2008 - 2009

Student Health Insurance Plan Brochure

Aetna Student Health

Underwritten by:
Aetna Life Insurance Company (ALIC)

Policy No. 697418
Your Aetna Student Health Insurance

• It is your responsibility to familiarize yourself with this Student Health Insurance Plan. Limitations and exclusions must be applied to the coverage as a means of cost containment. The best way to make this coverage work for you is to be informed and proactive. Check the covered benefits before your procedure whenever possible. Know the specifics and communicate with your provider.

• This plan is a three tier Preferred Provider Network.

Preferred Provider (in-area): UK Hospital and UK College of Medicine Physicians (Kentucky Clinic) are the first tier of Preferred Providers. With both inpatient and outpatient services at UK Hospital and UK Clinic, the Deductible is waived and there is 100% coverage of the Negotiated Charge for covered services to the benefit maximum. This tier offers the lowest out-of-pocket costs available.

Preferred Provider (out-of-area): The second tier of coverage is with the Aetna Preferred Provider Network. This tier will extend Preferred Provider Negotiated Rates for covered services when it is necessary for you to seek care away from UK. Visit www.aetnastudenthealth.com for the DocFind® feature to locate doctors in the Aetna Preferred Provider Network.

Non-Preferred Provider: The third tier of coverage refers to services and Physicians outside of both the UK and Aetna Preferred Provider Networks. If you seek care at Non-Preferred Providers, you could experience significantly higher out-of-pocket costs.

• Utilize University Health Service.

University Health Service (UHS) is a large outpatient clinic available to all UK students for their healthcare needs including primary care, gynecology, mental health, nutrition counseling, and health education. Utilizing UHS is an excellent way to receive fast, efficient, and high quality clinical care. During the fall and spring semesters, all full-time University of Kentucky students pay for access to the Health Service through their tuition and mandatory fees. In the summer or for part-time students, the Health Service may be accessed by voluntarily paying a health fee or by being seen on a fee-for-service basis. Claims for charges incurred at UHS for covered benefits will be filed with Aetna Student Health by the Health Service. For complete information regarding University Health Service, visit www.uky.edu/StudentAffairs/UHS. Bluegrass Community and Technical College (BCTC) students may receive services through UHS. For BCTC eligibility information or specific instructions about how to pay the health fee, visit www.uky.edu/UK-eStore.

All visits are by appointment. For an appointment call (859) 323-APPT (2778).

University Health Service Clinic Hours:
Fall and Spring while school is in session
For follow-ups and urgent care
Summer and when class is not in session

Monday – Friday 8:00 a.m. – 6:00 p.m.
Saturday 9:00 a.m. – 11:00 a.m.
Monday – Friday 8:00 a.m. – 4:30 p.m.

See inside back cover for important numbers and helpful websites.
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The University of Kentucky Student Health Insurance Plan is sponsored by Aetna Student Health. The University of Kentucky Student Health Insurance Plan has been developed especially for University of Kentucky and the Bluegrass Community and Technical College (BCTC) students. The Plan provides coverage for Accidents and Sicknesses that occur on and off campus and includes special cost-saving features to keep the coverage as affordable as possible. University of Kentucky is pleased to offer the Plan through Aetna Student Health as described in this Brochure.

Please keep this Brochure, as it provides a general summary of your coverage. A complete description of the benefits and full terms and conditions may be found in the Master Policy. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits.

Where To Find Help

Online at www.aetnastudenthealth.com and by phone toll free at (888) 834-4690:

- View this Policy Brochure
- Insurance Benefits
- Enrollment
- Claims
- Inpatient Admission Pre-Certification
- Aetna VisionSM Discount Program

Additional details available online with Aetna Navigator®:

As an Aetna Student Health Insurance Plan member, you have access to Aetna Navigator®, your secure member website via www.aetnastudenthealth.com, packed with personalized claims and health information. You can take full advantage of our interactive website to complete a variety of self-service transactions online.

- Request replacement member ID cards
- View Claim Explanation of Benefits (EOB) statements
- Research the price of a drug and learn if there are alternatives
- Find health care professionals and facilities that participate in your Plan
- E-mail Aetna Student Health Customer Service
- View the latest health information and news, and more!

Pharmacy Claims:
Aetna Pharmacy Management (APM): (800) 238-6279 (Available 24 hours)

Worldwide Emergency Travel Assistance Services:
On Call International at 1-(866) 525-1956 (within U.S.)
If outside the U.S., call collect by dialing the U.S. access code plus 1-(603) 328-1956. Please also visit www.aetnastudenthealth.com and visit your school-specific site for further information.

University of Kentucky Insurance Coordinators:
University Health Service www.uky.edu/StudentAffairs/UHS, (859) 323-5823
Graduate School Funding Office www.gradschool.uky.edu, (859) 257-6608
(funded graduate students only)
Office of International Affairs www.uky.edu/IntlAffairs, (859) 257-4067 ext. 238
(international students only)
University of Kentucky Student Health Insurance Plan

This is a brief description of the Accident and Sickness Medical Expense benefits available for University of Kentucky and the Bluegrass Community and Technical College (BCTC) students and their eligible dependents. The Plan is underwritten by Aetna Life Insurance Company (called Aetna). The exact provisions governing this insurance are contained in the Master Policy issued to University of Kentucky. Please contact Aetna Student Health at (888) 834-4690 or your university insurance coordinator during normal business hours to view the Master Policy.

<table>
<thead>
<tr>
<th>Premium Rates and Policy Periods</th>
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</thead>
<tbody>
<tr>
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<tr>
<td></td>
</tr>
<tr>
<td>Student</td>
</tr>
<tr>
<td>Spouse</td>
</tr>
<tr>
<td>Child</td>
</tr>
<tr>
<td>All Children</td>
</tr>
</tbody>
</table>

Coverage will become effective the date the correct premium is received by the Company or a representative of the Company or the effective date of the coverage, whichever is later.
Eligibility

**Funded Graduate Students of the University of Kentucky**

Funded graduate students are automatically enrolled in the Student Health Insurance Plan by the Graduate School Funding Office. Funded graduate students are eligible to have the insurance premium paid by the University. No action is needed on your part to sign up for the insurance. The enrollment process is designed to be completely hassle-free. There is no paperwork or enrollment form for you to complete. You will be automatically enrolled in the Plan.

“Funded Graduate Student” means you are enrolled, degree-seeking, and are receiving support from the University in the form of a full-time assistantship (TA, RA, GA), qualifying fellowship, or a combination of these positions. Full-time standing is typically defined as an assignment of 20 hours per week or a fellowship stipend of $9,000 or more.

Eligibility is determined by the Graduate School each semester. The insurance coverage period is **August 26, 2008 to December 31, 2008** for Fall and **January 1, 2009 to August 25, 2009** for Spring/Summer. Changes with your assignment, fellowship, or status may affect your eligibility.

See our website via the Graduate School page: [www.gradschool.uky.edu](http://www.gradschool.uky.edu) for additional information about eligibility, the declination form for domestic students, dependent enrollment details, and a list of frequently asked questions. If you have specific inquiries, contact the Insurance Coordinator at the Graduate School Funding Office, (859) 257-6608 or grad.fundedhealth@uky.edu.

**International Students and Scholars**

All International students are required by the University to have health insurance which meets the University of Kentucky minimum criteria. If you are on an F-1, J-1 or J-2 Visa, you are automatically enrolled in the Student Health Insurance Plan when you register for classes. The charge for insurance is applied directly to your student bill.

