures, such as orthoptics, vision therapy or vision training;
- Eye exams during your **stay** in a **hospital** or other facility for health care;
- Eye exams to diagnose or treat an **illness** or **injury**;
- Eye exams for contact lenses or their fitting;
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
- Replacement of lenses or frames that are lost or stolen or broken;
- Acuity tests;
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
- Services to treat errors of refraction.

Work related: Any **injury** related to employment or self-employment including any **injuries** that arise out of (or in the course of) any work for pay or profit unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your workers' compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular **injury** under such law, that **injury** will be considered "non-occupational" regardless of cause.

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SECTION 5 – EXCLUSIONS AND LIMITATIONS**

PRE-EXISTING CONDITIONS

Expenses incurred by **you** as a result of a **pre-existing condition** will not be considered a **covered expense**.

EXCESS PROVISION

This Plan is an excess only Plan. As an excess only Plan, this Plan pays its Covered Medical Expenses after any other medical coverage. This Plan's liability will be determined without consideration to any limitation clause or clauses regarding other coverage contained in any other medical coverage. Benefits Payable under this Plan shall be limited to the Plan's Covered Medical Expense and reduced by the amount paid or payable by any other medical coverage. However, consideration will be given to the other medical coverage's liability due to a provider contract or other reasons when calculating this Plan's Benefits Payable. This Plan's applied **deductible** will be credited back into the Benefits Payable when both plans would apply a **deductible**.

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

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

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

**AETNA LIFE INSURANCE COMPANY
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SECTION 6 – GENERAL PROVISIONS**

ENTIRE CONTRACT CHANGES

Policy

The Entire Policy consists of:

- This Policy;
- The application, copy attached;
- The current rates on file with the Policyholder;
- Any riders, endorsements, inserts, attachments or amendments to this Policy.

Policy Changes

This policy shall be deemed to be automatically amended to conform with the provisions of applicable laws and regulations. This policy may also be amended by Aetna:

- Within 30 days written notice to the Policyholder; or
- By written agreement between Aetna and the Policyholder.

The consent of any other person is not needed. All agreements made by Aetna are signed by an authorized executive officer of Aetna. No one other than an authorized officer of Aetna may change or waive any of the policy terms or make any agreement binding Aetna.

The Policyholder will not have to give written agreement of a change in the policy if:

- The Policyholder has asked for the change and Aetna has agreed to it.
- The change is needed to correct an error in the Policy, including any Booklet-Certificate issued to anyone.
- The change is needed so that the Policy will conform to any law, regulation or ruling of a jurisdiction that affects a person covered under this Policy; or the federal government.
- The change has been initiated by Aetna and is not resulting in either: a reduction or elimination in benefits or coverage; or an increase in premium

The Policyholder will have to give written agreement of a change in the Policy:

- That reduces or eliminates benefits or coverage; or
- That increases benefits or coverage with a concurrent increase in premium during the Policy term, except if the increased benefits or coverage is required by law.

Payment of the applicable premium after notice of the proposed changes will be deemed to constitute the Policyholder's written agreement of those changes on behalf of all persons covered under this policy.

Misstatements

If any fact as to the Policyholder or **you** is found to have been an intentional misstatement of material fact, a fair change in premiums may be made. If the intentional misstatement of material fact affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

All statements made by the Policyholder and **you** shall be deemed representations and not warranties. No written statement made by **you** shall be used by Aetna in a contest unless a copy of the statement is or has been furnished to **you** or **your** beneficiary, or the person making the claim.

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Aetna's failure to implement or insist upon compliance with any provision of this Policy at any given time or times, shall not constitute a waiver of Aetna's right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of premiums. This applies whether or not the circumstances are the same.

Incontestability

Except as to an intentional misstatement of material fact, or issues concerning Premiums due:

- No statement made by the Policyholder or **you** shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing.
- No statement made by the Policyholder shall be the basis for voiding this Policy after it has been in force for 2 years from its effective date.
- No statement made by **you** shall be used in defense of a claim for loss incurred or starting after coverage as to which claim is made has been in effect for 2 years.

