2012–2013

Student Accident and Sickness Insurance Plan

Rochester Institute of Technology

Your student health insurance coverage, offered by Aetna Student Health*, may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions for annual dollar limits for student health insurance coverage are $100,000 for policy years before September 23, 2012, and $500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014. Your student health insurance coverage includes an annual limit of $100,000 per condition on all covered services including Essential Health Benefits. Other internal maximums (on Essential Health Benefits and certain other services) are described more fully in the benefits chart included inside this Plan summary. If you have any questions or concerns about this notice, contact (800) 466-3185. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.

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

Underwritten by:
Aetna Life Insurance Company
(ALIC)

Policy Number 812809

WHERE TO FIND HELP

In case of an emergency, call 911, or go directly to an emergency care facility. For non-emergency situations, please visit or call RIT's Student Health Center at (**585) 475-2255**.

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

Please contact:
Aetna
P.O. Box 981106
El Paso, TX 79998
(800) 466-3185

For questions about:
- ID Cards

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

For lost ID cards, contact:
Aetna Student Health
(800) 466-3185

For questions about:
- Enrollment/Eligibility
- International Waiver Process

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

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

Please contact:
Aetna Pharmacy Management
(888) RX-AETNA or (888) 792-3862 (Available 24 hours)

For questions about:
- Provider Listings'

Please contact:
Aetna Student Health
(800) 466-3185

A complete list of providers can be found using Aetna's **DocFind®** Service at: **www.aetnastudenthealth.com**

For questions about:
On Call International 24/7 Emergency Travel Assistance Services

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

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

The Rochester Institute of Technology Student Accident and Sickness Plan 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.

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 Rochester Institute of Technology (RIT). If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits. The Master Policy may be viewed at the University's Global Risk Management Services Offices during business hours.

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

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Dear Students, Parents and/or Guardians:

RIT is concerned about the health, safety and general physical and mental well-being of its students. We recognize, however, that students may encounter accidents and sickness while enrolled at RIT. The RIT Student Health Center, as a primary ambulatory care facility, is available to all students when medical attention is needed. To supplement this, a direct enrollment student insurance program is available through the university**. RIT requires all students to have adequate medical insurance coverage.**

Domestic students must enroll themselves directly in the Student Accident and Sickness Insurance Plan. Enrollment must be completed by **September 30, 201**2 (for students first registered in fall quarter). International students should refer to the International Student Enrollment Process.

This Brochure provides information about the health care services and programs offered by the RIT Student Health Center. These services are funded through quarterly health fees, which are separate from the charges for insurance coverage, the payment of which is required and billed automatically for all full-time undergraduate students. The health fee is also used to support other health related services and health education on campus. Part-time and graduate students may use the Student Health Center by paying the quarterly fee or by paying a per visit fee.

This Brochure also outlines the benefits offered in the RIT Student Insurance Plans underwritten by Aetna Life Insurance Company. Page 34 has a description of an Eye Care Discount Plan that is available to RIT students enrolled in the basic medical insurance plan.

The 2012-2013 Plans provide substantial benefits for **covered medical expenses** at a reasonable cost. Coverage includes the "Basic Student Accident & Sickness Plan", the optional "Enhanced Supplemental Medical Plan" and the "Excess Accident Plan". Coverage is also available for a student's spouse and/or **dependent** children at an additional charge. At no charge to students, RIT maintains the Excess Accident Plan available to all RIT students for accidents occurring on campus or off-campus during an RIT sponsored activity.

Enrollment Process
RIT requires all students to have adequate medical insurance.
If a student does not have coverage, this requirement may be satisfied by enrolling for Basic Accident & Sickness coverage **BEFORE THE ENROLLMENT DEADLINE DATE OF SEPTEMBER 30, 201**2**,** or later date if appropriate. Students can enroll in this Plan by:

- Going Online at **www.universityhealthplans.com**: Students have the option to either put the charge on their RIT student account or pay online with a credit card. Students first registering at RIT in the winter, spring or summer quarters must enroll within 30 days from the start of the quarter.

Note: *Graduate and part-time students may enroll voluntarily in the "Basic Student Accident & Sickness Plan".*

International Student Enrollment Process
ALL international undergraduate and graduate students (full and part-time) on A, B, E, F, G, I, J, K, O, Q, R and V visas will be automatically enrolled in the Basic Accident and Sickness policy on a semi-annual basis, based on registration status. Certain foreign scholars will be eligible for exemption from the RIT required insurance enrollment and will not be billed for this coverage.

For parents of entering students, we urge you to evaluate and consider purchasing the RIT Student Accident and Sickness Insurance Plan for your student, not only based upon the absence of insurance coverage, but as an important supplement to your existing coverage as well as enhanced ease of access to services which may be needed within the larger Rochester medical community.

For Student Health Center information please contact the Student Health Center at (**585) 475-2255** V or (**585) 475-5515** or **info@univhealthplans.com**.

Sincerely,
Melinda J. Ward
Director,
Risk Management & Insurance

RIT HEALTH SERVICES

Access to the RIT Student Health Center (SHC) is available to **all** students and does not require (or accept) the use of insurance. The SHC quarterly fee and the fee paid for the Student Accident and Sickness Insurance Plan are separate from and independent of each other. While the SHC does not bill or accept payment from any insurance company, staff will provide information and/or receipts as it is capable, to assist students in submitting claims for services rendered by other providers. **RIT requires all students to have insurance coverage through either their own personal insurance carrier or through this Student Accident and Sickness Plan which is made available through the university.**

CONFIDENTIALITY
The Student Health Center is committed to the maintenance of confidentiality in the provider-patient relationship. The release of health care information to anyone, including parents, requires specific written authorization by the student, except as required by law or for insurance reimbursement.

WHAT IS THE STUDENT HEALTH CENTER?
The Student Health Center (SHC) provides a full range of primary care, treatment and referral services, as well as related health education programs. The goal of all programs and services is to take care of students when they are ill, and assist them in learning how **TO STAY WELL**.

As a free-standing ambulatory care facility, the SHC is located in the August Center which is located between the residential and academic sides of campus. This well equipped facility provides comprehensive primary care which includes a variety of outpatient services, as well as an observation unit with three beds for use during Center hours.

HOW IS THE STUDENT HEALTH CENTER STAFFED?
The SHC is staffed by physicians, nurse practitioners, nurses, health educators, Physician Assistant (PA), administrative and support staff. The SHC providers are licensed/certified (as appropriate) in specialty areas that include Adult Medicine, Family Practice, Pediatrics, Psychiatry, Gynecology, Health Education, Sign Language Interpreting for the Deaf, Alcohol and Other Drug Counseling. The Center also serves as a teaching site for a variety of RIT academic programs including its Physician Assistant and Nutrition Programs. Clinical practicum experiences are provided for students of other colleges as well.

WHEN IS THE STUDENT HEALTH CENTER OPEN?
During the fall, winter and spring quarters, the SHC is open Monday-Thursday, 8:30 a.m. - 7:00 p.m., Friday, 8:30 a.m. - 4:30 p.m. Wednesdays 8:30 a.m.-12 p.m.; 2:30 p.m. - 7 p.m. (between 12:00 p.m. and 2:30 p.m: Open for emergencies only, please ring the doorbell). Hours of operation during academic breaks and the summer quarter are 8:30 a.m. - 4:30 p.m., Monday through Friday. The Center is closed during weekends and university holidays.

When the SHC is closed, campus coverage is provided through the RIT Ambulance, which is dispatched by calling Public Safety. This New York State certified ambulance service is staffed by well trained student volunteer emergency medical technicians who can assess medical conditions, treat and/or transport to a local Hospital emergency department as the situation requires.

WHO CAN USE THE STUDENT HEALTH CENTER?
The services and programs provided by the SHC are available to **all** students. Full-time undergraduate students are required to pay the quarterly health fee and are billed automatically. Part-time, graduate and co-op students may choose to pay the quarterly health fee or use the SHC on a fee-for-service basis.

STUDENT HEALTH FEE COVERAGE AND FINANCIAL RESPONSIBILITY
Most of the clinical and health education services provided by the SHC are paid for by the quarterly health fee with no additional charge to the student user of the service. This includes office visits, some routine laboratory work, immunization services, minor surgery, bed observation, on-site specialty services, substance abuse counseling, HIV antibody counseling and health education programs. Diagnostic x-ray and an array of laboratory services are provided in cooperation with community based providers, many of which may be billed by the provider to the student's health insurance carrier. Expenses that are the responsibility of the student, parent/guardian include but are not limited to certain specialty procedures and lab work processed at outside lab. Charges for pharmaceuticals purchased at the SHC or off-campus, procedures referred to off-campus providers through the medical or gynecologic clinics, lab work processed at outside laboratories, tuberculin PPD tests, some serum injections, and certain specialty procedures are the responsibility of the student or parent/guardian. In addition, the cost of receiving medical care or psychiatric counseling beyond that provided by the SHC or other on-campus services including referrals to specialists, use of hospital emergency departments or hospitalization, is the responsibility of the student or parent.

HEALTH SERVICES AND HOW TO USE THEM

The SHC offers five types of services: General medicine, Allergy/Immunization, Women's Health Care, Psychiatric Evaluation (ongoing mental health counseling is provided by the RIT Counseling Center in consultation and/or collaboration with the SHC psychiatrist as needed) and Health Education which includes alcohol and other drug counseling. All services are provided by appointment. Emergency appointments are accommodated as necessary.

The SHC clinical staff includes physicians, Physician Assistant (PA), nurses and nurse practitioners who provide medical assessment, diagnosis and treatment. Referrals are made as necessary, to outside providers/facilities to facilitate more comprehensive care.

ALLERGY/IMMUNIZATION CLINIC
Allergy injections are administered by appointment only on a regular basis in the Allergy Clinic at no additional charge to full-time undergraduate students. Students must provide their serum, instructions and schedule from their allergist.

WOMEN'S HEALTH CARE CLINIC
The Clinic is staffed by a full-time nurse practitioner with training and experience in gynecology. Comprehensive services are provided by appointment and include complete pelvic examinations, pap smears, contraceptive services, pregnancy testing and counseling, and treatment or referral as appropriate, for other gynecological problems.

PHYSICAL EXAMINATIONS
Appointments for physical exams which may be needed for co-op, internships or jobs are an additional cost to the student.

FORMULARY SERVICES
For the convenience of RIT students, a limited scope of prescriptive and non-prescriptive pharmaceuticals, crutches, canes and other non-returnable orthopedic soft goods may be purchased at the SHC. **Only prescriptions written by a SHC provider will be accepted.** Payment by Tiger Bucks, check or cash must be made at the time of service. The student may choose to use a community-based pharmacy for medication purchases.

LABORATORY SERVICES
Diagnostic laboratory testing is provided as needed in support of general medical and specialty services. Most of the lab work ordered by SHC providers, including complete blood counts, mono testing, strep throat and urine cultures, cholesterol testing and glucose testing is sent to a community-based lab. The patient (or the indicated insurance company) is billed directly for this service by the laboratory.

RADIOLOGY
Diagnostic x-ray services are provided by a community based radiology group. The patient is either billed directly by the radiology group for these services or provides insurance information to the provider for direct billing to the carrier. Some HMO (Health Maintenance Organization) and PPG (Preferred Provider Group) based insurance plans exclude coverage for x-rays not authorized or taken in conjunction with that HMO/PPG. While every effort will be made by SHC staff to coordinate your level of coverage with the need for diagnostic x-ray services, you should be aware of your insurance coverage requirements and limitations at the time of your visit.

EKG
Electrocardiograph (EKG) diagnostic procedures are performed by staff physicians as needed. There will be an additional charge for this service.

MINOR SURGERY
Certain minor surgical procedures are performed by SHC staff providers. Depending upon the level of severity as determined by the provider, procedures may include suturing of lacerations, incision and drainage of abscesses, removal of small growths, and splinting of sprains and strains or other minor injuries. There is no additional charge for this service for students who have paid the quarterly health fee.

BED OBSERVATION
Clinical providers may house patients for illnesses requiring observation, special treatment procedures, isolation of infectious disease, and/or for injury requiring in-bed care for the duration of hours of operation. This allows students to be observed and assisted until stable or until it is determined if another source for continuing care is needed. **There is no overnight service.**

HEALTH EDUCATION
Education is an integral part of the Student Health Center. Ask about formal and informal classes, counseling for personal assistance, special presentations for academic classes or campus residences, and our role as an assisting resource for class assignments.