The insurance coverage period is **August 26, 2008 to December 31, 2008** for Fall and **January 1, 2009 to August 25, 2009** for Spring/Summer.

In the event you are covered by an existing health insurance policy, you may be eligible to decline this Plan. In order to decline the insurance your coverage must meet or exceed the following standards:

- Deductible may not exceed $500
- $200,000 maximum per Accident or Sickness
- $10,000 benefit for medical evacuation
- $7,500 benefit for repatriation
- 80% of medical expenses must be paid by the insurance company
- Cover expenses related to pregnancy

The following International groups are eligible to enroll in the Student Health Insurance Plan on a voluntary basis:

- English as a Second Language (ESL) students
- Dependent coverage available for enrolled students/scholars
- B-1 Visa holders

If you have any questions, please call (859) 257-4067 ext. 238.
Undergraduate and Graduate Students
The Plan may be purchased on a voluntary basis for all eligible University of Kentucky and BCTC undergraduate and University of Kentucky graduate students. **Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased.** Home study, correspondence, Internet, and television (TV) courses do not fulfill the Eligibility requirements that the student actively attends classes.

Eligibility requirements:
- Undergraduate students enrolled in six credit hours or more
- Graduate students enrolled at the University of Kentucky
- Dietetic Interns
- Dependent coverage available for Dependents of enrolled students

Enrollment Process
Eligible students and dependents enrolling on a voluntary basis may purchase the coverage online at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com).

Go to [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com) and follow the simple steps below to enroll yourself and your dependents:

2. Click on “Students” tab, then select “Find Your School.”
3. Type in Policy Number **697418** or search by school name.
4. Once you’re on your school web page, click on “Enroll.”
5. Once at this page you will be instructed how to enroll yourself and/or any dependents.
6. A confirmation e-mail is sent within minutes of enrollment completion.

**Note:** Eligibility as defined by the Brochure and Master Policy is subject to verification through the University.
Dependent Coverage

Eligibility
Eligible students who enroll may also insure their eligible dependents. Eligible dependents are the spouse and unmarried children under 19 years of age who are not self-supporting. Dependent eligibility expires concurrently with that of the insured student.

Eligibility as defined by the Brochure and Master Policy is subject to verification by Aetna Student Health through the University.

*Insured dependents:* Coverage will become effective on the same date the insured student’s coverage becomes effective or date that premium is received. Coverage for insured dependents terminates in accordance with the Termination provisions described in the Master Policy. Examples include, but are not limited to, the date the student’s coverage terminates and the date the dependent no longer meets the definition of a dependent.

Newborn Infant Coverage and Adopted Child Coverage
A child born to a Covered Person shall be covered for Accident, Sickness, and congenital defects for 31 days from the date of birth. At the end of this 31-day period, coverage will cease under the 2008-2009 University of Kentucky Student Health Insurance Plan. To extend coverage for a newborn past the 31 days, the Covered Person must (1) enroll the child within 31 days of birth and (2) pay the appropriate premium, starting from the date of birth. For the appropriate pro-rated premium and application process, please contact the Aetna Student Health customer service at (888) 834-4690.

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

Premium Refund Policy
Except for medical withdrawal (during the current Policy Year) due to a covered Accident or Sickness, any student withdrawing from school during the first 31 days of the period for which coverage is purchased shall not be covered under the Policy and a full refund of the premium will be made unless a claim has been filed. Students or dependents entering into the armed forces of any country will be issued a refund for the unearned pro-rata premium upon written request. Written request must be submitted and received by Aetna Student Health within 90 days of withdrawal from school.
Pre-Existing Conditions/Continuously Insured Provisions

Pre-Existing Condition
Any Injury, Sickness, or condition that was diagnosed or treated, or would have caused a prudent person to seek diagnosis or treatment, within 12 months prior to the Covered Person’s effective date of insurance.

If, during the 12 months prior to the Covered Person’s effective date of insurance, services are rendered or supplies are received in connection with a pregnancy or a pregnancy is confirmed, the pregnancy is a Pre-Existing Condition whether or not the pregnancy commenced during that 12-month period.

Domestic violence is not considered a Pre-Existing Condition. Genetic information may not be used as a Pre-Existing Condition in the absence of a diagnosis.

The pre-existing condition clause is defined as any condition which originates, or medical advice, diagnosis, care or treatment recommended or received is within 12 months immediately prior to the insured’s effective date of coverage on this Plan. Individuals continuously insured under the Student Insurance Program, or covered for 9 consecutive months under prior qualifying coverage (with no more than 63 days lapse of coverage), are excluded from the pre-existing condition clause.

Continuously Insured
Persons who have remained continuously insured under the Policy or prior health insurance policies, including international policies or national health care, for at least nine consecutive months will be covered for any Pre-Existing Condition that manifests itself while continuously insured, except for expenses payable under prior health insurance policies. Once a break in continuous coverage occurs, the definition of Pre-Existing Conditions will apply. The Pre-Existing Condition exclusionary period will be reduced by the total number of months that the insured provides documentation of continuous coverage under a prior health insurance policy (including international policies or national healthcare).

Inpatient Admission Pre-Certification Program
Pre-admission certification is designed to help you receive quality, cost-effective medical care.

• All inpatient admissions, including length of stay, must be certified in advance by the patient, patient’s representative, Physician, or hospital by contacting Aetna Student Health.
• Pre-Certification does not guarantee the payment of benefits for your inpatient admission. Each claim is subject to medical policy review in accordance with the exclusions and limitations contained in the Policy, as well as a review of eligibility, adherence to notification guidelines, and benefit coverage under the Student Health Insurance Plan.
• If you do not secure Pre-Certification for non-emergency inpatient admissions or provide notification for emergency admissions, your Covered Medical Expenses will be subject to a $200 per admission Deductible.
Pre-Certification of Non-Emergency Inpatient Admissions
The patient, Physician, or hospital must telephone at least three business days prior to the planned admission.

Notification of Emergency Admissions
The patient, patient’s representative, Physician, or hospital must telephone within one business day following admission.

Aetna Student Health
Attention: Managed Care Dept.
P.O. Box 15708
Boston, MA 02215-0014
(888) 834-4690

Preferred Provider Network
Aetna has arranged for you to access a Preferred Provider Network in your local campus community. Providers, acute care facilities, and mental health networks are also available nationally if you require treatment or hospitalization outside the immediate area of the University of Kentucky campus.

Your first stop should be the University of Kentucky Hospital, University of Kentucky College of Medicine Physicians (Kentucky Clinic), or University Health Service, referred to as Preferred Providers* (in-area), for the highest level of out-of-pocket savings available. To maximize your savings and reduce your out-of-pocket expenses, this Plan includes two tiers of Preferred Providers.

When it is necessary to seek care away from UK, you can select and visit a member of the Aetna Network, labeled as Preferred Providers* (out-of-area). Members of this second tier will offer sizable discounts on their services. You can obtain information regarding Preferred Providers (out-of-area) through the Internet by accessing Aetna’s DocFind® at www.aetnastudenthealth.com or you may also contact Aetna Student Health at (888) 834-4690.

It is to your advantage to utilize a Preferred Provider because significant savings can be achieved from the substantially lower rates these providers have agreed to accept as payment for their services. Non-Preferred Care is subject to the Reasonable Charge allowance maximums. Any charges in excess of the Reasonable Charge allowance are not covered under the Plan.

*Preferred Providers are independent contractors and are neither employees nor agents of University of Kentucky, Aetna Student Health, or Aetna.
**Description of Benefits**

Payment will be made as allocated herein for Covered Medical Expenses incurred for any one Accident or any one Sickness while insured under the Plan, not to exceed an Aggregate Maximum while continuously insured of $500,000 for any one covered Accident or any one covered Sickness per Policy Year.