PREMIUMS

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

PREMIUMS DUE - EXPERIENCE RATING

The Premium due under this policy on any Premium Due Date will be the sum of the premium charges for the coverages provided under this Policy. Who is insured as of each Premium Due Date will be determined by Aetna in accordance with our records. A check does not constitute payment until it is honored by a bank. Aetna may return a check issued against insufficient funds without making a second deposit attempt. Aetna may accept a partial payment of Premium without waiving our right to collect the entire amount due.

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

Aetna may change premiums due to experience or a change in factors bearing on the risk assumed. Each change shall be made by written notice to the Policyholder by Aetna pursuant to *Changes in Premium* section.

Except as otherwise provided in the *Changes in Premium* provision, no experience reduction or increase in Premium Rates shall become effective less than 12 months after the effective date of this Policy.

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

**AETNA LIFE INSURANCE COMPANY
STUDENT SPORTS ACCIDENT INSURANCE
SECTION 6 – GENERAL PROVISIONS**

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

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

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

- The first day of the Policy Year in which Aetna receives proof that the refund should be made; or
- The date 3 months before Aetna receives proof, if this produces a larger refund.

This applies even if the premium was paid in error.

Grace Period. The Grace Period is the 30 consecutive day period immediately following the Premium Due Date granted for the payment of Premium and applicable fees, during which time the Policy will remain in force. If all Premiums and fees are not received before the end of the Grace Period, this Policy will be automatically terminated on the date the Grace Period expires terminated by Aetna pursuant to the section on *Termination*.

PAYMENT OF PREMIUMS

The Policyholder will pay premiums in advance. They may be paid at Aetna's Home Office, or to its authorized agent. The entire premium is due to be paid on the first day of the Policy month.

If the premiums and any fees are not paid by the Premium Due Date and before the end of the Grace Period, this policy will automatically terminate when the Grace Period ends Aetna will require the Policyholder to pay interest on the total premium amount and any fees overdue after the Premium Due Date including the premiums due for the Grace Period. The interest rate will be up to 1 1/2% per month for each month; or partial month; the balance remains unpaid. Aetna may recover from the Policyholder: costs of collecting any unpaid premiums or fees, including reasonable attorney's fees; and costs of suit.

Changes in Premium

Aetna may also change the Premium rates effective as of any Premium Due Date upon 60 days prior written notice to the Policyholder.

Retroactive Adjustments

Aetna may, at our discretion, make retroactive adjustments to the Policyholder's billings for the termination of insureds not posted to previous billings. However, the Policyholder may only receive a maximum of 1 month's credit for insureds terminations that occurred more than 30 days before the date the Policyholder notified Aetna of the termination. We may reduce any such credits by the amount of any payments Aetna may have made on behalf of such insured before Aetna was informed their coverage had been terminated. Retroactive additions will be made at Aetna's discretion based upon eligibility guidelines stated in the Booklet-Certificate, and are subject to the payment of all applicable premiums.

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INDEPENDENT CONTRACTOR RELATIONSHIPS; INDEMNIFICATION

Relationship between Aetna and Network Providers

The relationship between Aetna and **Network Providers** is a contractual relationship among independent contractors. **Network Providers** are not agents or employees of Aetna nor is Aetna an agent or employee of any **Network Providers**.

Network Providers are solely responsible for any health services rendered to their patients. Aetna makes no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any **Physician, Dentist, Hospital** or other **Network Providers**. Providers provide health care diagnosis, treatment and services to **you** while you are covered under this Policy. Aetna administers and determines plan benefits.

Relationship between the Parties

The relationship between the Parties is a contractual relationship between independent contractors. Neither Party is an agent or employee of the other in performing its obligations pursuant to this Policy.

