WHERE TO FIND HELP

In case of an emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility. For non-emergency situations please visit or call 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 shinsur@pobox.upenn.edu

For questions about:
• Status of Pharmacy Claim
• Pharmacy Claim Forms
• Excluded Drugs and Pre-Authorization

Please contact:
Aetna Pharmacy Management
(800) 238-6279 (Available 24 hours)
For questions about:
• Provider Listings

Please contact:
Aetna Student Health
(800) 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 HealthSM is the brand name for products and services provided by these companies and their applicable affiliated companies.

IMPORTANT NOTE
Please keep this Brochure, as it provides a general summary of your coverage. A complete description of the benefits and full terms and conditions may be found in the Master Policy issued to 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

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, using the Penn Portal http://medley.isc-sec.upenn.edu/penn_portal/view.php. 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.

Evelyn Wiener, MD
Director
POLICY PERIOD

For early start Graduate students who want to begin their coverage **July 1, 2011** or **August 1, 2011**, please contact the Student Health Insurance Office for an application. New Undergraduate and returning Graduate students may begin their coverage on **August 15, 2011**.

1. **Students**: Coverage for all insured students enrolled for the Fall Semester, will become effective at 12:01 a.m. on **August 15, 2011**, and will terminate at 11:59 p.m. on **August 14, 2012**, except for students who graduate in December whose plans will terminate at 11:59 p.m. on **February 14, 2012**.

2. **New Spring Semester Students**: Coverage for all insured students enrolled for the Spring Semester, will become effective at 12:01 a.m. on **January 01, 2012**, and will terminate at 11:59 p.m. on **August 14, 2012**.

3. **New Summer 2012 Students**: Coverage for all insured students enrolled for Summer Semester will become effective at 12:01 a.m. on **May 1, 2012**, and will terminate at 11:59 p.m. on **August 14, 2012**.

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 (33) 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. on **February 14, 2012**. 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. on **February 14, 2012** unless you enroll in classes in the spring term by **February 14, 2012**. 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

<table>
<thead>
<tr>
<th>Cost</th>
<th>Annual 08/15/11 – 08/14/2012</th>
<th>Spring Semester 01/01/2012 – 08/14/2012</th>
<th>Summer 05/01/12 – 08/14/2012</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Student</strong></td>
<td>$3,012</td>
<td>$1,906</td>
<td>$932</td>
</tr>
<tr>
<td><strong>Spouse</strong></td>
<td>$3,818</td>
<td>$2,385</td>
<td>$1,148</td>
</tr>
<tr>
<td><strong>One Child</strong></td>
<td>$3,818</td>
<td>$2,385</td>
<td>$1,148</td>
</tr>
<tr>
<td><strong>Two or More Children</strong></td>
<td>$4,456</td>
<td>$2,780</td>
<td>$1,335</td>
</tr>
</tbody>
</table>

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.

### 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**: $1500 per Policy Year.
- **Spouse**: $1500 per Policy Year.
- **Child**: $1500 per Policy Year.
UNIVERSITY OF PENNSYLVANIA
STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN

This is a brief description of the Accident and Sickness Medical Expense benefits available for the 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

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.

Students who want 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 through the PennPortal: go first to “Health & Welfare” and from there to “Appointments (215-746-3535), immunizations, health insurance, clinical fee and more.” Then click on the first link “Student Health Insurance (Enrollment and Waiver).”

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 and for no more than 24 months of cumulative 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, 2011** 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, 2012 will be enrolled in PSIP by the university effective **January 1, 2012** and billed the **$1,906** 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**

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 by going to the Penn Portal at [https://medley.isc-seo.upenn.edu/penn_portal/portal.php](https://medley.isc-seo.upenn.edu/penn_portal/portal.php).

Under “Health & Welfare,” follow the link to “Appointments (215-746-3535), immunizations, health insurance, clinical fee and more,” 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 for will be required to document acceptable coverage by **August 31, 2011** or they will be enrolled in PSIP by the University. Students who matriculate in **July, August, or September 2011** must submit a waiver no later than **August 31, 2011**. 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.

**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, 2011** will be enrolled in the PSIP effective **August 15, 2011**. The **2011-2012** PSIP is an annual plan, with a premium of **$3,012**. 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, 2012** will be enrolled in the PSIP effective **January 1, 2012** and billed the spring semester premium of **$1,906**. Students may not withdraw or cancel coverage in the Plan once the waiver deadline has passed.
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.

<table>
<thead>
<tr>
<th>Category</th>
<th>Waiver Deadline Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students enrolling for the Fall Semester</td>
<td>08/31/2011</td>
</tr>
<tr>
<td>Students enrolling for the Spring Semester</td>
<td>01/31/2012</td>
</tr>
</tbody>
</table>

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 14, 2012, you will be covered until February 14, 2012. 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
ELIGIBILITY
Covered students may also enroll their lawful spouse, domestic partner and children under age. 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; click on “Find Your School.” Students will need to submit a Dependent Enrollment Application with an electronic check or MasterCard/Visa payment.

The dependent enrollment deadline for the fall semester is August 31, 2011. The enrollment deadline date for the spring semester is January 31, 2012. The enrollment deadline date for the summer semester is May 31, 2012. 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**

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).

1. Click on “Enter DocFind”
2. Select zip code, city, or county
3. Enter criteria
4. Select Provider Category
5. Select Provider Type
6. Select Plan Type – Student Health Plans
7. Select “Start Search” or “More Options”
8. “More Options” enter criteria and “Search”

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

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.

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

PRE-CERTIFICATION REQUIREMENTS

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 and outpatient services or supplies require pre-certification:

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

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

**Pre-Certification of Non-Emergency Inpatient Admissions, Partial Hospitalization, Identified Outpatient Services and Home Health Services:** The patient, Physician or hospital must telephone at least three 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 48 hours following inpatient (or partial hospitalization) admission.
DESCRIPTION OF BENEFITS

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

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

SUMMARY OF BENEFITS CHART

<table>
<thead>
<tr>
<th>DEDUCTIBLES</th>
<th>Covered Medical Expenses for Preferred Care are payable:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students:</td>
<td>$300 per Policy Year.</td>
</tr>
<tr>
<td>Spouse:</td>
<td>$300 per Policy Year.</td>
</tr>
<tr>
<td>Child:</td>
<td>$300 per Policy Year.</td>
</tr>
</tbody>
</table>

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

| Students:   | $1500 per Policy Year.                                    |
| Spouse:     | $1500 per Policy Year.                                    |
| Child:      | $1500 per Policy Year.                                    |

Note: The Deductible does not apply to:
- Treatment Received at Student Health Service (with the exception of labs sent to a third party for processing)
- Emergency Room Care (Facility and Physician)
- Prescription Drugs
- Inpatient and Outpatient Mental Health or Substance Abuse Treatment
- Immunizations
- Annual Eye Exam

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 lifetime per condition.

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.

Preferred Care: Individual Out-of-Pocket: $1,500 per Policy Year.
Preferred Care: Family Out-of-Pocket: $3,000 per Policy Year.

Non-Preferred Care: Individual Out-of-Pocket: $4,000 per Policy Year.
Non-Preferred Care: Family Out-of-Pocket: $8,000 per Policy Year.
All coverage is based on Recognized Charges unless otherwise specified.

