

**2009-2010**

**Student Health Insurance Plan**



*Underwritten by:  
Aetna Life Insurance Company  
(ALIC)*

*Policy Number 724536*

*[www.aetnastudenthealth.com](http://www.aetnastudenthealth.com)*

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## 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 visit or call George Mason University Student Health Services at **(703) 993-2831**.

### For questions about:

- \* Insurance Benefits
- \* Enrollment
- \* Claims Processing
- \* Pre-Certification Requirements

Please contact:

Aetna Student Health  
P.O. Box 15708  
Boston, MA 02215-0014  
**(800) 878-1945**

### 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) 878-1945**

### For questions about:

- \* Enrollment Forms
- \* International Waiver Process

Please contact:

George Mason University Student Health Insurance Coordinator  
**(703) 993-2827**

### 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) 878-1945**

A complete list of providers can be found at the University Health Services Office, or you can use Aetna's **DocFind**<sup>®</sup> Service at either: [www.aetna.com/docfind/custom/studenthealth/index.html](http://www.aetna.com/docfind/custom/studenthealth/index.html) or: [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com)

### For questions about:

On Call International 24/7 Emergency Travel Assistance Services

Please contact:

On Call International at **(866) 525-1956 (within U.S.)**.

If outside the U.S., call collect by dialing **the U.S. access code** plus **(603) 328-1956**. Please also visit [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com) and visit your school-specific site for further information.

**IMPORTANT NOTE**

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

## STUDENT HEALTH SERVICES

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All currently enrolled George Mason University students are eligible to see a provider at Student Health Services free of charge. It is in the student's best interest to first seek treatment for injuries and illness at George Mason University's Student Health Services (except for an emergency medical condition).

### Student Health Services, Fairfax campus is open

Monday, Wednesday and Thursday 8:30am – 7:30pm

Tuesday 8:30am – 4:30pm

Friday 12:00pm – 4:30pm

**PLEASE NOTE: (Mon, Wed, and Thurs Health Services will be closed at 4:30pm during the fall and spring semesters when classes are not in session)**

For hours of operation for all campuses, including Arlington and Prince William, please refer to the web page at <http://www.gmu.edu/student/hcs/hours.html>. For more information regarding these services, please refer to our web page at: <http://www.gmu.edu/student/hcs/shs.html>

## POLICY PERIOD

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1. **Students:** Coverage for all insured students enrolled for the Fall Semester, will become effective at 12:01 AM on **August 16, 2009**, and will terminate at 12:01 AM on **August 15, 2010**.
2. **New Spring Semester students:** Coverage for all insured students enrolled for the Spring Semester, will become effective at 12:01 AM on **January 5, 2010**, and will terminate at 12:01 AM on **August 15, 2010**.
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 26 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.

### Enrollment Deadlines for All Voluntary/Domestic Students

**Annual Period** September 16, 2009

**Fall Semi Annual payment (first payment)** September 16, 2009

**Fall Semi Annual Payment (second payment)** February 16, 2010

**Spring Semester** February 16, 2010

**Summer Semester** June 16, 2010

## RATES

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	Annual	Semi-Annual Payment Plan Option**	Spring	Summer
<b>Plan Rates</b>	<b>8/16/09-8/15/10</b>	<b>8/16/09-8/15/10</b>	<b>1/05/10-8/15/10</b>	<b>5/16/10-8/15/10</b>
<b>Student Only</b>	<b>\$1,340*</b>	<b>\$685*</b>	<b>\$848*</b>	<b>\$356*</b>
<b>Spouse Only</b>	<b>\$3,983</b>	<b>\$1,991.50</b>	<b>\$2,490</b>	<b>\$997</b>
<b>Child(ren) Only</b>	<b>\$1,874</b>	<b>\$937</b>	<b>\$1,170</b>	<b>\$466</b>

\*The rates above include both premium for the student health plan underwritten by Aetna Life Insurance Company, as well as George Mason University's administrative fee.

*\*\*Please Note: Domestic students electing coverage for the year have the option to elect a Semi-Annual payment plan. To ensure continuous coverage, students must have funds available for the automatic charge by 2/16/10. Please be advised that the Semi-Annual rate is only offered to those students enrolling in the fall who are looking for a Payment Plan option. Students enrolling in the Spring must elect coverage from January 5, 2010.*

**Supplemental Coverage**

The Aggregate Maximum benefit under the Student Health Insurance Plan is \$50,000, per condition, per lifetime. If you have purchased the Student Health Insurance Plan, you are eligible to purchase the \$200,000 Supplemental Plan to increase the maximum to \$250,000 for students and their dependents.

Go online to enroll: Visit [www.aetnastudenthealth.com/schools/georgemason](http://www.aetnastudenthealth.com/schools/georgemason). Click on the “Enroll” tab under “Plans & Products Offered to You”.

Supplemental Coverage is available only to students and their dependents who are enrolled in the Student Health Insurance Plan. Supplemental Coverage must be purchased by **September 16, 2009**, for the Annual Policy and **February 16, 2010**, for newly enrolled Spring Semester students.

Supplemental Plan	Annual	Spring
<b>Plan Rates</b>	<b>8/16/09-8/15/10</b>	<b>1/05/10-8/15/10</b>
<b>Student Only</b>	<b>\$462</b>	<b>\$303</b>
<b>Spouse Only</b>	<b>\$1,386</b>	<b>\$915</b>
<b>Child(ren) Only</b>	<b>\$650</b>	<b>\$433</b>

**DEDUCTIBLES**

The following Deductibles are applied before Covered Medical Expenses for Non-Preferred Care are payable:

Individual: **\$200** per Policy Year

**GEORGE MASON UNIVERSITY  
STUDENT HEALTH INSURANCE PLAN**

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

**STUDENT COVERAGE**

**ELIGIBILITY**

All Domestic Undergraduate and Graduate students enrolled in six credit hours or more per semester are eligible to sign up. Domestic Undergraduate and Graduate students that are taking less than six credit hours but are completing course work to graduate and obtain their degree for the current academic year are also eligible to enroll. If you withdraw from George Mason University within the first 31 calendar days of the semester you are not eligible for the student health insurance plan. If you are auditing classes (earning 0 credits), you are not eligible for the Plan.

**Please Note:** Students enrolling in the Plan must meet and maintain the eligibility requirements as defined in this Brochure and the Master Policy in order to remain a covered student under the Policy. Students taking course work to graduate and obtain their degree for the current academic year, should contact the Insurance Coordinator whose office is at Student Health Services in Sub 1, room 219A @ **703-993-2827**.

The eligibility requirements for students do not apply when graduating midyear or when there is a documented medical leave of absence after attending classes for the first 31 calendar days of the current academic year. If the eligibility requirements are not met, Aetna's only obligation is to refund the premium.

- International students, visiting faculty and scholars on a F-1 or J-1 visa, at George Mason University, are eligible to enroll.
- All English Language Institute students are eligible to enroll.

### ***ENROLLMENT***

All Undergraduate and Graduate Students registered in six credit hours per semester or more are eligible to enroll in George Mason University's Student Health Insurance Plan on a voluntary basis. Undergraduate and Graduate students registered in a degree seeking program taking less than six credit hours are eligible to enroll if they are taking courses to complete their degree program for the current academic year.

**You can enroll online! Follow the steps described below to enroll yourself and your dependents:**

- Visit [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com).
- Click on "**Find Your School**" and type "**George Mason**" and click on the "**Enroll**" tab, and follow the steps.
- A confirmation **E-mail** is sent within minutes of enrollment completion.
- Enrollment Forms will be available at Student Health Services or by calling Aetna Student Health Customer Service.

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

### **WAIVER PROCESS/PROCEDURE**

George Mason University requires that all F-1 visa students have health insurance. J-1 visa students are required by federal mandate to have health insurance. A waiver may be granted only to those individuals already insured under other acceptable plans. Contact the Insurance Coordinator at the Student Health Services for the specific criteria.

Waiver Forms for the Annual Policy must be approved no later than September 16, 2009 (or February 10, 2010 for the Spring Semester). Students who do not obtain a Waiver approval by these dates, will automatically be enrolled in the Student Health Insurance Plan and the premium will be automatically charged on the tuition bill.

### **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**

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### ***ELIGIBILITY***

Covered students may also enroll their lawful spouse, and unmarried dependent children under age 25, who are full-time students.

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 12 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.

### **Dependent Enrollment Deadlines**

The final enrollment deadline for the Annual Policy is **September 16, 2009**, unless the dependent experiences a significant life change that directly affects their insurance coverage (An example of a significant life change would be loss of health coverage under another health plan). The final enrollment deadline for the Spring Semester is **February 16, 2010**.

