2009
2010

CURRY COLLEGE

Student Health Insurance Plan Brochure

Aetna

Aetna Student Health

Underwritten by:
Aetna Life Insurance Company (ALIC)

Policy Number: **697403**

Where to Find Help
In case of an emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

For questions about:
•Enrollment Forms
•Waiver Process
•University Health Services Referrals

Please contact:
University Health Plans
(800) 437-6448

For questions about:
•Insurance Benefits
•Claims Processing
•Pre-Certification Requirements

Please contact:
Aetna Student Health
P.O. Box 15708
Boston, MA 02215-0014
(877) 378-9475

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
(877) 378-9475

For questions about:
•Provider Listings

Please contact:
Aetna Student Health
(877) 378-9475

A complete list of providers can be found at the University Health Services Office, or you can use Aetna's DocFind® Service at either: www.aetna.com/docfind/custom/studenthealth/index.html or: 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.

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 Curry College. 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 College's Finance Department during business hours located at 1071 Blue Hill Avenue. Please refer to the Certificate of Coverage for a complete description of the benefits available.

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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POLICY PERIOD

1. **Students:** Coverage for all insured students enrolled for the Fall Semester, will become effective at 12:01 AM on **August 18, 2009,** and will terminate at 12:01 AM on **August 18, 2010.**

2. **New Spring Semester students:** Coverage for all insured students enrolled for the Spring Semester, will become effective at 12:01 AM on **January 21, 2010,** and will terminate at 12:01 AM on **August 18, 2010.**

RATES

	Annual	Spring Semester
Student	$673	$382

The rates above include both premium for the student health plan underwritten by Aetna Life Insurance Company, as well as Curry College administrative fee.

CURRY COLLEGE
STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN

This is a brief description of the Accident and Sickness Medical Expense benefits available for Curry College students. 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 College and may be viewed at the College's Finance Department during business hours located at 1071 Blue Hill Avenue. Please refer to the Certificate of Coverage for a complete description of the benefits available.

STUDENT COVERAGE
ELIGIBILITY

All registered full-time and three-quarter time students are eligible for the Student Health Insurance Plan. If you are eligible for the Student Health Insurance Plan you will be automatically enrolled unless proof of comparable coverage is provided. You may enroll in the Student Insurance Program only during the 31-day period beginning with the start of the first and second semesters. If you are eligible for the program after these enrollment opportunities, you must present documentation from your former insurance company that it is no longer providing you with health insurance coverage. Your effective date under this program will be the date your former policy terminated, if you make the request for coverage within 31 days after it expires. Otherwise, the effective date will be the 1st of the month following your request. Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. If the eligibility requirements are not met, Aetna's only obligation is to refund the premium.

ENROLLMENT

Eligible students will be automatically enrolled in this plan, unless the completed Waiver Form has been received by the College, by the specified enrollment deadline dates listed in the next section of this Brochure.

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, upon written request received by Aetna within 90 days of withdrawal from school.

WAIVER PROCESS/PROCEDURE
Eligible students will be automatically enrolled in this plan, unless the completed Waiver Form has been received by the College, by the specified enrollment deadline dates listed in the next section of this Brochure.

	Waiver Deadline Date
Annual Policy New Students Returning Students	 July 14, 2009 July 2, 2009
Spring Semester Newly Enrolled Spring Students	February 1, 2010

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

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

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

DEPENDENT COVERAGE
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 Curry College 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 immediately from the date of the filing of a petition to adopt if the child has been residing in the home of the policyholder as a foster child, or, in all other cases, immediately from the date of placement of the child for purposes of adoption in the home of a policyholder. 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.

CONTINUOUSLY INSURED
Persons who have remained continuously insured under this Policy or other policies will be covered for any Pre-Existing Condition, which manifests itself while continuously insured, except for expenses payable under prior policies in the absence of this Policy.

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 Curry College 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. A complete listing of participating providers is available at the Curry College Health Services.

You may also obtain information regarding Preferred Providers by contacting Aetna Student Health at (877) 378-9475, or through the Internet by accessing DocFind at www.aetna.com/docfind/custom/studenthealth/index.html

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

*Preferred providers are independent contractors and are neither employees nor agents of Curry College, Aetna Student Health, or Aetna.

PRE-CERTIFICATION PROGRAM

Pre-certification simply means calling Aetna Student Health prior to treatment to obtain approval for a medical procedure or service. Pre-certification may be done by you, your doctor, a hospital administrator, or one of your relatives. All requests for certification must be obtained by contacting Aetna Student Health at **(877) 378-9475** (attention Managed Care Department).

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

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

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

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

Pre-Certification of Non-Emergency Inpatient Admissions, Partial Hospitalization, Identified Outpatient Services and Home Health Services:
The patient, Physician or hospital must telephone at least three (3) business days prior to the planned admission or prior to the date the services are scheduled to begin.

Notification of Emergency Admissions:
The patient, patient's representative, Physician or hospital must telephone within one (1) business day following inpatient (or partial hospitalization) admission.

PRE-EXISTING CONDITIONS/ CONTINUOUSLY INSURED PROVISIONS

Pre-existing Condition
A preexisting condition is any injury, sickness, or condition that was diagnosed or treated, or would have caused a prudent person to seek diagnosis or treatment, within six months prior to the covered person's effective date of insurance.

Limitation
Expenses incurred by a covered person within six months following his or her effective date of coverage under this Policy as a result of a pre-existing condition will not be considered a Covered Medical Expense.

If a covered person has Qualifying Previous Health Coverage in effect 63 days prior to his or her effective date of coverage under this Policy, then any limitation as to a pre-existing condition under this Policy will apply for that covered person only to the extent that such limitation would have applied if he or she had remained covered under the Qualifying Previous Health Coverage.

"Qualifying Previous Health Coverage" means: (a) any blanket or general policy of medical, surgical, or hospital insurance; (b) any policy of accident or sickness insurance; (c) any nongroup medical, surgical, or hospital insurance; (d) any nongroup or group hospital or medical service plan issued by a health maintenance organization; (e) any nongroup health maintenance contract issued by a health maintenance organization; (f) any self-insured or self-funded employer group health plan; (g) any health coverage provided to persons serving in the armed forces of the United States; or (h) Medicare or Medicaid. In addition, Qualifying Previous Health Coverage may include any other health coverage as may be included by regulation of the Massachusetts Division of Insurance.

DESCRIPTION OF BENEFITS

Please Note:

The Curry College Student Health Insurance Plan may not cover all of your health care expenses. The Plan excludes coverage for certain services and contains limitations on the amounts it will pay. Please read the Curry College Student Health Insurance Plan Brochure carefully before deciding whether this Plan is right for you. While this document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. If you want to look at the full Plan description, which is contained in the Master Policy issued to Curry College, you may view it at College's Finance Department located at 1071 Blue Hill Avenue or you may contact Aetna Student Health at (877) 378-9475. Please refer to the Certificate of Coverage for a complete description of the benefits available.