Indemnification

Aetna agrees to indemnify and hold the Policyholder harmless against that portion of its liability to third parties as determined by a court of final jurisdiction or by binding arbitration caused directly by Aetna's willful misconduct, criminal conduct or material breach of this Policy.

The Policyholder agrees to indemnify and hold Aetna harmless against that portion of our liability to third parties as determined by a court of final jurisdiction or by binding arbitration caused directly by the Policyholder's negligence, breach of this Policy, breach of applicable state and federal laws, willful misconduct, criminal conduct, fraud, or its breach of a fiduciary responsibility in the case of an action under ERISA, related to or arising out of this Policy or the Policyholder's role as Plan Sponsor, as defined by ERISA.

The Policyholder agrees that Aetna is not responsible for patient care and related treatment decisions which are the sole responsibility of health care Providers, that health care Providers are not the agents of either, and that in no event shall the indemnity obligations described above apply to that portion of any liability, settlement and related expense caused by the acts or omissions of health care Providers with respect to the insureds covered under this Policy.

The indemnification obligations described above shall terminate upon the termination of the Policy except as to any matter concerning a claim that has been made in writing before termination or within 365 days after termination.

ASSIGNMENTS

Except for benefits provided by the plan for health care services to providers, coverage may be assigned only with the written consent of Aetna.

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NOTICE OF CLAIM

All claims should be reported promptly. The deadline for filing a claim is 30 days after the date of the loss. Failure to give notice within the time prescribed above does not invalidate or reduce any claim if it is shown that it was not reasonably possible to give the notice within that time and that notice was given as soon as was reasonably possible.

CLAIM FORMS

Upon receipt of a written notice of claim; Aetna or its authorized agent will give the claimant such forms as are usually given for filing proofs of loss. If such forms are not given within 16 days after the receipt of such notice; the claimant can fulfill the terms of this Policy as to proof of loss by giving written proof of:

- The occurrence of the loss; and
- The character of the loss; and
- The extent of the loss.

REINSTATEMENT

If any renewal premium is not paid within the time granted the Policyholder for payment; a subsequent acceptance of premium by Aetna or by any agent duly authorized by Aetna to accept such premium; without requiring in connection therewith an application for reinstatement; shall reinstate the Policy. Provided; however; that if Aetna or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered; the Policy will be reinstated upon approval of such application by Aetna or; lacking such approval; upon the 45th day following the date of such conditional receipt unless Aetna has previously notified the Policyholder in writing of its disapproval of such application.

The reinstated Policy shall cover only loss resulting from such accidental **injury** as may be sustained after the date of reinstatement. In all other respects; the Policyholder and Aetna shall have the same rights thereunder as they had under the Policy immediately before the due date of the defaulted premium; subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with the reinstatement shall be applied to a period for which premium has not been previously paid; but not to any period for more than 60 days prior to the date of reinstatement.

PROOFS OF LOSS

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

TIME OF PAYMENT OF CLAIMS

Benefits payable under this Policy will be paid as they accrue and as soon as due written proof of such loss has been received by Aetna or its authorized agent. However, with regard to payment of claims submitted by **preferred provider**, not later than the 45th day after the date **Aetna** receives a clean claim from a **preferred provider** in a non-electronic format or the 30th day after the date **Aetna** receives a clean claim from a **preferred provider** that is electronically submitted, **Aetna** shall make a determination of whether the claim is payable.

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PAYMENT OF CLAIMS

All benefits payable under the Policy, will be paid not later than the 60th day after the date the proof of loss is received. All benefits are payable to **you** or **your** assignee. Written proof must be provided. **Aetna** will notify **you** in writing of the acceptance or rejection of a claim not later than the 15th business day after the date **Aetna** receives all items, statements, and forms required by the insurer to secure final proof of loss. If the **Aetna** is unable to accept or reject the claim within the period specified above, **Aetna** will, within that same period, notify **you** of the reasons that **Aetna** needs additional time. **Aetna** will accept or reject the claim not later than the 45th day after the date **Aetna** notifies you that extra time is needed.

