

**2013 - 2014  
Penn Student  
Health Insurance Plan Brochure  
UNIVERSITY OF PENNSYLVANIA**



**Your student health insurance coverage, offered by Aetna Student Health\*, may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are \$2 million for policy years beginning on or after September 23, 2012, but before January 1, 2014. Restrictions for annual dollar limits for student health insurance coverage are \$500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014. Your student health insurance coverage includes an annual limit of \$2,000,000 on all covered services including Essential Health Benefits. Other internal maximums (on Essential Health Benefits and certain other services) are described more fully in the benefits chart included inside this Plan summary. If you have any questions or concerns about this notice, contact (800) 841-5374. 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.**

**\* Fully insured Aetna Student Health Insurance Plans are underwritten by Aetna Life Insurance Company (Aetna) and administered by Chickering Claims Administrators, Inc. Aetna Student Health is the brand name for products and services provided by these companies and their applicable affiliated companies.**

**Underwritten by:  
Aetna Life Insurance Company  
(ALIC)  
Policy Number 724535**

**aetna<sup>SM</sup>**

## **Student Health Service**

University of Pennsylvania  
3535 Market Street, Suite 100  
Philadelphia, PA 19104  
Telephone: **(215) 746-3535**  
E-mail: [shsinsur@pobox.upenn.edu](mailto:shsinsur@pobox.upenn.edu)  
Website: <http://www.vpul.upenn.edu/shs/insurance.php>  
**Penn Student Insurance Plan (PSIP)**

## **WHERE TO FIND HELP**

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In case of an emergency, call **911** or your local emergency hotline, or go directly to an emergency care facility.  
For non-emergency situations please visit or call Student Health Service at **(215) 746-3535**.

### **For questions about:**

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

#### *Please contact:*

Aetna Student Health  
P.O. Box 981106  
El Paso, TX 79998  
**(800) 841-5374**

### **For questions about:**

- ID Cards

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

#### *For lost ID cards, contact:*

Aetna Student Health  
**(800) 841-5374**

### **For questions about:**

- Enrollment Forms
- Waiver Process
- University Health Services Referrals
- Late Enrollment Guidelines (for Spouse, dependents, life-change, and newborns)
- Benefits
- Penn Authentication

#### *Please contact:*

Student Health Service  
University of Pennsylvania  
3535 Market Street, Suite 100  
Philadelphia, PA 19104  
**(215) 746-3535** or email [shsinsur@pobox.upenn.edu](mailto:shsinsur@pobox.upenn.edu)

### **For questions about:**

- Status of Pharmacy Claim
- Pharmacy Claim Forms
- Excluded Drugs and Pre-Authorization

*Please contact:*

Aetna Pharmacy Management  
**(888) RX-AETNA or (888) 792-3862** (Available 24 hours)

**For questions about:**

- Provider Listings

*Please contact:*

Aetna Student Health  
**(800) 841-5374**

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

**For questions about:**

On Call International 24/7 Emergency Travel Assistance Services

*Please contact:*

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

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

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

## **IMPORTANT NOTE**

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

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

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## STUDENT HEALTH SERVICE

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Dear Student,

Student wellness is essential to academic progress. In accordance with our institutional responsibility to safeguard the health and well-being of all students, the University maintains programs to ensure that students have access to health care along with health insurance to cover the costs of care. This Brochure describes the options for health insurance for students at the University of Pennsylvania. Please take a moment to review this information, so that you are familiar with our services.

The University provides outpatient medical care to students through the Student Health Service (SHS), a department of the Office of the Vice Provost for University Life. All full-time status students have coverage for care at the Student Health Service. The Student Health Service offers an array of clinical services, including initial and follow-up treatment of acute medical illness and injury, management of chronic health problems, health screening and preventive care. We also coordinate referrals to specialists outside of Student Health. The Student Health Service Brochure describes the services that we offer; detailed information is available on the SHS website (<http://www.vpul.upenn.edu/shs/insurance.php>). The focus of the Student Health Service is outpatient primary care, therefore, students also need medical insurance to cover the costs of care and services outside of SHS. All full-time students must have health insurance coverage for both inpatient and outpatient medical care and must provide information about their insurance coverage each year.

As a condition of enrollment in the University, full-time, dissertation-status, and exchange students (here for one semester or more) are required to either actively enroll the Penn Student Insurance Plan (PSIP) or provide proof of acceptable alternative coverage. Both of these actions are done via a secure website.

This Brochure describes the coverage available to you through the Penn Student Insurance Plan. If you are already covered through a health insurance plan, please take a few moments to review the provisions of that plan. Health insurance plans vary in the coverage they offer. Some provide excellent protection at home, but do not cover students while they are at school, studying abroad, or traveling. The Penn Student Insurance Plan has been developed to provide a comprehensive range of benefits for students whether they are here at Penn or traveling.

We have enclosed a guide that explains how to file your selection for coverage. All selections, whether enrollment in PSIP or waiver of coverage, must be submitted online. Insurance information submitted to other offices is not forwarded to the insurance workplace.

Our Insurance Office staff is available to answer any questions that you may have about PSIP, feel free to contact the Penn Student Insurance Office at **(215) 746-3535 menu option #3**, or send an email to: [shsinsur@pobox.upenn.edu](mailto:shsinsur@pobox.upenn.edu).



Evelyn Wiener, MD Director

## **POLICY PERIOD**

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For early start Graduate students who want to begin their coverage **July 1, 2013** or **August 1, 2013**, please contact the Student Health Insurance Office for an application. New Undergraduate and returning Graduate students may begin their coverage on **August 15, 2013**.

1. **Students:** Coverage for all insured students enrolled for the Fall Semester, will become effective at 12:01 a.m. (EST) on **August 15, 2013**, and will terminate at 11:59 p.m. (EST) on **July 31, 2014**, except for students who graduate in December whose plans will terminate at 11:59 p.m. (EST) on **February 06, 2014**.
2. **New Spring Semester Students:** Coverage for all insured students enrolled for the Spring Semester, will become effective at 12:01 a.m. (EST) on **January 01, 2014**, and will terminate at 11:59 p.m. (EST) on **July 31, 2014**.
3. **New Summer 2013 Students:** Coverage for all insured students enrolled for Summer Semester will become effective at 12:01 a.m. (EST) on **May 1, 2014**, and will terminate at 11:59 p.m. (EST) on **July 31, 2014**.
4. **Insured Dependents:** Coverage will become effective on the same date the insured student's coverage becomes effective, or the day after the postmarked date when the completed application and premium are sent, if later. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Master Policy. For more information on Termination of Covered Dependents see page (36) 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.
5. **December Graduates:** If you are a December Graduate, your coverage will terminate at 11:59 p.m. (EST) on **February 06, 2014**. If you have enrolled dependents, their coverage will terminate in conjunction with your own. After enrollment, students may only add a spouse, child, or a domestic partner according to the Spouse/Domestic Partner and Newborn and Adopted Children Enrollment guidelines.
6. **Students on Leave of Absence, or who drop or withdraw from the University after the first 30 days of classes.** Your coverage will terminate at 11:59 p.m. (EST) on **February 06, 2014** unless you enroll in classes in the spring term by **February 06, 2014**. If you have enrolled dependents, their coverage will terminate in conjunction with your own. After enrollment, students may only add a spouse, child, or a domestic partner according to the Spouse/Domestic Partner and Newborn and Adopted Children Enrollment guidelines.

The carrier reserves the right to make the final determination regarding eligibility for initial and continued enrollment in this Plan.

## RATES

<b>Cost Undergraduate and Graduate Students</b>			
	<b>Annual 08/15/13 – 07/31/2014</b>	<b>Spring Semester 01/01/2014 – 07/31/2014</b>	<b>Summer 05/01/14 – 07/31/2014</b>
Student	<b>\$2,774</b>	<b>\$1,677</b>	<b>\$730</b>
Spouse	<b>\$4,146</b>	<b>\$2,506</b>	<b>\$1,090</b>
One Child	<b>\$4,146</b>	<b>\$2,506</b>	<b>\$1,090</b>
Two or More Children	<b>\$4,880</b>	<b>\$2,949</b>	<b>\$1,282</b>

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

### **Financial Aid:**

For students in graduate and professional programs, the cost of the health insurance plan is already incorporated into the cost-of-attendance budget used for purposes of financial aid and student loan eligibility.

For undergraduates, the Federal Direct Loan Program and Parent Loan Program (PLUS) are available to help meet this expense, as long as the student has completed a FAFSA. In some cases, depending on the individual student's level of financial need, grant assistance may be available to aided students. If you have any questions, contact Student Financial Services. <http://www.sfs.upenn.edu/contacts/index.htm>.

## **UNIVERSITY OF PENNSYLVANIA STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN**

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

## STUDENT COVERAGE

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### **ELIGIBILITY**

All students of the University who are registered and are actively participating in credit courses leading to a degree or a certificate are eligible to participate in the Penn Student Insurance Plan (PSIP).

**NOTE: English Language Program (ELP) students are not eligible for PSIP and should contact their Program Director for other options.**

**Students must actively attend classes within the first 31 days after the date for which coverage is purchased. Internet classes and television (TV) courses may not fulfill the eligibility requirement that the covered student actively attends classes. If the eligibility requirements are not met, Aetna's only obligation is to refund the premium.**

### **ENROLLMENT**

**Your PennKey and Password authentication is required. For details, please go to <http://www.upenn.edu/computing/pennkey/>.**

Each school year, all full-time, dissertation and exchange students here for one semester or more must either enroll in PSIP or waive coverage with proof of comparable coverage by the stated deadline. Selections from previous years are not rolled forward or renewed. Students who do not enroll or waive participation in the Plan by the stated deadline will be subject to default enrollment in PSIP with student coverage only. Dependents are not default enrolled.

Part-time students are eligible to purchase this coverage as well, however, they are not default enrolled in the Plan.

### **Enrollment Deadline Dates**

Fall – 08/31/2013

Spring – 1/31/2014

Summer – 05/31/2014

Students who wish PSIP coverage are required to actively enroll online to ensure continuation of insurance benefits without disruption and to guarantee coverage in the event that their student registration status changes.

Eligible students can enroll online at <http://www.vpul.upenn.edu/shs/insurance.php>

(follow the links to the enrollment site). You must have your PennKey to access the system

### **CONTINUATION OF COVERAGE**

A **covered student** who has graduated or is otherwise ineligible for coverage under this Plan, and has been continuously insured under the Plan offered by the Policyholder (regular student Plan), may be covered for four and a half months provided that: (1) the **covered student** and **covered dependent** were covered by the regular student Plan for at least six months (2) a written request for continuation has been forwarded Aetna prior to August 31, 2013 and (3) premium payment has been made. Coverage under this provision ceases on the date this Plan terminates.

	<b>4.5 Months 8/15/13-12/31/13</b>
<b>Student Only:</b>	<b>\$2,183</b>
<b>Spouse/Domestic Partner:</b>	<b>\$4,647</b>
<b>Child(ren):</b>	<b>\$3,789</b>

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

### ***APPROVED LEAVE OF ABSENCE (LOA)***

**Students on approved medical or academic leave of absence may voluntarily continue their coverage for up to twelve months following the termination of their regular student coverage.**

**Students should contact the Penn Student Health Insurance Office for the appropriate approval form and Enrollment Forms. Payment must be made directly to Aetna Student Health.**

1. The Carrier reserves the right to make the final determination regarding eligibility for initial and continued enrollment in this Plan.
2. Students on judicial or dropped status are not eligible for Leave of Absence coverage through PSIP and should contact the Student Health Insurance Office to determine if other options for insurance coverage are available.
3. Students applying for Annual Leave of Absence coverage must have been insurance under the PSIP for the previous semester.
4. Leave of Absence students are not eligible for care at Student Health Service (SHS) and therefore not subject to the referral requirement.

### ***STUDY ABROAD STUDENTS***

If you are in a Study Abroad program in the Fall, you will not be enrolled in PSIP by the University. To enroll, you must actively enroll online prior to the **August 31, 2013** deadline.

If you choose not to enroll, and return to Penn in the spring semester, you must either actively enroll in PSIP or request a waiver online. Students who do not make a selection by **January 31, 2014** will be enrolled in PSIP by the University effective **January 1, 2014** and billed the **\$1,677** rate.

*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 PROCESS/PROCEDURE**

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Students who are covered under a health insurance plan that meets the criteria for alternative coverage may choose to waive participation in the (PSIP) Plan.

Students who wish to request a waiver of PSIP coverage must do so online.

Go to <http://www.vpul.upenn.edu/shs/insurance.php> and follow the links to the waiver site. You must have your PennKey to access the system and provide proof of alternative coverage by the specified deadline date(s). Students whose plans do not meet the minimum standards will be alerted and must bring their coverage up to an acceptable level prior to the waiver deadline date in order to waive participation in the Plan.