This Plan will never pay more than $50,000 in a Policy Year or more than $50,000 per condition per policy year, $5,000 per surgical procedure, $1,500 per Accident or Sickness for Anesthetist and Assistant Surgeon Expense, $1,500 per Accident or Sickness for Outpatient Benefits, $250 per Accident or Sickness for Ambulance Expenses. 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 only for the coverages listed below, and only up to the maximum amounts shown. Please refer to the Certificate of Coverage for a complete description of the benefits available.

Summary of Benefits Chart

COINSURANCE
Covered Medical Expenses are payable at the coinsurance percentage specified below, after any applicable deductible, up to a maximum benefit of $50,000 for any one Accident, or any one Sickness per Policy Year.

All coverage is based on Reasonable Charges unless otherwise specified.

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

Surgical Benefits (Inpatient and Outpatient)	
Surgical Expenses	**Covered Medical Expenses** for charges for surgical services, performed by a Physician, are payable as follows: Preferred Care: 80**%** of the Negotiated Charge. Non-Preferred Care: 80% of the Reasonable Charge. Benefits are limited to $5,000 per surgical procedure.
Anesthetist and Assistant Surgeon Expense	**Covered Medical Expenses** for the charges of an anesthetist and an assistant surgeon, during a surgical procedure, are payable at 30% of the amount paid to the surgeon. Benefits are limited to $1,500 per day, per condition per Policy Year.
Outpatient Benefits **Covered Medical Expenses** are payable up to a combined maximum of $1,500 per Accident or Sickness per Policy Year. **Covered Medical Expenses** include but are not limited to: Physician's office visits, hospital or outpatient department or emergency room visits, durable medical equipment, clinical lab, or radiological facility.	
Emergency Room Expense	**Covered Medical Expenses** incurred for treatment of an Emergency Medical Condition are payable as follows: Preferred Care: After a $50 Copay (waived if admitted), 100% of the Negotiated Charge. Non-Preferred Care: After a $50 Deductible (waived if admitted), 100% of the Reasonable Charge. Benefits are limited to $1,500 per condition per Policy Year **Please note:** this per visit Deductible does not apply towards meeting the annual Deductible.

Chiropractic Care	**Covered Medical Expenses** for Chiropractic Care are payable as follows: Preferred Care: After a $8 per visit Copay, 100% of the Negotiated Charge. Non-Preferred Care: After a $10 per visit Deductible, 100% of the Reasonable Charge. Benefits are limited to $1,500 per condition per Policy Year
Ambulance Expense	**Covered Medical Expenses** are payable as follows: 100% of the Reasonable Charge to a maximum of $250 per Accident or Sickness for the services of a professional ambulance to or from a hospital, when required due to the emergency nature of a covered Accident or Sickness.
Pre-Admission Testing Expense	**Covered Medical Expenses** for Pre-Admission testing charges while an outpatient before scheduled surgery are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 80% of the Reasonable Charge.
Physical Therapy Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: After a $8 per visit Copay, 100% of the Negotiated Charge. Non-Preferred Care: After a $10 per visit Deductible, 100% of the Reasonable Charge. Benefits are limited to $1,500 per condition per Policy Year.

Physician's Office Visits	**Covered Medical Expenses** are payable as follows: Preferred Care: After a $8 per visit Copay, 100% of the Negotiated Charge Non-Preferred Care: After a $10 per visit Deductible, 100% of the Reasonable Charge. Benefits are limited to $1,500 per condition per Policy Year **Please note:** This per visit Deductible does not apply towards meeting the annual Deductible.
Laboratory and X-Ray Expense	**Covered Medical Expenses** include expenses for diagnostic services, laboratory, and X-ray examinations. This includes human leukocyte antigen or histocompatibility locus antigen testing necessary to establish bone marrow transplant suitability. Also included is testing for A, B or DR antigens or any combination thereof. The testing must be consistent with rules, regulations and criteria established by the Massachusetts Department of Public Health. Benefits are payable as follows: Preferred Care: 100% of the Negotiated Charge. Non-Preferred Care: 100% of the Reasonable Charge. Benefits are limited to $1,500 per condition per Policy Year
High Cost Procedures Expense	**Covered Medical Expenses** include charges incurred by a covered person are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 80% of the Reasonable Charge. For purposes of this benefit, "High Cost Procedure" means any outpatient procedure costing over $200. Benefits are limited to $2,000 per Policy Year.

Durable Medical Equipment Expense	**Covered Medical Expenses** for Durable Medical Equipment (DME) are payable as follows: Preferred Care: 100% of the Negotiated Charge. Non-Preferred Care: 100% of the Reasonable Charge. Benefits are limited to $1,500 per condition per Policy Year. **Covered Medical Expenses** include a scalp hair prosthesis worn for hair loss suffered as the result of any form of cancer or leukemia. This Scalp Hair Prosthesis benefit is payable as any other DME, and limited to $350 per Policy Year.
Dental Injury Expense	**Covered Medical Expenses** include dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition: • Natural teeth damaged, lost, or removed, or • Other body tissues of the mouth fractured or cut due to injury. The accident causing the injury must occur while the person is covered under this Plan. Any such teeth must have been: • Free from decay, or • In good repair, and • Firmly attached to the jawbone at the time of the injury. The treatment must be done in the calendar year of the accident or the next one.

	If: • Crowns (caps), or • Dentures (false teeth), or • Bridgework, or • In-mouth appliances, are installed due to such injury, Covered Medical Expenses include only charges for: • The first denture or fixed bridgework to replace lost teeth, • The first crown needed to repair each damaged tooth, and • An in-mouth appliance used in the first course of orthodontic treatment after the injury. Surgery needed to: • Treat a fracture, dislocation, or wound. • Cut out cysts, tumors, or other diseased tissues. • Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement. Non-surgical treatment of infections or diseases. This does not include those of, or related to, the teeth. **Covered Medical Expenses** are payable as follows: <u>Preferred Care:</u> After a $8 per visit Copay, 100% of the Actual Charge <u>Non-Preferred Care:</u> After a $10 per visit Deductible, 100% of the Actural Charge. Benefits are limited to $1,500 per condition per Policy Year.

Impacted Wisdom Teeth Expense	**Covered Medical Expenses** for removal of one or more impacted wisdom teeth are payable as follows: 80% of Actual Charge. Benefits are limited to $1,500 per condition per Policy Year.
Consultant or Specialist Expense	**Covered Medical Expenses** include the expenses for the services of a consultant or specialist. The services must be requested by the attending physician for the purpose of confirming or determining to confirm or determine a diagnosis. A referral is required for this benefit; without a referral benefits will be limited OR payable at the Non-Preferred rate. Benefits are payable as follows: Preferred Care: After a $8 per visit Copay, 100% of the Negotiated Charge. Non-Preferred Care: After a $10 per visit Deductible, 100% of the Reasonable charge. Benefits are limited to $1,500 per condition per Policy Year.
Patient Care Service Expense (pursuant to a Qualified Clinical Trial)	**Covered Medical Expenses** include patient care service provided to an individual who is participating in a Qualified Clinical trial. This benefit includes only reasonable charges that: • Are consistent with the customary standard of care for someone with the patient's diagnosis; • Are consistent with the study protocol for the clinical trial; and • Would be covered if the patient did not participate in the trial. Benefits are payable on the same basis as any other sickness.

