2012 – 2013

Student Health Insurance Plan

Be advised that you may be eligible for coverage under a group health plan of a parent’s employer or under a parent’s individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent’s employer plan or the parent’s individual health insurance issuer for more information.

Underwritten by:
Aetna Life Insurance Company (ALIC)

Policy Number 697408
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 questions about:
- Insurance Benefits
- Claims Processing
- Pre-Certification Requirements

Please contact:
Aetna
P.O. Box 981106
El Paso, TX 79998
(888) 204-0187

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
(888) 204-0187

For questions about:
- Enrollment Forms
- Waiver Process

Please contact:
Regent University Business Office (757) 352-4059
or
Regent University Student Life (757) 352-4867

Local Administration by:
Wells Fargo Insurance Services
440 Monticello Ave.
Norfolk, VA 23510
debi.harding@wellsfargo.com
(757) 667-3543

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
(888) 204-0187

A complete list of providers can be found on Aetna’s DocFind® Service at
www.aetnastudenthealth.com/schools/RegentUniversity

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 (001) plus (603) 328-1956. Please also visit
www.aetnastudenthealth.com and visit your school-specific site for further information.

The Regent University Student Health Insurance Plan is underwritten by Aetna Life Insurance Company (ALIC) and
administered by Chickering Claims Administrators, Inc. Aetna Student HealthSM is the brand name for products and
services provided by these companies and their applicable affiliated companies.

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 Regent University. If any discrepancy exists between
this Brochure and the Policy, the Master Policy will govern and control the payment of benefits. The Master Policy may be
viewed at the University’s Business Office during business hours or online at
www.aetnastudenthealth.com/schools/RegentUniversity.

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

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

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

3. **Spring/Summer Students**: Coverage for all insured Fall students continuing Spring/Summer coverage will terminate at 11:59 p.m. on August 14, 2013.

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

5. **New Summer Semester Students**: Coverage for all insured students only attending school for Summer Semester will become effective at 12:01 a.m. on May 6, 2013, and will terminate at 11:59 p.m. on August 14, 2013.

6. **Insured Dependents**: Coverage will become effective on the same date the insured student’s coverage becomes effective. Coverage for insured Dependents terminates in accordance with the Termination Provisions described in the Master Policy. For more information, please see the Termination of Covered Dependents section of this Brochure. Examples include, but are not limited to: the date the student’s coverage terminates, the date the Dependent no longer meets the definition of a Dependent.

RATES

<table>
<thead>
<tr>
<th>Undergraduate and Graduate Students</th>
<th>Annual Insurance Rate 8/15/12-8/14/13</th>
<th>Fall Insurance Rate 8/15/12-2/14/13</th>
<th>Spring/Summer Insurance Rate 2/15/13-8/14/13</th>
<th>New Students Spring/Summer Insurance Rate 1/1/13-8/14/13</th>
<th>Summer Insurance Rate 5/6/13-8/14/13</th>
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<tr>
<td>Student Only</td>
<td>$2,456</td>
<td>$1,228</td>
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<td>Student/Spouse</td>
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<td>$4,297</td>
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<td>$2,378</td>
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<tr>
<td>Student/1 Child</td>
<td>$6,752</td>
<td>$3,376</td>
<td>$3,376</td>
<td>$3,376</td>
<td>$1,868</td>
</tr>
<tr>
<td>Student/Spouse/Child(ren)</td>
<td>$12,890</td>
<td>$6,445</td>
<td>$6,445</td>
<td>$6,445</td>
<td>$3,567</td>
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<tr>
<td>Student/Children</td>
<td>$6,752</td>
<td>$3,376</td>
<td>$3,376</td>
<td>$3,376</td>
<td>$1,868</td>
</tr>
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REGENT UNIVERSITY

STUDENT HEALTH INSURANCE PLAN

This is a brief description of the Student Health Insurance Medical Expense benefits available for Regent University students and their eligible Dependents. The plan is underwritten by Aetna Life Insurance Company (called Aetna). The exact provisions governing this insurance are contained in the Master Policy issued to the University and may be viewed at the University’s Business Office during business hours or online at www.aetnastudenthealth.com/schools/RegentUniversity.
STUDENT COVERAGE

ELIGIBILITY

Mandatory Coverage; Definition of “Tight Waiver”
All graduate students enrolled with six (6) or more on-campus credit hours and all undergraduate students enrolled with nine (9) or more on-campus credit hours (attending classes on site at the Virginia Beach Campus) are required to have Health Insurance Coverage and will automatically be billed and enrolled in the Student Medical Plan. All International F1 or J1 Visa students enrolled in class(es) at the Virginia Beach campus are required to have Health Insurance Coverage and will automatically be billed and enrolled in the Regent Student Insurance Plan. (Modular Classes and Residencies are considered distance classes for insurance eligibility purposes.) Tuition payment deadline is August 20, 2012. Enrollment and change deadline for the Fall policy term is September 14, 2012; Spring term deadline – February 1, 2013.

Definition of Tight Waiver
If a student has Comparable Coverage, they may submit an online waiver request with proof of Comparable Coverage. Comparable Coverage is defined as individual medical and Sickness indemnity plans, employer-sponsored group insurance plans, Medicare, TriCare, or Medicaid. A waiver form can be completed online at www.regent.edu/healthinsurance. Insurance fees appear on the tuition bill automatically for the Fall and Spring academic terms (the Spring term includes summer months). On-campus F1 and J1 International students who wish to use alternate coverage must first get approval from the Executive Director of Student Services. Tuition payment deadline is August 20, 2012. Enrollment and change deadline for the Fall policy term is September 14, 2012; Spring term deadline – February 1, 2013.

Students and Dependents Eligible for coverage
Students attending classes at the Virginia Beach campus, with local residency, who are enrolled with a total of six (6) or more credit hours (3 credit hours must be on site) may voluntarily enroll in the student medical insurance plan. (Modular Classes and Residencies are considered distance classes for insurance eligibility purposes.)

Eligible students who enroll may also cover their eligible Dependents. The insured student’s lawful spouse and children up to age 26 years of age are eligible. Dependents’ eligibility and coverage period must be concurrent with the insured student’s, unless the student or Dependent experiences a qualifying event that directly affects their insurance coverage. If a student or Dependent has a qualifying event, that individual may be added to the Student Health Insurance Plan as of the date of the event. An example of a qualifying event would be loss of health coverage under another health plan or birth of a child. Please note an application for coverage due to a qualifying event must be submitted to Regent within 30 days of the qualifying event.

All But Dissertation (ABD) Students
All students enrolled at Regent University in a Doctoral Program, on site at the Virginia Beach Campus, will be limited to 2 years of coverage once all coursework is completed and they are only working on their dissertation. Their beginning date of the limited period of insurance will be when they are classified as “All But Dissertation (ABD)” at Regent University.

Internship Programs or Student Teaching Placements – Voluntary Coverage
Students participating in mandatory, full-time internship programs or student teaching placements will remain eligible for the Regent-sponsored plan, provided they meet the following criteria:

1) The student must be living in the Hampton Roads area, OR, if the student receives a placement outside of Hampton Roads, that student must have been previously enrolled in the university plan.
2) The student must be receiving university credit for the internship or student teaching placement.
3) The student must be considered “full time” by the university.
4) The internship or student teaching placement must be required by the student’s program.
5) The internship or student teaching placement cannot extend beyond 12 months.
Optional Practical Training (OPT) or Academic Training (AT) Students
International students who are engaged in post-completion Optional Practical Training (OPT) or Academic Training must have health insurance, and will only be eligible to use the university’s health insurance plan for up to 12 months if they live in the local Hampton Roads area during their training. Students who live outside of the local area during their OPT or Academic Training period, or those whose Academic Training goes beyond 12 months, will be required to find alternate health insurance coverage, and must contact the Executive Director of Student Services to receive University approval for using that alternate coverage.

Study Abroad Students
Students may elect to enroll in the university-sponsored plan for the term that they participate in a Regent-sponsored study abroad experience if they were eligible to enroll in the plan the semester prior to the study abroad experience. (To be eligible to enroll, a student must take at least 6 credits in the semester, and at least 3 of those credits must be on campus.) If a student is not eligible to enroll in the plan for the semester prior to the study abroad experience, he/she would not be permitted to enroll in the plan for the study abroad term.

ENROLLMENT
How to Enroll
For new students, please complete the enrollment application for yourself and/or Dependents online at www.regent.edu/healthinsurance. Returning students with continuing eligibility for mandatory coverage (6 on-campus credits for graduate students and 9 on-campus credits for undergraduates) will automatically be enrolled under the same status (student only, student/spouse, etc.) as spring 2012 semester. Any changes to your status — including a reduction of credit hours that makes you ineligible for automatic enrollment - requires completion of a new Insurance Enrollment Form at www.regent.edu/healthinsurance.

Qualifying Events:
An example of a qualifying event would be loss of health coverage under another health plan or birth of a child. Please note an application for coverage due to a qualifying event must be submitted to Regent within 30 days of the qualifying event. Please complete an enrollment application for you or your Dependents online at www.regent.edu/healthinsurance. You may also contact Debi.Harding@wellsfargo.com or call (757) 667-3543 to provide additional enrollment information.

