

2009 – 2010

**Student Health Insurance
Plan Brochure**



Aetna Student Health

Underwritten by:
Aetna Life Insurance Company (ALIC)

Policy No. 697418

YOUR AETNA STUDENT HEALTH INSURANCE

It is your responsibility to familiarize yourself with this Student Health Insurance Plan. Limitations and exclusions must be applied to the coverage as a means of cost containment. The best way to make this coverage work for you is to be informed and proactive. Check the covered benefits before your procedure whenever possible. Know the specifics and communicate with your provider.

This Plan is a three-tiered Preferred Provider Network:

- **Preferred Provider (in-area):** *UK Hospital and UK College of Medicine Physicians (Kentucky Clinic) are the first tier of Preferred Providers.* With both inpatient and outpatient services at UK Hospital and UK Clinic, the deductible is waived and there is 100% coverage of the Negotiated Charge for covered services to the benefit maximum. This tier offers the lowest out-of-pocket costs available.
- **Preferred Provider (out-of-area):** *The second tier of coverage is with the Aetna Preferred Provider Network.* This tier will extend Preferred Provider Negotiated Rates for covered services when it is necessary for you to seek care away from UK. Visit www.aetnastudenthealth.com for the DocFind[®] feature to locate doctors in the Aetna Preferred Provider Network.
- **Non-Preferred Provider:** *The third tier of coverage refers to services and Physicians outside of both the UK and Aetna Preferred Provider Networks.* If you seek care at Non-Preferred Providers, you could experience significantly higher out-of-pocket costs.

UTILIZE UNIVERSITY HEALTH SERVICE.

University Health Service (UHS) is a large outpatient clinic available to all UK students for their healthcare needs including primary care, gynecology, behavioral health, nutrition counseling, and health education. Utilizing UHS is an excellent way to receive fast, efficient and high quality clinical care. During the fall and spring semesters, all full-time University of Kentucky students pay for access to the Health Service through their tuition and mandatory fees. In the summer or for part-time students, the Health Service may be accessed by voluntarily paying a health fee or by being seen on a fee-for-service basis. Claims for charges incurred at UHS for covered benefits will be filed with **Aetna Student Health** by the Health Service. For complete information regarding University Health Service, visit www.ukhealthcare.uky.edu/uhs/. Bluegrass Community and Technical College (BCTC) students may receive services through UHS. For BCTC eligibility information or specific instructions about how to pay the health fee, visit www.uky.edu/UK-eStore.

All visits are by appointment. For an appointment call **(859) 323-APPT (2778)**.

UNIVERSITY HEALTH SERVICE CLINIC HOURS:

Fall and Spring, while school is in session, Monday – Friday, 8:00 a.m. – 6:00 p.m.
For follow-ups and urgent care, Saturday, 9:00 a.m. – 11:00 a.m.

IMPORTANT NOTE

The University of Kentucky Student Health Insurance Plan has been developed especially for University of Kentucky and the Bluegrass Community and Technical College (BCTC) students. The Plan provides coverage for Accidents and Sicknesses that occur on and off campus and includes special cost-saving features to keep the coverage as affordable as possible. University of Kentucky is pleased to offer the Plan through Aetna Student Health as described in this Brochure. 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 University of Kentucky. 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 obtained by contacting Aetna Student Health at (888) 834-4690 or viewed at the University Health Service during business hours.

WHERE TO FIND HELP

In case of an emergency, call **911** or your local emergency hotline, or go directly to an emergency care facility. For non-emergency situations please visit or call University Health Services at **(859) 323-2778**.

Online at www.aetnastudenthealth.com and by phone toll free at (888) 834-4690:

For questions about:

- Insurance Benefits
- Enrollment
- Waiver Process
- Claims Processing
- Pre-Certification Requirements
- Provider Listings
- ID Cards

A complete list of providers can be obtained using Aetna's **DocFind**[®] Service at either: www.aetna.com/docfind/custom/studenthealth/index.html or www.aetnastudenthealth.com.

Please Note: 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.

University of Kentucky Insurance Coordinators - studentinsurance@email.uky.edu
Undergraduate students - www.ukhealthcare.uky.edu/uhs/, (859) 218-3208
Graduate students - www.gradschool.uky.edu, (859) 257-6608

Aetna Pharmacy Management (APM): (800) 238-6279 (Available 24 hours)

For questions about:

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

Worldwide Emergency Travel Assistance Services:

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

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

For questions about:

- On Call International 24/7 Emergency Travel Assistance Services

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

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PREMIUM RATES

| | Annual 8/25/09- 8/26/10 | 1 st Period 8/26/09- 10/28/09 | 2 nd Period 10/29/09- 12/31/09 | 3 rd Period 1/1/10- 3/25/10 | 4 th Period 3/26/10- 6/10/10 | 5 th Period 6/11/10- 8/25/10 |
|-----------------|-------------------------------|--|---|--|---|---|
| Student | \$1,064 | \$187 | \$187 | \$248 | \$221 | \$221 |
| Spouse | \$2,868 | \$503 | \$503 | \$668 | \$597 | \$597 |
| Child | \$2,264 | \$432 | \$432 | \$574 | \$513 | \$513 |
| All Children | \$4,258 | \$746 | \$746 | \$992 | \$887 | \$887 |

DEDUCTIBLES

The following deductibles are applied before **Covered Medical Expenses** are payable:
\$200 per Covered Person per Policy Year.

UNIVERSITY OF KENTUCKY STUDENT HEALTH INSURANCE PLAN

This is a brief description of the Accident and Sickness Medical Expense benefits available for University of Kentucky 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 obtained by calling Aetna Student Health at **(888) 834-4690** or viewed at the University Health Services during business hours.

STUDENT COVERAGE

ELIGIBILITY

Funded Graduate Students of the University of Kentucky

Funded Graduate students are automatically enrolled in the Student Health Insurance Plan by the Graduate School Funding Office. Funded graduate students are eligible to have the insurance premium paid by the University. No action is needed on your part to sign up for the insurance. The enrollment process is designed to be completely hassle-free. There is no paperwork or enrollment form for you to complete. You will be automatically enrolled in the Plan.

“Funded Graduate Student” means you are enrolled, degree-seeking, and are receiving support from the University in the form of a full-time assistantship (TA, RA, GA), qualifying fellowship, or a combination of these positions. Full-time standing is typically defined as an assignment of 20 hours per week or a fellowship stipend of **\$9,000** or more.

Eligibility is determined by the Graduate School each semester. The insurance coverage period is **August 26, 2009** to **December 31, 2009** for Fall and **January 1, 2010** to **August 25, 2010** for Spring/Summer. Changes with your assignment, fellowship, or status may affect your eligibility.

See www.gradschool.uky.edu for additional information about eligibility, the declination form for domestic students, dependent enrollment details, and a list of frequently asked questions. If you have specific inquiries, contact the Insurance Coordinator at the Graduate School Funding Office, (859) 257-6608 or grad.fundedhealth@uky.edu.

International Students and Scholars

All International students are required by the University to have health insurance which meets the University of Kentucky minimum criteria. If you are on an F-1, J-1 or J-2 Visa, you are automatically enrolled in the Student Health Insurance Plan when you register for classes. The charge for insurance is applied directly to your student bill.

The insurance coverage period is **August 26, 2009 to December 31, 2009** for Fall and **January 1, 2010 to August 25, 2010** for Spring/Summer.

In the event you are covered by an existing health insurance policy, you may be eligible to decline this Plan. See Page 7 for Waiver Process/Procedure.

The following International groups are eligible to enroll online in the Student Health Insurance Plan on a voluntary basis:

- English as a Second Language (ESL) students.
- Dependent coverage available for enrolled students/scholars.

If you have any questions, please call (859) 257-6608.

Undergraduate and Non-Funded Graduate Students

The Plan may be purchased on a voluntary basis for all eligible University of Kentucky and BCTC undergraduate and University of Kentucky graduate students. **Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased.**

Eligibility requirements:

- Undergraduate students enrolled in six credit hours or more.
- Graduate students enrolled at the University of Kentucky.
- Dependent coverage available for Dependents of insured students.

If you have any questions, please call (859) 218-3208.

Home study, correspondence, Internet classes, and television (TV) courses, do not fulfill the eligibility requirement that the student actively attend classes. If it is discovered that this eligibility requirement has not been met, our only obligation is to refund premium, less any claims paid.

ENROLLMENT

1. Visit www.aetnastudenthealth.com.
2. Search for your school.
3. Click on "Plans and Products..." and then "Enroll".
4. Follow directions to enroll yourself and/or any dependents.
5. Save confirmation e-mail sent within minutes of enrollment completion.

Note: Eligibility as defined by the Brochure and Master Policy is subject to verification through the University.

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

WAIVER PROCESS/PROCEDURE

International Students:

All International students are required by the University to have health insurance which meets the University of Kentucky minimum criteria. If you are on an F-1, J-1 or J-2 Visa, you are automatically enrolled in the Student Health Insurance Plan when you register for classes.

In the event you are covered by an existing health insurance policy, you may be eligible to decline this Plan. In order to decline the insurance your coverage must meet or exceed the following standards:

- Deductible may not exceed \$500.
- \$200,000 maximum per Accident or Sickness.
- \$10,000 benefit for medical evacuation.
- \$10,000 benefit for repatriation.
- 80% of medical expenses must be paid by the insurance company.
- Cover expenses related to pregnancy.
- Have a phone number contact within the United States.

Waiver Deadline Dates for International Students:

Fall – September 22, 2009

Spring – January 22, 2010

1. Visit www.aetnastudenthealth.com.
2. Search for your school.
3. Click on “Plans and Products...”and then “International Students”.
4. Follow directions to waive.
5. Save confirmation e-mail sent within minutes of waiver completion.

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

REFUND POLICY

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

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

DEPENDENT COVERAGE

ELIGIBILITY

Covered students may also enroll their lawful spouse, and unmarried dependent children under age 19, who reside with and are fully supported by the covered student. Dependent eligibility expires concurrently with that of the insured student.

ENROLLMENT

To enroll the dependent(s) of a covered student, please complete the online enrollment as explained above.