Full-time, dissertation and exchange students here for one semester or more whose plans do not meet the minimum standards will be required to document acceptable coverage by **August 31, 2013** or they will be enrolled in PSIP by the University. Students who matriculate in **July, August, or September 2013** must submit a waiver no later than **August 31, 2013**. Part-time students who become full-time at any point during the academic year will be subject to the requirement. The University reserves the right to audit all waivers to ensure compliance with University insurance standards and to enroll students into PSIP if their insurance plan does not meet the criteria for alternative coverage.

After the waiver deadline, students cannot cancel their PSIP coverage. Your waiver of previous Plan Years for PSIP will not roll forward to a new academic year. Students must request a waiver each academic year. Students who fail to submit a waiver request before the deadline will be billed for and enrolled in PSIP's annual plan.

### ***NON-RESPONDERS TO WAIVER PROCESS/PROCEDURE***

All full-time, dissertation and exchange students here for one semester or more are required to submit an online waiver request or enroll in PSIP online.

Students who are subject to the insurance requirement and do not respond by the following response due dates will be enrolled with student coverage only in PSIP by the University: New students beginning studies in **July, August, or**

**September** and returning students who do not enroll or waive online by **August 31, 2013** will be enrolled in the PSIP effective **August 15, 2013**. The **2013-2014** PSIP is an annual plan, with a premium of **\$2,774**. The premium is billed in two installments directly to student accounts and is subject to the payment guidelines of Student Financial Services.

New full-time, dissertation-status and exchange students here for one semester or more beginning studies in the spring semester who do not enroll or submit a waiver of alternative coverage by **January 31, 2014** will be enrolled in the PSIP effective **January 1, 2014** and billed the spring semester premium of **\$1,677**. Students may not withdraw or cancel coverage in the Plan once the waiver deadline has passed.

<b>Category</b>	<b>Waiver Deadline Date</b>
Students enrolling for the Fall Semester	<b>08/31/2013</b>
Students enrolling for the Spring Semester	<b>01/31/2014</b>

***LATE ENROLLMENT***

Coverage for late enrollees may be possible only under certain conditions. After the enrollment deadline, only those students who have involuntarily lost health insurance coverage through a “Qualifying Life Event” such as 1) removal from parent’s health insurance coverage after achieving a landmark birthday that disqualifies them from a parent’s health insurance plan or 2) losing private health insurance through loss of employment or divorce, may apply for late enrollment.

A certificate of credible coverage stating the date of the involuntary loss of health coverage and a signed application must be submitted to the Student Health Insurance Office within 31 days of the qualifying life event. Please contact the Student Health Insurance Office for details.

***AUDIT***

Waiver submissions may be audited by the University of Pennsylvania, Aetna Student Health, and/or their contractors or representatives. You may be required to provide, upon request, any coverage documents and/or other records demonstrating that you meet the school's requirements for waiving the Student Health Insurance Plan.

By submitting the waiver request, you agree that your current insurance plan may be contacted for confirmation that your coverage is in force for the applicable Policy Year and that it meets the school's waiver requirements.

**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. If you withdraw from school after the first 31 days of a coverage period, but before **February 06, 2014**, you will be covered until **February 06, 2014**. You will be refunded for the spring half of the premium.

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

## **DEPENDENT COVERAGE**

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### ***ELIGIBILITY***

Covered students may also enroll their lawful spouse, domestic partner and children under age 26. All spouses and domestic partners must have a Penn Guest Card at the time of application and enrollment. Covered students may enroll their eligible dependents online by specified deadline(s) by visiting [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com). Students will need to submit a Dependent Enrollment Application with a MasterCard, Visa, Discover or American Express payment.

If, while you are covered by this plan, you have a covered dependent child who is called up for active duty (state National Guard or reserves) while he or she is a full time student, Aetna Student Health will extend this child's coverage upon his or her return until you are no longer covered by this plan. This dependent coverage will be available at the first Fall or Spring enrollment period after the dependent child has 1) returned from duty and 2) returned to full time student status. The offered coverage for this dependent child will continue until A) you are no longer a student covered by this plan; or B) the dependent child is no longer a full time student *or* a period of time equal to the duration of the child's military duty has passed.

The dependent enrollment deadline for the fall semester is **August 31, 2013**. The enrollment deadline date for the Spring semester is **January 31, 2014**. The enrollment deadline date for the Summer semester is **May 31, 2014**.

The Dependent Enrollment Application and premium will not be accepted after the deadline. Please contact Aetna Student Health at **(800) 841-5374** with any questions regarding dependent enrollment.

### ***SPOUSE/DOMESTIC PARTNERS***

Students may add a spouse or a domestic partner within 31 days of the marriage or establishment of a domestic partnership. Proof may be requested by Aetna Student Health or the University of Pennsylvania's Student Health Service and may include the procurement of a Guest Card from the Penn Care Center.

### ***NEWBORN INFANT AND ADOPTED CHILD COVERAGE***

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

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

For information or general questions on dependent enrollment, contact Aetna Student Health at **(800) 841-5374**.

## **PREFERRED PROVIDER NETWORK**

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

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

You may also obtain information regarding Preferred Providers by contacting Aetna Student Health at (800) 841-5374, or through the Internet by accessing DocFind at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com).

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

## **REFERRAL REQUIREMENTS**

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Students' health care needs can best be satisfied when an organized system of health care providers at the University of Pennsylvania Health Services manages the treatment. Students covered under the Penn Student Insurance Plan should first seek treatment at SHS for each medical condition if within 25 miles of the University. The Student Health Service Providers will refer you, if appropriate, to an outside provider. A new referral for each condition is required at the beginning of each Policy Year.

Any care received with 25 miles of the University without a prior SHS referral will be payable subject to the Non-Preferred Benefit, including the **\$1,500** Deductible. A referral is not required in the following circumstances:

- Emergency Room Services (all follow-up treatment must be obtained through SHS),
- The student is more than 25 miles away from the University Health Services,
- Inpatient and Outpatient Mental Health and Substance Abuse Services,
- Women's Health Services,
- Maternity,
- Voluntary Termination of Pregnancy,
- Annual Eye Examination,
- Injury to Sound Natural Teeth, or Removal of Impacted Wisdom Teeth,
- Pediatric Care,
- Preventive/Routine Services (services considered preventive according to Health Care Reform and/or services rendered not to diagnosis or treat an Accident or Sickness).

The referral requirement does not apply to covered dependents or when SHS is closed.

## **PRE-CERTIFICATION PROGRAM**

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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 (800) 841-5374 (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 services require pre-certification:

- All inpatient admissions, including length of stay, to a hospital, skilled nursing facility, a facility established primarily for the treatment of substance abuse, or a residential treatment facility.
- All inpatient maternity care, after the initial 48/96 hours.
- All partial hospitalization in a hospital, residential treatment facility, or facility established primarily for the treatment of substance abuse

**Pre-Certification does not guarantee the payment of benefits for your inpatient admission.** Each claim is subject to medical policy review, in accordance with the exclusions and limitations contained in the Policy, as well as a review of eligibility, adherence to notification guidelines, and benefit coverage under the student Accident and Sickness Plan.

**Pre-Certification of Non-Emergency Inpatient Admissions, Partial Hospitalization:**

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 **two (2) business days** following inpatient (or partial hospitalization) admission.

**DESCRIPTION OF BENEFITS\***

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Please Note:

**THE PENN STUDENT 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 Penn Student 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 the University of Pennsylvania, you may view it at Student Health Service or you may contact Aetna Student Health at (800) 841-5374.

**This Plan will never pay more than \$2,000,000 per Policy Year for students or \$2,000,000 per Policy Year for dependents. Additional Plan maximums may also apply. Some illnesses or injuries 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 Policy 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**

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**DEDUCTIBLES\***

The following deductibles are applied before **Covered Medical Expenses** for **Preferred Care** are payable:

- Students: **\$300 per Policy Year**
- Spouse: **\$300 per Policy Year**
- Child: **\$300 per Policy Year**

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

- Students: **\$1,500 per Policy Year**
- Spouse: **\$1,500 per Policy Year**
- Child: **\$1,500 per Policy Year**

\*Per visit or admission deductibles do not apply towards satisfying the plan Deductible.

### 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, Preventive Care Immunizations (Facility or Office Visits), Well Woman Preventive Visits (Office Visits), Screening & Counseling Services (Office Visits) as illustrated under the Routine Physical Exam benefit type, 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*), and Female Generic Contraceptive Devices, Female Generic Contraceptive Prescription Drugs, and Female Over-the-Counter Contraceptive Methods.

In addition to state and federal requirements for waiver of the Annual Deductible, this plan will waive the Annual Deductible for Emergency Room Expense, Pap Smear Screening Expense, Prescribed Medicines Expense, Vision Care Exam Expense, Immunizations Expense, Diagnostic Testing For Learning Disabilities Expense, Treatment of Mental and Nervous Disorders Expense (inpatient and outpatient), and Alcoholism and Drug Addiction Treatment Expense (inpatient and outpatient).

### COINSURANCE

Covered Medical Expenses are payable at the coinsurance percentage specified below, after any applicable deductible, up to a maximum benefit of **\$2,000,000 per Policy Year** for students or **\$2,000,000 per Policy Year** for dependents.

### OUT OF POCKET MAXIMUMS

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

<u>Preferred Care</u> Individual Out-of-Pocket:	<b>\$1,500 per Policy Year</b>
<u>Preferred Care</u> Family Out-of-Pocket:	<b>\$3,000 per Policy Year</b>

<u>Non-Preferred Care</u> Individual Out-of-Pocket:	<b>\$4,000 per Policy Year</b>
<u>Non-Preferred Care</u> Family Out-of-Pocket:	<b>\$8,000 per Policy Year</b>

The following expenses do not apply toward meeting the **Out-of-Pocket Limit**:

- copays,
- expenses that are not **Covered Medical Expenses**,
- penalties,
- expenses for prescription drugs, and
- other expenses not covered by this Policy.

**All coverage is based on Recognized charges unless otherwise specified.**

<b>Inpatient Hospitalization Benefits</b>	
Room and Board Expense	<p><b>Covered Medical Expenses</b> are payable as follows:</p> <p><u>Preferred Care:</u> <b>90%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> After a <b>\$100</b> per admission deductible, <b>70%</b> of the Recognized Charge for a semi-private room.</p>
Intensive Care Room and Board Expense	<p><b>Covered Medical Expenses</b> are payable as follows:</p> <p><u>Preferred Care:</u> <b>90%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> After a <b>\$100</b> per admission deductible, <b>70%</b> of the Recognized Charge for the Intensive Care Room Rate for an overnight stay.</p>
Miscellaneous Hospital Expense	<p><b>Covered Medical Expenses</b> include, among others, expenses incurred during a hospital confinement for: anesthesia and operating room; laboratory tests and x-rays; oxygen tent; and drugs; medicines; and dressings.</p> <p>Benefits are payable as follows:</p> <p><u>Preferred Care:</u> <b>90%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>70%</b> of the Recognized Charge.</p>
Non-Surgical Physicians Expense	<p><b>Covered Medical Expenses</b> for charges for the non-surgical services of the attending Physician or a consulting Physician are payable as follows:</p> <p><u>Preferred Care:</u> <b>90%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>70%</b> of the Recognized Charge.</p>
<b>Surgical Expense - Inpatient</b>	
Surgical Expense	<p><b>Covered Medical Expenses</b> for charges for surgical services performed by a Physician are payable as follows:</p> <p><u>Preferred Care:</u> <b>90%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>70%</b> of the Recognized Charge.</p>
Anesthesia Expense	<p><b>Covered Medical Expenses</b> for the charges of anesthesia during a surgical procedure are payable as follows:</p> <p><u>Preferred Care:</u> <b>90%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>70%</b> of the Recognized Charge.</p>
Assistant Surgeon Expense	<p><b>Covered Medical Expenses</b> for the charges of an assistant surgeon during a surgical procedure are payable as follows:</p> <p><u>Preferred Care:</u> <b>90%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>70%</b> of the Recognized Charge.</p>
<b>Surgical Expense - Outpatient</b>	
Surgical Expense	<p><b>Covered Medical Expenses</b> for charges for surgical services performed by a Physician are payable as follows:</p> <p><u>Preferred Care:</u> <b>90%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>70%</b> of the Recognized Charge.</p>