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. A pro rata refund of premium will be made for such person, and any Covered Dependents, upon written request received by Aetna within 90 days of withdrawal from school.

WAIVER AND ENROLLMENT PROCESS/PROCEDURE
WAIVER PROCESS
If a student has Comparable Coverage they may submit an online waiver request with proof of Comparable Coverage. Comparable Coverage is defined as individual medical and Sickness indemnity plans, employer-sponsored group insurance plans, Medicare, TriCare, or Medicaid. A waiver form can be completed on line at www.regent.edu/healthinsurance.

On-campus F1 and J1 International students who wish to use alternate coverage must first get approval from the Executive Director of Student Services, who can be contacted at (757) 352-4867 or chughes@regent.edu.

ENROLLMENT AND WAIVER DEADLINES
Fall Semester: The deadline to enroll or waive coverage for the Fall Semester is September 14, 2012.
Spring/Summer Semesters: The deadline to enroll or waive coverage for the Spring/Summer Semester is February 1, 2013.

Aetna Student Health reserves the right to review, at any time, your eligibility to enroll in this Plan. If it is determined that you did not meet the school’s eligibility requirements for enrollment, your participation in the Plan may be rescinded in accordance with its terms.
REFUND POLICY

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

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

DEPENDENT COVERAGE

ELIGIBILITY

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

Coverage terminates on the child’s 26th birthday. Please see “Incapacitated Dependent Children” for exceptions to this rule. Dependents’ eligibility and coverage period must be concurrent with the insured student’s, unless the student or Dependent experiences a qualifying event that directly affects their insurance coverage. If a student or Dependent has a qualifying event, that individual may be added to the Student Health Insurance Plan as of the date of the event. An example of a qualifying event would be loss of health coverage under another health plan or birth of a child. Please note an application for coverage due to a qualifying event must be submitted to Regent within 30 days of the qualifying event.

Newborn Infant and Adopted Child Coverage

A child born to a Covered Person shall be covered for Injury, 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 Regent 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.

ENROLLMENT

To enroll the Dependent(s) of a Covered Student, please complete the Enrollment Form online at www.regent.edu/healthinsurance, then choose link at bottom of the page “Insurance Application.”

If the Insurance Application is received before September 14, 2012, then there will be no break in coverage. The Fall Semester enrollment deadline is September 14, 2012. Dependent enrollment applications will not be accepted after September 14, 2012, unless there is 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 Spring Semester enrollment deadline is February 1, 2013.

For information or general questions on Dependent enrollment, contact Wells Fargo Insurance Services at debi.harding@wellsfargo.com or (757) 667-3543.
PREFERRED PROVIDER NETWORK

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

You may obtain information regarding Preferred Providers by accessing DocFind at www.aetnastudenthealth.com/schools/RegentUniversity
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

Pre-Certification simply means calling Aetna Student Health prior to treatment to obtain approval for a medical procedure or service. Pre-Certification may be done by you, your doctor, a Hospital administrator, or one of your relatives. All requests for certification must be obtained by contacting Aetna Student Health at (888) 204-0187 (attention Managed Care Department).

- If you do not secure Pre-Certification for non-emergency Inpatient admissions, or provide notification for emergency admissions, your Covered Medical Expenses will be subject to a $200 per admission deductible.
- 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, Convalescent Facility, Skilled Nursing Facility, a facility established primarily for the treatment of substance abuse, or a Residential Treatment Facility.
- All Inpatient maternity care, after the initial 48/96 hours.
- All Partial Hospitalization in a Hospital, residential treatment facility, or facility established primarily for the treatment of substance abuse.

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*

Please Note:

The Regent 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 the Regent University Student Health Insurance Plan Brochure carefully before deciding whether this Plan is right for you. While this document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. If you want to look at the full Plan description, which is contained in the Master Policy issued to Regent University, you may view it at the Regent University Office of Student Affairs or you may contact Aetna Student Health at (888) 204-0187.

Plan maximums may also apply. Some illnesses may cost more to treat and health care providers may bill you for what the Plan does not cover.

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

All insurance coverage is subject to the terms of the Master Policy and applicable state filings. Under health care reform legislation, student health plans may be required to eliminate or modify certain existing benefit plan provisions, including, but not limited to, exclusions and limitations. Aetna reserves the right to modify its products and services in response to federal and/or state legislation, regulation or requests of government authorities.

*Benefit descriptions have been added to this brochure to help illustrate new Health Care Reform (HCR) requirements. HCR requirements are currently being filed for support in individual states and will appear in policy contracts and certificates of coverage once approved.
SUMMARY OF BENEFITS CHART

<table>
<thead>
<tr>
<th>AGGREGATE MAXIMUM</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANNUAL DEDUCTIBLES</strong>*</td>
<td></td>
</tr>
<tr>
<td>The following Deductibles are applied before Covered Medical Expenses are payable:</td>
<td></td>
</tr>
<tr>
<td>Per Covered Person:</td>
<td>Preferred Care</td>
</tr>
<tr>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td>*This Annual Deductible and the Prescribed Medicine Expense Annual Deductible do not apply towards satisfying each other.</td>
<td></td>
</tr>
</tbody>
</table>

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

The Policy Year Deductible is not applicable to the following covered expenses:
- Female Generic Contraceptive Devices
- Female Generic Contraceptive Prescription Drugs
- Female Over-the-Counter Contraceptive Methods

**COINSURANCE**
Covered Medical Expenses are payable at the Coinsurance percentage specified below, after any applicable Deductible.

**OUT-OF-POCKET LIMIT***
| Individual Out-of-Pocket | Preferred Care | Non-Preferred Care |
| $1,500 | $3,000 |

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 the Aggregate Maximum.

The following expenses do not apply toward meeting the Out-of-Pocket Limit:
- Deductibles;
- Copays;
- Expenses that are not Covered Medical Expenses;
- Penalties,
- Expenses for Prescription Drugs; and
- Other expenses not covered by this Policy.

*Out-of-Pocket accumulators are separate and do not apply towards satisfying each other.*

All coverage is based on Recognized Charges unless otherwise specified.
## Inpatient Hospitalization Benefits

**Room and Board Expense**

Covered Medical Expenses include but are not limited to charges incurred by a **Covered Person** for **Inpatient** coverage following a laparoscopy-assisted vaginal hysterectomy and vaginal hysterectomy while insured under this Policy.

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

Any decision to shorten such minimum coverages shall be made by the attending **Physician**; in consultation with the **Covered Person**.

Covered Medical Expenses are payable as follows:
- Preferred Care: After a $50 per admission **Copay**, 90% of the **Negotiated Charge**.
- Non-Preferred Care: After a $100 per admission **Deductible**, 70% of the **Recognized Charge**.

**Intensive Care Room and Board Expense**

Covered Medical Expenses are payable as follows:
- Preferred Care: After a $50 per admission **Copay**, 90% of the **Negotiated Charge**.
- Non-Preferred Care: After a $100 per admission deductible, 70% of the **Recognized Charge**.

**Miscellaneous Hospital Expense**

Covered Medical Expenses are payable as follows:
- Preferred Care: 90% of the **Negotiated Charge**.
- Non-Preferred Care: 70% of the **Recognized Charge**.

**Non-Surgical Physicians Expense**

Covered Medical Expenses for charges for the non-surgical services of the attending **Physician**, or a consulting **Physician**, are payable as follows:
- Preferred Care: 90% of the **Negotiated Charge**.
- Non-Preferred Care: 70% of the **Recognized Charge**.

### Surgical Benefits (Inpatient and Outpatient)

**Surgical Expense**

Covered Medical Expenses include charges for surgical services, performed by a **Physician**.

Covered Medical Expenses include **Medically Necessary** surgical treatment for symptomatic varicose veins.

Covered Medical Expenses are payable as follows:
- Preferred Care: 90% of the **Negotiated Charge**.
- Non-Preferred Care: 70% of the **Recognized Charge**.

**Anesthesia Expense**

Covered Medical Expenses for the charges of an anesthetist, during a surgical procedure.

Anesthesia will be covered if a member is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental or medical reason as determined by the individual’s **Physician** or by the **Dentist** providing the dental care.

Covered Medical Expenses are payable as follows:
- Preferred Care: 90% of the **Negotiated Charge**.
- Non-Preferred Care: 70% of the **Recognized Charge**.

**Assistant Surgeon Expense**

Covered Medical Expenses for the charges of an assistant surgeon, during a **Surgical Procedure**, are payable as follows:
- Preferred Care: 90% of the **Negotiated Charge**.
- Non-Preferred Care: 70% of the **Recognized Charge**.

**Ambulatory Surgical Expense**

Covered Medical Expenses for **Outpatient** surgery performed in an **Ambulatory Surgical Center** are payable as follows:
- Preferred Care: 90% of the **Negotiated Charge**.
- Non-Preferred Care: 70% of the **Recognized Charge**.

