2010 – 2011

Student Health Insurance Plan

Underwritten by:
Aetna Life Insurance Company (ALIC)
Policy Number 812806
THE UNIVERSITY OF VIRGINIA’S STUDENT HEALTH INSURANCE PLAN

All students of the University of Virginia are required to maintain health insurance during their enrollment. The University of Virginia endorses the Aetna Student Health Plan, which is available for purchase by students who need to obtain health insurance coverage. Although other health insurance coverage may be available, the University of Virginia Student Health Insurance Plan has been developed especially for eligible University of Virginia students. The Plan provides coverage for injuries and sicknesses that occur on and off campus and includes special features designed to keep the premium rates low. The University of Virginia is pleased to offer the Plan, as described in this Brochure, to students.

WHERE TO FIND HELP

In case of an emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility. For non-emergency situations please call or visit Elson Student Health Center at (434) 924-5362.

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

Please contact:
Aetna Student Health
P.O. Box 981106
El Paso, TX 79998
(800) 466-3027
www.uvastudentinsurance.com

For questions about:
- ID cards

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

For lost ID cards, contact:
Aetna Student Health
(800) 466-3027

For questions about:
- Services available at Student Health

Please contact:
University of Virginia Student Health
Insurance Liaison and Referral Coordinator
(434) 243-2702
or visit http://www.virginia.edu/studenthealth
For questions about:
- Status of Pharmacy Claim
- Pharmacy Claim Forms
- Excluded Drugs and Pre-Authorization

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

For questions about:
- Provider Listings

Please contact:
Aetna Student Health
(800) 466-3027

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

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

Please contact:
On Call International at (866) 525-1956 (within U.S.).
If outside the U.S., call collect by dialing the U.S. access code plus (603) 328-1956.

Please also visit www.uvastudenthealthinsurance.com for further information.

IMPORTANT NOTE

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

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

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Health Services</td>
<td>5</td>
</tr>
<tr>
<td>Policy Period</td>
<td>5</td>
</tr>
<tr>
<td>Rates</td>
<td>5</td>
</tr>
<tr>
<td>Deductibles</td>
<td>6</td>
</tr>
<tr>
<td>University of Virginia Student Accident and Sickness Insurance Plan</td>
<td>6</td>
</tr>
<tr>
<td>Student Coverage</td>
<td>6</td>
</tr>
<tr>
<td>Refund Policy</td>
<td>7</td>
</tr>
<tr>
<td>Dependent Coverage</td>
<td>7</td>
</tr>
<tr>
<td>Continuously Insured</td>
<td>8</td>
</tr>
<tr>
<td>Preferred Provider Network</td>
<td>8</td>
</tr>
<tr>
<td>Pre-Certification Program</td>
<td>9</td>
</tr>
<tr>
<td>Pre-Existing Conditions/Continuously Insured Provisions</td>
<td>9</td>
</tr>
<tr>
<td>Description of Benefits</td>
<td>10</td>
</tr>
<tr>
<td>Summary of Benefits Chart</td>
<td>10</td>
</tr>
<tr>
<td>Inpatient Hospitalization Benefits</td>
<td>11</td>
</tr>
<tr>
<td>Surgical Benefits</td>
<td>11</td>
</tr>
<tr>
<td>Outpatient Benefits</td>
<td>11</td>
</tr>
<tr>
<td>Mental Health &amp; Substance Abuse Benefits</td>
<td>18</td>
</tr>
<tr>
<td>Maternity Benefits</td>
<td>19</td>
</tr>
<tr>
<td>Additional Benefits</td>
<td>20</td>
</tr>
<tr>
<td>Additional Services and Discounts</td>
<td>29</td>
</tr>
<tr>
<td>General Provisions</td>
<td>31</td>
</tr>
<tr>
<td>Extension of Benefits</td>
<td>31</td>
</tr>
<tr>
<td>Termination of Insurance</td>
<td>31</td>
</tr>
<tr>
<td>Exclusions</td>
<td>33</td>
</tr>
<tr>
<td>Definitions</td>
<td>37</td>
</tr>
<tr>
<td>Claim Procedure</td>
<td>52</td>
</tr>
<tr>
<td>Prescription Drug Claim Procedure</td>
<td>53</td>
</tr>
<tr>
<td>On Call International</td>
<td>53</td>
</tr>
<tr>
<td>Aetna Navigator®</td>
<td>55</td>
</tr>
<tr>
<td>Notice</td>
<td>56</td>
</tr>
</tbody>
</table>
UNIVERSITY HEALTH SERVICES

UTILIZING SERVICES WITHIN THE ELSON STUDENT HEALTH CENTER
You are eligible to utilize Elson Student Health Center if you are a registered domestic or international student who pays the Comprehensive Student Activity Fee that includes the Student Health Fee. It is in the student’s interest to first seek treatment for injuries and illness at Student Health (except for treatment of an Emergency Medical Condition).

The Elson Student Health Center is open during the academic year Monday - Friday 8:00 a.m. till 5:00 p.m. and Saturday 8:30 a.m. till 12:00 p.m. for urgent care. By utilizing the services provided by Elson Student Health, medical care can be coordinated, medical cost should be contained, and health insurance premiums will generally be kept at reasonable rates. For more information regarding these services, please refer to the University’s web page at www.virginia.edu/studenthealth.

ELSON STUDENT HEALTH CENTER SERVICES
Student Health professional services are covered by your student activity fee. This means there is no charge for your visit with a Student Health provider (e.g., physician, nurse practitioner, mental health clinician, or health educator).

Unless otherwise noted, ancillary services (e.g., lab tests and X-rays) received at Student Health or ordered by a Student Health provider will be covered at 100% without a copay or deductible. Ancillary services provided at Student Health include, but are not limited to:

- Immunizations
- Injectable Medications (except contraceptives, which are covered under the Student Health Insurance Plan)
- Medical Supplies and Services
- Laboratory Tests

POLICY PERIOD
1. **Students**: Coverage for all insured students enrolled for the Fall Semester, will become effective at 12:01 a.m. on **August 15, 2010**, and will terminate at 12:01 a.m. on **August 15, 2011**.

2. **New Spring Semester Students**: Coverage for all newly insured students enrolled for the Spring Semester, will become effective at 12:01 a.m. on **January 1, 2011**, and will terminate at 12:01 a.m. on **August 15, 2011**.

3. **Insured Dependents**: Coverage will become effective on the same date the insured student’s coverage becomes effective, or the day after the postmarked date when the completed application and premium are sent, if later. Coverage for insured dependents terminates in accordance with the termination provisions described in the Master Policy. For more information on termination of covered dependents see page 31 of this Brochure. Examples include, but are not limited to: the date the student’s coverage terminates, the date the dependent no longer meets the definition of a dependent.
## RATES

<table>
<thead>
<tr>
<th></th>
<th>Cost</th>
</tr>
</thead>
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<tr>
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</tr>
<tr>
<td>Spouse</td>
<td>$3,246</td>
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<tr>
<td>Child</td>
<td>$2,782</td>
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<tr>
<td>All Children</td>
<td>$4,072</td>
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</tbody>
</table>

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

## DEDUCTIBLES

The following Deductibles are applied before Covered Medical Expenses are payable:
- $200 per individual, per Policy Year.
- $400 per family, per Policy Year.

**PRESCRIPTION DEDUCTIBLE**

A $50 per individual, per Policy Year Deductible is applied before Pharmacy expenses are paid.

## UNIVERSITY OF VIRGINIA

**STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN**

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

## STUDENT COVERAGE

**ELIGIBILITY**

Registered domestic or international students who pay a Comprehensive Student Activity Fee which includes the Student Health Fee are eligible to purchase the Student Health Insurance Plan. In addition, all Non-United States citizens (i.e., international students) must have appropriate health coverage as a condition of their admittance to the United States pursuant to federal regulations that are monitored by the University’s International Studies Office.
For registered domestic students to elect coverage, go to Aetna Student Health website at www.uvastudentinsurance.com. Follow the instructions on the “Enroll” tab or complete an Enrollment Form and mail it with the appropriate premium payment directly to Aetna Student Health by the indicated enrollment deadlines. If the online enrollment transaction is successfully completed or if the Enrollment Form and premium is post-marked on or prior to October 1, 2010, coverage will become effective August 15, 2010. Coverage for applications post-marked after October 1, 2010 will be rejected unless the student experiences a qualifying event that directly affects their insurance coverage. (If a student has a qualifying event, that student may be added to the Plan as of the date of the event and premium will be pro-rated accordingly. An example of a qualifying event would be loss of health coverage under another health plan.) Please note that an application for coverage due to a qualifying event must be submitted to Aetna Student Health within 30 days of the qualifying event.

For International Students: To ensure appropriate coverage, all new and returning international students will be financially responsible for the annual student premium ($2,152) and enrolled in the Plan. If a student can demonstrate to Student Health that they have comparable coverage under another health plan, the fee for this Plan will be removed from their University bill ONLY if the student actively waives by the deadline date of October 1, 2010.

For international students who can demonstrate comparable coverage and want to waive off of the Aetna Student Health Plan, go to Aetna Student Health website at www.uvastudentinsurance.com. Follow the instructions on the “International Students” tab.

PLEASE NOTE: For purposes of the University’s hard waiver requirement an international student is any non-immigrant student, meaning any student enrolled at the University pursuant to a visa. Permanent residents, refugees, asylees, and students with temporary protective status are considered immigrants or intending immigrants and are not subject to the University’s hard waiver program. Exchange students are also not currently subject to the hard waiver program. International students who are pursuing permanent resident, refugee, asylee or temporary protective status must submit appropriate documentation to the International Studies Office by October 1, 2010 to be exempt from the University’s hard waiver program. This is a firm deadline. Students who fail to submit appropriate documentation by October 1, 2010 will be automatically enrolled in the University’s Student Health Plan and be charged the full annual premium of $2,152.

REFUND POLICY
If you withdraw from school within the first 31 days of a coverage period, you will not be covered under the Policy and the full premium will be refunded, less any claims paid. After 31 days, you will be covered for the full period that you have paid the premium for, and no refund will be allowed. (This Refund Policy will not apply if you withdraw due to a covered accident or sickness.)