Anesthesia Expense	<p><b>Covered Medical Expenses</b> for the charges of anesthesia during a surgical procedure are payable as follows:</p> <p><u>Preferred Care:</u> <b>90%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>70%</b> of the Recognized Charge.</p>
Assistant Surgeon Expense	<p><b>Covered Medical Expenses</b> for the charges of an assistant surgeon during a surgical procedure are payable as follows:</p> <p><u>Preferred Care:</u> <b>90%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>70%</b> of the Recognized Charge.</p>
Ambulatory Surgical Expense	<p>Benefits are payable for <b>Covered Medical Expenses</b> incurred by a covered person for expenses incurred for outpatient surgery performed in a hospital outpatient surgery department or in an ambulatory surgical center. <b>Covered Medical Expenses</b> must be incurred on the day of the surgery or within 48 hours after the surgery</p> <p><u>Preferred Care:</u> <b>90%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>70%</b> of the Recognized Charge</p>
<p><b>Outpatient Benefits</b>  <b>Covered Medical Expenses</b> include but are not limited to: Physician's office visits, hospital or outpatient department or emergency room visits, durable medical equipment, clinical lab, or radiological facility.</p>	
Hospital Outpatient Department Expense	<p><b>Covered Medical Expenses</b> include treatment rendered in a Hospital Outpatient Department.</p> <p><b>Covered Medical Expenses</b> 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.</p> <p><u>Preferred Care:</u> <b>90%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>70%</b> of the Recognized Charge.</p>
Walk-in Clinic Visit Expense	<p><b>Covered Medical Expenses</b> include services rendered in a walk-in clinic.</p> <p><u>Preferred Care:</u> After a <b>\$30</b> copay per visit, <b>100%</b> of the Negotiated Charge  <u>Non-Preferred Care:</u> <b>70%</b> of the Recognized Charge.</p>
Emergency Room Expense	<p><b>Covered Medical Expenses</b> incurred for treatment of an Emergency Medical Condition are payable as follows:</p> <p><u>Preferred Care:</u> After a <b>\$100</b> copay per visit (waived if admitted), <b>100%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> After a <b>\$100</b> per visit deductible (waived if admitted), <b>100%</b> of the Recognized Charge.</p> <p><b>Important Note:</b> Please note that as <b>Non-Preferred Care Providers</b> do not have a contract with <b>Aetna</b>, the provider may not accept payment of your cost share (your <b>deductible</b> and <b>coinsurance</b>) 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 <b>Aetna</b> the bill at the address listed on the back of your member ID card and <b>Aetna</b> will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.</p>

<p>Urgent Care Expense</p>	<p>Benefits include charges for treatment by an urgent care provider.</p> <p><b>Please note: A covered person <u>should not seek medical care or treatment from an urgent care provider if their illness, injury, or condition, is an emergency condition.</u> The covered person should go directly to the emergency room of a hospital or call 911 (or the local equivalent) for ambulance and medical assistance.</b></p> <p><b><u>Urgent Care</u></b> Benefits include charges for an urgent care provider to evaluate and treat an urgent condition.</p> <p><b>Covered Medical Expenses</b> for urgent care treatment are payable as follows:</p> <p><u>Preferred Care:</u> <b>90%</b> of the Negotiated Charge. <u>Non-Preferred Care:</u> <b>70%</b> of the Recognized Charge.</p> <p>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.</p>
<p>Ambulance Expense</p>	<p><b>Covered Medical Expenses</b> are payable for the services of a professional ambulance to or from a hospital, when required due to the emergency nature of a covered Accident or Sickness.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care:</u> <b>100%</b> of the Negotiated Charge. <u>Non-Preferred Care:</u> <b>100%</b> of the Recognized Charge.</p>
<p>Pre-Admission Testing Expense</p>	<p><b>Covered Medical Expenses</b> for Pre-Admission testing charges while an outpatient before scheduled surgery are payable same basis as any other Sickness.</p>
<p>Physician's Office Visit Expense</p>	<p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care:</u> After a <b>\$30</b> copay per visit, <b>100%</b> of the Negotiated Charge. <u>Non-Preferred Care:</u> <b>70%</b> of the Recognized Charge.</p> <p>This benefit includes visits to specialists.</p>
<p>Laboratory and X-ray Expense</p>	<p><b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care:</u> <b>90%</b> of the Negotiated Charge. <u>Non-Preferred Care:</u> <b>70%</b> of the Recognized Charge.</p>
<p>High Cost Procedures Expense</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a <b>covered person</b> 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:</p> <ul style="list-style-type: none"> <li>• A physician's office; or</li> <li>• Hospital outpatient department; or emergency room; or</li> <li>• Clinical laboratory; or</li> <li>• Radiological facility; or other similar facility; licensed by the applicable state; or the state in which the facility is located.</li> </ul> <p><b>Covered Medical Expenses</b> for High Cost Procedures include charges for the following procedures and services:</p> <ul style="list-style-type: none"> <li>• C.A.T. Scan;</li> <li>• Magnetic Resonance Imaging; and</li> <li>• Contrast Materials for these tests.</li> </ul>

<p>High Cost Procedures Expense (continued)</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a <b>covered person</b> are payable as follows:</p> <p><u>Preferred Care:</u> <b>90%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>70%</b> of the Recognized Charge.</p>
<p>Therapy Expense</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a <b>covered person</b> for the following types of therapy provided on an outpatient basis:</p> <ul style="list-style-type: none"> <li>• Physical Therapy, or</li> <li>• Occupational Therapy.</li> </ul> <p>Expenses for Occupational Therapies are <b>Covered Medical Expenses</b>, only if such therapies are a result of <b>injury</b> or <b>sickness</b>.</p> <p><b>Covered Medical Expenses</b> are payable as follows:  <u>Preferred Care:</u> <b>90%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>60%</b> of the Recognized Charge.</p> <p><b>Covered Medical Expenses</b> include charges incurred by a <b>covered person</b> for the following types of therapy provided on an outpatient basis:</p> <ul style="list-style-type: none"> <li>• Chiropractic Care,</li> <li>• Speech Therapy,</li> <li>• Inhalation Therapy, or</li> <li>• Cardiac Rehabilitation.</li> </ul> <p>Expenses for Chiropractic Care are <b>Covered Medical Expenses</b>, if such care is related to neuromusculoskeletal conditions and conditions arising from: the lack of normal nerve, muscle, and/or joint function. Benefits are payable on the same basis as any other therapy.</p> <p>Expenses for Speech Therapies are <b>Covered Medical Expenses</b>, only if such therapies are a result of <b>injury</b> or <b>sickness</b>.</p> <p><b>Covered Medical Expenses</b> are payable as follows:  <u>Preferred Care:</u> After a <b>\$30</b> copay per visit, <b>100%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>70%</b> of the Recognized Charge.</p>
<p>Chemotherapy Expense</p>	<p><b>Covered Medical Expenses</b> for chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy, radiation therapy, tests and procedures, physiotherapy (for rehabilitation only after a surgery), and expenses incurred at a radiological facility. <b>Covered medical expenses</b> also include expenses for the administration of chemotherapy and visits by a health care professional to administer the chemotherapy. Such expenses are payable as follows:</p> <p><u>Preferred Care:</u> <b>90%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>70%</b> of the Recognized Charge.</p>
<p>Durable Medical and Surgical Equipment Expense</p>	<p><b>Covered Medical Expenses</b> are payable as follows:</p> <p><u>Preferred Care:</u> <b>90%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>60%</b> of the Recognized Charge.</p> <p>Benefits include orthopedic shoes, foot orthotics, or other devices to support the feet if they are <b>medically necessary</b> to prevent the complications of diabetes.</p>

<p>Durable Medical and Surgical Equipment Expense (continued)</p>	<p><b>Breast Feeding Durable Medical Equipment</b>  Coverage includes the rental or purchase of breast feeding <b>durable medical equipment</b> for the purpose of lactation support (pumping and storage of breast milk) as follows.</p> <p><u>Preferred Care:</u> <b>100%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>60%</b> of the Recognized Charge.</p> <p><i>Breast Pump</i>  <b>Covered expenses</b> include the following:</p> <ul style="list-style-type: none"> <li>• The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a <b>hospital</b>.</li> <li>• The purchase of: <ul style="list-style-type: none"> <li>• an electric breast pump (non-hospital grade), if requested within 60 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</li> <li>• 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.</li> </ul> </li> <li>• If an electric breast pump was purchased within the previous one period, the purchase of an electric or manual breast pump will <u>not</u> be covered until a five year period has elapsed from the last purchase of an electric pump.</li> </ul> <p><i>Breast Pump Supplies</i>  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.</p> <p>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.</p> <p><b>Aetna</b> 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 <b>Aetna</b>.</p> <p><b>Limitations:</b>  Unless specified above, not covered under this benefit are charges incurred for:</p> <ul style="list-style-type: none"> <li>• Services which are covered to any extent under any other part of this Plan.</li> </ul>
<p>Prosthetic Devices Expense</p>	<p><b>Covered Medical expenses</b> include charges for: artificial limbs or eyes, wigs required as a result of chemo or radiation therapy, and other non-dental prosthetic devices as a result of an accident or sickness.</p> <p><b>Covered Medical Expenses</b> do <b>not</b> include: eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet unless they are medically necessary to prevent the complications of diabetes.</p> <p>Benefits are payable as follows:</p> <p><u>Preferred Care:</u> <b>90%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>60%</b> of the Recognized Charge.</p>
<p>Physical Therapy Expense</p>	<p><b>Covered Medical Expenses</b> for physical therapy are payable as follows when provided by a licensed physical therapist:</p> <p><u>Preferred Care:</u> <b>90%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>60%</b> of the Recognized Charge.</p>

<p>Dental Injury Expense</p>	<p><b>Covered Medical Expenses</b> include dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition:</p> <ul style="list-style-type: none"> <li>• Natural teeth damaged, lost, or removed, or</li> <li>• Other body tissues of the mouth fractured or cut due to injury. The accident causing the injury must occur while the person is covered under this Plan.</li> </ul> <p>Any such teeth must have been:</p> <ul style="list-style-type: none"> <li>• Free from decay, or</li> <li>• In good repair, and</li> <li>• Firmly attached to the jawbone at the time of the injury.</li> </ul> <p><i>The treatment must be done in the calendar year of the accident or the next one.</i></p> <p>If:</p> <ul style="list-style-type: none"> <li>• Crowns (caps), or</li> <li>• Dentures (false teeth), or</li> <li>• Bridgework, or</li> <li>• In-mouth appliances,</li> </ul> <p>are installed due to such injury, <b>Covered Medical Expenses</b> include only charges for:</p> <ul style="list-style-type: none"> <li>• The first denture or fixed bridgework to replace lost teeth,</li> <li>• The first crown needed to repair each damaged tooth, and</li> <li>• An in-mouth appliance used in the first course of orthodontic treatment after the injury.</li> </ul> <p>Surgery needed to:</p> <ul style="list-style-type: none"> <li>• Treat a fracture, dislocation, or wound.</li> <li>• Cut out cysts, tumors, or other diseased tissues.</li> <li>• Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.</li> <li>• Non-surgical treatment of infections or diseases. This does not include those of, or related to, the teeth.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows:</p> <p><b>90%</b> of the Actual Charge.</p>
<p>Dental Expense for Impacted Wisdom Teeth</p>	<p><b>Covered Medical Expenses</b> for removal of one or more impacted wisdom teeth are payable as follows:</p> <p><b>90%</b> of the Actual Charge.</p>
<p>Allergy Testing and Treatment Expense</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a covered person for diagnostic testing and treatment of allergies and immunology services. <b>Covered Medical Expenses</b> include; but are not limited to; charges for the following:</p> <ul style="list-style-type: none"> <li>• laboratory tests;</li> <li>• physician office visits; including visits to administer injections;</li> <li>• prescribed medications for testing and treatment of the allergy; including any equipment used in the administration of prescribed medication; and</li> <li>• other medically necessary supplies and services;.</li> </ul> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other Sickness.</p>

<p>Diagnostic Testing For Learning Disabilities Expense</p>	<p><b>Covered Medical Expenses</b> for diagnostic testing for:</p> <ul style="list-style-type: none"> <li>• attention deficit disorder, or</li> <li>• attention deficit hyperactive disorder</li> </ul> <p>are payable as follows:</p> <p><u>Preferred Care</u>: <b>90%</b> of the Negotiated Charge.  <u>Non-Preferred Care</u>: <b>70%</b> of the Recognized Charge.</p> <p>Once a covered person has been diagnosed with one of these conditions, medical treatment will be payable as detailed under the outpatient Treatment of Mental and Nervous Disorders portion of this Plan.</p>
<p>Routine Physical Exam Expense</p>	<p>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.</p> <p>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:</p> <ul style="list-style-type: none"> <li>• Routine vision and hearing screenings given as part of the routine physical exam,</li> <li>• X-rays, lab, and other tests given in connection with the exam, and</li> <li>• Materials for the administration of immunizations for infectious disease and testing for tuberculosis.</li> </ul> <p><u>Preferred Care visits</u> are payable as follows: <b>100%</b> of the Negotiated Charge.  <u>Preferred Care immunizations</u> are payable at <b>100%</b> of the Negotiated Charge.</p> <p><u>Non-Preferred Care visits</u> are payable at <b>70%</b> of the Recognized Charge.  <u>Non-Preferred Care immunizations</u> are payable at <b>70%</b> of the Recognized Charge.</p> <p>In addition to any state regulations or guidelines regarding mandated Routine Physical Exam services, <b>Covered Medical Expenses</b> include services rendered in conjunction with,</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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: <ul style="list-style-type: none"> <li>• Screening and counseling services, such as: <ul style="list-style-type: none"> <li>○ Interpersonal and domestic violence;</li> <li>○ Sexually transmitted diseases; and</li> <li>○ Human Immune Deficiency Virus (HIV) infections.</li> </ul> </li> <li>• Screening for gestational diabetes.</li> <li>• High risk Human Papillomavirus (HPV) DNA testing for women age 18 and older and limited to once every three years.</li> </ul> </li> </ul> <p>*Sexually transmitted disease counseling expense is limited to two counseling visits per Policy Year.</p> <ul style="list-style-type: none"> <li>• X-rays, lab and other tests given in connection with the exam.</li> <li>• 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.</li> <li>• If the plan includes dependent coverage, for covered newborns, an initial <b>hospital</b> check-up.</li> </ul>

