Dear New or Returning Emory Undergraduate, Graduate or Professional Student:

Welcome to Emory…or welcome back to Emory! We are very pleased to provide you with information about the 2009-10 Emory University Student Health Insurance Plan, underwritten by Aetna Life Insurance Company (Aetna) and administered by Aetna Student Health of Boston, MA. Aetna is one of the largest health insurance companies in the nation and is a name that students and their families recognize and can trust. We feel that this is an excellent insurance Plan, and we hope you will agree.

Emory University feels that it is extremely important that students have insurance coverage while they pursue their studies. If a student does not have adequate health insurance to cover the medical costs of an unexpected illness or Injury, their education could be interrupted or even terminated.

Therefore, all new and continuing degree-seeking and all international Emory students (including Oxford College) are required to either have health insurance that meets specific waiver criteria or enroll in the Emory University Student Health Insurance Plan (EUSHIP).

Students who wish to waive coverage in the Emory University Student Health Insurance Plan must use the Online Waiver System to waive out of the Emory/Aetna Plan. You will access the site by entering the Emory University OPUS system. The waiver site opened on Monday, April 20, 2009. The waiver process must be successfully completed by the first day of classes, August 27, 2009.

If you have not successfully completed a waiver by August 27, 2009, you will be automatically enrolled in the EUSHIP and billed for your insurance through Emory Student Financial Services.

If you are a new student admitted after August 27, 2009, your school or college will provide you with the necessary paperwork to complete the waiver process after the deadline. If you are currently insured, you will need to carefully review your health insurance Policy, verifying that your plan is domiciled in the United States and meets the necessary waiver requirements (including providing you with access to inpatient and outpatient care in Atlanta and not just in your home city or country). In order for an insurance plan to meet the Emory University mandatory insurance waiver criteria, the insurance plan must feature, at a minimum, all three of the following:

1. **Coverage** that allows the insured student to receive outpatient, emergency, specialist and inpatient care, diagnostic testing and procedures, and mental health inpatient and outpatient care, including alcohol and substance abuse treatment, in Atlanta, GA. (Please note that having coverage for emergency care only in Atlanta does not meet this waiver requirement.)

2. **An individual deductible not greater than $2,500** per Policy Year. If the annual deductible exceeds **$2,500**, the insured student must have an approved Healthcare Savings Account (HSA) that will allow the student to seek needed medical and mental health care when recommended by a health care provider and will cover all deductible expenses over $2,500. (Please note that simply saying “We can afford to pay a higher deductible” does not meet this waiver criteria. The student and/or family must have an HSA that meets the requirements listed.)

3. **The insurance must be provided by an insurance company domiciled in the United States or must be provided by an international insurance company with a United States partner for handling claims in the United States.**

Please be aware the Emory/Aetna Student Health Insurance Plan meets, and in most cases significantly exceeds, these required coverage minimums. The Emory/Aetna Plan has no pre-existing condition limitations. In addition, in 2009-10, the Plan will add an Emory Core Network, with **100%** coverage with no annual deductible for covered services at Emory Healthcare (specialists, ER and in-patient), after the copay of **$25** for specialists and **$50** for ER (waived if admitted to the hospital). For more information about the 2009-10 Emory/Aetna Plan, visit the Student
Health Services website at www.studenthealth.emory.edu. To read the 2009-10 Plan Brochure, go to www.aetnastudenthealth.com, click on “Find Your School” and enter Emory University. You will need Adobe Acrobat Reader to view the 2009-10 Brochure.

Students (including International Students) may purchase coverage for their eligible spouse, domestic partner or child(ren) by directly enrolling and paying through Aetna Student Health. Dependent coverage will have the option to pay via check or credit card on an annual or quarterly basis. Optional coverage and dependent coverage cannot be paid via Emory Student Financial Services. In addition, optional Aetna Dental Coverage is available through the Aetna Student Health website.

There is more information about insurance, EUSHCS fees and billing practices on our EUSHCS website. If you have questions regarding the online insurance waiver process for mandatory health insurance students, please contact the EUSHCS Student Health Insurance Office at (404) 727-7560 or by email at mandatoryinsurance@listserv.cc.emory.edu.