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

DEPENDENT COVERAGE

ELIGIBILITY
Covered students may also enroll their lawful spouse, any child under the age of 19, and any dependent children under the age of 25 who are full time-students without regard to whether the child resides in the same household as the insured.

If a Plan covers a dependent child under the age 25 who is enrolled as a full-time student and cannot continue as a full-time student due to a medical condition, coverage will continue for up to twelve months from the date the child ceases to be a full-time student, or the date the child no longer qualifies as a dependent child under the terms of the Policy.

ENROLLMENT
To enroll the dependent(s) of a covered student, please include the dependent information and enroll online at www.uvastudentinsurance.com with a MasterCard/Visa payment or eCheck or return the Enrollment Form to Aetna Student Health together with your check, money order, or MasterCard/Visa payment.
DEPENDENT ENROLLMENT DEADLINES
In order for coverage to be effective August 15, 2010 the final enrollment deadline for the annual Policy is October 1, 2010.

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

Coverage is provided for a child legally placed for adoption with a covered student for 31 days from the moment of placement provided the child lives in the household of the covered student, and is dependent upon the covered student for support. To extend coverage for an adopted child past the 31 days, the covered student must 1) enroll the child within 31 days of placement of such child, and 2) pay any additional premium, if necessary, starting from the date of placement. For information or general questions on dependent enrollment, contact Aetna Student Health at (800) 466-3027.

CONTINUOUSLY INSURED
Persons who have remained continuously insured under this Policy or other Policies will be covered for any pre-existing condition, which manifests itself while continuously insured, except for expenses payable under prior policies in the absence of this Policy. Previously Covered Persons must re-enroll for coverage in order to avoid a break in coverage for conditions which existed in prior Policy Years. Once a break in continuous coverage occurs, the pre-existing conditions limitation will apply.

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

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

You may also obtain information regarding Preferred Providers by contacting Aetna Student Health at (800) 466-3027, or through the Internet by accessing DocFind® at www.uvastudentinsurance.com.

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

Pre-certification means calling Aetna Student Health prior to treatment to obtain approval for a medical procedure or service. Pre-certification may be done by you, your doctor, a hospital administrator, or one of your relatives. All requests for certification must be obtained by contacting Aetna Student Health at (800) 466-3027 (attention: Managed Care Department).

If you do not secure pre-certification for non emergency inpatient admissions, or provide notification for emergency admissions, your Covered Medical Expenses will be subject to a $200 per admission Deductible.

The following inpatient and outpatient services or supplies require pre-certification:
- All inpatient admissions, including length of stay, to a hospital, skilled nursing facility, a facility established primarily for the treatment of substance abuse, or a residential treatment facility.
- All inpatient maternity care, after the initial 48/96 hours.
- All partial hospitalization in a hospital, residential treatment facility, or facility established primarily for the treatment of substance abuse.

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

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

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

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

NOTIFICATION OF EMERGENCY ADMISSIONS

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

PRE-EXISTING CONDITIONS/CONTINUOUSLY INSURED PROVISIONS

PRE-EXISTING CONDITION

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

LIMITATION

Pre-existing conditions are not covered during the first twelve months that you are covered under this Plan unless:
(a) The Covered Person has been continuously insured; or
(b) No charges are incurred or treatment rendered for the condition for a period of three months while covered under this Policy; or
(c) The Covered Person has been covered under this Policy for twelve consecutive months, whichever happens first.

However, any period of time that the person was covered by previous individual or group policies providing hospital, medical, surgical, or major medical coverage on an expense-incurred basis may be counted toward the above requirement. In order to be counted, that prior coverage must have ended less than 63 days before the person’s coverage under the Policy took effect.
CONTINUOUSLY INSURED
You have been continuously insured if you (i) had “creditable health insurance coverage” (such as COBRA, HMO, another group or individual policy, Medicare or Medicaid) prior to enrolling in this Plan, and (ii) the creditable coverage ended within 63 days of the date you enrolled under this Plan. If both of these tests are met, then the pre-existing limitation period under this Plan will be reduced (and possibly eliminated altogether) by the number of days of your prior creditable coverage. You will be asked to provide evidence of your prior creditable coverage.

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

Note: Services at Elson Student Health are not subject to the pre-existing condition clause.

DESCRIPTION OF BENEFITS
Please Note:
THE UNIVERSITY OF VIRGINIA STUDENT HEALTH INSURANCE MAY NOT COVER ALL OF YOUR HEALTH CARE EXPENSES.

The Plan excludes coverage for certain services and contains limitations on the amounts it will pay. Please read this Plan Brochure carefully before deciding whether this Plan is right for you. While this document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. If you want to look at the full Plan description, which is contained in the Master Policy issued to the University of Virginia, you may view it at Elson Student Health Center or you may contact Aetna Student Health at (800) 466-3027.

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

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

SUMMARY OF BENEFITS CHART

<table>
<thead>
<tr>
<th>MEDICAL DEDUCTIBLES</th>
<th>The following Deductibles are applied before Covered Medical Expenses are payable:</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>$200 per individual, per Policy Year.</td>
</tr>
<tr>
<td></td>
<td>$400 per family, per Policy Year.</td>
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| COINSURANCE | Covered Medical Expenses are payable at the coinsurance percentage specified below, after any applicable Deductible, up to a maximum benefit of $1,000,000 per condition, per lifetime. |

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

| | Preferred Care Individual Out-of-Pocket: $1,500 |
| | Preferred Care Family Out-of-Pocket: $3,000 |
| | Non-Preferred Care Individual Out-of-Pocket: $2,000 |
| | Non-Preferred Care Family Out-of-Pocket: $4,000 |
All coverage is based on Reasonable Charges unless otherwise specified.

### Inpatient Hospitalization Benefits

| Hospital Room and Board Expenses | Covered Medical Expenses are payable as follows:  
Preferred Care: 80% of the Negotiated Charge.  
Non-Preferred Care: 70% of the Reasonable Charge for a semi-private room. |
| Intensive Care Unit Expenses | Covered Medical Expenses are payable as follows:  
Preferred Care: 80% of the Negotiated Charge.  
Non-Preferred Care: 70% of the Reasonable Charge for the Intensive Care Room Rate for an overnight stay. |
| Miscellaneous Hospital Expenses | Covered Medical Expenses are payable as follows:  
Preferred Care: 80% of the Negotiated Charge.  
Non-Preferred Care: 70% of the Reasonable Charge.  
Covered Medical Expenses include, but are not limited to: laboratory tests, X-rays, surgical dressings, anesthesia, supplies and equipment use, and medicines. |
| Physician Hospital Visit/Consultation Expenses | Covered Medical Expenses for charges for the non-surgical services of the attending physician, or a consulting physician, are payable as follows:  
Preferred Care: 80% of the Negotiated Charge.  
Non-Preferred Care: 70% of the Reasonable Charge. |

### Surgical Benefits (Inpatient and Outpatient)

| Surgical Expenses | Covered Medical Expenses for charges for surgical services, performed by a physician, are payable as follows:  
Preferred Care: 80% of the Negotiated Charge.  
Non-Preferred Care: 70% of the Reasonable Charge. |
| Anesthetist and Assistant Surgeon Expenses | Covered Medical Expenses for the charges of an anesthetist and an assistant surgeon, during a surgical procedure, are payable as follows:  
Preferred Care: 80% of the Negotiated Charge.  
Non-Preferred Care: 70% of the Reasonable Charge. |
| Ambulatory Surgical Expenses | Covered Medical Expenses for outpatient surgery performed in an ambulatory surgical center are payable as follows:  
Preferred Care: 80% of the Negotiated Charge.  
Non-Preferred Care: 70% of the Reasonable Charge.  
Covered Medical Expenses must be incurred on the day of the surgery or within 48 hours after the surgery. |

### Outpatient Benefits

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

| Covered Medical Expenses for outpatient treatment in a hospital are payable as follows:  
Preferred Care: 80% of the Negotiated Charge  
Non-Preferred Care: 70% of the Reasonable Charge. |
| Hospital Outpatient Department or Walk-In Clinic Expenses | Covered Medical Expenses incurred for treatment of an Emergency Medical Condition are |
| Expenses | payable as follows:  
| Preferred Care: After a **$75** per admission copay (waived if admitted), **90%** of the Negotiated Charge.  
| Non-Preferred Care: After a **$75** per admission deductible (waived if admitted), **90%** of the Reasonable Charge.  
| Please Note: This per visit deductible does not apply towards meeting the annual deductible. |  |
| Urgent Care Expenses | Benefits include charges for treatment by an urgent care provider.  
| Please Note: A Covered Person should not seek medical care or treatment from an urgent care provider if their illness, injury, or condition, is an emergency condition. The Covered Person should go directly to the emergency room of a hospital or call 911 (or the local equivalent) for ambulance and medical assistance.  
| Urgent Care | Benefits include charges for an urgent care provider to evaluate and treat an urgent condition.  
| Covered Medical Expenses for urgent care treatment are payable as follows:  
| Preferred Care: **80%** of the Negotiated Charge.  
| Non-Preferred Care: **70%** of the Reasonable Charge.  
| The Covered Person should contact their primary care physician after medical care is provided to treat an urgent condition.  
| No benefit will be paid under any other part of this Plan for charges made by an urgent care provider to treat a non-urgent condition. |  |
| Ambulance Expenses | Covered Medical Expenses are payable as follows:  
| **80%** of the Actual Charge for the services of a professional ambulance to or from a hospital, when required due to the emergency nature of a covered accident or sickness. |  |
| Pre-Admission Testing Expenses | Covered Medical Expenses for Pre-Admission testing charges while an outpatient before scheduled surgery are payable as follows:  
| Preferred Care: **80%** of the Negotiated Charge.  
| Non-Preferred Care: **70%** of the Reasonable Charge.  
| Please see the definition of Pre-Admission Testing on page 46 for more detailed information on this benefit. |  |
| Physician’s Office Visit Expenses | Covered Medical Expenses are payable as follows:  
| Preferred Care: After a **$20** per visit copay, **90%** of the Negotiated Charge  
| Non-Preferred Care: After a **$40** per visit Deductible, **90%** of the Reasonable Charge. |  |
| Laboratory and X-ray Expenses | Covered Medical Expenses are payable as follows:  
| Preferred Care: **80%** of the Negotiated Charge.  
| Non-Preferred Care: **70%** of the Reasonable Charge.  
| Please Note: Benefits are payable at **100%** of billed charges if ordered by Elson Student Health Center. |  |
### High Cost Procedures Expenses

**Covered Medical Expenses** include charges incurred by a **Covered Person** are payable as follows:
- **Preferred Care**: 80% of the Negotiated Charge.
- **Non-Preferred Care**: 70% of the Reasonable Charge.