MEDICAL TRANSPORT SERVICES
The SHC may assist students in arranging medical transport services when there is an acute/emergency medical need. The campus transportation department will assist patients in getting to consulting physicians or other referral locations by taxi, for which students must pay. Short-term on-campus transportation to and from class for disabling injuries may be authorized by staff providers for transport by the campus mobility van. In addition to the above, 24 hour ambulance service is available seven days a week through the RIT Ambulance Corps. The service is of no cost to students and is dispatched through Public Safety. The ambulance provides one-way transport to the emergency/urgent care facilities only. Should the RIT Ambulance not be available, another ambulance will be dispatched for which there may be a charge.

HOW STUDENTS ARE ACTIVE IN THE STUDENT HEALTH CENTER
The SHC welcomes and encourages student participation in the on-going process of enhancing and maintaining the needs of students. Feedback from individual health care consumers is strongly encouraged and may be provided in whatever way is most comfortable to the consumer.

SIGN LANGUAGE INTERPRETER
A full-time certified interpreter is on the staff to assist with clinical interactions between the provider and the deaf/hearing impaired patient as needed.

MEDICAL EXCUSES FOR CLASS ABSENTEEISM
The SHC does not issue written medical excuses. Verbal information will be made available to faculty only with the written permission of the student.

THE RIT STUDENT HEALTH CENTER IS ACCREDITED BY THE ACCREDITATION ASSOCIATION FOR AMBULATORY HEALTH CARE, INC. (AAAHC)

POLICY PERIOD

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

2. **New Spring Semester students**: Coverage for all insured students enrolled for the Spring Semester will become effective at 12:01 a.m. on **March 04, 2013,** and will terminate at 11:59 p.m. on **August 14, 2013.**

3. **Insured dependents**: Coverage will become effective on the same date the insured student's coverage becomes effective, or the day after the postmarked date when the completed application and premium are sent, if whichever is later. Coverage for insured **dependents** terminates in accordance with the Termination Provisions described in the Master Policy. For more information on Termination of Covered **Dependents** see Termination of Insurance section of this Brochure. Examples include, but are not limited to: the date the student's coverage terminates, the date the **dependent** no longer meets the definition of a **dependent**.

RATES

	Cost			
	Annual	**Winter/Spring/Summer**	**Spring/Summer**	**Summer**
	08/15/12-08/14/13	**11/26/12-08/14/13**	**03/04/13-08/14/13**	**05/28/13-08/14/13**
Student	$1,100	$825	$550	$275
Spouse	$2,183	$1,638	$1,092	$546
Child(ren)	$1,769	$1,326	$885	$442
Enhanced Supplemental Benefit	$341 per person	$341 per person	$341 per person	$341 per person

ROCHESTER INSTITUTE OF TECHNOLOGY
STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN

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

STUDENT COVERAGE

ELIGIBILITY

Enrollment is voluntary for all registered students except A,B,E,F,G,I,J,K,O,Q,R or V Visa International Students. All International undergraduate and graduate students (full and part time) on A, B, E, F, G, I, J, K, O, Q, R or V Visas will be automatically enrolled in the Basic Accident and Sickness policy on a semi-annual basis, based on registration status, and billed by the Bursar's Office.

All Lawful spouse and **dependent** children. Subject to the terms of this Plan, benefits are available for an eligible student and his or her eligible **dependents** only for the coverages listed below; and only up to the maximum amounts shown. The coverage sections of this Plan contain a complete description of the benefits available.

No person may be covered as both a **covered student** and as a **dependent**; and no person may be covered as a **dependent** of more than one **covered student**.

WAIVER PROCESS/PROCEDURE

For International Students only:
If you are eligible to waive the RIT Student Accident and Sickness Plan, please go to **www.universityhealthplans.com**, click on "Rochester Institute of Technology", then choose the option for the "RIT Student Accident and Sickness Plan". On the left hand side of the page, choose the option for the "International Student Waiver Form". If you have any questions, please contact University Health Plans at **(800) 437-6448** or **info@univhealthplans.com**.

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 for which you have paid the premium, and no refund will be allowed. (This refund policy will not apply if you withdraw due to a covered Accident or Sickness).

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

DEPENDENT COVERAGE

ELIGIBILITY

Covered students may also enroll their lawful spouse and dependent children up to age 26.

If this Plan provides coverage for **dependent** children who are full-time students to a higher age than other **dependent** children, coverage is provided for **covered dependent** children who are on a certified leave of absence from school due to illness, for a period of twelve months from the last day of attendance in school. The medical necessity of a leave of absence from school must be certified by the covered **dependent** student's attending **physician** who is licensed to practice. Written documentation of the illness must be submitted to Aetna.

ENROLLMENT

If an Insured adds a new **dependent** after the effective date of coverage, coverage will become effective for such **dependent** on the date the application and premium is received. An Enrollment Card and premium must be submitted within the thirty (31) day enrollment period for which the student is first enrolled. If the **dependent** is a newborn child and no other children are covered under the plan, notification of the birth along with the appropriate premium must be submitted within 31 days of such birth. (Addition of a spouse must be within 31 days of marital status change.)

An Enrollment Card and premium need not be submitted if the newly added **dependent** is a child and the Insured already has one or more covered children. However, written notice of the new child must be submitted within the 31-day period.

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 RIT Student Accident and Sickness Plan. To extend coverage for a newborn past the 31 days, the **Covered Student** must: 1) enroll the child within 31 days of birth, and 2) pay the additional premium, starting from the date of birth.

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

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 RIT 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.

You may also obtain information regarding Preferred Providers by contacting Aetna Student Health at **(800) 466-3185**, or by accessing DocFind online at **www.aetnastudenthealth.com**.

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

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

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 (**800) 466-3185** (attention Managed Care Department).

The following inpatient services require pre-certification:

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

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

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

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

DESCRIPTION OF BENEFITS

Please Note: The Rochester Institute of Technology 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 RIT Student Accident and Sickness 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 RIT, you may view it at Global Risk Management Services Offices or you may contact Aetna Student Health at (800) 466-3185.

This Plan will never pay more than $100,000 per sickness per policy year under the Basic Sickness Plan, and $100,000 per accident per policy year under the Accident Plan. Additional Plan maximums may also apply. Some conditions may cost more to treat and health care providers may bill you for what the Plan does not cover.

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

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

SUMMARY OF BENEFITS CHART

All coverage is based on Recognized Charges unless otherwise specified.

Basic Accident Plan **Benefits – Policy Year Maximum: $100,000 per condition**

Inpatient Hospitalization Benefits	
Room and Board Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $3,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $3,000, thereafter 80% of the Recognized Charge for a semi-private room.
Intensive Care Room and Board Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $3,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $3,000, thereafter 80% of the Recognized Charge for the Intensive Care Room Rate for an overnight stay.
Miscellaneous Hospital Expense	**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: 100% of the Negotiated Charge up to $3,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $3,000, thereafter 80% of the Recognized Charge.

Non-Surgical Physicians Expense	**Covered Medical Expenses** for charges for the non-surgical services of the attending Physician, or a consulting Physician, are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $3,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $3,000, thereafter 80% of the Recognized Charge.
Surgical Expense - Inpatient	
Surgical Expense	**Covered Medical Expenses** for charges for surgical services, performed by a Physician, are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $3,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $3,000, thereafter 80% of the Recognized Charge.
Anesthesia Expense	**Covered Medical Expenses** for the charges of anesthesia, during a surgical procedure, are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $3,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $3,000, thereafter 80% of the Recognized Charge.
Assistant Surgeon Expense	**Covered Medical Expenses** for the charges of an assistant surgeon, during a surgical procedure, are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $3,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $3,000, thereafter 80% of the Recognized Charge.
Surgical Expense - Outpatient	
Surgical Expense	**Covered Medical Expenses** for charges for surgical services, performed by a Physician, are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $3,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $3,000, thereafter 80% of the Recognized Charge.
Anesthesia Expense	**Covered Medical Expenses** for the charges of anesthesia, during a surgical procedure, are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $3,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $3,000, thereafter 80% of the Recognized Charge.

Assistant Surgeon Expense	**Covered Medical Expenses** for the charges of an assistant surgeon, during a surgical procedure, are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $3,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $3,000, thereafter 80% of the Recognized Charge.
Ambulatory Surgical Expense	Benefits are payable for Covered Medical Expenses incurred by a covered person for expenses incurred for outpatient surgery performed in a hospital outpatient surgery department or in an ambulatory surgical center. Covered Medical Expenses must be incurred on the day of the surgery or within 48 hours after the surgery. Preferred Care: 100% of the Negotiated Charge up to $3,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $3,000, thereafter 80% of the Recognized Charge. **Covered Medical Expenses** must be incurred on the day of the surgery or within 48 hours after the surgery.
Outpatient Benefits **Covered Medical Expenses** include but are not limited to: Physician's office visits, hospital or outpatient department or emergency room visits, durable medical equipment, clinical lab, or radiological facility.	
Hospital Outpatient Department Expense	**Covered Medical Expenses** includes treatment rendered in a Hospital Outpatient Department. Covered Medical Expenses do not include Emergency Room/Urgent Care Treatment, Walk-in Clinic, Therapy Expenses, Chemotherapy and Radiation, and outpatient surgical services, including physician, anesthesia and facility charges, which are covered as outlined under the individual benefit types listed in this schedule of benefits. Benefits are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $3,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $3,000, thereafter 80% of the Recognized Charge.
Walk-in Clinic Visit Expense	**Covered Medical Expenses** include services rendered in a walk-in clinic. Benefits are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $3,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $3,000, thereafter 80% of the Recognized Charge.

Emergency Room Expense	**Covered Medical Expenses** incurred for treatment of an Emergency Medical Condition are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $3,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $3,000, thereafter 80% of the Recognized Charge. **Important Note:** Please note that as **Non-Preferred Care Providers** do not have a contract with **Aetna**, the provider may not accept payment of your cost share (your **deductible** and **coinsurance)** as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. Please send **Aetna** the bill at the address listed on the back of your member ID card and **Aetna** will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.
Urgent Care Expense	*Benefits include charges for treatment by an urgent care provider.* **Please Note: A covered person should not seek medical care or treatment from an urgent care provider if their illness, injury, or condition, is an emergency condition. The covered person should go directly to the emergency room of a hospital or call 911 for ambulance and medical assistance.** **Urgent Care** Benefits include charges for an urgent care provider to evaluate and treat an urgent condition. **Covered Medical Expenses** for urgent care treatment are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $3,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $3,000, thereafter 80% of the Recognized Charge *No benefit will be paid under any other part of This Plan for charges made by an urgent care provider to treat a non-urgent condition.*
Ambulance Expense	**Covered Medical Expenses** are payable as follows: 100% of the Actual Charge for the services of a professional ambulance to or from a hospital, when required due to the emergency nature of a covered Accident or Sickness.
Pre-Admission Testing Expense	**Covered Medical Expenses** for Pre-Admission testing charges while an outpatient before scheduled surgery are payable same basis as any other condition.
Physician's Office Visit Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $3,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $3,000, thereafter 80% of the Recognized Charge. This benefit includes visits to specialists.

Laboratory and X-ray Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $3,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $3,000, thereafter 80% of the Recognized Charge.
High Cost Procedures Expense	Covered Medical Expenses include charges incurred by a covered person for High Cost Procedures that are required as a result of injury or sickness. Covered Medical Expenses for High Cost Procedures must be provided on an outpatient basis and are payable on the same basis as any other sickness. Expenses for High Cost Procedures may be incurred in the following: a) A physician's office; or b) Hospital outpatient department; or emergency room; or c) Clinical laboratory; or d) Radiological facility; or other similar facility; licensed by the applicable state; or the state in which the facility is located. Covered Medical Expenses for High Cost Procedures include charges for the following procedures; and services: a) C.A.T. Scan; b) Magnetic Resonance Imaging **Covered Medical Expenses** are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $3,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $3,000, thereafter 80% of the Recognized Charge.
Therapy Expense	**Covered Medical Expenses** include charges incurred by a **covered person** for the following types of therapy provided on an outpatient basis: • Physical Therapy, • Chiropractic Care, • Speech Therapy, • Inhalation Therapy, or • Occupational Therapy. Expenses for Speech and Occupational Therapies are **Covered Medical Expenses,** only if such therapies are a result of **injury** or **sickness**. **Covered Medical Expenses** are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $3,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $3,000, thereafter 80% of the Recognized Charge.