NEWBORN INFANT AND ADOPTED CHILD COVERAGE

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

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

For the appropriate pro-rated premium, and application process for newborn infant and adopted child enrollment, or for general questions and/or information on dependent enrollment, please contact Aetna Student Health customer service at **(888) 834-4690**.

Please Note: Previously Covered Persons must re-enroll for dependent coverage by the appropriate published deadline depending on term/period chosen, in order to avoid a break in coverage for conditions which existed in prior Policy Years. Once a break in continuous coverage occurs, a condition existing during such a break which is a pre-existing condition will not be payable. See Continuously Insured Section of this Brochure.

CONTINUOUSLY INSURED

Persons who have remained continuously insured under this Policy or other prior health insurance policies including international policies or national health care, for at least nine consecutive months will be covered for any pre-existing condition, which manifests itself while continuously insured, except for expenses payable under prior policies in the absence of this Policy. Previously Covered Persons must re-enroll for coverage, including dependent coverage, by **the appropriate published deadline depending on term/period chosen** in order to avoid a break in coverage for conditions which existed in prior Policy Years. Once a break in continuous coverage occurs, the pre-existing conditions limitation will apply (see page 9-10). The pre-existing condition exclusionary period will be reduced by the total number of months that the insured provides documentation of continuous coverage under a prior health insurance policy.

PREFERRED PROVIDER NETWORK

Aetna has arranged for you to access a Preferred Provider Network in your local campus community. Providers, acute care facilities, and mental health networks are also available nationally if you require treatment or hospitalization outside the immediate area of the University of Kentucky campus.

Your first stop should be the University of Kentucky Hospital, University of Kentucky College of Medicine Physicians (Kentucky Clinic), or University Health Service, referred to as Preferred Providers* (in-area), for the highest level of out-of-pocket savings available. To maximize your savings and reduce your out-of-pocket expenses, this Plan includes two tiers of Preferred Providers.

When it is necessary to seek care away from UK, you can select and visit a member of the Aetna Network, labeled as Preferred Providers* (out-of-area). Members of this second tier will offer sizable discounts on their services. You can obtain information regarding Preferred Providers (out-of-area) through the Internet by accessing Aetna's DocFind® at www.aetnastudenthealth.com or you may also contact Aetna Student Health at **(888) 834-4690**.

It is to your advantage to utilize a Preferred Provider because significant savings can be achieved from the substantially lower rates these providers have agreed to accept as payment for their services. Non-Preferred Care is subject to the Reasonable Charge allowance maximums. Any charges in excess of the Reasonable Charge allowance are not covered under the Plan.

**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 REQUIREMENTS

Pre-certification simply means calling Aetna Student Health prior to treatment to obtain approval for a medical procedure or service. Pre-certification may be done by you, your doctor, a hospital administrator, or one of your relatives. All requests for certification must be obtained by contacting Aetna Student Health at **(888) 834-4690** (attention Managed Care Department).

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

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

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

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

Pre-Certification of Non-Emergency Inpatient Admissions, Partial Hospitalization, Identified Outpatient Services and Home Health Services:

The patient, Physician or hospital must telephone at least **three 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 business day** following Inpatient (or partial hospitalization) admission.

PRE-EXISTING CONDITIONS/ CONTINUOUSLY INSURED PROVISIONS

PRE-EXISTING CONDITION

A pre-existing condition is an injury or disease that was present before your first day of coverage under a group health insurance plan. If you received treatment or services for that injury or disease or you took prescription drugs or medicines for that injury or disease during the **twelve months** prior to your first day of coverage, that injury or disease will be considered a pre-existing condition.

Domestic violence is not considered a pre-existing condition. Genetic information may not be used as a pre-existing condition in the absence of a diagnosis.

If, during the twelve months prior to the Covered Person's effective date of insurance, services are rendered or supplies are received in connection with a pregnancy or a pregnancy is confirmed, the pregnancy is a pre-existing condition whether or not the pregnancy commenced during that twelve month period.

LIMITATION

Expenses incurred by a Covered Person as a result of a pre-existing condition will not be considered **Covered Medical Expense** until (a) no charges are incurred or treatment rendered for the condition for a period of six months while covered under this Policy, or (b) the Covered Person has been covered under this Policy for nine consecutive months, whichever happens first.

CONTINUOUSLY INSURED

You have been continuously insured if you (i) had “creditable health insurance coverage” (such as COBRA, HMO, another group or individual policy, Medicare or Medicaid) prior to enrolling in this Plan, **and** (ii) the creditable coverage ended within **60 days** of the date you enrolled under this Plan. If both of these tests are met, then the pre-existing limitation period under this Plan will be reduced and possibly eliminated altogether by the number of days of your prior creditable coverage. You will be asked to provide evidence of your prior creditable coverage.

Once a break of more than **60 days** in your continuous coverage occurs, the definition of pre-existing conditions will apply.

DESCRIPTION OF BENEFITS

PLEASE NOTE: THE UNIVERSITY OF KENTUCKY STUDENT HEALTH INSURANCE PLAN MAY NOT COVER ALL OF YOUR HEALTH CARE EXPENSES.

The Plan excludes coverage for certain services and contains limitations on the amounts it will pay. Please read the University of Kentucky Student Health Insurance Plan Brochure carefully before deciding whether this Plan is right for you. While this document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. If you want to look at the full Plan description, which is contained in the Master Policy issued to University of Kentucky you may view it at University Health Service or you may contact Aetna Student Health at (888) 834-4690.

This Plan will never pay more than:

- **\$500,000 Per Accident or Sickness per Policy Year**
- **\$1,000 per Policy Year-Pharmacy Maximum**
- **\$500 per Policy Year- Behavioral Health**
- **\$2,500 per Condition per Policy Year Non Surgical Outpatient Maximum**
- **\$10,000 per Condition Surgical Outpatient Maximum**

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

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

The payment of any copays, deductibles, the balance above the Reasonable Charge or any Coinsurance amount, and any medical expenses not covered are the responsibility of the Covered Person. Once the deductible is satisfied and once the insurance company has paid \$5,000 in claims, benefits will be payable at 100% thereafter up to \$500,000 per Accident or Sickness per Policy Year. Please note that internal benefit maximums apply.

Benefit does not apply to any Hospital Room and Board Expenses or to any Miscellaneous Hospital Expenses, including Physician Hospital Visits. These expenses will remain payable at the coinsurance levels outlined in the Summary of Benefits Chart up to the Plan Maximum.

SUMMARY OF BENEFITS CHART

DEDUCTIBLES

The following deductibles are applied before **Covered Medical Expenses** are payable:
\$200 per Covered Person per Policy Year.

The Plan deductible is waived for care at University Health Service, care received by University of Kentucky College of Medicine Physicians, and for care at University of Kentucky Hospital.

COINSURANCE

Covered Medical Expenses are payable at the coinsurance percentage specified below, after any applicable deductible, up to a maximum benefit of **\$500,000** for any one Accident, or any one Sickness per Policy Year.

This Plan is a three-tiered Preferred Provider Network:

Tier One -- In Area Preferred Care-When services are provided by:

- University Health Service.
- University of Kentucky Hospital.
- University of Kentucky College of Medicine Physicians (Kentucky Clinic).

Tier Two -- Out of Area Preferred Care-When services are provided by:

- Aetna Preferred Provider Network participating providers.

Tier Three -- Non-Preferred Care-When services are provided by:

- Those providers not participating in the Aetna Preferred Provider Network.

All coverage is based on Reasonable Charges unless otherwise specified.

| | University of Kentucky Hospital University of Kentucky College of Medicine Physicians (in-area) | Preferred Care (out-of-area) | Non-Preferred Care |
|---|---|---|---|
| Inpatient Hospitalization Benefits | | | |
| <i>Inpatient Hospitalization Benefits are limited to the Plan Aggregate Maximum of \$500,000 per Accident or Sickness per Policy Year.</i> | | | |
| Pre-Admission Testing Expenses <i>Covered Medical Expenses for Pre-Admission testing charges while an outpatient before scheduled surgery. Please see the Definition of Pre-Admission Testing on page 48 for more detailed information on this benefit.</i> | 100% of the Negotiated Charge. | 80% up to \$5,000, then 100% thereafter of the Negotiated Charge. | 80% up to \$5,000, then 100% thereafter of the Reasonable Charge. |

| | | | |
|---|--|---|---|
| Hospital Room and Board Expenses | 100% of the Negotiated Charge for an overnight stay. | 80% of the Negotiated Charge for an overnight stay. | 80% of the Reasonable Charge for a semi-private room rate for an overnight stay. |
| Intensive Care Unit Room and Board Expenses | 100% of the Negotiated Charge for an overnight stay. | 80% of the Negotiated Charge for an overnight stay. | 80% of the Reasonable Charge for the Intensive Care Room Rate for an overnight stay. |
| Miscellaneous Hospital Expenses <i>Covered Medical Expenses include, but are not limited to: laboratory tests, X-rays, surgical dressings, anesthesia, therapy (including chemotherapy), supplies and equipment use, and medicines (excluding take home drugs) and use of operating room.</i> | 100% of the Negotiated Charge. | 80% of the Negotiated Charge. | 80% of the Reasonable Charge. |
| Well Newborn Nursery Room and Board Expenses <i>Covered Medical Expenses include routine nursery care provided immediately after birth while hospital confined.</i> | 100% of the Negotiated Charge and limited to four days. | 80% of the Negotiated Charge and limited to four days. | 80% of the Reasonable Charge and limited to four days. |
| Well Newborn Nursery Care (Physician) Expenses <i>Covered Medical Expenses include 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 one visit per day.</i> | 100% of the Negotiated Charge and limited to four days. | 80% of the Negotiated Charge and limited to four days. | 80% of the Reasonable Charge and limited to four days. |
| Surgical Expenses -Inpatient <i>Covered Medical Expenses for charges for surgical services, performed by a Physician.</i> | 100% of the Negotiated Charge. | 80% up to \$5,000 , then 100% thereafter of the Negotiated Charge. | 80% up to \$5,000 , then 100% thereafter of the Reasonable Charge. |