For purposes of this benefit, “High Cost Procedure” means any outpatient procedure costing over **$200**.

*Please see the definition of High Cost Procedures on page 41 for more detailed information on this benefit.*

*Please Note*: Benefits are payable at **100%** of billed charges if ordered by Elson Student Health Center.

### Therapy Expenses

**Covered Medical Expenses** include charges incurred by a **Covered Person** for the following types of therapy provided on an outpatient basis:
- Physical Therapy,
- Chiropractic Care,
- Speech Therapy,
- Inhalation Therapy, or
- Occupational Therapy.

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

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

- **Preferred Care**: 80% of the Negotiated Charge.
- **Non-Preferred Care**: 70% of the Reasonable Charge.

**40 visit** maximum per Policy Year for Physical, Occupational, Speech & Hearing Therapy.

Chiropractic Care is payable as follows:
- **Preferred Care**: After a **$20** per visit copay, 90% of the Negotiated Charge.
- **Non-Preferred Care**: 70% of the Reasonable Charge.

**25 visit** maximum per Policy Year for Chiropractic Care.

### Chemotherapy Expenses

**Covered Medical Expenses** also include charges incurred by a **Covered Person** for the following types of therapy provided on an outpatient basis:
- Radiation therapy,
- Chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy,
- Dialysis, and
- Respiratory therapy.

Benefits for these types of therapies are payable for **Covered Medical Expenses** on the same basis as any other sickness.

- **Preferred Care**: 80% of the Negotiated Charge.
- **Non-Preferred Care**: 70% of the Reasonable Charge.
| Durable Medical Equipment Expenses | **Covered Medical Expenses** are payable as follows:  
Preferred Care: 80% of the Negotiated Charge.  
Non-Preferred Care: 70% of the Reasonable Charge. |
|-----------------------------------|-------------------------------------------------------------------------------------------------|
| Prosthetic Devices Expenses       | **Covered Medical Expenses** include coverage for medically necessary prosthetic devices, as well as repair, fitting, replacement and components. Covered on the same basis as any other sickness.  
For purposes of this benefit:  
“Component” means the materials and equipment needed to ensure the comfort and functioning of a prosthetic device.  
“Limb” means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot.  
“Prosthetic device” means an artificial device to replace, in whole or in part, a limb.  
**Covered Medical Expenses do not** include: eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet.  
**Covered Medical Expenses** are payable as follows:  
Preferred Care: 80% of the Negotiated Charge.  
Non-Preferred Care: 70% of the Reasonable Charge. |
| Dental Injury Expenses            | **Covered Medical Expenses** include dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition:  
- Natural teeth damaged, lost, or removed, or  
- Other body tissues of the mouth fractured or cut due to injury. The accident causing the injury must occur while the person is covered under this Plan.  
Any such teeth must have been:  
- Free from decay, or  
- In good repair, and  
- Firmly attached to the jawbone at the time of the injury.  
If:  
- Crowns (caps), or  
- Dentures (false teeth), or  
- Bridgework, or  
- In-mouth appliances, are installed due to such injury, **Covered Medical Expenses** include only charges for:  
- The first denture or fixed bridgework to replace lost teeth,  
- The first crown needed to repair each damaged tooth, and  
- An in-mouth appliance used in the first course of orthodontic treatment after the injury.  
Surgery needed to:  
- Treat a fracture, dislocation, or wound.  
- Cut out cysts, tumors, or other diseased tissues.  
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.  
Non-surgical treatment of infections or diseases. This does not include those of, or related to, the teeth.  
**Covered Medical Expenses** are payable as follows: 80% of Actual Charge. |
### Dental Anesthesia and Hospitalization Expenses

**Covered Medical Expenses** will include medically necessary general anesthesia and hospitalization or facilities charges for a licensed outpatient surgery facility for dental care if it is determined by provider that patient requires general anesthesia and admission to a hospital or outpatient surgery facility in order to effectively and safely provide dental care. It is provided for those Covered Persons under the age of five, severely disabled individuals, or persons who have a medical condition and requires admission to a hospital or outpatient surgery facility and general anesthesia for dental care treatment.

Medical necessity is determined by the treating provider as to whether age, physical condition or mental condition of the Covered Person requires authorization for general anesthesia and the admission to a hospital or outpatient surgery facility to safely provide dental care.

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

### Allergy Testing and Treatment Expenses

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

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

**Covered Medical Expenses** are payable as follows:
- **Preferred Care:** 80% of the Negotiated Charge.
- **Non-Preferred Care:** 70% of the Reasonable Charge.

### Diagnostic Testing for Attention Disorders and Learning Disabilities Expenses

**Covered Medical Expenses** for diagnostic testing for:
- Attention Deficit Disorder, or
- Attention Deficit Hyperactive Disorder, or
- Dyslexia,

are payable on the same basis as any other sickness.

Once a Covered Person has been diagnosed with one of these conditions, medical treatment will be payable as detailed under the outpatient Treatment of Mental and Nervous Disorders portion of this Policy.
| Routine Physical Exam Expenses | Benefits include expenses for a routine physical exam performed by a physician. A routine physical exam is a medical exam given by a physician, for a reason other than to diagnose or treat a suspected or identified injury or sickness. Included as a part of the exam are:  
- X-rays, lab, and other tests given in connection with the exam, and  
- Materials for the administration of immunizations for infectious disease and testing for tuberculosis.  

**Preferred Care**: After a $20 per visit copay, 90% of the Negotiated Charge.  
**Non-Preferred Care**: After a $100 per visit deductible, 90% of the Reasonable Charge.  

Please see the immunization section of this Brochure for immunization benefits paid.  

Also included as **Covered Medical Expenses** are charges made by a physician for one annual routine gynecological exam. |

| Preventive Health Care Services Expenses | **Covered Medical Expenses** include charges incurred by a Covered Person for Preventive Health Care Services which includes routine preventive and primary care services, rendered to a covered dependent child under seven years of age on an outpatient basis.  

**Preventive Health Care Services**  
These are services provided for a routine physical exam of the child. Included are:  
- A review and written record of the child’s complete medical history.  
- Taking measurements and blood pressure.  
- Developmental and behavioral assessment.  
- Vision and hearing screening.  
- Other diagnostic screening tests including: one series of hereditary and metabolic tests performed at birth, urinalysis, tuberculin test, and blood tests such as hematocrit and hemoglobin tests.  
- Immunizations for infectious disease.  
- Counseling and guidance of the child and the child’s parents or guardian on the results of the physical exam.  

**Covered Medical Expenses** will only include charges incurred for:  
- The first **nine exams** performed during the first two years of the child’s life.  
- **One exam** performed during each year of life thereafter through age six.  

**Covered Medical Expenses** are payable as follows:  
**Preferred Care**: 90% of the Negotiated Charge.  
**Non-Preferred Care**: 90% of the Reasonable Charge. |
Early Intervention Services Expenses

The charges below are included as **Covered Medical Expenses** for a dependent child under the age of three years (who has been certified by the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Act) even though they may not be incurred in connection with a disease or injury. You must submit proof of such certification with the initial claim.

The services covered are designed to help an individual attain or retain the capability to function age-appropriately within his/her environment, including services that enhance functional ability without effecting a cure. They include, but are not limited to, the following:

- Speech and language therapy given in connection with a speech impairment: which results from a congenital abnormality, disease, or injury.
- Occupational or physical therapy expected to result in significant improvement of a body function: impaired by a congenital abnormality, disease, or injury.
- Assistive technology services.
- Assistive technology devices.

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

- **Preferred Care**: After a $20 copay, 90% of the Negotiated Charge.
- **Non-Preferred Care**: After a $40 deductible, 90% of the Reasonable Charge.

There is a benefit maximum of $5,000 per Policy Year.

Well Baby Care Expenses

Benefits include charges for routine preventive and primary care services, rendered to a covered dependent child on an outpatient basis.

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

Also included are all necessary audiological examinations using any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing, as well as any follow-up audiological examinations as recommended by a physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss.

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

- **Preferred Care**: 90% of the Negotiated Charge.
- **Non-Preferred Care**: 90% of the Reasonable Charge.

Newborn Hearing Screening Expenses

Coverage for infant hearing screenings and all necessary audiological examinations for newborn children.

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

- **Preferred Care**: 90% of the Negotiated Charge.
- **Non-Preferred Care**: 90% of the Reasonable Charge.
### Immunizations Expenses

**Covered Medical Expenses** include charges for all routine and necessary immunizations such as (diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella, and such other immunizations as may be prescribed by the Commissioner of Health) for newborn children to age three; and

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

Student and dependent spouse:
- **Preferred Care:** After a $20 per visit copay, 90% of the Negotiated Charge.
- **Non-Preferred Care:** After a $100 per visit Deductible, 90% of the Reasonable Charge.

Dependent children under age seven:
- **Preferred Care:** 90% of the Negotiated Charge.
- **Non-Preferred Care:** 90% of the Reasonable Charge.

Dependent children age seven to 19:
- **Preferred Care:** 80% of the Negotiated Charge.
- **Non-Preferred Care:** 70% of the Reasonable Charge.

### Consultant or Specialist Expenses

**Covered Medical Expenses** include the expenses for the services of a consultant or specialist, when referred by the School Health Services. The services must be requested by the attending physician for the purpose of confirming or determining to confirm or determine a diagnosis.