### **Follow the steps described below to enroll your dependents:**

- Visit [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com).
- Click on "**Find Your School**" and type "**George Mason**" and click on the "**Enroll**" tab, and follow the steps.
- A confirmation **E-mail** is sent within minutes of enrollment completion.
- Enrollment Forms will be available at Student Health Services or by calling Aetna Student Health Customer Service.

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

### ***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 George Mason University Student Health Insurance Plan. To extend coverage for a newborn past the 31 days, the Covered Student must: 1) enroll the child within 31 days of birth, and 2) pay the additional premium, starting from the date of birth.

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

For information or general questions on dependent enrollment, contact Aetna Student Health at, **(800) 878-1945**.

## **PREFERRED PROVIDER NETWORK**

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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 George Mason University campus.

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

You may also obtain information regarding Preferred Providers by contacting Aetna Student Health at **(800) 878-1945**, or through the Internet by accessing DocFind at [www.aetna.com/docfind/custom/studenthealth/index.html](http://www.aetna.com/docfind/custom/studenthealth/index.html)

1. Click on "Enter DocFind"
2. Select zip code, city, or county

3. Enter criteria
4. Select Provider Category
5. Select Provider Type
6. Select Plan Type – Student Health Plans
7. Select “Start Search” or “More Options”
8. “More Options” enter criteria and “Search”

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

## **PRE-CERTIFICATION PROGRAM**

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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) 878-1945** (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.
- **If you do not secure pre-certification** for partial hospitalizations, your Covered Medical Expenses will be subject to a **\$200** Deductible.

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

- All inpatient admissions, including length of stay, to a hospital, 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 (3) 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 (1) business day** following inpatient (or partial hospitalization) admission.

## DESCRIPTION OF BENEFITS

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**Please Note:**

The George Mason University Student Health Insurance Plan may not cover all of your health care expenses. The Plan excludes coverage for certain services and contains limitations on the amounts it will pay. Please read this George Mason University (GMU) Student Health Insurance Plan Brochure carefully before deciding whether the 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 GMU, you may view it at University health Services or you may contact Aetna Student Health at (800) 878-1945.

This Plan will never pay more than \$50,000, per condition, lifetime. Other per policy year maximums: Prescription - \$750, Outpatient - \$5,000. Additional Plan maximums may also apply. Some illnesses may cost more to treat and health care providers may bill you for what the Plan does not cover.

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

## SUMMARY OF BENEFITS CHART

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### DEDUCTIBLES

The following Deductibles are applied before Covered Medical Expenses for Non-Preferred Care are payable:

Individual:                   **\$200** per condition per Policy Year

### COINSURANCE

Covered Medical Expenses are payable at the coinsurance percentage specified below, after any applicable deductible, up to a maximum benefit of **\$50,000 per condition, lifetime.**

### OUT-OF-POCKET MAXIMUMS

Once the Individual **Out-of-Pocket Limit** has been satisfied, **Covered Medical Expenses** will be payable at 100% for the remainder of the Policy Year, up to \$50,000 per condition, lifetime.

Individual **Inpatient** Out-of-Pocket Limit:                   **\$10,000**

**Please note: Outpatient services are not subject to the Out-Of-Pocket Limit.**

All coverage is based on Reasonable Charges unless otherwise specified.

<b>Inpatient Hospitalization Benefits</b>	
Hospital Room and Board Expense	<p><b>Covered Medical Expenses</b> are payable as follows:  <u>Preferred Care: 80%</u> of the Negotiated Charge.  <u>Non-Preferred Care: 60%</u> of the Reasonable Charge for a semi-private room.</p>
Intensive Care Unit Expense	<p><b>Covered Medical Expenses</b> are payable as follows:  <u>Preferred Care: 80%</u> of the Negotiated Charge.  <u>Non-Preferred Care: 60%</u> of the Reasonable Charge for the Intensive Care Room Rate for an overnight stay.</p>
Miscellaneous Hospital Expense	<p><b>Covered Medical Expenses</b> are payable as follows:  <u>Preferred Care: 80%</u> of the Negotiated Charge.  <u>Non-Preferred Care: 60%</u> of the Reasonable Charge.</p> <p><b>Covered Medical Expenses</b> include, but are not limited to: laboratory tests, x-rays, surgical dressings, anesthesia, supplies and equipment use, and medicines.</p>
Physician Hospital Visit/ Consultation Expenses	<p><b>Covered Medical Expenses</b> for charges for the non-surgical services of the attending Physician, or a consulting Physician, are payable as follows:  <u>Preferred Care: 80%</u> of the Negotiated Charge.  <u>Non-Preferred Care: 60%</u> of the Reasonable Charge.</p>
<b>Surgical Benefits (Inpatient and Outpatient)</b>	
Surgical Expense	<p><b>Covered Medical Expenses</b> for charges for surgical services, performed by a Physician, are payable as follows:  <u>Preferred Care: 80%</u> of the Negotiated Charge.  <u>Non-Preferred Care: 60%</u> of the Reasonable Charge.</p>
Anesthetist and Assistant Surgeon Expense	<p><b>Covered Medical Expenses</b> for the charges of an anesthetist and an assistant surgeon, during a surgical procedure, are payable as follows:  <u>Preferred Care: 80%</u> of the Negotiated Charge.  <u>Non-Preferred Care: 60%</u> of the Reasonable Charge.</p>
Outpatient Hospital Services for Surgery Expense	<p><b>Covered Medical Expenses</b> are payable as follows:  <u>Preferred Care: 80%</u> of the Negotiated Charge.  <u>Non-Preferred Care: 60%</u> of the Reasonable Charge.</p>
Ambulatory Surgical Expense	<p><b>Covered Medical Expenses</b> for outpatient surgery performed in an ambulatory surgical center are payable as follows:  <u>Preferred Care: 80%</u> of the Negotiated Charge.  <u>Non-Preferred Care: 60%</u> of the Reasonable Charge</p> <p><b>Covered Medical Expenses</b> must be incurred on the day of the surgery or within 48 hours after the surgery.</p>

<p><b>Outpatient Benefits</b></p> <p><b>Covered Medical Expenses</b> are payable up to a combined maximum of <b>\$5,000</b> per Condition per Policy Year.</p> <p><b>Covered Medical Expenses</b> 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.</p>	
Hospital Outpatient Department or Walk-In Clinic Expense	<p><b>Covered Medical Expenses</b> for outpatient treatment in a hospital are payable as follows:</p> <p><u>Preferred Care</u>: <b>80%</b> of the Negotiated Charge</p> <p><u>Non-Preferred Care</u>: <b>60%</b> of the Reasonable Charge.</p>
Emergency Room Expense	<p><b>Covered Medical Expenses</b> incurred for treatment of an Emergency Medical Condition are payable as follows:</p> <p><u>Preferred Care</u>: After a <b>\$300</b> Copay (waived if admitted), <b>80%</b> of the Negotiated Charge.</p> <p><u>Non-Preferred Care</u>: After a <b>\$300</b> Deductible (waived if admitted), <b>60%</b> of the Reasonable Charge.</p> <p><i>Please note: this per visit Deductible does not apply towards meeting the annual Deductible.</i></p>
Urgent Care Expense	<p><i>Benefits include charges for treatment by an urgent care provider.</i></p> <p><b>Please note: A covered person <u>should not seek medical care or treatment from an urgent care provider if their illness, injury, or condition, is an emergency condition.</u> 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.</b></p> <p><b>Urgent Care</b> Benefits include charges for an urgent care provider to evaluate and treat an urgent condition.</p> <p><b>Covered Medical Expenses</b> for urgent care treatment are payable as follows:</p> <p><u>Preferred Care</u>: <b>80%</b> of the Negotiated Charge</p> <p><u>Non-Preferred Care</u>: <b>60%</b> of the Reasonable Charge.</p> <p>When travel to a preferred care provider for treatment of an urgent condition is not feasible, a covered person may call Aetna to request authorization to see a non-preferred urgent care provider so that such treatment may be paid at the preferred level of benefits. If it is not feasible to request authorization prior to treatment, then it should be done as soon as possible after treatment but not later than:</p> <ul style="list-style-type: none"> <li>• the next day during normal business hours, or</li> <li>• if the covered person is confined in a hospital directly after receiving urgent care, not later than 48 hours following the start of the confinement unless it is not possible for the covered person to request authorization within that time. In that case, it must be done as soon as reasonably possible.</li> </ul> <p>However:</p> <ul style="list-style-type: none"> <li>• if the treatment is received, or</li> <li>• the confinement occurs,</li> </ul> <p>on a Friday or Saturday, authorization must be requested within 72 hours following treatment or the start of the confinement.</p> <p>If the covered person does not request authorization from Aetna to see a non-preferred urgent care provider, charges incurred for urgent care will be paid at the non-preferred covered percentage after the non-preferred deductible.</p> <p>The covered person should contact their primary care physician after medical care is provided to treat an urgent condition.</p>