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| Anesthetist and Assistant Surgeon Expenses -Inpatient <i>Covered Medical Expenses for the charges of an anesthetist and an assistant surgeon, during a surgical procedure.</i> | 100% of the Negotiated Charge. | 80% up to \$5,000 , then 100% thereafter of the Negotiated Charge. | 80% up to \$5,000 , then 100% thereafter of the Reasonable Charge. |
| Non-Surgical Physicians Expenses (Physician Hospital Visit/Consultation Expenses). <i>Covered Medical Expenses for charges for the non-surgical services of the attending Physician, or a consulting Physician.</i> | 100% of the Negotiated Charge. | 80% of the Negotiated Charge. | 80% of the Reasonable Charge. |

Surgical Benefits - Outpatient

Outpatient Surgical benefits are limited to an Aggregate Maximum of \$10,000 per condition, per Policy Year.

| | | | |
|--|---------------------------------------|---|---|
| Surgical Expenses -Outpatient <i>Covered Medical Expenses for charges for surgical services, performed by a Physician.</i> | 100% of the Negotiated Charge. | 80% up to \$5,000 , then 100% thereafter of the Negotiated Charge. | 80% up to \$5,000 , then 100% thereafter of the Reasonable Charge. |
| Anesthetist and Assistant Surgeon Expenses -Outpatient <i>Covered Medical Expenses for the charges of an anesthetist and an assistant surgeon, during a surgical procedure.</i> | 100% of the Negotiated Charge. | 80% up to \$5,000 , then 100% thereafter of the Negotiated Charge. | 80% up to \$5,000 , then 100% thereafter of the Reasonable Charge. |
| Outpatient Hospital Services for Surgery Expenses | 100% of the Negotiated Charge. | 80% up to \$5,000 , then 100% thereafter of the Negotiated Charge. | 80% up to \$5,000 , then 100% thereafter of the Reasonable Charge. |
| Ambulatory Surgical Expenses <i>Covered Medical Expenses for outpatient surgery performed in an ambulatory surgical center. Expenses must be incurred on the day of the surgery or within 48 hours after the surgery.</i> | N/A | 80% up to \$5,000 , then 100% thereafter of the Negotiated Charge. | 80% up to \$5,000 , then 100% thereafter of the Reasonable Charge. |

| | | | |
|--|---|---|---|
| Routine Colorectal Cancer Screening Expenses | <p>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:</p> <ul style="list-style-type: none"> • One fecal occult blood test every twelve months in a row. • A Sigmoidoscopy at age 50 and every three years thereafter. • One digital rectal exam every twelve months in a row. • A double contrast barium enema, once every five years. • A colonoscopy, once every ten years. • Virtual colonoscopy. • Stool DNA. | | |
| | 100% of the Negotiated Charge. | 80% up to \$5,000, then 100% thereafter of the Negotiated Charge. | 80% up to \$5,000, then 100% thereafter of the Reasonable Charge. |

| | | | |
|---|--------------------------------|---|---|
| <p>Outpatient Benefits</p> <p>Covered Medical Expenses include but are not limited to: Physician’s office visits, hospital or outpatient department or emergency room visits, radiological facility or other similar facility licensed by the state, physical therapy, clinical lab tests and procedures.</p> <p><i>Benefits are limited to an Aggregate Outpatient Benefit Maximum of \$2,500 per condition, per Policy Year. Multiple conditions per policy year will be paid subject to Benefit Maximums as shown below.</i></p> | | | |
| Physician’s Office Visits | 100% of the Negotiated Charge. | 80% up to \$5,000, then 100% thereafter of the Negotiated Charge. | 80% up to \$5,000, then 100% thereafter of the Reasonable Charge. |
| Emergency Room Expenses <i>Covered Medical Expenses incurred for treatment of an Emergency Medical Condition.</i> | 100% of the Negotiated Charge. | 80% up to \$5,000, then 100% thereafter of the Negotiated Charge. | 80% up to \$5,000, then 100% thereafter of the Reasonable Charge. |
| Dermatological Expenses <i>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.</i> <i>Covered Medical Expenses do not include treatment for cosmetic treatment and procedures. Removal of warts, malignant moles and lesions are covered only at University Health Service or when referred by UHS.</i> | 100% of the Negotiated Charge. | 80% up to \$5,000, then 100% thereafter of the Negotiated Charge. | 80% up to \$5,000, then 100% thereafter of the Reasonable Charge. |

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| <p>Voluntary Termination of Pregnancy Expenses</p> <p><i>This benefit is in lieu of any other Policy benefits.</i></p> | N/A | 80% up to \$5,000, then 100% thereafter of the Negotiated Charge. | 80% up to \$5,000, then 100% thereafter of the Reasonable Charge. |
| <p>Diabetic Testing Supplies</p> <p><i>See page 28 of this Brochure for benefit details.</i></p> | 100% of the Negotiated Charge. | 80% up to \$5,000, then 100% thereafter of the Negotiated Charge. | 80% up to \$5,000, then 100% thereafter of the Reasonable Charge. |
| <p>Consultant or Specialist Expenses</p> <p><i>When in accordance with the attending Physician request.</i></p> | 100% of the Negotiated Charge. | 80% up to \$5,000, then 100% thereafter of the Negotiated Charge. | 80% up to \$5,000, then 100% thereafter of the Reasonable Charge. |
| <p>Laboratory and X-Ray Expenses</p> <p><i>Laboratory expense for Allergy testing is limited to \$300 per Policy Year.</i></p> | 100% of the Negotiated Charge. | 80% up to \$5,000, then 100% thereafter of the Negotiated Charge. | 80% up to \$5,000, then 100% thereafter of the Reasonable Charge. |
| <p>Diagnostic Testing for Attention Disorders and Learning Disabilities Expenses</p> <p><i>Covered Medical Expenses</i> for diagnostic testing for:</p> <ul style="list-style-type: none"> • <i>Attention Deficit Disorder, or</i> • <i>Attention Deficit Hyperactive Disorder, or</i> • <i>Dyslexia.</i> <p><i>Once a Covered Person has been diagnosed with one of these conditions, medical treatment will be payable as detailed under the outpatient Treatment of Behavioral and Nervous Disorders portion of this Policy.</i></p> | 100% of the Negotiated Charge. | 80% of the Negotiated Charge. | 80% of the Reasonable Charge. |
| <p>Podiatric Expenses</p> <p><i>Covered Medical Expenses</i> include charges for podiatric services, provided on an outpatient basis following an injury. Expenses for routine foot care, such as trimming of corns, calluses, and nails, are not <i>Covered Medical Expenses.</i></p> | 100% of the Negotiated Charge. | 80% up to \$5,000, then 100% thereafter of the Negotiated Charge. | 80% up to \$5,000, then 100% thereafter of the Reasonable Charge. |

| Behavioral Health Benefits | | | |
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| <p>Behavioral Illness - Inpatient Expenses</p> <p><i>Covered Medical Expenses include charges for treatment received during partial hospitalization or intensive outpatient in a hospital or treatment facility. Prior review and must be obtained on a case-by-case basis. When approved, benefits will be payable in place of an inpatient admission, whereby two days of partial hospitalization or intensive outpatient treatment may be exchanged for one day of full hospitalization.</i></p> <p><i>Benefits for Behavioral and Nervous Disorders will count toward any Alcoholism and Drug Addiction Treatment maximums.</i></p> <p><i>Benefits are limited to 30 days per Policy Year per condition for any one or related mental health condition.</i></p> | <p>100% of the Negotiated Charge.</p> | <p>80% of the Negotiated Charge.</p> | <p>80% of the Reasonable Charge.</p> |
| <p>Behavioral Illness - Outpatient</p> <p><i>Benefits for Behavioral and Nervous Disorders will count toward any Alcoholism and Drug Addiction Treatment maximums.</i></p> <p><i>Benefits are limited to one visit per day with a \$500 maximum per Policy Year.</i></p> | <p>100% of the Negotiated Charge.</p> <p><i>University Health Service treatment is payable up to a 100% of the Negotiated Charge up to a maximum of \$400.</i></p> | <p>50% of the Negotiated Charge.</p> | <p>50% of the Reasonable Charge.</p> |

Substance Abuse Benefits

No payment shall be made by the carrier to the provider except upon completion of the phase of program of treatment by the patient, under the guidance and direction of a physician licensed to practice in the Commonwealth or a professional, designated by such physician, who is a recognized staff member of a treatment facility licensed by the office or accredited by the Joint Commission on the Accreditation of Hospitals.

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| <p>Substance Abuse - Inpatient including Emergency Detoxification Expenses</p> <p><i>Covered Medical Expenses include the treatment of a substance abuse condition while confined as an inpatient in a hospital or facility licensed for such treatment.</i></p> <p><i>Covered Medical Expenses include charges 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 two days of partial hospitalization or intensive outpatient treatment may be exchanged for one day of full hospitalization.</i></p> <p><i>Covered Medical Expenses also include the emergency detoxification treatment and residential treatment of a substance abuse condition while confined as an inpatient in a hospital or facility licensed for such treatment.</i></p> <p><i>Benefits for Alcoholism and Drug Addiction Treatment will count toward any Behavioral and Nervous Disorders maximums.</i></p> <p><i>Benefits are limited to 30 days per Policy Year.</i></p> | <p>100% of the Negotiated Charge.</p> | <p>80% of the Negotiated Charge.</p> | <p>50% of the Reasonable Charge.</p> |
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| <p>Substance Abuse - Outpatient Expenses</p> <p><i>Covered Medical Expenses for outpatient treatment of alcoholism or substance abuse.</i></p> <p><i>Benefits for Alcoholism and Drug Addiction Treatment will count toward any Behavioral and Nervous Disorders maximums.</i></p> <p><i>Benefits are limited to \$500 per Policy Year.</i></p> | <p>100% of the Negotiated Charge.</p> | <p>50% of the Negotiated Charge.</p> | <p>50% of the Reasonable Charge.</p> |
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| <p>Maternity Benefits</p> <p><i>Outpatient Benefits are limited to an Aggregate Outpatient Benefit Maximum of \$2,500 per condition, per Policy Year.</i></p> <p><i>Inpatient Benefits are limited to the Plan Aggregate Maximum of \$500,000 per Accident or Sickness per Policy Year.</i></p> | | | |
| <p>Maternity Expenses-including Complications of Pregnancy</p> <p><i>Covered Medical Expenses include Inpatient care for a minimum of 48 hours, following vaginal delivery for the mother and her newly born child, or inpatient care for a minimum of 96 hours following cesarean section for the mother and her newly born child.</i></p> <p>Any decision to shorten such minimum coverages shall be made by the attending Physician, in consultation with the mother. In such cases, covered services may include: home visits, parent education, and assistance and training in breast or bottle-feeding. Complications of pregnancy are payable on the same basis as any other sickness.</p> | <p>Inpatient: 100% of the Negotiated Charge.</p> <p>Outpatient: 100% of the Negotiated Charge.</p> | <p>Inpatient: 80% of the Negotiated Charge for an overnight stay.</p> <p>Outpatient: 80% up to \$5,000, then 100% thereafter of the Negotiated Charge.</p> | <p>Inpatient: 80% of the Reasonable Charge for an overnight stay.</p> <p>Outpatient: 80% up to \$5,000, then 100% thereafter of the Reasonable Charge.</p> |