### Inpatient Hospitalization Benefits

<table>
<thead>
<tr>
<th>Description</th>
<th>Covered Medical Expenses are payable as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Room and Board Expenses</td>
<td>Preferred Care: After a $100 per admission copay, 100% of the Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: After a $100 per admission deductible, 70% of the Recognized Charge for a semi-private room.</td>
</tr>
<tr>
<td>Intensive Care Unit Expenses</td>
<td>Preferred Care: After a $100 per admission copay, 100% of the Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: After a $100 per admission deductible, 70% of the Recognized Charge for the Intensive Care Room Rate for an overnight stay.</td>
</tr>
<tr>
<td>Miscellaneous Hospital Expenses</td>
<td>Preferred Care: After a $100 per admission copay, 100% of the Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: After a $100 per admission deductible, 70% of the Recognized Charge for a semi-private room.</td>
</tr>
</tbody>
</table>

### Surgical Benefits (Inpatient and Outpatient)

Surgical expenses include, but are not limited to: childbirth (vaginal or c-section), endoscopy, mole removal and biopsies. Some injection procedures are considered as invasive surgery and therefore may be billed as a surgical procedure.

<table>
<thead>
<tr>
<th>Description</th>
<th>Covered Medical Expenses for charges for surgical services, performed by a Physician, are payable as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Expenses</td>
<td>Preferred Care: After a $150 copay, 100% of the Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: After a $150 copay, 70% of the Recognized Charge.</td>
</tr>
<tr>
<td>Anesthesia Expenses</td>
<td>Preferred Care: After a $150 copay, 100% of the Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: After a $150 copay, 70% of the Recognized Charge.</td>
</tr>
<tr>
<td>Assistant Surgeon Expenses</td>
<td>Preferred Care: After a $150 copay, 100% of the Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: After a $150 copay, 70% of the Recognized Charge.</td>
</tr>
<tr>
<td>Ambulatory Surgical Expenses</td>
<td>Covered Medical Expenses must be incurred on the day of the surgery or within 48 hours after the surgery.</td>
</tr>
<tr>
<td></td>
<td>Preferred Care: After a $150 copay, 100% of the Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: After a $150 copay, 70% of the Recognized Charge.</td>
</tr>
</tbody>
</table>

Benefits are payable for Covered Medical Expenses incurred by a covered person for expenses incurred for outpatient surgery performed in a hospital outpatient surgery department or in an ambulatory surgical center. Covered Medical Expenses must be incurred on the day of the surgery or within 48 hours after the surgery.
<table>
<thead>
<tr>
<th>Outpatient Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Medical Expenses</strong> 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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital Outpatient Department or Walk-In Clinic Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits are payable for Covered Medical Expenses incurred by a covered person for diagnostic X-ray and laboratory services; consultants or specialists, etc.</td>
</tr>
<tr>
<td>Preferred Care: After a $30 copay, 100% of the Negotiated Charge.</td>
</tr>
<tr>
<td>Non-Preferred Care: 70% of the Recognized Charge.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Room Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Medical Expenses</strong> incurred for treatment of an Emergency Medical Condition are payable as follows:</td>
</tr>
<tr>
<td>Preferred Care: After a $100 copay (waived if admitted), 100% of the Negotiated Charge.</td>
</tr>
<tr>
<td>Non-Preferred Care: After a $100 Deductible (waived if admitted), 100% of the Recognized Charge.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Urgent Care Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits include charges for treatment by an urgent care provider.</td>
</tr>
</tbody>
</table>

**Please Note:** A Covered Person should not seek medical care or treatment from an urgent care provider if their illness, injury, or condition, is an emergency condition. The Covered Person should go directly to the emergency room of a hospital or call 911 for ambulance and medical assistance.

**Urgent Care**
Benefits include charges for an urgent care provider to evaluate and treat an urgent condition.

| Covered Medical Expenses for urgent care treatment are payable as follows: |
| Preferred Care: After a $30 per visit copay, 100% of the Negotiated Charge. |
| Non-Preferred Care: 70% of the Recognized Charge. |

<table>
<thead>
<tr>
<th>Ambulance Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Medical Expenses</strong> are payable as follows:</td>
</tr>
<tr>
<td>100% of the Actual Charge for the services of a professional ambulance to or from a hospital, when required due to the emergency nature of a covered Accident or Sickness.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pre-Admission Testing Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Medical Expenses</strong> for Pre-Admission testing charges while an outpatient before scheduled surgery are payable as follows:</td>
</tr>
<tr>
<td>Preferred Care: 100% of the Negotiated Charge.</td>
</tr>
<tr>
<td>Non-Preferred Care: 70% of the Recognized Charge.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician’s Office Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Medical Expenses</strong> are payable as follows:</td>
</tr>
<tr>
<td>Preferred Care: After a $30 per visit copay, 100% of the Negotiated Charge.</td>
</tr>
<tr>
<td>Non-Preferred Care: 70% of the Recognized Charge.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Laboratory and X-ray Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Medical Expenses</strong> are payable as follows:</td>
</tr>
<tr>
<td>Preferred Care: After a $35 copay, 100% of the Negotiated Charge.</td>
</tr>
<tr>
<td>Non-Preferred Care: 70% of the Recognized Charge.</td>
</tr>
</tbody>
</table>
| High Cost Procedures Expenses | **Covered Medical Expenses** include charges incurred by a **Covered Person** are payable as follows: 
**Preferred Care**: After a **$50** copay, **100%** of the Negotiated Charge. 
**Non-Preferred Care**: **70%** of the Recognized Charge. |
| Therapy Expenses | **Covered Medical Expenses** include charges incurred by a **Covered Person** for the following types of therapy provided on an outpatient basis: 
- Chiropractic Care, 
- Speech Therapy, or 
- Inhalation Therapy 
Expenses for Chiropractic Care are **Covered Medical Expenses**, if such care is related to neuromusculoskeletal conditions and conditions arising from: the lack of normal nerve, muscle, and/or joint function. Benefits are payable on the same basis as any other therapy. 
Expenses for Speech and Occupational Therapies are **Covered Medical Expenses**, only if such therapies are a result of **injury** or **sickness**. 
**Covered Medical Expenses** are payable as follows: 
**Preferred Care**: **100%** of the Negotiated Charge after a **$30** copay. 
**Non-Preferred Care**: **70%** of the Recognized Charge. |
| Chemotherapy Expenses | **Covered Medical Expenses** 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. 
**Covered Medical Expenses** 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: 
**Preferred Care**: **100%** of the Negotiated Charge. 
**Non-Preferred Care**: **70%** of the Recognized Charge. |
| Durable Medical Equipment Expenses | **Covered Medical Expenses** are payable as follows: 
**Preferred Care**: **90%** of the Negotiated Charge. 
**Non-Preferred Care**: **60%** of the Recognized Charge. 
Benefits include orthopedic shoes, foot orthotics, or other devices to support the feet if they are **medically necessary** to prevent the complications of diabetes. |
| Prosthetic Devices Expenses | **Covered Medical Expenses** include charges for: artificial limbs, or eyes, and other non-dental prosthetic devices, as a result of an accident or sickness. 
**Covered Medical Expenses do not** include: eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet unless they are medically necessary to prevent the complications of diabetes. 
Benefits are payable as follows: 
**Preferred Care**: **90%** of the Negotiated Charge. 
**Non-Preferred Care**: **60%** of the Recognized Charge. |
| Outpatient Physical and Occupational Therapy Expenses | **Covered Medical Expenses** for physical therapy and occupational therapy are payable as follows when provided by a licensed physical therapist: 
**Preferred Care**: **90%** of the Negotiated Charge. 
**Non-Preferred Care**: **60%** of the Recognized Charge. |
Dental Injury Expenses

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

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

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

If:
- Crowns (caps), or
- Dentures (false teeth), or
- Bridgework, or
- In-mouth appliances,

are installed due to such injury, **Covered Medical Expenses** include only charges for:
- The first denture or fixed bridgework to replace lost teeth,
- The first crown needed to repair each damaged tooth, and
- An in-mouth appliance used in the first course of orthodontic treatment after the injury.