If **your** beneficiary is a minor or, in **Aetna's** opinion, legally unable to give a valid release for payment of any accidental death benefit coverage, the benefit will be payable to the guardian of the estate of the minor, or to the custodian under the Uniform Transfer to Minors Act, or an adult caretaker, when permitted under applicable state law.

When a **PCP** provides for **your** care, or care is provided by a **network provider, (network services or supplies)**, the **network provider** will take care of filing claims. However, when you seek care on your own (**out-of-network services and supplies**), you are responsible for filing your own claims.

RECOVERY OF OVERPAYMENT

If a benefit payment is made by **Aetna**, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, **Aetna** has the right:

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

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

**REIMBURSEMENT TO TEXAS DEPARTMENT
OF HUMAN SERVICES**

All health expenses payable on behalf of **your** dependent child will be paid to the Texas Department of Human Services if, when you submit proof of loss, you notify **Aetna** in writing that the following applies and **you** request such direct payment be made:

- the Texas Department of Human Services is paying benefits for **your** child under the financial and medical assistance service program administered pursuant to the Human Resource Code; and

you either:

- have possession of or access to the child pursuant to a court order; or
- are not entitled to possession of or access to the child and are required by the court to pay child support.

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PHYSICAL EXAMINATION AND EVALUATIONS

Aetna will have the right and opportunity to have a **physician** or **dentist** vocational expert, or other medical or vocational professional of its choice examine any person who is requesting certification or benefits for new and ongoing claims. Multiple exams, evaluations and functional capacity exams may be required during your disability for an ongoing claim. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at Aetna's expense no cost to you.

LEGAL ACTION

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Aetna will not try to reduce or deny a benefit payment on the grounds that a condition existed before your coverage went into effect, if the loss occurs more than 2 years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

RECORDS MAINTAINED

The Policyholder will furnish to Aetna, on a monthly basis (or as otherwise required), such information as Aetna may reasonably require to administer this Policy. This information may be on our form (or such other form as Aetna may reasonably approve) by facsimile (or such other means as Aetna may reasonably approve). This includes, but is not limited to, information needed to enroll **you**, process terminations, and effect changes in family status.

The Policyholder represents that all enrollment and eligibility information that has been or will be supplied to Aetna is accurate. The Policyholder acknowledges that Aetna can and will rely on such enrollment and eligibility information in determining whether a person is eligible for coverage under this Policy. To the extent such information is supplied to Aetna by the Policyholder (in electronic or hard copy format), the Policyholder agrees to:

- Maintain a reasonably complete record of such information (in electronic or hard copy format, including evidence of coverage elections, evidence of eligibility, changes to such elections and terminations) for at least 7 years or until the final rights and duties under this Policy have been resolved, and to make such information available to Aetna upon request.
- If applicable, obtain from **you** a "Disclosure of Healthcare Information" authorization in the form currently being used by Aetna in the enrollment process (or such other form as Aetna may reasonably approve).

The Policyholder must notify **you** of the termination of the Policy in compliance with all applicable laws. However, Aetna reserves the right to notify **you** of termination of the Policy for any reason, including non-payment of premium. The Policyholder shall provide written notice to **you** of **your** rights upon termination of coverage.

**AETNA LIFE INSURANCE COMPANY
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EXAMINATION AND AUDIT

Aetna has the right to inspect all of the Policyholder's records on this Policy at any reasonable time. This right will extend until the latest of:

- 2 years after the termination date of the Policy; or
- The date all claims under the Policy have been settled.
- The date the Policy is in the Policyholder's possession and may be inspected by **you** at any time during normal business hours at the Policyholder's office.

Aetna will have the right and opportunity, at its own expense to have your financial records audited as often as Aetna may reasonably require at all reasonable times while a claim is pending or payable and for any ongoing recertification.