**Covered Medical Expenses** are covered as follows:
- **Preferred Care:** After a $20 per visit copay, 90% of the Negotiated Charge.
- **Non-Preferred Care:** After a $40 per visit Deductible, 90% of the Reasonable Charge.

### Mental Health and Substance Abuse Benefits

**Covered Medical Expenses** for the diagnosis and treatment of biologically based mental illnesses are payable on the same basis as any other sickness.

**Biologically-Based Mental Disorders Inpatient Expenses**

**Covered Medical Expenses** for the diagnosis and treatment of biologically based mental illnesses are payable as follows:
- **Preferred Care:** After a $20 copay, 90% of the Negotiated Charge.
- **Non-Preferred Care:** After a $40 deductible, 90% of the Reasonable Charge.
| Treatment of Non-Biologically Based Mental and Nervous Disorders, Alcoholism, or Substance Abuse Inpatient Expenses | **Covered Medical Expenses** for the Treatment of Non-Biologically Based Mental and Nervous Disorders, Alcoholism, or Substance Abuse while confined as an inpatient in a hospital or facility licensed for such treatment are payable as follows:  
**Preferred Care:** 80% of the Negotiated Charge.  
**Non-Preferred Care:** 70% of the Reasonable Charge.  

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

30 day maximum per condition, per year. |
| --- | --- |
| Treatment of Non-Biologically Based Mental and Nervous Disorders, Alcoholism, or Substance Abuse Outpatient Expenses | **Covered Medical Expenses** for outpatient Treatment of Non-Biologically Based Mental and Nervous Disorders, Alcoholism, or Substance Abuse are payable as follows:  
**Preferred Care:** After a $20 copay 90% of the Negotiated Charge.  
**Non-Preferred Care:** 70% of the Reasonable Charge for the first five visits, 50% thereafter.  

The outpatient benefit maximum is 40 outpatient visits per Policy Year.  

Medication management visits shall be covered in the same manner as a medication management visit for the treatment of physical illness and shall not be counted as an outpatient treatment visit. |

### Maternity Benefits

| Maternity Expenses | **Covered Medical Expenses** include inpatient care of the Covered Person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery.  

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.  

**Covered Medical Expenses** for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other sickness.  
**Preferred Care:** 80% of the Negotiated Charge.  
**Non-Preferred Care:** 70% of the Reasonable Charge. |
| Well Newborn Nursery Care Expenses | Benefits include charges for routine care of a Covered Person’s newborn child as follows:  
- hospital charges for routine nursery care during the mother’s confinement,  
- physician’s charges for circumcision, and  
- physician’s charges for visits to the newborn child in the hospital and consultations.  

**Covered Medical Expenses** are payable as follows:  
**Preferred Care:** 80% of the Negotiated Charge.  
**Non-Preferred Care:** 70% of the Reasonable Charge. |
### Additional Benefits

| Prescription Drug Benefit Expenses | Prescription Drug Benefits are payable as follows After a **$50** per Policy Year Deductible, per Covered Person:  
**Preferred Care Pharmacy:** **100%** of the Negotiated Charge, following a **$30** copay for each brand name prescription drug or a **$10** copay for each generic prescription drug.  
**Non-Preferred Care Pharmacy:** **100%** of the Reasonable Charge, following a **$30** copay for each brand name prescription drug or a **$10** copay for each generic prescription drug.  
You must pay out-of-pocket for prescriptions at a Non-Preferred pharmacy and then submit the receipt with a prescription claim form for reimbursement.  
This pharmacy benefit is provided to cover medically necessary prescriptions associated with a covered sickness or accident occurring during the Policy Year. Please use your Aetna Student Health ID card when obtaining your prescriptions.  
Prior Authorization is required for certain prescription drugs, Imitrex, certain stimulants, growth hormones and for any prescription quantities larger than a **30-day** supply.  
*(This is only a partial list.)*  
Medications not covered by this benefit include, but are not limited to: allergy sera, inhalers, all acne medications, drugs whose sole purpose is to promote or to stimulate hair growth, appetite suppressants, smoking deterrents, immunization agents and vaccines, and non-self injectables. *(This is only a partial list.)*  
For assistance or for a complete list of excluded medications, or drugs requiring prior authorization, please contact Aetna Pharmacy Management at *(800) 238-6279* (available **24 hours**).  
Aetna Specialty Pharmacy provides specialty medications and support to members living with chronic conditions. The medications offered may be injected, infused or taken by mouth. For additional information please go to [www.AetnaSpecialtyRx.com](http://www.AetnaSpecialtyRx.com). |
| Diabetic Testing Supplies Expenses | Benefits include charges 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 by this benefit.  
**Covered Medical Expenses** are payable under the Prescription Drug Expense benefit. |
| Hypodermic Needles Expenses | **Covered Medical Expenses** for hypodermic needles and syringes used in the treatment of Diabetes are payable as follows:  
**Covered Medical Expenses** are payable under the Prescription Drug Expense benefit. |
| **Outpatient Diabetic Self-management Education Programs Expenses** | **Covered Medical Expenses** for outpatient Diabetic self-management education programs are payable as follows:  
Preferred Care: After a **$20** per visit copay, **90%** of the Negotiated Charge.  
Non-Preferred Care: After a **$40** per visit deductible, **90%** of the Reasonable Charge.  

*Please see the definition on page 45 of this Brochure for more information on Diabetic Self-Management Education Courses.* |
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<tr>
<td><strong>TMJ Expenses</strong></td>
<td><strong>Covered Medical Expenses</strong> include charges incurred by a Covered Person for treatment of Temporomandibular Joint (TMJ) Dysfunction. Benefits are payable as any other sickness.</td>
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| **Bones and Joints Expenses** | **Covered Medical Expenses** include charges incurred by a **Covered Person** for the diagnosis and surgical treatment involving any bone or joint of the head, neck, face or jaw if the treatment is required due to a medical condition or injury which prevents normal function of the bone or joint.  
Payable as any other sickness. |
| **Cleft Lip/Palate or Ectodermal Dysplasia Expenses for Newborns** | Inpatient and outpatient dental, oral surgical and orthodontic services which are medically necessary for the treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia subject to deductibles, coinsurance and maximums no more restrictive than for any covered sickness or injury.  
Treatment may include:  
- Oral surgery and facial surgery. This includes pre-operative and post operative care performed by a physician.  
- Oral prosthesis treatment, obturators and orthodontic appliances.  
- Initial installation of partial or full removable dentures or of fixed bridgework  
- Replacement of dentures or fixed bridgework when required as a result of structural changes in the mouth or jaw due to growth.  
- Cleft orthodontic therapy.  
- Diagnostic services of a physician to find out if and to what extent the child’s ability to speak or hear has been lost or impaired.  
- Rehabilitative services given by a physician that is expected to restore or improve the child’s ability to speak. This includes speech aids and training in the use of such aids  
- Psychological assessment and counseling.  
  - Genetic assessment and counseling for the child and the child’s parents.  
  - Hearing aids.  
A legally qualified audiologist or speech therapist will be deemed to be a “physician” for the purposes of this section.  

**Covered Medical Expenses** will be payable as any other sickness. |
| Clinical Trial Expenses | Clinical Trial Expenses are payable for **Covered Medical Expenses** incurred by each Covered Person. A clinical trial meets the following conditions:

- The clinical trial is intended to treat cancer in a patient who has been so diagnosed,
- The clinical trial has been peer reviewed, and is approved by one of the United States National Institutes of Health (NIH), a cooperative group or center of the NIH including the National Cancer Institute Clinical Cooperative Group and the National Cancer Institute Community Clinical Oncology Program, and

With respect to Phase II, Phase III, or Phase IV clinical trials, the treatment shall be provided if approved by:

- The NIH,
- A National Cancer Institute cooperative group or center,
- The FDA in the form of an investigational new drug application,
- The federal Department of Veterans Affairs, and
- An institutional review board approved by the Office of Protection from Research Risks of the NCI.

With respect to Phase I clinical trials, treatment may be provided on a case-by-case basis.

The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training, and treat a sufficient volume of patients to maintain that expertise.

Coverage shall apply only if:

- There is no clearly superior, non-investigational treatment alternative,
- The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative, and
- The Covered Person or physician or health care provider conclude that the Covered Person’s participation in the clinical trial would be appropriate pursuant to this Policy.

Clinical Trial Expense benefits incurred during participation in clinical trials for treatment studies on cancer shall be reimbursed the same as other medical/surgical procedures.

Payable as any other sickness. |

| Home Treatment of Hemophilia Expenses | **Covered Medical Expenses** include charges incurred by a **Covered Person** for expenses incurred in connection with the treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. The benefits to be provided shall include coverage for the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders when the home treatment program is under the supervision of the state-approved hemophilia treatment center.

- “Blood infusion equipment” includes, but is not limited to, syringes and needles.
- “Blood product” includes, but is not limited to, Factor VII, Factor VIII, Factor IX, and cryoprecipitate.
- “Hemophilia” means a lifelong hereditary bleeding disorder usually affecting males that results in prolonged bleeding primarily into joints and muscles
- “Home treatment program” means a program where individuals or family members are trained to provide infusion therapy at home in order to achieve optimal health and cost effectiveness.
- “State-approved hemophilia treatment center” means a hospital or clinic which receives federal or state Maternal and Child Health Bureau, and/or Centers for Disease Control funds to conduct comprehensive care for persons with hemophilia and other congenital bleeding disorders.

**Covered Medical Expenses** will be payable as any other sickness. |
### Prescription Contraceptive Devices Expenses

**Covered Medical Expenses** include:
- Charges incurred for contraceptive devices that by law need a physician’s prescription, and that have been approved by the FDA.
- Related outpatient contraceptive services such as: Consultations, Exams, Procedures, and other medical services and supplies.

Benefits for contraceptive devices and outpatient contraceptive services are payable as any other sickness.

### Pap Smear Expenses

**Covered Medical Expenses** include one annual routine Pap smear screening for women age 18 and older.

Benefits are payable as follows:
- **Preferred Care**: 80% of the Negotiated Charge.
- **Non-Preferred Care**: 70% of the Reasonable Charge.

Please Note: Benefit is 100% if ordered from Elson Student Health Center.