As with any health insurance plan, you need to carefully read the Brochure to make certain you understand the coverage and restrictions. However, I hope this overview will help you as you make your health insurance decisions for 2009-10 and beyond. If you have questions about the Emory University Student Health Insurance Plan, you can call the EUSHCS Student Health Insurance Office at (404) 727-7560.

Best wishes for a healthy and academically productive year!

Michael J. Huey, MD
Executive Director
Emory University Student Health and Counseling Services
THE EMORY UNIVERSITY STUDENT HEALTH INSURANCE PLAN
The Emory University Student Health Insurance Plan has been developed especially for Emory University students. The Plan provides coverage for illnesses and injuries that occur on and off campus, and includes special cost-saving features to keep the coverage as affordable as possible. Emory University is pleased to offer the Plan as described in this Brochure.

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

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

WHERE TO FIND HELP
In case of an emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

For questions about:
• Insurance Benefits
• Enrollment
• Claims Processing

Please contact:
Aetna Student Health
P.O. Box 15708
Boston, MA 02215-0014
(877) 261-8403

For questions about:
• ID Cards

ID cards will be issued as soon as possible and will be mailed to the preferred mailing address you have on file with OPUS. (International Students need to update your preferred address to an Atlanta address 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. **Note:** Please be advised you will receive a unique Aetna member ID number on your membership card.

For lost ID cards, contact:
Aetna Student Health
(877) 261-8403

Or visit [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com), click on “Find Your School” and enter “Emory University.” A personalized temporary identification card can also be obtained by registering for Aetna Navigator® or you can contact the Emory University Student Health Insurance Office at (404) 727-7560 to assist you.

For questions about:
• Enrollment Forms
• Online Waivers
• Compliance
• Certification
Please contact:
Emory University
Student Health Services Insurance Office
1525 Clifton Road
Atlanta, GA 30322
(404) 727-7560
mandatoryinsurance@listserv.cc.emory.edu

For questions about:
- Provider Listings

A complete list of providers can be found at the Emory University Health Services Insurance Office (EUSHS), or you can use Aetna’s DocFind® Service at either: www.aetna.com/docfind/custom/studenthealth/index.html or www.aetnastudenthealth.com. Click on “Find Your School” and enter “Emory University.” You can use DocFind to find out whether a specific provider belongs to Aetna’s network or to find Preferred Providers practicing in your area.

Or

Please contact:
Aetna Student Health
(877) 261-8403

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

Please contact:
On Call International at (866) 525-1956 (within U.S.).
If outside the U.S., call collect by dialing the U.S. access code plus (603) 328-1956. Please also visit www.aetnastudenthealth.com and visit your school-specific site for further information.

Worldwide Web Access:
Aetna Student Health: www.aetnastudenthealth.com

Got Questions? Get Answers with Aetna Navigator®
As an Aetna Student Health Insurance Plan 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 on to 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.
- Click on “Find Your School.”
- Enter “Emory University” and then click on “Search.”
- Click on Aetna Navigator and then the “Access Navigator” link.
- Follow the instructions for First Time User by clicking on the “Register Now” link.
- Select a user name, password and security phrase.

Your registration is now complete, and you can begin accessing your personalized information!

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.
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EMORY UNIVERSITY STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN
This is a brief description of the Accident and Sickness Medical Expense benefits available for Emory University students and their eligible dependents. The Plan is underwritten by Aetna Life Insurance Company (called Aetna). The exact provisions governing this insurance are contained in the Master Policy issued to the University and may be viewed at the University’s Student Health Services Insurance Office during business hours.

EMORY UNIVERSITY HEALTH INSURANCE REQUIREMENT
Health insurance coverage is mandatory for all new and continuing degree-seeking and all international students enrolled at Emory University (including Oxford College). Students are required to participate in the Emory University Student Health Insurance Plan or provide proof of other adequate health insurance as explained under the Enrollment section in this Brochure.

STUDENT COVERAGE
ELIGIBILITY
Students must actively and physically attend classes to be eligible for enrollment in this Plan. Students must actively attend classes for the first 31 days after the date for which coverage is purchased. Distance learning or online students taking home study, correspondence, or television courses are not eligible for coverage under the Plan.