Covered Medical Expenses must be incurred on the day of or within 48 hours of the surgery.
### Outpatient Benefits

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

<table>
<thead>
<tr>
<th>Hospital Outpatient Department Expense</th>
<th><strong>Covered Medical Expenses</strong> includes treatment rendered in a Hospital Outpatient Department. <strong>Covered Medical Expenses</strong> do not include Emergency Room/Urgent Care Treatment, Walk-in Clinic, Therapy Expenses, Chemotherapy and Radiation, and Outpatient surgical services, including Physician, anesthesia and facility charges, which are covered as outlined under the individual benefit types listed in this schedule of benefits. <strong>Covered Medical Expenses</strong> are payable as follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 70% of the Recognized Charge.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walk-in Clinic Expense</td>
<td><strong>Covered Medical Expenses</strong> includes treatment rendered in a Walk-in Clinic. <strong>Covered Medical Expenses</strong> are payable as follows: Preferred Care: After a $20 per visit Copay, 100% of the Negotiated Charge. Non-Preferred Care: After a $35 per visit Deductible, 100% of the Recognized Charge.</td>
</tr>
<tr>
<td>Emergency Room Expense</td>
<td><strong>Covered Medical Expenses</strong> incurred for treatment of an Emergency Medical Condition are payable as follows: Preferred Care: After a $200 per visit Copay*, 100% of the Negotiated Charge. Non-Preferred Care: After a $200 per visit deductible*, 100% of the Recognized Charge. *The per visit Copay/deductible is waived if admitted as Inpatient. <strong>Important Note:</strong> Please note that as Non-Preferred Care Providers do not have a contract with Aetna, the provider may not accept payment of your cost share (your Deductible and Coinsurance) as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. Please send Aetna the bill at the address listed on the back of your member ID card and Aetna will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.</td>
</tr>
<tr>
<td>Urgent Care Expense</td>
<td>Benefits include charges for treatment by an Urgent Care Provider. <strong>Please note:</strong> A Covered Person should not seek medical care or treatment from an urgent care provider if their illness, Injury, or condition, is an emergency condition. The Covered Person should go directly to the emergency room of a Hospital or call 911 (or the local equivalent) for ambulance and medical assistance. <strong>Urgent Care</strong> Benefits include charges for an Urgent Care Provider to evaluate and treat an urgent condition. <strong>Covered Medical Expenses</strong> for urgent care treatment are payable as follows: Preferred Care: After a $50 per visit Copay, 100% of the Negotiated Charge. Non-Preferred Care: After a $75 per visit Deductible, 100% of the Recognized Charge. 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.</td>
</tr>
<tr>
<td>Ambulance Expense</td>
<td><strong>Covered Medical Expenses</strong> are payable at 100% of the Actual Charge after a $100 per trip Copay/deductible 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. Benefits include coverage to professional ambulance services of a newly born to the nearest available Hospital/special care unit for treatment of illnesses, congenital defects or complications of birth. Ambulances services will also be provided to the mother, if needed.</td>
</tr>
<tr>
<td>Pre-Admission Testing Expense</td>
<td><strong>Covered Medical Expenses</strong> for Pre-Admission testing charges while an <strong>Outpatient</strong> before scheduled surgery are payable on the same basis as any other <strong>Sickness</strong>.</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Physician’s Office Visits Expense | **Covered Medical Expenses** are payable as follows:  
Preferred Care: After a $20 per visit **Copay**, 100% of the **Negotiated Charge**.  
Non-Preferred Care: After a $35 per visit **Deductible**, 100% of the **Recognized Charge**.  
This benefit includes visits to specialists.  
**Covered Medical Expenses** includes coverage for telemedicine when services are rendered by a health care provider without person-to-person contact with the provider.  
“Telemedicine” means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.  
Neither a telephone conversation nor an electronic mail message between a health care practitioner and patient constitutes “telemedicine.”  
**Covered Medical Expenses** include the expenses incurred by **Covered Person** in connection with the services performed by a qualified interpreter/transliterator, other than a family member of the **Covered Person**, when such services are used by the **Covered Person** in connection with medical treatment or diagnostic consultations performed by a **Physician** or dental provider.  
Such medical treatment or consultation must be covered under this **Policy** and the services must be required due to the **Covered Person’s** hearing impairment or his/her failure to understand or otherwise communicate in spoken language. |
| Consultant Expense | **Covered Medical Expenses** include the expenses for the services of a consultant. The services must be requested by the attending **Physician** for the purpose of confirming or determining a diagnosis.  
**Covered Medical Expenses** are payable as follows:  
Preferred Care: After a $20 per visit **Copay**, 100% of the **Negotiated Charge**.  
Non-Preferred Care: After a $35 per visit **Deductible**, 100% of the **Recognized Charge**. |
| Laboratory and X-Ray Expense | **Covered Medical Expenses** include **Outpatient** charges for lab and X-ray services, including but not limited to human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in **bone marrow transplantation**.  
**Covered Medical Expenses** are payable as follows:  
Preferred Care: 90% of the **Negotiated Charge**.  
Non-Preferred Care: 70% of the **Recognized Charge**.  
Benefits for human leukocyte antigen testing are limited to one such testing per enrollee per lifetime at a cost of no greater than $75. |
| High Cost Procedures Expense | **Covered Medical Expenses** include charges incurred by a **Covered Person** for High Cost Procedures that are required as a result of **Injury** or **Sickness**. Expenses for High Cost Procedures; which must be provided on an **Outpatient** basis; may be incurred in the following:  
a) A **physician’s** office; or  
b) **Hospital Outpatient** department; or emergency room; or  
c) Clinical laboratory; or  
d) Radiological facility; or other similar facility; licensed by the applicable state; or the state in which the facility is located.  
**Covered Medical Expenses** for High Cost Procedures include charges for the following procedures and services:  
a) C.A.T. Scan;  
b) Magnetic Resonance Imaging; and  
c) Contrast Materials for these tests.  
**Covered Medical Expenses** are payable as follows:  
Preferred Care: 90% of the **Negotiated Charge**.  
Non-Preferred Care: 70% of the **Recognized Charge**. |
| Therapy Expense | Covered Medical Expenses include charges incurred by a Covered Person for the following types of therapy provided on an Outpatient basis:  
- Physical Therapy,  
- Chiropractic Care,  
- Speech Therapy,  
- Inhalation Therapy,  
- Occupational Therapy, or  
- Cardiac Rehabilitation  

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

Expenses for Speech and Occupational Therapies are Covered Medical Expenses, only if such therapies are a result of Injury or Sickness.  

All therapy must be provided by a therapist who is licensed in accordance with state law; and practicing within the scope of their license.  

Covered Medical Expenses are payable as follows:  
Preferred Care: 90% of the Negotiated Charge.  
Non-Preferred Care: 70% of the Recognized Charge.  

Covered Medical Expenses also include charges incurred by a Covered Person for the following types of therapy provided on an Outpatient basis:  
- Radiation therapy,  
- Chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy,  
- Orally administered anticancer drugs prescribed to kill or slow the growth of cancerous cells.  
- Administration of high dose chemotherapy with autologous bone marrow transplantation or stem cell transplantation for the treatment of breast cancer.  
- Dialysis,  
- Cardiac Rehabilitation and  
- Respiratory therapy.  

Covered Medical Expenses include expenses incurred by a Covered Person for: cognitive rehabilitation therapy, cognitive speech/communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services or community reintegration services, if such services are necessary as a result of and related to an acquired brain Injury.  

Covered Medical Expenses include Early Intervention Services as defined in the law for an eligible Dependent child from birth to age 3 who has significant delays in development or has a diagnosed physical or mental condition. Coverage requires a written plan for services provided by a qualified early intervention service provider.  

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

Early Intervention Services are limited to $6,249 per Policy Year. |

| Physical Therapy Expense | Covered Medical Expenses for physical therapy are payable as follows when provided by a licensed physical therapist:  
Preferred Care: 90% of the Negotiated Charge.  
Non-Preferred Care: 70% of the Recognized Charge. |
### Durable Medical Equipment Expense

**Covered Medical Expenses** are payable as follows:
- **Preferred Care:** 90% of the **Negotiated Charge**
- **Non-Preferred Care:** 70% of the **Recognized Charge**.

**Breast Feeding Durable Medical Equipment**
Coverage includes the rental or purchase of breast feeding **Durable Medical Equipment** for the purpose of lactation support (pumping and storage of breast milk) as follows.
- **Preferred Care:** 100% of the **Negotiated Charge**
- **Non-Preferred Care:** 70% of the **Recognized Charge**

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

If an electric breast pump was purchased within the previous one period, the purchase of an electric or manual breast pump will **not** be covered until a five year period has elapsed from the last purchase of an electric pump.

**Breast Pump Supplies**
Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. The **Covered Person** is responsible for the entire cost of any additional pieces of the same or similar equipment that he or she purchases or rents for personal convenience or mobility.

**Aetna** reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **Aetna**.

**Limitations:**
Unless specified above, not covered under this benefit are charges incurred for:
- Services which are covered to any extent under any other part of this Plan.
**Dental Injury Expense**

**Covered Medical Expenses** include dental work, surgery, and **orthodontic treatment** needed to remove, repair, replace, restore, or reposition:
- Natural teeth damaged, lost, or removed, or
- Other body tissues of the mouth fractured or cut due to Injury. The accident causing the Injury must occur while the person is covered under this Plan.

Any such teeth must have been:
- Free from decay, or
- In good repair, and
- Firmly attached to the jawbone at the time of the Injury.