Surgery needed to:
- Treat a fracture, dislocation, or wound.
- Cut out cysts, tumors, or other diseased tissues.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Non-surgical treatment of infections or diseases. This does not include those of, or related to, the teeth.

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

90% of the Actual Charge.

---

Impacted Wisdom Teeth Expenses

**Covered Medical Expenses** for removal of one or more impacted wisdom teeth are payable as follows:

90% of the Actual Charge.

---

Allergy Testing and Treatment Expenses

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

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

**Covered Medical Expenses** are payable on the same basis as any other condition.
<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
</tr>
</thead>
</table>
| Diagnostic Testing for Attention Disorders and Learning Disabilities Expenses | **Covered Medical Expenses** for diagnostic testing for:  
  - Attention Deficit Disorder, or  
  - Attention Deficit Hyperactive Disorder.  
  Benefits are payable on the same basis as any other condition. |
| Routine Physical Exam Expenses            | Benefits include expenses for a routine physical exam performed by a physician. If charges for a routine physical exam given to a child who is a covered dependent are covered under any other benefit section, those charges will not be covered under this section.  
  A routine physical exam is a medical exam given by a physician, for a reason other than to diagnose or treat a suspected or identified injury or sickness. Included as a part of the exam are:  
  - X-rays, lab, and other tests given in connection with the exam, and  
  - Materials for the administration of immunizations for infectious disease and testing for tuberculosis.  
  **Preferred Care**: visits are payable at **100%** of the Negotiated Charge after a per visit copay of $30.  
  **Preferred Care**: immunizations are payable at **90%** of the Negotiated Charge.  
  **Non-Preferred Care**: visits are payable at **70%** of the Recognized Charge.  
  **Non-Preferred Care**: immunizations are payable at **60%** of the Recognized Charge.  
  - For a **child** who is a covered dependent:  
    - The physical exam must include at least:  
      - A review and written record of the patient’s complete medical history,  
      - A check of all body systems, and  
      - A review and discussion of the exam results with the patient or with the parent or guardian.  
  - For all exams given to covered dependent **under age two**, **Covered Medical Expenses** will **not include** charges for the following:  
    - More than six exams performed during the first year of the child’s life,  
    - More than two exams performed during the second year of the child’s life.  
  - For all exams given to a covered dependent from **age two up to age six**, **Covered Medical Expenses** will **not include** charges for more than one exam in twelve months in a row.  
  - For all exams given to a covered dependent from **age six and over**, **Covered Medical Expenses** will **not include** charges for more than one exam in 24 months in a row.  
  Also included as **Covered Medical Expenses** are charges made by a physician for one annual routine gynecological exam. A referral is not required for this benefit.  
  **Covered Medical Expenses** do not include Routine Sexually Transmitted Disease Screenings. |
| Well Baby Care Expenses | Benefits include charges for routine preventive and primary care services, rendered to a covered dependent child on an outpatient basis.  

**Routine preventive and primary care** services are services rendered to a covered dependent child, from the date of birth through the attainment of **two 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.  

Benefits for materials for the administration of immunizations are covered at **90%**.  

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.  

**Covered Medical Expenses** are payable as follows:  
Preferred Care: **100%** after a per visit copay of **$30**. Benefits are payable for scheduled visits in accordance with the prevailing clinical standards of the American Academy of Pediatrics, or  
Non-Preferred Care: **70%** of the Recognized Charge. Benefits are payable for scheduled visits in accordance with the prevailing clinical standards of the American Academy of Pediatrics. |
| Immunizations Expenses | **Covered Medical Expenses** include:  
- charges incurred by a covered student for the materials for the administration of appropriate and **medically necessary** immunizations, and testing for tuberculosis, and  
- charges incurred by a covered dependent up to age 19, for the materials for the administration of appropriate and **medically necessary** immunizations, when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics.  

**Preferred Care**: **90%** of the Negotiated Charge.  
**Non-Preferred Care**: **60%** of the Recognized Charge.  

**Covered Medical Expenses do not** include a physician’s office visit in connection with immunization or testing for tuberculosis.  

**Please Note**: This Plan also covers Penn required pre-matriculation immunizations (Covered **100%** at Student Health Service).  

Guardasil (HPV vaccine) is covered at **$40** copay per injection at Penn Student Health Service only. |
| Consultant or Specialist Expenses | **Covered Medical Expenses** include the expenses for the services of a consultant or specialist, when referred by the School Health Services. The services must be requested by the attending physician for the purpose of confirming or determining to confirm or determine a diagnosis.  

**Covered Medical Expenses** are covered as follows:  
Preferred Care: After a **$30** per visit copay, **100%** of the Negotiated Charge.  
Non-Preferred Care: **70%** of the Recognized Charge. |
### Mental Health Benefits

<table>
<thead>
<tr>
<th>Category</th>
<th>Covered Medical Expenses</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental or Nervous Disorders Inpatient Expenses</td>
<td>for the diagnosis and treatment of mental or nervous disorders are payable on the same basis as any other sickness.</td>
<td>Preferred Care: 100% of the Negotiated Charge. Non-Preferred Care: 70% of the Recognized Charge. Treatment is limited to a maximum of 30 days per Policy Year, per condition for any one or related mental health condition.</td>
</tr>
<tr>
<td>Mental or Nervous Outpatient Expenses</td>
<td>for the diagnosis and treatment of mental or nervous disorders are payable on the same basis as any other sickness.</td>
<td>Preferred Care: After a $25 copay, 100% of the Negotiated Charge. Non-Preferred Care: 70% of the Recognized Charge, up to $80 maximum per visit. Outpatient treatment is subject to a maximum of 50 visits per condition, per Policy Year.</td>
</tr>
</tbody>
</table>

### Substance Abuse Benefits

<table>
<thead>
<tr>
<th>Category</th>
<th>Covered Medical Expenses</th>
<th>Details</th>
</tr>
</thead>
</table>
| Treatment of Alcohol or Drug Addiction Inpatient Expenses | include inpatient treatment either in a hospital or in a non-hospital residential facility for the treatment of alcohol or drug addiction. | Benefits are payable on the same basis as any other condition. Hospital 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 30 days of confinement per Policy Year. This 30 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. This maximum does not apply to confinements solely for detoxification needed due to alcoholism or drug abuse. Non-Hospital Residential Facility Certain charges for the treatment of alcohol or drug addiction are covered. Benefits include 30 days of confinement per Policy Year. The expenses covered are those for: Board and room. Other necessary services and supplies. During a Covered Person’s lifetime, benefits will not be paid for more than 90 days of confinement. Hospital or Non-Hospital Residential Facility Charges for confinement solely for detoxification needed due to alcoholism or drug abuse are covered during the: first seven days of any one confinement; and first four such confinements in the Covered Person’s lifetime. 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
Treatment of Alcohol or Drug Addiction

Inpatient Expenses  

Purposes of inpatient treatment of alcohol or drug addiction shall include, but not be limited to, the following:  
- Lodging and dietary services.  
- Physician, psychologist, nurse, certified addictions counselor and trained staff services.  
- Diagnostic X-rays in connection with inpatient detoxification treatment.  
- Psychiatric, psychological and medical laboratory testing.  
- Drugs, medicines, equipment use and supplies.  
- Rehabilitation therapy and counseling.  
- Family counseling and intervention.  