RESPONSIBILITIES OF THE POLICYHOLDER

Aetna will not be liable to **you** for the fulfillment of any obligation prior to information being received in a form satisfactory to Aetna. The Policyholder must notify Aetna of the date in which **your** eligibility ceases for the purpose of termination of coverage under this Policy. Subject to applicable law, unless otherwise provided in the Booklet-Certificate, Aetna will consider **your** eligibility to continue until stopped by the Policyholder.

Access

Make records directly related to **your** coverage under this Policy available to Aetna for inspection, at our expense, at the Policyholder's office, during regular business hours, upon reasonable advance request. This provision shall survive termination of this Policy.

Forms

Distribute materials to **you** regarding enrollment and coverage features. This includes coverage Booklet-Certificates as described in the Booklet-Certificate provision.

Policies and Procedures; Compliance Verification

Comply with all policies and procedures established by Aetna in administering and interpreting this Policy. The Policyholder shall, upon request, provide a certification of its compliance with Aetna's participation and contribution requirements. The Policyholder shall, upon request, submit proof that it continues to meet the definition of an eligible group as provided under applicable law or regulation.

POLICYHOLDER ERROR

A clerical error in keeping records; or a delay in making an entry; will not alone decide if insurance is valid. An equitable adjustment in premiums will be made when the error or delay is found. If the clerical error affects the existence or amount of insurance, the facts as determined by Aetna will be used to decide if insurance is in force and its amount. Aetna may also modify or replace a Policy or other document issued in error.

**AETNA LIFE INSURANCE COMPANY
STUDENT SPORTS ACCIDENT INSURANCE
SECTION 6 – GENERAL PROVISIONS**

SUBROGATION AND RIGHT OF REIMBURSEMENT

As used herein, the term “**Third Party**”, means any party that is, or may be, or is claimed to be responsible for **injuries** to **you**. Such **injuries** are referred to as “**Third Party Injuries**”. “**Third Party**” includes any party responsible for payment of expenses associated with the care of treatment of **Third Party Injuries**.

If this plan pays benefits under this Policy to **you** for expenses incurred due to **Third Party Injuries**, then Aetna retains the right to repayment of the full cost of all benefits provided by this plan on your behalf that are associated with the **Third Party Injuries**. Aetna’s rights of recovery apply to any recoveries made by **you** or on **your** behalf from the following sources, including but not limited to:

- Payments made by a **Third Party** or any insurance company on behalf of the **Third Party**;
- Any payments or awards under an uninsured or underinsured motorist coverage policy;
- Any Workers’ Compensation or disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners’ medical payments coverage or premises or homeowners’ insurance coverage; and
- Any other payments from a source intended to compensate **you** for **injuries** resulting from an **accident** or alleged negligence.

By accepting benefits under this plan, **you** specifically acknowledge Aetna’s right of subrogation. When this plan pays health care benefits for expenses incurred due to **Third Party Injuries**, Aetna shall be subrogated to **your** right of recovery against any party to the extent of the full cost of all benefits provided by this plan. Aetna may proceed against any party with or without **your** consent.

By accepting benefits under this plan, you also specifically acknowledge Aetna’s right of reimbursement. This right of reimbursement attaches when this plan has paid health care benefits for expenses incurred due to **Third Party Injuries** and **you** or **your** representative has recovered any amounts from a **Third Party**. By providing any benefit under this Policy, Aetna is granted right to reimbursement from s the proceeds of any settlement, judgment or other payment received by **you** to the extent of the full cost of all benefits provided by this plan. Aetna’s right of reimbursement is cumulative with and not exclusive of Aetna’s subrogation right and Aetna may choose to exercise either or both rights of recovery.