	<p><b>Non-Urgent Care</b>  <b>Covered Medical Expenses</b> for charges made by an urgent care provider to treat a <i>non-urgent condition</i> are payable as follows:  <u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge  <u>Non-Preferred Care:</u> <b>60%</b> of the Reasonable Charge.</p> <p><i>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.</i></p> <p>Non-urgent care includes, but is not limited to, the following:</p> <ul style="list-style-type: none"> <li>• routine or preventive care (this includes immunizations),</li> <li>• follow-up care,</li> <li>• physical therapy,</li> <li>• elective surgical procedures, and</li> <li>• any lab and radiologic exams which are not related to the treatment of the urgent condition.</li> </ul> <p>A separate preferred urgent care copay/deductible applies to each visit for urgent care by a covered person to an urgent care provider. This does not apply if the covered person is admitted to a hospital as an inpatient right after a visit to an urgent care provider.</p>
Ambulance Expense	<p><b>Covered Medical Expenses</b> are payable as follows:  <b>80%</b> 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.</p>
Pre-Admission Testing Expense	<p><b>Covered Medical Expenses</b> for Pre-Admission testing charges while an outpatient before scheduled surgery are payable on the same basis as any other sickness.</p> <p><i>Please see the Definition of Pre-Admission Testing on page 41 for more detailed information on this benefit.</i></p>
Physician's Office Visits	<p><b>Covered Medical Expenses</b> are payable as follows:  <u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>60%</b> of the Reasonable Charge.</p>
Laboratory and X-Ray Expense	<p><b>Covered Medical Expenses</b> are payable as follows:  <u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>60%</b> of the Reasonable Charge.</p>
High Cost Procedures Expense	<p><b>Covered Medical Expenses</b> include charges incurred by a <b>covered person</b> are payable as follows:  <u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>60%</b> of the Reasonable Charge.</p> <p>For purposes of this benefit, "High Cost Procedure" means any outpatient procedure costing over <b>\$200</b>.</p> <p><i>Please see the Definition of High Cost Procedures on page 36 for more detailed information on this benefit.</i></p>
Therapy Expense	<p><b>Covered Medical Expenses</b> include charges incurred by a <b>covered person</b> for the following types of therapy provided on an outpatient basis:</p> <ul style="list-style-type: none"> <li>• Physical Therapy,</li> <li>• Speech Therapy,</li> <li>• Inhalation Therapy, or</li> <li>• Occupational Therapy.</li> </ul> <p>Expenses for Speech and Occupational Therapies are <b>Covered Medical Expenses</b> only if such therapies are a result of <b>injury</b> or <b>sickness</b>.</p> <p>Physical therapy must be for rehabilitation <b>only after a surgery</b>. All other therapy must be initiated within 6 months of the onset of symptoms. All therapy must be provided by a therapist who is licensed in accordance with state law, and practicing within the scope of</p>

	<p>their license. All therapy must be completed within 60 days of the date that it starts.</p> <p><u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>60%</b> of the Reasonable Charge.</p>
Chemotherapy Expense	<p><b>Covered Medical Expenses</b> also include charges incurred by a <b>covered person</b> for the following types of therapy provided on an outpatient basis:</p> <ul style="list-style-type: none"> <li>• Radiation therapy,</li> <li>• Chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy,</li> <li>• Dialysis, and</li> <li>• Respiratory therapy.</li> </ul> <p>Benefits for these types of therapies are payable for <b>Covered Medical Expenses</b> on the same basis as any other sickness.</p> <p><u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge  <u>Non-Preferred Care:</u> <b>60%</b> of the Reasonable Charge</p>
Durable Medical Equipment Expense	<p><b>Covered Medical Expenses</b> are payable as follows:  <u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>60%</b> of the Reasonable Charge.</p>
Prosthetic Devices Expense	<p>Benefits include charges for: artificial limbs, or eyes, and other non-dental prosthetic devices, as a result of an accident or sickness.</p> <p><b>Covered Medical Expenses</b> do <b>not</b> include: eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet.</p> <p><b>Covered Medical expenses</b> are payable as follows:  <u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>60%</b> of the Reasonable Charge.</p>
Chiropractic Therapy Expense	<p>Expenses for Chiropractic Care are <b>Covered Medical Expenses</b> if such care is related to neuromusculoskeletal conditions and conditions arising from: the lack of normal nerve, muscle, and/or joint function.</p> <p><u>Preferred Care:</u> After a <b>\$35</b> per visit Copay, <b>80%</b> of the Negotiated Charge.  <u>Non-Preferred care:</u> After a <b>\$35</b> per visit Deductible, <b>60%</b> of the Reasonable Charge.</p> <p>Please Note: Benefits are limited to <b>\$1,000</b> per condition, per Policy year,</p>
Dental Injury Expense	<p><b>Covered Medical Expenses</b> include dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition:</p> <ul style="list-style-type: none"> <li>• Natural teeth damaged, lost, or removed, or</li> <li>• 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.</li> </ul> <p>Any such teeth must have been:</p> <ul style="list-style-type: none"> <li>• Free from decay, or</li> <li>• In good repair, and</li> <li>• Firmly attached to the jawbone at the time of the injury.</li> </ul> <p>If:</p> <ul style="list-style-type: none"> <li>• Crowns (caps), or</li> <li>• Dentures (false teeth), or</li> <li>• Bridgework, or</li> <li>• In-mouth appliances,</li> </ul> <p>are installed due to such injury, <b>Covered Medical Expenses</b> include only charges for:</p> <ul style="list-style-type: none"> <li>• The first denture or fixed bridgework to replace lost teeth,</li> <li>• The first crown needed to repair each damaged tooth, and</li> </ul>

	<ul style="list-style-type: none"> <li>• An in-mouth appliance used in the first course of orthodontic treatment after the injury.</li> </ul> <p>Surgery needed to:</p> <ul style="list-style-type: none"> <li>• Treat a fracture, dislocation, or wound.</li> <li>• Cut out cysts, tumors, or other diseased tissues.</li> <li>• Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.</li> </ul> <p>Non-surgical treatment of infections or diseases. This does not include those of, or related to, the teeth.</p> <p><b>Covered Medical Expenses</b> are payable as follows:  <b>80%</b> of actual charge.</p>
Allergy Testing Expense	<p>Benefits include charges incurred for diagnostic testing of allergies.</p> <p><b>Covered Medical Expenses</b> are payable as follows:  <u>Preferred Care: 80%</u> of the Negotiated Charge.  <u>Non-Preferred Care: 60%</u> of the Reasonable Charge.</p>
Diagnostic Testing for Learning Disabilities Expense	<p><b>Covered Medical Expenses</b> for diagnostic testing for learning disabilities are payable as follows:  <u>Preferred Care: 80%</u> of the Negotiated Charge.  <u>Non-Preferred Care: 60%</u> of the Reasonable Charge.</p> <p>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.</p> <p>Please Note: Testing &amp; Treatment for ADD &amp; ADHD is not covered.</p>
Early Intervention Services Expense	<p>The charges below are included as Covered Medical Expenses for a dependent child under the age of 3 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.</p> <p>The services covered are designed to help an individual attain or retain the capability to function age-appropriately within his or her environment, including services that enhance functional ability without effecting a cure. They include, but are not limited to, the following</p> <ul style="list-style-type: none"> <li>• Speech and language therapy given in connection with a speech impairment: which results from a congenital abnormality, disease, or injury.</li> <li>• Occupational or physical therapy expected to result in significant improvement of a body function: impaired by a congenital abnormality, disease, or injury.</li> <li>• Assistive technology services.</li> <li>• Assistive technology devices.</li> </ul> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other sickness.  Please note: There is a benefit maximum of \$5000 per <b>Policy Year</b>.</p>
Well Baby Care Expense	<p>Benefits include charges for routine preventive and primary care services, rendered to a covered dependent child on an outpatient basis.</p> <p><b>Routine preventive and primary care</b> services are services rendered to a covered dependent child, from the date of birth through the attainment of <b>three (3)</b> 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.</p> <p><b>Covered Medical Expenses</b> are payable as follows  <u>Preferred Care: 80%</u> of the Negotiated Charge.  <u>Non-Preferred Care: 60%</u> of the Reasonable Charge.</p>