**In addition to the Plan’s Aggregate Maximum the Policy may contain benefit level maximums. Please review the Summary of Benefits section of this Brochure for any additional benefit level maximums.**

The payment of any Copays, Deductibles, the balance above the Reasonable Charge or any Coinsurance amount, and any medical expenses not covered are the responsibility of the Covered Person.

Once the Deductible is satisfied and once the insurance company has paid $5,000 in claims, benefits will be payable at 100% thereafter up to $500,000 per Accident or Sickness per Policy Year. Please note that internal benefit maximums apply. **Benefit does not apply to the Hospital Room and Board Expense and the Miscellaneous Hospital Expense. These expenses will remain payable at the Coinsurance levels outlined in the Summary of Benefits Chart up to the Plan Maximum.**

**Summary of Benefits Chart**

This Plan always pays benefits in accordance with any applicable Kentucky Insurance Law(s).

<table>
<thead>
<tr>
<th>Plan Maximum</th>
<th>$500,000 Per Accident or Sickness Per Policy Year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Deductible</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$200 Per Covered Person Per Policy Year</td>
</tr>
<tr>
<td></td>
<td>The Plan Deductible is waived for care at University Health Service, care received by University of Kentucky College of Medicine Physicians, and for care at University of Kentucky Hospital.</td>
</tr>
<tr>
<td>University Health Service, University of Kentucky Hospital, University of Kentucky College of Medicine Physicians (Kentucky Clinic)</td>
<td>Covered Medical Expenses are payable at 100% of the Negotiated Charge and/or Actual Charge</td>
</tr>
<tr>
<td>Hospital Room and Board Expenses</td>
<td>University of Kentucky Hospital, University of Kentucky College of Medicine Physicians (in-area)</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>100% of the Negotiated Charge for an overnight stay</td>
<td>80% of the Negotiated Charge for an overnight stay</td>
</tr>
<tr>
<td>Intensive Care Unit Expenses</td>
<td>100% of the Negotiated Charge for an overnight stay</td>
</tr>
<tr>
<td>Miscellaneous Hospital Expenses</td>
<td>100% of the Negotiated Charge</td>
</tr>
<tr>
<td>Well Newborn Nursery Care</td>
<td>100% of the Negotiated Charge and limited to four (4) days</td>
</tr>
<tr>
<td>Physician Hospital Visit Expenses</td>
<td>100% of the Negotiated Charge</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>100% of the Negotiated Charge</td>
</tr>
<tr>
<td>Pre-Admission Testing</td>
<td>100% of the Negotiated Charge</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>100% of the Negotiated Charge</td>
</tr>
</tbody>
</table>

**Inpatient Hospitalization Benefits**

*Inpatient Hospitalization Benefits are limited to the Plan Aggregate Maximum of $500,000 per Accident or Sickness per Policy Year.*

**Inpatient Surgical Benefits**

*As an inpatient benefit while hospital confined.*
### Inpatient Surgical Benefits (continued)

<table>
<thead>
<tr>
<th>Anesthetist Expenses and Assistant Surgeon Expenses</th>
<th>100% of the Negotiated Charge</th>
<th>80% of the Negotiated Charge</th>
<th>80% of the Reasonable Charge</th>
</tr>
</thead>
</table>

### Outpatient Surgical Benefits

*Outpatient Surgical Benefits are limited to an Aggregate Maximum of $10,000 per Accident or Sickness per Policy Year.*

<table>
<thead>
<tr>
<th>Surgical Expenses</th>
<th>100% of the Negotiated Charge</th>
<th>80% of the Negotiated Charge</th>
<th>80% of the Reasonable Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthetist Expenses and Assistant Surgeon Expenses</td>
<td>100% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>80% of the Reasonable Charge</td>
</tr>
<tr>
<td>Day Surgery Miscellaneous Expenses</td>
<td>100% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>80% of the Reasonable Charge</td>
</tr>
</tbody>
</table>

### Outpatient Benefits

*Outpatient Benefits limited to an Aggregate Maximum of $2,500 per Accident or Sickness per Policy Year.* Covered Medical Expenses include, but are not limited to: Physician’s office visits, hospital or outpatient department or emergency room visits, durable medical equipment, physical therapy, clinical lab tests and procedures, radiological facility, or other similar facility licensed by the state.

<table>
<thead>
<tr>
<th>Physician’s Office Visits</th>
<th>100% of the Negotiated Charge</th>
<th>80% of the Negotiated Charge</th>
<th>80% of the Reasonable Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermatology Benefit</td>
<td>100% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>80% of the Reasonable Charge</td>
</tr>
<tr>
<td>Physical Therapy Expenses</td>
<td>100% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>80% of the Reasonable Charge</td>
</tr>
<tr>
<td>Emergency Care Benefit</td>
<td>100% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>80% of the Reasonable Charge</td>
</tr>
<tr>
<td>Voluntary Termination of Pregnancy Expenses</td>
<td>80% of the Negotiated Charge</td>
<td>80% of the Reasonable Charge</td>
<td></td>
</tr>
<tr>
<td>Diabetes Treatment Expenses Benefit</td>
<td>100% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>80% of the Reasonable Charge</td>
</tr>
<tr>
<td>Consultant Physician Expenses</td>
<td>100% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>80% of the Reasonable Charge</td>
</tr>
</tbody>
</table>

*Please see page 19 of this Brochure for further details.*
### Outpatient Benefits (continued)

<table>
<thead>
<tr>
<th>Service</th>
<th>100% of the Negotiated Charge</th>
<th>80% of the Negotiated Charge</th>
<th>80% of the Reasonable Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab and X-ray Expenses</td>
<td>100% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>80% of the Reasonable Charge</td>
</tr>
<tr>
<td>Tests and Procedures</td>
<td>100% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>80% of the Reasonable Charge</td>
</tr>
<tr>
<td>ADD and ADHD Testing and Treatment</td>
<td>100% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>80% of the Reasonable Charge</td>
</tr>
</tbody>
</table>

### Mental Health and Substance Abuse

<table>
<thead>
<tr>
<th>Service</th>
<th>100% of the Negotiated Charge</th>
<th>80% of the Negotiated Charge</th>
<th>80% of the Reasonable Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Expenses – Mental Health</td>
<td>100% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>80% of the Reasonable Charge</td>
</tr>
</tbody>
</table>

Inpatient Mental Health Treatment is limited to a maximum of 30 days per Policy Year per condition for any one or related mental health condition. Includes the charges made for treatment received during partial hospitalization or intensive outpatient in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis. When approved, benefits will be payable in place of an inpatient admission, whereby two days of partial hospitalization or intensive outpatient treatment may be exchanged for one day of full hospitalization. Psychiatric Hospitals are not covered.

<table>
<thead>
<tr>
<th>Service</th>
<th>100% of the Negotiated Charge</th>
<th>50% of the Negotiated Charge</th>
<th>50% of the Reasonable Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Expenses – Mental Health</td>
<td>100% of the Negotiated Charge</td>
<td>50% of the Negotiated Charge</td>
<td>50% of the Reasonable Charge</td>
</tr>
</tbody>
</table>

Outpatient Mental Health treatment is payable up to a Maximum of $500 per Policy Year.