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.  

Benefits are payable as follows:  
**Preferred Care**: 100% of the Negotiated Charge.  
**Non-Preferred Care**: 70% of the Recognized Charge.  

| Treatment of Alcohol or Drug Addiction | Covered Medical Expenses | 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. Charges for group, family or individual counseling are included.  
- 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 30 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.  
- 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 50 visits in any one Policy Year and the Special Outpatient Lifetime Maximum of 120 visits.  

**Covered Medical Expenses** for the purposes of Outpatient Treatment of Alcohol or Drug Addiction shall include, but not be limited to, the following:  
- Physician, psychologist, nurse, certified addictions counselor and trained staff services.  
- Psychiatric, psychological and medical laboratory testing.  
- Drugs, medicines, equipment use and supplies.  
- Rehabilitation therapy and counseling.  
- Family counseling and intervention.  

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.  

Benefits are payable as follows:  
**Preferred Care**: After a $25 per visit copay, 100% of the Negotiated Charge.  
**Non-Preferred Care**: 70% of the Recognized Charge, up to a maximum or $80 per visit.
**Maternity Benefits**

<table>
<thead>
<tr>
<th>Covered Medical Expenses</th>
<th>Maternity Expenses include inpatient care of the Covered Person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>Covered Medical Expenses</td>
<td>Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other sickness.</td>
</tr>
<tr>
<td></td>
<td>Office Visits and Lab/X-ray copays are waived for Pre-Natal/Maternity Care.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Well Newborn Nursery Care Expenses</th>
<th>Benefits include charges for routine care of a Covered Person’s newborn child as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• hospital charges for routine nursery care during the mother’s confinement, but for not more than four days (for a normal delivery),</td>
</tr>
<tr>
<td></td>
<td>• physician’s charges for circumcision, and</td>
</tr>
<tr>
<td></td>
<td>• physician’s charges for visits to the newborn child in the hospital and consultations, but for not more than one visit per day.</td>
</tr>
<tr>
<td>Covered Medical Expenses</td>
<td>Covered Medical Expenses are payable as follows:</td>
</tr>
<tr>
<td>Preferred Care</td>
<td>Preferred Care: 100% of the Negotiated Charge.</td>
</tr>
<tr>
<td>Non-Preferred Care</td>
<td>Non-Preferred Care: 70% of the Recognized Charge.</td>
</tr>
</tbody>
</table>

**Additional Benefits**

<table>
<thead>
<tr>
<th>Prescription Drug Benefits</th>
<th>Prescription Drug Benefits are payable as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Care Pharmacy</td>
<td>Preferred Care Pharmacy: $30 copay for each Brand Name Prescription Drug or a $15 copay for each Generic Prescription Drug, then 100% of Negotiated Charge.</td>
</tr>
<tr>
<td>Non-Preferred Care Pharmacy</td>
<td>Non-Preferred Care Pharmacy: $30 Deductible for each Brand Name Prescription, or a $15 for each Generic Prescription Drug, 100% of the Recognized Charge.</td>
</tr>
</tbody>
</table>

A benefit will be paid at the preferred level of coverage for a prescription drug dispensed by a Non-Preferred Pharmacy only:

- For an emergency condition, or
- On Referral of a person’s Primary Care Physician.

This Pharmacy benefit is provided to cover Medically Necessary Prescriptions associated with a covered Sickness or Accident occurring during the Policy Year. Please use your Aetna Student Health ID card when obtaining your prescriptions.

Prior Authorization is required for certain Prescription Drugs, including growth hormones and for any Prescription quantities larger than a 30-day supply. *(This is only a partial list.*)

Medications not covered by this benefit include, but are not limited to: drugs whose sole purpose is to promote or to stimulate hair growth, fertility medications, Viagra, Levitra, Cialis, appetite suppressants, smoking deterrents and non-self injectables. *(This is only a partial list.*)

For assistance or for a complete list of excluded medications, or drugs requiring prior authorization, please contact Aetna Pharmacy Management at (800) 238-6279 (available 24 hours).

Aetna Specialty Pharmacy provides specialty medications and support to members living with chronic conditions. The medications offered may be injected, infused or taken by mouth. For additional information please go to [www.AetnaSpecialtyRx.com](http://www.AetnaSpecialtyRx.com).

Mail order prescriptions are covered at 2x the copay per 90 day supply.
| Diabetic Equipment and Supplies Expenses | **Covered Medical Expenses** 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.  

Diabetic equipment and supplies include, but are not limited to:
- lancet devices,
- blood glucose monitors,
- test strips,
- monitor supplies,
- insulin,
- injection aids,
- syringes,
- insulin infusion devices,
- pharmacological agents for controlling blood sugar, and
- orthopedic shoes, foot orthotics, or other devices to support the feet that are medically necessary to prevent complications of diabetes.  

**Covered Medical Expenses** are payable on the same basis as any other sickness.  

**Please Note:** Diabetic testing supplies and insulin are covered under the prescription drug portion of this Plan. Equipment is covered under the durable medical expense benefit. |
| Hypodermic Needles Expenses | **Covered Medical Expenses** for hypodermic needles and syringes are payable under the prescription drug portion of the Plan.  

Expenses incurred for the treatment of diabetes will be covered on the same basis as any other sickness, and an individual benefit maximum will not apply.  

Expenses incurred for hypodermic needles for the treatment of diabetes will apply to the Aggregate Maximum for the Policy Year.  

**Please Note:** Diabetic testing supplies and insulin are covered under the prescription drug portion of this Plan. Equipment is covered under the durable medical expense benefit. |
| Outpatient Diabetic Self-Management Education Programs Expenses | **Covered Medical Expenses** for outpatient diabetic self-management education programs are payable as follows:  

**Preferred Care:** 100% of the Negotiated Charge.  

**Non-Preferred Care:** 70% of the Recognized Charge. |
| Prescription Contraceptive Device Expenses | Covered Medical Expenses include:  
• Charges incurred for contraceptive drugs and devices that by law need a physician's prescription, and that have been approved by the FDA.  
• Related outpatient contraceptive services such as:  
  o Consultations,  
  o Exams,  
  o Procedures, and  
  o Other medical services and supplies.  
Benefits for contraceptive drugs are payable on the same basis as any other condition. Benefits for contraceptive devices and outpatient contraceptive services are payable on the same basis as any other condition. |
| Pap-Smear Expenses | Covered Medical Expenses includes one routine gynecological exam each calendar year and one annual routine Pap-smear screening for women age 18 and older.  
Covered Medical Expenses are payable on the same basis as any expense with waiver of any Plan Deductible. |
| Mammography Expenses | Covered Medical Expenses include charges for routine mammograms.  
Benefits will be paid for Expenses incurred for the following:  
1. A mammogram on an annual basis for women 40 years of age and older.  
2. For women less than 40 years of age, a mammogram when recommended by the women's physician.  
Benefits are payable on the same basis as any other condition. |
| Mastectomy and Breast Reconstruction Expense Benefits | 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:  
1. reconstruction of the breast on which a mastectomy has been performed,  
2. surgery and reconstruction of the other breast to produce a symmetrical appearance,  
3. prostheses, and  
4. treatment of physical complications of all stages of mastectomy, including lymphedemas.  
Covered Medical Expenses 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. |
| Elective Abortion Expenses | If, as a result of pregnancy having its inception during the Policy Year, a Covered Person incurs expenses in connection with an elective abortion, a benefit is payable.  
Covered Medical Expenses for Elective Abortion Expense are covered as follows:  
Preferred Care: After a $150 copay, 100% of the Negotiated Charge.  
Non-Preferred Care: 70% of the Recognized Charge.  
This benefit is in lieu of any other Policy benefits. |
### Routine Colorectal Cancer Screening Expense

Even though not incurred in connection with a sickness or injury, benefits 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:

- One fecal occult blood test every 12 months in a row
- A Sigmoidoscopy at age 50 and every 3 years thereafter
- One digital rectal exam every 12 months in a row
- A double contrast barium enema, once every 5 years
- A colonoscopy, once every 10 years
- Virtual colonoscopy
- Stool DNA.