Newborn Hearing Screening Expense	<p>Coverage for infant hearing screenings and all necessary audiological examinations for newborn children.</p> <p>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.</p> <p><b>Covered Medical Expenses</b> are payable as follows:</p> <p><u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>60%</b> of the Reasonable Charge.</p> <p>Outpatient Benefits are limited to <b>\$5,000</b> per condition, per Policy Year.</p>
Immunizations Expense	<p><b>Covered Medical Expenses</b> 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 3.</p> <p><u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>60%</b> of the Reasonable Charge.</p>
Consultant or Specialist Expense	<p><b>Covered Medical Expenses</b> 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.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other sickness.</p>
Student Health Service	<p>100% coverage for the following services if provided at Mason's Student Health Services:</p> <ul style="list-style-type: none"> <li>* NEW: Adult Immunizations <ul style="list-style-type: none"> <li>o Hepatitis B, 3 doses</li> <li>o Tetanus and Diphteria / Tdap</li> <li>o Varicella</li> <li>o Titers for MMR, Varicella and Hepatitis B</li> <li>o MMR, 2 doses</li> <li>o Meningococcal Vaccine</li> <li>o PPD or TB test</li> </ul> </li> <li>* Contraceptives: Apri and Velivet</li> <li>* Gardasil immunization</li> <li>* Annual GYN Exam / Including Pap Test</li> <li>* High Risk HPV DNA</li> <li>* Repeat Pap due to Abnormal Results</li> <li>* Urine Pregnancy Test</li> <li>* Rapid Strep Test</li> <li>* Mono Test</li> <li>* Urine Analysis</li> <li>* Hemoglobin-Hemocue</li> <li>* Wet Mount</li> </ul>

<b>Mental Health and Substance Abuse Benefits</b>	
Biologically-Based Mental Disorders Inpatient Expense	<p><b>Covered Medical Expenses</b> for the diagnosis and treatment of biologically based mental illnesses are payable:</p> <p><u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>60%</b> of the Reasonable Charge.</p>
Biologically-Based Mental Disorders Outpatient Expense	<p><b>Covered Medical Expenses</b> for the diagnosis and treatment of biologically based mental illnesses are payable:</p> <p><u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>60%</b> of the Reasonable Charge.</p>
Treatment of Non-Biologically Based Mental and Nervous Disorders, Alcoholism, or Substance Abuse Inpatient Expense	<p><b>Covered Medical Expenses</b> for the Treatment of Non-Biologically Based Mental and Nervous Disorders, Alcoholism, or Substance Abuse while confined as a inpatient in a hospital or facility licensed for such treatment are payable as follows:</p> <p><u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>60%</b> of the Reasonable Charge.</p> <p><b>Covered Medical Expenses</b> also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission, whereby 2 days of partial hospitalization may be exchanged for 1 day of full hospitalization.</p> <p>There is a benefit maximum of 30 days per condition per policy year.</p>
Treatment of Non-Biologically Based Mental and Nervous Disorders, Alcoholism, or Substance Abuse Outpatient Expense	<p><b>Covered Medical Expenses</b> for outpatient Treatment of Non-Biologically Based Mental and Nervous Disorders, Alcoholism, or Substance Abuse are payable as follows:</p> <p><u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge for the first 5 visits; 50% of the Negotiated Charge for the next 15 visits  <u>Non-Preferred Care:</u> <b>80%</b> of the Reasonable Charge for the first 5 visits; 50% of the Reasonable Charge for the next 21 visits.</p> <p>The outpatient benefit is 26 visits per policy year.</p> <p><b>Medication management visits</b> 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.</p> <p>Please note: When a deductible is applied to the outpatient visit that visit can not count towards the 26 visit benefit.</p>

<b>Maternity Benefits</b>	
Maternity Expense	<p><b>Covered Medical Expenses</b> 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.</p> <p>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.</p> <p><b>Covered Medical Expenses</b> for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other sickness.</p>
Well Newborn Nursery Care Expense	<p>Benefits include charges for routine care of a covered person's newborn child as follows:</p> <ul style="list-style-type: none"> <li>• hospital charges for routine nursery care during the mother's confinement,</li> <li>• physician's charges for circumcision, and</li> <li>• physician's charges for visits to the newborn child in the hospital and consultations.</li> </ul> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other sickness.</p>
<b>Additional Benefits</b>	
Prescription Drug Benefit	<p>Prescription Drug Benefits are payable as follows:</p> <p><u>Participating Pharmacy</u>: <b>100%</b> of the Negotiated Charge after a <b>\$40 Copay</b> for each Brand Name Prescription Drug or a <b>\$20 Copay</b> for each Generic Prescription Drug.</p> <p><u>Non-Participating Pharmacy</u>: <b>75%</b> of the Reasonable Charge after a <b>\$40 Copay</b> for each Brand Name Prescription Drug or a <b>\$20 Copay</b> for each Generic Prescription Drug.</p> <p><b>Please note:</b> You are required to pay in full at the time of service for all Prescriptions dispensed at a Non-Participating Pharmacy. (Please refer to the Prescription Drug Claim Procedure section of this Brochure for information regarding the claim submission and reimbursement process.)</p> <p>Covered Medical Expenses are payable up to a maximum of <b>\$750</b> per Policy Year.</p> <p>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</p> <p>Prior Authorization is required for certain Prescription Drugs, certain stimulants, growth hormones and for any Prescription quantities larger than a 30-day supply. (<b><i>This is only a partial list.</i></b>)</p> <p>Medications not covered by this benefit include, but are not limited to: allergy sera, drugs whose sole purpose is to promote or to stimulate hair growth, appetite suppressants, smoking deterrents, immunization agents and vaccines, and non-self injectables. (<b><i>This is only a partial list.</i></b>)</p> <p>For assistance or <b>for a complete list of excluded medications</b>, or drugs requiring <b>prior authorization</b>, please contact Aetna Pharmacy Management at <b>(800) 238-6279</b> (available 24 hours).</p> <p>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 <a href="http://www.AetnaSpecialtyRx.com">www.AetnaSpecialtyRx.com</a></p>
Diabetic Testing Supplies Expense	<p>Benefits include charges for testing material used to detect the presence of sugar in the person's urine or blood for monitoring glycemic control.</p> <p>Diabetic Testing Supplies are limited to:</p> <ul style="list-style-type: none"> <li>• Lancet devices,</li> <li>• glucose monitors, and</li> <li>• test strips.</li> </ul> <p>Syringes, insulin, or other items used in the treatment of diabetes are not covered by this benefit.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other sickness.</p> <p>See <u>Prescription Drug Benefit</u>.</p>

Hypodermic Needles Expense	<p><b>Covered Medical Expenses</b> for hypodermic needles and syringes used in the treatment of diabetes are payable on the same basis as any other sickness.  <u>See Prescription Drug Benefit.</u></p>
Outpatient Diabetic Self-management Education Programs Expense	<p><b>Covered Medical Expenses</b> for outpatient diabetic self-management education programs are payable as follows:  <u>Preferred Care: 80%</u> of the Negotiated Charge.  <u>Non-Preferred Care: 60%</u> of the Reasonable Charge.</p> <p><i>Please see the definition on page 35 of this Brochure for more information on Diabetic Self-Management Education Programs.</i></p>
TMJ	<p><b>Covered Medical Expenses</b> include charges incurred by a covered person for treatment of Temporomandibular Joint (TMJ) Dysfunction. Benefits are payable on the same basis as any other sickness.</p>
Bones and Joints Expense	<p><b>Covered Medical Expenses</b> include charges incurred by a <b>covered person</b> 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.</p> <p><b>Covered Medical Expenses</b> are payable as follows:  <u>Preferred Care: 80%</u> of the Negotiated Charge.  <u>Non-Preferred Care: 60%</u> of the Reasonable Charge.</p>
Cleft Lip/Palate or Ectodermal Dysplasia Expense for Newborns	<p>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.</p> <p>Treatment may include:</p> <ul style="list-style-type: none"> <li>• Oral surgery and facial surgery. This includes pre-operative and post operative care performed by a <b>physician</b>.</li> <li>• Oral prosthesis treatment, obturators and orthodontic appliances.</li> <li>• Initial installation of partial or full removable dentures or of fixed bridgework</li> <li>• Replacement of dentures by dentures or fixed bridgework by fixed bridgework when required as a result of structural changes in the mouth or jaw due to growth.</li> <li>• Cleft orthodontic therapy.</li> <li>• Diagnostic services of a <b>physician</b> to find out if and to what extent the child's ability to speak or hear has been lost or impaired.</li> <li>• Rehabilitative services given by a <b>physician</b> 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</li> <li>• Psychological assessment and counseling</li> <li>• Genetic assessment and counseling for the child and the child's parents.</li> <li>• Hearing aids</li> </ul> <p>A legally qualified audiologist or speech therapist will be deemed to be a "<b>physician</b>" for the purposes of this section.</p> <p><b>Covered Medical Expenses</b> will be payable as follows:  <u>Preferred Care: 80%</u> of the Negotiated Charge.  <u>Non-Preferred Care: 60%</u> of the Reasonable Charge.</p>