POLICY PERIODS
The Effective and Termination Dates of Coverage for each school are shown below:
Registered Emory University Students:
- Allied Health: 8/15/09 to 8/14/10
- Business: 8/15/09 to 8/14/10
- Emory College: 8/15/09 to 8/14/10
- Graduate School of Arts and Sciences: 8/15/09 to 8/14/10
- Law School: 8/15/09 to 8/14/10
- Nursing School: 8/15/09 to 8/14/10
- Oxford Campus: 8/15/09 to 8/14/10
- School of Public Health: 8/15/09 to 8/14/10
- Theology: 8/15/09 to 8/14/10
- International Students: 8/01/09 to 7/31/10
- School of Medicine: 7/15/09 to 7/14/10

Please note that the Emory University Student Health Insurance Plan is an Annual Policy. Coverage purchased starting with the Fall 2009 Semester will continue through the following Summer 2010 Semester. Students enrolling during the Fall 2009 Semester are responsible for paying the insurance premium for the Spring/Summer Semester.

Enrollment only for the Spring/Summer Semester or the Summer Semester is restricted to students newly enrolled at Emory University at that time, or for students who lose their private insurance (parent’s or personal insurance) due to a change of life event. Examples of “change of life events” include: exceeding the age maximum on a parent’s policy, losing private insurance through loss of employment or divorce, etc.

Please Note: Students who graduate at the end of the Fall Semester, or who do not otherwise enroll in classes for the Spring/Summer Semester, will not be eligible to continue coverage under the Emory University Student Health Insurance Plan unless they purchase the continuation Plan within 31 days of the start of the Spring Semester.
**COVERAGE EFFECTIVE DATES**

<table>
<thead>
<tr>
<th>School of Medicine Students (1st Year through 4th Year Medical)</th>
</tr>
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<tr>
<td><strong>Annual Coverage</strong></td>
</tr>
<tr>
<td>7/15/09 – 7/14/10</td>
</tr>
<tr>
<td>Waiver Deadline Date: 8/27/09</td>
</tr>
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<table>
<thead>
<tr>
<th>International Students</th>
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</thead>
<tbody>
<tr>
<td><strong>Annual Coverage</strong></td>
</tr>
<tr>
<td>8/01/09 – 7/31/10</td>
</tr>
<tr>
<td>Waiver Deadline Date: 8/27/09</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>All Other Schools (including GSAS)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Coverage</strong></td>
</tr>
<tr>
<td>8/15/09 – 8/14/10</td>
</tr>
<tr>
<td>Waiver Deadline Date: 8/27/09</td>
</tr>
</tbody>
</table>

**ENROLLMENT**

**Mandatory Student Enrollment and Waiver Process:**
All degree-seeking and International Students who do not submit proof of comparable coverage through the Online Waiver system by the deadline date and who are automatically charged for the insurance, will have an effective date of coverage as indicated in “Coverage Effective Dates”. If you have other coverage and wish to waive enrollment in the Emory Student Health Insurance Plan as listed above, please submit proof of comparable coverage through the Online Waiver system by the waiver deadline dates of **August 27, 2009** for Fall Semester, **January 19, 2010** for new students enrolling for the Spring Semester, and **May 19, 2010** for new students enrolling for the Summer.

**To Waive Online:**
- Login to OPUS (<https://www.opus.emory.edu>) using your Network ID and password.
- First time users should select Obtain Network ID and Password and follow the prompts.