Chemotherapy Expense	**Covered Medical Expenses** for chemotherapy, including oral chemotherapy and anti-nausea drugs used in conjunction with the chemotherapy, radiation therapy, tests and procedures, physiotherapy (for rehabilitation only after a surgery), and expenses incurred at a radiological facility. **Covered medical expenses** also include expenses for the administration of chemotherapy and visits by a health care professional to administer the chemotherapy. Such expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $3,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $3,000, thereafter 80% of the Recognized Charge
Durable Medical and Surgical Equipment Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $3,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $3,000, thereafter 80% of the Recognized Charge.
Prosthetic Devices Expense	Benefits include charges for: artificial limbs, or eyes, and other non-dental prosthetic devices, as a result of an accident or sickness. **Covered Medical Expenses** do **not** include: eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet. **Covered Medical expenses** are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $3,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $3,000, thereafter 80% of the Recognized Charge.
Physical Therapy Expense	**Covered Medical Expenses** for physical therapy are payable as follows when provided by a licensed physical therapist: Preferred Care: 100% of the Negotiated Charge up to $3,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $3,000, thereafter 80% of the Recognized Charge.

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: 100% of the Actual Charge up to $3,000, thereafter 80% of the Actual Charge.
Musculoskeletal/ Chiropractic Therapy Expense	**Covered Medical Expenses** include charges for Musculoskeletal Therapy provided on an outpatient basis. For purposes of this benefit, "Musculoskeletal Therapy" means the diagnosis, and treatment, by manual or mechanical means, of the musculoskeletal structure, due to lack of normal nerve, muscle, and/or joint function. Benefits for chiropractic care will be paid on the same basis as those payable for care or services provided by other health professionals in the diagnosis, treatment and management of the same or similar conditions, injuries, complaints, disorders or ailments.
Consultant 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 a diagnosis. Benefits are payable as follows: <u>Preferred Care</u>: 100% of the Negotiated Charge up to $3,000, thereafter 80% of the Negotiated Charge. <u>Non-Preferred Care</u>: 100% of the Recognized Charge up to $3,000, thereafter 80% of the Recognized Charge

Additional Benefits	
Prescribed Medicines Expense	Prescription Drug Benefits are payable as follows: Preferred Care Pharmacy: **100%** of the Negotiated Charge, following a **$30 Copay** for each Brand Name Prescription Drug or a **$10 Copay** for each Generic Prescription Drug. Covered Medical Expenses are payable up to a maximum of **$100,000** per Policy Year. Non-Preferred Care Pharmacy: **100%** of the Recognized charge, following a **$30** Deductible for each Brand Name Prescription or a **$10** Deductible for each Generic Prescription Drug, Covered Medical Expenses are payable up to a maximum of **$100,000** per Policy Year. You must pay out of pocket for Prescriptions at a Non-Preferred Pharmacy and then submit the receipt with a Prescription Claim Form for reimbursement. This Pharmacy benefit is provided to cover Medically Necessary Prescriptions associated with a covered Sickness or Accident occurring during the Policy Year. Please use your Aetna Student Health ID card when obtaining your prescriptions. Prior Authorization may be required for certain Prescription Drugs and some medications may not be covered under this Plan. For assistance and a complete list of excluded medications, or drugs requiring prior authorization, please contact Aetna Pharmacy Management at **(888) RX-AETNA or (888) 792-3862** (available 24 hours). Aetna Specialty Pharmacy provides specialty medications and support to members living with chronic conditions. The medications offered may be injected, infused or taken by mouth. For additional information please go to **www.AetnaSpecialtyRx.com.**
Acupuncture In Lieu Of Anesthesia Expense	**Covered Medical Expenses** include acupuncture therapy, when acupuncture is used in lieu of other anesthesia, for a surgical or dental procedure covered under This Plan. The acupuncture must be administered by a health care provider who is a legally qualified physician, practicing within the scope of their license. Preferred Care: 100% of the Negotiated Charge up to $3,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $3,000, thereafter 80% of the Recognized Charge.
Podiatric Expense	**Covered Medical Expenses** include charges for podiatric services, provided on an outpatient basis following an injury. Benefits are payable same basis as any other condition. Expenses for routine foot care, such as trimming of corns, calluses, and nails, are **not Covered Medical Expenses**.
Home Health Care Expense	**Covered Medical Expenses** include charges incurred by a covered person for home health care services made by a home health agency pursuant to a home health care plan. Preferred Care: 100% of the Negotiated Charge up to $3,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $3,000, thereafter 80% of the Recognized Charge.

Transfusion or Dialysis of Blood Expense	**Covered Medical Expenses** include charges for the transfusion or dialysis of blood, including the cost of: whole blood, blood components, and the administration thereof. Benefits are payable same basis as any other condition.
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: 100% of the Negotiated Charge up to $3,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $3,000, thereafter 80% of the Recognized Charge.
Skilled Nursing Facility Expense	**Covered Medical Expenses** include charges incurred by a covered person for confinement in a skilled nursing facility for treatment rendered: • in lieu of confinement in a hospital as a full time inpatient, or • within 24 hours following a hospital confinement and for the same or related cause(s) as such hospital confinement. **Covered Medical Expenses** are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $3,000, thereafter 80% of the Negotiated Charge for the semi-private room rate. Non-Preferred Care: 100% of the Recognized Charge up to $3,000, thereafter 80% of the Recognized Charge for the semi-private room rate.
Rehabilitation Facility Expense	**Covered Medical Expenses** include charges incurred by a covered person for confinement as a full time inpatient in a rehabilitation facility. Confinement in the rehabilitation facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of hospital or skilled nursing facility confinement. **Covered Medical Expenses** for Rehabilitation Facility Expense are covered as follows: Preferred Care: 100% of the Negotiated Charge up to $3,000, thereafter 80% of the Negotiated Charge for the rehabilitation facility's daily room and board maximum for semi-private accommodations Non-Preferred Care: 100% of the Recognized Charge up to $3,000, thereafter 80% of the Recognized Charge for the rehabilitation facility's daily room and board maximum for semi-private accommodations.

Basic Sickness Plan **Benefits – Policy Year Maximum: $100,000 per condition**	
Inpatient Hospitalization Benefits	
Room and Board Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 80% of the Recognized Charge for a semi-private room.
Intensive Care Room and Board Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 80% of the Recognized Charge for the Intensive Care Room Rate for an overnight stay.
Miscellaneous Hospital Expense	**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 Recognized Charge.
Non-Surgical Physicians Expense	**Covered Medical Expenses** for charges for the non-surgical services of the attending Physician, or a consulting Physician, are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 80% of the Recognized Charge.
Surgical Expense - Inpatient	
Surgical Expense	**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 Recognized Charge.
Anesthesia Expense	**Covered Medical Expenses** for the charges of anesthesia, during a surgical procedure, are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 80% of the Recognized Charge.
Assistant Surgeon Expense	**Covered Medical Expenses** for the charges of an assistant surgeon, during a surgical procedure, are as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 80% of the Recognized Charge.
Surgical Expense - Outpatient	
Surgical Expense	**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 Recognized Charge.
Anesthesia Expense	**Covered Medical Expenses** for the charges of anesthesia, during a surgical procedure, are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 80% of the Recognized Charge.

Assistant Surgeon Expense	**Covered Medical Expenses** for the charges of an assistant surgeon, during a surgical procedure, are as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 80% of the Recognized Charge.
Ambulatory Surgical Expense	Benefits are payable for Covered Medical Expenses incurred by a covered person for expenses incurred for outpatient surgery performed in a hospital outpatient surgery department or in an ambulatory surgical center. Covered Medical Expenses must be incurred on the day of the surgery or within 48 hours after the surgery. Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 80% of the Recognized Charge. **Covered Medical Expenses** must be incurred on the day of the surgery or within 48 hours after the surgery.
Outpatient Benefits **Covered Medical Expenses** include but are not limited to: Physician's office visits, hospital or outpatient department or emergency room visits, durable medical equipment, clinical lab, or radiological facility.	
Hospital Outpatient Department Expense	**Covered Medical Expenses** includes treatment rendered in a Hospital Outpatient Department. Covered Medical Expenses do not include Emergency Room/Urgent Care Treatment, Walk-in Clinic, Therapy Expenses, Chemotherapy and Radiation, and outpatient surgical services, including physician, anesthesia and facility charges, which are covered as outlined under the individual benefit types listed in this schedule of benefits. Benefits are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $2,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% up to $2,000 of the Recognized Charge, thereafter 80% of the Recognized Charge.
Walk-in Clinic Visit Expense	**Covered Medical Expenses** include services rendered in a walk-in clinic. Benefits are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $2,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% up to $2,000 of the Recognized Charge, thereafter 80% of the Recognized Charge.
Emergency Room Expense	**Covered Medical Expenses** incurred for treatment of an Emergency Medical Condition are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $2,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% up to $2,000 of the Recognized Charge, thereafter 80% of the Recognized Charge. **Important Note:** Please note that as **Non-Preferred Care Providers** do not have a contract with **Aetna**, the provider may not accept payment of your cost share (your **deductible** and **coinsurance)** as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. Please send **Aetna** the bill at the address listed on the back of your member ID card and **Aetna** will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.

Urgent Care Expense	*Benefits include charges for treatment by an urgent care provider.* **Please Note: A covered person <u>should not seek medical care or treatment from an urgent care provider if their illness, injury, or condition, is an emergency condition.</u> The covered person should go directly to the emergency room of a hospital or call 911 for ambulance and medical assistance.** **Urgent Care** Benefits include charges for an urgent care provider to evaluate and treat an urgent condition. **Covered Medical Expenses** for urgent care treatment are payable as follows: <u>Preferred Care</u>: 100% of the Negotiated Charge up to $2,000, thereafter 80% of the Negotiated Charge. <u>Non-Preferred Care</u>: 100% up to $2,000 of the Recognized Charge, thereafter 80% of the Recognized Charge. *No benefit will be paid under any other part of This Plan for charges made by an urgent care provider to treat a non-urgent condition.*
Ambulance Expense	**Covered Medical Expenses** are payable as follows: 100% of the Actual Charge for the services of a professional ambulance to or from a hospital, when required due to the emergency nature of a covered Accident or Sickness.
Pre-Admission Testing Expense	**Covered Medical Expenses** for Pre-Admission testing charges while an outpatient before scheduled surgery are payable same basis as any other condition.
Physician's Office Visit Expense	**Covered Medical Expenses** are payable as follows: <u>Preferred Care</u>: 100% of the Negotiated Charge up to $2,000, thereafter 80% of the Negotiated Charge. <u>Non-Preferred Care</u>: 100% up to $2,000 of the Recognized Charge, thereafter 80% of the Recognized Charge. This benefit includes visits to specialists.
Laboratory and X-ray Expense	**Covered Medical Expenses** are payable as follows: <u>Preferred Care</u>: 100% of the Negotiated Charge up to $2,000, thereafter 80% of the Negotiated Charge. <u>Non-Preferred Care</u>: 100% up to $2,000 of the Recognized Charge, thereafter 80% of the Recognized Charge.

High Cost Procedures Expense	Covered Medical Expenses include charges incurred by a covered person for High Cost Procedures that are required as a result of injury or sickness. Covered Medical Expenses for High Cost Procedures must be provided on an outpatient basis and are payable on the same basis as any other sickness. Expenses for High Cost Procedures may be incurred in the following: a) A physician's office; or b) Hospital outpatient department; or emergency room; or c) Clinical laboratory; or d) Radiological facility; or other similar facility; licensed by the applicable state; or the state in which the facility is located. Covered Medical Expenses for High Cost Procedures include charges for the following procedures; and services: a) C.A.T. Scan; b) Magnetic Resonance Imaging **Covered Medical Expenses** are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $2,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $2,000, thereafter 80% of the Recognized Charge.
Therapy Expense	**Covered Medical Expenses** include charges incurred by a **covered person** for the following types of therapy provided on an outpatient basis: • Physical Therapy, • Chiropractic Care, • Speech Therapy, • Inhalation Therapy, or • Occupational Therapy. Expenses for Speech and Occupational Therapies are **Covered Medical Expenses,** only if such therapies are a result of **injury** or **sickness**. **Covered Medical Expenses** are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $2,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% up to $2,000 of the Recognized Charge, thereafter 80% of the Recognized Charge.
Chemotherapy Expense	**Covered Medical Expenses** for chemotherapy, including oral chemotherapy and anti-nausea drugs used in conjunction with the chemotherapy, radiation therapy, tests and procedures, physiotherapy (for rehabilitation only after a surgery), and expenses incurred at a radiological facility. **Covered medical expenses** also include expenses for the administration of chemotherapy and visits by a health care professional to administer the chemotherapy. Such expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $2,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $2,000, thereafter 80% of the Recognized Charge.