### Mammography Expenses

**Covered Medical Expenses** include:
- A baseline mammogram for women between the ages of 35 to 40,
- A mammogram every two years, or more frequently based on the recommendation of the woman’s **physician** for women ages 40 to 50, or
- A mammogram on an annual basis for women 50 years of age and older.

Benefits are payable as follows:
- **Preferred Care**: 80% of the Negotiated Charge (annual deductible waived).
- **Non-Preferred Care**: 70% of the Reasonable Charge (annual deductible waived).

### Inpatient Coverage Following a Laparoscopy-Assisted Vaginal Hysterectomy And Vaginal Hysterectomy Expenses

**Covered Medical Expenses** include charges incurred by a Covered Person for inpatient coverage following a laparoscopy-assisted vaginal hysterectomy and vaginal hysterectomy while insured under this Policy. Benefits are payable for **Covered Medical Expenses** on the same basis as any other sickness.

**Covered Medical Expenses** include:
- Inpatient care for a minimum of 48 hours following a vaginal hysterectomy, or
- Inpatient care for a minimum of 23 hours following a laparoscopy-assisted vaginal hysterectomy.

Any decision to shorten such minimum coverages shall be made by the attending physician, in consultation with the Covered Person.

Benefits are payable as follows:
- **Preferred Care**: 80% of the Negotiated Charge.
- **Non-Preferred Care**: 70% of the Reasonable Charge.
### Mastectomy Expenses

**Covered Medical Expenses** include expenses incurred by a Covered Person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy, for:
1. reconstruction of the breast on which a mastectomy has been performed,
2. surgery and reconstruction of the other breast to produce a symmetrical appearance,
3. prostheses, and
4. treatment of physical complications of all stages of mastectomy, including lymphedemas.

Benefits are payable as follows:
- **Preferred Care**: 80% of the Negotiated Charge.
- **Non-Preferred Care**: 70% of the Reasonable Charge.

### Inpatient Coverage Following A Mastectomy Expenses

**Covered Medical Expenses** include charges incurred by a Covered Person for inpatient coverage following a mastectomy while insured under this Policy. Benefits are payable for **Covered Medical Expenses** on the same basis as any other sickness.

**Covered Medical Expenses** include:
- Inpatient care for a minimum of 48 hours following a radical or modified radical mastectomy, or
- Inpatient care for a minimum of 24 hours following a total mastectomy or a partial mastectomy with lymph node dissection,

For the treatment of breast cancer.

Any decision to shorten such minimum coverages shall be made by the attending physician, in consultation with the Covered Person.

Benefits are payable as follows:
- **Preferred Care**: 80% of the Negotiated Charge.
- **Non-Preferred Care**: 70% of the Reasonable Charge.

### Bone Marrow and Stem Cell Transplants for Breast Cancer Expenses

Expenses incurred for the treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplants, or stem cell transplants when performed pursuant to protocols approved by the institutional review board of any United States medical teaching college including, but not limited to, National Cancer Institute protocols that have been favorably reviewed and utilized by hematologists or oncologist experienced in dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants.

Payable as any other sickness.

### Lymphedema Expenses

Coverage for prescribed equipment, supplies, complex decongestive therapy, and outpatient self-management training and education for the treatment of lymphedema.

These expenses are payable on the same basis as any other sickness.
| Morbid Obesity Expenses | Coverage for the treatment of morbid obesity through gastric bypass surgery or such other methods as recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity.

These expenses are payable on the same basis as any other sickness. |
|-------------------------|-------------------------------------------------------------------------------------------------|
| Elective Abortion Expenses | If, as a result of pregnancy having its inception during the Policy Year, a Covered Person incurs expenses in connection with an elective abortion, a benefit is payable. 

**Covered Medical Expenses** for Elective Abortion Expense are covered as follows: 
**Preferred Care**: 80% of the Negotiated Charge.  
**Non-Preferred Care**: 70% of the Reasonable Charge. |
| Family Planning Expenses | Benefits include charges incurred for the following, although they are not incurred in connection with the diagnosis or treatment of a sickness or injury:
- Charges by a physician or hospital for:
  - a vasectomy for voluntary sterilization,
  - a tubal ligation for voluntary sterilization, and
  - voluntary abortions.

**Covered Medical Expenses** do not include the reversal of a sterilization procedure.

**Covered Medical Expenses** are payable as follows: 
**Preferred Care**: 80% of the Negotiated Charge.  
**Non-Preferred Care**: 70% of the Reasonable Charge. |
| Chlamydia Screening Test Expenses | Benefits include charges incurred for an annual Chlamydia screening test. 

Benefits will be paid for Chlamydia screening expenses incurred for:
- Women who are:
  - under the age of 20 if they are sexually active, and
  - at least 20 years old if they have multiple risk factors.
- Men who have multiple risk factors.

**Covered Medical Expenses** are payable as follows: 
**Preferred Care**: 80% of the Negotiated Charge.  
**Non-Preferred Care**: 70% of the Reasonable Charge. 

**Please Note**: Benefit is 100% if ordered from Elson Student Health Center. 

*Please see definition on page 38 for more information on this benefit.* |
| Routine Screening for Sexually Transmitted Disease Expenses | **Covered Medical Expenses** include charges for Covered Persons who are at least 18 years old and who are sexually active for annual routine screening for sexually transmitted diseases.

Benefits are payable as follows: 
**Preferred Care**: 80% of the Negotiated Charge.  
**Non-Preferred Care**: 70% of the Reasonable Charge. 

**Please Note**: Benefit is 100% if ordered from Elson Student Health Center. 

*Please see definition on page 49 for more information on this benefit.* |
| Routine Colorectal Cancer Screening Expenses | Coverage for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations.  

These expenses are payable on the same basis as any other sickness.  

**Covered Medical Expenses** are payable as follows:  
Preferred Care: 80% of the Negotiated Charge.  
Non-Preferred Care: 70% of the Reasonable Charge. |
| Routine Prostate Cancer Screening Expenses | Covered Medical Expenses include charges incurred by a Covered Person for the screening of cancer as follows:  
- for a male age 50 or over; and  
- for a male age 40 and over who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society,  
  one digital rectal exam and one prostate specific antigen test each Policy Year.  

Preferred Care: 80% of the Negotiated Charge.  
Non-Preferred Care: 70% of the Reasonable Charge. |
| Elective Surgical Second Opinion Expenses | Covered Medical Expenses will include expenses incurred for a second opinion consultation by a specialist on the need for non-emergency elective surgery which has been recommended by the Covered Person’s physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation.  

Benefits are payable as follows:  
Preferred Care: After a $20 per visit copay, 90% of the Negotiated Charge.  
Non-Preferred Care: After a $40 per visit Deductible, 90% of the Reasonable Charge. |
| Acupuncture Expenses | Acupuncture is a Covered Medical Expense when it is administered for the following indications by a health care provider, who is a legally qualified physician, who is practicing within the scope of their license:  
- Adult postoperative and chemotherapy nausea and vomiting,  
- Nausea of pregnancy,  
- Postoperative dental pain,  
- Fibromyalgia/myofacial pain,  
- Chronic low back pain secondary to osteoarthritis.  

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

Acupuncture Expense benefits are payable as follows:  
Preferred Care: 80% of the Negotiated Charge.  
Non-Preferred Care: 70% of the Reasonable Charge. |
| **Acupuncture in Lieu of Anesthesia Expenses** | **Covered Medical Expenses** include acupuncture therapy, when acupuncture is used in lieu of other anesthesia, for a surgical or dental procedure covered under this Plan.  
The acupuncture must be administered by a health care provider who is a legally qualified physician, practicing within the scope of their license.  
Preferred Care: **80%** of the Negotiated Charge.  
Non-Preferred Care: **70%** of the Reasonable Charge. |
| Dermatological Expenses | **Covered Medical Expenses** include charges for the diagnosis and treatment of skin disorders, excluding laboratory fees. Related laboratory expenses are covered under the Outpatient Expense Benefit.  
Benefits are payable on the same basis as any other sickness.  
**Covered Medical Expenses do not include cosmetic treatment and procedures.** |
| Podiatric Expenses | **Covered Medical Expenses** include charges for podiatric services, provided on an outpatient basis following an injury.  
Benefits are payable as follows:  
Preferred Care: After a **$20** copay, **90%** of the Negotiated Charge.  
Non-Preferred Care: After a **$40** deductible, **90%** of the Reasonable Charge.  
Expenses for routine foot care, such as trimming of corns, calluses, and nails, are **not Covered Medical Expenses.** |
| Home Health Care Expenses | **Covered Medical Expenses** include charges incurred by a Covered Person for home health care services made by a home health agency pursuant to a home health care plan, but only if:  
(a) The services are furnished by, or under arrangements made by, a licensed home health agency,  
(b) The services are given under a home care plan. This plan must be established pursuant to the written order of a physician, and the physician must renew that plan every **60 days.** Such physician must certify that the proper treatment of the condition would require inpatient confinement in a hospital (or skilled nursing facility) if the services and supplies were not provided under the home health care plan. The physician must examine the Covered Person at least once a month,  
(c) Except as specifically provided in the home health care services, the services are delivered in the patient’s place of residence on a part-time, intermittent visiting basis while the patient is confined,  
(d) The care starts within **seven days** after discharge from a hospital as an inpatient, and  
(e) The care is for the same condition that caused the hospital confinement, or one related to it.  
1. Part-time or intermittent nursing care by: a registered nurse (R.N.), a licensed practical nurse (L.P.N.), or under the supervision on a R.N. if the services of a R.N. are not available,  
2. Part time or intermittent home health aide services, that consist primarily of care of a medical or therapeutic nature by other than a R.N.,  
3. Physical, occupational, speech therapy, or respiratory therapy, |
<table>
<thead>
<tr>
<th>Home Health Care Expenses (continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Medical supplies, drugs and medicines, and laboratory services. However, these items are covered only to the extent they would be covered if the patient was confined to a hospital,</td>
</tr>
<tr>
<td>5. Medical social services by licensed or trained social workers,</td>
</tr>
<tr>
<td>6. Nutritional counseling.</td>
</tr>
</tbody>
</table>

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

**Preferred Care**: 80% of the Negotiated Charge.
**Non-Preferred Care**: 70% of the Reasonable Charge.

Benefits are limited to 90 visits per Policy Year.