Child Health Supervision Services Benefits (Well Baby Care)

Applies to covered dependent children only

*Covered Medical Expenses include Routine preventive and primary care services are services rendered to a covered dependent child, from the date of birth through the attainment of **two** years of age. Services include: initial hospital check-ups, other hospital visits, physical examinations, including routine hearing and vision examinations, medical history, developmental assessments, and materials for the administration of appropriate and necessary immunizations and laboratory tests, when given in accordance with the prevailing recommendations for Preventative Pediatric Health Care of the American Academy of Pediatrics.*

Benefits are limited to an Aggregate Outpatient Benefit Maximum of \$2,500 per Policy Year as well as following benefit specific limits.

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| <p>Routine Well Child Exam</p> <p><i>The physical exam must include at least:</i></p> <ul style="list-style-type: none"> • <i>A review and written record of the patient's complete medical history;</i> • <i>A check of all body systems;</i> • <i>A review and discussion of the exam results with the patient or with the parent or guardian.</i> | <p>100% of the Negotiated Charge.</p> | <p>80% of the Negotiated Charge.</p> | <p>80% of the Reasonable Charge.</p> |
| <p>Vision Care Exam</p> <p><i>Benefit maximum of \$50 per exam.</i></p> | <p>100% of the Negotiated Charge.</p> | <p>80% of the Negotiated Charge.</p> | <p>80% of the Reasonable Charge.</p> |
| <p>Routine Hearing Exam</p> <p><i>Includes screening for the detection of hearing loss by a licensed audiologist, a Physician, a hospital or other hearing screening provider for children age range from birth through twelve months.</i></p> <p><i>Benefit maximum of \$50 per exam.</i></p> | <p>100% of the Negotiated Charge.</p> | <p>80% of the Negotiated Charge.</p> | <p>80% of the Reasonable Charge.</p> |

Women's Health Benefits

Benefits include Mammogram, routine gynecological exams and Pap-smears.

Benefits are limited to an Aggregate Outpatient Benefit Maximum of \$2,500 per condition, per Policy Year. Multiple conditions (non-routine) per Policy Year will be paid subject to Benefit Maximums as shown below.

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| <p>Mammography Expenses</p> <p><i>Covered Medical Expenses will include one baseline mammogram for women between the ages of 35 and 40. Women age 40 and older have coverage for an annual mammogram per Policy Year. Covered Medical Expenses are payable on the same basis as any X-ray expense.</i></p> | <p>100% of the Negotiated Charge.</p> | <p>80% up to \$5,000, then 100% thereafter of the Negotiated Charge.</p> | <p>80% up to \$5,000, then 100% thereafter of the Reasonable Charge.</p> |
| <p>Pap-smear Expenses</p> <p><i>Covered Medical Expenses include one annual routine Pap-smear screening for women age 18 and older. Covered Medical Expenses are payable on the same basis as any outpatient expense.</i></p> | <p>100% of the Negotiated Charge.</p> | <p>80% up to \$5,000, then 100% thereafter of the Negotiated Charge.</p> | <p>80% up to \$5,000, then 100% thereafter of the Reasonable Charge.</p> |

Additional Benefits

Please note specific limitations as necessary.

Multiple conditions per Policy Year will be paid subject to Benefit Maximums as shown below.

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| <p>High Cost Procedures Expenses</p> <p><i>For purposes of this benefit, "High Cost Procedure" means any outpatient procedure costing over \$200. Includes, but not limited to C.A.T. Scans, Magnetic Resonance Imaging (M.R.I.) and Laser treatments. Please see the Definition of High Cost Procedures on page 44 for more detailed information on this benefit. Benefits are limited to \$2,000 per condition, per Policy Year.</i></p> | <p>100% of the Negotiated Charge.</p> | <p>80% up to \$5,000, then 100% thereafter of the Negotiated Charge.</p> | <p>80% up to \$5,000, then 100% thereafter of the Reasonable Charge.</p> |
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| <p>Radiation and Chemotherapy Expenses</p> <p><i>Covered Medical Expenses for chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy, radiation therapy, tests and procedures, and expenses incurred at a radiological facility.</i></p> <p><i>Covered Medical Expenses also include expenses for the administration of chemotherapy and visits by a health care professional to administer the chemotherapy.</i></p> <p><i>Benefits are limited to the Plan Aggregate Maximum of \$500,000 per Accident or Sickness per Policy Year.</i></p> | <p>Inpatient: 100% of the Negotiated Charge.</p> <p>Outpatient: 100% of the Negotiated Charge.</p> | <p>Inpatient: 80% of the Negotiated Charge.</p> <p>Outpatient: <i>Following Surgery-</i> 80% up to \$5,000, then 100% thereafter, of the Negotiated Charge.</p> <p><i>Not Following Surgery-</i> 100% of the Negotiated Charge after a \$15 copay.</p> | <p>Inpatient: 80% of the Reasonable Charge.</p> <p>Outpatient: <i>Following Surgery-</i> 80% up to \$5,000, then 100% thereafter, of the Reasonable Charge.</p> <p><i>Not Following Surgery-</i> 100% of the Reasonable Charge after a \$15 copay.</p> |
| <p>Immunizations Expenses</p> <p><i>Routine adult immunizations are not covered. Benefit available for insured students at University Health Service ONLY.</i></p> <p><i>Routine Child to 19 years: in accordance with American Academy of Pediatric standards.</i></p> <p><i>Benefits are limited to an Aggregate Outpatient Benefit Maximum of \$2,500 per condition, per Policy Year.</i></p> <p><i>Please Note: TB testing and titers are not considered immunizations.</i></p> | <p>100% of the Negotiated Charge.</p> | <p>80% up to \$5,000, then 100% thereafter of the Negotiated Charge.</p> | <p>80% up to \$5,000, then 100% thereafter of the Reasonable Charge.</p> |
| <p>Allergy Testing Expenses</p> <p><i>Covered Medical Expenses include charges incurred for diagnostic testing of allergies. Allergy Testing is subject to a maximum benefit of \$300 per Policy Year.</i></p> <p><i>Please Note: Allergy Treatment is not covered.</i></p> | <p>100% of the Negotiated Charge.</p> | <p>80% of the Negotiated Charge.</p> | <p>80% of the Reasonable Charge.</p> |

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| <p>Durable Medical Equipment Expenses</p> <p><i>Please Note: Prescription is required. Replacement equipment is not covered.</i></p> <p>Benefits are limited to the Plan Aggregate Maximum of \$500,000 per Accident or Sickness per Policy Year.</p> | <p>100% of the Negotiated Charge.</p> | <p>80% up to \$5,000, then 100% thereafter of the Negotiated Charge.</p> | <p>80% up to \$5,000, then 100% thereafter of the Reasonable Charge.</p> |
| <p>Prosthetic Devices Expenses</p> <p>Covered Medical Expenses include charges for: artificial limbs, or eyes, and other non-dental prosthetic devices, as a result of an accident or sickness.</p> <p>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.</p> <p>Benefits are limited to the Plan Aggregate Maximum of \$500,000 per Accident or Sickness per Policy Year.</p> <p><i>Please Note: Prescription is required. Replacement equipment is not covered.</i></p> | <p>100% of the Negotiated Charge.</p> | <p>80% up to \$5,000, then 100% thereafter of the Negotiated Charge.</p> | <p>80% up to \$5,000, then 100% thereafter of the Reasonable Charge.</p> |
| <p>Dental Injury Expenses</p> <p><i>For the treatment of accidental injury to sound, natural teeth.</i></p> <p>Benefits are limited to the Plan Aggregate Maximum of \$500,000 per Accident or Sickness per Policy Year.</p> <p><i>See page 27 of this Brochure for benefit details.</i></p> | <p>100% of the Negotiated Charge.</p> | <p>80% up to \$5,000, then 100% thereafter of the Actual Charge.</p> | <p>80% up to \$5,000, then 100% thereafter of the Actual Charge.</p> |

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| <p>Temporomandibular Joint (TMJ) Dysfunction Expenses</p> <p>Covered Medical Expenses include charges incurred by a Covered Person for non-surgical treatment related to Temporomandibular Joint (TMJ) Disorders and craniomandibular jaw disorders.</p> <p>Benefits are limited to an Aggregate Outpatient Benefit Maximum of \$2,500 per condition, per Policy Year.</p> | <p>100% of the Negotiated Charge.</p> | <p>Payable as any other condition.</p> | <p>Payable as any other condition.</p> |
| <p>Ambulance Expenses</p> <p>Covered Medical Expenses for the services of a professional ambulance to or from a hospital, when required due to the emergency nature of a covered Accident or Sickness.</p> <p>Benefits are limited to the Plan Aggregate Maximum of \$500,000 per Accident or Sickness per Policy Year.</p> | <p>N/A</p> | <p>80% of the Negotiated Charge.</p> | <p>80% of the Reasonable Charge.</p> |
| <p>Hospice Benefits</p> <p>The maximum number of days inpatient confinement is 30 days per Policy Year.</p> <p>The maximum benefit is \$3,000 per lifetime.</p> | <p>Covered Medical Expenses include charges for hospice care provided for a terminally ill Covered Person during a hospice benefit period.</p> <p>Please see definition on page 53 for more information on Hospice Care Expenses.</p> <p>Benefits for Hospice expenses require pre-certification.</p> | | |
| <p>Vision Care Exam Expenses - Adult</p> <p>Benefits are limited to one routine eye exam per Policy Year. The maximum benefit is \$150 Per Policy Year.</p> <p>See page 30 of this Brochure for benefit details.</p> | <p>100% of the Negotiated Charge.</p> | <p>80% of the Negotiated Charge.</p> | <p>80% of the Reasonable Charge.</p> |
| <p>N/A</p> | <p>80% of the Negotiated Charge.</p> | <p>80% of the Reasonable Charge.</p> | |