<p>Clinical Trial Expense</p>	<p>Clinical Trial Expenses are payable for <b>Covered Medical Expenses</b> incurred by each <b>covered person</b>. A clinical trial meets the following conditions:</p> <ul style="list-style-type: none"> <li>• The clinical trial is intended to treat cancer in a patient who has been so diagnosed,</li> <li>• 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</li> </ul> <p>With respect to Phase II, Phase III, or Phase IV clinical trials, the treatment shall be provided if approved by:</p> <ul style="list-style-type: none"> <li>• The NIH,</li> <li>• A National Cancer Institute cooperative group or center,</li> <li>• The FDA in the form of an investigational new drug application,</li> <li>• The federal Department of Veterans Affairs, and</li> <li>• An institutional review board approved by the Office of Protection from Research Risks of the NCI.</li> </ul> <p>With respect to Phase I clinical trials, treatment may be provided on a case-by-case basis.</p> <p>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.</p> <p>Coverage shall apply only if:</p> <ul style="list-style-type: none"> <li>• There is no clearly superior, non-investigational treatment alternative,</li> <li>• 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</li> <li>• The <b>covered person</b> or <b>physician</b> or health care provider conclude that the covered person's participation in the clinical trial would be appropriate pursuant to this policy.</li> </ul> <p>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.</p>
<p>Home Treatment of Hemophilia Expense</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a <b>covered person</b> 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.</p> <ul style="list-style-type: none"> <li>• "Blood infusion equipment" includes, but is not limited to, syringes and needles.</li> <li>• "Blood product" includes, but is not limited to, Factor VII, Factor VIII, Factor IX, and cryoprecipitate.</li> <li>• "Hemophilia" means a lifelong hereditary bleeding disorder usually affecting males that results in prolonged bleeding primarily into joints and muscles</li> <li>• "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.</li> <li>• "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.</li> </ul> <p><b>Covered Medical Expenses</b> will be payable on the same basis as any other sickness.</p>

<p>Prescription Contraceptive Devices</p>	<p><b>Covered Medical Expenses</b> include:</p> <ul style="list-style-type: none"> <li>• Charges incurred for contraceptive drugs and devices that by law need a <b>physician's prescription</b>, and that have been approved by the FDA.</li> <li>• Related outpatient contraceptive services such as: <ul style="list-style-type: none"> <li>• Consultations,</li> <li>• Exams,</li> <li>• Procedures, and</li> <li>• Other medical services and supplies</li> </ul> </li> </ul> <p>Benefits for contraceptive devices and outpatient contraceptive services are payable as follows:  <u>Preferred Care: 80%</u> of the Negotiated Charge.  <u>Non-Preferred Care: 60%</u> of the Reasonable Charge.</p> <p>Please Note: For Contraceptive Drugs see Prescription benefit</p>
<p>Pap Smear Expense</p>	<p><b>Covered Medical Expenses</b> include one annual routine pap smear screening for women age 18 and older.</p> <p>Benefits are payable on the same basis as any other sickness.</p>
<p>Mammography Expense</p>	<p><b>Covered Medical Expenses</b> include:</p> <ul style="list-style-type: none"> <li>• A baseline mammogram for women between the ages of 35 to 40,</li> <li>• A mammogram every two years, or more frequently based on the recommendation of the woman's <b>physician</b> for women ages 40 to 50, or</li> <li>• A mammogram on an annual basis for women 50 years of age and older.</li> </ul> <p>Benefits are payable on the same basis as any other sickness.</p>
<p>Inpatient Coverage Following A Laparoscopy-Assisted Vaginal Hysterectomy And Vaginal Hysterectomy Expense</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a <b>covered person</b> for inpatient coverage following a <b>Covered Medical Expenses</b> include charges incurred by a <b>covered person</b> for inpatient coverage following a laparoscopy-assisted vaginal hysterectomy and vaginal hysterectomy while insured under this Policy. Benefits are payable for <b>Covered Medical Expenses</b> on the same basis as any other <b>sickness</b>.</p> <p><b>Covered Medical Expenses</b> include:</p> <ul style="list-style-type: none"> <li>• In-patient care for a minimum of 48 hours following a vaginal hysterectomy, or</li> <li>• In-patient care for a minimum of 23 hours following a laparoscopy-assisted vaginal hysterectomy.</li> </ul> <p>Any decision to shorten such minimum coverages shall be made by the attending <b>physician</b>, in consultation with the <b>covered person</b>.</p> <p>Benefits are payable on the same basis as any other sickness.</p>
<p>Mastectomy Expense</p>	<p><b>Covered Medical Expenses</b> include expenses incurred by a <b>covered person</b> who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy, for:</p> <ol style="list-style-type: none"> <li>(1) reconstruction of the breast on which a mastectomy has been performed,</li> <li>(2) surgery and reconstruction of the other breast to produce a symmetrical appearance,</li> <li>(3) prostheses, and</li> <li>(4) treatment of physical complications of all stages of mastectomy, including lymphedemas.</li> </ol> <p>Benefits are payable on the same basis as any other sickness.</p>

<p>Inpatient Coverage Following A Mastectomy Expense</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a <b>covered person</b> for inpatient coverage following a mastectomy while insured under this Policy. Benefits are payable for <b>Covered Medical Expenses</b> on the same basis as any other <b>sickness</b>.</p> <p><b>Covered Medical Expenses</b> include:</p> <ul style="list-style-type: none"> <li>• In-patient care for a minimum of 48 hours following a radical or modified radical mastectomy, or</li> <li>• In-patient care for a minimum of 24 hours following a total mastectomy or a partial mastectomy with lymph node dissection</li> </ul> <p>For the treatment of breast cancer.</p> <p>Any decision to shorten such minimum coverages shall be made by the attending <b>physician</b>, in consultation with the <b>covered person</b>.</p> <p>Benefits are payable on the same basis as any other sickness.</p>
<p>Bone Marrow and Stem Cell Transplants for Breast Cancer</p>	<p>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.</p> <p>These expenses are payable on the same basis as any other <b>sickness</b>.</p>
<p>Lymphedema Expense</p>	<p>Coverage for prescribed equipment, supplies, complex decongestive therapy, and outpatient self-management training and education for the treatment of lymphedema.</p> <p>These expenses are payable on the same basis as any other <b>sickness</b>.</p> <p>Benefits are payable as follows:  <u>Preferred Care: 80%</u> of the Negotiated Charge.  <u>Non-Preferred Care: 60%</u> of the Reasonable Charge.</p>
<p>Morbid Obesity Expense</p>	<p>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.</p> <p>These expenses are payable on the same basis as any other <b>sickness</b>.</p> <p>Benefits are payable as follows:  <u>Preferred Care: 80%</u> of the Negotiated Charge.  <u>Non-Preferred Care: 60%</u> of the Reasonable Charge.</p>
<p>Elective Abortion Expenses</p>	<p>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.</p> <p><b>Covered Medical Expenses</b> for Elective Abortion Expense are covered as follows:  <u>Preferred Care: 80%</u> of the Negotiated Charge.  <u>Non-Preferred Care: 60%</u> of the Reasonable Charge.</p> <p>This benefit is in lieu of any other Policy benefits.</p>
<p>Routine Colorectal Cancer Screening Expense</p>	<p>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.</p> <p><b>Covered Medical Expenses</b> are payable as follows:  <u>Preferred Care: 80%</u> of the Negotiated Charge.  <u>Non-Preferred Care: 60%</u> of the Reasonable Charge.</p>

<p>Routine Prostate Cancer Screening Expense</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a covered person for the screening of cancer as follows:</p> <ul style="list-style-type: none"> <li>• for a male age 50 or over; and</li> <li>• 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</li> </ul> <p>One digital rectal exam and one prostate specific antigen test each Policy Year.</p> <p><u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>60%</b> of the Reasonable Charge.</p>
<p>Elective Surgical Second Opinion Expense</p>	<p><b>Covered Medical Expenses</b> 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.</p> <p>Benefits are payable as follows:  <u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>60%</b> of the Reasonable Charge.</p>
<p>Acupuncture in Lieu of Anesthesia Expense</p>	<p><b>Covered Medical Expenses</b> include acupuncture therapy, when acupuncture is used in lieu of other anesthesia, for a surgical or dental procedure covered under this Plan.</p> <p>The acupuncture must be administered by a health care provider who is a legally qualified physician, practicing within the scope of their license.</p> <p><u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>60%</b> of the Reasonable Charge.</p>
<p>Dermatological Expense</p>	<p><b>Covered Medical Expenses</b> include charges for the diagnosis and treatment of skin disorders. Related laboratory expenses are covered under the Outpatient Expense Benefit.</p> <p>Benefits are payable on the same basis as any other sickness.</p> <p><i>Covered Medical Expenses do not include treatment for acne, or cosmetic treatment and procedures.</i></p>
<p>Podiatric Expense</p>	<p><b>Covered Medical Expenses</b> include charges for podiatric services, provided on an outpatient basis following an injury.</p> <p>Benefits are payable on the same basis as any other sickness.</p> <p>Expenses for routine foot care, such as trimming of corns, calluses, and nails, are <b>not Covered Medical Expenses</b>. See exclusion 37 for more details.</p>
<p>Home Health Care Expenses</p>	<p><b>Covered Medical Expenses</b> 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:</p> <ol style="list-style-type: none"> <li>(a) The services are furnished by, or under arrangements made by, a licensed home health agency</li> <li>(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</li> <li>(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</li> </ol>