<p>Routine Physical Exam Expense (continued)</p>	<p><b>Important Note:</b>  <i>For details on the frequency and age limits that apply to Routine Physical Exams and Routine Cancer Screenings, a covered person may contact his or her physician or Member Services by logging onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a> or calling the toll-free number on the back of the ID card.</i></p> <p>For a <b>child</b> who is a covered dependent:</p> <ul style="list-style-type: none"> <li>• The physical exam must include at least: <ul style="list-style-type: none"> <li>• A review and written record of the patient's complete medical history,</li> <li>• A check of all body systems, and</li> <li>• A review and discussion of the exam results with the patient or with the parent or guardian.</li> </ul> </li> <li>• For all exams given to covered dependent <b>under age 2, Covered Medical Expenses will <u>not include</u></b> charges for the following: <ul style="list-style-type: none"> <li>• <b><u>More than</u></b> 6 exams performed during the first year of the child's life,</li> <li>• <b><u>More than</u></b> 2 exams performed during the second year of the child's life.</li> </ul> </li> <li>• For all exams given to a covered dependent from <b>age 2 and over, Covered Medical Expenses will <u>not include</u></b> charges for <b><u>more than</u></b> one exam in 12 months in a row.</li> </ul> <p>For all exams given to a covered student or a spouse who is a covered dependent, <b>Covered Medical Expenses will <u>not include</u></b> charges for <b><u>more than</u></b>:</p> <ul style="list-style-type: none"> <li>• One exam in 12 months in a row.</li> </ul> <p><b>Covered Medical Expenses</b> incurred by a woman, are charges made by a physician for, one annual routine gynecological exam.</p> <p><b>Screening and Counseling Services:</b></p> <p><b>Covered Medical Expenses</b> include charges made by a <b>physician</b> in an individual or group setting for the following:</p> <p><b>Depression Screening</b>  This service is limited to once per year.</p> <p><b>Obesity</b>  Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:</p> <ul style="list-style-type: none"> <li>• Preventive counseling visits and/or risk factor reduction intervention;</li> <li>• Medical nutrition therapy;</li> <li>• Nutritional counseling; and</li> <li>• Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.</li> </ul> <p>Services in this category are subject to a combined limit of 26 individual or group visits by any recognized provider per Policy Year. The 10 Healthy Diet Counseling visits will be counted toward the total number of visits allowed for Obesity counseling.</p> <p><b>Misuse of Alcohol and/or Drugs</b>  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.</p> <p>Services in this category are subject to a combined limit of 5 individual or group visits by any recognized provider per Policy Year.</p>
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<p>Routine Physical Exam Expense (continued)</p>	<p><b>Use of Tobacco Products</b>  Screening and counseling services to aid a covered person to stop the use of tobacco products.</p> <p>Coverage includes:</p> <ul style="list-style-type: none"> <li>• Preventive counseling visits;</li> <li>• Treatment visits; and</li> <li>• Class visits;</li> </ul> <p>to aid a covered person to stop the use of tobacco products.</p> <p>Tobacco product means a substance containing tobacco or nicotine including:</p> <ul style="list-style-type: none"> <li>• cigarettes;</li> <li>• cigars;</li> <li>• smoking tobacco;</li> <li>• snuff;</li> <li>• smokeless tobacco; and</li> <li>• candy-like products that contain tobacco.</li> </ul> <p>Services in this category are subject to a combined limit of 8 individual or group visits by any recognized provider per Policy Year.</p> <p><b>Limitations:</b>  Unless specified above, not covered under this Screening and Counseling Services benefit are charges incurred for:</p> <ul style="list-style-type: none"> <li>• Services which are covered to any extent under any other part of this Plan</li> </ul> <p>Screening and Counseling Services are payable as follows:</p> <p><u>Preferred Care:</u> <b>100%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>70%</b> of the Recognized Charge.</p>
<p>Well Baby Care Expense</p>	<p>Benefits include charges for routine preventive and primary care services, rendered to a covered dependent child on an outpatient basis.</p> <p><b>Routine preventive and primary care</b> services are services rendered to a covered dependent child, from the date of birth through the attainment of <b>two (2)</b> years of age. Services include: initial hospital check-ups, other hospital visits, physical examinations, including routine hearing and vision examinations, medical history, developmental assessments, and materials for the administration of appropriate and necessary immunizations and laboratory tests, when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics.</p> <p>Coverage for such services shall be provided only to the extent that such services are provided by, or under the supervision of a physician, or other licensed professional.</p> <p><b>Covered Medical Expenses</b> are payable as follows:</p> <p><u>Preferred Care:</u>  <b>100%</b> of the Negotiated Charge. Benefits are payable for scheduled visits in accordance with the prevailing clinical standards of the American Academy of Pediatrics.</p> <p><u>Non-Preferred Care:</u>  <b>70%</b> of the Recognized Charge. Benefits are payable for scheduled visits in accordance with the prevailing clinical standards of the American Academy of Pediatrics.</p>

<p>Immunizations Expense</p>	<p><b>Covered Medical Expenses</b> include:</p> <ul style="list-style-type: none"> <li>• charges incurred by a covered student and dependent spouse for the materials for the administration of appropriate and <b>medically necessary</b> immunizations, and testing for tuberculosis, and</li> <li>• charges incurred by a covered dependent up to age 19, for the materials for the administration of appropriate and <b>medically necessary</b> immunizations, when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics.</li> </ul> <p><u>Preferred Care:</u> <b>100%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>70%</b> of the Recognized Charge.</p> <p><b>Covered Medical Expenses do not include</b> a physician’s office visit in connection with immunization or testing for tuberculosis.</p>
<p>Consultant Expense</p>	<p><b>Covered Medical Expenses</b> include the expenses for the services of a consultant or specialist. The services must be requested by the attending physician for the purpose of confirming or determining a diagnosis.</p> <p><b>Covered Medical Expenses</b> are covered as follows:</p> <p><u>Preferred Care:</u> After a <b>\$30</b> copay per visit, <b>100%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>70%</b> of the Recognized Charge.</p>
<p><b>Treatment Of Mental And Nervous Disorders Expense</b></p>	
<p>Inpatient Expense</p>	<p><b>Covered Medical Expenses</b> for the diagnosis and treatment of mental or nervous disorders are payable on the same basis as any other sickness.</p> <p><u>Preferred Care:</u> <b>90%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>70%</b> of the Recognized Charge.</p> <p>Benefits are limited to a maximum of <b>30</b> days per policy year.</p>
<p>Outpatient Expense</p>	<p><b>Covered Medical Expenses</b> for the diagnosis and treatment of mental or nervous disorders are payable on the same basis as any other sickness.</p> <p><u>Preferred Care:</u> After a <b>\$30</b> copay per visit, <b>100%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>70%</b> of the Recognized Charge.</p> <p>Benefits are limited to a maximum of <b>50</b> visits per condition per policy year.</p>
<p><b>Alcoholism And Drug Addiction Treatment Expense</b></p>	
<p>Inpatient Expense</p>	<p><b>Covered Medical Expenses</b> include inpatient treatment either in a hospital or in a non-hospital residential facility for the treatment of alcohol or drug addiction.</p> <p><b>Hospital</b>  Charges for the treatment of alcohol or drug addiction are covered only if there is not a separate alcoholism or drug abuse non-hospital residential facility section in the hospital. Benefits include <b>30</b> days of confinement per Policy Year payable on the same basis as any other condition.</p> <p>This <b>30</b>-day confinement benefit will be reduced by any days of non-hospital residential facility confinements for treatment of alcoholism or drug abuse that are covered below in the same Policy Year.</p> <p>This maximum does not apply to confinements solely for detoxification needed due to alcoholism or drug abuse.</p>

<p>Inpatient Expense (continued)</p>	<p><b><i>Non-Hospital Residential Facility</i></b>          Certain charges for the treatment of alcohol or drug addiction are covered. Benefits include <b>30</b> days of confinement per Policy Year. The expenses covered are those for:</p> <ul style="list-style-type: none"> <li>• Board and room.</li> <li>• Other necessary services and supplies.</li> </ul> <p>During a covered person's lifetime, benefits will not be paid for more than <b>90</b> days of confinement.</p> <p><b><i>Hospital or Non-Hospital Residential Facility</i></b>          Charges for confinement solely for <b>detoxification</b> needed due to alcoholism or drug abuse are covered during the:</p> <ul style="list-style-type: none"> <li>• first <b>7</b> days of any one confinement; and</li> <li>• first <b>4</b> such confinements in the covered person's lifetime.</li> </ul> <p>If a private room is used in a non-hospital residential facility, any charge for daily board and room over the Private Room Limit will not be covered. Covered Medical Expenses for the purposes of inpatient treatment of alcohol or drug addiction shall include, but not be limited to, the following:</p> <ul style="list-style-type: none"> <li>• Lodging and dietary services.</li> <li>• Physician, psychologist, nurse, certified addictions counselor and trained staff services.</li> <li>• Diagnostic X-rays in connection with inpatient detoxification treatment.</li> <li>• Psychiatric, psychological and medical laboratory testing.</li> <li>• Drugs, medicines, equipment use and supplies.</li> <li>• Rehabilitation therapy and counseling.</li> <li>• Family counseling and intervention.</li> </ul> <p>The above provision concerning alcohol and drug addiction applies only to treatment resulting from the certification by a licensed physician or licensed psychologist that the covered person is suffering from alcohol or other drug abuse or dependency.</p> <p>Benefits are payable as follows:</p> <p><u>Preferred Care</u>: <b>90%</b> of the Negotiated Charge.  <u>Non-Preferred Care</u>: <b>70%</b> of the Recognized Charge.</p> <p>Benefits are limited to a maximum of <b>30</b> days per policy year.</p>
<p>Outpatient Expense</p>	<p><b>Covered Medical Expenses</b> include charges made by a hospital or non-hospital residential facility and incurred by a covered person while not confined as a full-time inpatient for treatment of alcohol or drug addiction.</p> <p>Charges for group, family or individual counseling are included.</p> <ul style="list-style-type: none"> <li>• Benefits while a covered person is participating in a partial hospitalization treatment program will not be paid for more than the Partial Hospitalization Treatment Policy Year Maximum of <b>30</b> sessions in any one Policy Year. A treatment session begins when the covered person enters the place of treatment. It ends when the covered person leaves the place of treatment.</li> <li>• Benefits while the covered person is not participating in a partial hospitalization treatment program will not be payable for more than the Special Outpatient Maximum of <b>50</b> visits in any one Policy Year and the Special Outpatient Lifetime Maximum of <b>120</b> visits.</li> </ul>

<p>Outpatient Expense (continued)</p>	<p><b>Covered Medical Expenses</b> for the purposes of Outpatient Treatment of Alcohol or Drug Addiction shall include, but not be limited to, the following:</p> <ul style="list-style-type: none"> <li>• Physician, psychologist, nurse, certified addictions counselor and trained staff services.</li> <li>• Psychiatric, psychological and medical laboratory testing.</li> <li>• Drugs, medicines, equipment use and supplies.</li> <li>• Rehabilitation therapy and counseling.</li> <li>• Family counseling and intervention.</li> </ul> <p>These outpatient treatment provisions apply only to treatment resulting from the certification by a licensed physician or licensed psychologist that the covered person is suffering from alcohol or other drug abuse or dependency.</p> <p>Benefits are payable as follows:</p> <p><u>Preferred Care</u>: After a <b>\$30</b> copay per visit, <b>100%</b> of the Negotiated Charge.  <u>Non-Preferred Care</u>: <b>70%</b> of the Recognized Charge.</p> <p>Benefits are limited to a maximum of <b>50</b> visits per policy year and up to <b>120</b> visits lifetime.</p>
<p><b>Maternity Benefits</b></p>	
<p>Maternity Expense</p>	<p><b>Covered Medical Expenses</b> include inpatient care of the covered person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery.</p> <p>Any decision to shorten such minimum coverages shall be made by the attending Physician in consultation with the mother. In such cases, covered services may include: home visits, parent education, and assistance and training in breast or bottle-feeding.</p> <p><b>Covered Medical Expenses</b> for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other sickness.</p> <p><b>Prenatal Care</b></p> <p>Prenatal care will be covered for services received by a pregnant female in a <b>physician's</b>, obstetrician's, or gynecologist's office but only to the extent described below.</p> <p>Coverage for prenatal care under this benefit is limited to pregnancy-related <b>physician</b> office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).</p> <p><b>Comprehensive Lactation Support and Counseling Services</b></p> <p><b>Covered Medical Expenses</b> will include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy and in the post partum period by a certified lactation support provider. The "post partum period" means the 60 day period directly following the child's date of birth. <b>Covered expenses</b> incurred during the post partum period also include the rental or purchase of breast feeding equipment as described below.</p> <p>Lactation support and lactation counseling services are <b>covered expenses</b> when provided in either a group or individual setting.</p> <p><b>Covered Medical Expenses</b> for Prenatal Care and Comprehensive Lactation Support and Counseling Services are payable as follows:</p> <p><u>Preferred Care</u>: <b>100%</b> of the Negotiated Charge.  <u>Non-Preferred Care</u>: <b>70%</b> of the Recognized Charge.</p>