A completed waiver must be submitted by the posted deadline date.
## RATES

<table>
<thead>
<tr>
<th>School of Medicine</th>
<th>Annual Term</th>
<th>Spring/Summer Semester*</th>
<th>Summer Semester*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7/15/09 – 7/14/10</td>
<td>1/8/10 – 7/14/10</td>
<td>5/18/10 – 7/14/10</td>
</tr>
<tr>
<td>Student Only</td>
<td>$2,158</td>
<td>$1,112</td>
<td>$340</td>
</tr>
<tr>
<td>Spouse Only</td>
<td>$5,088</td>
<td>$2,620</td>
<td>$809</td>
</tr>
<tr>
<td>Child(ren) Only</td>
<td>$2,284</td>
<td>$1,177</td>
<td>$364</td>
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<table>
<thead>
<tr>
<th>International Students</th>
<th>Annual Term</th>
<th>Spring/Summer Semester*</th>
<th>Summer Semester*</th>
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<tbody>
<tr>
<td></td>
<td>8/1/09 – 7/31/10</td>
<td>1/8/10 – 7/31/10</td>
<td>5/18/10 – 7/31/10</td>
</tr>
<tr>
<td>Student Only</td>
<td>$2,158</td>
<td>$1,212</td>
<td>$440</td>
</tr>
<tr>
<td>Spouse Only</td>
<td>$5,088</td>
<td>$2,860</td>
<td>$1,049</td>
</tr>
<tr>
<td>Child(ren) Only</td>
<td>$2,284</td>
<td>$1,284</td>
<td>$471</td>
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</table>

<table>
<thead>
<tr>
<th>All Other Schools</th>
<th>Annual Term</th>
<th>Spring/Summer Semester*</th>
<th>Summer Semester*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8/15/09 – 8/14/10</td>
<td>1/8/10 – 8/14/10</td>
<td>5/18/10 – 8/14/10</td>
</tr>
<tr>
<td>Student Only</td>
<td>$2,158</td>
<td>$1,293</td>
<td>$521</td>
</tr>
<tr>
<td>Spouse Only</td>
<td>$5,088</td>
<td>$3,053</td>
<td>$1,241</td>
</tr>
<tr>
<td>Child(ren) Only</td>
<td>$2,284</td>
<td>$1,371</td>
<td>$557</td>
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</table>

The rates above include both the premiums for the Student Health Plan underwritten by Aetna Life Insurance Company and Emory University’s $20 administrative charge. (Please note that the Emory administrative charge was not previously listed separately. For 2009-10, the amount listed as premium has been reduced by $20 to account for the Emory administrative charge.)

*Enrollment is only open for newly enrolled students at Emory during the Spring/Summer Semester, or Summer Semester (for students who have lost their personal or private insurance due to a change of life event).

### 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.

### CHANGE IN STATUS/QUALIFYING EVENT

Please note that if you are not enrolling during the Fall Semester, you will be unable to enroll during the Spring or Summer Semesters. Open enrollment during the Spring or Summer Semesters is only available to students newly enrolled at Emory University during that semester. After the enrollment deadline, only those students who have involuntarily lost health insurance coverage through a “Qualifying Life Event” such as (1) removal from a parent’s health insurance plan after achieving a landmark birthday that disqualifies them from a parent’s health insurance plan, or (2) losing private insurance through loss of employment or divorce, may apply for late enrollment in the
Emory University Student Health Insurance Plan. These students must provide proof that they have lost insurance through another group (certificate and letter of ineligibility) within 31 days of the qualifying event. Premiums are not pro-rated, and the student will be responsible for paying full premium for the term in which they enroll. Coverage under the Aetna Student Health Insurance Plan will be effective the day after the prior coverage terminates, or the date the student enrolls and pays the correct premium, whichever is later.

**DEPENDENT COVERAGE**

**ELIGIBILITY**

Eligible students who do enroll may also cover their eligible dependents. Dependent eligibility and coverage period must be concurrent with the insured student’s. Eligible dependents are defined as, the spouse or domestic partner (as defined below) residing with the covered student and unmarried children under 19 years of age if not attending school, or through age 25 provided that the child is chiefly dependent upon the covered student for support and maintenance and that in each Policy Year, since reaching age 19, the child has been enrolled for five months or more as a full-time student at a postsecondary institution of higher learning or if not so enrolled, would have been eligible to be so enrolled and was prevented from enrolling due to illness or injury. The child must reside with and be fully supported by the covered student. Dependent eligibility expires concurrently with that of the covered student.