Mental Health and Substance Abuse Benefits	
Biologically-Based Mental Illness & Other Mental Illnesses - Inpatient Expense	**Covered Medical Expenses** for the diagnosis and treatment of the following mental illnesses are payable as any sickness. a) Biologically based mental disorders, b) Rape related mental or emotional disorders for victims of rape or victims of assault with intent to commit rape, c) Non-biologically based mental, behavioral or emotional disorders described in the Diagnostic and Statistical Manual (DSM) that substan tially interfere with or substantially limit the functioning and social interactions of children and adolescents under the age of 19; or, d) Psychopharmacological services and neuropsychological assessment services. **Covered Medical Expenses** also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission, whereby 2 days of partial hospitalization may be exchanged for 1 day of full hospitalization. Please see definition of Mental Illness on page 43 for more detailed information on biologically-based Mental Illness.

Biologically-Based Mental Illness & Other Mental Illnesses - Outpatient Expense	**Covered Medical Expenses** for the diagnosis and treatment of the following mental illnesses are payable as any Sickness: a) Biologically based mental disorders, b) Rape related mental or emotional disorders for victims of rape or victims of assault with intent to commit rape, c) Non-biologically based mental, behavioral or emotional disorders described in the Diagnostic and Statistical Manual (DSM) that substan tially interfere with or substantially limit the functioning and social interactions of children and adoles cents under the age of 19; or, d) Psychopharmacological services and neuropsychological assessment services. Please see definition of Mental Illness on page 43 for more detailed information on biologically-based Mental Illness.
Non-Biologically Based Mental and Emotional Disorders - Inpatient Expense	**Covered Medical Expenses** for the treatment of a mental health while confined as a inpatient in a hospital or facility licensed for such treatment are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 80% of the Reasonable charge. Inpatient mental health treatment is limited to a maximum of 60 days per Policy Year for any one or related mental health condition. **Covered Medical Expenses** also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission, whereby 2 days of partial hospitalization may be exchanged for 1 day of full hospitalization.

Non-Biologically Based Mental and Emotional Disorders - Outpatient Expense	**Covered Medical Expenses** for outpatient treatment of a mental health condition are payable as follows: Preferred Care: After a $8 Copay 100% of the Negotiated Charge. Non-Preferred Care: After a $10 Deductible, 100% of the Reasonable Charge. Benefits are limited to 24 visits per Policy Year.
Substance Abuse Inpatient Expense	**Covered Medical Expenses** include inpatient treatment in an accredited or licensed Hospital or in any other public or private facility thereof providing services especially for the detoxification or rehabilitation of any intoxicated persons or alcoholics and which is licensed by the Dept. of Public health for those services, or in a residential alcohol treatment program as defined by Massachusetts law. Benefits will be payable as any Sickness.
Substance Abuse Outpatient Expense	**Covered Medical Expenses** include outpatient services furnished by licensed physicians or psychotherapists working in an accredited or licensed Hospital or in any other public or private facility thereof providing services especially for the detoxification or rehabilitation of any intoxicated persons or alcoholics and which is licensed by the Dept. of Public health for those services. Benefits will be payable as any Sickness.

Maternity Benefits	
Maternity Expense	**Covered Medical Expenses** include inpatient care of the covered person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery. Any decision to shorten such minimum coverages shall be made by the attending Physician in consultation with the mother. In such cases, covered services may include: home visits, parent education, and assistance and training in breast or bottle-feeding. **Covered Medical Expenses** for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other sickness.

Additional Benefits	
Diabetic Treatment, Supplies And Outpatient Self-Management Education Expenses	**Covered Medical Expenses** include expenses incurred for the diagnosis and treatment of diabetes, including those for drugs, diabetic supplies and equipment, and an outpatient diabetic self-management education prescribed as part of a treatment plan. Charges for diabetic treatment will also be covered medical expense for laboratory tests as described below; but only if the person is not confined in a hospital or convalescent facility as a full-time inpatient. Laboratory Tests include: • Glycosylated hemoglobin; or HbAlc tests; and urinary protein/microalbu min and lipid profiles. Charges for diabetic equipment include: • Blood glucose monitors, including monitors for the legally blind; • Test strips for glucose monitors; • Visual reading and urine testing strips; • Ketone strips; • Voice-synthesizers; • Diagnostic lab work (including urinary profile) and X-rays specific to the treatment of diabetes; • Visual magnifying aids for the legally blind; and • Insulin; injection aids; lancets; cartridges for the legally blind; syringes; insulin pumps and supplies; insulin infusion devices; and oral agents for controlling blood sugar. • Prosthetics: therapeutic/molded shoes and shoe inserts prescribed by a Physician and approved by the FDA for the purposes for which they were prescribed for insureds who have severe diabetic foot disease.

	A "diabetic self-management education program" is a scheduled program on a regular basis, which is designed to instruct a person in the self-management of diabetes. It is a day care program of educational services and self-care training, (including medical nutrition 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. Charges incurred for the following are not included: • 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. Benefits are payable as any Sickness.
Non Prescription Enteral Formula Expense	**Covered Medical Expenses** include Non Prescription Enteral formulas for which a physician has issued a written order. Such formulas must be medically necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudoobstruction, and inherited diseases of amino acids and organic acids. Covered expenses for inherited diseases of amino acids and organic acids will include food products modified to be low protein in an amount not to exceed $5,000 per Policy Year for any covered person. Benefits are payable as any Sickness.

Pap Smear Expense	**Covered Medical Expenses** include one annual routine pap smear screening for women age 18 and older. Benefits are payable as any Sickness. A referral is not required for this benefit.
Mammogram Expense	**Covered Medical Expenses** include one baseline mammogram for women between age 35 and 40. Coverage is also provided for one routine annual mammogram for women age 40 and older, as well as when medically indicated for women with risk factors who are under age 40. Risk factors for women under 40 are: • Prior personal history of breast cancer • Positive Genetic Testings • Family history of breast cancer; or • Other risk factors Mammogram screenings coverage must also include comprehensive ultrasound screening for the entire breast or breasts if a mammogram demonstrates heterogenous or dense breast tissue and when determined to be medically necessary by a licensed physician. Benefits are payable as any Sickness. A referral is not required for this benefit.
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: <u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-preferred Care:</u> 80% of the Reasonable Charge. This benefit is in lieu of any other Policy benefits. Benefits are limited to $300 per occurrence.