**The treatment must be done in the calendar year of the accident or the next one.**

If:
- Crowns (caps), or
- Dentures (false teeth), or
- Bridgework, or
- In-mouth appliances,
- are installed due to such Injury, **Covered Medical Expenses** include only charges for:
  - The first denture or fixed bridgework to replace lost teeth,
  - The first crown needed to repair each damaged tooth, and
  - An in-mouth appliance used in the first course of **orthodontic treatment** after the Injury.

Surgery needed to:
- Treat a fracture, dislocation, or wound.
- Cut out cysts, tumors, or other diseased tissues.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- Non-surgical treatment of infections or diseases. This does not include those of, or related to, the teeth.

**Covered Medical Expenses** are payable at **90% of the Actual Charge**.

| Allergy Testing and Treatment Expense | Benefits include charges incurred for diagnostic testing and treatment of allergies and immunology services. **Covered Medical Expenses** include, but are not limited to, charges for the following:
| **Covered Medical Expenses** include, but are not limited to, charges for the following:
- Laboratory tests,
- Physician office visits, including visits to administer injections,
- Prescribed medications for testing and treatment of the allergy, including any equipment used in the administration of prescribed medication, and
- Other Medically Necessary supplies and services.

**Covered Medical Expenses** are payable as follows:
- **Preferred Care**: 90% of the **Negotiated Charge**.
- **Non-Preferred Care**: 70% of the **Recognized Charge**.
<table>
<thead>
<tr>
<th>Mental Health and Substance Abuse Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental and Emotional Disorders</strong></td>
</tr>
<tr>
<td><strong>Inpatient Expense</strong></td>
</tr>
<tr>
<td><strong>Covered Medical Expenses</strong> for the treatment of a mental health condition while confined as <strong>Inpatient</strong> in a <strong>Hospital</strong> or facility licensed for such treatment are payable as follows: Preferred Care: After a $50 per admission <strong>Copay</strong>, <strong>90%</strong> of the <strong>Negotiated Charge</strong>. Non-Preferred Care: After a $100 per admission <strong>Deductible</strong>, <strong>70%</strong> of the <strong>Recognized Charge</strong>. <strong>Covered Medical Expenses</strong> also include the charges made for treatment received during <strong>Partial Hospitalization</strong> in a <strong>Hospital</strong> 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 <strong>Inpatient</strong> admission, whereby <strong>2 days</strong> of <strong>Partial Hospitalization</strong> may be exchanged for <strong>1 day</strong> of full hospitalization.</td>
</tr>
<tr>
<td><strong>Mental and Emotional Disorders</strong></td>
</tr>
<tr>
<td><strong>Outpatient Expense</strong></td>
</tr>
<tr>
<td><strong>Covered Medical Expenses</strong> for <strong>Outpatient</strong> treatment of a mental health condition are payable as follows: Preferred Care: After a $20 per visit <strong>Copay</strong>, <strong>100%</strong> of the <strong>Negotiated Charge</strong>. Non-Preferred Care: After a $35 per visit <strong>Deductible</strong>, <strong>100%</strong> of the <strong>Recognized Charge</strong>. <strong>Covered Medical Expenses</strong> include diagnosis, assessment and services (including treatment that is educational or habilitative in nature) for <strong>Covered Persons</strong> from birth to age 19 for Autism Spectrum Disorder (ASD). For purposes of this benefit, ASD means Autistic Disorder, Asperger syndrome, pervasive development disorder not otherwise specified. <strong>Covered Medical Expenses</strong> are payable on the same basis as any <strong>Sickness</strong>.</td>
</tr>
<tr>
<td><strong>Substance Abuse</strong></td>
</tr>
<tr>
<td><strong>Inpatient Expense</strong></td>
</tr>
<tr>
<td><strong>Covered Medical Expenses</strong> for the treatment of a substance abuse condition while confined as <strong>Inpatient</strong> in a <strong>Hospital</strong> or facility licensed for such treatment are payable as follows: Preferred Care: After a $50 per admission <strong>Copay</strong>, <strong>90%</strong> of the <strong>Negotiated Charge</strong>. Non-Preferred Care: After a $100 per admission <strong>Deductible</strong>, <strong>70%</strong> of the <strong>Recognized Charge</strong>. <strong>Covered Medical Expenses</strong> also include the charges made for treatment received during <strong>Partial Hospitalization</strong> in a <strong>Hospital</strong> 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 <strong>Inpatient</strong> admission, whereby <strong>2 days</strong> of <strong>Partial Hospitalization</strong> may be exchanged for <strong>1 day</strong> of full hospitalization.</td>
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</tr>
<tr>
<td><strong>Outpatient Expense</strong></td>
</tr>
<tr>
<td><strong>Covered Medical Expenses</strong> for <strong>Outpatient</strong> treatment of a substance abuse condition are payable as follows: Preferred Care: After a $20 per visit <strong>Copay</strong>, <strong>100%</strong> of the <strong>Negotiated Charge</strong>. Non-Preferred Care: After a $35 per visit <strong>Deductible</strong>, <strong>100%</strong> of the <strong>Recognized Charge</strong>.</td>
</tr>
</tbody>
</table>
| Maternity Expense | Covered Medical Expenses include Inpatient care of the Covered Person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery. Any decision to shorten such minimum coverages shall be made by the attending Physician in consultation with the mother. If a Covered Person is discharged earlier, benefits will be payable for 2 post-delivery home visits by a health care provider. The first such visit shall occur within 48 hours of discharge. In such cases, covered services may include: home visits, parent education, and assistance and training in breast or bottle-feeding.

The home care visit will not be subject to any Deductible, Copay or insurance.

Covered Medical Expenses include services of a licensed midwife unless those services duplicate the services already provided by the Covered Person’s Physician.

Covered Medical Expenses for childbirth, and complications of pregnancy are payable on the same basis as any other Sickness.

**Prenatal Care**

Prenatal care will be covered for services received by a pregnant female in a Physician’s, obstetrician’s, or gynecologist’s office but only to the extent described below.

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

**Comprehensive Lactation Support and Counseling Services**

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

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

Covered Medical Expenses for Prenatal Care and Comprehensive Lactation Support and Counseling Services are payable as follows:

| Preferred Care | 100% of the Negotiated Charge. |
| Non-Preferred Care | Payable as any other Sickness. |

| Well Newborn Nursery Care Expense | Benefits include charges for routine care of a Covered Person’s newborn child as follows:

- Hospital charges for routine nursery care during the mother’s confinement, but for not more than four days,
- Physician’s charges for circumcision, and
- Physician’s charges for visits to the newborn child in the Hospital and consultations, but for not more than 1 visit per day.

Covered Medical Expenses are payable as follows:

| Preferred Care | 90% of the Negotiated Charge. |
| Non-Preferred Care | 70% of the Recognized Charge. |
## Additional Benefits

<table>
<thead>
<tr>
<th>Prescription Drug Benefit</th>
<th>Prescribed Drug* Annual Deductible: $50</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>After the Annual Deductible, Prescription Drug Benefits are payable as follows:</td>
</tr>
<tr>
<td></td>
<td>Preferred Care Pharmacy: 100% of the Negotiated Charge, following a $10 per prescription Copay for Generic Prescription Drugs, a $35 per prescription Copay for Brand Name Prescription Drug, a $60 per prescription Copay for Non-Formulary Drugs.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care Pharmacy: 70% of the Recognized Charge.</td>
</tr>
<tr>
<td></td>
<td>This Pharmacy benefit is provided to cover Medically Necessary Prescriptions associated with a covered Sickness or Accident occurring during the Policy Year. Covered Medical Expenses also include prescription smoking cessations aids. Please use your Aetna Student Health ID card when obtaining your prescriptions.</td>
</tr>
<tr>
<td></td>
<td>Prior Authorization is required for certain Prescription Drugs; for off-label use of Prescription Drugs for treatment of cancer, HIV or AIDS; Imitrex; certain stimulants; growth hormones and for any prescription quantities larger than a 30-day supply. <em>(This is only a partial list).</em></td>
</tr>
<tr>
<td></td>
<td>Medications not covered by this benefit include, but are not limited to: inhalers; all acne medications; drugs whose sole purpose is to promote or to stimulate hair growth; appetite suppressants and non-self injectables. <em>(This is only a partial list).</em></td>
</tr>
<tr>
<td></td>
<td>For assistance or for a complete list of excluded medications, or drugs requiring prior authorization, please contact Aetna Pharmacy Management at (800) 238-6279 (available 24 hours).</td>
</tr>
<tr>
<td></td>
<td>A Mail Order Pharmacy is available, contact Aetna Pharmacy Management for additional information.</td>
</tr>
<tr>
<td></td>
<td><em>Contraceptive Drugs and Device benefits are illustrated under the Family Planning Benefit of this Policy.</em></td>
</tr>
</tbody>
</table>

### Hospice Benefit

Covered Medical Expenses include charges for hospice care provided for a terminally ill Covered Person during a hospice benefit period.

Covered Medical Expenses are payable as follows:

- Preferred Care: 90% of the Negotiated Charge.
- Non-Preferred Care: 70% of the Recognized Charge.

### Licensed Nurse Expense

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.

For purposes of determining this maximum, a shift means 8 consecutive hours.