Durable Medical and Surgical Equipment Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: **100%** of the Negotiated Charge up to $2,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $2,000, thereafter 80% of the Recognized Charge. **Breast Feeding Durable Medical Equipment** Coverage includes the rental or purchase of breast feeding **durable medical equipment** for the purpose of lactation support (pumping and storage of breast milk) as follows. Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $2,000, thereafter 80% of the Recognized Charge. *Breast Pump* C**overed expenses** include the following: • The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a **hospital**. • The purchase of: - an electric breast pump (non-hospital grade), if requested within 30 days from the date of the birth of the child. A purchase will be covered once every five years following the date of the birth; or - a manual breast pump, if requested within 6-12 months from the date of the birth of the child. A purchase will be covered once every five years following the date of the birth. • If an electric breast pump was purchased within the previous one period, the purchase of an electric or manual breast pump will not be covered until a five year period has elapsed from the last purchase of an electric pump. *Breast Pump Supplies* Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump. Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. The covered person is responsible for the entire cost of any additional pieces of the same or similar equipment that he or she purchases or rents for personal convenience or mobility. **Aetna** reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **Aetna**. **Limitations:** Unless specified above, not covered under this benefit are charges incurred for: • Services which are covered to any extent under any other part of this Plan>
Prosthetic Devices Expense	Benefits include charges for artificial limbs or eyes, wigs required as a result of chemo or radiation therapy, and other non-dental prosthetic devices, as a result of an accident or sickness. **Covered Medical Expenses** do **not** include: eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet. **Covered Medical expenses** are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $2,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $2,000, thereafter 80% of the Recognized Charge.

Physical Therapy Expense	**Covered Medical Expenses** for physical therapy are payable as follows when provided by a licensed physical therapist. Preferred Care: 100% of the Negotiated Charge up to $2,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $2,000, thereafter 80% of the Recognized Charge.
Dental Expense for Impacted Wisdom Teeth	**Covered Medical Expenses** for removal of one or more impacted wisdom teeth are payable as follows: 100% of the Actual Charge up to $2,000, thereafter 80% of the Actual Charge.
Allergy Testing Expense	Covered Medical Expenses include charges incurred by a covered person for diagnostic testing of allergies. Covered Medical Expenses include; but are not limited to; charges for the following: • laboratory tests; • physician office visits • prescribed medications for testing of the allergy; including any equipment used in the administration of prescribed medication; and • other medically necessary supplies and services. No benefits are payable under this Policy for the treatment of allergies. **Covered Medical Expenses** are payable same basis as any other condition.
Diagnostic Testing For Learning Disabilities Expense	**Covered Medical Expenses** for diagnostic testing for: • attention deficit disorder, or • attention deficit hyperactive disorder. Benefits are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 80% of the Recognized Charge. Once a covered person has been diagnosed with one of these conditions, medical treatment will be payable as detailed under the outpatient Treatment of Mental and Nervous Disorders portion of This Plan.
Musculoskeletal/ Chiropractic Therapy Expense	**Covered Medical Expenses** include charges for Musculoskeletal Therapy provided on an outpatient basis. For purposes of this benefit, “Musculoskeletal Therapy” means the diagnosis, and treatment, by manual or mechanical means, of the musculoskeletal structure, due to lack of normal nerve, muscle, and/or joint function. Benefits for chiropractic care will be paid on the same basis as those payable for care or services provided by other health professionals in the diagnosis, treatment and management of the same or similar conditions, injuries, complaints, disorders or ailments.

Routine Physical Exam Expense	Benefits include expenses for a routine physical exam performed by a physician. If charges for a routine physical exam given to a child who is a covered dependent are covered under any other benefit section, those charges will not be covered under this section. A routine physical exam is a medical exam given by a physician, for a reason other than to diagnose or treat a suspected or identified injury or sickness. Included as a part of the exam are: • Routine vision and hearing screenings given as part of the routine physical exam, • X-rays, lab, and other tests given in connection with the exam, and • Materials for the administration of immunizations for infectious disease and testing for tuberculosis. Preferred Care **visits** are payable as follows: 100% of the Negotiated Charge. Preferred Care **immunizations** are payable at **100%** of the Negotiated Charge. Non-Preferred Care **visits** are payable as follows: 100% of the Recognized Charge up to $2,000, thereafter 80% of the Recognized Charge. Non-Preferred Care **immunizations** are payable at 100% of the Recognized Charge up to $2,000, thereafter 80% of the Recognized Charge. In addition to any state regulations or guidelines regarding mandated Routine Physical Exam services, **Covered Medical Expenses** include services rendered in conjunction with, • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force. • For females, screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to: - Screening and counseling services, such as: Interpersonal and domestic violence; Sexually transmitted diseases; and Human Immune Deficiency Virus (HIV) infections. - Screening for gestational diabetes. - High risk Human Papillomavirus (HPV) DNA testing for women age 18 and older and limited to once every three years. • X-rays, lab and other tests given in connection with the exam. • Immunizations for infectious diseases and the materials for administration of immunizations that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. • If the plan includes dependent coverage, for covered newborns, an initial **hospital** checkup. • For a **child** who is a covered dependent, he physical exam must include at least: - A review and written record of the patient's complete medical history, - A check of all body systems, and - A review and discussion of the exam results with the patient or with the parent or guardian. • For all exams given to covered dependent **under age 2, Covered Medical Expenses** will **not include** charges for the following: - **More than** 6 exams performed during the first year of the child's life, - **More than** 2 exams performed during the second year of the child's life. • For all exams given to a covered dependent from **age 2 and over**, **Covered Medical Expenses** will **not include** charges for **more than** one exam in 12 months in a row. • For all exams given to a covered student or a spouse who is a covered dependent, **Covered Medical Expenses** will **not include** charges for **more than**: - One exam in 12 months in a row.

Routine Physical Exam Expense *(continued)*	**Covered Medical Expenses** incurred by a woman, are charges made by a physician for, • One annual routine gynecological exam. **Screening and Counseling Services:** **Covered Medical Expenses** include charges made by a **physician** in an individual or group setting for the following are covered at 100% of the Negotiated Charge when services are provided by a **Preferred Care Provider:** ***Obesity*** Screening and counseling services to aid in weight reduction due to obesity. Coverage includes: • Preventive counseling visits and/or risk factor reduction intervention; • Medical nutrition therapy; • Nutritional counseling; and • Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease. ***Misuse of Alcohol and/or Drugs*** Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment. ***Use of Tobacco Products*** Screening and counseling services to aid a covered person to stop the use of tobacco products. Coverage includes: • Preventive counseling visits; • Treatment visits; and • Class visits; to aid a covered person to stop the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including: • cigarettes; • cigars; • smoking tobacco; • snuff; • smokeless tobacco; and • candy-like products that contain tobacco. **Limitations** Unless specified above, not covered under this Screening and Counseling Services benefit are charges incurred for: • Services which are covered to any extent under any other part of this Plan.

Well Baby Care Expense	Benefits include charges for routine preventive and primary care services, rendered to a covered dependent child on an outpatient basis. **Routine preventive and primary care** services are services rendered to a covered dependent child, from the date of birth through the attainment of **two (2)** years of age. Services include: initial hospital check-ups, other hospital visits, physical examinations, including routine hearing and vision examinations, medical history, developmental assessments, and materials for the administration of appropriate and necessary immunizations and laboratory tests, when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics. Coverage for such services shall be provided only to the extent that such services are provided by, or under the supervision of a physician, or other licensed professional. **Covered Medical Expenses** are payable as follows Preferred Care: **100%** of the Negotiated Charge. Benefits are payable for scheduled visits in accordance with the prevailing clinical standards of the American Academy of Pediatrics. Non-Preferred Care: 100% of the Recognized Charge up to $2,000, thereafter 80% of the Recognized Charge. Benefits are payable for scheduled visits in accordance with the prevailing clinical standards of the American Academy of Pediatrics.
Immunizations Expense	**Covered Medical Expenses** include: • charges incurred by a covered student and dependent spouse for the materials for the administration of appropriate and **medically necessary** immunizations, and testing for tuberculosis, and • charges incurred by a covered dependent up to age 19, for the materials for the administration of appropriate and **medically necessary** immunizations, when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics. Preferred Care: 100% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $2,000, thereafter 80% of the Recognized Charge. **Covered Medical Expenses do not include** a physician's office visit in connection with immunization or testing for tuberculosis.
Consultant 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 a diagnosis. Benefits are payable as follows: Preferred Care: 100% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge.

TREATMENT OF MENTAL AND NERVOUS DISORDERS	
Biologically based Mental Illness and for Children with Serious Emotional Disturbances	"Biologically Based Mental Illness" means a mental, nervous or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Such biologically based mental illnesses are defined as schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive-compulsive disorder, bulimia and anorexia. "Children with Serious Emotional Disturbances" means: persons under the age of eighteen years who have diagnoses of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders, and where there are one or more of the following: • Serious suicidal symptoms or other life-threatening self-destructive behaviors, • Significant psychotic symptoms (hallucinations, delusion, bizarre behaviors), • Behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage, or • Behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household. **Inpatient** **Covered Medical Expenses** include expenses incurred by a **covered person** while confined as a full-time inpatient in a **hospital** or **residential treatment facility** for the treatment of Biologically based Mental Illness or Children with Serious Emotional Disturbances. These expenses are covered on the same basis as inpatient treatment for any **sickness**. Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 80% of the Recognized Charge. Includes the charges made for treatment received during partial hospitalization or intensive outpatient in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis. When approved, benefits will be payable in place of an inpatient admission, whereby 2 days of partial hospitalization or intensive outpatient treatment may be exchanged for 1 day of full hospitalization **Outpatient** **Covered Medical Expenses** include expenses while a **covered person** is not confined as a full-time inpatient in a **hospital,** for the treatment of Biologically based Mental Illness or Children with Serious Emotional Disturbances. These expenses are covered on the same basis as outpatient treatment for any **sickness**. Preferred Care: 100% of the Negotiated Charge up to $2,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $2,000, thereafter 80% of the Recognized Charge. ***Not Covered are Charges for Services*:** • While incarcerated, confined or committed to a local correctional facility or a prison, or a custodial facility for youth. • Provided solely because such services are ordered by a court. • Deemed to be cosmetic in nature.

Other than Biologically based Mental Illness and Children with Serious Emotional Disturbances	**Inpatient Benefits** **Covered Medical Expenses** include expenses incurred by a **covered person** while confined as a full-time inpatient in a **hospital** or **residential treatment facility** for the treatment of Mental Illness other than Biologically based Mental Illness or Children with Serious Emotional Disturbances. Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 80% of the Recognized Charge. Includes the charges made for treatment received during partial hospitalization or intensive outpatient in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis. When approved, benefits will be payable in place of an inpatient admission, whereby 2 days of partial hospitalization or intensive outpatient treatment may be exchanged for 1 day of full hospitalization **Outpatient Treatment** **Covered Medical Expenses** include expenses while a **covered person** is not confined as a full-time inpatient in a **hospital,** for the treatment of Mental Illness other than Biologically based Mental Illness or Children with Serious Emotional Disturbances. Preferred Care: 100% of the Negotiated Charge up to $2,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Negotiated Charge up to $2,000, thereafter 80% of the Recognized Charge. ***Not Covered are Charges for Services*:** • While incarcerated, confined or committed to a local correctional facility or a prison, or a custodial facility for youth. • Provided solely because such services are ordered by a court. • Deemed to be cosmetic in nature.

Alcoholism And Drug Addiction Treatment Expense	
Inpatient Expense	**Covered Medical Expenses** include the treatment of a substance abuse condition while confined as a inpatient in a hospital or facility licensed for such treatment. 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. Benefits are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 80% of the Recognized Charge.
Outpatient Expense	**Covered Medical Expenses** for outpatient diagnosis and treatment of a substance abuse condition are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $2,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $2,000, thereafter 80% of the Recognized Charge.