	<p>(d) The care starts within 7 days after discharge from a hospital as an inpatient, and</p> <p>(e) The care is for the same condition that caused the hospital confinement, or one related to it.</p> <p>Home Health Care Services</p> <p>(1) Part-time or intermittent nursing care by: a registered nurse (R. N.), a licensed Practical nurse (L.P.N.), or under the supervision on an R.N. if the services of an R. N. are not available,</p> <p>(2) Part time or intermittent home health aide services, that consist primarily of care of a medical or therapeutic nature by other than an R.N.,</p> <p>(3) Physical, occupational. speech therapy, or respiratory therapy,</p> <p>(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,</p> <p>(5) Medical social services by licensed or trained social workers,</p> <p>(6) Nutritional counseling.</p> <p><b>Covered Medical Expenses</b> will <b>not</b> 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.</p> <p><u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.</p> <p><u>Non-Preferred Care:</u> <b>60%</b> of the Reasonable Charge.</p> <p>A visit means a maximum of 4 continuous hours of home health service</p>
<p>Transfusion or Dialysis of Blood Expense</p>	<p><b>Covered Medical Expenses</b> include charges for the transfusion or dialysis of blood, including the cost of: whole blood, blood components, and the administration thereof.</p> <p>Benefits are payable as follows:</p> <p><u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.</p> <p><u>Non-Preferred Care:</u> <b>60%</b> of the Reasonable Charge.</p>
<p>Hospice Benefit</p>	<p><b>Covered Medical Expenses</b> include charges for hospice care provided for a terminally ill covered person during a hospice benefit period.</p> <p>Benefits are payable as follows:</p> <p><u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.</p> <p><u>Non-Preferred Care:</u> <b>60%</b> of the Reasonable Charge.</p> <p><i>Please see definition on page 37 for more information on Hospice Care Expenses.</i></p> <p><i>Benefits for Hospice expenses require pre-certification.</i></p>
<p>Licensed Nurse Expense</p>	<p>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.</p> <p><b>Covered Expenses</b> for a Licensed Nurse are covered as follows:</p> <p><u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge.</p> <p><u>Non-Preferred Care:</u> <b>60%</b> of the Reasonable Charge.</p> <p>For purposes of determining this maximum, a shift means 8 consecutive hours.</p>

<p>Skilled Nursing Facility Expense</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a covered person for confinement in a skilled nursing facility for treatment rendered:</p> <ul style="list-style-type: none"> <li>• in lieu of confinement in a hospital as a full time inpatient, or</li> <li>• within 24 hours following a hospital confinement and for the same or related cause(s) as such hospital confinement.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows:  <u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge for the semi-private room rate.  <u>Non-Preferred Care:</u> <b>60%</b> of the Reasonable Charge for the semi-private room rate..</p> <p><b><i>Benefits for Skilled Nursing require pre-certification.</i></b></p>
<p>Rehabilitation Facility Expense</p>	<p><b>Covered Medical Expenses</b> 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.</p> <p><b>Covered Medical Expenses</b> for Rehabilitation Facility Expense are covered as follows:  <u>Preferred Care:</u> <b>80%</b> of the Negotiated Charge for the rehabilitation facility's daily room and board maximum for semi-private accommodations  <u>Non-Preferred Care:</u> <b>60%</b> of the Reasonable Charge for the rehabilitation facility's daily room and board maximum for semi-private accommodations.</p> <p><b><i>Benefits for Rehabilitation Facility expenses require pre-certification.</i></b></p>

## ADDITIONAL SERVICES AND DISCOUNTS

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

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

**Aetna Fitness<sup>SM</sup> Discount Program:** Aetna's Fitness discount program provides members with access to preferred membership rates at nearly 10,000 fitness clubs nationwide and in Canada in the GlobalFit<sup>TM</sup> network. Members can also save on GlobalFit's other programs and services, such as at-home weight loss programs, home fitness equipment and videos and even one-on-one health coaching services\* to help them quit smoking, reduce stress, lose weight, or meet any other health goal.

*\*Offered by WellCall, Inc. through GlobalFit*

**Aetna Weight Management<sup>SM</sup> Discount Program:** Helps you achieve your weight loss goals and develop a balanced approach to your active lifestyle. This program provides members and their eligible family members access to discounts on Jenny Craig<sup>®</sup> weight loss programs and products. Start with a FREE 30-day trial membership\* then choose either a 6\* -or 12\* -month program\*\* that's right for you. You also receive individual weight loss consultations, personalized menu planning, tailored activity planning, motivational materials and much more.

*\* Offers good at participating centers in the United States, Canada and Puerto Rico and through Jenny Direct at-home. Additional cost for all food purchases and shipping where applicable.*

*\*\*Additional weekly food discounts will grow throughout the year, based on active participation.*

### **Find a meal plan that works for you at eDiets<sup>®</sup>:**

Get a personalized plan for healthy eating that fits your lifestyle, and save 25 percent on weekly eDiets dues. You'll have access to customized weekly menus, recipes, support boards, chats, nutrition tools and fitness tips.

### **Use Zagat<sup>®</sup> reviews as a guide for your night out:**

Planning a night on the town? Or, want to visit a city where you've never been? Subscribe to Zagat online and get a 30 percent discount on their members-only services. You can sign up for access to restaurant reviews only, or choose full access and get ratings and reviews on hotels, restaurants, movies and other attractions.

You can even order printed guides at a discount!

### **Give the gift of relaxation to yourself or a friend through SpaWish:**

Get a 10 percent discount when you buy a gift certificate of at least \$100, good for services at any of over 1,000 spas across the U.S. Choose a spa close to home or near your favorite place to visit!

### **Get trusted health information from the MayoClinic.com Bookstore:**

Choose from newsletters and books — with recipes for healthy living, advice on staying in shape, guides on living with certain health conditions and more. It's all at your fingertips — and at a discount! The size of the discount will depend on the item price and other available discounts.

### **Aetna's Informed Health<sup>®</sup> Line:**

Get answers from a registered nurse at any time — just call our toll-free Informed Health Line. With one simple call, you can:

- Learn more about health conditions that you or your family members have.
- Find out more about a medical test or procedure.
- Come up with questions to ask your doctor.

### **Talk to a registered nurse:**

Our nurses can discuss more than 5,000 health and wellness topics. Call them anytime you have a health question.

**Listen to our Audio Health Library:\***

Call and learn about a topic that interests you. Choose from thousands of health conditions. Listen in English or Spanish. You can also transfer to a registered nurse at any time during your call.

*\*Not all topics discussed within the Audio Health Library are covered expenses under your health insurance plan.*

**Go online for even more health information**

If you like to go online for health information, check out the Healthwise® Knowledgebase. You can learn more about a health condition you have, medications you take, and more. Link to it through your secure Aetna Navigator® website at [www.aetnavigators.com](http://www.aetnavigators.com).

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

**Beginning Right<sup>SM</sup> Maternity Program:** Give your baby a healthy start. Our Beginning Right Maternity Program comes with your health insurance plan. Use it throughout your pregnancy and after your baby is born. If you have health conditions or risk factors that may need special attention, we can help. Our nurses can give you personal case management to help you find ways to lower your risks. The more you know the better chance you have for good health ... for you and your baby.

**Aetna Natural Products and Services<sup>SM</sup> Discount Program:** Offers members access to reduced rates on services from natural therapy professionals, including acupuncturists, chiropractors, massage therapists and dietetic counselors, and access to discounts on over-the-counter vitamins, herbal and nutritional supplements and health-related products, such as foot care and natural body care products.

**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 Connections<sup>SM</sup> Disease Management Program** – This program offers support for over 35 conditions with smart technology and supportive services to ensure a healthier you. Our goal is to make it easier to manage your health and live your life well. Our CareEngine® system continuously scans your health data to identify safety risks and solutions. Using technology to look for opportunities for better care and programs and services helps to meet your individual needs. You may also receive a call or letter from the Aetna Health Connections Disease Management nurse. Call us at **1-866-269-4500** to get started.