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| <p>Hospital Outpatient Department or Walk-In Clinic Expenses</p> <p><i>Covered Medical Expenses for outpatient treatment in a hospital.</i></p> <p><i>Benefits are limited to an Aggregate Outpatient Benefit Maximum of \$2,500 per condition, per Policy Year.</i></p> | <p>100% of the Negotiated Charge.</p> | <p>80% up to \$5,000, then 100% thereafter of the Negotiated Charge.</p> | <p>80% up to \$5,000, then 100% thereafter of the Reasonable Charge.</p> |
| <p>Urgent Care Expenses</p> <p><i>Covered Medical Expenses include charges for treatment by an urgent care provider.</i></p> <p><i>Please see page 53 of this Brochure for more information on urgent care providers.</i></p> <p><i>See page 29 of this Brochure for benefit details.</i></p> <p><i>Benefits are limited to an Aggregate Outpatient Benefit Maximum of \$2,500 per condition, per Policy Year.</i></p> | <p>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.</p> <p><u>Urgent Care</u> Benefits include charges for an urgent care provider to evaluate and treat an urgent condition.</p> | | |
| | <p>N/A</p> | <p>80% up to \$5,000, then 100% thereafter of the Negotiated Charge.</p> | <p>80% up to \$5,000, then 100% thereafter of the Reasonable Charge.</p> |
| <p>Therapy Expenses</p> <p><i>Outpatient Benefits not following surgery limited to ten visits per condition, per Policy Year.</i></p> <p><i>See page 29 of this Brochure for benefit details.</i></p> <p><i>Outpatient Benefits following surgery. Benefits are limited to an Aggregate Outpatient Benefit Maximum of \$2,500 per condition, per Policy Year.</i></p> | <p>Inpatient: 100% of the Negotiated Charge.</p> <p>Outpatient: Following Surgery - 100% of the Negotiated Charge.</p> <p>Not Following Surgery – 100% of the Negotiated Charge after a \$15 copay.</p> | <p>Inpatient: 80% of the Negotiated Charge.</p> <p>Outpatient: Following Surgery- 80% up to \$5,000, then 100% thereafter, of the Negotiated Charge.</p> <p>Not Following Surgery- 100% of the Negotiated Charge after a \$15 copay.</p> | <p>Inpatient: 80% of the Reasonable Charge.</p> <p>Outpatient: Following Surgery- 80% up to \$5,000, then 100% thereafter, of the Reasonable Charge.</p> <p>Not Following Surgery- 100% of the Reasonable Charge after a \$15 copay.</p> |

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| <p>Outpatient Diabetic Self-management Education Programs Expenses</p> <p><i>Please see page 28 of this Brochure for further details.</i></p> <p><i>Please see the Definition of Outpatient Diabetic Self-management Education Programs on page 48 for more detailed information on this benefit.</i></p> <p><i>Benefits are limited to \$200 per Policy Year.</i></p> | <p>100% of the Negotiated Charge.</p> | <p>After a \$20 copay, 70% of the Negotiated Charge.</p> | <p>After a \$20 copay, 50% of the Reasonable Charge.</p> |
| <p>Home Health Care Expenses</p> <p><i>Benefits are limited to 60 visits per Policy Year. A visit means a maximum of four continuous hours of home health service. This includes treatment requiring a registered or licensed practical nurse</i></p> <p><i>Please see page 28 of this Brochure for further benefit details and page 44 for definitions.</i></p> | <p>N/A</p> | <p>80% of the Negotiated Charge incurred within twelve months from the date of the first home health care visit.</p> | <p>80% of the Reasonable Charge incurred within twelve months from the date of the first home health care visit.</p> |
| <p>Transfusion or Dialysis of Blood Expenses</p> | <p>N/A</p> | <p>Payable as any other Condition.</p> | <p>Payable as any other Condition.</p> |
| <p>Autism Expenses</p> <p><i>Benefits for Autism will be subject to a \$500 maximum benefit per month, per covered child. This limit shall not apply to other health conditions of the child and services for the child not related to the treatment of Autism.</i></p> <p><i>Not covered are services rendered by a person who resides with the claimant or who is part of the claimant's family.</i></p> | <p>Covered Medical Expenses include the services of a health care provider for rendering these services to a child who is at least two years of age and under 22 years of age.</p> <p>Covered Medical Expenses include therapeutic services (such as psychotherapy and speech/language therapy), respite, and rehabilitative care (such as occupational/physical therapy), for the treatment of autism of a child covered under the Policy.</p> <p>Covered Medical Expenses are payable on the same basis as any other expenses subject to the maximum monthly benefit.</p> | | |

Prescription Drug Benefits

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| <p>Prescription Drug Benefits</p> <p>A benefit will be paid at the preferred level of coverage for a prescription drug dispensed by a Non-Preferred pharmacy only:</p> <ul style="list-style-type: none"> • For an emergency condition, or • On Referral of a person's Primary Care Physician. <p>Subject to a maximum of \$1,000 per Policy Year.</p> | <p>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.</p> <p>Prior Authorization is required for certain Prescription Drugs, including growth hormones and for any Prescription quantities larger than a 30-day supply. <i>(This is only a partial list.)</i></p> <p>Medications not covered by this benefit include, but are not limited to: allergy sera, inhalers, drugs whose sole purpose is to promote or to stimulate hair growth, appetite suppressants, immunization agents and vaccines, and non-self injectables. <i>(This is only a partial list.)</i></p> <p>Allergy Prescriptions will be covered at Kentucky Clinic Pharmacies ONLY.</p> <p>For assistance or for a complete list of excluded medications, or drugs requiring prior authorization, please contact Aetna Pharmacy Management at (800) 238-6279 (available 24 hours).</p> <p>Aetna Specialty Pharmacy provides specialty medications and support to members living with chronic conditions. The medications offered may be injected, infused or taken by mouth. For additional information please go to www.AetnaSpecialtyRx.com.</p> | | |
| | <p><u>Kentucky Clinic Pharmacies:</u> Following a \$30 copay for each Brand Name Prescription Drug or a \$10 copay for each Generic Prescription Drug. Covered Medical Expenses are payable at 100% up to a maximum of \$1,000 per Policy Year.</p> | <p>Following a \$45 copay for each Brand Name Prescription Drug or a \$15 copay for each Generic Prescription Drug. Covered Medical Expenses are payable at 100% up to a maximum of \$1,000 per Policy Year.</p> | <p>Following a \$45 deductible for each Brand Name Prescription or a \$15 deductible for each Generic Prescription Drug. Covered Medical Expenses are payable at 100% up to a maximum of \$1,000 per Policy Year.</p> |

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| <p>Non Prescription Enteral Formula Expenses</p> <p>Covered Medical Expenses include charges incurred by a Covered Person, for non-prescription enteral formulas as prescribed and administered under the direction of a physician, that are medically necessary for the treatment of inherited metabolic diseases.</p> <p>Covered Medical Expenses for inherited diseases of amino acids and organic acids, will also include food products modified to be low protein.</p> | <p>N/A</p> | <p>Payable as any other condition.</p> | <p>Payable as any other condition.</p> |
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BENEFIT DETAILS

DENTAL INJURY EXPENSES

Covered Medical Expenses include dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition:

- Natural teeth damaged, lost, or removed, or
- Other body tissues of the mouth fractured or cut due to injury.

The accident causing the injury must occur while the person is covered under this Plan.

Any such teeth must have been:

- Free from decay, or
- In good repair, and
- Firmly attached to the jawbone at the time of the injury.

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.

DIABETIC SELF-MANAGEMENT EDUCATION-PROGRAM EXPENSES

Covered Medical Expenses include charges incurred by a covered student for outpatient diabetic self-management education programs. An “outpatient diabetic self-management education program” is a scheduled program on a regular basis, which is designed to instruct a Covered Person in the self-management of diabetes. It is a day care program of educational services and self-care training (including medical nutritional therapy). The program must be under the supervision of an appropriately licensed, registered, or certified health care professional, whose scope of practice includes diabetic education or management. Charges incurred for the following are not **Covered Medical Expenses**:

- A diabetic education program whose only purpose is weight control, or which is available to the public at no cost; or
- A general program not just for diabetics; or
- A program made up of services not generally accepted as necessary for the management of diabetes. **\$200** deductible applies.

DIABETIC TESTING SUPPLIES

Covered Medical Expenses include charges for testing material used to detect the presence of sugar in the person’s urine or blood for monitoring glycemic control.

Diabetic Testing Supplies are limited to:

- Lancet devices,
- glucose monitors, and
- test strips,
- insulin pumps and supplies.

Syringes & Insulin covered under Prescription Drug benefit with **\$1,000** per Policy Year benefit.

HOME HEALTH CARE EXPENSES

Covered Medical Expenses include charges incurred by a Covered Person for home health care services made by a home health agency pursuant to a home health care plan, but only if:

- (a) The services are furnished by, or under arrangements made by, a licensed home health agency.
- (b) The services are given under a home care plan. This plan must be established pursuant to the written order of a physician, and the physician must renew that plan every 60 days. Such physician must certify that the proper treatment of the condition would require inpatient confinement in a hospital (or skilled nursing facility) if the services and supplies were not provided under the home health care plan. The physician must examine the Covered Person at least once a month.
- (c) Except as specifically provided in the home health care services, the services are delivered in the patient’s place of residence on a part-time, intermittent visiting basis while the patient is confined.

HOME HEALTH CARE SERVICES

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

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

THERAPY EXPENSES

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

Expenses for Speech and Occupational Therapies are **Covered Medical Expenses**, only if such therapies are a result of **injury** or **sickness**.