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 medical expenses** may include at least one home care visit. This home care visit may be requested at any time within 48 hours of the time of a vaginal delivery, or within 96 hours of a delivery, and shall be delivered within 24 hours after discharge, or 24 hours of the mother's request, whichever is later. The home care visit will not be subject to any deductible, copay or insurance. **Covered Medical Expenses** for maternity care also include: • Parent education • Assistance and training in breast or bottle feeding and, • The performance of any necessary maternal and newborn clinical assessments A referral is not required for this benefit. **Covered Medical Expenses** for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other sickness. **Covered Medical Expenses** include services of a licensed midwife unless those services duplicate the services already provided by the covered person's physician. During the initial 48 or 96 hours, no pre-certification is required for the mother, or her newly born child. Pre-certification is required, after the 48, or 96 hours. **Covered Medical Expenses** include coverage for blood lead testing for prenatal/maternity care. **Prenatal Care** Prenatal care will be covered at 100% of the Negotiated Charge* for services received by a pregnant female in a **physician's**, obstetrician's, or gynecologist's office but only to the extent described below. Coverage for prenatal care under this benefit is limited to pregnancy-related **physician** office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check). **Comprehensive Lactation Support and Counseling Services** **Covered Medical Expenses** will be covered at 100% of the Negotiated Charge* and include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy and in the postpartum period by a certified lactation support provider. The "postpartum period" means the 60 day period directly following the child's date of birth. **Covered expenses** incurred during the postpartum period also include the rental or purchase of breast feeding equipment as described below. Lactation support and lactation counseling services are **covered expenses** when provided in either a group or individual setting. *100% of the Negotiated Charge refers to Preferred Care only. Non-Preferred Care will be covered as any other Sickness.

Well Newborn Nursery Care Expense	Benefits include charges for routine care of a covered person's newborn child as follows: • hospital charges for routine nursery care during the mother's confinement, but for not more than four days for a normal delivery, • physician's charges for circumcision, and • physician's charges for visits to the newborn child in the hospital and consultations, but for not more than 1 visit per day. **Covered Medical Expenses** are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 80% of the Recognized Charge.
Additional Benefits	
Prescribed Medicines Expense	Prescription Drug Benefits are payable as follows: Preferred Care Pharmacy*:* **100%** of the Negotiated Charge, following a **$30 Copay** for each Brand Name Prescription Drug or a **$10 Copay** for each Generic Prescription Drug. Covered Medical Expenses are payable up to a maximum of **$100,000** per Policy Year. Non-Preferred Care Pharmacy: **100%** of the Recognized charge, following a **$30** Deductible for each Brand Name Prescription or a **$10** Deductible for each Generic Prescription Drug, Covered Medical Expenses are payable up to a maximum of **$100,000** per Policy Year. You must pay out of pocket for Prescriptions at a Non-Preferred Pharmacy and then submit the receipt with a Prescription Claim Form for reimbursement. This Pharmacy benefit is provided to cover Medically Necessary Prescriptions associated with a covered Sickness or Accident occurring during the Policy Year. Covered Medical Expenses also include prescription smoking cessations aids. Please use your Aetna Student Health ID card when obtaining your prescriptions. Prior Authorization may be required for certain Prescription Drugs and some medications may not be covered under this Plan. For assistance and a complete list of excluded medications, or drugs requiring prior authorization, please contact Aetna Pharmacy Management at **(888) RX-AETNA or (888) 792-3862** (available 24 hours). Aetna Specialty Pharmacy provides specialty medications and support to members living with chronic conditions. The medications offered may be injected, infused or taken by mouth. For additional information please go to **www.AetnaSpecialtyRx.com.** **Please Note: Covered Medical Expenses** for prescribed supplies for the treatment of diabetes will not be subject to the listed per Policy Year Prescription Drug limit.
Diabetic Treatment and Supplies Expenses	**Covered Medical Expenses** include expenses incurred in connection with the treatment of diabetes, including diabetic testing supplies and equipment, including: Blood glucose monitors (including monitors for the legally blind), data management systems, test strips, insulin injecting aids, cartridges for the legally blind, syringes, insulin pumps and appurtenances, insulin infusion devices and oral agents for controlling blood sugar. Benefits are payable on the same basis as any Sickness.
Outpatient Diabetic Self-Management Education Program Expense	**Covered Medical Expenses** will include training designed to instruct a person in the self-management of diabetes. It may include training in self-care or diet. Such education may be provided in a group setting, and when medically necessary, diabetic self-management education shall also include home visits. Benefits for Self-Management Education and Home Health Care are payable on the same basis as any Sickness.

Non-Prescription Enteral Formula Expense	Benefits include charges incurred by a covered person for non-prescription enteral formulas, for which a physician has issued a written order, and are 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 Medical Expenses** for inherited diseases of amino acids and organic acids, will also include food products modified to be low protein. **Covered Medical Expenses** are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $2,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $2,000, thereafter 80% of the Recognized Charge.
Temporomandibular Joint Dysfunction Expense	**Covered Medical Expenses** include charges incurred, by a **covered person,** for non-surgical treatment of Temporomandibular Joint (TMJ) Dysfunction, when the TMJ disorder is medical in origin. Benefits are payable on the same basis as any other sickness.
Pap Smear Screening Expense	**Covered Medical Expenses** include one annual routine pap smear screening for women age 18 and older. Benefits are payable on the same basis as any Sickness. Preferred Care: 100% of the Negotiated Charge. Non-preferred Care: 100% of the Recognized Charge up to $2,000, thereafter 80% of the Recognized Charge.
Mammogram Expense	**Covered Medical Expenses** include one baseline mammogram for women between age 35 and 40. Coverage is also provided for one routine annual mammogram for women age 40 and older, as well as when medically indicated for women with risk factors who are under age 40. Risk factors for women under 40 are: • Prior personal history of breast cancer • Positive Genetic Testings • Family history of breast cancer, or • Other risk factors Mammogram screenings coverage 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 on the same basis as any Sickness. Preferred Care: 100% of the Negotiated Charge. Non-preferred Care: 100% of the Recognized Charge up to $2,000, thereafter 80% of the Recognized Charge.
Breast Cancer Treatment Expense	**Covered Medical Expenses** include inpatient hospital care for lymph node dissection or lumpectomy for the treatment of breast cancer, or a mastectomy covered by the policy. Benefits are payable on the same basis as any other sickness.

Reconstructive Surgery As Result of Mastectomy Expense	**Covered Medical Expenses** will include expenses incurred for: • all stages of reconstruction of the breast on which a mastectomy has been performed; and • surgery and reconstruction of the other breast to produce a symmetrical appearance. Benefits are payable on the same basis as any Sickness.
Elective Abortion Expense	If, as a result of pregnancy having its inception during the Policy Year, a covered person incurs expenses in connection with an elective abortion, a benefit is payable. **Covered Medical Expenses** for Elective Abortion Expense are covered as follows: Preferred Care: 100% of the Negotiated Charge up to $2,000, thereafter 80% of the Negotiated Charge. Non-preferred Care: 100% of the Recognized Charge up to $2,000, thereafter 80% of the Recognized Charge. This benefit is in lieu of any other Policy benefits.
Family Planning Expense	For females with reproductive capacity, **Covered Medical Expenses** include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this benefit must be approved by the Food and Drug Administration (FDA). Coverage includes counseling services on contraceptive methods provided by a **physician**, obstetrician or gynecologist. Such counseling services are **Covered Medical Expenses** when provided in either a group or individual setting. The following contraceptive methods are **covered expenses** under this benefit: *Voluntary Sterilization* **Covered expenses** include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants. **Covered expenses** under this *Preventive Care* benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement. *Contraceptives* **Covered expenses** include charges made by a **physician** or **pharmacy** for: • Female contraceptives that are **generic prescription drugs**. The prescription must be submitted to the pharmacist for processing. *This contraceptives benefit covers only **generic prescription drugs**.* • Female contraceptive devices and related services and supplies that are generic prescription devices when prescribed in writing by a **physician**. *This contraceptives benefit covers only those devices that are generic prescription devices.* • FDA-approved female over-the-counter contraceptive methods that are prescribed by your **physician**. The **prescription** must be submitted to the pharmacist for processing. These items are limited to one per day and a 30 day supply per **prescription**. **Limitations** Unless specified above, not covered under this benefit are charges for: • Services which are covered to any extent under any other part of this Plan; • Services and supplies incurred for an abortion; • Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care; • Services which are for the treatment of an identified **illness** or **injury**;

Family Planning Expense *(continued)*	• Services that are not given by a **physician** or under his or her direction; • Psychiatric, psychological, personality or emotional testing or exams; • Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA; • Male contraceptive methods, sterilization procedures or devices; • The reversal of voluntary sterilization procedures, including any related follow-up care. **Covered Medical Expenses** are payable as follows: Preferred Care: 100% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $2,000, 80% thereafter of the Recognized Charge. **Important Note:** Brand-Name Prescription Drug or Devices will be covered at 100% of the Negotiated Charge, including waiver of Annual Deductible if a Generic Prescription Drug or Device is not available in the same therapeutic drug class or the prescriber specifies Dispense as Written.
Chlamydia Screening Test Expense	**Covered Medical Expenses** include charges incurred for an annual Chlamydia screening test. Benefits will be paid for Chlamydia screening expenses incurred for: • Women who are: - under the age of 20 if they are sexually active, and - at least 20 years old if they have multiple risk factors. • Men who have multiple risk factors. Benefits are payable as follows: Preferred Care: 100% of the Negotiated Charge. Non-preferred Care: 100% of the Recognized Charge up to $2,000, thereafter 80% of the Recognized Charge.
Routine Screening For Sexually Transmitted Disease Expense	Covered Medical Expenses include charges incurred; by a covered person; for annual routine screening for sexually transmitted diseases. As used above, "routine screening for sexually transmitted disease" means any laboratory test that specifically detects for infection by one or more agents of: • gonorrhea; • syphilis; • hepatitis; • HIV; and • genital herpes; and which test is approved for such purposes by the FDA. Benefits will be paid; for routine screening for sexually transmitted disease expenses incurred by covered persons who are at least 18 years old and who are sexually active. Benefits are payable as follows: Preferred Care: 100% of the Negotiated Charge. Non-preferred Care: 100% of the Recognized Charge up to $2,000, thereafter 80% of the Recognized Charge.

Routine Colorectal Cancer Screening Expense	**Covered Medical Expenses** include charges for colorectal cancer examination and laboratory tests, for any nonsymptomatic person age 50 or more, or a symptomatic person under age 50, for the following: • One fecal occult blood test every 12 months in a row • A Sigmoidoscopy at age 50 and every 3 years thereafter • One digital rectal exam every 12 months in a row • A double contrast barium enema, once every 5 years • A colonoscopy, once every 10 years • Virtual colonoscopy • Stool DNA. Benefits are payable as follows: Preferred Care: 100% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $2,000, thereafter 80% of the Recognized Charge.
Routine Prostate Cancer Screening Expense	**Covered Medical Expenses** include charges incurred for the screening of cancer, as follows: • For a male age 40 and over, with a family history of prostate cancer or other prostate cancer risk factors, Standard Diagnostic Testing once each Policy Year. • For a male age 50 or over, who is asymptomatic, Standard Diagnostic Testing once each Policy Year. For a male, any age, with a prior history of prostate cancer, Standard Diagnostic Testing as recommended, by the covered person's physician. Standard Diagnostic Testing includes, but is not limited to: • a digital rectal examination, and • a prostate-specific antigen test. Benefits are payable as follows: Preferred Care: 100% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $2,000, thereafter 80% of the Recognized Charge.
Second Opinion For Cancer Treatment Expense	**Covered Medical Expenses** include a second opinion consultation by a specialist for the diagnosis or recommended treatment of cancer. The specialist must be board certified in the medical field relating to the diagnosis. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation. If the covered person does not **obtain a referral** from a Preferred Care provider for Non-Preferred Care, the level of coinsurance for Non-Preferred Care may be reduced. With a referral, benefits will be payable at the same level for a Non-Preferred Care as it would be for Preferred Care. Benefits are payable on the same basis as any Sickness.