Covered Medical Expenses are payable as follows:

- Preferred Care: 90% of the Negotiated Charge.
- Non-Preferred Care: 70% of the Recognized Charge.

### Skilled Nursing Facility Expense

Covered Medical Expenses include charges incurred by a Covered Person for confinement in a Skilled Nursing Facility for treatment rendered:

- In lieu of confinement in a Hospital as a full time Inpatient, or
- Within 24 hours following a Hospital Confinement and for the same or related cause(s) as such Hospital Confinement.

Covered Medical Expenses are payable as follows:

- Preferred Care: After a $50 per admission Copay, 90% of the Negotiated Charge.
- Non-Preferred Care: After a $100 per admission Deductible, 70% of the Recognized Charge.
**Home Health Care Expenses**

**Covered Medical Expenses** include charges incurred by a **Covered Person** for **Home Health Care** services made by a **Home Health Agency** pursuant to a **Home Health Care Plan**, but only if:

a) The services are furnished by, or under arrangements made by, a licensed **Home Health Agency**.

b) The services are given under a home care plan. This plan must be established pursuant to the written order of a **Physician**, and the **Physician** must renew that plan every **60 days**. Such **Physician** must certify that the proper treatment of the condition would require **Inpatient** confinement in a **Hospital** or **Skilled Nursing Facility** if the services and supplies were not provided under the **Home Health Care Plan**. The **Physician** must examine the **Covered Person** at least once a month.

c) Except as specifically provided in the **Home Health Care** services, the services are delivered in the patient’s place of residence on a part-time, intermittent visiting basis while the patient is confined.

d) The care starts within 7 days after discharge from a **Hospital** as an **Inpatient**, and

e) The care is for the same condition that caused the **Hospital** confinement, or one related to it.

**Home Health Care Services**

1) Part-time or intermittent nursing care by: a Registered Nurse (R.N.), a Licensed Practical Nurse (L.P.N.), or under the supervision on an R.N. if the services of an R.N. are not available,

2) Part time or intermittent **home health aide** services, that consist primarily of care of a medical or therapeutic nature by other than an R.N.,

3) Physical, occupational, speech therapy, or respiratory therapy,

4) Medical supplies, drugs and medicines, and laboratory services. However, these items are covered only to the extent they would be covered if the patient was confined to a **Hospital**,

5) Medical social services by licensed or trained social workers,

6) Nutritional counseling.

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

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

A visit means a maximum of 4 continuous hours of home health service.

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

- **Preferred Care**: 90% of the **Negotiated Charge**.
- **Non-Preferred Care**: 70% of the **Recognized Charge**.
| Early Intervention Services Expenses | 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.

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

**Covered Medical Expenses** are payable as any other Sickness.

There is a benefit maximum of $6,249 per Policy Year. |
| Rehabilitation Facility Expense | **Covered Medical Expenses** include charges incurred by a **Covered Person** for confinement as a full time **Inpatient** in a rehabilitation facility. Confinement in the rehabilitation facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of **Hospital** or **Skilled Nursing Facility** confinement.

**Covered Medical Expenses** are payable as follows:
- Preferred Care: 90% of the **Negotiated Charge**.
- Non-Preferred Care: 70% of the **Recognized Charge**. |
| Convalescent Facility Expense | Benefits include charges for **Room and Board** during a period of convalescent care and confinement.

**Covered Medical Expenses** are payable as follows:
- Preferred Care: After a $50 per admission **Copay**, 90% of the **Negotiated Charge**.
- Non-Preferred Care: After a $100 per admission **Deductible**, 70% of the **Recognized Charge**. |
| Acupuncture Expense | Acupuncture is a **Covered Medical Expense** when it is administered for the following indications by a health care provider, who is a legally qualified **Physician**, who is practicing within the scope of their license:
- Adult postoperative and chemotherapy nausea and vomiting
- Nausea of pregnancy
- Postoperative dental pain
- Fibromyalgia/myofacial pain
- Chronic low back pain secondary to osteoarthritis.

**Covered Medical Expenses** are payable as follows:
- Preferred Care: 90% of the **Negotiated Charge**.
- Non-Preferred Care: 70% of the **Recognized Charge**. |
| Acupuncture in Lieu of Anesthesia Expense | **Covered Medical Expenses** include acupuncture therapy when acupuncture is used in lieu of other anesthesia for a surgical or dental procedure covered under this Plan.

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

**Covered Medical Expenses** are payable on the same basis as any other Sickness. |
| **Dermatological Expense** | **Covered Medical Expenses** include charges for the diagnosis and treatment of skin disorders, excluding laboratory fees. Related laboratory expenses are covered under the **Outpatient** Expense Benefit.  
Benefits are payable on the same basis as any other **Sickness**.  
**Covered Medical Expenses do not include treatment for acne, or cosmetic treatment and procedures.** |
| **Diagnostic Testing for Attention Disorders and Learning Disabilities Expense** | **Covered Medical Expense** includes coverage for the diagnosis and treatment of attention deficit hyperactivity disorder (ADHD).  
**Covered Medical Expenses** are payable as follows:  
**Preferred Care:** 90% of the **Negotiated Charge**.  
**Non-Preferred Care:** 70% of the **Recognized Charge**. |
| **Second Surgical Opinion Expense** | To the extent that this Policy provides coverage for surgery; this Policy shall provide coverage for expenses incurred for a second opinion consultation by a specialist on the need for non-elective surgery or cancer consultation 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.  
**Covered Medical Expenses** are payable on the same basis as any **Sickness**. |
| **Diabetic Testing Supplies and Equipment Expense** | **Covered Medical Expenses** include equipment, supplies and **Prescription Drugs** considered **Medically Necessary** to manage and treat diabetes.  
Diabetic Testing Supplies and Equipment benefits include:  
• Blood glucose monitors and blood glucose testing strips,  
• Blood glucose monitors designed to assist the visually impaired,  
• Insulin pumps and all related and necessary supplies,  
• Ketone urine test strips,  
• Lancets and lancet puncture devices,  
• Pen delivery systems for the administration of insulin,  
• Podiatric devices to prevent or treat diabetes-related complications,  
• Insulin syringes  
• Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin  
• Insulin  
• Prescriptive medications for the treatment of diabetes  
• Glucagon  
**Covered Medical Expenses** are payable on the same basis as any other **Sickness**. |
| **Hypodermic Needles Expense** | **Covered Medical Expenses** for hypodermic needles and syringes used in the treatment of diabetes are payable same basis as any other condition. |
| Diabetic Daycare Self-Management Education Programs | **Covered Medical Expenses** for Diabetic Daycare Self-Management Education Programs include programs directed and supervised by a licensed **Physician** who is board certified in internal medicine or pediatrics. Diabetic daycare self-management and education programs will be provided by health care professionals including, but not limited to, **Physicians**, Registered Nurses, Registered Pharmacists, and Registered Dieticians who are knowledgeable about the disease process of diabetes and the treatment of diabetic patients. As used in this section, diabetic daycare self-management education programs means instruction which will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy thereby avoiding frequent hospitalizations and complications. These programs do not include programs whose sole or primary purpose is weight reduction. **Covered Medical Expenses** are payable on the same basis as any other **Sickness**. |
| Non Prescription Enteral Formula Expense | **Covered Medical Expenses** include charges incurred for special dietary treatment, both tube-fed and oral, when **Medically Necessary** and **Physician** recommended. **Covered Medical Expenses** are payable as follows: **Preferred Care**: 90% of the **Negotiated Charge**. **Non-Preferred Care**: 70% of the **Recognized Charge**. |
| Morbid Obesity Expense | Coverage for the treatment of morbid obesity through gastric bypass surgery or such other methods as recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity. These expenses are payable on the same basis as any other **Sickness**. |
| Bone Marrow & Stem Cell Transplants for Breast Cancer Expense | 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. These expenses are payable on the same basis as any other **Sickness**. |
For females with reproductive capacity, **Covered Medical Expenses** include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this benefit must be approved by the Food and Drug Administration (FDA).

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

The following contraceptive methods are **Covered Medical Expenses** under this benefit:

**Voluntary Sterilization**

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

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

**Contraceptives**

**Covered Medical Expenses** include charges made by a **Physician** or **Pharmacy** for:

- Female contraceptives that are *Generic Prescription Drugs*. The prescription must be submitted to the pharmacist for processing. *This contraceptives benefit covers only Generic Prescription Drugs.*
- Female contraceptive devices and related services and supplies that are *generic prescription* devices when prescribed in writing by a **Physician**. *This contraceptives benefit covers only those devices that are Generic Prescription Devices.*
- FDA-approved female over-the-counter contraceptive methods that are prescribed by your **Physician**. The **Prescription** must be submitted to the pharmacist for processing. These items are limited to one per day and a **30 day** supply per **Prescription**.

**Limitations**

Unless specified above, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this Plan,
- Services and supplies incurred for an abortion,
- Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care,
- Services which are for the treatment of an identified **Illness** or **Injury**, 
- Services that are not given by a **Physician** or under his or her direction,
- Psychiatric, psychological, personality or emotional testing or exams,
- Any contraceptive methods that are only “reviewed” by the FDA and not “approved” by the FDA,
- **Male** contraceptive methods, sterilization procedures or devices,
- The reversal of voluntary sterilization procedures, including any related follow-up care.