<table>
<thead>
<tr>
<th>Service</th>
<th>100% of the Negotiated Charge</th>
<th>80% of the Negotiated Charge</th>
<th>50% of the Reasonable Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Expenses – Substance Abuse</td>
<td>100% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>50% of the Reasonable Charge</td>
</tr>
</tbody>
</table>

Inpatient Substance Abuse Treatment is limited to a maximum of 30 days per Policy Year per condition for any one or related Substance Abuse condition.
### Mental Health and Substance Abuse (continued)

<table>
<thead>
<tr>
<th>Inpatient Expenses – Substance Abuse (continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes the charges made for treatment received during partial hospitalization or intensive outpatient in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis. When approved, benefits will be payable in place of an inpatient admission, whereby two days of partial hospitalization or intensive outpatient treatment may be exchanged for one day of full hospitalization. Inpatient treatment is payable up to an Aggregate Maximum of $500 per Policy Year.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient Expenses – Substance Abuse Care for treatment, detoxification, or rehabilitation of alcoholism or substance abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Substance Abuse treatment is payable up to an Aggregate Maximum of $500 per Policy Year.</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Maternity Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient charges subject to the outpatient maximum of $2,500 per Policy Year.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maternity Expenses (includes Complications of Pregnancy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Medical Expenses include inpatient care for a minimum of 48 hours, following vaginal delivery for the mother and her newly born child, or inpatient care for a minimum of 96 hours following cesarean section for the mother and her newly born child. Any decision to shorten such minimum coverages shall be made by the attending Physician, in consultation with the mother. In such cases, covered services may include: home visits, parent education, and assistance and training in breast or bottle-feeding. Complications of pregnancy are payable on the same basis as any other Sickness.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>100% of the Negotiated Charge</th>
<th>50% of the Negotiated Charge</th>
<th>50% of the Reasonable Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Expenses – Substance Abuse Care for treatment, detoxification, or rehabilitation of alcoholism or substance abuse</td>
<td>100% of the Negotiated Charge</td>
<td>50% of the Negotiated Charge</td>
<td>50% of the Reasonable Charge</td>
</tr>
<tr>
<td>Maternity Expenses (includes Complications of Pregnancy)</td>
<td>100% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>80% of the Reasonable Charge</td>
</tr>
</tbody>
</table>
## Child Health Supervision Service Benefit (covered dependent children only)

*Child Health Supervision Services includes periodic visits which shall include a history, a physical examination (including screening for the detection of hearing loss by a licensed audiologist, a Physician, a hospital or other hearing screening provider for children age range from birth through 12 months), a developmental assessment and anticipatory guidance, and appropriate immunization and laboratory tests. Such services and periodic visits shall be provided in accordance with prevailing medical standards consistent with Recommendations for Preventative Pediatric Health Care of the American Academy of Pediatrics.*

*Up to an Aggregate Maximum of $2,500 per Policy Year.*

<table>
<thead>
<tr>
<th>Service</th>
<th>100% of the Negotiated Charge</th>
<th>80% of the Negotiated Charge</th>
<th>80% of the Reasonable Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vision Care Exam</strong></td>
<td>Up to $50 per exam.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Hearing Exam</strong></td>
<td>100% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>80% of the Reasonable Charge</td>
</tr>
<tr>
<td><strong>Routine Well Child Exams</strong></td>
<td>100% of the Negotiated Charge</td>
<td>80% of the Negotiated Charge</td>
<td>80% of the Reasonable Charge</td>
</tr>
</tbody>
</table>

### Additional Benefits

**High Cost Procedure Expenses**

*High cost procedures in excess of $200, such as, but not limited to, outpatient diagnostic C.A.T. Scans, Magnetic Resonance Imaging, and Laser treatments are payable up to an Aggregate Maximum of $2,000 per Policy Year.*

<table>
<thead>
<tr>
<th>High Cost Procedure Expenses</th>
<th>100% of the Negotiated Charge</th>
<th>80% of the Negotiated Charge</th>
<th>80% of the Reasonable Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapy Expenses</td>
<td>100% of the Negotiated Charge after a $15 Copay per visit</td>
<td>100% of the Negotiated Charge after a $15 Copay per visit</td>
<td>100% of the Reasonable Charge after a $15 Deductible per visit</td>
</tr>
</tbody>
</table>

**Radiation and Chemotherapy Expenses**

<table>
<thead>
<tr>
<th>Radiation and Chemotherapy Expenses</th>
<th>100% of the Negotiated Charge</th>
<th>80% of the Negotiated Charge</th>
<th>80% of the Reasonable Charge</th>
</tr>
</thead>
</table>

**Women’s Health Benefits**

*Benefits include mammogram (see coverage details), routine annual gynecological exams and pap smears.*

Covered Medical Expenses will include one baseline mammogram for women between the ages of 35 and 40. Women under age 40 have coverage for mammograms when recommended by a Physician. Women age 40 and older have coverage for an annual routine mammogram per Policy Year.

Covered Medical Expenses are payable on the same basis as any X-ray expense.

Covered Medical Expenses include a routine annual gynecological exam and an annual Pap smear screening for women age 18 and older. If follow-up diagnostic Pap smears are Medically Necessary, they will be covered on the same basis as any outpatient expense.

Covered Medical Expenses are payable on the same basis as any outpatient expense.
**Additional Benefits (continued)**

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Benefit %</th>
<th>Negotiated Charge</th>
<th>Reasonable Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Immunizations</strong></td>
<td>100%</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Benefit available for insured students at University Health Service only. <em>TB testing is not an immunization.</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Allergy Testing Expenses</strong></td>
<td>100%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><em>Up to $300 per Policy Year.</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Educational Exposure to Blood Borne Pathogen Benefit</strong></td>
<td>Educational exposure to blood borne pathogens benefit to cover 100% of medication from day one (1) through day twenty eight (28). This benefit is not part of the Prescription Drug benefit but part of the medical Plan. <strong>Please note:</strong> You are required to pay in full at the time of service for all Prescriptions related to exposure and submit claims for reimbursement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>100%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><em>Prescription is required. Replacement equipment is not covered.</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dental Expense</strong></td>
<td>100%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><em>For the treatment of accidental injury to sound, natural teeth.</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Temporomandibular Joint Dysfunction</strong></td>
<td>100%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><em>Covered Medical Expenses include charges incurred by a Covered Person for non-surgical treatment of Temporomandibular Joint (TMJ) Dysfunction.</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Removal of warts, malignant moles, and lesions</strong></td>
<td>100%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><em>Covered only at University Health Service or when referred by University Health Service.</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ambulance Expense</strong></td>
<td>_________</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Vision Exam Only Benefit (adult)</strong></td>
<td>100%</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td><em>Up to $150 per Policy Year.</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospice Care Expense</strong></td>
<td>Covered Medical Expenses for inpatient care will be covered on the same basis as any inpatient expense subject to a lifetime maximum of 30 days. Covered Medical Expenses for outpatient care will be covered on the same basis as any outpatient expense subject to a lifetime maximum of $3,000.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Additional Benefits (continued)

<table>
<thead>
<tr>
<th>Home Health Care Expense</th>
<th>Covered Medical Expenses are payable at 80% of the Reasonable Charge. The maximum number of covered visits is limited to 30. Four hours of home health aide service shall be considered as one home care visit.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pervasive Mental Development Disorder Service Expenses</td>
<td>Covered Medical Expenses include the services of a health care provider for rendering these services to a child who is at least two years of age and under 22 years of age. Covered services include therapeutic services (such as psychotherapy and speech/language therapy) and rehabilitative services (such as occupational/physical therapy) and respite services. Not covered are services rendered by a person who resides with the claimant or who is part of the claimant’s family or services which would be paid for under any other part of the Plan. Covered Medical Expenses are payable on the same basis as any other expenses subject to a maximum benefit payable of $500 per month.</td>
</tr>
</tbody>
</table>