Second Surgical Opinion Expense	**Covered Medical Expense**s will include expenses incurred for a second opinion consultation by a specialist on the need for surgery which has been recommended by the covered person's physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation. Benefits are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $2,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $2,000, thereafter 80% of the Recognized Charge.
Acupuncture In Lieu Of Anesthesia Expense	**Covered Medical Expenses** include acupuncture therapy, when acupuncture is used in lieu of other anesthesia, for a surgical or dental procedure covered under This Plan. The acupuncture must be administered by a health care provider who is a legally qualified physician, practicing within the scope of their license. Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 80% of the Recognized Charge.
Dermatological Expense	**Covered Medical Expenses** include charges for the diagnosis and treatment of skin disorders, excluding laboratory fees. Related laboratory expenses are covered under the Outpatient Expense Benefit. Benefits are payable same basis as any other condition. *Covered Medical Expenses do not include cosmetic treatment and procedures.*
Podiatric Expense	**Covered Medical Expenses** include charges for podiatric services, provided on an outpatient basis following an injury. Benefits are payable same basis as any other condition. Expenses for routine foot care, such as trimming of corns, calluses, and nails, are **not Covered Medical Expenses**.
Hypodermic Needles Expense	**Covered Medical Expenses** for hypodermic needles and syringes used in the treatment of diabetes are payable same basis as any Sickness.
Home Health Care Expense	**Covered Medical Expenses** include charges incurred by a covered person for home health care services made by a home health agency pursuant to a home health care plan. Preferred Care: 100% of the Negotiated Charge up to $2,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $2,000, thereafter 80% of the Recognized Charge.
Transfusion or Dialysis of Blood Expense	**Covered Medical Expenses** include charges for the transfusion or dialysis of blood, including the cost of: whole blood, blood components, and the administration thereof. Benefits are payable same basis as any other condition.

Hospice Expense	**Covered Medical Expenses** include charges for end of life services provided for a terminally ill covered person, including Acute Care services at an Acute Care Facility. Benefits are payable as follows: Preferred Care: 100% of the Negotiated Charge up to $2,000, thereafter 80% of the Negotiated Charge. Non-Preferred Care: 100% of the Recognized Charge up to $2,000, thereafter 80% of the Recognized Charge.
Licensed Nurse Expense	Benefits include charges incurred by a covered person who is confined in a hospital as a resident bed-patient, and requires the services of a registered nurse or licensed practical nurse. **Covered Expenses** for a Licensed Nurse are covered as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 80% of the Recognized Charge.
Skilled Nursing Facility Expense	**Covered Medical Expenses** include charges incurred by a covered person for confinement in a skilled nursing facility for treatment rendered: • in lieu of confinement in a hospital as a full time inpatient, or • within 24 hours following a hospital confinement and for the same or related cause(s) as such hospital confinement. **Covered Medical Expenses** are payable as follows: Preferred Care: 80% of the Negotiated Charge for the semi-private room rate. Non-Preferred Care: 80% of the Recognized Charge for the semi-private room rate.
Rehabilitation Facility Expense	**Covered Medical Expenses** include charges incurred by a covered person for confinement as a full time inpatient in a rehabilitation facility. Confinement in the rehabilitation facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of hospital or skilled nursing facility confinement. **Covered Medical Expenses** for Rehabilitation Facility Expense are covered as follows: Preferred Care: 80% of the Negotiated Charge for the rehabilitation facility's daily room and board maximum for semi-private accommodations Non-Preferred Care: 80% of the Recognized Charge for the rehabilitation facility's daily room and board maximum for semi-private accommodations.

Bone Density Screening Expense	**Covered Medical Expenses** include bone mineral density measurements or tests. Benefits will be paid for expenses incurred by a **covered person** for a bone density screening upon the recommendation of the covered person's physician for: 1) an individual previously diagnosed as having osteoporosis or having a family history of osteoporosis, or 2) an individual with symptoms or conditions indicative of the presence, or the significant risk of osteoporosis, or 3) an individual on a prescribed drug regimen posing a significant risk of osteoporosis, or 4) an individual with lifestyle factors to such a degree as posing a significant risk of osteoporosis, or 5) with such age, gender, and/or physiological characteristics which pose a significant risk for osteoporosis. Benefits will also include drugs and devices approved by the FDA or generic equivalents as approved substitutes for the treatment of osteoporosis. Benefits are payable on the same basis as any Sickness.

Supplemental Medical Coverage

An Enhanced Supplemental Plan is available for an additional cost, subject to the following enrollment conditions. Please note that mental health services are not eligible for coverage under this Supplemental Plan. When this optional Supplemental Plan is purchased, **Covered Medical Expenses** incurred for an Injury or Sickness while insured and in excess of the **$100,000** per policy year for any one Accident or in excess of **$100,000** per policy year for any one Sickness, will be payable at **100%** up to a maximum policy year benefit of **$250,000** for any one covered Accident or any one covered Sickness.

Covered Medical Expenses include (a) Hospital room and board, (b) miscellaneous Hospital expenses, (c) inpatient and outpatient surgery, (d) inpatient and outpatient Anesthesia, (e) inpatient and outpatient Doctor visits, (f) consultant, (g) licensed nurse, (h) Hospital outpatient department, (I) emergency room, (j) diagnostic x-ray and lab tests, (k) outpatient prescription drug, (l) ambulance, (m) durable medical equipment, and (n) other expenses incurred for the care and treatment of an Injury or Sickness, subject to the exclusions and limitations of the Plan.

Only students and **dependents** insured for the Basic Accident Plan and Sickness Plan may purchase this Enhanced Supplemental Plan. The Supplemental Plan must be purchased by **September 30, 2012** for the Fall Quarter, or within 30 days after the start of the quarter in which the student is first enrolled in the Basic Plan for the academic year. Students and **Dependents** must enroll in the Basic **Accident** and **Sickness** Plan in order to be eligible for the Optional Supplemental Plan. The Optional Supplemental Plan must be purchased at the same time as enrollment under the Basic Plan.

Note: *To purchase this optional coverage, students will need to download and submit an Enrollment Form, found at www.universityhealthplans.com, and include premium payment. Students who purchase the Enhanced Supplemental Plan must also enroll any eligible dependents who are insured under the Basic Plan. Dependents may not be enrolled for this Enhanced Supplemental Plan without the student being enrolled or without being insured under the Basic Plan.*

EXCESS ACCIDENT PLAN

RIT maintains an Excess Accident Plan, at no charge, for all RIT students. This Excess Accident Plan provides up to **$10,000** of coverage in full at the **Negotiated Charge** or **Recognized Charge** (Preferred and Non-Preferred Providers respectively) for accidents occurring on campus or occurring off-campus at an RIT sponsored activity. (Accidental Death and Dismemberment Benefit provided and underwritten by United States Fire Insurance Company, USFIC).

All other primary medical insurance benefits must be first paid prior to this Excess Accident Plan's benefits being paid. If the student is enrolled under the RIT Basic Student Accident and Sickness Insurance Plan, that Plan is considered primary coverage. Any accident claims submitted under the Basic Plan will automatically be submitted to the Excess Accident Plan if all accident expenses have not been covered under the Basic Plan and the accident meets the definition of a covered accident under this Plan. Claim Forms for students not enrolled in the RIT Basic Plan can be obtained by calling the Global Risk Management Services Office at **(585) 475-4903**.

ADDITIONAL SERVICES AND DISCOUNTS

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

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

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

Aetna Hearing℠ discount program: Access to discounts on hearing aids and hearing tests from HearPO. Guaranteed lowest pricing* on over 1000 models from seven leading manufacturers.
**Competitor copy required for verification of price and model. Limited to manufacturers offered through the HearPO program. Local provider quotes only will be matched, no internet quotes*

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

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

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

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

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

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

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

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

Vital Savings by Aetna® 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	**2012/2013 Rates 9/1/12-8/31/13**
Student Only	$29
Student + One Dependent	$51
Student + Two or more Dependents	$73

Vital Savings by Aetna® on Dental* is a dental discount program helping you and your dependents save. In most instances, savings range from 15-50 percent on services from general dentistry and cleanings to root canals, crowns, and orthodontia (braces) No claims to file. Enroll online at **www.aetnastudenthealth.com**.
**Actual costs and savings vary by provider and geographic area.*

Vital Savings on Dental	**2012/2013 Rates 9/1/12-8/31/13**
Student Only	$29
Student + One Dependent	$51
Student + Two or more Dependents	$73

Vital Savings by Aetna® 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. In most instances, for dental, savings range from 15-50 percent on services from general dentistry and cleanings to root canals, crowns, and orthodontia (braces) No claims to file.
**Actual costs and savings vary by provider and geographic area.*

Vital Savings on Pharmacy and Dental	**2012/2013 Rates 9/1/12-8/31/13**
Student Only	$46
Student + One Dependent	$81
Student + Two or more Dependents	$115

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

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

Aetna's Informed Health® Line*:
Call toll free **1 (800) 556-1555** 24 hours a day, 7 days a week.
Get health answers 24/7. When you have an Aetna health benefits and health insurance plan, you have instant access to the information you need. Our tools and resources can help you:

- Make more informed decisions about your care
- Communicate better with your doctors
- Save time and money, by showing you how to get the right care at the right time

When you call our Informed Health Line, you can talk directly to a registered nurse. Our nurses can discuss a wide variety of health and wellness topics.

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

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

Use the **Healthwise® Knowledgebase** to find out more about a health condition you have or medications you take. It explains things in terms that are easy to understand. Get to it through your secure Aetna Navigator® member website, at **www.aetnastudenthealth.com**.

GENERAL PROVISIONS

STATE MANDATED BENEFITS
The Plan will pay benefits in accordance with any applicable New York 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 minor child or **Dependent** of any **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.

COORDINATION OF BENEFITS

If the **Covered Person** is insured under more than one group health plan, the benefits of the plan that covers the insured student will be used before those of a plan that provides coverage as a **dependent**. When both parents have group health plans that provide coverage as a **dependent**, the benefits of the plan of the parent whose birth date falls earlier in the year will be used first. The benefits available under this Plan may be coordinated with other benefits available to the **Covered Person** under any auto insurance, Workers' Compensation, Medicare, or other coverage. The Plan pays in accordance with the rules set forth in the Policy.

EXTENSION OF BENEFITS

If Basic Sickness Expense, coverage for a **Covered Person** ends while he is **totally disabled**, benefits will continue to be available for expenses incurred for that person only while the **Covered Person** continues to be **totally disabled**. Benefits will end 31 days after the date coverage ends. Benefits will continue to be available for a **Covered Person** who incurs medical expenses directly relating to a pregnancy that began before coverage under this Plan ceased. Such benefits will be covered only for the period of that pregnancy.

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

TERMINATION OF INSURANCE

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

TERMINATION OF STUDENT COVERAGE

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

1) the date this Plan terminates,
2) the last day for which any required premium has been paid,
3) 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,

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

TERMINATION OF DEPENDENT COVERAGE

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

1) For a child, on the first premium due date following the child's 26th birthday
2) The date the **covered student** fails to pay any required premium,
3) For the spouse, the date the marriage ends in divorce or annulment,
4) The date **dependent** coverage is deleted from this Plan,
5) For a domestic partner, the earlier to occur of:
   - the date this Plan no longer allows coverage for domestic partners, and
   - the date of termination of the domestic partnership. In that event, a completed and signed declaration of Termination of Domestic Partnership must be provided to the Policyholder
6) The date the **dependent** ceases to be in an eligible class.

Termination will not prejudice any claim for a charge that is incurred prior to the date coverage ends.

INCAPACITATED DEPENDENT CHILDREN
Insurance may be continued for incapacitated **dependent** children who reach the age at which insurance would otherwise cease. The **dependent** child must be chiefly **dependent** for support upon the **covered student** and be incapable of self-sustaining employment because of mental or physical handicap.

Due proof of the child's incapacity and dependency must be furnished to Aetna by the **covered student** within 31 days after the date insurance would otherwise cease. Such child will be considered a **covered dependent,** so long as the **covered student** submits proof to Aetna at reasonable intervals during the two (2) years following the child's attainment of the limiting age and each year thereafter, that the child remains physically or mentally unable to earn his own living. The premium due for the child's insurance will be the same as for a child who is not so incapacitated.