Hospice Care Expense	**Covered Medical Expenses** include charges for hospice care provided for a terminally ill covered person during a hospice benefit period. Benefits are payable as any Sickness. Please see definition on page 51 for more information on Hospice Care Expenses. Benefits for Hospice expenses require pre-certification.
Licensed Nurse Expense	Benefits include charges incurred by a covered person who is confined in a hospital as a resident bed patient, and requires the services of a registered nurse or licensed practical nurse. **Covered Expenses** for a Licensed Nurse are covered as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 80% of the Reasonable Charge.
Bone Marrow Transplants For Breast Cancer	Benefits are payable for expenses incurred by a covered person who has been diagnosed with breast cancer that has progressed to metastatic disease as follows: (a) Referral to and participation in clinical trails when an oncologist recommends participation on the grounds that the proposed procedure shows promise as a useful treatment for that covered person and the proposed procedure is likely to be at least as effective as conventional treatment for that covered person; and (b) A bone marrow transplant, provided that the covered person has been found to meet eligibility criteria established for enrollment in a clinical trial even if the covered person is not formally enrolled in that clinical trial; and (c) Coverage for a bone marrow transplant to the extent that benefits generally are provided for other medical procedures.

	The clinical trial will be conducted: (a) At a licensed health facility which is located at the principal site of an academic medical center which participates in National Cancer Institute (NCI) sponsored or approved research in any cancer specialty area; or (b) At a licensed health facility which has a formal affiliation agreement with an academic medical center to provide bone marrow transplantation as part of a NCI sponsored or approved research protocol. DEFINITIONS **"Bone marrow transplant"** means use of high dose chemotherapy and radiation in conjunction with transplantation of autologuous bone marrow or peripheral blood stem cells which originate in the bone marrow. **"Metastatic disease"** means Stage III and Stage IV breast cancer, as well as Stage II breast cancer which has spread to ten or more lymph nodes, as defined by the American College of Surgeons. Benefits are payable as any Sickness.
Cardiac Rehabilitation Expense Benefits	**Covered Medical Expenses** include cardiac rehabilitation treatment in connection with documented cardiovascular disease. Such treatment shall include, but not be limited to, outpatient treatment which is to be initiated within 26 weeks after the diagnosis of such disease. DEFINITIONS "Cardiac Rehabilitation" means multidisciplinary, medically necessary treatment of persons with documented cardiovascular disease, which shall be provided in either a hospital or other setting and which shall meet standards promulgated by the Commissioner of Public Health.

	"Cardiac Rehabilitation Program" is a program operated by a duly licensed clinic or hospital which treats cardiovascular disease through cardiac rehabilitation treatment. "Cardiac Rehabilitation Treatment" means treatment of cardiovascular disease by a cardiovascular rehabilitation program that teaches and monitors the following: (a) Risk reduction; (b) Lifestyle adjustment to such disease; (c) Therapeutic exercise; (d) Proper diet; (e) Use of proper prescription drugs; (f) Self-assessment skills; and (g) Self-help skills. Benefits are payable as any Sickness.
Speech, Hearing and Language Disorders Expense	**Covered Medical Expenses** include medically necessary diagnosis and treatment of speech, hearing and language disorders by individuals licensed as speech-language pathologists or audiologists. **Covered Medical Expenses** are payable for diagnosis or treatment of speech, hearing and language disorder services provided in a hospital, clinic or private office.

Infertility Expense	**Covered Medical Expenses** include medically necessary expenses for the diagnosis and treatment of infertility. Benefits are payable for non-experimental infertility procedures including: (a) Artificial insemination (AI); (b) In Vitro Fertilization.and Embryo Placement (IVF) (c) Gamete intrafallopian transfer (GIFT); (d) Sperm, egg and/or inseminated egg procurement, processing, and banking to the extent such costs are not covered by the donor's insurer, if any; (e) Intracytoplasmic sperm injection (ICSI) for treatment of male factor infertility; and (f) Zygote intrafallopian transfer (ZIFT). DEFINITIONS "Infertility" means the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year. "Non-experimental infertility procedure" means a procedure recognized as generally accepted as non-experimental by: (a) the American Fertility Society, (b) the American College of Obstetrics and Gynecology, or (c) a fertility expert recognized by the Insurance Commissioner. EXCLUSIONS The following services do not qualify as non-experimental procedures: (a) Any experimental infertility procedure, until the procedure becomes recognized as non-experimental and is so recognized by the Commissioner; (b) Surrogacy; (c) Reversal of voluntary sterilization; and (d) Cryopreservation of eggs. Benefits are payable on the same basis as any pregnancy-related procedure.

Speech Or Hearing Therapy Expenses	**Covered Medical Expense** includes coverage for expenses incurred for the diagnosis or treatment by a physician for acute speech, hearing and language disorders; but only if the charges are made for: • Diagnostic services rendered to find out if and to what extent the person's ability to speak or hear is lost or impaired. • Rehabilitative services rendered that are expected to restore or improve a person's ability to speak or hear. Not covered are charges for: • Diagnostic or rehabilitative services rendered before the person becomes eligible for coverage or after termination of coverage. • Hearing aids, hearing aid evaluation tests and hearing aid batteries. • Hearing exams required as a condition of employment. • Special education (including lessons in sign language) to instruct a person, whose ability to speak or hear is lost or impaired, to function without that ability. • Diagnostic or rehabilitative services for treatment of speech, hearing and language disorders: - That any school system, by law, must provide; or - As to speech therapy, to the extent such coverage is already provided for under Early Intervention and Home Health Care Services. • Any services unless they are provided in accordance with a specific treatment plan: Which details the treatment to be rendered and the frequency and dura tion of the treatment; and provides for ongoing services and is renewed only if such treatment is still necessary. **Covered Medical Expenses** are payable as any Sickness.

Newborn Infants and Adoptive Children Care Expense	**Covered Medical Expenses** include coverage of injury or sickness for newly born infants and adoptive children, including hereditary and metabolic screening at birth, and the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, or premature birth. **Covered Medical Expenses** include special medical formulas which are approved by the commissioner of the department of public health, prescribed by a physician, and are medically necessary for treatment of phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, or methylmalonic acidemia in infants and children or medically necessary to protect the unborn fetuses of pregnant women with phenylketonuria. **Covered Medical Expenses** include hearing tests performed on a newborn dependent child of a covered person before the infant is discharged from the hospital or birthing center and screening for lead poisoning. Benefits are payable as any Sickness.
Prosthetic Device Expense	**Covered Medical Expenses** include expenses incurred by a covered person for prosthetic devices, including repairs. For purposes of this benefit, "prosthetic device" means an artificial limb device to replace, in whole or in part, an arm or a leg. **Covered Medical Expenses** will include the most appropriately medically necessary model that adequately meets the need of the covered person. Benefits are payable as follows: Preferred Care: 100% of the Negotiated Charge. Non-Preferred Care: 100% of the Reasonable Charge. Benefits are limited to $1,500 per condition 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. To learn more about these additional services and search for providers visit, **www.aetnastudenthealth.com**.