Students must enroll their eligible dependents and must pay the required premium as described below:
1. By the deadline date for dependent enrollment (by September 15, 2009 for Fall Semester, February 8, 2010 for the dependents of new students enrolling for the Spring/Summer Semester, and June 18, 2010 for the dependents of new students enrolling for the Summer Semester.)
2. Within 31 days after you acquire a new dependent.
3. Within 31 days after a dependent terminates coverage under another health insurance plan. The premium rate for the late addition of dependents will not be pro-rated. The student must pay the full premium for the enrollment period and the dependent will be made effective the date the enrollment application and premium are received and approved by Aetna Student Health.

To be considered a Domestic Partner, and eligible to be covered as a dependent of an insured student under the Emory University Student Health Insurance Plan, you must meet the following criteria:
1. The Domestic Partnership must have been in existence for a period of 12 consecutive months prior to the application for coverage under this Plan.
2. The members of the Domestic Partnership are not legally married to anyone.
3. The members of the Domestic Partnership must be 18 years of age or older.
4. The members of the Domestic Partnership are not related by blood closer than would bar marriage in the State of Georgia and are mentally competent to consent to contract.
5. The members of the Domestic Partnership are each other’s sole Domestic Partner, and intend to remain so indefinitely and are responsible for their common welfare. Students who elect to enroll their Domestic Partner are required to complete an Affidavit for Domestic Partnership, which is available at EUSHCS.

**NEWBORN INFANT AND ADOPTED CHILD COVERAGE**

A child born to a Covered Person shall be covered for Accident, Sickness, premature birth, and congenital defects, for 31 days from the date of birth. At the end of this 31 day period, coverage will cease under the Emory University 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 pro-rated premium, starting from the date of birth.

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

For information or general questions on dependent enrollment, contact Aetna Student Health at (877) 261-8403.
PREFERRED PROVIDER NETWORK

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

To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider*. It is to your advantage to use a Preferred Provider because savings may be achieved from the Negotiated Charges these providers have agreed to accept as payment for their services. A complete listing of participating providers, including those in the Emory Core Provider Network, is available at the Emory University Student Health Services Insurance Office.

You may also obtain information regarding Preferred Providers by contacting Aetna Student Health at (877) 261-8403, or through the Internet by accessing DocFind at www.aetnastudenthealth.com.

1. Click on “Enter DocFind”
2. Select Emory University from the “Find Your School” drop down box (top right of the screen)
3. Click “go”
4. Click on “Find a Doctor: DocFind” (left side of screen)
5. Click on “Find a Doctor, Hospital, or Pharmacy”
6. Click on “Enter DocFind”
7. Select zip code, city or count
8. Enter criteria
9. Select Provider Category
10. Select Provider Type
11. Select Plan Type – Student Health Plans
12. Select “Start Search” or “More Options”
13. “More Options” enter criteria and “Search”

*Preferred Providers are independent contractors and are neither employees nor agents of Emory University, Aetna Student Health, or Aetna.

PRE-CERTIFICATION REQUIREMENTS

Pre-admission certification is designed to help you receive quality, cost-effective medical care.

- All inpatient admissions, including length of stay, must be certified by contacting Aetna Student Health.
- 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 Health Insurance Plan.
- 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.

PRE-CERTIFICATION OF NON-EMERGENCY INPATIENT ADMISSIONS

The patient, Physician, or hospital must telephone at least three business days prior to the planned admission.

NOTIFICATION OF EMERGENCY ADMISSIONS

The patient, patient’s representative, Physician, or hospital must telephone within one business day following admission.

Aetna Student Health
Attention: Managed Care Dept.
P.O. Box 15708
Boston, MA 02215-0014
(877) 261-8403
REFERRAL REQUIREMENTS

PLEASE NOTE: THERE IS A MANDATORY REFERRAL REQUIREMENT UNDER THIS PLAN. STUDENTS AND DEPENDENTS (INCLUDING DEPENDENT CHILDREN AGE 12 YEARS AND OVER) ARE REQUIRED TO BE SEEN AT EMORY UNIVERSITY STUDENT HEALTH AND COUNSELING SERVICES (EUSHCS) FIRST (OR AT OXFORD COLLEGE STUDENT HEALTH CENTER FOR OXFORD STUDENTS). IF APPROPRIATE, EUSHCS WILL REFER THE COVERED PERSON TO AN OUTSIDE PROVIDER FOR TREATMENT. THERE WILL BE NO COVERAGE FOR TREATMENT RECEIVED WITHOUT A REFERRAL FROM EUSHCS.