<p>Well Newborn Nursery Care Expense</p>	<p>Benefits include charges for routine care of a covered person's newborn child as follows:</p> <ul style="list-style-type: none"> <li>• hospital charges for routine nursery care during the mother's confinement, but for not more than four days,</li> <li>• physician's charges for circumcision, and</li> <li>• physician's charges for visits to the newborn child in the hospital and consultations, but for not more than 1 visit per day.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows:</p> <p><u>Preferred Care</u>: <b>90%</b> of the Negotiated Charge.  <u>Non-Preferred Care</u>: <b>70%</b> of the Recognized Charge.</p>
<p><b>Additional Benefits</b></p>	
<p>Prescribed Medicines Expense</p>	<p>Prescription Drug Benefits* are payable as follows:</p> <p><u>Preferred Care Pharmacy</u>: <b>100%</b> of the Negotiated Charge, following a <b>\$40</b> copay for each Brand Name Prescription Drug or a <b>\$20</b> copay for each Generic Prescription Drug.</p> <p><u>Non-Preferred Care Pharmacy</u>: <b>100%</b> of the Recognized Charge, following a <b>\$40</b> Deductible for each Brand Name Prescription or a <b>\$20</b> Deductible for each Generic Prescription Drug. You must pay out of pocket for Prescriptions at a Non-Preferred Pharmacy and then submit the receipt with a Prescription Claim Form for reimbursement.</p> <p>This Pharmacy benefit is provided to cover Medically Necessary Prescriptions associated with a covered Sickness or Accident occurring during the Policy Year. <b>Covered Medical Expenses</b> also include prescription smoking cessations aids. Please use your Aetna Student Health ID card when obtaining your prescriptions.</p> <p>Prior Authorization may be required for certain Prescription Drugs and some medications may not be covered under this Plan. For assistance and a complete list of excluded medications, or drugs requiring prior authorization, please contact Aetna Pharmacy Management at <b>(888) RX-AETNA</b> or <b>(888) 792-3862</b> (available 24 hours).</p> <p>Aetna Specialty Pharmacy provides specialty medications and support to members living with chronic conditions. The medications offered may be injected, infused or taken by mouth. For additional information, please go to <b>www.AetnaSpecialtyRx.com</b>.</p> <p>*Contraceptive Drugs and Device benefits are illustrated under the Family Planning Benefit of this Policy.</p> <p><b><i>IMPORTANT INFORMATION ABOUT THE MEDICATION FORMULARY GUIDE</i></b></p> <p>The medications listed in the Medication Formulary Guide (guide) are subject to annual review and modification by Aetna. However, if a medication is removed from the market by the FDA, it will be immediately removed from the guide without prior notice.</p> <p>A <b>covered person</b> may call the Member Services toll-free telephone number on the I.D. card to obtain:</p> <ul style="list-style-type: none"> <li>• up-to-date information on the inclusion or exclusion of a drug; or</li> <li>• a copy of the current listing which will be provided within 30 days of the request.</li> </ul> <p>A <b>covered person</b> may also visit Aetna's website for the most current formulary information at:  <b>www.aetnaushc.com/products/rx/index.html</b></p> <p>For <b>medically necessary</b> exceptions to the guide, a <b>covered person's physician</b> may contact the Pharmacy Management Precertification Unit to request coverage as a medical exception. They are granted in accordance with the policies and procedures established by Aetna.</p>

<p>Diabetic Equipment and Supplies Expense</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a covered person for equipment, supplies and testing material used to detect the presence of sugar in the person’s urine or blood for monitoring glycemic control used for the treatment of diabetes.</p> <p>Diabetic equipment and supplies include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• lancet devices,</li> <li>• blood glucose monitors,</li> <li>• test strips,</li> <li>• monitor supplies,</li> <li>• insulin,</li> <li>• injection aids,</li> <li>• syringes,</li> <li>• insulin infusion devices,</li> <li>• pharmacological agents for controlling blood sugar, and</li> <li>• orthopedic shoes, foot orthotics, or other devices to support the feet that are medically necessary to prevent complications of diabetes.</li> </ul> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other Sickness.</p>
<p>Hypodermic Needles Expense</p>	<p><b>Covered Medical Expenses</b> for hypodermic needles and syringes are payable on the same basis as any other Sickness.</p>
<p>Outpatient Diabetic Self-Management Education Program Expense</p>	<p><b>Covered Medical Expenses</b> for outpatient diabetic self-management education programs are payable on the same basis as any other Sickness.</p>
<p>Pap Smear Screening Expense</p>	<p><b>Covered Medical Expenses</b> includes one routine gynecological exam each calendar year and one annual routine pap smear screening for women age 18 and older.</p> <p><b>Covered Medical Expenses</b> are payable as follows:</p> <p><u>Preferred Care: 100%</u> of the Negotiated Charge.  <u>Non-Preferred Care: 70%</u> of the Recognized Charge.</p>
<p>Mammogram Expense Benefit</p>	<p><b>Covered Medical Expenses</b> include charges for routine mammograms.</p> <p>Benefits will be paid for Expenses incurred for the following:</p> <ul style="list-style-type: none"> <li>• A mammogram on an annual basis for women 40 years of age and older.</li> <li>• For women less than 40 years of age, a mammogram when recommended by the woman's physician.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows:</p> <p><u>Preferred Care: 100%</u> of the Negotiated Charge.  <u>Non-Preferred Care: 70%</u> of the Recognized Charge.</p>
<p>Mastectomy and Breast Reconstruction Expense</p>	<p>Coverage will be provided to a covered person who is receiving benefits for a necessary mastectomy and who elects breast reconstruction after the mastectomy for:</p> <ul style="list-style-type: none"> <li>• reconstruction of the breast on which a mastectomy has been performed,</li> <li>• surgery and reconstruction of the other breast to produce a symmetrical appearance,</li> <li>• prostheses, and</li> <li>• treatment of physical complications of all stages of mastectomy, including lymph edemas.</li> </ul>

Mastectomy and Breast Reconstruction Expense (continued)	<p><b>Covered Medical Expenses</b> are payable on the same basis as any other Sickness. This coverage will be provided in consultation with the attending physician and the patient. It will be subject to the same annual deductibles and coinsurance provisions that apply to the mastectomy.</p>
Elective Abortion Expense	<p>If, as a result of pregnancy having its inception during the Policy Year, a covered person incurs expenses in connection with an elective abortion, a benefit is payable.</p> <p><b>Covered Medical Expenses</b> for Elective Abortion Expense are covered as follows:</p> <p><u>Preferred Care</u>: <b>90%</b> of the Negotiated Charge.  <u>Non-preferred Care</u>: <b>70%</b> of the Recognized Charge.</p> <p>This benefit is in lieu of any other Policy benefits.</p>
Family Planning Expense	<p>For females with reproductive capacity, <b>Covered Medical Expenses</b> 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).</p> <p>Coverage includes counseling services on contraceptive methods provided by a <b>physician</b>, obstetrician or gynecologist. Such counseling services are <b>Covered Medical Expenses</b> when provided in either a group or individual setting.</p> <p>The following contraceptive methods are <b>covered expenses</b> under this benefit:</p> <p><i>Voluntary Sterilization</i>  <b>Covered expenses</b> 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.</p> <p><b>Covered expenses</b> under this <i>Preventive Care</i> 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.</p> <p><i>Contraceptives</i>  <b>Covered expenses</b> include charges made by a <b>physician</b> or <b>pharmacy</b> for:</p> <ul style="list-style-type: none"> <li>• female contraceptives that are <b>generic prescription drugs</b>. The prescription must be submitted to the pharmacist for processing. <i>This contraceptives benefit covers only generic prescription drugs.</i></li> <li>• female contraceptive devices and related services and supplies that are generic prescription devices when prescribed in writing by a <b>physician</b>. <i>This contraceptives benefit covers only those devices that are generic prescription devices.</i></li> <li>• FDA-approved female over-the-counter contraceptive methods that are prescribed by your <b>physician</b>. The <b>prescription</b> must be submitted to the pharmacist for processing. These items are limited to one per day and a 30 day supply per <b>prescription</b>.</li> </ul> <p><b>Limitations:</b>  Unless specified above, not covered under this benefit are charges for:</p> <ul style="list-style-type: none"> <li>• Services which are covered to any extent under any other part of this Plan;</li> <li>• Services and supplies incurred for an abortion;</li> <li>• Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care;</li> <li>• Services which are for the treatment of an identified <b>illness</b> or <b>injury</b>;</li> <li>• Services that are not given by a <b>physician</b> or under his or her direction;</li> <li>• Psychiatric, psychological, personality or emotional testing or exams;</li> <li>• Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA;</li> </ul>

<p>Family Planning Expense (continued)</p>	<ul style="list-style-type: none"> <li>• <u>Male</u> contraceptive methods, sterilization procedures or devices;</li> <li>• The reversal of voluntary sterilization procedures, including any related follow-up care.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows:</p> <p><u>Preferred Care:</u> <b>100%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>70%</b> of the Recognized Charge.</p> <p><b>Important note:</b> Brand-Name Prescription Drug or Devices will be covered at <b>100%</b> 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.</p>
<p>Chlamydia Screening Test Expense</p>	<p><b>Covered Medical Expenses</b> include charges incurred for an annual Chlamydia screening test incurred for:</p> <ul style="list-style-type: none"> <li>• Women who are: <ul style="list-style-type: none"> <li>• under the age of 20 if they are sexually active, and</li> <li>• at least 20 years old if they have multiple risk factors.</li> </ul> </li> <li>• Men who have multiple risk factors.</li> </ul> <p>Benefits are payable as follows:</p> <p><u>Preferred Care:</u> <b>100%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>70%</b> of the Recognized Charge.</p>
<p>Routine Screening for Sexually Transmitted Disease Expense</p>	<p><b>Covered Medical Expenses</b> 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.</p> <p>Benefits are payable as follows:</p> <p><u>Preferred Care:</u> <b>100%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>70%</b> of the Recognized Charge.</p>
<p>Routine Colorectal Cancer Screening Expense</p>	<p><b>Covered Medical Expenses</b> include charges for colorectal cancer examination and laboratory tests, for any nonsymptomatic person age 50 or more, or a symptomatic person under age 50, for the following:</p> <ul style="list-style-type: none"> <li>• One fecal occult blood test every 12 months in a row</li> <li>• A Sigmoidoscopy at age 50 and every 3 years thereafter</li> <li>• One digital rectal exam every 12 months in a row</li> <li>• A double contrast barium enema, once every 5 years</li> <li>• A colonoscopy, once every 10 years</li> <li>• Virtual colonoscopy</li> <li>• Stool DNA.</li> </ul> <p>Benefits are payable as follows:</p> <p><u>Preferred Care:</u> <b>100%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>70%</b> of the Recognized Charge.</p>

<p>Routine Prostate Cancer Screening Expense</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a covered person for the screening of cancer as follows:</p> <ul style="list-style-type: none"> <li>for a male age 50 or over, one digital rectal exam and one prostate specific antigen test each Policy Year.</li> </ul> <p>Benefits are payable as follows:</p> <p><u>Preferred Care</u>: <b>100%</b> of the Negotiated Charge.  <u>Non-Preferred Care</u>: <b>70%</b> of the Recognized Charge.</p>
<p>Second Surgical Opinion Expense</p>	<p><b>Covered Medical Expenses</b> will include expenses incurred for a second opinion consultation by a specialist on the need for surgery which has been recommended by the covered person's physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation.</p> <p><b>Covered Medical Expenses</b> are payable as follows:</p> <p><u>Preferred Care</u>: After a <b>\$30</b> copay per visit, <b>100%</b> of the Negotiated Charge.  <u>Non-Preferred Care</u>: <b>70%</b> of the Recognized Charge.</p>
<p>Acupuncture In Lieu Of Anesthesia Expense</p>	<p><b>Covered Medical Expenses</b> include acupuncture therapy when acupuncture is used in lieu of other anesthesia for a surgical or dental procedure covered under this Plan.</p> <p>The acupuncture must be administered by a health care provider who is a legally qualified physician, practicing within the scope of their license.</p> <p>Acupuncture Expense benefits are payable as follows:</p> <p><u>Preferred Care</u>: <b>90%</b> of the Negotiated Charge.  <u>Non-Preferred Care</u>: <b>70%</b> of the Recognized Charge.</p>
<p>Dermatological Expense</p>	<p><b>Covered Medical Expenses</b> include charges for the diagnosis and treatment of skin disorders, excluding laboratory fees. Related laboratory expenses are covered under the Outpatient Expense Benefit.</p> <p><b>Covered Medical Expenses</b> are payable same basis as any other Sickness.</p> <p><b>Covered Medical Expenses</b> do not include cosmetic treatment and procedures.</p>
<p>Podiatric Expense</p>	<p><b>Covered Medical Expenses</b> include charges for podiatric services, provided on an outpatient basis following an injury and for the treatment of diabetes.</p> <p><b>Covered Medical Expenses</b> include those incurred to measure and fit orthopedic shoes, foot orthotics, or other devices to support the feet that are <b>medically necessary</b> to prevent complications of diabetes.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other Sickness.</p> <p>Expenses for routine foot care, such as trimming of corns, calluses, and nails, are <b>not Covered Medical Expenses</b>.</p>