**Covered Medical Expenses** are payable on the same basis as any other condition.

### Elective Surgical Second Opinion Expenses

**Covered Medical Expenses** will include expenses incurred for a second opinion consultation by a specialist on the need for non-emergency elective surgery which has been recommended by the **Covered Person**’s physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation.

Benefits are payable as follows:

- **Preferred Care**: After a **$30** per visit copay, **100%** of the Negotiated Charge.
- **Non-Preferred Care**: **70%** of the Recognized Charge.

### Acupuncture in Lieu of Anesthesia Expenses

**Covered Medical Expenses** include acupuncture therapy, when acupuncture is used in lieu of other anesthesia, for a surgical or dental procedure covered under this Plan.

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

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

### Dermatological Expenses

**Covered Medical Expenses** include charges for the diagnosis and treatment of skin disorders, excluding laboratory fees. Related laboratory expenses are covered under the Outpatient Expense Benefit.

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

### Podiatric Expenses

**Covered Medical Expenses** include charges for podiatric services, provided on an outpatient basis following an injury and for the treatment of diabetes.

Podiatric Expense Benefits incurred as a result of an injury are payable on the same basis as any other condition.

**Covered Medical Expenses** include those incurred to measure and fit orthopedic shoes, foot orthotics, or other devices to support the feet that are **medically necessary** to prevent complications of diabetes.

Expenses for routine foot care, such as trimming of corns, calluses, and nails, are **not Covered Medical Expenses**.
| Home Health Care Expenses | Covered Medical Expenses include charges incurred by a Covered Person for home health care services made by a home health agency pursuant to a home health care plan, but only if: 
(a) The services are furnished by, or under arrangements made by, a licensed home health agency, 
(b) The services are given under a home care plan. This plan must be established pursuant to the written order of a physician, and the physician must renew that plan every 60 days. Such physician must certify that the proper treatment of the condition would require inpatient confinement in a hospital (or skilled nursing facility) if the services and supplies were not provided under the home health care plan. The physician must examine the Covered Person at least once a month, 
(c) Except as specifically provided in the home health care services, the services are delivered in the patient's place of residence on a part-time, intermittent visiting basis while the patient is confined, 
(d) The care starts within seven days after discharge from a hospital as an inpatient, and 
(e) The care is for the same condition that caused the hospital confinement, or one related to it. |
| --- | --- |
| Home Health Care Services | 1. Part-time or intermittent nursing care by: a registered nurse (R.N.), a licensed practical nurse (L.P.N.), or under the supervision on a R.N. if the services of an R.N. are not available, 
2. Part time or intermittent home health aide services, that consist primarily of care of a medical or therapeutic nature by other than a R.N., 
3. Physical, occupational, speech therapy, or respiratory therapy, 
4. Medical supplies, drugs and medicines, and laboratory services. However, these items are covered only to the extent they would be covered if the patient was confined to a hospital, 
5. Medical social services by licensed or trained social workers, 
6. Nutritional counseling. |
| Covered Medical Expenses will not include: 1) services by a person who resides in the Covered Person's home, or is a member of the Covered Person's immediate family, 2) homemaker or housekeeper services, 3) maintenance therapy, 4) dialysis treatment, 5) purchase or rental of dialysis equipment, or 6) food or home delivered services. |
| Benefits are payable as follows: 
Preferred Care: 100% of the Negotiated Charge. 
Non-Preferred Care: 100% of the Recognized Charge. |
| A visit means a maximum of four continuous hours of home health service. 
There is a benefit maximum of 40 visits per Policy Year. |
| Transfusion or Dialysis of Blood Expenses | Covered Medical Expenses include charges for the transfusion or dialysis of blood, including the cost of: whole blood, blood components, and the administration thereof. 
Benefits are payable on the same basis as any other condition. |
| Hospice Benefit Expenses | Covered Medical Expenses include charges for hospice care provided for a terminally ill Covered Person during a hospice benefit period. 
Benefits are payable as follows: 
Preferred Care: 100% of the Negotiated Charge. 
Non-Preferred Care: 70% of the Recognized Charge. |
| **Licensed Nurse Expenses** | 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.  

**Covered Medical Expenses** for a Licensed Nurse are covered as follows:  
**Preferred Care**: 100% of the Negotiated Charge.  
**Non-Preferred Care**: 70% of the Recognized Charge. |
| **Skilled Nursing Facility Expenses** | **Covered Medical Expenses** include charges incurred by a **Covered Person** for confinement in a skilled nursing facility for treatment rendered:  
- in lieu of confinement in a hospital as a full time inpatient, or  
- within 24 hours following a hospital confinement and for the same or related cause(s) as such hospital confinement.  

**Covered Medical Expenses** are payable as follows:  
**Preferred Care**: After a $100 per day of confinement or per admission copay, 100% of the Negotiated Charge for the semi-private room rate.  
**Non-Preferred Care**: After a $100 per day of confinement or per admission Deductible, 70% of the Recognized Charge for the semi-private room rate. |
| **Rehabilitation Facility Expenses** | **Covered Medical Expenses** include charges incurred by a **Covered Person** for confinement as a full time inpatient in a rehabilitation facility. Confinement in the rehabilitation facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of hospital or skilled nursing facility confinement.  

**Covered Medical Expenses** for Rehabilitation Facility Expense are covered as follows:  
**Preferred Care**: After a $100 per day of confinement or per admission copay, 100% of the Negotiated Charge for the rehabilitation facility’s daily room and board maximum for semi-private accommodations.  
**Non-Preferred Care**: After a $100 per day of confinement or per admission Deductible, 70% of the Recognized Charge for the rehabilitation facility’s daily room and board maximum for semi-private accommodations. |
| **Vision Care Exam Expenses** | Benefits include charges for any service shown below, which is furnished by a legally qualified ophthalmologist or optometrist.  

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

Benefits are limited to one routine eye exam per Policy Year.  

**Covered Medical Expenses** will be payable as follows:  
**Preferred Care**: 90% of the Negotiated Charge.  
**Non-Preferred Care**: 60% of the Recognized Charge.  

**Limitations**  
The following limitations apply:  
- No benefits will be payable for a charge which is:  
  - For any eye exam to diagnose or treat a disease or injury.  
  - For drugs or medicines.  
  - For a vision care service that is a **Covered Medical Expense** in whole or in part, under any other part of this Plan, or under any other group plan.  
  - For a vision care service for which a benefit is provided in whole or in part, under any workers’ compensation law or any other law of like purpose. |
### Vision Care Exam Expenses (cont.)