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

- **Preferred Care**: 100% of the **Negotiated Charge**.
- **Non-Preferred Care**: 70% of the **Recognized Charge**.

**Important note**: **Brand-Name Prescription Drug** or Devices will be covered at **100%** of the **Negotiated Charge**, including waiver of Annual **Deductible** if a **Generic Prescription Drug** or Device is not available in the same therapeutic drug class or the prescriber specifies Dispense as Written.
| Prosthetic Devices Expense | **Covered Medical Expenses** include charges for prosthetic and orthotic devices that are **Medically Necessary** to restore or maintain the ability to complete activities of daily living or essential job-related activities and that are not solely for comfort or convenience.  

**Covered Medical Expenses** will include all services and supplies **Medically Necessary** for the effective use of a prosthetic or orthotic device, including formulating its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments, and instructing the patient in the use of the device. Wigs required as a result of chemo or radiation therapy.  

As used in this section, Orthotic device means a rigid or semirigid device supporting a weak or deformed leg, foot, arm, hand, back or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck. Prosthetic device means an artificial limb device or appliance designed to replace in whole or in part an arm or a leg.  

Benefits are payable at the lesser of 80% of **Actual Charges** or 100% of Medicare Allowable.  

The initial purchase and installation of a prosthetic device is not subject to any **Copay** or **Deductible**.  

Repair and replacement of such prosthetic devices are covered provided that such repair or replacement is not due to loss or misuse of the device. These repair/replacement benefits are subject to **Copay** and/or deductible.  

**Covered Medical Expenses** also include charges for a scalp hair prosthesis worn for hair loss as a result of alopecia areata, alopecia totalis, alopecia medicamentosa resulting from the treatment of any form of cancer or leukemia, or permanent loss of scalp hair due to Injury.  

Scalp hair prosthesis are limited to $350 per **Policy Year**.  

**Covered Medical Expenses** include the professional services associated with the practice of fitting, dispensing, servicing, or sale of hearing instruments or hearing aids by a hearing instrument dispenser or other hearing care professional.  

Hearing Aids Expenses are limited to one hearing aid for each ear every three years. |
| --- | --- |
| Temporomandibular Joint Dysfunction (TMJ) Expense | **Covered Medical Expenses** include charges incurred by a **Covered Person** for the diagnosis and surgical treatment involving any bone or joint of the head, neck, face or jaw if the treatment is required due to a medical condition or Injury which prevents normal function of the bone or joint.  

**Covered Medical Expenses** are payable on the same basis as any other **Sickness**. |
| Transfusion or Dialysis of Blood Expense | **Covered Medical Expenses** include charges for the transfusion or dialysis of blood, including the cost of: whole blood, blood components, and the administration thereof.  

**Covered Medical Expenses** are payable on the same basis as any other **Sickness**. |
| Podiatric Expense | **Covered Medical Expenses** include orthotic and prosthetic devices prescribed by surgeons or doctors of podiatric medicine. Any coverage for prosthetic devices shall include original and replacement devices, as prescribed by a **Physician** and surgeon or doctor of podiatric medicine acting within the scope of his or her license.  

**Covered Medical Expenses** include special footwear needed by persons who suffer from foot disfigurement. As used in this section, foot disfigurement shall include, but not be limited to, disfigurement from cerebral palsy, arthritis, polio, spina bifida, and diabetes, and foot disfigurement caused by Accident or developmental disability.  

**Covered Medical Expenses** are payable on the same basis as any other **Sickness**. |
<table>
<thead>
<tr>
<th>Preventive Treatment</th>
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</table>
| **Routine Physical Exam Expense** | Benefits include expenses for a routine physical exam performed by a **Physician**. If charges for a routine physical exam given to a child who is a **Covered Dependent** are covered under any other benefit section, those charges will not be covered under this section.  

A routine physical exam is a medical exam given by a **Physician**, for a reason other than to diagnose or treat a suspected or identified **Injury** or **Sickness**. Included as a part of the exam are:
- Routine vision and hearing screenings given as part of the routine physical exam.
- X-rays, lab, and other tests given in connection with the exam, and
- Materials for the administration of immunizations for infectious disease and testing for tuberculosis.

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

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

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- For females, screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services, such as:
    - Interpersonal and domestic violence,
    - Sexually transmitted diseases, and
    - Human Immune Deficiency Virus (HIV) infections.
- Screening for gestational diabetes.
- High risk Human Papillomavirus (HPV) DNA testing for women age 18 and older and limited to once every three years.
- X-rays, lab and other tests given in connection with the exam. Immunizations for infectious diseases and the materials for administration of immunizations that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- If the plan includes **Dependent** coverage, for covered newborns, an initial **Hospital checkup**.

For a **child** who is a **Covered Dependent**, the physical exam must include at least:
- A review and written record of the patient's complete medical history,
- A check of all body systems, and
- A review and discussion of the exam results with the patient or with the parent or guardian.

For all exams given to a **Covered Dependent under age 2**, **Covered Medical Expenses** will **not include** charges for the following:
- **More than 6** exams performed during the first year of the child's life,
- **More than 2** exams performed during the second year of the child's life.

For all exams given to a **Covered Dependent from age 2 and over**, **Covered Medical Expenses** will **not include** charges for **more than** one exam in 12 months in a row.
| Routine Physical Exam Expense continued | For all exams given to a **Covered Student** or a spouse who is a **Covered Dependent**, **Covered Medical Expenses** will **not include** charges for **more than** one exam in 12 months in a row.

**Covered Medical Expenses** incurred by a woman are charges made by a **Physician** for one annual routine gynecological exam.

**Screening and Counseling Services:**
**Covered Medical Expenses** include charges made by a **Physician** in an individual or group setting for the following:

**Obesity**
Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:
- Preventive counseling visits and/or risk factor reduction intervention,
- Medical nutrition therapy,
- Nutritional counseling, and
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

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

**Use of Tobacco Products**
Screening and counseling services to aid a **Covered Person** to stop the use of tobacco products. Coverage includes Preventive counseling visits, treatment visits, and class visits, to aid a **Covered Person** to stop the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including: cigarettes, cigars, smoking tobacco, snuff, smokeless tobacco, and candy-like products that contain tobacco.

**Limitations:**
Unless specified above, not covered under this Screening and Counseling Services benefit are charges incurred for services which are covered to any extent under any other part of this Plan.

| Routine Colorectal Cancer Screening Expense | **Covered Medical Expenses** include charges incurred by a **Covered Person** for colorectal cancer examination and laboratory tests; for any nonsymptomatic **Covered Person**, in accordance with standard, accepted published medical practice guidelines for colorectal cancer screening, who is:
- At least fifty (50) years of age; or
- Less than fifty (50) years of age and at high risk for colorectal cancer according to the standard, accepted published medical practice guidelines.

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

| Pap Smear Screening Expense | **Covered Medical Expenses** include one routine annual Pap smear screening (or an alternative cervical cancer screening test when recommended by a **Physician** or a health care provider), and an FDA approved human papillomavirus screening test for women age 18 and older.

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

**Covered Medical Expenses** include one baseline mammogram for women between age 35 and 40. Coverage is also provided for one routine annual mammogram for women age 40 and older, as well as when medically indicated for women with risk factors who are under age 40. Risk factors for women under 40 are:

- Prior personal history of breast cancer
- Positive Genetic Testings
- Family history of breast cancer; or
- Other risk factors

Mammogram screenings coverage will also include comprehensive ultrasound screening for the entire breast or breasts if a mammogram demonstrates heterogenous or dense breast tissue and when determined to be **Medically Necessary** by a licensed **Physician**.

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

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

### Routine Screening for Sexually Transmitted Disease Expense

**Covered Medical Expenses** include charges for **Covered Persons** who are at least 18 years old and who are sexually active for annual routine screening for sexually transmitted diseases.

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

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

### Routine Prostate Cancer Screening Expense

**Covered Medical Expenses** include charges incurred by a **Covered Person** for the screening of cancer in accordance with the latest screening guidelines issued by the American Cancer Society for the ages, family histories and frequencies referenced in such guidelines.

Plans cover one annual (or more frequently if recommended by a **Physician**) digital rectal exam and PSA test.

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

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

### Vision Care Exam Expense

Benefits include charges for any service shown below which is furnished by a legally qualified ophthalmologist or optometrist.

Routine Eye Exam Expenses include charges for a complete eye exam that includes refraction. A routine eye exam does not include charges for a contact lens exam.

Contact Lens Exam Expenses: Charges for an eye exam performed for the sole purpose of the fitting of contact lenses.

Benefits are limited to one routine eye exam and one contact lens exam per **Policy Year**.