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By accepting benefits under this plan, **you** or **your** representatives further agree to:

- Notify Aetna promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to **Third Party Injuries** sustained by **you**;
- Cooperate with Aetna and do whatever is necessary to secure Aetna's rights of subrogation and reimbursement under this Policy;
- Give Aetna a right to reimbursement on any recovery, settlement, or judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with **Third Party Injuries** provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement);
- Pay, as the first priority, from any recovery, settlement judgment, or other source of compensation, any and all amounts due Aetna as reimbursement for the full cost of all benefits associated with **Third Party Injuries** paid by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by Aetna in writing; and
- Do nothing to prejudice Aetna's rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid by this plan.
- Serve as a constructive trustee for the benefits of this plan over any settlement or recovery funds received as a result of **Third Party Injuries**.

Aetna may recover full cost of all benefits paid by this plan under this Policy without regard to any claim of fault on **your** part, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from Aetna's recovery, and Aetna is not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by **you** to pursue **your** claim or lawsuit against any **Third Party** without the prior express written consent of Aetna. In the event **you** or **your** representative fail to cooperate with Aetna, **you** shall be responsible for all benefits paid by this plan in addition to costs and attorney's fees incurred by Aetna in obtaining repayment.

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DISCONTINUANCE OF POLICY

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

Aetna has the right to terminate this Policy at any time after the end of the grace period if the premium has not been paid. Aetna must give written notice of the termination date. This right is subject to the terms of any laws or regulations.

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

Policyholder shall be liable to Aetna for the unpaid premiums if:

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

**AETNA LIFE INSURANCE COMPANY
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SECTION 7 – APPEALS**

APPEALS PROCEDURE

Aetna has established a procedure for resolving **your** complaints. If **you** have a complaint, please follow this procedure:

- An Appeal is defined as a written request for review of a decision that has been denied in whole or in part, after consideration of any relevant information, a request for:
 - Claim payment;
 - Certification;
 - Eligibility; or
 - Referrals.
- An Appeal must be submitted to Aetna within 60 days of the date Aetna provides notice of denial. The Aetna address is on **your** ID card.
- An acknowledgment letter will be sent to **you** within 5 days of Aetna's receipt of the Appeal. This letter may request additional information. If so, the additional information must be submitted to Aetna within 15 days of the date of the letter.
- **You** will be sent a response within 30 days of Aetna's receipt of the Appeal. The response will be based on the information provided with or subsequent to the Appeal.
- If the Appeal concerns an eligibility issue, and if additional information is not submitted to Aetna after receipt of Aetna's response, the decision is considered Aetna's final response 60 days after receipt of the Appeal. For all other Appeals, if additional information is to be submitted to Aetna after receipt of Aetna's response, it must be submitted within 15 days of the date of Aetna's response letter.
- Aetna's final response will be sent within 30 days from the date of Aetna's first response letter. If additional time is needed to resolve the Appeal, Aetna will provide a written notification:
 - Indicating that additional time is needed;
 - Explaining why such time is needed; and
 - Setting a new date for a response.The additional time will not be extended beyond another 30 days.
- In any urgent or emergency situation, the Expedited Appeal procedure may be initiated by a telephone call to Member Services. Aetna's Member Services telephone number is on **your** ID card. A verbal response to the Appeal will be given to the provider within 2 business days, provided that all necessary information is available. Written notice of the decision will be sent within 2 business days of Aetna's verbal response. If **you** are dissatisfied with Aetna's response, the Appeal procedure outlined above may be utilized.
- Aetna will keep the records of **your** complaint for 3 years.

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SECTION 7 – APPEALS**

Independent Medical Review Process

If, after exhausting the internal Appeals Procedure or **your** grievance remains unresolved after 30 days, **you** may be eligible to request an Independent Medical Review. A request for an Independent Medical Review must be submitted within 6 months from the date **you** receive **your** final determination letter. The final determination letter will instruct **you** on how to submit a request for an Independent Medical Review.

You are only eligible to request an Independent Medical Review for the following:

- The medical services or treatment were denied either because they were not **medically necessary**; or
- Because the proposed service or treatment is considered experimental or investigational.

For more information on the Independent Medical Review Process, **you** may call Member Services at the toll-free number shown on **your** ID Card.