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

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

Aetna Weight Management℠ Discount Program: Helps you achieve your weight loss goals and develop a balanced approach to your active lifestyle. This program provides members and their eligible family members access to discounts on Jenny Craig® weight loss programs and products. Start with a FREE 30-day trial membership* then choose either a 6* -or 12* -month program** that's right for you. You also receive individual weight loss consultations, personalized menu planning, tailored activity planning, motivational materials and much more.
* Offers good at participating centers in the United States, Canada and Puerto Rico and through Jenny Direct at-home. Additional cost for all food purchases and shipping where applicable.
**Additional weekly food discounts will grow throughout the year, based on active participation.

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

Use Zagat® reviews as a guide for your night out:
Planning a night on the town? Or, want to visit a city where you've never been? Subscribe to Zagat online and get a 30 percent discount on their members-only services. You can sign up for access to restaurant reviews only, or choose full access and get ratings and reviews on hotels, restaurants, movies and other attractions. You can even order printed guides at a discount!

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

Aetna's Informed Health® Line:
Get answers from a registered nurse at any time — just call our toll-free Informed Health Line at (800) 556-1555. With one simple call, you can:
• Learn more about health conditions that you or your family members have.
• Find out more about a medical test or procedure.
• Come up with questions to ask your doctor.

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

Listen to our Audio Health Library:*
Call and learn about a topic that interests you. Choose from thousands of health conditions. Listen in English or Spanish. You can also transfer to a registered nurse at any time during your call.
*Not all topics discussed within the Audio Health Library are covered expenses under your health insurance plan.

Go online for even more health information
If you like to go online for health information, check out the Healthwise® Knowledgebase. You can learn more about a health condition you have, medications you take, and more. Link to it through your secure Aetna Navigator® website at **www.aetnanavigator.com**.

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

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

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

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

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

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

Discount programs provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Discounts are subject to change without notice. Discount programs may not be available in all states. Discount programs may be offered by vendors who are independent contractors and not employees or agents of Aetna.

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

Vital Savings℠ on Dental* is a dental discount program helping you and your dependents save an average of 15% to **50%** on a wide array of dental services – with one low annual fee of **$29** per person. Enroll online at **www.aetnastudenthealth.com**.

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

Vital Savings℠ on Pharmacy is a discount program helping you and your dependents lower your prescription drug costs. Present your card to participating pharmacies and receive a discount at the time of purchase, no claims to file. Enroll online at **www.aetnastudenthealth.com**.

Vital Savings℠ on Pharmacy and Dental is a discount program helping you and your dependents save on prescription drug costs and a wide array of dental services. Enroll online at **www.aetnastudenthealth.com**. Save time and money on enrollment fees by joining both programs in one step.

Vital Savings Total Savings on Dental and Pharmacy

	Annual-Dental 9/1/09 – 8/31/10	Annual-Pharmacy 9/1/09 – 8/31/10	Annual-Combo 9/1/09 – 8/31/10
Student Only	$29	$29	$46
Student and One Dependent	$51	$51	$81
Student and Two or more Dependents	$73	$73	$115

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

GENERAL PROVISIONS

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

SUBROGATION/REIMBURSEMENT
RIGHT OF RECOVERY PROVISION

Immediately upon paying or providing any benefit under this Plan, Aetna shall be subrogated to all rights of recovery a Covered Person has against any party potentially responsible for making any payment to a Covered Person, due to a Covered Person's Injuries or illness, to the full extent of benefits provided, or to be provided by Aetna. In addition, if a Covered Person receives any payment from any potentially responsible party, as a result of an Injury or illness, Aetna has the right to recover from, and be reimbursed by the Covered Person for all amounts this Plan has paid, and will pay as a result of that Injury or illness, up to and including the full amount the Covered Person receives, from all potentially responsible parties. 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 Covered Person, entitled to receive any benefits from this Plan.

As used in this provision, the term "responsible party" means any party possibly responsible for making any payment to a Covered Person or on a Covered Person's behalf due to a Covered Person's injuries or illness or any insurance coverage responsible making such payment, including but not limited to:
- Uninsured motorist coverage,
- Underinsured motorist coverage,
- Personal umbrella coverage,
- Med-pay coverage,
- Workers compensation coverage,
- No-fault automobile insurance coverage, or
- Any other first party insurance coverage.

The Covered Person shall do nothing to prejudice Aetna's subrogation and 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.

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 this entire subrogation and reimbursement provision 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" or "non-economic damages" only.

In the event any claim is made that any part of this subrogation and reimbursement provision is ambiguous or questions arise concerning the meaning or intent of any of its 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 this provision.

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 will be reduced by such excess.

EXTENSION OF BENEFITS

If a covered person is confined to a hospital on the date his or her coverage terminates, charges incurred during the continuation of that hospital confinement shall also be included in the term "Expense", but only while they are incurred during the 90 day period following such termination of insurance.

If a covered person is unable to renew coverage due to a loss of eligibility due to his or her graduation, expenses incurred after the termination of insurance will be payable provided they commenced while insured and resulted from a covered Accident or Sickness. However, no payment will be made under this provision beyond 52 weeks from the date of the Accident or the date of the first treatment of the Sickness.

TERMINATION OF INSURANCE

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

TERMINATION OF STUDENT COVERAGE
Insurance for a covered student will end on the first of these to occur:

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

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

EXCLUSIONS
This Policy does not cover nor provide benefits for:

1. Expense incurred as a result of dental treatment; except for treatment resulting from injury to sound; natural teeth as provided elsewhere in this Policy.

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

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

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

5. Expense incurred as a result of an injury or sickness due to working for wage or profit or for which benefits are payable under any Workers' Compensation or Occupational Disease Law.

6. Expense incurred as a result of an injury sustained or sickness contracted while in the service of the Armed Forces of any country. Upon the covered person entering the Armed Forces of any country; the unearned pro rata premium will be refunded to the Policyholder.

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

8. Expense incurred for elective treatment or elective surgery except as specifically provided elsewhere in this Policy and performed while this Policy is in effect.

9. Expense incurred for cosmetic surgery, reconstructive surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons, except to the extent needed to:
Improve the function of a part of the body that:

- Is not a tooth or structure that supports the teeth, and
- Is malformed:
  - As a result of a severe birth defect, including harelip, webbed fingers, or toes, or
  - As direct result of:
    * Disease, or
    * Surgery performed to treat a disease or injury.

Repair an injury (including reconstructive surgery for prosthetic device for a covered person who has undergone a mastectomy,) which occurs while the covered person is covered under this Policy. Surgery must be performed:

- In the calendar year of the accident which causes the injury, or
- In the next calendar year.

This exclusion does not apply to reconstructive surgery when such service is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part or when such service is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician.

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

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

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

13. Expense incurred after the date insurance terminates for a covered person except as may be specifically provided in the Extension of Benefits Provision.

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

15. Expense incurred for any services rendered by a member of the covered person's immediate family or a person who lives in the covered person's home.

16. Expense incurred for treatment of temporomandibular joint dysfunction and associated myofascial pain.

17. Expense for outpatient prescriptions.

18. Expense for allergy serums and injections.

19. 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.