*All of the above services, programs or benefits may be offered by vendors who are independent contractors and not employees or agents of Aetna.*

*Discount programs provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Discounts are subject to change without notice. Discount programs may not be employees or agents of Aetna.*

***Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professionals.***

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

\* In Texas, the Preferred Provider Organization (PPO) plan is known as the Participating Dental Network (PDN).

Student:	\$394 (Annual)	\$241 (Spring)
Student + 1 Dependent:	\$774 (Annual)	\$473 (Spring)
Student + 2 or more Dependents:	\$1,231 (Annual)	\$753 (Spring)

*The Aetna Dental PPO insurance plan is underwritten by Aetna Life Insurance Company.*

**Vital Savings<sup>SM</sup> on Dental\*** is a dental discount program helping you and your dependents save an average of 15% to 50% on a wide array of dental services – with one low annual fee of \$25 per student. Enroll online at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com). **Please Note: This is included for students who are enrolled in the Student Health Insurance Plan.** Participation in the student health insurance plan is not necessary to purchase this benefit.  
Student: **\$25**

Student + 1 Dependent: **\$44**

Student + 2 or more Dependents: **\$63**

\*Actual costs and savings vary by provider and geographic area.

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

## **GENERAL PROVISIONS**

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### **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**

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

### **TERMINATION OF INSURANCE**

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

### **TERMINATION OF STUDENT COVERAGE**

Insurance for a **covered student** will end on the first of these to occur:

- (a) the date this 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,
  - (3) the child's 25<sup>th</sup> 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 2 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 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.

## EXCLUSIONS

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This Policy does not cover nor provide benefits for:

1. Expense incurred as a result of dental treatment; except for treatment resulting from **injury to sound; natural teeth** or for extraction of impacted wisdom teeth as provided elsewhere in this Policy.
2. Expense incurred for eye refractions; vision therapy; radial keratotomy; eyeglasses; contact lenses (except when required after cataract surgery); or other vision or hearing aids; or **prescriptions** or examinations except as required for repair caused by a covered **injury**.
3. Expense incurred as a result of **injury** due to participation in a riot. "Participation in a riot" means taking part in a riot in any way; including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense; so long as they are not taken against persons who are trying to restore law and order.
4. Expense incurred as a result of an **accident** occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation; except as a fare-paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.
5. Expense incurred as a result of an **injury** or **sickness** due to working for wage or profit or for which benefits are payable under any Workers' Compensation or Occupational Disease Law.
6. Expense incurred as a result of an **injury** sustained or **sickness** contracted while in the service of the Armed Forces of any country. Upon the **covered person** entering the Armed Forces of any country; the unearned pro-rata premium will be refunded to the Policyholder.
7. Expense incurred for treatment provided in a governmental **hospital** unless there is a legal obligation to pay such charges in the absence of insurance.
8. Expense incurred for **elective treatment** or elective surgery except as specifically provided elsewhere in this Policy and performed while this Policy is in effect.
9. Expense incurred for cosmetic surgery; reconstructive surgery; or other services and supplies which improve; alter; or enhance appearance; whether or not for psychological or emotional reasons; except to the extent needed to:
  - 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. Expense 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. Expense 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. Expense incurred as a result of preventive medicines; serums; vaccines or oral contraceptive.
13. Expense incurred as a result of commission of a felony.
14. Expense incurred after the date insurance terminates for a **covered person** except as may be specifically provided in the Extension of Benefits Provision.
15. Expense incurred for services normally provided without charge by the school and covered by the school fee for services.
16. Expense incurred for any services rendered by a member of the **covered person's** immediate family or a person who lives in the **covered person's** home.
17. Expense incurred for treatment of temporomandibular joint dysfunction and associated myofascial pain.
18. 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.
19. Expense 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.
20. Expenses for treatment of **injury** or **sickness** to the extent that payment is made; as a judgment or settlement; by any person deemed responsible for the **injury** or **sickness** (or their insurers).
21. Expense incurred for which no member of the **covered person's** immediate family has any legal obligation for payment.
22. Expense incurred for **custodial care**. **Custodial care** means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes **room and board** and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:
  - by whom they are prescribed; or
  - by whom they are recommended; or
  - by whom or by which they are performed.
23. Expense incurred for the removal of an organ from a **covered person** for the purpose of donating or selling the organ to any person or organization. This limitation does not apply to a donation by a **covered person** to a spouse; child; brother; sister; or parent.
24. Expenses incurred for blood or blood plasma; except charges by a hospital for the processing or administration of blood.
25. Expenses incurred for the repair or replacement of existing artificial limbs; orthopedic braces; or orthotic devices.
26. 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.

27. Expenses incurred for gastric bypass; and any restrictive procedures; for weight loss except for the treatment of morbid obesity.
28. Expenses incurred for breast reduction/mammoplasty.
29. Expenses incurred for gynecal mastea (male breasts).
30. Expenses incurred for any sinus surgery; except for acute purulent sinusitis.
31. Expense incurred by a **covered person**; not a United States citizen; for services performed within the **covered person's** home country; if the **covered person's** home country has a socialized medicine program.
32. Expense incurred for; or related to; services; treatment; testing; educational testing; training; or medication for Attention Deficit Disorder; Attention Deficit Hyperactive Disorder; or Learning Disabilities; or other developmental delays.
33. Expense incurred for acupuncture; unless services are rendered for anesthetic purposes.
34. Expense incurred for alternative; holistic medicine; and/or therapy; including but not limited to; yoga and hypnotherapy.
35. Expense for: (a) care of flat feet; (b) supportive devices for the foot; (c) care of corns; bunions; or calluses; (d) care of toenails; and (e) care of fallen arches; weak feet; or chronic foot strain; except that (c) and (d) are not excluded when **medically necessary**; because the **covered person** is diabetic; or suffers from circulatory problems.
36. Expense 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. The Policy will only pay for those losses; which are not payable under the automobile medical payment insurance Policy.
37. Expense incurred when the person or individual is acting beyond the scope of his/her/its legal authority.
38. Expense incurred for hearing aids; the fitting; or prescription of hearing aids.
39. Expenses incurred for hearing exams.
40. Expense for care or services to the extent the charge would have been covered under Medicare Part A or Part B; even though the **covered person** is eligible; but did not enroll in Part B.

41. Expense for telephone consultations; charges for failure to keep a scheduled visit; or charges for completion of a claim form.
42. Expense for personal hygiene and convenience items; such as air conditioners; humidifiers; hot tubs; whirlpools; or physical exercise equipment; even if such items are prescribed by a **physician**.
43. Expense for incidental surgeries; and standby charges of a **physician**.
44. Expense for treatment and supplies for programs involving cessation of tobacco use.
45. Expense 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.
46. Expense incurred for **injury** resulting from the plan or practice of intercollegiate sports; in excess of \$250 (participating in sports clubs; or intramural athletic activities; is not excluded).
47. Expense for contraceptive methods; devices or aids; and charges for services and supplies for or related to gamete intrafallopian transfer; artificial insemination; in-vitro fertilization (except as required by the state law); or embryo transfer procedures; elective sterilization or its reversal; or elective abortion; unless specifically provided for in this Policy.
48. Expenses incurred for massage therapy.
49. Expense incurred for; or related to; sex change surgery; or to any treatment of gender identity disorder.
50. Expense for charges that are not **reasonable charges**; as determined by Aetna.
51. Expense for charges that are not **recognized charges**; as determined by Aetna; except that this will not apply if the charge for a service; or supply; does not exceed the **recognized charge** for that service or supply; by more than the amount or percentage; specified as the Allowable Variation.
52. Expense for treatment of **covered students** who specialize in the mental health care field; and who receive treatment as a part of their training in that field.
53. Expenses for treatment of **injury** or **sickness** to the extent payment is made; as a judgement or settlement; by any person deemed responsible for the **injury** or **sickness** (or their Insurers).
54. 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.
55. Expense incurred for a treatment; service; or supply; which is not **medically necessary**; as determined by Aetna; for the diagnosis care or treatment of the **sickness** or **injury** involved. This applies even if they are prescribed; recommended; or approved; by the person's attending **physician**; or **dentist**.

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

- be care; or treatment; which is likely to produce a significant positive outcome as; and no more likely to produce a negative outcome than; any alternative service or supply; both as to the **sickness** or **injury** involved; and the person's overall health condition;
- be a diagnostic procedure which is indicated by the health status of the person; and be as likely to result in information that could affect the course of treatment as; and no more likely to produce a negative outcome than; any alternative service or supply; both as to the **sickness** or **injury** involved; and the person's overall health condition; and

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

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

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

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

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

## DEFINITIONS

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### **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 **from one Policy Year to the next**.