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

URGENT CARE EXPENSES

When travel to a Preferred Care Provider for treatment of an urgent condition is not feasible, a Covered Person may call Aetna to request authorization to see a Non-Preferred urgent care provider so that such treatment may be paid at the preferred level of benefits. If it is not feasible to request authorization prior to treatment, then it should be done as soon as possible after treatment but not later than:

- the next day during normal business hours, or
- if the Covered Person is confined in a hospital directly after receiving urgent care, not later than 48 hours following the start of the confinement unless it is not possible for the Covered Person to request authorization within that time. In that case, it must be done as soon as reasonably possible.

However:

- if the treatment is received, on a Friday or Saturday, or
- the confinement occurs, on a Friday or Saturday,

authorization must be requested within 72 hours following treatment or the start of the confinement.

If the Covered Person does not request authorization from Aetna to see a Non-Preferred urgent care provider, charges incurred for urgent care will be paid at the Non-Preferred covered percentage after the Non-Preferred deductible.

The Covered Person should contact their primary care physician after medical care is provided to treat an urgent condition.

NON-URGENT CARE

Covered Medical Expenses for charges made by an urgent care provider to treat a **non-urgent condition** includes, but is not limited to, the following:

- routine or preventive care (this includes immunizations),
- follow-up care,
- physical therapy,
- elective surgical procedures, and
- any lab and radiologic exams which are not related to the treatment of the urgent condition.

VISION CARE EXAM-ADULT

Limitations

The following limitations apply:

No benefits will be payable for a charge which is:

- For any eye exam to diagnose or treat a disease or injury.
- For drugs or medicines.
- For a vision care service that is a **Covered Medical Expense** in whole or in part, under any other part of this Policy, or under any other group plan.
- For a vision care service for which a benefit is provided in whole or in part, under any workers' compensation law or any other law of like purpose.
- For special procedures. This means things such as orthoptics or vision training.
- For any vision care supply.
- For an eye exam which:
 - Is required by an employer as a condition of employment, or
 - An employer is required to provide under a labor agreement, or
 - Is required by any law of a government.
- For a service received while the person is not a Covered Person.
- For a service which does not meet professionally accepted standards.
- For any exams given while the person is confined in a hospital or other facility for medical care.
- For an eye exam, or any part of an eye exam, performed for the purpose of the fitting of contact lenses.

ADDITIONAL SERVICES AND DISCOUNTS

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

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

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

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

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

**Offered by WellCall, Inc. through GlobalFit.*

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

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

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

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

Aetna's Informed Health[®] Line: Get answers from a registered nurse at any time — just call our toll-free Informed Health Line. With one simple call, you can:

- Learn more about health conditions that you or your family members have.
- Find out more about a medical test or procedure.
- Come up with questions to ask your doctor.

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

Listen to our Audio Health Library:* Call and learn about a topic that interests you. Choose from thousands of health conditions. Listen in English or Spanish. You can also transfer to a registered nurse at any time during your call.

**Not all topics discussed within the Audio Health Library are covered expenses under your health insurance Plan.*

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

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

Give the gift of relaxation to yourself or a friend through SpaWish: Get a 10% discount when you buy a gift certificate of at least \$100, good for services at any of over 1,000 spas across the U.S. Choose a spa close to home or near your favorite place to visit!

OPTIONAL PRODUCTS AVAILABLE

With our **Aetna Advantage™ Dental benefits and insurance Plan**, you select a primary care dentist (PCD) and have most of your preventive and restorative services covered by a co-payment or reduced fee for each visit. Enroll online at www.aetnastudenthealth.com.

Price:

| | Annual 9/1/09-8/31/10 | Spring 1/1/10-8/31/10 |
|------------|----------------------------------|----------------------------------|
| Student | \$128.46 | \$85.65 |
| Spouse | \$129.63 | \$86.42 |
| Child(ren) | \$200.64 | \$133.76 |

The Aetna Advantage™ Dental benefits and insurance Plan is underwritten by Aetna Life Insurance Company, Aetna Dental Inc., Aetna Dental of California Inc. and/or Aetna Health Inc. In Arizona, Advantage Dental is underwritten by Aetna Health Inc.

Vital SavingsSM on Dental* is a dental discount Program helping you and your dependents save an average of 15% to 50% on a wide array of dental services – with one low annual fee of \$25 per person. Enroll online at www.aetnastudenthealth.com.

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

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

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

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

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

GENERAL PROVISIONS

STATE MANDATED BENEFITS

The Plan will pay benefits in accordance with any applicable Kentucky 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.

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

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, Supplemental Sickness Expense coverage for a Covered Person ends while he/she is totally disabled, benefits will continue to be available for expenses incurred for that person, only while the Covered Person continues to be totally disabled. Benefits will continue until the earlier of: (1) coverage for the disability is obtained under another policy, (2) total disability ceases, (3) maximum benefits level are received, or (4) twelve months from the date coverage ends.

If a Covered Person is confined to a hospital on the date his/her insurance terminates, expenses incurred after the termination date and during the continuance of that hospital confinement, shall be payable in accordance with the policy, until the earlier of (1) discharge, (2) maximum benefits are received, or (3) twelve months from the date coverage ends.

TERMINATION OF INSURANCE

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

TERMINATION OF STUDENT COVERAGE

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

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

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

TERMINATION OF DEPENDENT COVERAGE

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

- (a) For a child, on the first premium due date following the first to occur of:
 1. the date the child is no longer chiefly dependent upon the student for support and maintenance,
 2. the date of the child's marriage, and
 3. the child's 19th birthday.
- (b) The date the **covered student** fails to pay any required premium.
- (c) For the spouse, the date the marriage ends in divorce or annulment.
- (d) The date **dependent** coverage is deleted from this Policy.
- (e) The date the **dependent** ceases to be in an eligible class.

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

INCAPACITATED DEPENDENT CHILDREN

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

Due proof of the child's incapacity and dependency must be furnished to Aetna by the **covered student** within 31 days after the date insurance would otherwise cease. Such child will be considered a **covered dependent**, so long as the **covered student** submits proof to Aetna at reasonable intervals during the two 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/her 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 Policy, and has been continuously insured under the Plan offered by the Policyholder (regular Student Plan), may be covered for up to twelve continuous months provided that: (1) a written request for continuation has been forwarded to Aetna within 31 days of the termination of coverage, and (2) premium payment has been made. Coverage under this provision ceases on the date this Policy terminates.

The continuation application is available upon request from the University Health Service Insurance Coordinator in person or by phone at **(859) 323-5823** or email www.ukhealthcare.uky.edu/uhs/. **There are no refunds allowable.**

EXCLUSIONS

This Policy does not cover nor provide benefits for:

1. Expenses incurred as a result of dental treatment, including removal of impacted wisdom teeth, except for treatment resulting from injury to sound, natural teeth.
2. Expenses incurred for services normally provided without charge by the Policyholder's Health Service, Infirmary or **Hospital**, or by health care providers employed by the Policyholder.
3. Expenses incurred for eye refractions, vision therapy, radial keratotomy, eyeglasses, contact lenses (except when required after cataract surgery), or other vision or hearing aids, or **prescriptions** or examinations except as required for repair caused by a covered **injury**.
4. Expenses incurred as a result of **injury** due to participation in a riot. "Participation in a riot" means taking part in a riot in any way, including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense, so long as they are not taken against persons who are trying to restore law and order.
5. Expenses incurred as a result of an **accident** occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.
6. Expenses incurred as a result of an **injury** or **sickness** for which benefits are payable under any Workers' Compensation or Occupational Disease Law.
7. Expenses incurred as a result of an **injury** sustained or **sickness** contracted while in the service of the Armed Forces of any country. Upon the **Covered Person** entering the Armed Forces of any country, the unearned pro-rata premium will be refunded to the Policyholder.

8. Expenses incurred for treatment provided in a governmental **hospital** unless there is a legal obligation to pay such charges in the absence of insurance.
9. Expenses incurred for **elective treatment** or elective surgery except as specifically provided elsewhere in this Policy and performed while this Policy is in effect.
10. Expenses incurred for cosmetic surgery, reconstructive surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons, except to the extent needed to:
 - Improve the function of a part of the body that:
 - is not a tooth or structure that supports the teeth, and
 - is malformed:
 - as a result of a severe birth defect, including harelip, webbed fingers, or toes, or
 - as direct result of:
 - disease, or
 - surgery performed to treat a disease or **injury**.
 - Repair an **injury** (including reconstructive surgery for prosthetic device for a **Covered Person** who has undergone a mastectomy) which occurs while the **Covered Person** is covered under this Policy. Surgery must be performed:
 - in the calendar year of the accident which causes the **injury**, or
 - in the next calendar year.
11. Expenses covered by any other valid and collectible medical, health or accident insurance to the extent that benefits are payable under other valid and collectible insurance whether or not a claim is made for such benefits.
12. Expenses for **injuries** sustained as the result of a motor vehicle accident to the extent that benefits are payable under other valid and collectible insurance whether or not claim is made for such benefits.
13. Expenses incurred as a result of preventative medicines (except immunizations as they are covered at UHS).
14. Expenses incurred after the date insurance terminates for a **Covered Person** except as may be specifically provided in the Extension of Benefits Provision.
15. Expenses incurred for a treatment, service, or supply which is not medically necessary as determined by Aetna, for the diagnosis care or treatment of the sickness or injury involved.
16. Expenses incurred for injury resulting from the play or practice of collegiate or intercollegiate sports.
17. Expenses incurred for allergy treatment. Allergy prescriptions will be covered at the Kentucky Clinic only.
18. Expenses for the contraceptive methods, devices or aids, and charges for or related to artificial insemination, in-vitro fertilization, or embryo transfer procedures, elective sterilization or its reversal or elective abortion unless specifically provided for in this Policy.
19. Expenses incurred for which no member of the **Covered Person's** immediate family has any legal obligation for payment.
20. Expenses incurred for **custodial care**. **Custodial care** means services and supplies furnished to a person mainly to help him/her in the activities of daily life. This includes **room and board** and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:
 - by whom they are prescribed, or
 - by whom they are recommended, or
 - by whom or by which they are performed.