- For special procedures. This means things such as orthoptics or vision training.
- For any vision care supply.
- For an eye exam which:
  - Is required by an employer as a condition of employment, or
  - An employer is required to provide under a labor agreement, or
  - Is required by any law of a government.
- For a service received while the person is not a **Covered Person**.
- For a service which does not meet professionally accepted standards.
- For any exams given while the person is confined in a hospital or other facility for medical care.

### Transgender Coverage

**Covered Medical Expenses** include charges incurred by a **Covered Person** for gender reassignment.

**Covered Medical Expenses** are payable on the same basis as any other condition except that surgery for gender reassignment is limited to a maximum of $50,000 per **Policy Year**.
ADDITIONAL SERVICES AND DISCOUNTS

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

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

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

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

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

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

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

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

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

**University of Pennsylvania Wellness Program- Bike Helmet Reimbursement:** University of Pennsylvania will provide a $25 reimbursement to covered students when they purchase a bike helmet. Please contact the University for details.

**Zagat discounts:** Discount off a one-year online membership to ZAGAT.com, with access to ratings and reviews of over 40,000 restaurants, hotels and more in hundreds of cities worldwide.

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

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

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

**Beginning Right® Maternity Program:** Make healthy choices for you and your baby. Learn what decisions are good ones for you and your baby. Our Beginning Right maternity program helps prepare you for the exciting changes pregnancy brings.
Vital Savings by Aetna® on Dental* is a dental discount program helping you and your dependents save with one low annual fee of $25 per student. In most instances, savings range from 15-50 percent on services from general dentistry and cleanings to root canals, crowns, and orthodontia (braces). No claims to file. Enroll online at www.aetnastudenthealth.com.

- Student: $25
- Student + one dependent: $44
- Student with family: $63

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

The Vital Savings by Aetna® program (the “Program”) is not insurance. The program does not meet the Minimum Creditable Coverage requirements in Massachusetts. It provides Members with access to discounted fees according to schedules negotiated by Aetna Life Insurance Company for the Vital Savings by Aetna discount program. The range of discounts provided under the Program will vary depending on the type of provider and type of service received. The Program does not make payments directly to the participating providers. Each Member must pay for all services or products but will receive a discount from the providers who have contracted with the Discount Medical Plan Organization to participate in the Program. Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, CT 06156, 1-888-BeVital, is the Discount Medical Plan Organization.

Health programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health/dental care professional. The availability and terms of specific discount programs and wellness services are subject to change without notice. Not all programs are available in all states.

Aetna Dental® PPO
With our Aetna Dental® PPO insurance plan, participating dentists may offer discounted rates on additional services such as tooth whitening. Enroll and search dentists online at www.aetnastudenthealth.com.

*Discounts for non-covered services may not be available in all states. The Aetna Dental PPO insurance plan is underwritten by Aetna Life Insurance Company.

Annual coverage: 08/15/2011 to 08/14/2012
- Student: $295
- Student + one dependent: $600
- Student + two or more dependents: $1,049

Spring coverage: 01/01/2012 to 08/14/2012
- Student: $197
- Student + one dependent: $400
- Student + two or more dependents: $699

Summer coverage: 05/01/2012 to 08/14/2012
- Student: $98
- Student + one dependent: $200
- Student + two or more dependents: $350

Aetna’s Informed Health® Line*:
Call toll free 1-800-556-1555 24 hours a day, 7 days a week. Get health answers 24/7. When you have an Aetna health benefits and health insurance plan, you have instant access to the information you need. Our tools and resources can help you:
- Make more informed decisions about your care.
- Communicate better with your doctors.
- Save time and money, by showing you how to get the right care at the right time.
When you call our Informed Health Line, you can talk directly to a registered nurse. Our nurses can discuss a wide variety of health and wellness topics.

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

Listen to the Audio Health Library:*It explains thousands of health conditions in English and Spanish. Transfer easily to a registered nurse at any time during the call.

*Not all topics in the audio health service are covered expenses under your plan.*

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

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

STATE MANDATED BENEFITS
The Plan will pay benefits in accordance with any applicable 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/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/her 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/her insurance carrier.
- The Covered Person (or person authorized by law to represent the Covered Person if he/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.

**NON-DUPLICATION OF BENEFITS**
This provision applies if a covered student:
(a) Is covered by any other group or blanket health care plan, and
(b) Would, as a result, receive medical expense or service benefits in excess of the actual expenses incurred.

In this case, the medical expense benefits the Plan will pay the will be reduced by such excess. This provision will not apply to the first $100 of any one claim.

**EXTENSION OF BENEFITS**
If Basic Sickness Expense, Supplemental Sickness Expense coverage for a **Covered Person** ends while he/she 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 on the date his/her insurance terminates, expenses incurred after the termination date and during the continuance of that hospital confinement, shall be payable in accordance with the policy, but only while they are incurred during the 31 day period, following such termination of insurance.

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

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

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

Insurance for a covered student’s dependent will end when insurance for the covered student ends. Before then, coverage will end:

- (a) For a child, on the first premium due date following the first to occur of:
  1. the date the child is no longer chiefly dependent upon the student for support and maintenance,
  2. the date of the child’s marriage, and
  3. the child’s 19th birthday
- (b) The date the covered student fails to pay any required premium.
- (c) For the spouse, the date the marriage ends in divorce or annulment.
- (d) The date dependent coverage is deleted from this Plan.
- (e) For a domestic partner, the earlier to occur of:
  1. the date this Plan no longer allows coverage for domestic partners, and
  2. 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.
- (f) 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:

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

**CONTINUATION OF COVERAGE**

A covered student who has graduated or is otherwise ineligible for coverage under this Plan, and has been continuously insured under the Plan offered by the Policyholder (regular student Plan), may be covered for up to three, six, nine or twelve 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, 2011 for fall coverage or March 31, 2012 for Spring coverage, and (3) premium payment has been made. Coverage under this provision ceases on the date this Plan terminates.

<table>
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<tr>
<th></th>
<th>3 Months</th>
<th>6 Months</th>
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<th>12 Months</th>
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EXCLUSIONS

This Plan does not cover nor provide benefits for:

1. Expenses incurred as a result of dental treatment, except for treatment resulting from injury to sound, natural teeth or for extraction of impacted wisdom teeth as provided elsewhere in this Plan.

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

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

4. Expenses incurred as a result of injury due to participation in a riot. “Participation in a riot” means taking part in a riot in any way, including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense, so long as they are not taken against persons who are trying to restore law and order.

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

6. Expenses incurred as a result of an injury or sickness due to working for wage or profit or for which benefits are payable under any Workers’ Compensation or Occupational Disease Laws.

7. Expenses incurred as a result of an injury sustained or sickness contracted while in the service of the Armed Forces of any country. Upon the Covered Person entering the Armed Forces of any country, the unearned pro-rata premium will be refunded to the Policyholder.

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

9. Expenses incurred for cosmetic surgery, reconstructive surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons, except to the extend needed to:
   - Improve the function of a part of the body that:
     - is not a tooth or structure that supports the teeth, and
     - is malformed:
       - as a result of a severe birth defect, including harelip, webbed fingers, or toes, or
       - as direct result of:
         - disease, or
         - surgery performed to treat a disease or injury.
   - Repair an injury which occurs while the Covered Person is covered under this Plan. Surgery must be performed:
     - in the calendar year of the accident which causes the injury, or
     - in the next calendar year.

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

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

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

13. Expenses incurred after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits Provision.
14. Expenses incurred for services normally provided without charge by the school and covered by the school fee for services.