### Prescription Drug Benefits

<table>
<thead>
<tr>
<th>Kentucky Clinic Pharmacy</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Medical Expenses for Outpatient Prescription Drugs</td>
<td><strong>Generic Prescription Drug:</strong> 100% of the Negotiated Charge after a $10 per Prescription Copay</td>
<td><strong>Generic Prescription Drug:</strong> 100% of the Negotiated Charge after a $15 per Prescription Copay</td>
</tr>
<tr>
<td>Prescription Drug Aggregate Maximum: $1,000 per Policy Year. The maximum Prescription Drug benefit for Prescriptions received at the Kentucky Clinic Pharmacy and all other outside Pharmacies, whether they are a Preferred or Non-Preferred Pharmacy is limited to $1,000 per Policy Year. Allergy Prescriptions will be covered at Kentucky Clinic Pharmacy only. Please note: You are required to pay in full at the time of service for all Prescriptions dispensed at a Non-Participating Pharmacy. Please see page 36 for additional details on reimbursement.</td>
<td><strong>Brand Name Prescription Drug:</strong> 100% of the Negotiated Charge after a $30 per Prescription Copay</td>
<td><strong>Brand Name Prescription Drug:</strong> 100% of the Negotiated Charge after a $45 per Prescription Copay</td>
</tr>
</tbody>
</table>
**DIABETIC TESTING SUPPLIES EXPENSES**
Covered Medical Expenses include charges incurred by a covered student for testing material used to detect the presence of sugar in the person’s urine or blood for monitoring glycemic control. Diabetic Testing Supplies are limited to:
- Lancet devices;
- glucose monitors; and
- test strips.
Syringes, insulin, or other items used in the treatment of diabetes, are not Covered Medical Expenses.

**OUTPATIENT DIABETIC SELF-MANAGEMENT EDUCATION PROGRAM EXPENSES**
Covered Medical Expenses include charges incurred by a covered student for outpatient diabetic self-management education programs.

An “outpatient diabetic self-management education program” is a scheduled program on a regular basis, which is designed to instruct a Covered Person in the self-management of diabetes. It is a day care program of educational services and self-care training (including medical nutritional therapy). The program must be under the supervision of an appropriately licensed, registered, or certified health care professional, whose scope of practice includes diabetic education or management.

Charges incurred for the following are not Covered Medical Expenses:
- A diabetic education program whose only purpose is weight control, or which is available to the public at no cost; or
- A general program not just for diabetics; or
- A program made up of services not generally accepted as necessary for the management of diabetes.

Outpatient Diabetic Self-Management Education Program Expenses are covered at 70% for [Preferred Care](#) and 50% for [Non-Preferred Care](#); with a benefit maximum of $200 per Policy Year, after a Copay/Deductible of $20 per visit.

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**Continuation Plan**

**Post Student Status** – A covered student who has graduated or is otherwise ineligible for coverage under this Policy, and has been continuously insured under the Plan offered by the Policyholder (regular student plan), may be covered for up to 12 months provided that:

Students presently enrolled in the University of Kentucky Student Health Insurance Plan are eligible to continue their coverage by enrolling in the Accident and Sickness Continuation Plan offered by Aetna Student Health. This Continuation Plan coverage is only available to insured students who lose their eligibility for the Student Insurance Plan through graduation or are leaving school. The Plan will be available to terminating students (and their dependents) as long as they were enrolled for a minimum of 90 days prior to the effective date of the Continuation Plan. Coverage is effective from the date of purchase and continues until the end of the period for which the premium is paid. To enroll, complete the enrollment form and remit the appropriate premium within 30 days after the termination date of the regular policy for coverage to be continuous. Any application and premium received after the 30 days from the termination date deadline will not be accepted and the premium will be refunded. Coverage may be purchased for a three, six, nine or twelve month Period of Coverage. The continuation application is available upon request from the University Health Service Insurance Coordinator in person or by phone at (859) 323-5823 or email at [dgull0@email.uky.edu](mailto:dgull0@email.uky.edu). **There are no refunds available.**
Additional Services and Discounts

As a member of the Plan, you can also take advantage of the following services, discounts, and programs. For additional information regarding these services please visit Aetna Navigator’s homepage at www.aetnastudenthealth.com. These are not underwritten by Aetna. To learn more about these additional services and search for providers, visit www.aetnastudenthealth.com.

Aetna Vision℠ Discount Program
The Aetna Vision discount program helps you save on many eye care products, including sunglasses, contact lenses, non-prescription sunglasses, contact lens solutions and other eye care accessories. Plus, you can receive up to a 15% discount on LASIK surgery (the laser vision correction procedure).

Aetna Fitness℠ Discount Program
Aetna’s Fitness Program provides members with access to services provided by GlobalFit℠, the nation’s most comprehensive provider of fitness clubs and programs supporting members’ healthy lifestyles. Members can access GlobalFit’s national network of nearly 10,000 fitness clubs at preferred rates* or GlobalFit’s other programs and services, such as at-home weight loss programs, home fitness options and even one-on-one health coaching services.

*At some clubs, participation may be restricted to new club members.

eDiets®
25% discount on weekly dues for an eDiet membership.

Zagat Survey® Healthy Dining
30% discounts on online subscriptions to restaurant and lifestyle guides.

SpaWish® Gift Certificate
Spa gift certificates redeemable at a national network of 1,300 day spas.

Mayo Clinic Bookstore.com
Discounts for books on health and wellness.

Aetna’s Informed Health® Line
Get credible health information 24 hours a day from Informed Health Line. Call us toll free, anytime day or night, 365 days a year.

You never know when a health question might come up. Informed Health Line connects you to a team of registered nurses experienced in providing information on a variety of health topics – 24 hours a day, 7 days a week.

You also have access to our Audio Health Library, a recorded collection of thousands of health topics that’s available in English or Spanish. Transfer easily to an Informed Health Line registered nurse at any time during your call.

Or, to get credible health information online, register for Aetna Navigator (visit www.aetnastudenthealth.com to register), our password-protected member website. After logging in, click on Take Action on Your Health, Treating Illness and then Health A-Z.
To reach an Informed Health Line Nurse, please call (800) 556-1555.
For TDD (hearing and speech impaired only), please call (800) 270-2386.

*Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Also, the topics discussed by the nurses, on the audio tapes or online may not necessarily be covered by your health Plan.

Health and Wellness Resources
This dynamic, interactive website will give you health care and assessment tools to calculate body mass index, financial health, risk activities and health and wellness indicators. The site provides resources for wellness programs and activities.

Aetna Natural Products and Services SM Program
Save on acupuncture, chiropractic care, massage therapy and dietetic counseling. Also, save on over-the-counter vitamins, herbal and nutritional supplements and other health-related products. All products and services are delivered through American Specialty Health Networks, Inc. and Healthyroads, Inc.

Quit&Fit TM Tobacco Cessation Program
This tobacco cessation program provides support and collaboration as you quit smoking. A coaching program can be combined with counseling, interactive web tools and education. You will also be eligible for awards and rewards.

Vital Savings SM on Dental is a dental discount program helping you and your dependents save an average of 30- to 50-percent on a wide array of dental services – with one low annual fee of $25 per person. Enroll online at www.aetnastudenthealth.com.