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

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

- The disease can be expected to cause death within one year, in the absence of effective treatment, and
- The care or treatment is effective for that disease, or shows promise of being effective for that disease, as demonstrated by scientific data. In making this determination, Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

Also, this exclusion will not apply with respect to drugs that:

- Have been granted treatment investigational new drug (IND), or Group c/treatment IND status, or
- Are being studied at the Phase III level in a national clinical trial, sponsored by the National Cancer Institute,
- If Aetna determines that available, scientific evidence demonstrates that the drug is effective, or shows promise of being effective, for the disease.

23. Expenses incurred for gastric bypass, and any restrictive procedures, for weight loss.
24. Expenses incurred for breast reduction/mamoplasty.
25. Expenses incurred for gynecal mastea (male breasts).
26. Expenses incurred for any sinus surgery, except for acute purulent sinusitis.
27. Expenses incurred for: care, treatment, services, or supplies for or related to obstructive sleep apnea, and sleep disorders, including CPAP, and UPP.
28. Expenses incurred as a result of dental treatment.
29. Expenses incurred by a **Covered Person**, not a United States citizen, for services performed within the **Covered Person's** home country, if the **Covered Person's** home country has a socialized medicine program.
30. Expenses incurred for acupuncture, unless services are rendered for anesthetic purposes.
31. Expenses incurred for alternative, holistic medicine, and/or therapy, including but not limited to, yoga and hypnotherapy.

32. Expenses 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.
33. Expenses incurred for **custodial care**, private duty nursing services and supplies, provided by a sanitarium, or rest cures. **Custodial care** means services and supplies furnished to a person, mainly to help him/her in the activities of daily life. This includes **room and board** and other institutional care. The person does not have to be disabled. Such services and supplies are **custodial care** without regard to:
 - by whom they are prescribed, or
 - by whom they are recommended, or
 - by whom or by which they are performed.
34. Expenses incurred when the person or individual is acting beyond the scope of his/her/its legal authority.
35. Expenses for transplants, other than cornea and kidney.
36. Expenses for telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
37. Expenses for personal hygiene and convenience items, such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if such items are prescribed by a **physician**.
38. Expenses for treatment and supplies for programs involving cessation of tobacco use, except when being treated at the University of Kentucky Health Service.
39. Expenses 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.
40. Expenses incurred for massage therapy.
41. Expenses incurred for, or related to, sex change surgery, or to any treatment of gender identity disorder.
42. Expenses for charges that are not **Reasonable Charges**, as determined by Aetna.
43. Expenses for treatment of **covered students** who specialize in the Behavioral health care field, and who receive treatment as a part of their training in that field.
44. 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).
45. Expenses arising from a **pre-existing condition**.
46. Expenses for routine physical exams, including expenses in connection with well newborn care, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage of such exams, immunizations, services, or supplies is specifically provided in the Policy.
47. Expenses incurred for a treatment, service, or supply, which is not **medically necessary**, as determined by Aetna, for the diagnosis care or treatment of the **sickness** or **injury** involved. This applies even if they are prescribed, recommended, or approved, by the person's attending **physician**, or **dentist**.

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

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

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

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

- those that do not require the technical skills of a medical, a behavioral health, or a dental professional, or
- those furnished mainly for the personal comfort or convenience of the person, any person who cares for him/her, or any persons who is part of his/her family, any healthcare provider, or healthcare facility, or
- those furnished solely because the person is an inpatient on any day on which the person's **sickness** or **injury** could safely, and adequately, be diagnosed, or treated, while not confined, or those furnished solely because of the setting, if the service or supply could safely and adequately be furnished in a **physician's** or a **dentist's** office, or other less costly setting.

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

DEFINITIONS

Accident

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

Actual Charge

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

Aggregate Maximum

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

Ambulatory Surgical Center

A freestanding ambulatory surgical facility that:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Makes charges.
- Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery which requires general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
 - physicians who practice surgery in an area **hospital**, and
 - **dentists** who perform oral surgery.
- Has at least 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.

Chlamydia Screening Test

This is any laboratory test of the urogenital tract that specifically detects for infection by one or more agents of Chlamydia trachomatis, and which test is approved for such purposes by the FDA.

Coinsurance

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

Complications of Pregnancy

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

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

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

Complications of Pregnancy also include:

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

Convalescent Facility

This is an institution that:

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

Copay

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

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

Covered Dental Expenses

Those charges for any treatment, service, or supplies, covered by this Policy which are:

- not in excess of the **reasonable and customary** charges, or
- not in excess of the charges that would have been made in the absence of this coverage,
- and incurred while this Policy is in force as to the **Covered Person**.

Covered Dependent

A **covered student's dependent** who is insured under this Policy.

Covered Medical Expenses

Those charges for any treatment, service or supplies covered by this Policy which are:

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

Covered Person

A **covered student** and any **covered dependent** while coverage under this Policy is in effect.

Covered Student

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

Deductible

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

Dental Consultant

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

Dental Provider

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

Dentist

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

Dependent

(a) the **covered student's** spouse residing with the **covered student**, or (b) the **covered student's** unmarried child under the age of 19 years. The child must reside with, and be fully supported by, the **covered student**.

The term "child" includes a **covered student's** step-child, adopted child, and a child for whom a petition for adoption is pending and who is residing with the **covered student**, and who is chiefly dependent on the **covered student** for his/her full support.

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

Designated Care

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

Designated Care Provider

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

Diabetic Self-Management Education Course

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

The following are not considered Diabetic Self-Management Education Courses for the purposes of this Plan:

- A Diabetic Education program whose only purpose is weight control, or which is available to the public at no cost, or
- A general program not just for diabetics, or
- A program made up of services not generally accepted as necessary for the management of diabetes.

Directory

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

Durable Medical and Surgical Equipment

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

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

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

Elective Treatment

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

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

Emergency Admission

One where the **physician** admits the person to the **hospital** or **residential treatment facility** right after the sudden and at that time, unexpected onset of a change in a person's physical or mental condition which:

- requires confinement right away as a full-time inpatient, and
- if immediate inpatient care was not given could, as determined by Aetna, reasonably be expected to result in:
 - loss of life or limb, or
 - significant impairment to bodily function, or
 - permanent dysfunction of a body part.

Emergency Condition

This is any traumatic injury or condition which:

- occurs unexpectedly,
- requires immediate diagnosis and treatment, in order to stabilize the condition, and
- is characterized by symptoms such as severe pain and bleeding.

Emergency Medical Condition

This means a recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his/her condition, **sickness**, or **injury**, is of such a nature that failure to get immediate medical care could result in:

- Placing the person's health in serious jeopardy, or
- Serious impairment to bodily function, or
- Serious dysfunction of a body part or organ, or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Generic Prescription Drug or Medicine

A **prescription drug** which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

High Cost Procedure

High Cost Procedures include the following procedures and services:

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

Home Health Agency

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

Home Health Aide

A certified or trained professional who provides services through a **home health agency** which are not required to be performed by a R.N., L.P.N., or L.V.N., primarily aid the **Covered Person** in performing the normal activities of daily living while recovering from an **injury** or **sickness**, and are described under the written **Home Health Care Plan**.

Home Health Care

Health services and supplies provided to a **Covered Person** on a part-time, intermittent, visiting basis. Such services and supplies must be provided in such person's place of residence, while the person is confined as a result of **injury** or **sickness**. Also, a **physician** must certify that the use of such services and supplies is to treat a condition as an alternative to confinement in a **hospital** or **skilled nursing facility** (This facility is defined in the Title XVIII of the Social Security Act).

Home Health Care Plan

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

Hospice

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

Hospice Benefit Period

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

Hospice Care Expenses

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

Hospital

A facility which meets all of these tests:

- it provides inpatient 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 stay of 18 or more hours in a row as a resident bed patient in a **hospital**.

Injury

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

Intensive Care Unit

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

Jaw Joint Disorder

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

Mail Order Pharmacy

An establishment where **prescription drugs** are legally dispensed by mail.

Medically Necessary

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

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

- Be care or treatment which is likely to produce as significant positive outcome as any alternative service or supply, both as to the **sickness** or **injury** involved and the person's overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply, both as to the **sickness** or **injury** involved and the person's overall health condition,
- Be a diagnostic procedure which is indicated by the health status of the person. It must be as likely to result in information that could affect the course of treatment as any alternative service or supply, both as to the **sickness** or **injury** involved and the person's overall health condition. It must be no more likely to produce a

negative outcome than any alternative service or supply, both as to the **sickness** or **injury** involved and the person's overall health condition, and

- As to diagnosis, care, and treatment, be no more costly (taking into account all health expenses incurred in connection with the treatment, service, or supply,) than any alternative service or supply to meet the above tests.

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

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

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

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

Medication Formulary

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

Member Dental Provider

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

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

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

Member Dental Provider Service Area

The area within a 50 mile radius of the **covered student's member dental provider**.

Negotiated Charge

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

Non-Occupational Disease

A **non-occupational disease** is a disease that does not:

- arise out of (or in the course of) any work for pay or profit, or
- result in any way from a disease that does.

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the **covered student**:

- is covered under any type of workers' compensation law, and
- is not covered for that disease under such law.

Non-Occupational Injury

A non-occupational injury is an accidental bodily **injury** that does not:

- arise out of (or in the course of) any work for pay or profit, or
- result in any way from an **injury** which does.

Non-Preferred Care

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

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

Non-Preferred Care Provider

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

Non-Preferred Pharmacy

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

Non-Preferred Prescription Drug Expense

An expense incurred for a **prescription drug** that is not a **Preferred prescription drug expense**.

One Sickness

A **sickness** and all recurrences and related conditions which are sustained by a **Covered Person**.

Orthodontic Treatment

Any

- medical service or supply, or
- dental service or supply,
- furnished to prevent or to diagnose or to correct a misalignment:
 - of the teeth, or
 - of the bite, or
 - of the jaws or jaw joint relationship,

whether or not for the purpose of relieving pain. Not included is:

- the installation of a space maintainer, or
- surgical procedure to correct malocclusion.