The child's insurance under this provision will end on the earlier of:
1) the date specified under the provision entitled Termination of **Dependent** Coverage, or
2) the date the child is no longer incapacitated and **dependent** on the **covered student** for support

CONTINUATION OF COVERAGE
A **covered student** who has graduated or is otherwise ineligible for coverage under this Plan, and has been continuously insured under the plan offered by the Policyholder (regular student plan), may be covered for either 3 or 6 months provided that: 1) a written request for continuation has been forwarded to Aetna 31 days prior to the termination of coverage, and 2) premium payment has been made. Coverage under this provision ceases on the date this Plan terminates.

EXCLUSIONS

This Plan does not cover nor provide benefits for:

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

2. Expense incurred for eye refractions, vision therapy, radial keratotomy (unless medically necessary); 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. Aviation. This does not apply if a person is a fare paying passenger or a scheduled charter flight operated by a scheduled airline.

5. Expense incurred as a result of an injury or sickness due to working for wage or profit or for which benefits are provided 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 (a) improve the function of a part of the body that is not a tooth or structure that supports the teeth and (b) is malformed as a result of a severe birth defect, including harelip, webbed fingers or toes; or (c) as direct result of disease or surgery performed to treat a disease or injury. This exclusion does not apply to reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection, or other diseases of the involved part and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect. (d) Repair of 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 next calendar year.

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

11. Expense for injuries sustained as the result of a motor vehicle accident to the extent that benefits are provided under any mandatory automobile "no fault" coverage.

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 a treatment, service, or supply which is not medically necessary as determined by Aetna for the diagnosis care or treatment of the sickness or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending physician or dentist. In order for a treatment, service, or supply to be considered medically necessary, the service or supply must: (a) be care or treatment which is likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the sickness or injury involved and the person's overall health condition; (b) be a diagnostic procedure which is indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the sickness or injury involved and the person's overall health condition; and (c) as to diagnosis, care, and treatment, be no more costly (taking into account all health expenses incurred in connection with the treatment, service, or supply) than any alternative service or supply to meet the above tests. In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration: (a) information relating to the affected person's health status; (b) reports in peer reviewed medical literature; (c) reports and guidelines published by nationally recognized health care organizations that include supporting scientific data; (d) generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment; (e) the opinion of health professionals in the generally recognized health specialty involved; and (f) any other relevant information brought to Aetna's attention. In no event will the following services or supplies be considered to be medically necessary: (a) those that do not require the technical skills of a medical, a mental health, or a dental professional; or (b) those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, or any persons who is part of his or her family, any healthcare provider, or healthcare facility; or (c) those furnished solely because the person is an inpatient on any day on which the person's sickness or injury could safely and adequately be diagnosed or treated while not confined; or (d) those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

17. Expense incurred for injury resulting from the play or practice of collegiate or intercollegiate sports, including collegiate or intercollegiate club sports and intramurals.

18. Expense incurred by a covered person for services performed within the covered person's home country (other than the United States, Canada, or Mexico) if the covered person's home country has a socialized medicine program.

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

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

21. Expenses incurred for or in connection with procedures, services, or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational (a) if there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or (b) if required by the FDA, approval has not been granted for marketing; or (c) a recognized national medical or dental society or regulatory agency has determined in writing that it is experimental, investigational, or for research purposes; or (d) the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment, states that it is experimental, investigational, or for research purposes. However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease if Aetna determines that: (a) The disease can be expected to cause death within one year in the absence of effective treatment; and (b) The care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination, Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved. Also, this exclusion will not apply with respect to drugs that: (a) Have been granted treatment investigational new drug (IND), or Group treatment IND status; or (b) Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or (c) Are recognized for treatment of the specific type of cancer for

which the drug has been prescribed in one of the following reference compendia: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, The United States Pharmacopeia Drug Information; or (d) Recommended by review article or editorial comment in a major peer reviewed professional journal; or (e) If Aetna determines that available; scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

22. Expense incurred for acupuncture unless services are rendered for anesthetic purposes.

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

24. Expense for: (a) care of flat feet; (b) supportive devices for the foot; (c) care of corns; bunions; or calluses; (d) care of toenails; and (e) care of fallen arches; weak feet; or chronic foot strain; except that (c) and (d) are not excluded when medically necessary because the covered person is diabetic or suffers from circulatory problems.

25. Expense for injuries sustained as the result of a motor vehicle accident to the extent that benefits are payable under other valid and collectible insurance whether or not claim is made for such benefits. The Policy will only pay for those losses which are not payable under the automobile medical payment insurance Policy.

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

27. 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.

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

29. 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.

30. Expense for incidental surgeries and standby charges of a physician.

31. Expense incurred as a result of dental treatment, including extraction of wisdom teeth, except for treatment resulting from injury to sound natural teeth as provided elsewhere in this Policy.

32. Expense for contraceptive methods, devices, or aids and charges for services and supplies for or related to gamete intrafallopian transfer, artificial insemination, in-vitro fertilization (except as required by the state law) or embryo transfer procedures, elective sterilization or its reversal, or elective abortion unless specifically provided for in this Policy.

33. Expenses incurred for massage therapy.

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

35. 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.

36. 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.

37. Expenses for treatment of injury or sickness to the extent payment is made as a judgment or settlement by any person deemed responsible for the injury or sickness (or their Insurers).

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.

Adverse Benefit Determination
A denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a service, supply or benefit because it is determined to be experimental or investigational or not medically necessary or appropriate. Such **adverse benefit determination** may be based on:

- Your eligibility for coverage;
- Plan limitations or exclusions;
- The results of any Utilization Review activities (determination as to whether or not an admission, extension of stay, or other health care service or supply is **medically necessary**, based on the information provided).

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

Ambulatory Surgical Center
A freestanding ambulatory surgical facility that:

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

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

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

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 Dependent
- A **covered student's dependent** who is insured under this Plan.

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

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

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

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

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

The term "child" includes a **covered student's** step-child, adopted child whose coverage is effective upon the earlier of the date of placement for the purpose of adoption, or the date of the entry of an order granting the adoptive parent custody of the child for purposes of adoption. The term **dependent** does not include a person who is: (a) an eligible student, or (b) a member of the armed forces.

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

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

Diabetic Self-Management Education
Training designed to instruct a person in the self-management of diabetes. It may include training in self-care or diet. If a physician, nurse practitioner or clinical nurse specialist diagnoses diabetes, or diagnoses a significant change in the person's diabetic symptoms, or condition that requires a change in the person's self-management of the disease or determines that a person who is a diabetic needs re-education, or refresher education, this diabetic self-management education may be provided by the **physician** or other licensed health care provider legally qualified by the State of New York to provide diabetic management education, or their staff, as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon the referral of a physician, or other licensed health care provider legally qualified by the State of New York to provide diabetic management education. When diabetic self-management education is provided by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon referral by a physician, such education may be provided in a group setting. When medically necessary, diabetic self-management education shall also include home visits.

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

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

- tubal ligation,
- vasectomy,
- breast reduction,
- sexual reassignment surgery,
- submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis,
- treatment for weight reduction,
- learning disabilities,
- temporomandibular joint dysfunction (TMJ),
- immunization,
- treatment of infertility, and
- routine physical examinations

Emergency Admission
One where the **physician** admits the person to the **Hospital** or **residential treatment facility** right after the sudden and at that time, unexpected onset of a change in a person's medical or behavioral condition which:

- requires confinement right away as a full-time inpatient, and
- manifests itself by symptoms of sufficient severity, including severe pain, that if immediate medical attention was not given could, as determined by a prudent lay person possessing an average knowledge of medicine and health, reasonably be expected to result in:
  1) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy,
  2) serious impairment to such person's bodily functions,
  3) serious dysfunction of any bodily organ or part of such person, or
  4) serious disfigurement of such person.

Emergency Medical Condition
A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

1) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy,
2) serious impairment to such person's bodily functions,
3) serious dysfunction of any bodily organ or part of such person, or
4) serious disfigurement of such person.

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.

Grievance
A request for review of a determination, other than a determination meeting the definition of **adverse benefit determination**.

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 a R.N., L.P.N., or L.V.N., primarily aid the **Covered Person** in performing the normal activities of daily living while recovering from an **injury** or **sickness**, and are described under the written **Home Health Care Plan**.

Home Health Care
Health services and supplies provided to a **Covered Person** on a part-time, intermittent, visiting basis. Such services and supplies must be provided in such person's place of residence, while the person is confined as a result of **injury** or **sickness**. Also, a **physician** must certify that the use of such services and supplies is to treat a condition as an alternative to confinement in a **hospital** or **skilled facility** and the services must be furnished by, or under arrangements made by, a licensed home health agency.

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 follow within 7 days of discharge and be for the same or related cause(s) as a period of Hospital or skilled nursing confinement. The **physician** must examine the **Covered Person** at least once a month, and the **physician** must renew the written plan every 60 days.

Home Health Care Services
- Part-time or intermittent nursing care by: a registered nurse (R. N.), a licensed practical nurse (L.P.N.), or under the supervision on an R.N. if the services of an R. N. are not available,
- Part time or intermittent home health aide services, that consist primarily of care of a medical or therapeutic nature by other than an R.N.,
- Physical, occupational. speech therapy, or respiratory therapy,
- Medical supplies, drugs and medicines, and laboratory services. However, these items are covered only to the extent they would be covered if the patient was confined to a Hospital,
- Medical social services by licensed or trained social workers,
- Nutritional counseling.

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

Hospital
A facility which meets all of these tests:
- It provides in-patient services for the care 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 documented inpatient stay in a **Hospital** as a resident bed patient.

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**.

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. A service or supply will not be considered as **medically necessary** if:
- It is provided only as a convenience to the **Covered Person** or provider, or
- it is not the appropriate treatment for the **Covered Person**'s diagnosis or symptoms, or
- it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment.

The fact that any particular **physician** may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply medically necessary.

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

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

Non-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.

Partial Hospitalization
Continuous treatment consisting of not less than four hours and not more than twelve hours in any 24 hour period under a program based in a **hospital**.

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

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

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

Preferred Care
Care provided by a
- A **Covered Person's** primary care physician, or a preferred care provider of the primary care **physician**, or
- A health care provider that is not a Preferred Care Provider for an emergency medical condition when travel to a Preferred Care Provider, is not feasible, or
- A Non-Preferred Urgent Care Provider when travel to a Preferred Urgent Care Provider for treatment is not feasible, and if authorized by Aetna.

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

Preferred Pharmacy
A **pharmacy**, including a **mail order pharmacy**, which is party to a contract with Aetna to dispense drugs to persons covered under this Plan, but only:
- While the contract remains in effect, and
- While such a ph**armacy** 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 Medical Condition,** of a person's Primary Care Physician, or
  - A **dentist** who is a **Non-Preferred Care Provider,** but only one who is not of a type that falls into one or more of the categories of providers listed in the **directory** of **Preferred Care Providers**.

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

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

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

Primary Care Physician
This is the **Preferred Care Provider** who is:
- Selected by a person from the list of **Primary Care Physicians** in the directory,
- Responsible for the person's on-going health care, and
- Shown on Aetna's records as the person's **Primary Care Physician.**
-

For purposes of this definition, a **Primary Care Physician** also includes the **School Health Services**.

Rare Disease
A life threatening or disabling condition or disease that: (1)(a) is currently or has been subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network; or (b) affects fewer than 200,000 United States residents per year; and (2) for which there does not exist a standard health service or procedure covered by the plan that is more clinically beneficial than the requested health service or treatment.

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 room and board and other necessary services and supplies. They must be regularly made at a daily or weekly rate.

School Health Services
Any organization, facility, or clinic operated, maintained, or supported by the school or other entity under contract to the school which provides health care services to enrolled students and their **dependents**.

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

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

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

Skilled Nursing Facility
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 R.N.s,
- A capacity of six or more beds,
- 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.

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

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

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

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

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

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

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

Urgent Care Provider
This is:

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

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

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

PRESCRIPTION DRUG CLAIM PROCEDURE

To be reimbursed for your prescription, submit a completed Aetna Prescription Drug claim form. To obtain a claim form visit University Health Plans at **www.universityhealthplans.com** or Aetna Student Health at **www.aetnastudenthealth.com.** You will be reimbursed for covered medications directly by Aetna.

When submitting a claim, please include all Prescription receipts, indicate that you attend RIT and include your name, address and identification number.