<p>Home Health Care Expense</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a covered person for home health care services made by a home health agency pursuant to a home health care plan, but only if:</p> <ul style="list-style-type: none"> <li>• The services are furnished by, or under arrangements made by, a licensed home health agency,</li> <li>• The services are given under a home care plan. This plan must be established pursuant to the written order of a physician, and the physician must renew that plan every 60 days. Such physician must certify that the proper treatment of the condition would require inpatient confinement in a hospital or skilled nursing facility if the services and supplies were not provided under the home health care plan. The physician must examine the covered person at least once a month,</li> <li>• Except as specifically provided in the home health care services, the services are delivered in the patient's place of residence on a part-time, intermittent visiting basis while the patient is confined,</li> <li>• The care starts within 7 days after discharge from a hospital as an inpatient, and</li> <li>• The care is for the same condition that caused the hospital confinement, or one related to it.</li> </ul> <p>Home Health Care Services</p> <ul style="list-style-type: none"> <li>• 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,</li> <li>• 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.,</li> <li>• Physical, occupational. speech therapy, or respiratory therapy,</li> <li>• 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,</li> <li>• Medical social services by licensed or trained social workers,</li> <li>• Nutritional counseling.</li> </ul> <p><b>Covered Medical Expenses</b> will <b>not</b> include: 1) services by a person who resides in the covered person's home, or is a member of the covered person's immediate family, 2) homemaker or housekeeper services, 3) maintenance therapy, 4) dialysis treatment, 5) purchase or rental of dialysis equipment, or 6) food or home delivered services.</p> <p><b>Home Health Care</b> Expense benefits are payable as follows:</p> <p><u>Preferred Care:</u> <b>100%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>100%</b> of the Recognized Charge.</p> <p>Benefits are limited to a maximum of <b>40</b> visits per policy year.  A visit means a maximum of <b>4</b> continuous hours of home health service.</p>
<p>Transfusion or Dialysis of Blood Expense</p>	<p><b>Covered Medical Expenses</b> include charges for the transfusion or dialysis of blood, including the cost of: whole blood, blood components, and the administration thereof.</p> <p><b>Covered Medical Expenses</b> are payable as same basis as any other Sickness.</p>
<p>Hospice Expense</p>	<p><b>Covered Medical Expenses</b> include charges for hospice care provided for a terminally ill covered person during a hospice benefit period.</p> <p>Benefits are payable as follows:</p> <p><u>Preferred Care:</u> <b>90%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>70%</b> of the Recognized Charge.</p>

Licensed Nurse Expense	<p>Benefits include charges incurred by a covered person who is confined in a hospital as a resident bed-patient, and requires the services of a registered nurse or licensed practical nurse.</p> <p><b>Covered Expenses</b> for a Licensed Nurse are covered as follows:  <u>Preferred Care:</u> <b>90%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>70%</b> of the Recognized Charge.</p>
Skilled Nursing Facility Expense	<p><b>Covered Medical Expenses</b> include charges incurred by a covered person for confinement in a skilled nursing facility for treatment rendered:</p> <ul style="list-style-type: none"> <li>• in lieu of confinement in a hospital as a full time inpatient, or</li> <li>• within 24 hours following a hospital confinement and for the same or related cause(s) as such hospital confinement.</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows:</p> <p><u>Preferred Care:</u> <b>90%</b> of the Negotiated Charge for the semi-private room rate.  <u>Non-Preferred Care:</u> After a <b>\$100</b> per admission deductible, <b>70%</b> of the Recognized Charge for the semi-private room rate.</p>
Rehabilitation Facility Expense	<p><b>Covered Medical Expenses</b> include charges incurred by a covered person for confinement as a full time inpatient in a rehabilitation facility. Confinement in the rehabilitation facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of hospital or skilled nursing facility confinement.</p> <p><b>Covered Medical Expenses</b> for Rehabilitation Facility Expense are covered as follows:</p> <p><u>Preferred Care:</u> <b>90%</b> of the Negotiated Charge for the rehabilitation facility's daily room and board maximum for semi-private accommodations.  <u>Non-Preferred Care:</u> After a <b>\$100</b> per admission deductible, <b>70%</b> of the Recognized Charge for the rehabilitation facility's daily room and board maximum for semi-private accommodations.</p>
Vision Care Exam Expense	<p>Benefits include charges for any service shown below, which is furnished by a legally qualified ophthalmologist or optometrist.</p> <p>Routine Eye Exam Expenses: Charges for a complete eye exam that includes refraction. A routine eye exam does not include charges for a contact lens exam.</p> <p>Contact Lens Exam Expenses: Charges for an eye exam performed for the sole purpose of the fitting of contact lenses.</p> <p>Benefits are limited to one routine eye exam per Policy Year.</p> <p><b>Covered Medical Expenses</b> will be payable as follows:</p> <p><u>Preferred Care:</u> <b>90%</b> of the Negotiated Charge.  <u>Non-Preferred Care:</u> <b>60%</b> of the Recognized Charge.</p> <p><b>Limitations</b>  The following limitations apply:</p> <p>No benefits will be payable for a charge which is:</p> <ul style="list-style-type: none"> <li>• For any eye exam to diagnose or treat a disease or injury.</li> <li>• For drugs or medicines.</li> <li>• 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.</li> </ul>

Vision Care Exam Expense (continued)	<ul style="list-style-type: none"> <li>• 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.</li> <li>• For special procedures. This means things such as orthoptics or vision training.</li> <li>• For any vision care supply.</li> <li>• For an eye exam which: <ul style="list-style-type: none"> <li>• Is required by an employer as a condition of employment, or</li> <li>• An employer is required to provide under a labor agreement, or</li> <li>• Is required by any law of a government.</li> </ul> </li> <li>• For a service received while the person is not a covered person.</li> <li>• For a service which does not meet professionally accepted standards.</li> <li>• For any exams given while the person is confined in a hospital or other facility for medical care.</li> <li>• For an eye exam, or any part of an eye exam, performed for the purpose of the fitting of contact lenses.</li> </ul>
Transgender Coverage	<p><b>Covered Medical Expenses</b> include charges incurred by a Covered Person for gender reassignment.</p> <p><b>Covered Medical Expenses</b> are payable on the same basis as any other condition except that surgery for gender reassignment is limited to a maximum of <b>\$50,000 per Policy Year</b>.</p>

## GENERAL PROVISIONS

### STATE MANDATED BENEFITS

The Plan will pay benefits in accordance with any applicable Pennsylvania State Insurance Law(s).

### REIMBURSEMENT/RIGHT OF RECOVERY PROVISION

If a loss or Injury sustained by a Covered Person is caused by the act or omission of a third party, benefits otherwise payable under this Plan for Covered Medical Expenses under the Plan for such loss or Injury will be paid only on the condition that the Covered Person (or his or her legally authorized representative if the person is legally incapable) shall agree in writing:

- To pay Aetna to the extent that a third party settlement or judgment includes an amount (or portion thereof) previously paid by Aetna for the same medical services or benefits as incurred by the Covered Person.
- To provide Aetna a lien, to the extent of such benefits paid. The lien may be filed with the person whose act caused the Injuries, his agent, or a court jurisdiction in the matter.

A "Covered Person" includes, for the purposes of this provision, anyone on whose behalf this Plan pays or provides any benefit, including, but not limited to, the minor child or dependent of any Covered Person, entitled to receive any benefits from this Plan.

Aetna shall exercise such reimbursement rights to the extent permitted by law.

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

## **SUBROGATION/RIGHT OF RECOVERY PROVISION**

As a condition to payment of benefits under this Plan for expenses incurred by a Covered Person due to Injury or illness for which a third party may be liable:

- Aetna shall, to the extent of benefits it has paid, be subrogated to (has the right to pursue) all rights of recovery of Covered Persons against such third party to the extent permitted by law.
- Aetna shall have the right to recover from the Covered Person amounts received by judgment, settlement, or otherwise from such third party or his or her insurance carrier.
- The Covered Person (or person authorized by law to represent the Covered Person if he or she is not legally capable) shall:
  - Execute and deliver any documents that are required; and
  - Do whatever else is necessary to secure such rights as determined by Aetna.

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

A "Covered Person" includes, for the purposes of this provision, anyone on whose behalf this Plan pays or provides any benefit, including, but not limited to, the minor child or dependent of any Covered Person, entitled to receive any benefits from this Plan.

Aetna shall exercise such subrogation rights to the extent permitted by law.

## **SUBROGATION AND REIMBURSEMENT/RIGHT OF RECOVERY PROVISIONS**

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

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

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

## **EXCESS PROVISION**

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

For the purposes of calculating a benefit under this Plan, the liability of the other medical coverage shall be considered and shall not depend upon whether timely application for benefits from other medical coverage is made by **you** or on **your**

behalf. If any other medical coverage provides benefits on an excess only basis, the coverage for the Covered Member which has been in effect the longest shall pay benefits first.

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

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

**HMO/PPO Provision** – In the event that **covered expenses** are denied under a Health Maintenance Organization, Preferred Provider Organization (PPO) or other group medical plan the member 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 expense**.

## **EXTENSION OF BENEFITS**

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If Basic Sickness Expense coverage for a **covered person** ends while he is **totally disabled**, benefits will continue to be available for expenses incurred for that person, only while the **covered person** continues to be **totally disabled**. Benefits will end three months from the date coverage ends.

If a Covered Person is confined to a hospital, expenses incurred after the termination date and during the continuance of that hospital confinement, shall be payable in accordance with the policy, but only while they are incurred during the 31 day period following such termination of insurance.

## **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:

- the date this Plan terminates,
- the last day for which any required premium has been paid,
- 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,
- 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:

- For a child, on the last day of the Policy Period following the child's 26<sup>th</sup> birthday,
- The date the **covered student** fails to pay any required premium,
- For the spouse, the date the marriage ends in divorce or annulment,
- The date **dependent** coverage is deleted from this Plan,
- For a domestic partner, the earlier to occur of:
  - a) the date this Plan no longer allows coverage for domestic partners, and
  - b) the date of termination of the domestic partnership. In that event, a completed and signed declaration of Termination of Domestic Partnership must be provided to the Policyholder.
- 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 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:

- the date specified under the provision entitled Termination of Dependent Coverage, or
- the date the child is no longer incapacitated and dependent on the **covered student** for support.

## EXCLUSIONS

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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 or as provided elsewhere in this Plan.
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 Laws.
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 cosmetic surgery, reconstructive surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons except: (a) to the extent needed to improve the function of a part of the body that is not a tooth or structure that supports the teeth, and is malformed as a result of a severe birth defect, including harelip, webbed fingers or toes, or (b) as a direct result of surgery performed to treat a disease or injury, or (c) to repair an injury which occurs while the covered person is covered under this Policy. Surgery must be performed in the calendar year of the accident which causes the injury or in the next calendar year.
9. 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.
10. Expense incurred as a result of commission of a felony.
11. Expense incurred after the date insurance terminates for a covered person except as may be specifically provided in the Extension of Benefits Provision. This exclusion does not apply to newborns during the initial period of coverage of 31 days from the moment of birth.
12. Expense incurred for services normally provided without charge by the school and covered by the school fee for services.
13. 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.
14. Expense incurred for treatment of temporomandibular joint dysfunction and associated myofascial pain.
15. 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.
16. Expense for the contraceptive methods, devices, or aids and charges for or related to artificial insemination, in-vitro fertilization, or embryo transfer procedures, elective sterilization or its reversal or elective abortion unless specifically provided for in this Policy.
17. Expenses for treatment of injury or sickness to the extent that payment is made as a judgment or settlement by any person deemed responsible for the injury or sickness (or their insurers).
18. Expense incurred for which no member of the covered person's immediate family has any legal obligation for payment.
19. 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, by whom they are recommended, or by whom or by which they are performed.
20. 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.
21. Expenses incurred for blood or blood plasma except charges by a hospital for the processing or administration of blood.
22. 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 (a) 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 (b) if required by the FDA, approval has not been granted for marketing; or (c) a recognized national medical or dental society or regulatory agency has determined in writing that it is experimental, investigational, or for research purposes; or (d) the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating

facility or by another facility studying the same drug, device, procedure, or treatment, states that it is experimental, investigational, or for research purposes. However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease if Aetna determines that: (a) The disease can be expected to cause death within one year in the absence of effective treatment; and (b) 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: (a) Have been granted treatment investigational new drug (IND), or Group c/treatment IND status; or (b) Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or (c) If Aetna determines that available; scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

23. Expenses incurred for breast reduction/mammoplasty unless they are incurred in connection with a mastectomy and breast reconstruction.
24. Expenses incurred for gynecomastia (male breasts).
25. Expense incurred as a result of dental treatment except for treatment resulting from injury to sound natural teeth, dental abscesses, or for removal of wisdom teeth as provided elsewhere in this Policy.
26. Expense incurred for acupuncture unless services are rendered for anesthetic purposes.
27. Expense incurred for alternative holistic medicine and/or therapy, including but not limited to yoga and hypnotherapy.
28. 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.
29. Expense incurred when the person or individual is acting beyond the scope of his/her/its legal authority.
30. Expense incurred for hearing aids, the fitting or prescription of hearing aids.
31. Expenses incurred for hearing exams not performed in conjunction with a routine physical exam.
32. 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.
33. Expense for telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
34. 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.
35. Expense for services or supplies provided for the treatment of obesity and/or weight control, unless specifically provided in the policy.
36. Expense for incidental surgeries and standby charges of a physician.
37. Expense incurred for injury resulting from the play or practice of intercollegiate sports (participating in sports clubs or intramural athletic activities is not excluded).
38. Expenses incurred for massage therapy.
39. 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.
40. 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.