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


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

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

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

20. Expenses incurred for experimental or investigational procedures.

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

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

23. Expenses incurred for the removal of an organ from a **Covered Person** for the purpose of donating or selling the organ to any person or organization. This limitation does not apply to a donation by a **Covered Person** to a spouse, child, brother, sister, or parent.

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

25. Expenses incurred for the repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices unless they are **medically necessary** to prevent the complications of diabetes.

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

However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease, if Aetna determines that:
   - The disease can be expected to cause death within one year, in the absence of effective treatment, and
• The care or treatment is effective for that disease, or shows promise of being effective for that disease, as demonstrated by scientific data. In making this determination, Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

Also, this exclusion will not apply with respect to drugs that:
• Have been granted treatment investigational new drug (IND), or Group c/treatment IND status, or
• Are being studied at the Phase III level in a national clinical trial, sponsored by the National Cancer Institute,
• If Aetna determines that available, scientific evidence demonstrates that the drug is effective, or shows promise of being effective, for the disease.

27. Expenses incurred for breast reduction/mamoplasty unless they are incurred in connection with a mastectomy and breast reconstruction.

28. Expenses incurred for gynecomastia (male breasts).

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

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

31. Expenses for injurie{s} 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.

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

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

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

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

36. Expenses for services or supplies provided for the treatment of obesity and/or weight control.

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

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

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

40. Expenses incurred for massage therapy.

41. Expenses for charges that are not Recognized Charges, as determined by Aetna, except that this will not apply if the charge for a service, or supply, does not exceed the Recognized Charge for that service or supply, by more than the amount or percentage, specified as the Allowable Variation.

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

44. Expenses incurred for a treatment, service, or supply, which is not medically necessary, as determined by Aetna, for the diagnosis care or treatment of the sickness or injury involved. This applies even if they are prescribed, recommended, or approved, by the person’s attending physician, or dentist.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Dependent**
(a) the covered student’s spouse residing with the covered student, or (b) the person identified as a domestic partner as determined by the University of Pennsylvania, and (c) the covered student’s child under the age of 26 years.

The term “child” includes a covered student’s 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.

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

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

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

*The following are not considered Diabetic Self-Management Education Courses for the purposes of this Plan:*
• A Diabetic Education program whose only purpose is weight control, or which is available to the public at no cost; or
• A general program not just for diabetics; or
• A program made up of services not generally accepted as necessary for the management of diabetes.
Directory
This is a listing of all Preferred Care Providers in the service area covered under the Policy for the class of students of which the student is a member. This listing is given to the School for distribution to all students concerned. A current list of participating providers is also available through Aetna’s on-line provider directory, DocFind®, at www.aetna.com.

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, over-bed tables, elevators, communication aids, vision aids, and telephone alert systems.

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

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

Emergency Condition
This is any traumatic injury or condition which:
- occurs unexpectedly,
- requires immediate diagnosis and treatment, in order to stabilize the condition, and
- is characterized by symptoms such as severe pain and bleeding.
Emergency Medical Condition
This means a recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his/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
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.

High Cost Procedure
High Cost Procedures include the following procedures and services:

- C.A.T. Scan,
- Magnetic Resonance Imaging,
- Laser treatment, which must be provided on an outpatient basis, and may be incurred in the following:
  1. A physician’s office, or
  2. Hospital outpatient department, or emergency room, or
  3. Clinical laboratory, or
  4. Radiological facility, or other similar facility, licensed by the applicable state, or the state in which the facility is located.

Home Health Agency
An agency 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 a R.N., L.P.N., or L.V.N., primarily aid the Covered Person in performing the normal activities of daily living while recovering from an injury or sickness, and are described under the written Home Health Care Plan.
Home Health Care
Health services and supplies provided to a **Covered Person** on a part-time, intermittent, visiting basis. Such services and supplies must be provided in such person’s place of residence, while the person is confined as a result of **injury** or **sickness**. Also, a **physician** must certify that the use of such services and supplies is to treat a condition as an alternative to confinement in a **hospital** or **skilled nursing facility**.

Home Health Care Plan
A 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 six months to live. It ends after six months (or such later period for which treatment is certified) or on the death of the patient, if sooner.

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

Hospital
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/her, or any person who is part of his/her family, any healthcare provider, or healthcare facility, or
• Those furnished solely because the person is an inpatient on any day on which the person’s sickness or injury could safely and adequately be diagnosed or treated while not confined, or
• Those furnished solely because of the setting if the service or supply could safely and adequately be furnished, in a physician’s or a dentist’s office, or other less costly setting.
Medication Formulary
A listing of prescription drugs which have been evaluated and selected by Aetna clinical pharmacists, for their therapeutic equivalency and efficacy. This listing includes both brand name and generic prescription drugs. This listing is subject to periodic review, and modification by Aetna.

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

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

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

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

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:
  o It provides all medical detoxification services on the premises, 24 hours a day.
  o It provides all normal infirmary 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.
  o At all time 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.

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

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

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the covered student:
• is covered under any type of workers’ compensation law, and
• is not covered for that disease under such law.
Non-Occupational Injury
A non-occupational injury is an accidental bodily injury that does not:
• arise out of (or in the course of) any work for pay or profit, or
• result in any way from an injury which does.

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

Non-Preferred Care Provider
• a health care provider that has not contracted to furnish services or supplies at a Negotiated Charge, or
• a Preferred Care Provider that is furnishing services or supplies without the referral of a School Health Services.

Non-Preferred Pharmacy
A pharmacy not party to a contract with Aetna, or a pharmacy who is party to such a contract but who does not dispense prescription drugs in accordance with its terms.

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

Non-Specialist
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.

Outpatient Surgical Treatment
Surgical treatment furnished in a surgery center located in Pennsylvania to patients who:
• do not require hospitalization, but
• requires constant medical supervision following the surgical procedure performed.

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

The following expenses do not apply toward meeting the Out-of-Pocket Limit:
• copays,
• expenses that are not Covered Medical Expenses,
• expenses for designated care or Non-Preferred Care,
• penalties,
• expenses for prescription drugs, and
• other expenses not covered by this Plan.
Outpatient Diabetic Self-Management Education Program
A scheduled program on a regular basis, which is designed to instruct a Covered Person in the self-management of diabetes. It is a day care program of educational services and self-care training, (including medical nutritional therapy). The program must be under the supervision of an appropriately licensed, registered, or certified health care professional whose scope of practice includes diabetic education or management.

Partial Hospitalization for Treatment of Mental or Nervous Disorders
Continuous treatment consisting of not less than four hours and not more than twelve hours in any 24 hour period under a program based in a hospital.

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.

Pervasive Developmental Disorder
A neurological condition, including Asperger’s Syndrome and Autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Pharmacy
An establishment where prescription drugs are legally dispensed.

Physician
A legally qualified physician. Also, to the extent required by the 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.

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

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

If the person cancels the scheduled surgery, benefits are paid at the covered percentage that would have applied in the absence of this benefit.
Preferred Care
Care provided by:
- a Covered Person’s primary care physician, or a Preferred Care Provider on the referral of the primary care physician, or
- a health care provider that is not a Preferred Care Provider for an emergency medical condition when travel to a Preferred Care Provider, or referral by a Covered Person’s primary care physician prior to treatment, is not feasible, or
- a Non-Preferred Urgent Care Provider when travel to a Preferred Urgent Care Provider for treatment is not feasible, and if authorized by Aetna.

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

Preferred Pharmacy
A pharmacy, including a mail order pharmacy, which is party to a contract with Aetna to dispense drugs to persons covered under this Plan, but only:
- while the contract remains in effect, and
- while such a pharmacy dispenses a prescription drug, under the terms of its contract with Aetna.