<table>
<thead>
<tr>
<th>Transfusion or Dialysis of Blood Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Medical Expenses</strong> include charges for the transfusion or dialysis of blood, including the cost of: whole blood, blood components, and the administration thereof.</td>
</tr>
</tbody>
</table>

Benefits are payable as follows:
**Preferred Care**: 80% of the Negotiated Charge.
**Non-Preferred Care**: 70% of the Reasonable Charge.

<table>
<thead>
<tr>
<th>Hospice Benefit Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Medical Expenses</strong> include charges for hospice care provided for a terminally ill Covered Person during a hospice benefit period.</td>
</tr>
</tbody>
</table>

Benefits are payable as follows:
**Preferred Care**: 90% of the Negotiated Charge.
**Non-Preferred Care**: 90% of the Reasonable Charge.

*Please see definition on page 42 for more information on Hospice Care Expenses.*

<table>
<thead>
<tr>
<th>Licensed Nurse Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits include charges incurred by a Covered Person who is confined in a hospital as a resident bed-patient, and requires the services of a registered nurse or licensed practical nurse.</td>
</tr>
</tbody>
</table>

**Covered Medical Expenses** for a licensed nurse are covered as follows:
**Preferred Care**: 80% of the Negotiated Charge.
**Non-Preferred Care**: 70% of the Reasonable Charge.

For purposes of determining this maximum, a shift means eight consecutive hours.

<table>
<thead>
<tr>
<th>Skilled Nursing Facility Expenses</th>
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</thead>
<tbody>
<tr>
<td><strong>Covered Medical Expenses</strong> include charges incurred by a Covered Person for confinement in a skilled nursing facility for treatment rendered:</td>
</tr>
<tr>
<td>• in lieu of confinement in a hospital as a full time inpatient, or</td>
</tr>
<tr>
<td>• within 24 hours following a hospital confinement and for the same or related cause(s) as such hospital confinement.</td>
</tr>
</tbody>
</table>

**Covered Medical Expenses** are payable as follows:
**Preferred Care**: 80% of the Negotiated Charge for the semi-private room rate.
**Non-Preferred Care**: 70% of the Reasonable Charge for the semi-private room rate.
## Rehabilitation Facility Expenses

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

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

- **Preferred Care**: After a 80% of the Negotiated Charge for the rehabilitation facility’s daily room and board maximum for semi-private accommodations.
- **Non-Preferred Care**: 70% of the Reasonable Charge for the rehabilitation facility’s daily room and board maximum for semi-private accommodations.

## ADDITIONAL SERVICES AND DISCOUNTS

As a member of the Plan, you can also take advantage of the following services, discounts, and programs. These are not underwritten by Aetna and are not insurance. To learn more about these additional services and search for providers visit, [www.uvastudentinsurance.com](http://www.uvastudentinsurance.com).

**Aetna BookSM Discount Program**: Access to a 10% discount on any book or DVD purchase from the [MayoClinic.com](http://www.mayoclinic.com) Bookstore.

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

**Aetna HearingSM Discount Program**: Access to discounts on hearing devices and hearing exams from HearPO®. Average savings on hearing aids is 25%.

**Aetna Natural Products and ServicesSM Discount Program**: Access to reduced rates on services from participating providers for acupuncture, chiropractic care, massage therapy and dietetic counseling. Also, access to discounts on over-the-counter vitamins, herbal and nutritional supplements and natural products.

All products and services are provided through American Specialty Health Incorporated (ASH) and its subsidiaries.

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

**Aetna Weight ManagementSM Discount Program**: Access to discounts on Jenny Craig® weight loss programs and products. Also, access to a 30% discount on monthly eDiet membership dues. eDiets is an online diet, fitness and healthy living website.

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

**Zagat Discounts**: Access to a 30% discount on a one-year online subscription fee to [Zagat.com](http://www.zagat.com). The Zagat website provides access to over 40,000 restaurants, nightspots, hotels and attractions around the world.

*These services, programs or benefits are offered by vendors who are independent contractors and not employees or agents of Chickering Claims Administrators, Inc., Aetna Life Insurance or their affiliates.*

*Discount programs and other programs above provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Discount programs may be offered by vendors who are independent contractors and not employees or agents of Aetna.*
Aetna’s Informed Health® Line:
Call toll free 1-800-556-1555 24 hours a day, 7 days a week.
Get health answers 24/7. When you have an Aetna health benefits and health insurance plan, you have instant access to the information you need. Our tools and resources can help you:
• Make more informed decisions about your care
• Communicate better with your doctors
• Save time and money, by showing you how to get the right care at the right time

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

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

Use the Healthwise® Knowledgebase to find out more about a health condition you have or medications you take. It explains things in terms that are easy to understand. Get to it through your secure Aetna Navigator® member website, at www.aetnastudenthealth.com.

Health and Wellness Portal: This dynamic, interactive website at www.uvastudentinsurance.com 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.

Beginning Right® Maternity Program: Make healthy choices for you and your baby. Learn what decisions are good ones for you and your baby. Our Beginning Right maternity program helps prepare you for the exciting changes pregnancy brings.

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

Aetna Health ConnectionsSM Disease Management Program: This program addresses over 35 health conditions, using smart technology and supportive services to personalize your experience. The program helps you learn ways to improve your health. Our CareEngine® system compares your health data with over 1,000 current evidence-based guidelines of care. It runs constantly to identify safety risks and solutions, opportunities for better care and program services that can help you reach your health goals. You may receive a call or letter, depending on the situation. Or, to get started right away, call us at 1-866-269-4500.

The Concordia Flex Dental Plan, underwritten by United Concordia, gives you the freedom to visit any licensed dentist in the country for covered services – with no referrals required. Find information online at www.uvastudentinsurance.com.

Health/Dental information programs provide general health/dental information and are not a substitute for diagnosis or treatment by a physician or other health/dental care professional.
GENERAL PROVISIONS

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

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

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

TERMINATION OF INSURANCE
Benefits are payable under this 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.

TERMINATION OF STUDENT COVERAGE
Insurance for a covered student will end on the first of these to occur:
(a) the date this Policy terminates,
(b) the last day for which any required premium has been paid,
(c) the date on which the covered student withdraws from the school because of entering the armed forces of any country. Premiums will be refunded on a pro-rata basis when application is made within 90 days from withdrawal,
(d) the date the covered student is no longer in an eligible class.

If withdrawal from school is for other than entering the armed forces, no premium refund will be made. Students will be covered for the Policy term for which they are enrolled, and for which premium has been paid.

TERMINATION OF DEPENDENT COVERAGE
Insurance for a covered student’s dependent will end when insurance for the covered student ends. Before then, coverage will end:
(a) For a child, on the first premium due date following the first to occur of:
   1. the date the child is no longer chiefly dependent upon the student for support and maintenance,
   2. the date of the child’s marriage, and
   3. the child’s 25th birthday.
(b) The date the covered student fails to pay any required premium.
(c) For the spouse, the date the marriage ends in divorce or annulment.
(d) The date dependent coverage is deleted from this Policy.
(e) The date the dependent ceases to be in an eligible class.

Termination will not prejudice any claim for a charge that is incurred prior to the date coverage ends.
INCAPACITATED DEPENDENT CHILDREN
Insurance may be continued for incapacitated dependent children who reach the age at which insurance would otherwise cease. The dependent child must be chiefly dependent for support upon the covered student and be incapable of self-sustaining employment because of mental or physical handicap.

Due proof of the child’s incapacity and dependency must be furnished to Aetna by the covered student within 31 days after the date insurance would otherwise cease. Such proof will not be required more often than once each year after two years from the date the child reached the age at which insurance would have ceased if the child were not incapacitated. The premium due for the child’s insurance will be the same as for a child who is not so incapacitated. Such child will be considered a covered dependent, so long as the covered student submits proof to Aetna each year, that the child remains physically or mentally unable to earn his/her own living. The premium due for the child’s insurance will be the same as for a child who is not so incapacitated.

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

CONTINUATION OF COVERAGE
A covered student who has graduated or is otherwise ineligible for coverage under this Policy, and has been continuously insured under the Plan offered by the Policyholder (regular Student Plan), may be covered for either 3, 6 or 9 months (but not to exceed 9 months) provided that: (1) a written request for continuation has been forwarded to Aetna 21 days after the termination of coverage, (2) premium payment has been made, (3) the student has been on the base plan for at least 6 months. Coverage under this provision ceases on the date this Policy terminates.
EXCLUSIONS
This Policy does not cover nor provide benefits for:
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 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.
3. 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.
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, but, as to benefits payable under Workers’ Compensation, only if:
   • The Workers’ Compensation Commission denies benefits for the injury or sickness and the Covered Person does not request a review of the denial within 20 days, or
   • The Workers’ Compensation Commission has, after review of an award, denied benefits for the injury or sickness.
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 elective treatment or elective surgery except as specifically provided elsewhere in this Policy and performed while this Policy is in effect.
9. 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 extend needed to:
   • Improve the function of a part of the body that:
     ○ is not a tooth or structure that supports the teeth, and
     ○ is malformed:
       ▪ as a result of a severe birth defect, including harelip, webbed fingers, or toes, or
       ▪ as direct result of:
         ■ disease, or
         ■ surgery performed to treat a disease or injury.
   • Repair an injury (including reconstructive surgery for prosthetic device for a Covered Person who has undergone a mastectomy) which occurs while the Covered Person is covered under this Policy. Surgery must be performed:
     ○ in the calendar year of the accident which causes the injury, or
     ○ in the next calendar year.
10. 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.
11. 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.

12. Expenses incurred as a result of commission of a felony.

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

14. Expenses incurred for any services rendered by a member of the Covered Person’s immediate family or a person who lives in the Covered Person’s home.

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

16. Expenses incurred by a Covered Person not a United States Citizen for services performed within the Covered Person’s home country.