With our Aetna Dental ® Advantage Plan, you select a primary care dentist (PCD) and have most of your preventive and restorative services covered by a copayment or reduced fee for each visit. Enroll online at www.aetnastudenthealth.com. The cost to enroll in the Aetna Advantage Dental plan is as follows: Student: $124.24 Spouse: $125.37 Child(ren): $194.04

1 Discount programs provide access to discounted prices and are NOT insured benefits.
2 Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professionals.
3 These services, programs or benefits are offered by vendors who are independent contractors and not employees or agents of Aetna.

“The Vital Savings by Aetna® program (the “Program”) is not insurance. The Program provides Members with access to discounted fees pursuant to schedules negotiated by Aetna Life Insurance Company for the Vital Savings by Aetna® discount program. The Program does not make payments directly to the providers participating in the Program. Each Member is obligated to pay for all services or products but will receive a discount from the providers who have contracted with the Discount Medical Plan Organization to participate in the Program. Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, CT 06156, 1-877-698-4825, is the Discount Medical Plan Organization.

1 Aetna Dental Advantage Plan is provided or administered by Aetna Dental Inc., Aetna Dental of California Inc., and/or Aetna Health Inc.
Chickering Claims Administrators, Inc. (CCA) has contracted with On Call International (On Call) to provide Covered Persons with access to certain accidental death and dismemberment benefits, worldwide emergency travel assistance services and other benefits. A brief description of these benefits is outlined below.

Accidental Death and Dismemberment (ADD) Benefits
These benefits are underwritten by United States Fire Insurance Company (USFIC) and include the following:

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

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

- Unlimited Emergency Medical Evacuation
- Unlimited Medically Supervised Repatriation (while traveling or on campus)
- Unlimited Return of Mortal Remains (while traveling or on campus)
- $2,500 Joining of Ill Family Member Accommodations
- Return of Traveling Companion

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

- 24/7 Emergency Travel Arrangements
- Translation Assistance
- Emergency Travel Funds Assistance
- Lost Luggage and Travel Documents Assistance
- Assistance with Replacement of Credit Card/Travelers Checks
- 24/7 U.S. Nurse Help Line
- Medical/Dental/Pharmacy Referral Service
- Hospital Deposit Arrangements
- Dispatch of Physician
- Emergency Medical Record Assistance

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

The information contained above is a just summary of the ADD, MER and WETA benefits and services available through On Call, USFIC and VSC. For a copy of the plan documents applicable to the ADD, MER and WETA coverage, including a full description of coverage, exclusions and limitations, please contact Aetna Student Health at www.aetnastudenthealth.com or (888) 834-4690.
NOTE: In order to obtain coverage, all MER and WETA services must be provided and arranged through On Call. Reimbursement will not be provided for any services not provided and arranged through On Call. Although certain emergency medical services may be covered under the terms of the Covered Person's student health insurance plan (the “Plan”), neither On Call, USFIC nor WETA provides coverage for emergency medical treatment rendered by doctors, hospitals, pharmacies or other health care providers. Coverage for such services will be provided in accordance with the terms of the Plan and exclusions and limitations may apply.

To file a claim for ADD benefits, or to obtain MER and WETA benefits/services, or for any questions related to those benefits/services, please call On Call International at the following numbers listed on the On Call ID card provided to Covered Persons when they enroll in the Plan: Toll Free 1-866-525-1956 or collect 1-603-328-1956. All Covered Persons should carry their On Call ID card when traveling.

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

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

### General Provisions

#### State Mandated Benefits
The Plan will always pay benefits in accordance with any applicable Kentucky Insurance Law(s).

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

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

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

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

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

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

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

**Coordination of Benefits**

If the Covered Person is insured under more than one group health plan, the benefits of the plan that covers the insured student will be used before those of a plan that provides coverage as a dependent. When both parents have group health plans that provide coverage as a dependent, the benefits of the plan of the parent whose birth date falls earlier in the year will be used first. The benefits available under the Plan may be coordinated with other benefits available to the Covered Person under any auto insurance, Workers’ Compensation, Medicare, or other coverage. The Plan pays in accordance with the rules set forth in the Policy.
Definitions

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

**Actual Charge:** The Actual Charge made for a covered service by the provider that furnishes it.

**Aggregate Maximum:** The maximum benefit that will be paid under the Policy for all Covered Medical Expenses incurred by a Covered Person that accumulate during the Policy Year.

**Brand Name Prescription Drug or Medicine:** A Prescription Drug which is protected by trademark registration.

**Coinsurance:** The percentage of Covered Medical Expenses payable by Aetna under the Student Health Insurance Plan.

**Copay:** The amount that must be paid by the Covered Person at the time services are rendered by a Preferred Provider. Copay amounts are the responsibility of the Covered Person.

**Covered Medical Expenses:** Those charges for any treatment, service, or supplies covered by the Policy which are: (a) not in excess of the Reasonable Charges, or (b) not in excess of the charges that would have been made in the absence of this coverage, and (c) incurred while the Policy is in force as to the Covered Person except with respect to any expenses payable under the Extension of Benefits provision.

**Deductible:** A specific amount of Covered Medical Expenses that must be incurred and paid for by the Covered Person before benefits are payable under the Plan. Deductible amounts are the responsibility of the Covered Person. Copays do not apply towards meeting the Deductible.

**Elective Treatment:** Medical treatment that is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Covered Person’s effective date of coverage. Elective treatment includes, but is not limited to: tubal ligation; vasectomy; breast reduction; sexual reassignment surgery; submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis; treatment for weight reduction; learning disabilities; temporomandibular joint (TMJ) dysfunction; immunization; vaccines; treatment of infertility; and routine physical examinations.

**Emergency Medical Condition:** This means a recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, Sickness, or Injury is of such a nature that failure to get immediate medical care could result in:
• Placing the person’s health in serious jeopardy; or
• Serious impairment to bodily function; or
• Serious dysfunction of a body part or organ; or
• In the case of a pregnant woman, serious jeopardy to the health of the fetus.

It does include an Accident or serious illness such as heart attack, stroke, poisoning, loss of
consciousness or respiration, and convulsions. It does not include elective care, routine care,
or care for non-emergency illness.

**Experimental or Investigative:** Those 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 disease or Injury
  involved; or
• If required by the FDA, approval has not been granted for marketing; or
• A recognized national medical or dental society or regulatory agency has determined, in writing,
  that it is experimental, investigational, or for research purposes; or
• The written protocol or protocols used by the treating facility, or the protocol or protocols of any
  other facility studying substantially the same drug, device, procedure, or treatment, or the written
  informed consent used by the treating facility or by another facility studying the same drug, device,
  procedure, or treatment states that it is experimental, investigational, or for research purposes.

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

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

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

• Have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or
• Are being studied at the Phase III Level in a national clinical trial sponsored by the National
  Cancer Institute; or
• If Aetna determines that available scientific evidence demonstrates that the drug is effective or
  shows promise of being effective for the disease.

**Generic Prescription Drug or Medicine:** A Prescription Drug that is not protected by trademark
registration, but is produced and sold under the chemical formulation name.
**Injury:** Bodily Injury caused by an Accident; this includes related conditions and recurrent symptoms of such Injury.

**Medically Necessary:** A service or supply that is necessary and appropriate for the diagnosis or treatment of a Sickness including a clinically significant mental illness or Injury based on generally accepted current medical practice.

In order for a treatment, service, or supply to be considered Medically Necessary, the service or supply must:

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

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- Information relating to the affected person’s health status;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment;
- The opinion of health professionals in the generally recognized health specialty involved; and
- Any other relevant information brought to Aetna’s attention.