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

Prescriber
Any person, while acting within the scope of his/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 spouse.

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

Service Area
The geographic area, as determined by Aetna, in which the Preferred Care Providers are located.
Sickness
Disease or illness including related conditions and recurrent symptoms of the sickness. Sickness also includes pregnancy, and complications of pregnancy. All injuries or sickness due to the same or a related cause are considered one injury or sickness.

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

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

Surgical Expenses
Charges by a physician for,
  • a surgical procedure,
  • a necessary preoperative treatment during a hospital stay in connection with such procedure, and
  • usual postoperative treatment.

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

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

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

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

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

- A freestanding medical facility which:
  - Provides unscheduled medical services to treat an urgent condition if the Covered Person's physician is not reasonably available.
  - Routinely provides ongoing unscheduled medical services for more than eight consecutive hours.
  - Makes charges.
  - Is licensed and certified as required by any state or federal law or regulation.
  - Keeps a medical record on each patient.
  - Provides an ongoing quality assurance program. This includes reviews by physicians other than those who own or direct the facility.
  - Is run by a staff of physicians. At least one such physician must be on call at all times.
  - Has a full-time administrator who is a licensed physician.

- A physician's office, but only one that:
  - has contracted with Aetna to provide urgent care, and
  - is with Aetna’s consent, included in the Provider Directory as a Preferred Urgent Care Provider.

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

Walk-in Clinic
A clinic with a group of physicians, which is not affiliated with a hospital, that provides: diagnostic services, observation, treatment, and rehabilitation on an outpatient basis.
CLAIM PROCEDURE
On occasion, the claims investigation process will require additional information in order to properly adjudicate the claim. This investigation will be handled directly by Aetna.

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

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. Out of Country claim for Covered Medical Expenses should be submitted with appropriate medical service and payment information from the provider of service. Covered Medical Expenses for services received outside of the United States will be payable at the Preferred Care coinsurance level of benefits.
5. You will receive an “Explanation of Benefits” when your claims are processed. The Explanation of Benefits will explain how your claim was processed, according to the benefits of your Student Accident and Sickness Insurance Plan.

HOW TO APPEAL A CLAIM
Aetna Student Health
P.O. Box 14464
Lexington, KY 40512

Aetna has established a procedure for resolving complaints or grievances by Covered Persons (or their authorized representative). As required by Pennsylvania statute, a Covered Person must follow the following internal appeals procedure prior to filing a complaint appeal with the Pennsylvania Department of Health. However, any inquiries, complaints, grievances or questions regarding premium rate increases may be filed with the Pennsylvania Department of Health without first completing the internal appeal procedure described below.

An Appeal is defined as an oral or written request for review of a decision that has been denied in whole, or in part, for: claim payment, certification, eligibility, or referral, etc. This will be done after consideration of any relevant information.

First Level Appeal Review
• An Appeal must be submitted to Aetna within 45 days of the date Aetna provides notice of denial or the date of the occurrence of the issue being complained about, whichever is more beneficial to the Covered Person. The Aetna address is on the ID card.
• An acknowledgment letter will be sent to the Covered Person within five days of Aetna’s receipt of the Appeal. This letter may request additional information. If so, it must be submitted to Aetna within 15 days of the date of the letter.
• The initial review will be completed within 30 days of Aetna’s receipt of the appeal request. Once the decision is made, the Covered Person will be sent a response within five business days. The response will be based upon the information provided with, or right after, the Appeal and it will include the basis for the decision and the procedure to file a request for a Second Level Appeal Review.
• If the Appeal concerns an eligibility issue, and if additional information is not submitted to Aetna after receipt of Aetna’s response, the decision is considered Aetna’s final response 60 days after receipt of the Appeal. For all other Appeals, if additional information is to be submitted to Aetna after receipt of Aetna’s response, it must be submitted within 15 days of the date of Aetna’s response letter.
• If additional time is needed to resolve the Appeal, Aetna will send the **Covered Person** a written letter indicating that additional time is needed, explaining why such time is needed, and setting a new date for a response. The additional time will not be extended beyond another 30 days.

• In any urgent or emergency situation, the Expedited Appeal procedure may be initiated by a telephone call to Member Services. Aetna’s Member Services telephone number is on the ID card. A verbal response to the Appeal will be given to the provider within 48 hours, provided that all necessary information is available. Written notice of the decision will be sent within two business days of Aetna’s verbal response.

**Second Level Appeal Review**

If the **Covered Person** (or authorized representative) is not satisfied with the First Level Appeal Review decision, the **Covered Person** may request a Second Level Appeal Review. A Second Level Appeal Review committee shall be appointed. The **Covered Person** has a right to appear before the committee. The review will be completed within 45 days of Aetna’s receipt of the Second Level Appeal Review request. Once the decision is made, the **Covered Person** will be sent a response letter within five business days. The letter will include the decision, the basis for the decision and the procedure for filing a complaint appeal with the Pennsylvania Department of Health.

**EXTERNAL REVIEW PROCESS**

If, after exhausting the internal Appeals Procedure the **Covered Person** (or authorized representative) is still dissatisfied with Aetna’s response, the **Covered Person** may be eligible to request an External Review. A request for an External Review must be submitted to the Pennsylvania Department of Insurance (Department) within 15 calendar days from the date the **Covered Person** receives the final determination letter. This letter will instruct the **Covered Person** on how to submit a request for an External Review. If the Department fails to solicit an Independent Utilization Review Organization within two business days of receiving the request then Aetna will designate and notify a certified Independent Utilization Review Organization. A fee of $25 may be charged by Aetna for filing a request for an External Review.

For more information on the External Review Program, the **Covered Person** may call Member Services at the toll-free number shown on his or her 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.
ON CALL INTERNATIONAL
Chickering Claims Administrators, Inc. (CCA) has contracted with On Call International (On Call) to provide Covered Persons with access to certain accidental death and dismemberment benefits, worldwide emergency travel assistance services and other benefits.
A brief description of these benefits is outlined below.

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

Medical Evacuation and Repatriation (MER) Benefits. The following benefits are underwritten by Virginia Surety Company (VSC), with medical and travel assistance services provided by On Call. These benefits are designed to assist Covered Persons when traveling more than 100 miles from home, anywhere in the world.
• Unlimited Emergency Medical Evacuation
• Unlimited Medically Supervised Repatriation
• Unlimited Return of Mortal Remains
• Return of Traveling Companion
• $2,500 Emergency Return Home in the event of death or life-threatening illness of a parent or sibling

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

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

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

The information contained above is a just summary of the ADD, MER, WETA, and NDPE benefits and services available through On Call, USFIC, VSC and CV. For a copy of the plan documents applicable to the ADD, MER, WETA and NDPE coverage, including a full description of coverage, exclusions and limitations, please contact Aetna Student Health at www.aetnastudenthealth.com or (800) 966-7772.

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

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

All Covered Persons should carry their On Call ID card when traveling.

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

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

AETNA NAVIGATOR®

GOT QUESTIONS? GET ANSWERS WITH AETNA 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.
- Find your school in the School Directory.
- Click on Aetna Navigator® Member Website and then the “Register for Aetna Navigator” link.
- Follow the instructions for the registration process, including selecting a user name, password and security phrase.

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

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

Administered by:
Aetna Student Health
P.O. Box 981106
El Paso, TX 79998
(800) 841-5374
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 HealthSM is the brand name for products and services provided by these companies and their applicable affiliated companies.