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

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

**Limitations**

No benefits will be payable for a charge which is:

- For any eye exam to diagnose or treat a disease or **Injury**.
- For drugs or medicines.
- For a vision care service that is a **Covered Medical Expense** in whole or in part, under any other part of this Plan, or under any other group plan.
- For a vision care service for which a benefit is provided in whole or in part, under any workers’ compensation law or any other law of like purpose.
<table>
<thead>
<tr>
<th>Vision Care Exam Expense continued</th>
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<tbody>
<tr>
<td>• For special procedures. This means things such as orthoptics or vision training.</td>
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<tr>
<td>• For any vision care supply.</td>
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<tr>
<td>• For an eye exam which:</td>
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<tr>
<td>- is required by an employer as a condition of employment, or</td>
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<td>- an employer is required to provide under a labor agreement, or</td>
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<td>- is required by any law of a government.</td>
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<tr>
<td>• For a service received while the person is not a Covered Person.</td>
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<tr>
<td>• For a service which does not meet professionally accepted standards.</td>
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<tr>
<td>• For any exams given while the person is confined in a Hospital or other facility for medical care.</td>
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<thead>
<tr>
<th>Routine Hearing Exam Expense</th>
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<tr>
<td>Benefits include charges for an audiometric exam. The services must be performed by a Physician certified as an otolaryngologist or otologist, or an audiologist who either:</td>
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<tr>
<td>• Is legally qualified in audiology, or</td>
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<tr>
<td>• Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements, and</td>
</tr>
<tr>
<td>• Who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.</td>
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<tr>
<td>Covered Medical Expenses are payable as follows:</td>
</tr>
<tr>
<td>Preferred Care: 100% of the Negotiated Charge.</td>
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<tr>
<td>Non-Preferred Care: 100% of the Recognized Charge.</td>
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<tr>
<td>The maximum number of Routine Hearing exams is 1 per Policy Year.</td>
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</table>

**Limitations**

No benefits will be payable for a charge which is:

• For any ear or hearing exam to diagnose or treat a disease or Injury.
• For drugs or medicines.
• For any hearing care service or supply which is a covered expense in whole or in part, under any other part of this Plan, or under any other group plan.
• For any hearing care service or supply for which a benefit is provided under any workers’ compensation law, or any other law of like purpose, whether benefits are payable as to all, or only part of the charges.
• For any hearing care service or supply which does not meet professionally accepted standards.
• For any service or supply received while the person is not covered.
• For any exams given while the person is confined in a Hospital, or other facility for medical care.
• For hearing aids, and the fitting or prescription of hearing aids.
• For any exam which:
  • Is required by an employer as a condition of employment, or
  • An employer is required to provide under a labor agreement, or
  • Is required by any law of a government.
ADDITIONAL SERVICES AND DISCOUNTS

As a member of the Plan, you can also take advantage of the following services, discounts, and programs. These are not underwritten by Aetna and are not insurance. Please note that these programs are subject to change. To learn more about these additional services and search for providers, visit www.aetnastudenthealth.com/schools/RegentUniversity.

**Aetna BookSM discount program:** Access to discounts on books and other items from the American Cancer Society Bookstore, the MayoClinic.com Bookstore and Pranamaya.

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

**Aetna HearingSM discount program:** Access to discounts on hearing aids and hearing tests from HearPO. Guaranteed lowest pricing* on over 1000 models from seven leading manufacturers.

*Competitor copy required for verification of price and model. Limited to manufacturers offered through the HearPO program. Local provider quotes only will be matched, no internet quotes

**Aetna Natural Products and ServicesSM discount program:** Access to reduced rates on services from participating providers for acupuncture, chiropractic care, massage therapy and dietetic counseling. Also, access to discounts on over-the-counter vitamins, herbal and nutritional supplements and natural products. All products and services are provided through American Specialty Health Incorporated (ASH) and its subsidiaries.

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

**Aetna Weight ManagementSM discount program:** Access to discounts on eDiets® diet plans and products, Jenny Craig® weight loss programs and products, and Nutrisystem® weight loss meal plans.

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

**At Home Products discount program**- Access to discounts on health care products that members can use in the privacy and comfort of their home.

**Aetna Specialty Pharmacy:** provides specialty medications and support to members living with chronic conditions and illnesses. These medications are usually injected or infused, or some may be taken by mouth. Custom compounded doses and forms are also available. For additional information please go to www.AetnaSpecialtyRx.com.

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

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

**Aetna’s Informed Health® Line:**

Call toll free (800) 556-1555 24 hours a day, 7 days a week. When you have an Aetna health benefits and health insurance plan, you have instant access to the information you need. Our tools and resources can help you: Make more informed decisions about your care; Communicate better with your doctors; and Save time and money, by showing you how to get the right care at the right time. When you call our Informed Health Line, you can talk directly to a registered nurse. Our nurses can discuss a wide variety of health and wellness topics. *

While only your doctor can diagnose, prescribe or give medical advice, the Informed Health Line nurses can provide information on more than 5,000 health topics. Contact your doctor first with any questions or concerns regarding your health care needs.

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

Use the Healthwise® Knowledgebase to find out more about a health condition you have or medications you take. It explains things in terms that are easy to understand.

Get to it through your secure Aetna Navigator® member website, at www.aetnastudenthealth.com.
GENERAL PROVISIONS

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

EXCESS PROVISION
This Plan is an excess only Plan. As an excess only Plan, this Plan pays its Covered Medical Expenses after any other medical coverage. This Plan’s liability will be determined without consideration to any limitation clause or clauses regarding other coverage contained in any other medical coverage. Benefits Payable under this Plan shall be limited to the Plan’s Covered Medical Expenses and reduced by the amount paid or payable by any other medical coverage. However, consideration will be given to the other medical coverage’s liability due to a provider contract or other reasons when calculating this Plan’s Benefits Payable.

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

“Other medical coverage” means, except for: gifts; donations; subrogation of any person’s right of recovery for personal injuries from a third person; or any individually underwritten and individually issued policy or subscription contract providing exclusively for Accident and Sickness benefits and for which the entire premium has been paid by the insured, a member of the insured’s family, or the insured’s guardian or conservator; any reimbursement for or recovery of any element of incurred covered charges available from any other source whatsoever whether through an insurance policy or other type of coverage, including but not limited to the following:
- Any group, accident-only, blanket, disability, health, or Accident and Sickness insurance.
- Any arrangement of benefits for members of a group, whether insured or uninsured.
- Any prepaid service arrangement such as Blue Cross or Blue Shield, individual or group practice plans or health maintenance organizations.
- Any amounts payable for injuries related to the Covered Person’s job to the extent that he or she actually received benefits under a Workers’ Compensation Law.
- Social Security Disability Benefits, except that Other Medical Insurance shall not include any increase in Social Security Disability Benefits payable to the Covered Person after the Covered Person becomes disabled while insured hereunder.
- Any benefits payable under any program provided or sponsored solely or primarily by any governmental agency or subdivision or through operation of law or regulation.

HMO/PPO Provision – In the event that expenses are denied under a Health Maintenance Organization, Preferred Provider Organization (PPO) or other group medical plan the Covered Person has in force, and such denial is because care or treatment was received outside of the network’s geographic area, benefits will be payable under this coverage, provided the expense is a Covered Medical Expense.
TERMINATION OF INSURANCE

Benefits are payable under this Plan 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 Plan terminates,
b) The last day for which any required premium has been paid,
c) The date on which the Covered Student withdraws from the school because of entering the armed forces of any country. Premiums will be refunded on a pro-rata basis 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 child’s 26th birthday.
b) The date the Covered Student fails to pay any required premium.
c) For the spouse, the date the marriage ends in divorce or annulment.
d) The date Dependent coverage is deleted from this Plan.
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

This Plan does not cover nor provide benefits for:

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

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: (a) is not a tooth or structure that supports the teeth; and is malformed, (b) as a result of a severe birth defect; including harelip; cleft lip/cleft palate, webbed fingers; or toes; or (c) as direct result of: disease; congenital defects or surgery performed to treat a disease or Injury.
   • Repair an Injury (including reconstructive surgery and prosthetic devices 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 incurred as a result of commission of a felony.

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

13. Expense incurred for services normally provided without charge by the school and covered by the school fee for services.

14. 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.
15. Expense incurred for **Injury** resulting from the play or practice of intercollegiate sports; collegiate intercollegiate club sports and intramurals are covered.

16. 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.

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

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

19. 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.

20. Expenses incurred for blood or blood plasma; except charges by a Hospital for the processing or administration of blood.

21. 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 drugs 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.

22. Expenses incurred for gynecomastia (male breasts).

23. Expenses incurred for any sinus surgery; except for acute purulent sinusitis.

24. Expenses incurred for: care; treatment; services; or supplies for or related to obstructive sleep apnea; and sleep disorders; including CPAP; and UPP.
25. 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.

26. Expense incurred for; or related to; services; treatment; testing; educational testing; training; or medication for Attention Deficit Disorder; or Learning Disabilities; or other developmental delays.

27. Expense incurred for alternative; holistic medicine; and/or therapy; including but not limited to; yoga and hypnotherapy.

28. 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.

29. 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.

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

31. Expense incurred for hearing aids; the fitting; or prescription of hearing aids, unless provided in policy.

32. Expense for services or supplies used to treat conditions related to hyperkinetic syndromes; learning disabilities; behavioral problems; mental retardation; or senile deterioration; beyond the period necessary to diagnose the condition.

33. 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.

34. Expense for telephone consultations, except as required by state mandate; charges for failure to keep a scheduled visit; or charges for completion of a claim form.

35. 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**.

36. Expense for services or supplies provided for the treatment of obesity and/or weight control, except 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.