In no event will the following services or supplies be considered to be Medically Necessary:

- Those that do not require the technical skills of a medical, mental health, or dental professional; or
- Those furnished mainly for: the personal comfort or convenience of the person, any person who cares for him or her, or any person who is part of his or her family, any health care provider or health care facility; or
- Those furnished solely because the person is an inpatient on any day on which the person’s Sickness or Injury could safely and adequately be diagnosed or treated while not confined; or
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a Physician’s or a dentist’s office, or other less costly setting.
**Negotiated Charge:** The maximum charge a Preferred Care Provider has agreed to make as to any service or supply for the purpose of the benefits under the Plan.

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

**Non-Preferred Care Provider (or Non-Preferred Provider):** A health care provider that has not contracted to furnish services or supplies at a Negotiated Charge.

**Non-Preferred Pharmacy:** A Pharmacy not party to a contract with Aetna, or a Pharmacy that is party to such a contract but which does not dispense Prescription Drugs in accordance with its terms.

**Pharmacy:** An establishment where Prescription Drugs are legally dispensed.

**Physician:** A legally qualified Physician licensed by the state in which they practice, and any other practitioner who must by law be recognized as a doctor legally qualified to render treatment.

**Pre-Existing Condition:** Any Injury, Sickness, or condition that was diagnosed or treated, or would have caused a prudent person to seek diagnosis or treatment, within 12 months prior to the Covered Person’s effective date of insurance.

If, during the 12 months prior to the Covered Person’s effective date of insurance, services are rendered or supplies are received in connection with a pregnancy or a pregnancy is confirmed, the pregnancy is a Pre-Existing Condition whether or not the pregnancy commenced during that 12 month period.

Domestic violence is not considered a Pre-Existing Condition. Genetic information may not be used as a Pre-Existing Condition in the absence of a diagnosis.

**Preferred Care:** Care provided by a Preferred Care Provider, or any health care provider for an Emergency Condition when travel to a Preferred Care Provider is not feasible.

**Preferred Care Provider (or Preferred Provider):** A health care provider that has contracted to furnish services or supplies for a Negotiated Charge, but only if the provider is, with Aetna’s consent, included in the Directory as a Preferred Care Provider for the service or supply involved, and the class of which the Covered Person is a member.

**Preferred Pharmacy:** A Pharmacy which is party to a contract with Aetna to dispense drugs to persons covered under the Policy, but only while the contract remains in effect and when the Pharmacy dispenses a Prescription Drug under the terms of its contract with Aetna.
**Prescription:** An order of a prescriber for a Prescription Drug. If it is an oral order, it must be promptly put in writing by the Pharmacy.

**Reasonable Charge:** Only that part of a charge which is reasonable is covered. The Reasonable Charge for a service or supply is the lowest of:

- The provider’s usual charge for furnishing it; and
- The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- The charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

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

In determining the Reasonable Charge for a service or supply that is:

- Unusual; or
- Not often provided in the area; or
- Provided by only a small number of providers in the area.

Aetna may take into account factors, such as:

- The complexity;
- The degree of skill needed;
- The type of specialty of the provider;
- The range of services or supplies provided by a facility; and
- The prevailing charge in other areas.

**Sickness:** A disease or illness including related conditions and recurrent symptoms of the Sickness. Sickness also includes pregnancy and complications of pregnancy.
Exclusions

This list is only a partial list. Please refer to the School’s Master Policy on file at the school for a complete list of exclusions.

1. Expenses incurred for services normally provided without charge by the Policyholder’s Health Service, Infirmary, or Hospital, or by health care providers employed by the Policyholder.

2. Expenses incurred as a result of dental treatment except for treatment resulting from Injury to sound, natural teeth as provided elsewhere in this Policy.

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

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

5. Expenses incurred as a result of an Injury or Sickness due to working for wage or profit or for which benefits are payable under any Workers’ Compensation or Occupational Disease Law.

6. Expenses incurred as a result of an Injury sustained or Sickness contracted while in the service of the Armed Forces of any country. Upon the covered person entering the Armed Forces of any country, the unearned pro-rata premium will be refunded to the Policyholder.

7. Expenses incurred for treatment provided in a governmental hospital unless there is a legal obligation to pay such charges in the absence of insurance.

8. Expenses incurred for cosmetic surgery, reconstructive surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons, except to the extent needed to:
   - Improve the function of a part of the body that:
     - Is not a tooth or structure that supports the teeth; and
     - Is malformed:
       - As a result of a severe birth defect, including harelip, webbed fingers, or toes; or
       - As a direct result of:
         - Disease; or
         - Surgery performed to treat a disease or Injury.
• Repair an Injury (including reconstructive surgery for prosthetic device for a Covered Person who has undergone a mastectomy), which occurs while the Covered Person is covered under this Policy. Surgery must be performed:
  – In the calendar year of the Accident which causes the Injury; or
  – In the next calendar year.

9. Expenses covered by any other valid and collectible medical, health or accident insurance to the extent that benefits are payable under other valid and collectible insurance whether or not a claim is made for such benefits.

10. Expenses for Injuries sustained as the result of a motor vehicle accident to the extent that benefits are payable under other valid and collectible insurance whether or not claim is made for such benefits.

11. Expenses incurred after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits Provision.

12. Expenses for treatment of Injury or Sickness to the extent that payment is made, as a judgment or settlement, by any person deemed responsible for the Injury or Sickness (or their insurers).

13. Expenses incurred for which no member of the Covered Person’s immediate family has any legal obligation for payment.

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

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


17. Expenses incurred for gynecal mastea (male breasts).

18. Expenses incurred for services performed within the Covered Person’s home country if the Covered Person’s home country has a socialized medicine program.

19. Expenses incurred for acupuncture, unless services are rendered for anesthetic purposes.

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

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

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

23. Expenses for personal hygiene and convenience items, such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if such items are prescribed by a Physician.

24. Expenses for treatment and supplies for programs involving cessation of tobacco use (except when being treated at the University of Kentucky Health Service).
25. Expenses incurred for allergy treatment, allergy prescriptions will be covered at the Kentucky Clinic only.

26. Expenses incurred for massage therapy.

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

28. Expenses for treatment of covered students who specialize in the mental health care field, and who receive treatment as a part of their training in that field.

29. Expenses arising from a Pre-Existing Condition.

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

31. Expenses incurred from Injury resulting from the play or practice of collegiate or intercollegiate sports.

32. 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.

33. Expenses for the contraceptive methods, devices or aids, and charges for or related to artificial insemination, in-vitro fertilization, or embryo transfer procedures, elective sterilization or its reversal unless specifically provided for in this Policy.

34. Expenses incurred for any sinus surgery, except for acute purulent sinusitis.

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

36. Expenses incurred as a result of preventive medicines (except immunizations as they are covered at University Health Services), serums, vaccines (except as listed in the Child Health Supervision Services Benefit).

37. Expenses incurred for care, treatment, services, or supplies for or related to obstructive sleep apnea, and sleep disorders, including CPAP, and UPP.

38. Expenses incurred for the removal of an organ from a Covered Person for the purpose of donating or selling the organ to any person or organization. This limitation does not apply to a donation by a Covered Person to a spouse, child, brother, sister, or parent.
39. Expenses incurred for Elective Treatment or elective surgery except as specifically provided elsewhere in this Policy and performed while this Policy is in effect.

40. Expenses for transplants, other than cornea and kidney.

41. Expenses incurred for a treatment, service, or supply, which is not Medically Necessary, as determined by Aetna, for the diagnosis, care, or treatment of the Sickness or Injury involved.