17. Treatment for injury to the extent benefits are payable under any state No-fault automobile coverage, first party medical benefits payable under any other mandatory No-fault law.

18. 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 or elective abortion unless specifically provided for in this Policy.

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

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

21. Expenses incurred for custodial care. Custodial care means services and supplies furnished to a person mainly to help him/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.

22. Expenses incurred for blood or blood plasma, except charges by a hospital for the processing or administration of blood.

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

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

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

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

24. Expenses incurred for gastric bypass, and any restrictive procedures, for weight loss except for the treatment of morbid obesity.

25. Expenses incurred for breast reduction/mammoplasty.

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

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

28. Expenses incurred by a Covered Person, not a United States citizen, for services performed within the Covered Person’s home country, if the Covered Person’s home country has a socialized medicine program.

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

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

32. Expenses for care or services to the extent the charge would have been covered under Medicare Part A or Part B, even though the Covered Person is eligible, but did not enroll in Part B.

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

34. 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.

35. Expenses for incidental surgeries, and standby charges of a physician.

36. Expenses for treatment and supplies for programs involving cessation of tobacco use.

37. Expenses incurred as a result of dental treatment, including extraction of wisdom teeth, except for treatment resulting from injury to sound natural teeth, as provided elsewhere in this Policy.

38. Expenses incurred for massage therapy.

39. Expenses incurred for, or related to, sex change surgery, or to any treatment of gender identity disorder.
40. Expenses for charges that are not **Reasonable Charges**, as determined by Aetna.

41. 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.

42. 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.

43. Expenses arising from a **pre-existing condition**.

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

45. 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. This applies even if they are prescribed, recommended, or approved, by the person’s attending **physician**, or **dentist**.

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

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

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

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

**DEFINITIONS**

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

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

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

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

**Biologically Based Mental Disorders**
Are:
- Schizophrenia,
- Schizoaffective Disorder,
- Bipolar Disorder,
- Major Depressive Disorder,
- Panic Disorder,
- Obsessive-Compulsive Disorder,
- Attention Deficit Hyperactivity Disorder,
- Autism, and
- Drug and Alcoholism addiction.

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

Bone Marrow Transplant
Use of high does chemotherapy and radiation in conjunction with transplantation of autologous bone marrow or peripheral blood stem cells, which originate in the bone marrow.

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

Chlamydia Screening Test
This is any laboratory test of the urogenital tract that specifically detects for infection by one or more agents of Chlamydia trachomatis, and which test is approved for such purposes by the FDA.

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

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

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

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

Convalescent Facility
This is an institution that:
• Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:
  o professional nursing care by a R.N., or by a L.P.N. directed by a full-time R.N., and
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time R.N.
- Is supervised full-time by a physician or R.N.
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Makes charges.

**Copay**
This is a fee charged to a person for Covered Medical Expenses.

For Prescribed Medicines Expenses, the copay is payable directly to the pharmacy for each prescription, kit, or refill, at the time it is dispensed. In no event will the copay be greater than the pharmacy’s charge per prescription, kit, or refill.

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

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

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

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

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

**Deductible**
The amount of Covered Medical Expenses that are paid by each Covered Person during the Policy Year before benefits are paid.

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

**Dental Provider**
This is any dentist, group, organization, dental facility, or other institution, or person legally qualified to furnish dental services or supplies.
Dentist
A legally qualified dentist. Also, a physician who is licensed to do the dental work he/she performs.

Dependent
(a) the covered student’s spouse residing with the covered student, or (b) the covered student’s unmarried child under the age of 19 years. The child must reside with, and be fully supported by, the covered student.

The term “child” includes a covered student’s step-child, adopted child whose coverage is effective upon the earlier of the date of placement for the purpose of adoption, or the date of the entry of an order granting the adoptive parent custody of the child for purposes of adoption and who is residing with the covered student, and who is chiefly dependent on the covered student for his/her full support.

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

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

Designated Care Provider
A health care provider (or pharmacy,) that is affiliated with, and has an agreement with, the School Health Services to furnish services and supplies at a Negotiated Charge.

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

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

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

Durable Medical and Surgical Equipment
No more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:
- made to withstand prolonged use,
- made for and mainly used in the treatment of a disease or injury,
- suited for use in the home,
- not normally of use to person's who do not have a disease or injury,
- not for use in altering air quality or temperature,
- not for exercise or training.

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

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

Emergency Admission
One where the physician admits the person to the hospital or residential treatment facility right after the sudden and at that time, unexpected onset of a change in a person’s physical or mental condition which:
• requires confinement right away as a full-time inpatient, and
• if immediate inpatient care was not given could, as determined by Aetna, reasonably be expected to result in:
  o loss of life or limb, or
  o significant impairment to bodily function, or
  o permanent dysfunction of a body part.

Emergency Condition
This is any traumatic injury or condition which:
• occurs unexpectedly,
• requires immediate diagnosis and treatment, in order to stabilize the condition, and
• is characterized by symptoms such as severe pain and bleeding.

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

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

High Cost Procedure
High Cost Procedures include the following procedures and services:
• C.A.T. Scan,
• Magnetic Resonance Imaging,
• Laser treatment, which must be provided on an outpatient basis, and may be incurred in the following:
  (a) A physician’s office, or
  (b) Hospital outpatient department, or emergency room, or
  (c) Clinical laboratory, or
  (d) Radiological facility, or other similar facility, licensed by the applicable state, or the state in which the facility is located.
**Home Health Agency**
- an agency licensed as a **home health agency** by the state in which **home health care** services are provided, or
- an agency certified as such under Medicare, or
- an agency approved as such by Aetna.

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

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

**Home Health Care Plan**
A written plan of care established and approved in writing by a **physician**, for continued health care and treatment in a **Covered Person**'s home. It must either follow within **24 hours** of and be for the same or related cause(s) as a period of **hospital** or skilled nursing confinement, or be in lieu of **hospital** or skilled nursing confinement.

**Hospice**
A facility or program providing a coordinated program of home and inpatient care which treats terminally ill patients. The program provides care to meet the special needs of the patient during the final stages of a terminal illness. Care is provided by a team made up of trained medical personnel, counselors, and volunteers. The team acts under an independent **hospice** administration and it helps the patient cope with physical, psychological, spiritual, social, and economic stresses. The **hospital** administration must meet the standards of the National Hospice Organization and any licensing requirements.

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

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

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

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

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

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

Intensive Care Unit
A designated ward, unit, or area within a hospital for which a specified extra daily surcharge is made and which is staffed and equipped to provide, on a continuous basis, specialized or intensive care or services, not regularly provided within such hospital.

Jaw Joint Disorder
This is a Temporomandibular Joint Dysfunction or any similar disorder in the relationship between the jaws or jaw joint, and the muscles, and nerves.

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

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

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

- Be care or treatment which is likely to produce as significant positive outcome as any alternative service or supply, both as to the sickness or injury involved and the person’s overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply, both as to the sickness or injury involved and the person’s overall health condition,

- Be a diagnostic procedure which is indicated by the health status of the person. It must be as likely to result in information that could affect the course of treatment as any alternative service or supply, both as to the sickness or injury involved and the person’s overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply, both as to the sickness or injury involved and the person’s overall health condition, and

- As to diagnosis, care, and treatment, be no more costly (taking into account all health expenses incurred in connection with the treatment, service, or supply,) than any alternative service or supply to meet the above tests.

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

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

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

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

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

**Medication Management Visit**
A visit no more than **20 minutes** in length with a licensed **physician** or other licensed health care provider with prescriptive authority for the sole purpose of monitoring and adjusting medications prescribed for mental health or substance abuse treatment.

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

A **covered student’s member dental provider** is a **member dental provider** currently chosen, in writing by the **covered student**, to provide dental care to the **covered student**.

A **member dental provider** chosen by a **covered student** takes effect as the **covered student’s member dental provider** on the effective date of that **covered student’s** coverage.

**Member Dental Provider Service Area**
The area within a 50 mile radius of the **covered student’s member dental provider**.

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

**Non-Occupational Disease**
A **non-occupational disease** is a disease that does not:
- arise out of (or in the course of) any work for pay or profit, or
- result in any way from a disease that does.

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the **covered student**:
- is covered under any type of workers’ compensation law, and
- is not covered for that disease under such law.

**Non-Occupational Injury**
A **non-occupational injury** is an accidental bodily **injury** that does not:
- arise out of (or in the course of) any work for pay or profit, or
- result in any way from an **injury** which does.

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

**Non-Preferred Care Provider**
- a health care provider that has not contracted to furnish services or supplies at a **Negotiated Charge**, or
- a **Preferred Care Provider** that is furnishing services or supplies without the referral of a **School Health Services**.
Non-Preferred Pharmacy
A pharmacy not party to a contract with Aetna, or a pharmacy who is party to such a contract but who does not dispense prescription drugs in accordance with its terms.

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

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

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

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

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

Out-of-Area Emergency Dental Care
Medically necessary care or treatment for an Emergency Medical Condition that is rendered outside a 50 mile radius of the covered student’s member dental provider. Such care is subject to specific limitations set forth in this Policy.

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

The following expenses do not apply toward meeting the Out-of-Pocket Limit:
- deductibles,
- copays,
- expenses that are not Covered Medical Expenses,
- expenses for designated care or Non-Preferred Care,
- penalties,
- expenses for prescription drugs, and
- other expenses not covered by this Policy.

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

Partial Hospitalization
Continuous treatment consisting of not less than four hours and not more than twelve hours in any 24 hour period under a program based in a hospital.
Pervasive Developmental Disorder
A neurological condition, including Asperger’s Syndrome and Autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Pharmacy
An establishment where prescription drugs are legally dispensed.

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

Policy Year
The period of time from anniversary date to anniversary date except in the first year when it is the period of time from the effective date to the first anniversary date.