41. Expenses for routine physical exams, including expenses in connection with well newborn care, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage of such exams, immunizations, services, or supplies is specifically provided in the Policy.
42. 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: (a) 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; (b) 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 (c) 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: (a) information relating to the affected person's health status; (b) reports in peer reviewed medical literature; (c) reports and guidelines published by nationally recognized health care organizations that include supporting scientific data; (d) generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment; (e) the opinion of health professionals in the generally recognized health specialty involved; and (f) any other relevant information brought to Aetna's attention. In no event will the following services or supplies be considered to be medically necessary: (a) those that do not require the technical skills of a medical, a mental health, or a dental professional; or (b) those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, or any persons who is part of his or her family, any healthcare provider, or healthcare facility; or (c) 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 (d) those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

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

## **DEFINITIONS**

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

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

**Aggregate Maximum:** the maximum benefit that will be paid under this Policy for all **Covered Medical Expenses** incurred by a **covered person** that accumulate 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.

**Birth Center:** a freestanding facility that meets all of the following tests:

As to a facility located in Pennsylvania, it:

- Meets licensing requirements of the Commonwealth of Pennsylvania.
- Provides maternity care to childbearing families not requiring hospitalization.
- Provides a homelike atmosphere for maternity care including prenatal labor, delivery, and postpartum care related to medically uncomplicated pregnancies.

As to a facility located in a jurisdiction other than Pennsylvania, it:

- 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.

**Complications of Pregnancy:** conditions which require **hospital** stays before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy. These conditions are:

- acute nephritis or nephrosis; or
- cardiac decompensation or missed abortion; or
- similar conditions as severe as these.

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

**Complications of Pregnancy** also include:

- non-elective cesarean section; and
- termination of an ectopic pregnancy; and
- spontaneous termination when a live birth is not possible. (This does not include voluntary abortion)

**Convalescent Facility:** This is an institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury: professional nursing care by a **R.N.** or by a **L.P.N.** directed by a full-time **R.N.**; and physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**
- Is supervised full-time by a physician or **R.N.**
- Keeps a complete medical record on each patient.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Makes charges.

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

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

**Covered Dental Expenses:** those charges for any treatment; service; or supplies; covered by this Policy which are:

- not in excess of the **recognized charges**; or
- not in excess of the charges that would have been made in the absence of this coverage;
- and incurred while this Policy is in force as to the **covered person**.

**Covered dependent:** a **covered student's dependent** who is insured under this Policy.

**Covered Medical Expense:** those charges for any treatment, service or supplies covered by this Policy which are:

- not in excess of the **recognized charges**; or
- not in excess of the charges that would have been made in the absence of this coverage; and
- incurred while this Policy is in force as to the **covered person** except with respect to any expenses payable under the Extension of Benefit Provisions.

**Covered person:** a **covered student** and any **covered dependent** while coverage under this Policy is in effect.

**Covered student:** a student of the Policyholder who is insured under this Policy.

**Deductible:** the amount of **Covered Medical Expenses** that are paid by each **covered person** during the **policy year** before benefits are paid.

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

**Dental Provider:** This is any **dentist**; group; organization; dental facility; or other institution; or person.

**Dentist:** a legally qualified **dentist**. Also, a **physician** who is licensed to do the dental work he or she performs.

**Dependent:** (a) the **covered student's** spouse residing with the **covered student**; or (b) the person identified as a domestic partner in the "Declaration of Domestic Partnership" which is completed and signed by the **covered student**; and (c) the **covered student's** unmarried child under the age of 26 years (or 23 if a student).

The term "child" includes a **covered student's** biological child, step-child, adopted child, and a child for whom a petition for adopting is pending.

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

**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:

- vasectomy;
- breast reduction, unless it is performed in connection with a mastectomy and breast reconstruction;
- 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); and
- treatment of infertility.

**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 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.

A medical condition will be considered an emergency medical condition based upon whichever one of the following is most favorable to the **covered person**:

- the presenting symptoms; or
- the final diagnosis of the medical condition;
- as they are reported to Aetna by the hospital emergency room provider.

**Emergency Services:** this means any health care service or supply provided to a **covered person** to treat an **emergency medical condition**. Coverage for such services is available 24 hours a day.

**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.

**Home Health Agency:** this is an agency or organization which meets fully every one of the following requirements:  
As to an agency or organization located in Pennsylvania:

- It is staffed and equipped to provide nursing and at least one therapeutic service to disabled, aged, injured, or sick persons in their place of residence. It may provide other health related services to protect and maintain persons in their own home.
- It meets any applicable licensing standards established by the Commonwealth of Pennsylvania.

As to an agency or organization located in any other jurisdiction:

- 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:** this is a plan that provides for care and treatment of an **injury** or **sickness** after discharge from a hospital. The care and treatment must be:

- prescribed in writing by the attending physician within 24 hours from the **hospital, convalescent facility** or **skilled nursing facility** discharge; and
- an alternative to staying in a **hospital, convalescent facility** or **skilled nursing facility**.

**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 (including pastoral); and volunteers. The team acts under an independent **hospice** administration and it helps the patient cope with physical; psychological; spiritual; social; and economic stresses. Coverage includes bereavement counseling for the immediate family. 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.

**Hospital:** This is an institution which meets fully every one of the following tests:

As to an institution located in Pennsylvania:

- It engages primarily in providing for compensation and on an inpatient basis, facilities for medical diagnosis, treatment, and care of injured and sick persons under the supervision of a staff of physicians.
- It meets any applicable licensing requirements established by the Commonwealth of Pennsylvania.

As to an institution located in any other jurisdiction which has established licensing requirements:

- It engages primarily in providing for compensation and on an inpatient basis, facilities for medical diagnosis, treatment and care of injured and sick persons under the supervision of a staff of physicians.
- It meets any applicable licensing requirements established by the jurisdiction.
- As to an institution located in any other jurisdiction which has not established licensing requirements:
- It engages primarily in providing for compensation and on an inpatient basis, facilities for medical diagnosis, treatment and care of injured and sick persons under the supervision of a staff of physicians.
- It continuously provides 24-hour registered graduate nursing (**R.N.**) service.

- It is not, other than incidentally, a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.

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

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

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

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

**Mail Order Pharmacy:** an establishment where **prescription drugs** are legally dispensed by mail.

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

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

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

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

- information relating to the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis; care; or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to Aetna's attention.
- In no event will the following services or supplies be considered to be **medically necessary**:
- Those that do not require the technical skills of a medical; a mental health; or a dental professional; or
- Those furnished mainly for: the personal comfort; or convenience; of the person; any person who cares for him or her; or any person who is part of his or her family; any healthcare provider; or healthcare facility; or
- Those furnished solely because the person is an inpatient on any day on which the person's **sickness** or **injury** could safely and adequately be diagnosed or treated while not confined; or
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished; in a **physician's** or a **dentist's** office; or other less costly setting.

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

**Non-Hospital Residential Facility:** This is an institution (or distinct part thereof) which meets the following tests: If the facility is located in the Commonwealth of Pennsylvania:

- It is primarily engaged in providing for compensation from its patients, a program for diagnosis, evaluation and effective treatment of alcohol or drug addiction.
- It meets any applicable licensing standards established by the Commonwealth of Pennsylvania.
- If the facility is located in any other jurisdiction:
- It is primarily engaged in providing, for compensation from its patient, a program for diagnosis, evaluation and effective treatment of alcohol or drug addiction.
- It meets any applicable licensing standards established by the jurisdiction in which it is located.
- If there are not any licensing standards established by the jurisdiction in which it is located:
- It provides all medical detoxification services on the premises, 24 hours a day.
- It provides all normal infirmity-level medical services required during the treatment period, whether or not related to the alcohol or drug addiction. Also, it provides, or has an agreement with a **hospital** in the area to provide any other medical services that may be required.
- At all times during the treatment period, it is under the supervision of a staff of **physicians** and provides skilled nursing services by licensed nursing personnel under the direction of a full-time **R.N.**
- It prepares and maintains a written individual plan of treatment for each patient based on a diagnostic assessment of the patient's medical, psychological and social needs with documentation that the plan is under the supervision of a **physician**.

**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 **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** or **Primary Care Physician**.

**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**.

**Non-Specialist:** this is a physician who is not a Specialist.

**One Sickness:** a **sickness** and all recurrences and related conditions which are sustained by a **covered person**.

**Out-of-Area Emergency Dental Care:** **medically necessary** care or treatment for an **emergency medical condition** that is rendered outside of the service area.

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

The following expenses do not apply toward meeting the **Out-of-Pocket Limit**:

- **copays**;
- expenses that are not **Covered Medical Expenses**;
- penalties,
- expenses for prescription drugs; and
- other expenses not covered by this Policy.

**Outpatient Surgical Treatment:** Surgical treatment furnished in a surgery center located in Pennsylvania to patients who:

- do not require hospitalization; but
- require constant medical supervision following the surgical procedure performed.

**Partial hospitalization for treatment of mental or nervous disorders:** 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**.

**Partial Hospitalization Treatment Program for Alcohol or Drug Addiction:** This is a planned program of services for the treatment of alcohol or drug addiction, given in a hospital or in a non-hospital residential facility on less than a full-time inpatient basis but more than on an outpatient basis and meeting both of the following requirements:

- It involves any generally accepted form of evaluation and treatment of a condition diagnosed as alcohol or drug addiction which does not require full-time confinement in a hospital or non-hospital residential facility.
- It is supervised by a physician who both reviews the program and evaluates its effectiveness at least once a week.

**Pharmacy:** an establishment where **prescription drugs** are legally dispensed.

**Physician:** a legally qualified physician. Also, to the extent required by law, a practitioner who performs a service for which coverage is provided when it is performed by a physician.

**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.

**Preferred Care:** care provided by

- a **covered person's primary care physician**; or a **preferred care provider** on the referral of the **primary care physician**; or
- a health care provider that is not a **Preferred Care Provider** for an **emergency medical condition** when travel to a **Preferred Care Provider**; or referral by a **covered person's primary care physician** prior to treatment; is not feasible; or
- a **Non-Preferred Urgent Care Provider** when travel to a **Preferred Urgent Care Provider** for treatment is not feasible; and if authorized by Aetna.

**Preferred Care Provider:** a health care provider that has contracted to furnish services or supplies for a **negotiated charge**; but only if the provider is; with Aetna's consent; included in the directory as a **Preferred Care Provider** for:

- the service or supply involved; and
- the class of **covered persons** of which he or she is a member.

**Preferred Pharmacy:** a **pharmacy**; including a **mail order pharmacy**; which is party to a contract with Aetna to dispense drugs to persons covered under this Policy; but only:

- while the contract remains in effect; and
- while such a **pharmacy** dispenses a **prescription drug**; under the terms of its contract with Aetna.

**Preferred Prescription Drug Expense:** An expense incurred for a **prescription drug** that:

- is dispensed by a **Preferred Pharmacy**; or for an **emergency medical condition** only; by a **non-preferred pharmacy**; and
- is dispensed upon the **Prescription** of a **Prescriber** who is: a **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.

**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:** 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.
- 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.

**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.

**Specialist:** this is a **physician** who:

- practices in any generally accepted medical or surgical sub-specialty; and
- is providing other than routine medical care.