20. Expense for elective sterilization or its reversal or elective abortion unless specifically provided for in this Policy.

21. 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).

22. Expense incurred for which no member of the covered person's immediate family has any legal obligation for payment.

23. Expense incurred for custodial care. Custodial care means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes room and board and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:

- By whom they are prescribed; or
- By whom they are recommended; or
- By whom or by which they are performed.

24. Expense incurred for the removal of an organ from a covered person for the purpose of donating or selling the organ to any person or organization. This limitation does not apply to a donation by a covered person to a spouse; child; brother; sister; or parent.

25. Expenses incurred for the repair or replacement of existing artificial limbs; orthopedic braces; or orthotic devices.

26. Expenses incurred for or in connection with: procedures; services; or supplies that are; as determined by Aetna; to be experimental or investigational. A drug; a device; a procedure; or treatment will be determined to be experimental or investigational if:

There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature; to substantiate its safety and effectiveness; for the disease or injury involved; or

If required by the FDA; approval has not been granted for marketing; or

A recognized national medical or dental society or regulatory agency has determined; in writing; that it is experimental; investigational; or for research purposes; or

The written protocol or protocols used by the treating facility; or the protocol or protocols of any other facility studying substantially the same drug; device; procedure; or treatment; or the written informed consent used by the treating facility; or by another facility studying the same drug; device; procedure; or treatment; states that it is experimental; investigational; or for research purposes.

However; this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease; if Aetna determines that:

The disease can be expected to cause death within one year; in the absence of effective treatment; and

The care or treatment is effective for that disease; or shows promise of being effective for that disease; as demonstrated by scientific data. In making this determination; Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

Also; this exclusion will not apply with respect to: drugs and medicines 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; or to the extent coverage for such drug and medicine is specifically provided in the Policy.

27. Expenses incurred for gastric bypass; and any restrictive procedures; for weight loss.

28. Expenses incurred for breast reduction/mamoplasty.

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

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

31. Expense incurred by a covered person; not a United States citizen; for services performed within the covered person's home country; if the covered person's home country has a socialized medicine program.

32. Expense incurred for acupuncture; unless services are rendered for anesthetic purposes.

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

34. Expense incurred for prescription drugs; except when administered during a hospital confinement.

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

36. Expense for care or services to the extent the charge would have been covered under Medicare Part A or Part B; even though the covered person is eligible; but did not enroll in Part B.

37. Expense for telephone consultations; charges for failure to keep a scheduled visit; or charges for completion of a claim form.

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

39. Expense for services or supplies provided for the treatment of obesity and/or weight control.

40. Expense for incidental surgeries; and standby charges of a physician.

41. Expense for treatment and supplies for programs involving cessation of tobacco use.

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

43. Expense for elective sterilization or its reversal; or elective abortion; unless specifically provided for in this Policy.

44. Expenses incurred for massage therapy.

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

46. Expense for charges that are not recognized charges; as determined by Aetna; except that this will not apply if the charge for a service; or supply; does not exceed the recognized charge for that service or supply; by more than the amount or percentage; specified as the Allowable Variation.

47. Expense for charges that are not reasonable charges; as determined by Aetna; except that this will not apply if the charge for a service; or supply; does not exceed the reasonable charge for that service or supply; by more than the amount or percentage; specified as the Allowable Variation.

48. Expense for treatment of covered students who specialize in the mental health care field; and who receive treatment as a part of their training in that field.

49. 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.

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

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

- Be care; or treatment; which is likely to produce a significant positive outcome as; and no more likely to produce a negative outcome than; any alternative service or supply; both as to the sickness or injury involved; and the person's overall health condition;
- Be a diagnostic procedure which is indicated by the health status of the person; and be as likely to result in information that could affect the course of treatment as; and no more likely to produce a negative outcome than; any alternative service or supply; both as to the sickness or injury involved; and the person's overall health condition; and
- As to diagnosis; care; and treatment; be no more costly (taking into account all health expenses incurred in connection with the treatment
- Those that do not require the technical skills of a medical; a mental health; or a dental professional; or
- Those furnished mainly for the personal comfort or convenience of the person; any person who cares for him or her; or any persons who is part of his or her family; any healthcare provider; or healthcare facility; or

- Those furnished solely because the person is an inpatient on any day on which the person's sickness or injury could safely; and adequately; be diagnosed; or treated; while not confined; or those furnished solely because of the set ting; 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.
- 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.

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

DEFINITIONS

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

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

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

Ambulatory Surgical Center
A freestanding ambulatory surgical facility that:
- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Makes charges.
- Is directed by a staff of physicians. At least one of them must be on the premises when surgery is performed and during the recovery period.

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

Biologically Based Mental Illness

The definition of "mental illness" means "biologically based" mental disorders appearing in the most recent edition of the Diagnostic and Statistical Manual (DSM). These include:

- Schizophrenia
- Schizoaffective disorder
- Major depressive disorder
- Bipolar disorder
- Paranoia and other psychotic disorders
- Obsessive compulsive disorder
- Panic disorder
- Delirium and dementia
- Affective disorders
- Eating Disorders
- Post-Traumatic Stress Disorder
- Substance Abuse
- Autism

The definition of "mental illness" also includes:

- Rape-related mental disorders for victims of a rape or victims of an assault with intent to commit rape;
- Non biologically based mental, behavioral disorders described in the DSM that substantially interfere with or substantially limit the functioning of a student under the age of 19:
- Any biologically based mental disorders appearing in the DSM that are scientifically recognized and approved by the Commissioner of Department of Mental Health in consultation with the Commissioner of the Division of Insurance; and all other mental disorders described in the most recent edition of the DSM.

Birthing Center

A freestanding facility that:

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

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

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 Policy which are:
- Not in excess of the reasonable and customary charges, or
- Not in excess of the charges that would have been made in the absence of this coverage,
- And incurred while this Policy is in force as to the covered person.

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

Covered Person
A covered student while coverage under this Policy is in effect.

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

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

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

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

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

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

Designated Care Provider
A health care provider that is affiliated with, and has an agreement with, the School Health Services to furnish services and supplies at a negotiated charge.

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

Durable Medical and Surgical Equipment
No more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

- Made to withstand prolonged use,
- Made for and mainly used in the treatment of a disease or injury,
- Suited for use in the home,
- Not normally of use to person's who do not have a disease or injury,
- Not for use in altering air quality or temperature,
- Not for exercise or training.

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

Effective Treatment of Alcoholism Or Drug Abuse
This means a program of alcoholism or drug abuse therapy that is prescribed and supervised by a physician; and either:

- Has a follow-up therapy program directed by a physician; on at least a monthly basis; or
- Includes meetings at least twice a month; with organizations devoted to the treatment of alcoholism or drug abuse.

These are not effective treatment:
As to drug abuse:

Detoxification; and.
Maintenance care. This means providing an environment free of drugs.

As to alcoholism:
Maintenance care. This means providing an environment free of alcohol.