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

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**Extension of Benefits**

If a Covered Person is totally disabled on the date his or her insurance terminates, expenses incurred after the termination date and during the continuance of that total disability shall be payable in accordance with the Policy, but only while they are incurred during the 90-day period following such termination of insurance.

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**Termination of Insurance**

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

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**Medical Conversion Policy**

When coverage under a Student Health Insurance Plan ceases for any reason, other than non-payment of premium, a Covered Person may be eligible to convert to an individual, personal medical policy. Application must be made within 31 days after coverage under the Student Health Insurance Plan ceases. No medical exam will be required. The Policy is issued by Aetna. Please contact Aetna Student Health for more information.

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**Medical Claim Procedure**

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

Aetna Student Health  
P.O. Box 15708  
Boston, MA 02215-0014  
(888) 834-4690  
(617) 218-8400 (outside United States)

Customer Service Representatives are available 8:30 a.m. to 5:30 p.m., Monday through Friday (EST) for any questions.
1. Bills must be submitted within 90 days from the date of treatment.

2. Payment for Covered Medical Expenses will be made directly to the hospital or Physician concerned unless bill receipts and proof of payment are submitted.

3. Any itemized medical bills should be mailed promptly to the above address. In the event of a disagreement over the payment of a claim, a written request to review the claim must be mailed to Aetna Student Health within 60 days from the date appearing on the Explanation of Benefits.

Appeals and Complaints Procedure
Our complaints and appeals process is designed to address Covered Persons’ coverage issues, complaints and problems. If you have a coverage issue or other problem, review your Plan documents for more information and call the Customer Service toll-free number on your ID card.

A representative will address your concern. If you are dissatisfied with the outcome of your initial contact, you may appeal the decision. Your appeal will be decided in accordance with the procedure applicable to your Plan.

You may also submit your request, in writing, along with all pertinent correspondence, to:

Aetna Student Health
P.O. Box 15717
Boston, MA 02215-0014

Additional information is available on the web page for the applicable State Insurance Department or other agency regarding your rights, including how to obtain regulatory review of Covered Persons concerns. The applicable Internet address for the State Insurance Department for your Plan is: www.doi.state.ky.us.

External Review
Aetna has developed an external review process to give Covered Persons an added option of requesting an objective and timely external review of certain coverage denials. Once the Aetna internal coverage decision review process is exhausted, Covered Persons may appeal the decision if the coverage denial involves more than $500 (or the applicable amount specified by your state) and is based on lack of Medical Necessity or on the Experimental or Investigational nature of the proposed service or treatment.

An external review organization will refer the case to review by an independent Physician with appropriate expertise in the area in question. After all necessary information is submitted, external review generally will be decided within 30 days of the request. Expedited reviews are available when a Covered Person’s Physician certifies that a delay in service would jeopardize the Covered Person’s health. Once the review is complete, the Plan will abide by the decision of the external reviewer.
Certain states mandate external review of additional benefit or service issues or require a filing fee. In addition, certain states mandate the use of their own external review providers for Medical Necessity and Experimental/Investigational coverage decisions.

For further details regarding your Plan’s grievance and external review process, call the Customer Services toll-free number on your ID card, or visit Aetna’s website at www.aetna.com, where you may obtain an external review request form. You may also call your State Insurance or Health Department for additional information regarding state mandated external review procedures.

### Prescription Drug Claim Procedure

**Preferred Care:** When obtaining a covered Prescription, please present your Aetna Student Health ID card to an Aetna Preferred Pharmacy along with your applicable Copay. The Pharmacy will submit a claim to Aetna for the drug.

When you need to fill a Prescription and do not have your ID card with you, you may obtain your Prescription from an Aetna Preferred Pharmacy and be reimbursed by submitting a completed Aetna Prescription Drug claim form. A claim form is available by calling (800) 238-6279. You will be reimbursed for covered medications directly by Aetna. Please note, in addition to your Copay, you may be required to pay the difference between the retail price you paid for the Prescription Drug and the amount Aetna would have paid if you had presented your ID card and the Pharmacy had billed Aetna directly.

Information regarding Preferred Care Pharmacy locations is available by accessing the Internet at: www.aetna.com/docfind.

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

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

Claim forms, Pharmacy locations, and claims status information can be obtained by contacting Aetna Pharmacy Management at (800) 238-6279.

When submitting a claim, please include all Prescription receipts, indicate that you attend University of Kentucky, and include your name, address, and student identification number.

### General Information – Provider Compensation

When you receive services from your Primary Care Provider (PCP), your PCP has agreed to accept Aetna’s payment plus any Copay required by your Plan as payment in full for covered services. If you receive services from other Physicians, hospitals, or providers in our network with a referral from your PCP for services covered under your Plan, these providers have agreed to accept Aetna’s payment plus any Copay required by your Plan as payment in full.

Any provider who meets our enrollment criteria and who is willing to meet the terms and conditions for participation has a right to become a participating provider in our network.
Important Note

Please keep this Brochure, as it provides a general summary of your coverage. A complete description of the benefits and full terms and conditions may be found in the Master Policy. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits.

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

Administered by:
Aetna Student Health
P.O. Box 15708
Boston, MA 02215-0014
(888) 834-4690 (toll free)
www.aetnastudenthealth.com

Underwritten by:

Aetna

Aetna Life Insurance Company (ALIC)
151 Farmington Avenue
Hartford, CT 06156
(860) 273-0123
Policy No. 697418

The Student Health Insurance Plan Brochure (the “Plan”) is underwritten by Aetna Life Insurance Company (ALIC). The Plan is administered by Chickering Claims Administrators, Inc. Aetna Student Health is the brand name for products and services provided by these companies.
Aetna considers nonpublic personal member information confidential and has policies and procedures in place to protect the information against unlawful use and disclosure. When necessary for your care or treatment, the operation of your health plan, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, Pharmacies, hospitals, and other caregivers), vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. Participating network/Preferred Providers are also required to give you access to your medical records within a reasonable amount of time after you make a request. By enrolling in the Plan, you permit us to use and disclose this information as described above on behalf of yourself and your dependents. To obtain a copy of our Notice of Privacy Practices describing in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Customer Services number on your ID card or visit Aetna Student Health’s Student Connection Link on the Internet at: www.aetnastudenthealth.com.
University of Kentucky
Important Phone Numbers

Campus Police 911
UK Hospital Emergency Department (859) 323-5901
University Health Service (859) 323-5823
Appointments (859) 323-2778
Phone Information Nurse (859) 323-4636
Insurance (859) 323-5823
Kentucky Clinic Appointments (859) 257-1000
Office of International Affairs (859) 257-4067 Ext. 238
Graduate School Funding Office (859) 257-6608
The Plan is Underwritten by:
Aetna Life Insurance Company (ALIC)

Submit all Claims and Inquiries to:
Aetna Student Health
P.O. Box 15708
Boston, MA 02215-0014
(888) 834-4690
www.aetnastudenthealth.com

Aetna Pharmacy Management (APM)
(800) 238-6279

World Wide Emergency Travel Assistance
On Call International
(866) 525-1956 (within US)
Call collect (dial U.S. access code) plus (603) 328-1956 (outside US)

For additional information on dental plans:
(888) 834-4690
www.aetnastudenthealth.com

Your Home Page @ Aetna Navigator®
Once you’re a member of the Plan, you have access to Aetna Navigator, your secure member website. It’s packed with personalized claims and health information. When you register with Aetna Navigator, you’ll have your own personal home page to:

• View your most recent claims
• Order ID cards
• Print a temporary ID card
• See who is covered under your Plan
• And much more!