A **physician** who:

- practices in such a sub-specialty; and
- is providing routine medical care (such as could be given by a primary care physician),
- will not be considered a Specialist for purposes of applying this plan's copay provisions.

**Surgery Center:** this is a freestanding ambulatory surgical facility that meets all of the following tests:

As to a facility located in Pennsylvania, it:

- Meets licensing requirements of the Commonwealth of Pennsylvania.
- Does not include individual or group practice offices of private **physicians** or **dentists**, unless such offices have a distinct part used solely for **outpatient surgical treatment** on a regular and organized basis.

As to a facility located in a jurisdiction other than Pennsylvania, it:

- 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** - This includes but is not limited to:

- 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**.

Also, a **physician's** office; but only one that:

- has contracted with Aetna to provide urgent care; and
- is; with Aetna's consent; included in the Provider **Directory** as a Preferred Urgent Care Provider.
- It is not the emergency room or outpatient department of a **hospital**.

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

## **CLAIM PROCEDURE**

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

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

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.

## APPEALS PROCEDURE

### *Definitions*

**Adverse Benefit Determination (Decision):** A denial; reduction; termination of; or failure to; provide or make payment (in whole or in part) for a service, supply or benefit.

Such **adverse benefit determination** may be based on:

- Your eligibility for coverage.
- Coverage determinations, including plan limitations or exclusions.
- The results of any Utilization Review activities.
- A decision that the service or supply is **experimental or investigational**.
- A decision that the service or supply is not **medically necessary**.

As to medical and **prescription drug** claims, an **adverse benefit determination** also means the termination of a covered person's coverage back to the original effective date (rescission) as it applies under any rescission provision appearing in the Policy.

**Appeal:** An oral or written request to **Aetna** to reconsider an **adverse benefit determination**.

**Complaint:** Any oral or written expression of dissatisfaction about quality of care or the operation of the Plan.

**Concurrent Care Claim Extension:** A request to extend a course of treatment that was previously approved.

**Concurrent Care Claim Reduction or Termination:** A decision to reduce or terminate a course of treatment that was previously approved.

**External Review:** A review of an **adverse benefit determination** or a **final adverse benefit determination** by an Independent Review Organization/External Review Organization (ERO) assigned by the State Insurance Commissioner Aetna or the U.S. Office of Personnel Management, as determined by Aetna and made up of **physicians** or other appropriate health care **providers**. The ERO must have expertise in the problem or question involved.

**Final Adverse Benefit Determination:** An **adverse benefit determination** that has been upheld by **Aetna** at the exhaustion of the appeals process.

**Pre-service Claim:** Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

**Post-Service Claim:** Any claim that is not a "Pre-Service Claim."

**Urgent Care Claim:** Any claim for medical care or treatment in which a delay in treatment could:

- seriously jeopardize your life or health;
- jeopardize your ability to regain maximum function;
- cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

### *Full and Fair Review of Claim Determinations and Appeals*

As to medical and **prescription drug** claims and **appeals** only, **Aetna** will provide you with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue. This will be provided to you in advance of the date on which the notice of the **final adverse benefit determination** is required to be provided so that you may respond prior to that date.

Prior to issuing a **final adverse benefit determination** based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of **final adverse determination** is required.

### ***Claim Determinations – Health Coverage***

Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below. As to medical and **prescription drug** claims only, if **Aetna** makes an **adverse benefit determination**, written notice will be provided to you, or in the case of a concurrent care claim, to your **provider**.

#### **Urgent Care Claims**

**Aetna** will notify you of an **urgent care** claim decision as soon as possible, but not later than 72 hours after the claim is made.

If more information is needed to make an **urgent care claim** decision, **Aetna** will notify the claimant within 72 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide **Aetna** with the additional information. **Aetna** will notify the claimant within 48 hours of the earlier to occur:

- the receipt of the additional information; or
- the end of the 48 hour period given the **physician** to provide **Aetna** with the information.

#### **Pre-Service Claims**

**Aetna** will notify you of a **pre-service** claim decision as soon as possible, but not later than 15 calendar days after the claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 15 calendar day claim decision period is required. Such an extension, of no longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 15 calendar day period. If this extension is needed because **Aetna** needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information.

#### **Post-Service Claims**

**Aetna** will notify you of a **post-service** claim decision as soon as possible, but not later than 30 calendar days after the claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 30 calendar day claim decision period is required. Such an extension, of no longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 30 calendar day period. If this extension is needed because **Aetna** needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information.

#### **Concurrent Care Claim Extension**

Following a request for a **concurrent care claim extension**, **Aetna** will notify you of a claim decision for **urgent care** as soon as possible but not later than 24 hours, provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. A decision will be provided not later than 15 calendar days with respect to all other care, following a request for a **concurrent care claim extension**.

#### **Concurrent Care Claim Reduction or Termination**

**Aetna** will notify you of a claim decision to reduce or terminate a previously approved course of treatment with enough time for you to file an **appeal**.

As to medical and **prescription drug** claims only, if you file an **appeal**, coverage under the plan will continue for the previously approved course of treatment until a final **appeal** decision is rendered. During this continuation period, you are responsible for any **copayments**; **coinsurance**; and **deductibles**; that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under **appeal**. If **Aetna's** initial claim decision is upheld in the final **appeal** decision, you will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.

## ***Complaints***

If you are dissatisfied with the service you receive from the Plan or want to complain about a **network provider** you must call or write Member Services. The complaint must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. **Aetna** will review the information and provide you with a written response within 30 calendar days of the receipt of the **complaint**, unless more information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

## ***Appeals of Adverse Benefit Determinations***

You may submit an **appeal** if **Aetna** gives notice of an **adverse benefit determination**. This Plan provides for one level of **appeal**. As to medical and **prescription drug** claims only, a **final adverse benefit determination** notice may also provide an option to request an **External Review** (*if available*).

You have 180 calendar days with respect to Health Claims following the receipt of notice of an **adverse benefit determination** to request your Level One **appeal**. Your **appeal** may be submitted orally or must be submitted in writing and must include:

- Your name.
- The school's name.
- A copy of **Aetna's** notice of an **adverse benefit determination**.
- Your reasons for making the **appeal**.
- Any other information you would like to have considered.

Send your written **appeal** to the address shown on the notice of **adverse benefit determination**, or you may call in your **appeal** using the telephone number listed on the notice.

You may also choose to have another person (an authorized representative) make the **appeal** on your behalf. You must provide written consent to **Aetna**.

As to medical and **prescription drug** claims only, you may be allowed to provide evidence or testimony during the appeal process in accordance with the guidelines established by the Federal Department of Health and Human Services.

## ***Appeal – Medical and Prescription Drug Claims***

A review of an **Appeal** of an **adverse benefit determination** shall be provided by **Aetna** personnel. They shall not have been involved in making the **adverse benefit determination**.

## **Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)**

**Aetna** shall issue a decision within 72 hours of receipt of the request for an **appeal**.

## **Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)**

**Aetna** shall issue a decision within 30 calendar days of receipt of the request for an **appeal**.

## **Post-Service Claims**

**Aetna** shall issue a decision within 60 calendar days of receipt of the request for an Appeal.

## **Exhaustion of Process**

You must exhaust the applicable Level One processes of the Appeal Procedure before you:

- Contact the Pennsylvania Department of Insurance to request an investigation of a **complaint** or **appeal**; or
- File a complaint or **appeal** with the Pennsylvania Department of Insurance; or
- Establish any:
  - litigation;
  - arbitration; or
  - administrative proceeding;
- regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the Appeals Procedure.

As to medical and **prescription drug** claims only, under certain circumstances you may seek simultaneous review through the internal Appeals Procedure and **External Review** processes — these include **Urgent Care Claims** and situations where you are receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.

**Important Note:**

As to medical and **prescription drug** claims only, if **Aetna** does not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services, you are considered to have exhausted the **appeal** requirements and may proceed with **External Review** or any of the actions mentioned above. There are limits, though, on what sends a claim or an **appeal** straight to an **External Review**. Your claim or internal **appeal** *will not* go straight to **External Review** if:

- a rule violation was minor and isn't likely to influence a decision or harm you;
- it was for a good cause or was beyond **Aetna's** control; and
- it was part of an ongoing, good faith exchange between you and **Aetna**.

**External Review**

As to medical and **prescription drug** claims only, you may receive an **adverse benefit determination** or **final adverse benefit determination** because **Aetna** determines that:

- the claim involves medical judgment;
- the care is not **necessary** or appropriate;
- a service, supply or treatment is **experimental or investigational** in nature.

In these situations, you may request an **External Review** if you or your provider disagrees with **Aetna's** decision.

To request an **External Review**, any of the following requirements must be met:

- You have received an **adverse benefit determination** notice by **Aetna**, and **Aetna** did not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services.
- You have received a **final adverse benefit determination** notice of the denial of a claim by **Aetna**.
- Your claim was denied because **Aetna** determined that the care was not **necessary** or appropriate or was **experimental or investigational**.
- You qualify for a faster review as explained below.

The notice of **adverse benefit determination** or **final adverse benefit determination** that you receive from **Aetna** will describe the process to follow if you wish to pursue an **External Review**, and include a copy of the *Request for External Review Form*.

You must submit the *Request for External Review Form* to the U.S. Office of Personnel Management within 123 calendar days of the date you received the **adverse benefit determination** or **final adverse benefit determination** notice. You also must include a copy of the notice and all other pertinent information that supports your request.

The U.S. Office of Personnel Management will contact the ERO that will conduct the review of your claim. The ERO will select one or more independent clinical reviewers with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the *Request for External Review Form*, and will follow **Aetna's** contractual documents and plan criteria governing the benefits. You will be notified of the decision of the ERO usually within 45 calendar days of **Aetna's** receipt of your request form and all the necessary information.

A faster review is possible if your **physician** certifies (by telephone or on a separate *Request for External Review Form*) that a delay in receiving the service would:

- seriously jeopardize your life or health; or
- jeopardize your ability to regain maximum function; or

- if the **adverse benefit determination** relates to **experimental or investigational** treatment, if the **physician** certifies that the recommended or requested health care service, supply or treatment would be significantly less effective if not promptly initiated.

You may also receive a faster review if the **final adverse benefit determination** relates to an admission; availability of care; continued **stay**; or health service for which you received **emergency care**, but have not been discharged from a facility.

Faster reviews are decided within 72 hours after **Aetna** receives the request.

**Aetna** will abide by the decision of the ERO, except where **Aetna** can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the ERO to **Aetna**. **Aetna** is responsible for the cost of sending this information to the ERO and for the cost of the external review.

For more information about the Appeals Procedure or **External Review** processes, call the Member Services telephone number shown on your ID card.

## **PRESCRIPTION DRUG CLAIM PROCEDURE**

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

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

## **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.

**Services rendered without On Call International's coordination and approval are not covered. No claims for reimbursement will be accepted. If the Member is able to leave the Member's host country by normal means, On Call International will assist the Member in rebooking flights or other transportation. Expenses for non-emergency transportation are the Member's responsibility.**

**On Call phone number: 1-866-525-1956 or collect 1-603-328-1956**

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 (airfare only)
- **\$2,500** Return of Traveling Companion
- **\$2,500** Return of Dependent Children

- **\$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
- **\$1,000** Return of Personal Belongings

#### **Natural Disaster and Political Evacuation Services (NDPE)**

The following benefits are underwritten by United States Fire Insurance Company (USFIC) with medical, travel, and 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 a one-way economy class airline ticket to 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.

If the **Covered Person** is delayed at the safe haven, On Call shall arrange and pay for reasonable lodging expenses up to **\$100** per day for a maximum of three days. (Economy airfare and lodging costs shall not exceed a combined single limit of **\$5,000** USD per **Covered Person**).

Subject to a maximum benefit of **\$100,000** per Covered Person per Event.

**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](http://www.aetnastudenthealth.com) or (800) 841-5374.**

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.

Chickering Claims Administrators, Inc. (CCA) provides access to certain Accidental Death and Dismemberment (AD&D); Medical Evacuation/Repatriation (MER); Natural Disaster and Political Evacuation (NDPE); and Worldwide Emergency Travel Assistance (WETA) coverages and services through a contractual relationship with On Call International, LLC (On Call). AD&D coverage is underwritten by Fairmont Specialty dba United States Fire Insurance Company (USFIC). MER, NDPE and WETA membership services are administered by On Call.

CCA and On Call are independent contractors and not employees or agents of the each other. Neither CCA nor any of its affiliates provides or administers ADD, MER, NPDE and WETA benefits/services and neither CCA nor any of its affiliates is responsible in any way for the benefits/services provided by or through On Call.

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

### **Need help with registering onto Aetna Navigator?**

Registration assistance is available toll free, Monday through Friday, from 7 a.m. to 9 p.m. Eastern Time at **(800) 225-3375**.

**NOTICE**

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

**Administered by:**

Aetna Student Health  
P.O. Box 981106  
El Paso, TX 79998  
**(800) 841-5374**  
[www.aetnastudenthealth.com](http://www.aetnastudenthealth.com)

**Underwritten by:**

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

Policy No. 724535



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