CLAIM PROCEDURE

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

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

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

1. Bills must be submitted within 120 days from the date of treatment.
2. Payment for **Covered Medical Expenses** will be made directly to the **Hospital** or **physician** concerned, unless bill receipts and proof of payment are submitted.
3. If itemized medical bills are available at the time the claim form is submitted, attach them to the claim form. Subsequent medical bills should be mailed promptly to the above address.
4. You will receive an "Explanation of Benefits" when your claims are processed. The Explanation of Benefits will explain how your claim was processed, according to the benefits of your Student Accident and Sickness Insurance Plan.

HOW TO APPEAL A CLAIM
In the event a **Covered Person** disagrees with how a claim was processed, he/she may request a review of the decision. The **Covered Person**'s request must include why he/she disagrees with the way the claim was processed. The request must also include any additional information that supports the claim (e.g., medical records, **Physician's** office notes, operative reports, **Physician's** letter of medical necessity, etc.). Please submit all requests to:

Aetna Student Health
P.O. Box 14464
Lexington, KY 40512

Or call in the appeal to Customer Service using the toll-free telephone number shown on the member ID card.

INTERNAL APPEALS PROCEDURE
Aetna has established a procedure for resolving appeals by **Covered Persons**. If the **Covered Person** has an appeal, please follow this procedure:
•An Appeal is defined as an oral or written request to Aetna to reconsider an **adverse benefit determination**.

First Level Appeals Procedure
- An Appeal must be submitted to Aetna within 180 days of the date Aetna provides notice of denial. The Aetna address is on the **Covered Person's** ID card. The Appeal may be submitted by the **Covered Person,** or by a representative, designated by the **Covered Person**.
- The **Covered Person** may submit an oral grievance in connection with:
- A denial of, or failure to pay for, a referral, or
- A determination as to whether a benefit is covered under this Plan, by calling Member Services. Aetna's Member Services telephone number is on the **Covered Person's** ID card. If the **Covered Person** is required to leave a recorded message, the **Covered Person's** message will be acknowledged within one business day after the call was recorded.
- An acknowledgment letter will be sent to the **Covered Person** within 1 day of Aetna's receipt of an oral Appeal, and 5 days of Aetna's receipt of a written Appeal. This letter may request additional information. If so, the additional information must be submitted to Aetna within 15 days of the date of the letter.
- The **Covered Person** will be sent a response within 30 days of Aetna's receipt of the Appeal. The response will be based on the information provided with, or subsequent to, the Appeal.

- If the Appeal concerns an eligibility issue, and if additional information is not submitted to Aetna after receipt of Aetna's response, the decision is considered Aetna's final response, 45 days after receipt of the Appeal. For all other Appeals, if additional information is to be submitted to Aetna after receipt of Aetna's response, it must be submitted within 15 days of the date of Aetna's response letter.
- Aetna's response will be sent within 30 days from the date of Aetna's first response letter.

In any urgent or emergency situation, the Expedited Appeal procedure may be initiated by a telephone call to Member Services. Aetna's Member Services telephone number is on the **Covered Person's** ID card. A verbal response to the Appeal will be given to the **Covered Person** and **Covered Person's** provider within 2 days, provided that all necessary information is available. Written notice of the decision will be sent within 2 business days of Aetna's verbal response.

Second Level Appeals Procedure
If the **Covered Person** is dissatisfied with Aetna's grievance determination, the **Covered Person,** or a representative designated by the **Covered Person,** may submit a written appeal within 60 business days after receipt of such determination.
- An acknowledgement letter will be sent to the **Covered Person** within 15 days of Aetna's receipt of the written appeal. This letter may request additional information. If so, the additional information must be submitted to Aetna within 15 days of the date of the letter.
- Aetna's final response for an urgent or emergency situation will be sent within 2 business days. For all other situations, a response will be sent within 30 business days from the date of Aetna's receipt of all necessary information.

If additional time is needed to resolve an Appeal, except in an urgent or emergency situation, Aetna will provide a written notification, indicating that additional time is needed, explaining why such time is needed, and setting a new date for a response. The additional time will not be extended beyond another 30 days.

The **Covered Person** must exhaust the Internal Appeals Procedure before requesting an External Appeal. However, the **Covered Person** is not required to exhaust the Internal Appeals Procedure prior to requesting an External Appeal, if the **Covered Person** and Aetna have agreed that the matter may proceed directly to an External Appeal. Aetna will keep the records of the **Covered Persons** complaint for 7 years.

EXTERNAL REVIEW PROCESS

EXTERNAL APPEAL
RIGHT TO AN EXTERNAL APPEAL
Under certain circumstances, the **Covered Person** has a right to an external appeal of a denial of coverage. Specifically, if Aetna has denied coverage on the basis that the service is not necessary, or is an experimental or investigational treatment, the **Covered Person** may appeal that decision to an External Appeal Agent, an in**dependent** entity certified by the State, to conduct such appeals.

RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS NOT NECESSARY
If Aetna has denied coverage on the basis that the service is not necessary, the **Covered Person** may appeal to an External Appeal Agent, if the **Covered Person** satisfies the following criteria listed below:
- The service, procedure, or treatment, must otherwise be a **Covered Medical Expense** under this Plan, and
- The **Covered Person** must have received a final adverse determination through the first level of Aetna's internal review process, and Aetna must have upheld the denial, or the **Covered Person** and Aetna must agree in writing, to waive any internal appeal.

RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS EXPERIMENTAL OR INVESTIGATIONAL
If the **Covered Person** has been denied coverage on the basis that the service is an experimental or investigational treatment, the **Covered Person** must satisfy the following criteria:

- The service must otherwise be a **Covered Medical Expense** under this Plan, and
- The **Covered Person** must have received a final adverse determination through the first level of Aetna's internal appeal process, and Aetna must have upheld the denial, or the **Covered Person** and Aetna must agree in writing to waive any internal appeal.

In addition, the **Covered Person's** attending **physician** must certify that the **Covered Person** has a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one which, according to the current diagnosis of the attending **physician**, has a high probability of death. A "disabling condition or disease" is any medically determinable physical or medical impairment that can be expected to result in death, or that has lasted, or can be expected to last, for a continuous period of not less than 12 months, which renders the **Covered Person** unable to engage in any substantial gainful activities. In the case of a **dependent** child under the age of 18, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

The **covered person's** attending physician must also certify that the life-threatening or disabling condition or disease is one for which standard health services are ineffective, or medically inappropriate, or one for which there does not exist a more beneficial standard service or procedure covered under This Plan, or one for which there exists a clinical trial (as defined by law) or **rare disease**. In the case of a **rare disease**, the attending **physician** may not be the treating **physician**.

In addition, the **Covered Person's** attending **physician** must have recommended at least one of the following:

- A service, procedure or treatment that 2 documents from available medical and scientific evidence indicate is likely to be more beneficial to the **covered person** than any standard Covered Medical Expense (only certain documents will be considered in support of this recommendation – the **covered person's** attending physician should contact the State in order to obtain current information as to what documents will be considered acceptable) or in the case of a **rare disease**, based on the **physician's** certification and such other evidence as you, your designee of the attending **physician** may present; or
- A clinical trial for which the **Covered Person** is eligible (only certain clinical trials can be considered).

For the purposes of this section, the **covered person's** attending **physician** must be a licensed, board certified, or board eligible **physician**, qualified to practice in the area appropriate to treat the **covered person's** life-threatening or disabling condition or disease. In the case of a **rare disease**, the attending **physician** may not be the treating **physician**.

THE EXTERNAL APPEAL PROCESS
If, through the Aetna's internal appeal process, the **Covered Person** has received a final adverse determination upholding a denial of coverage on the basis that the service is not necessary, or is an experimental or investigational treatment, the **Covered Person** has 45 days from receipt of such notice to file a written request for an external appeal. If the **Covered Person** and Aetna have agreed to waive any internal appeal, the **Covered Person** has 45 days from the receipt of such waiver to file a written request for an external appeal. Aetna will provide an external appeal application with the final adverse determination issued through the Aetna's internal appeal process or its written waiver of an internal appeal.

The **Covered Person** may also request an external appeal application from the New York State Department of Insurance at **(800) 400-8882**. The completed application must be submitted to the New York State Department of Insurance at the address listed in the application. If the **Covered Person** satisfies the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

The **Covered Person** will have the opportunity to submit additional documentation with the request. If the External Appeal Agent determines that the information the **Covered Person** submit represents a material change from the information on which Aetna based its denial, the External Appeal Agent will share this information with Aetna in order for it to exercise its right to reconsider its decision. If Aetna chooses to exercise this right, Aetna will have 3 business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), Aetna does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of the completed application. The External Appeal Agent may request additional information from the **Covered Person**, the **Covered Person's physician** or Aetna. If the External Appeal Agent requests additional information, it will have 5 additional business days to make its decision. The External Appeal Agent must notify the **Covered Person** in writing of its decision within 2 business days.

If the **Covered Person's** attending **physician** certifies that a delay in providing the service that has been denied poses an imminent or serious threat to the **Covered Person's** health, the **Covered Person** may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 3 days of receipt of the completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify the **Covered Person** and Aetna by telephone or facsimile of that decision. The External Appeal Agent must also notify the **Covered Person** in writing of its decision.

If the External Appeal Agent overturns Aetna's decision that a service is not necessary, or approves coverage of an experimental or investigational treatment, Aetna will provide coverage subject to the other terms and conditions of this Plan. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, Aetna will only cover the costs of services required to provide treatment to the **Covered Person** according to the design of the trial. Aetna shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this Plan for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both the **Covered Person** and Aetna. The External Appeal Agent's decision is admissible in any court proceeding.

RESPONSIBILITIES

It is the **Covered Person's** responsibility to initiate the external appeals process. The **Covered Person** may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. If the requested service has already been provided to the **Covered Person**, the **Covered Person's** attending **physician** may file an expedited appeal application on the **Covered Person's** behalf, but only if the **Covered Person** has consented to this in writing.

Under New York State law, the **Covered Person's** completed request for appeal must be filed within 45 days of either the date upon which the **Covered Person** receives written notification from Aetna that it has upheld a denial of coverage, or the date upon which the **Covered Person** receives a written waiver of any internal appeal. Aetna has no authority to grant an extension of this deadline.

COVERED SERVICES AND EXCLUSIONS

In general, this Plan does not cover experimental or investigational treatments. However, this Plan shall cover an experimental or investigational treatment approved by an External Appeal Agent in accordance with this section. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, Aetna will only cover the costs of services required to provide treatment to the **Covered Person,** according to the design of the trial. Aetna shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this Plan for non-experimental or non-investigational treatments provided in such clinical trial.

WORLDWIDE TRAVEL ASSISTANCE SERVICES

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

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

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

- Unlimited Emergency Medical Evacuation
- Unlimited Medically Supervised Repatriation
- Unlimited Return of Deceased Remains
- Unlimited Family Reunion
- $2,500 Return of Traveling Companion
- $2,500 Bereavement Reunion - in the event of a Covered Person's death, On Call will fly a family member to identify the remains and accompany the remains back to the deceased's home country
- $2,500 Emergency Return Home in the event of death or life-threatening illness of a parent, sibling or spouse

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

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

- 24/7 Emergency Travel Arrangements
- Translation Assistance
- Emergency Travel Funds Assistance
- Lost Luggage and Travel Documents Assistance
- Assistance with Replacement of Credit Card/Travelers Checks
- Medical/Dental/Pharmacy Referral Service
- Hospital Deposit Arrangements
- Dispatch of **Physician**
- Emergency Medical Record Assistance
- Legal Consultation and Referral
- Bail Bonds Assistance

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

The information contained above is a just summary of the ADD, MER, WETA, and NDPE benefits and services available through On Call. For a copy of the plan documents applicable to the ADD, MER, WETA and NDPE coverage, including a full description of coverage, exclusions and limitations, please contact Aetna Student Health at www.aetnastudenthealth.com or (800) 466-3185.

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

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

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

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

AETNA'S NAVIGATOR

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 and your dependents. To obtain a copy of our Notice of Privacy Practices describing in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Customer Services number on your ID card or visit **www.aetnastudenthealth.com**.

Administered by:
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El Paso, TX 79998
www.aetnastudenthealth.com

Underwritten by:
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(860) 273-0123

Policy No. 812809

The Rochester Institute of Technology Student Accident and Sickness Plan 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.