### **Ambulatory Surgical Center**

A freestanding ambulatory surgical facility that:

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

### **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 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.
- Provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by a R.N. or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
- Is equipped and has trained staff to handle medical emergencies and provide immediate support measures to sustain life if complications arise during labor and if a child is born with an abnormality which impairs function or threatens life.
- Accepts only patients with low risk pregnancies.
- Has a written agreement with a hospital in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. This includes reviews by physicians who do not own or direct the facility.
- Keeps a medical record on each patient and child.

**Bone Marrow Transplant**

Use of high dose 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:

- professional nursing care by a **R.N.**, or by a **L.P.N.** directed by a full-time **R.N.**, and
- physical restoration services to help patients to meet a goal of self-care in daily living activities.
  - Provides 24 hour a day nursing care by licensed nurses directed by a full-time R.N.
  - Is supervised full-time by a physician or R.N.
  - Keeps a complete medical record on each patient.
  - Has a utilization review plan.
  - Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
  - Makes charges.

### **Copay**

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

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

### **Covered Dental Expenses**

Those charges for any treatment, service, or supplies, covered by this 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 Expense**

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 or she performs.

**Dependent**

(a) the **covered student's** spouse residing with the **covered student**, or (b) the person identified as a domestic partner in the "Declaration of Domestic Partnership" which is completed and signed by the **covered student**, and (c) the **covered student's** unmarried child under the age of 19 years (or 25 if a full time student). 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 or 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:
  - loss of life or limb, or
  - significant impairment to bodily function, or
  - permanent dysfunction of a body part.

### **Emergency Condition**

This is any traumatic injury or condition which:

- occurs unexpectedly,
- requires immediate diagnosis and treatment, in order to stabilize the condition, and
- is characterized by symptoms such as severe pain and bleeding.

### **Emergency Medical Condition**

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

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

### **Generic Prescription Drug or Medicine**

A **prescription drug** which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

### **High Cost Procedure**

High Cost Procedures include the following procedures and services:

- C.A.T. Scan,
- Magnetic Resonance Imaging,
- Laser treatment, which must be provided on an outpatient basis, and may be incurred in the following:
  - (a) A **physician's** office, or
  - (b) **Hospital** outpatient department, or emergency room, or
  - (c) Clinical laboratory, or
  - (d) Radiological facility, or other similar facility, licensed by the applicable state, or the state in which the facility is located.

**Home Health Agency**

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

**Home health aide**

A certified or trained professional who provides services through a **home health agency** which are not required to be performed by an RN, LPN, or LVN, primarily aid the **covered person** in performing the normal activities of daily living while recovering from an **injury** or **sickness**, and are described under the written **Home Health Care Plan**.

**Home Health Care**

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

**Home Health Care Plan**

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

**Hospice**

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

**Hospice benefit period**

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

**Hospice Care Expenses**

The 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 an RN, LPN, or LVN, charges for physical and respiratory therapy in the home, charges for the use of medical equipment, charges for visits by licensed or trained social workers, psychologists or counselors, charges for bereavement counseling of the covered person's immediate family prior to, and within 3 months after, the covered person's death, and charges for respite care for up to 5 days in any 30 day period.

**Hospital**

A facility which meets all of these tests:

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

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

**Hospital Confinement**

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

**Injury**

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

**Intensive Care Unit**

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

**Jaw Joint Disorder**

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

**Mail Order Pharmacy**

An establishment where **prescription drugs** are legally dispensed by mail.

**Medically Necessary**

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

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

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

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

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

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

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

**Medication Formulary**

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

**Medication Management Visit**

A visit no more than twenty 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 twenty-four hour period under a program based in a **hospital**.

**Pervasive Developmental Disorder**

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

**Pharmacy**

An establishment where **prescription drugs** are legally dispensed.

**Physician**

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

**Policy Year**

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

**Pre-Admission Testing:**

Tests done by a hospital, surgery center, licensed diagnostic lab facility, or physician, in its own behalf, to test a person while an outpatient before scheduled surgery if:

- the tests are related to the scheduled surgery,
- the tests are done within the 7 days prior to the scheduled surgery,
- the person undergoes the scheduled surgery in a **hospital** or **surgery center**, this does not apply if the tests show that surgery should not be done because of his physical condition,
- the charge for the surgery is a **Covered Medical Expense** under this Plan,
- the tests are done while the person is not confined as an inpatient in a **hospital**,
- the charges for the tests would have been covered if the person was confined as an inpatient in a **hospital**,
- the test results appear in the person's medical record kept by the **hospital** or **surgery center** where the surgery is to be done, and
- the tests are not repeated in or by the **hospital** or **surgery center** where the surgery is done.

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

**Pre-Existing Condition**

Any **injury, sickness**, or condition that was diagnosed or treated, or would have caused a prudent person to seek diagnosis or treatment, within 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**, or referral by a **covered person's primary care physician** prior to treatment, 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:
  - a **Designated Care Provider**, or
  - a Preferred Care Provider, or
  - a Non-Preferred Care Provider, but only for an emergency condition, or on referral of a person's Primary Care Physician, or
  - a **dentist** who is a **Non-Preferred Care Provider**, but only one who is not of a type that falls into one or more of the categories of providers listed in the **directory of Preferred Care Providers**.

**Prescriber**

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

**Prescription**

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

**Prescription Drugs**

Any of the following:

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

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 semiprivate rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

**Service Area**

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

**Sickness**

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

**Skilled Nursing Facility**

A lawfully operating institution engaged mainly in providing treatment for people convalescing from **injury or sickness**. It must have:

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

### **Surgical assistant**

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

### **Surgical expense**

Charges by a **physician** for,

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

### **Surgical procedure**

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

### **Totally Disabled**

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

### **Urgent Admission**

One where the **physician** admits the person to the **hospital** due to:

- the onset of or change in a disease, or
- the diagnosis of a disease, or
- an **injury** caused by an **accident**,

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

### **Urgent Condition**

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

- is severe enough to require prompt medical attention to avoid serious deterioration of the **covered person's** health,
- includes a condition which would subject the **covered person** to severe pain that could not be adequately managed without urgent care or treatment,
- does not require the level of care provided in the emergency room of a **hospital**, and
- requires immediate outpatient medical care that cannot be postponed until the **covered person's physician** becomes reasonably available.

### **Urgent Care Provider**

This is:

- A freestanding medical facility which:
  - Provides unscheduled medical services to treat an **urgent condition** if the **covered person's physician** is not reasonably available.
  - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
  - Makes charges.
  - Is licensed and certified as required by any state or federal law or regulation.
  - Keeps a medical record on each patient.
  - Provides an ongoing quality assurance program. This includes reviews by **physicians** other than those who own or direct the facility.
  - Is run by a staff of **physicians**. At least one such **physician** must be on call at all times.
  - Has a full-time administrator who is a licensed **physician**.
- A **physician's** office, but only one that:
  - has contracted with Aetna to provide urgent care, and
  - is, with Aetna's consent, included in the Provider **Directory** as a Preferred Urgent Care Provider.

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

### **Walk-in Clinic**

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

## **CLAIM PROCEDURE**

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

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

1. Bills must be submitted within 90 days from the date of treatment.
2. Payment for Covered Medical Expenses will be made directly to the hospital or physician concerned, unless bill receipts and proof of payment are submitted.
3. If itemized medical bills are available at the time the claim form is submitted, attach them to the claim form. Subsequent medical bills should be mailed promptly to the 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 15717  
Boston, MA 02215-0014

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](http://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](http://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**

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

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

## **WORLDWIDE EMERGENCY TRAVEL ASSISTANCE SERVICES**

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### **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 Ten Thousand Dollars (\$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) 878-1945..**

### **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
- 24/7 U.S. Nurse Help Line
- 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 1- (866) 525-1956 or collect 1-(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.

#### **Got Questions? Get Answers with Aetna's Navigator®**

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

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

#### **How do I register?**

- Go to [www.aetnastudenthealth.com](http://www.aetnastudenthealth.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.aetnastudenthealth.com](http://www.aetnastudenthealth.com).

### **Administered by:**

Aetna Student Health.

P.O. Box 15708

Boston, MA 02215-0014

**(800) 878-1945**

[www.aetnastudenthealth.com](http://www.aetnastudenthealth.com)



### **Underwritten by:**

Aetna Life Insurance Company (ALIC)

151 Farmington Avenue

Hartford, CT 06156

**(860) 273-0123**

Policy No. 724536

The George Mason University Student Health Insurance Plan is underwritten by Aetna Life Insurance Company (ALIC) and administered by Chickering Claims Administrators, Inc. Aetna Student Health<sup>SM</sup> is the brand name for products and services provided by these companies and their applicable affiliated companies.

*Notes*