37. Expense for incidental surgeries; and standby charges of a **Physician**.

38. Expense for services and supplies in connection with psychological testing; or neuropsychological testing.

39. 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.

40. Expense 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; or elective abortion.

41. Expenses incurred for massage therapy.

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

43. 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.
44. 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.

45. Expenses for treatment of **Injury** or **Sickness** to the extent payment is made; as a judgment or settlement; by any person deemed responsible for the **Injury** or **Sickness** (or their Insurers).

46. 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 health care provider; or health care facility; or
     - Those furnished solely because the person is an **Inpatient** on any day on which the person’s **Sickness** or **Injury** could safely; and adequately; be diagnosed; or treated; while not confined; or those furnished solely because of the setting; if the service or supply could safely and adequately be furnished in a **Physician’s** or a **dentist’s** office; or other less costly setting.

47. Expenses incurred for the treatment of acne.

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

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

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

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

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.

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.

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

Breast Cancer Diagnostic Services
A procedure intended to aid in the diagnosis of breast cancer, delivered on an Inpatient or Outpatient basis, including but not limited to mammogram, mammography, surgical breast biopsy, and pathologic examination and interpretation.

Breast Cancer Outpatient Treatment Services
A procedure intended to treat cancer of the human breast, delivered on an Outpatient basis, including but not limited to surgery, radiation therapy, chemotherapy, hormonal therapy, and related medical follow-up services.

Breast Cancer Rehabilitative Services
A procedure intended to improve the result of, or ameliorate the debilitating consequences of, treatment of breast cancer, delivered on an Inpatient or Outpatient basis, including by not limited to reconstructive plastic surgery, physical therapy, and psychological and social support services.

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

Complications of Pregnancy
Conditions which require a Hospital stay 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, 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 Plan which are:
- Not in excess of the Recognized Charges, or
- Not in excess of the charges that would have been made in the absence of this coverage,
- And incurred while this Plan is in force as to the Covered Person.

Covered Dependent
A Covered Student’s Dependent who is insured under this Plan.

Covered Medical Expense
Those charges for any treatment, service or supplies covered by this Plan which are:
- Not in excess of the Recognized Charges, or
- Not in excess of the charges that would have been made in the absence of this coverage, and
- Incurred while this Plan is in force as to the Covered Person except with respect to any expenses payable under the Extension of Benefit Provisions.

Covered Person
A Covered Student and any Covered Dependent while coverage under this Plan is in effect.

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

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

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

Dental Provider
This is any Dentist, group, organization, dental facility, or other institution, or person legally qualified to furnish dental services or supplies.

Dentist
A legally qualified Dentist. Also, a Physician who is licensed to do the dental work he 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 child under the age of 26.

The term “child” includes a Covered Student’s step-child, adopted child, and a child for whom a petition for adoption is pending.

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 Plan, 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 Physician’s office, or
• Hospital Outpatient department, or emergency room, or
• Clinical laboratory, or
• 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 **Recognized Charges** made by a **Hospice** for the following services or supplies: charges for **Inpatient** care, charges for drugs and medicines, charges for part-time nursing by 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 health care provider, or health care facility, or
• Those furnished solely because the person is an Inpatient on any day on which the person’s Sickness or Injury could safely and adequately be diagnosed or treated while not confined, or
• Those furnished solely because of the setting if the service or supply could safely and adequately be furnished, in a Physician's or a Dentist's office, or other less costly setting.

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.

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

Non-Occupational Disease
A Non-Occupational Disease is a disease that does not:
• Arise out of (or in the course of) any work for pay or profit, or
• Result in any way from a disease that does.

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the Covered Student:
• Is covered under any type of workers’ compensation law, and
• Is not covered for that disease under such law.
Non-Occupational Injury
A Non-Occupational Injury is an accidental bodily Injury that does not:

- Arise out of (or in the course of) any work for pay or profit, or
- Result in any way from an Injury which does.

Non-Preferred Care
A health care service or supply furnished by a health care provider that is not a Designated Care Provider, or that is not a Preferred Care Provider, if, as determined by Aetna:

- The service or supply could have been provided by a Preferred Care Provider, and
- The provider is of a type that falls into one or more of the categories of providers listed in the Directory.

Non-Preferred Care Provider

- A health care provider that has not contracted to furnish services or supplies at a Negotiated Charge, or
- A Preferred Care Provider that is furnishing services or supplies without the referral 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 Dental Provider. Such care is subject to specific limitations set forth in this Plan.

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

Partial Hospitalization
Continuous treatment consisting of not less than four hours and not more than twelve hours in any 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 for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months prior to the Covered Person’s enrollment in the Plan, or up to 6 months after the effective date of the Policy.

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,
- 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 Plan, but only while the contract remains in effect, and while such a Pharmacy dispenses a Prescription Drug, under the terms of its contract with Aetna.
Preferred Prescription Drug Expense
An expense incurred for a Prescription Drug that:

- Is dispensed by a Preferred Pharmacy, or for an Emergency Medical Condition only, by a Non-Preferred Pharmacy, and
- Is dispensed upon the Prescription of a Prescriber who is:
  - a Designated Care Provider or a Preferred Care Provider, or
  - a Non-Preferred Care Provider, but only for an emergency 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,
- Non-experimental medication for controlling blood sugar, if prescribed by a Physician, and
- Medications used in the treatment of foot ailments, infections, and other medical conditions of the foot, ankle, or nails associated with diabetes, if prescribed by a Physician.

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.

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.

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.

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

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

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

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

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

HOW TO APPEAL A CLAIM

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
P.O. Box 14464
Lexington, KY 40512

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

External Review

Aetna has developed an external review process to give members an added option of requesting an objective and timely external review of certain coverage denials. Once the Aetna internal coverage decision review process is exhausted, members may elect external review if the coverage denial for which the member would be financially responsible involves more than $500 and is based on lack of Medical Necessity or on the experimental or investigational nature of the proposed service or treatment.

An external review organization will refer the case to review by a neutral, independent Physician with appropriate expertise in the area in question. After all necessary information is submitted, external review generally will be decided within 30 days of the request. Expedited reviews are available when a member’s Physician certifies that a delay in service would jeopardize the member’s health. Once the review is complete, the Plan will abide by the decision of the external reviewer.

Certain states mandate external review of additional benefit or service issues or require a filing fee. In addition, certain states mandate the use of their own external review providers for Medical Necessity and experimental/investigational coverage decisions. For further details regarding your Plan’s grievance and external review process, call the Customer Services toll-free number on your ID card, or visit Aetna’s website at www.aetna.com, where you may obtain an external review request form. You may also call your State Insurance or Health Department for additional information regarding state mandated external review procedures.
PRESCRIPTION DRUG CLAIM PROCEDURE

When obtaining a covered prescription, please present your ID card to a Preferred Care Provider, 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 Care Provider, and be reimbursed by submitting a completed Aetna Prescription Drug claim form. You will be reimbursed for covered medications, less your Copay.

WORLDWIDE TRAVEL ASSISTANCE SERVICES

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

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

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

Natural Disaster and Political Evacuation Services (NDPE)
The following benefits are underwritten by United States Fire Insurance Company (USFIC), with security assistance services provided by On Call. If a Covered Person requires emergency evacuation due to governmental or social upheaval, which places him/her in imminent bodily harm (as determined by On Call security personnel in accordance with local and U.S. authorities), On Call will arrange and pay for his/her transportation to the nearest safe location, and then to the his/her home country. If a Covered Person requires emergency evacuation due to a natural disaster, which makes his/her location Uninhabitable, On Call will arrange and pay for his/her evacuation from a safe departure point to the nearest safe haven, and then home. Benefits are payable up to $100,000 per event per person.

Worldwide Emergency Travel Assistance (WETA) Services. On Call provides the following travel assistance services:
- 24/7 Emergency Travel Arrangements
- Translation Assistance
- Emergency Travel Funds Assistance
- Lost Luggage and Travel Documents Assistance
- Assistance with Replacement of Credit Card/Travelers Checks
- Medical/Dental/Pharmacy Referral Service
- Hospital Deposit Arrangements
- Dispatch of Physician
- Emergency Medical Record Assistance
- Legal Consultation and Referral
- Bail Bonds Assistance

The On Call International Global Response Center can be reached 24 hours a day, 365 days a year.
The information contained above is a just summary of the ADD, MER, WETA, and NDPE benefits and services available through On Call. For a copy of the plan documents applicable to the ADD, MER, WETA and NDPE coverage, including a full description of coverage, exclusions and limitations, please contact Aetna Student Health at www.aetnastudenthealth.com or (800) 966-7772.

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

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

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

These services, programs or benefits are offered by vendors who are independent contractors and not employees or agents of Aetna.
GOT QUESTIONS? GET ANSWERS WITH AETNA’S NAVIGATOR®

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

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

**How do I register?**

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

Administered by:
Aetna
P.O. Box 981106
El Paso, TX 79998
(888) 204-0187
www.aetnastudenthealth.com

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

Policy No. 697408

The Regent University Student Health Insurance Plan is underwritten by Aetna Life Insurance Company (ALIC) and administered by Chickering Claims Administrators, Inc. Aetna Student HealthSM is the brand name for products and services provided by these companies and their applicable affiliated companies.