Detoxification
This is care mainly to overcome the aftereffects of a specific episode of drinking.

Effective Treatment of A Mental Disorder or Biologically-Based Mental Illness and Rape Related Mental or Emotional Disorders
This a program that:

- Is prescribed and supervised by a physician; and
- Is for a mental disorder or a biologically-based mental illness that can be favorably changed.
- Is for Rape-related mental or emotional disorders for victims of rape; or victims of an assault with intent to commit rape.

Treatment is generally provided by or under the direction of a mental health professional such as psychotherapist; psychologists; licensed independent clinical social workers; certified clinical specialist in psychiatric and mental health nursing; and mental health counselors.

Elective Treatment
Medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the covered person's effective date of coverage. Elective treatment includes, but is not limited to:

- Tubal ligation,
- Vasectomy,
- Breast reduction,
- Sexual reassignment surgery,
- Submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis,
- Treatment for weight reduction,
- Learning disabilities,
- Temporamandibular 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:
- Placing the person's health or that of another person in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of any body part or organ; or
- In the case of a pregnant woman; serious jeopardy to the health of the fetus.

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 Dental Care
Medically necessary care or treatment for an emergency medical condition. Such care is subject to specific limitations set forth in this Policy.

Emergency Medical Condition
A recent and severe medical condition; including; but not limited to; severe pain that in the absence of prompt medical attention; could reasonably be expected by a prudent person who possesses an average knowledge of medicine and health; to believe that his or her condition; sickness; or injury; is of such a nature that failure to get immediate medical care could result in:

- Placing the person's health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman; serious jeopardy to the health of the fetus.
- It does include an accident or serious illness such as heart attack; stroke; poisoning; loss of consciousness or respiration; and convulsions. It does not include elective care; routine care; care for non-emergency illness; or care required as a result of circumstances which would have been foreseen; prior to the covered person's departure from the College area.

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

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

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

Home Health Agency

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

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

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

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

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

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

Hospital
A facility which meets all of these tests:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished, in a physician's or a dentist's office, or other less costly setting.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Orthodontic treatment
Any
- Medical service or supply, or
- Dental service or supply,
- Furnished to prevent or to diagnose or to correct a misalignment:
- Of the teeth, or
- Of the bite, or
- Of the jaws or jaw joint relationship,
- Whether or not for the purpose of relieving pain. Not included is:
- The installation of a space maintainer, or
- Surgical procedure to correct malocclusion.

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

Partial hospitalization
Continuous treatment consisting of not less than four hours and not more than twelve hours in any twenty four hour period under a program based in a hospital.

Pharmacy
An establishment where prescription drugs are legally dispensed.

Physician
(a) legally qualified physician licensed by the state in which he or she practices; and (b) any licensed nurse midwife; registered nurse; anesthetist; or other licensed medical practitioner; whose services are required to be covered by law; and who renders such services within the scope of his or her license. For the treatment of Mental Illness; the "physician" also includes a licensed clinical psychologist; licensed clinical social worker; and a licensed clinical psychiatric nurse practitioner; who is acting within the scope of his or her license; and any other practitioner whose services are required to be covered by law; when rendered by that practitioner.

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-Existing Condition
Any injury, sickness, or condition that was diagnosed or treated, or would have caused a prudent person to seek diagnosis or treatment, within 6 months prior to the covered person's effective date of insurance.

Preferred Care
a health care service or supply that is provided by:
- A covered person's primary care physician; or a preferred care provider on the referral of the primary care physician; or
- A Non-Preferred Urgent Care Provider; when travel to a Preferred Urgent Care Provider for treatment is not feasible; or

- A health care provider that is not a preferred care provider for the following situations:
  - For an emergency medical condition when travel to a preferred care provider; is not feasible; or
  - For treatment or services furnished by a physician that has a type of practice that is not listed in the Directory; but whose services are required to be covered by law; or
  - For treatment or services furnished by a physician; within a geographic area covered in the Directory; but only if a preferred care provider is not reasonably available; provided you contact Aetna; and Aetna con firms that a preferred care provider is not reasonably available.

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

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

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

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

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

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.

Prosthetic Device
An artificial limb device to replace, in whole or in part, an arm or leg.

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

Reasonable Charge
Only that part of a charge which is reasonable is covered. The reasonable charge for a service or supply is the lowest of:
- The provider's usual charge for furnishing it, and
- The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a simi lar service or supply and the manner in which charges for the service or supply are made, and
- The charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

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

In determining the reasonable charge for a service or supply that is:

- Unusual, or
- Not often provided in the area, or
- Provided by only a small number of providers in the area.

Aetna may take into account factors, such as:

- The complexity,
- The degree of skill needed,
- The type of specialty of the provider,
- The range of services or supplies provided by a facility, and
- The prevailing charge in other areas.

Recognized Charge

Only that part of a charge which is recognized is covered. The recognized charge for a service or supply is the lowest of:

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

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

In determining the recognized charge for a service or supply that is:

- Unusual, or
- Not often provided in the area, or
- Provided by only a small number of providers in the area.

Aetna may take into account factors, such as:

- The complexity,
- The degree of skill needed,
- The type of specialty of the provider,
- The range of services or supplies provided by a facility, and
- The recognized charge in other areas.

Residential Treatment Facility
A treatment center for children and adolescents, which provides residential care and treatment for emotionally disturbed individuals, and is licensed by the department of children and youth services, and is accredited as a residential treatment center by the council on accreditation or the joint commission on accreditation of health organizations.

Respite Care
Care provided to give temporary relief to the family or other care givers in emergencies and from the daily demands for caring for a terminally ill covered person.

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

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.

Semi-Private Rate
The charge for room and board which an institution applies to the most beds in its semiprivate rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

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

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

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

- Organized facilities for medical services,
- 24 hours nursing service by RNs,
- A capacity of six or more beds,
- A daily medical records for each patient, and
- A physician available at all times.

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

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

A physician who:
practices in such a sub-specialty; and
is providing routine medical care (such as could be given by a primary care physician);

will not be considered a Specialist for purposes of applying this plan's copay provisions.

Surgery Center
A free standing ambulatory surgical facility that:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Makes charges.
- Is directed by a staff of physicians. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery which requires general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
  - Physicians who practice surgery in an area hospital, and
  - Dentists who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by a registered nurse.

- Is equipped and has trained staff to handle medical emergencies.
- It must have:
  - A physician trained in cardiopulmonary resuscitation, and
  - A defibrillator, and
  - A tracheotomy set, and
  - A blood volume expander.
- Has a written agreement with a hospital in the area for immediate emergency transfer of patients. Written procedures for such a transfer must be displayed, and the staff must be aware of them.
- Provides an ongoing quality assurance program. The program must include reviews by physicians who do not own or direct the facility.
- Keeps a medical record on each patient.

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

Surgical Expense
Charges by a physician for,
- A surgical procedure,
- A necessary preoperative treatment during a hospital stay in connection with such procedure, and
- Usual postoperative treatment.