Pre-Admission Testing
Tests done by a hospital, surgery center, licensed diagnostic lab facility, or physician, in its own behalf, to test a person while an outpatient before scheduled surgery if:
- the tests are related to the scheduled surgery,
- the tests are done within the seven days prior to the scheduled surgery,
- the person undergoes the scheduled surgery in a hospital or surgery center, this does not apply if the tests show that surgery should not be done because of his/her physical condition,
- the charge for the surgery is a Covered Medical Expense under this Plan,
- the tests are done while the person is not confined as an inpatient in a hospital,
- the charges for the tests would have been covered if the person was confined as an inpatient in a hospital,
- the test results appear in the person’s medical record kept by the hospital or surgery center where the surgery is to be done, and
- the tests are not repeated in or by the hospital or surgery center where the surgery is done.

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

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

Preferred Care
Care provided by:
- a Covered Person’s Primary Care Physician, or a Preferred Care Provider on the referral of the Primary Care Physician, or
- a health care provider that is not a Preferred Care Provider for an Emergency Medical Condition when travel to a Preferred Care Provider, is not feasible, or
- a Non-Preferred Urgent Care Provider when travel to a Preferred Urgent Care Provider for treatment is not feasible, and if authorized by Aetna.

Preferred Care Provider
A health care provider that has contracted to furnish services or supplies for a Negotiated Charge, but only if the provider is, with Aetna’s consent, included in the directory as a Preferred Care Provider for:
- the service or supply involved, and
- the class of Covered Persons of which you are member.
Preferred Pharmacy
A pharmacy, including a mail order pharmacy, which is party to a contract with Aetna to dispense drugs to persons covered under this Policy, but only:
- while the contract remains in effect, and
- while such a pharmacy dispenses a prescription drug, under the terms of its contract with Aetna.

Preferred Prescription Drug Expense
An expense incurred for a prescription drug that:
- is dispensed by a Preferred Pharmacy, or for an Emergency Medical Condition only, by a Non-Preferred pharmacy, and
- is dispensed upon the Prescription of a Prescriber who is:
  o a Designated Care Provider, or
  o a Preferred Care Provider, or
  o a Non-Preferred Care Provider, but only for an Emergency Medical Condition, or on referral of a person’s Primary Care Physician, or
  o a dentist who is a Non-Preferred Care Provider, but only one who is not of a type that falls into one or more of the categories of providers listed in the directory of Preferred Care Providers.

Prescriber
Any person, while acting within the scope of his/her license, who has the legal authority to write an order for a prescription drug.

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

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

Prescription drugs include: Drugs for cancer treatment, provided such drugs are approved by the Federal Food and Drug Administration for use in the treatment of cancer, even if the drug has not been approved by the Federal Food and Drug Administration for the specific type of cancer for which the drug has been prescribed.

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

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

Reasonable and Customary
The charge which is the smallest of:
- the Actual Charge,
- the charge usually made for a covered service by the provider who furnishes it, and
- the prevailing charge made for a covered service in the geographic area by those of similar professional standing.
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.

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

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

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

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

Residential Treatment Facility
A treatment center for children and adolescents, which provides residential care and treatment for emotionally disturbed individuals, and is licensed by the department of children and youth services, and is accredited as a residential treatment center by the council on accreditation or the joint commission on accreditation of health organizations.
Respite Care
Care provided to give temporary relief to the family or other care givers in emergencies and from the daily demands for caring for a terminally ill Covered Person.

Room and Board
Charges made by an institution for board and room and other necessary services and supplies. They must be regularly made at a daily or weekly rate.

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

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

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

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

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

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

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

Stem Cells
A human or animal cell that has the ability to reproduce itself for long periods of time.
Surgery Center
A free standing ambulatory surgical facility that:

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

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

Surgical Expenses
Charges by a physician for,

- a surgical procedure,
- a necessary preoperative treatment during a hospital stay in connection with such procedure, and
- usual postoperative treatment.

Surgical Procedure
- a cutting procedure,
- suturing of a wound,
- treatment of a fracture,
- reduction of a dislocation,
- radiotherapy (excluding radioactive isotope therapy), if used in lieu of a cutting operation for removal of a tumor,
- electrocauterization,
- diagnostic and therapeutic endoscopic procedures,
- injection treatment of hemorrhoids and varicose veins,
- an operation by means of laser beam,
- cryosurgery.
**Totally Disabled**  
Due to disease or **injury**, the **Covered Person** is not able to engage in most of the normal activities of a person of like age and sex in good health.

**Urgent Admission**  
One where the **physician** admits the person to the **hospital** due to:  
- the onset of or change in a disease, or  
- the diagnosis of a disease, or  
- an **injury** caused by an **accident**,  

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

**Urgent Condition**  
This means a sudden illness, **injury**, or condition, that:  
- is severe enough to require prompt medical attention to avoid serious deterioration of the **Covered Person’s** health,  
- includes a condition which would subject the **Covered Person** to severe pain that could not be adequately managed without urgent care or treatment,  
- does not require the level of care provided in the emergency room of a **hospital**, and  
- requires immediate outpatient medical care that cannot be postponed until the **Covered Person’s physician** becomes reasonably available.

**Urgent Care Provider**  
This is:  
- A freestanding medical facility which:  
  - Provides unscheduled medical services to treat an **urgent condition** if the **Covered Person’s physician** is not reasonably available.  
  - Routinely provides ongoing unscheduled medical services for more than **eight consecutive hours**.  
  - Makes charges.  
  - Is licensed and certified as required by any state or Federal Law or regulation.  
  - Keeps a medical record on each patient.  
  - Provides an ongoing quality assurance program. This includes reviews by **physicians** other than those who own or direct the facility.  
  - Is run by a **staff of physicians**. At least one such **physician** must be on call at all times.  
  - Has a full-time administrator who is a licensed **physician**.  
- A physician’s office, but only one that:  
  - has contracted with Aetna to provide urgent care, and  
  - is, with Aetna’s consent, included in the Provider **Directory** as a **Preferred Urgent Care Provider**.

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

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

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

Customer Service Representatives are available 8:30 a.m. to 5:30 p.m., Monday through Friday, ET for any questions.

Claim address:
Aetna Student Health
P.O. Box 981106
El Paso, TX 79998

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

HOW TO APPEAL A CLAIM

Appeals and Complaints Procedure

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

You can also contact Customer Services at the toll-free number on your ID card for more information. 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 14464
Lexington, KY 40512

You may also seek additional information on the web page for the applicable State Insurance Department or other agency regarding your rights, including how to obtain regulatory review of member concerns. The applicable internet address for the State Insurance Department for your Plan is www.state.va.us/scc/division/boi/index.htm.

EXTERNAL REVIEW

Aetna has developed an external review process to give members 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, members may elect external review if the coverage denial for which the member would be financially responsible for involves more than $500 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 a neutral, 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 member’s physician certifies that a delay in service would jeopardize the member’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**
When obtaining a covered prescription, please present your ID card to a Preferred Pharmacy, along with your applicable copay. The pharmacy will bill Aetna for the cost of the drug, plus a dispensing fee, less the copay amount.

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

You must pay out-of-pocket for prescriptions at a Non-Preferred Pharmacy and then submit the receipt with a Prescription Claim Form for reimbursement.

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

**ACCIDENTAL DEATH AND DISMEMBERMENT (ADD) BENEFITS**
Benefits are payable for the Accidental Death and Dismemberment of **Covered Persons**, up to a maximum of $10,000.

**NOTE:** For most school plans, ADD benefits are provided by Aetna Life Insurance Company (ALIC). However, in some states, ADD benefits may be provided through a contractual relationship between Chickering Claims Administrators, Inc. (CCA) and On Call International (On Call). ADD coverage provided through On Call is underwritten by United States Fire Insurance Company (USFIC). Please refer to your school’s policy to determine whether ALIC or USFIC underwrites ADD benefits for your specific Plan. Should you have questions or need to file a claim please contact (800) 466-3207.

**MEDICAL EVACUATION AND REPATRIATION (MER) AND WORLDWIDE EMERGENCY TRAVEL ASSISTANCE (WETA) SERVICES PROVIDED THROUGH ON CALL INTERNATIONAL, INC.**

Chickering Claims Administrators, Inc. (CCA) has contracted with On Call International, Inc. (On Call) to provide **Covered Persons** with access to certain Medical Evacuation and Repatriation (MER) and Worldwide Emergency Travel Assistance (WETA) benefits and/or services.

**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)
- Return of Traveling Companion
- **$2,500** Emergency Return Home in the event of death or life-threatening illness of a parent or sibling

**WORLDWIDE EMERGENCY TRAVEL ASSISTANCE (WETA) SERVICES**
On Call provides the following travel assistance services:
- 24/7 Emergency Travel Arrangements
• Translation Assistance
• Emergency Travel Funds Assistance
• Lost Luggage and Travel Documents Assistance
• Assistance with Replacement of Credit Card/Travelers Checks
• Medical/Dental/Pharmacy Referral Service
• Hospital Deposit Arrangements
• Dispatch of Physician
• Emergency Medical Record Assistance

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 such services not provided and arranged through On Call. Although certain medical services may be covered under the terms of the Covered Person’s Student Health Insurance Plan (the “Plan”), On Call does not provide coverage for 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 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 (866) 525-1956 or collect (603) 328-1956. All Covered Persons should carry their On Call ID cards when traveling.

CCA and On Call are independent contractors and not employees or agents of the other. CCA provides access to certain ADD, MER and WETA benefits/services through a contractual arrangement with On Call. However, neither CCA nor any of its affiliates underwrites or administers any MER or WETA benefits/services. Neither CCA nor any of its affiliates underwrites or administers any ADD benefits that are provided through On Call. 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.
AETNA NAVIGATOR®

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

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

**HOW DO I REGISTER?**

- Go to **www.uvastudentinsurance.com**.
- Find your school in the School Directory.
- Click on Aetna Navigator® Member Website and then the “Register for Aetna Navigator” link.
- Follow the instructions for the registration process, including selecting a user name, password and security phrase.

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

**NEED HELP WITH REGISTERING ONTO AETNA NAVIGATOR?**
Registration assistance is available toll free, Monday through Friday, from 7 a.m. to 9 p.m. Eastern Time at *(800) 225-3375.*
NOTICE

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

Administered by:
Aetna Student Health
P.O. Box 981106
El Paso, TX 79998
(800) 466-3027
www.aetnastudenthealth.com

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

Policy No. 812806

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