Out-of-Area Emergency Dental Care

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

Out-of-Pocket Limit

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

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

- **deductibles**,
- **copays**,
- expenses that are not **Covered Medical Expenses**,
- expenses for **designated care** or **Non-Preferred Care**,
- penalties,
- expenses for prescription drugs, and
- other expenses not covered by this Policy.

Outpatient Diabetic Self-Management Education Program

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

Partial Hospitalization

Continuous treatment consisting of no less than four hours and no more than twelve hours in any 24 hour period under a program based in a **hospital**.

Pervasive Developmental Disorder

A neurological condition, including Asperger's syndrome and Autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Pharmacy

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

Physician

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

Policy Year

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

Pre-Admission Testing:

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

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

If the person cancels the scheduled surgery, benefits are paid at the covered percentage that would have applied in the absence of this benefit.

Pre-Existing Condition

Any **injury**, **sickness**, or condition that was diagnosed or treated, or would have caused a prudent person to seek diagnosis or treatment, within six to twelve months prior to the **Covered Person's** effective date of insurance.

If, during the twelve months prior to the **Covered Person's** effective date of insurance, services are rendered or supplies are received in connection with a pregnancy or pregnancy is confirmed, the pregnancy is a pre-existing condition whether or not the pregnancy commenced during that twelve month period.

Domestic Violence is not considered a pre-existing condition. Genetic information may not be used as a pre-existing condition in the absence of a diagnosis.

Preferred Care

Care provided by:

- a **Covered Person's primary care physician**, or a **Preferred Care Provider**,
- 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 Policy, but only:

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

Preferred Prescription Drug Expense

An expense incurred for a **prescription drug** that:

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

Prescriber

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

Reasonable and Customary

The charge which is the smallest of:

- the **Actual Charge**,
- the charge usually made for a covered service by the provider who furnishes it, and
- the prevailing charge made for a covered service in the geographic area by those of similar professional standing.

Reasonable Charge

Only that part of a charge which is reasonable is covered. The **Reasonable Charge** for a service or supply is the lowest of:

- The provider's usual charge for furnishing it, and
- The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, and
- The charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

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

In determining the **Reasonable Charge** for a service or supply that is:

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

Aetna may take into account factors, such as:

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

Recognized Charge

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

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

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

In determining the **Recognized Charge** for a service or supply that is:

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

Aetna may take into account factors, such as:

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

Residential Treatment Facility

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

Respite Care

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

Room and Board

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

Routine Screening for Sexually Transmitted Disease

This is any laboratory test approved for such purposes by the FDA that specifically detects for infection by one or more agents of:

- Gonorrhea,
- Syphilis,
- Hepatitis,
- HIV, and
- Genital Herpes.

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,
- a daily medical records for each patient, and
- a **physician** available at all times.

Sound Natural Teeth

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

Surgery Center

A free standing ambulatory surgical facility that:

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

Surgical Assistant

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

Surgical Expenses

Charges by a **physician** for,

- a surgical procedure,
- a necessary preoperative treatment during a **hospital** stay in connection with such procedure, and
- usual postoperative treatment.

Surgical Procedure

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

Totally Disabled

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

Urgent Admission

One where the **physician** admits the person to the **hospital** due to:

- the onset of or change in a disease, or
- the diagnosis of a disease, or
- an **injury** caused by an **accident**,
- which, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within two weeks from the date the need for the confinement becomes apparent.

Urgent Condition

This means a sudden illness, **injury**, or condition, that:

- is severe enough to require prompt medical attention to avoid serious deterioration of the **Covered Person's** health,
- includes a condition which would subject the **Covered Person** to severe pain that could not be adequately managed without urgent care or treatment,
- does not require the level of care provided in the emergency room of a **hospital**, and
- requires immediate outpatient medical care that cannot be postponed until the **Covered Person's physician** becomes reasonably available.

Urgent Care Provider

This is:

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

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

Walk-in Clinic

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

CLAIM PROCEDURE

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

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

1. Bills must be submitted within 90 days from the date of treatment.
2. Payment for **Covered Medical Expenses** will be made directly to the hospital or physician concerned, unless bill receipts and proof of payment are submitted.
3. If itemized medical bills are available at the time the claim form is submitted, attach them to the claim form. Subsequent medical bills should be mailed promptly to the above address.
4. In the event of a disagreement over the payment of a claim, a written request to review the claim must be mailed to Aetna, within one year from the date appearing on the Explanation of Benefits.
5. You will receive an "Explanation of Benefits" when your claims are processed. The Explanation of Benefits will explain how your claim was processed, according to the benefits of your Student Accident and Sickness Insurance Plan.

Please submit all claims to:

Aetna Student Health
P.O. Box 15708
Boston, MA 02215 - 0014

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 requests must be made in writing within 180 days of receipt of the Explanation of Benefits (EOB). 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 15717
Boston, MA 02215-0014

PRESCRIPTION DRUG CLAIM PROCEDURE

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

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

ON CALL INTERNATIONAL

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

ACCIDENTAL DEATH AND DISMEMBERMENT (ADD) BENEFITS

Benefits are payable for the Accidental Death and Dismemberment of Covered Persons, up to a maximum of \$10,000.

NOTE: For most school Plans, ADD benefits are provided by Aetna Life Insurance Company (ALIC). However, in some states, ADD benefits may be provided through a contractual relationship between Chickering Claims Administrators, Inc. (CCA) and On Call International (On Call). ADD coverage provided through On Call is underwritten by United States Fire Insurance Company (USFIC). Please refer to your school's Policy to determine whether ALIC or USFIC underwrites ADD benefits for your specific Plan. Should you have questions or need to file a claim please contact (888) 834-4690.

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

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

MEDICAL EVACUATION AND REPATRIATION (MER) BENEFITS

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

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

WORLDWIDE EMERGENCY TRAVEL ASSISTANCE (WETA) SERVICES

On Call provides the following travel assistance services:

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

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

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

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

AETNA 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:

Chickering Claims Administrators, Inc.
P.O. Box 15708
Boston, MA 02215-0014
(888) 834-4690
www.aetnastudenthealth.com

Underwritten by:

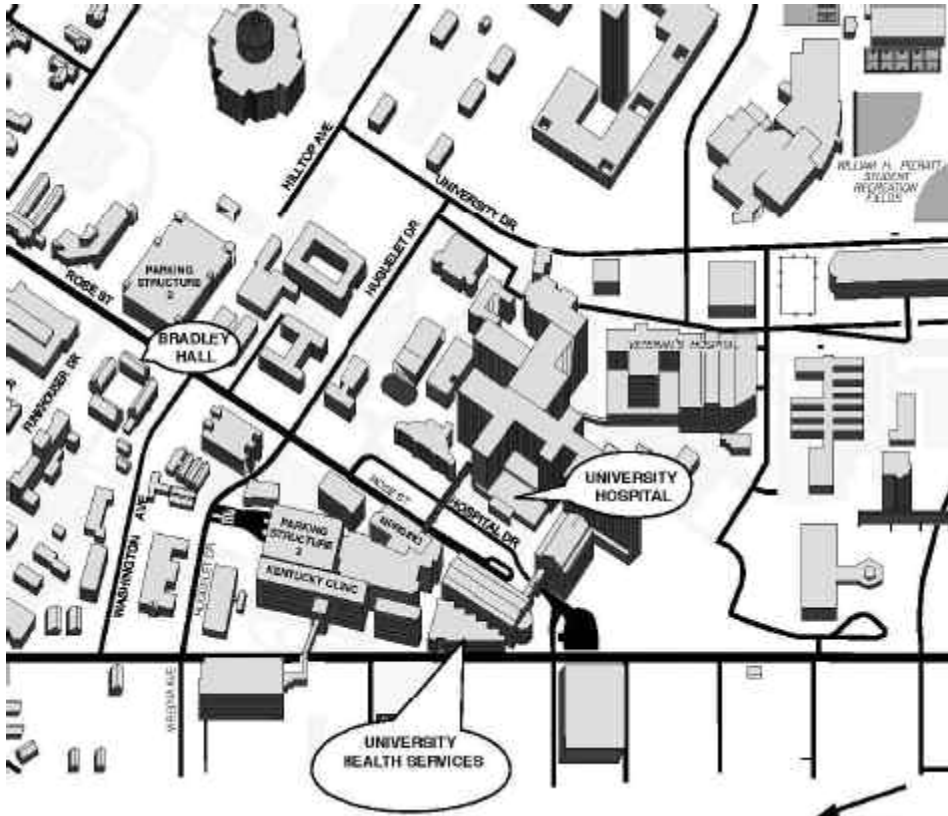
Aetna Life Insurance Company (ALIC)
151 Farmington Avenue
Hartford, CT 06156
(860) 273-0123

Policy No. 697418

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

UNIVERSITY OF KENTUCKY IMPORTANT PHONE NUMBERS

| | |
|--|----------------|
| Campus Police | 911 |
| UK Hospital Emergency Department | (859) 323-5901 |
| Kentucky Clinic Appointments | (859) 257-1000 |
| University Health Service..... | (859) 323-5823 |
| Appointments | (859) 323-2778 |
| Phone Information Nurse | (859) 323-4636 |
| Undergraduate Insurance Office..... | (859) 218-3208 |
| Graduate School Insurance Office..... | (859) 257-6608 |



The Plan is Underwritten by:
Aetna Life Insurance Company (ALIC)

Submit all Claims and Inquiries to:
Aetna Student Health
P.O. Box 15708
Boston, MA 02215-0014
(888) 834-4690
www.aetnastudenthealth.com

Aetna Pharmacy Management (APM)
(800) 238-6279

World Wide Emergency Travel Assistance
On Call International
(866) 525-1956 (within US)
Call collect (**dial U.S. access code**) plus **(603) 328-1956** (outside US)

For additional information on dental Plans:
(888) 834-4690
www.aetnastudenthealth.com

Your Home Page @ Aetna Navigator®

Once you're a member of the Plan, you have access to Aetna Navigator, your secure member website. It's packed with personalized benefits and health information. When you register with Aetna Navigator, you'll have your own personal home page to:

- View your most recent claims
- Order ID cards
- Print a temporary ID card
- See who is covered under your Plan
- And much more!

Visit *www.aetnastudenthealth.com*.