Surgical Procedure
- A cutting procedure,
- Suturing of a wound,
- Treatment of a fracture,
- Reduction of a dislocation,
- Radiotherapy (excluding radioactive isotope therapy), if used in lieu of a cutting operation for removal of a tumor,
- Electrocauterization,
- Diagnostic and therapeutic endoscopic procedures,
- Injection treatment of hemorrhoids and varicose veins,
- An operation by means of laser beam,
- Cryosurgery.

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

Urgent Admission
One where the physician admits the person to the hospital due to:

- The onset of or change in a disease, or
- The diagnosis of a disease, or
- An injury caused by an accident,

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

Urgent Condition
This means a sudden illness, injury, or condition, that:

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

Urgent Care Provider
This is:

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

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

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

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

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

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. In the event of a disagreement over the payment of a claim, a written request to review the claim must be mailed to Aetna, within one year from the date appearing on the Explanation 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.

Inquiries
The Inquiry process is a process prior to the Appeal process during which Aetna may attempt to answer questions and/or resolve concerns communicated on behalf of the claimant to their satisfaction within three (3) business days. This process shall not be used for review of an Adverse Determination, which must be reviewed through the Appeal process.

Complaints
If an inquiry is not resolved in three (3) business days or if you are dissatisfied with the service you receive from the Plan or want to complain about a participating provider you must call Aetna Customer Service within 30 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written response within 30 calendar days of the receipt of the complaint, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations
You may submit an Appeal if Aetna gives notice about a Complaint or an Adverse Benefit Determination. This Plan provides for two levels of Appeal. It will also provide an option to request an external review of the Adverse Benefit Determination.

You have 180 calendar days with respect to Health claims and 60 calendar days with respect to all Other claims following the receipt of notice about a Complaint or an Adverse Benefit Determination to request your level one Appeal. Your appeal must be made by telephone, in person, by mail, or by electronic means and should include:

- Your name;
- Your school's name- Curry College;
- A copy of Aetna's notice of an Adverse Benefit Determination;
- Your reasons for making the appeal; and
- Any other information you would like to have considered.

A claimant may contact Member Services at the toll-free telephone number on their ID card for assistance in resolving Appeals. A claimant may also contact the Office of Patient Protection at their toll-free number **(1-800-436-7757)**, facsimile **(617-624-5046)** or via the internet site (www.state.ma.us/dph/opp)., regarding an external appeal.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to Aetna. All rights of the claimant also extend to the claimant's authorized representative, which includes a claimant's guardian, conservator, holder of a power of attorney, health care agent designated pursuant to the law, family member, or another person authorized by the claimant in writing or by law with respect to a specific Appeal or external review, provided that if the claimant is unable to designate a representative, where such designation would otherwise be required, a conservator, holder of a power of attorney, or family member in that order or priority may be the claimant's representative or appoint another responsible party to serve as the claimant's authorized representative. If the authorized representative is a health care provider, the claimant must specify a named individual who will act on behalf of the authorized representative and a telephone number for that individual.

Expedited Appeals Review Process
In the event the claimant is a hospital inpatient, the claimant shall receive a written resolution of an expedited review of the Appeal prior to hospital discharge and the opportunity to request continuation of services.

In the event the Appeal is of an emergent or urgent nature where the physician believes that denial of coverage for a medically necessary service would cause serious harm to the claimant, an Aetna Medical Director shall review the matter as soon as possible or within 48 hours and communicate a decision to the claimant by telephone. In addition, Aetna will provide the claimant with a written resolution which shall include identification of the specific information considered and an explanation of the basis for the decision. The written resolution shall include a substantive clinical justification therefore that is consistent with generally accepted principles of professional medical practice.

External Review
A claimant, who remains aggrieved by an Adverse Determination and has exhausted at least one level of Appeal, may seek further review of the Appeal by filing a request in writing with the Office of Patient Protection. The request for an external review must be made within 45 days of receipt of the Aetna determination. For the purposes of this provision, an Adverse Determination is based upon a review of information provided by Aetna to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other health care services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care or effectiveness.

Please review your Certificate of Coverage for additional information concerning your appeal rights.

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

Accidental Death and Dismemberment (ADD) Benefits
Benefits are payable for the Accidental Death and Dismemberment of Covered Persons, up to a maximum of Ten Thousand Dollars ($10,000).

NOTE: For most school plans, ADD benefits are provided by Aetna Life Insurance Company (ALIC). However, in some states, ADD benefits may be provided through a contractual relationship between Chickering Claims Administrators, Inc. (CCA) and On Call International (On Call). ADD coverage provided through On Call is underwritten by United States Fire Insurance Company (USFIC). Please refer to your school's policy to determine whether ALIC or USFIC underwrites ADD benefits for your specific Plan. Should you have questions or need to file a claim please contact **(877) 378-9475**.

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

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

Medical Evacuation and Repatriation (MER) Benefits
The following benefits are underwritten by Virginia Surety Company (VSC), with medical and travel assistance services provided by On Call. These benefits are designed to assist Covered Persons when traveling more than 100 miles from home, anywhere in the world.

- Unlimited Emergency Medical Evacuation
- Unlimited Medically Supervised Repatriation (while traveling or on campus)
- Unlimited Return of Mortal Remains (while traveling or on campus)
- Return of Traveling Companion
- $2,500 Emergency Return Home in the event of death or life-threatening illness of a parent or sibling.

Worldwide Emergency Travel Assistance (WETA) Services
On Call provides the following travel assistance services:

- 24/7 Emergency Travel Arrangements
- Translation Assistance
- Emergency Travel Funds Assistance
- Lost Luggage and Travel Documents Assistance
- Assistance with Replacement of Credit Card/Travelers Checks
- 24/7 U.S. Nurse Help Line
- Medical/Dental/Pharmacy Referral Service
- Hospital Deposit Arrangements
- Dispatch of Physician
- Emergency Medical Record Assistance

NOTE: In order to obtain coverage, all MER and WETA services must be provided and arranged through On Call. Reimbursement will NOT be provided for any such services not provided and arranged through On Call. Although certain medical services may be covered under the terms of the Covered Person's student health insurance plan (the "Plan"), On Call does not provide coverage for medical treatment rendered by doctors, hospitals, pharmacies or other health care providers. Coverage for such services will be provided in accordance with the terms of the Plan and exclusions and limitations may apply.

To obtain MER and WETA benefits/services, or for any questions related to those benefits/services, please call On Call International at the following numbers listed on the On Call ID card provided to Covered Persons when they enroll in the Plan: Toll Free **1- (866) 525-1956** or collect **1-(603) 328-1956**. All Covered Persons should carry their On Call ID cards when traveling.

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

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

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

How do I register?

- Go to **www.aetnastudenthealth.com**
- 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. 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 15708
Boston, MA 02215-0014
(877) 378-9475
www.aetnastudenthealth.com

Underwritten by:
Aetna Life Insurance Company (ALIC)
151 Farmington Avenue
Hartford, CT 06156
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Policy No. 697403

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