Emory University Student Health and Counseling Services (EUSHCS) offers students primary and specialty services coordinated by EUSHCS. All covered students and covered dependents age 12 years or older in need of medical care should, except in the case of a medical emergency, first seek treatment and be evaluated at EUSHCS. You may be referred to an outside medical provider if required medical care is unavailable at the time of service. Students on the Oxford Campus must obtain a referral from the Oxford Campus Student Health Center. If you are enrolled in the Student Health Insurance Plan, a referral is necessary to receive benefits under your Student Health Insurance Plan, except in the following circumstances:

1. Treatment of an Emergency Medical Condition; or
2. When the EUSHCS (or the Oxford College Student Health Center for Oxford students) is closed; or
3. When the service is rendered at another facility during breaks or vacation periods; or
4. When medical care is received by a Covered Person who is more than 50 miles from campus; or
5. When medical care is received by a Covered Person who is no longer able to use the EUSHCS due to a change in student status; or
6. Ob/Gyn services; or
7. Dermatological services; or
8. All X-rays, Labs, and High Cost Procedures.

A new referral must be obtained if continuous treatment is being received from one Policy Year to the next.

NOTE: Dependents under age 12 are not permitted to use the EUSHS and do not need a referral from EUSHS in order to receive benefits for covered services.
DESCRIPTION OF BENEFITS

Please Note: The Emory University 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 Emory University 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 Emory University, you may view it at Student Health Services Insurance Office or you may contact Aetna Student Health at (877) 261-8403.

This Plan will never pay more than $250,000 in a Policy Year or more than $250,000 per lifetime, per covered Injury or covered Sickness, or more than $1,500 in a Policy Year for pharmacy benefits. Additional Plan maximums may also apply. Some illnesses may cost more to treat and health care providers may bill you for what the Plan does not cover.

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

SUMMARY OF BENEFITS CHART

<table>
<thead>
<tr>
<th>DEDUCTIBLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>The following deductibles are applied before Covered Medical Expenses for NON-CORE NETWORK Preferred Care are payable:</td>
</tr>
<tr>
<td>Student: <strong>$200</strong> per Policy Year</td>
</tr>
<tr>
<td>Spouse: <strong>$200</strong> per Policy Year</td>
</tr>
<tr>
<td>Child: <strong>$200</strong> per Policy Year</td>
</tr>
</tbody>
</table>

| The following deductibles are applied before Covered Medical Expenses for Non-Preferred Care are payable: |
| Student: **$400** per Policy Year |
| Spouse: **$400** per Policy Year |
| Child: **$400** per Policy Year |

<table>
<thead>
<tr>
<th>COINSURANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Medical Expenses are payable at the coinsurance percentage specified below, after any applicable deductible, up to a maximum benefit of <strong>$250,000</strong> per covered Injury or covered Sickness per Lifetime).</td>
</tr>
</tbody>
</table>

All coverage is based on Reasonable Charges unless otherwise specified.
<table>
<thead>
<tr>
<th>Inpatient Hospitalization Benefits</th>
</tr>
</thead>
</table>
| **Hospital Room and Board Expenses** | **Covered Medical Expenses** including, but not limited to, inpatient services following a mastectomy or lymph node dissection as advised by the attending physician in consultation with the patient are payable as follows: 
Core Network: **100%** of Negotiated Charge. 
Preferred Care: **80%** of the Negotiated Charge for the first **$50,000**; **100%** of Negotiated Charge thereafter. 
Non-Preferred Care: **60%** of the Reasonable Charge for a semi-private room for the first **$50,000**; **100%** of the Reasonable Charge thereafter. |
| **Intensive Care Unit Expenses** | **Covered Medical Expenses** are payable as follows: 
Core Network: **100%** of Negotiated Charge. 
Preferred Care: **80%** of the Negotiated Charge for the first **$50,000**; **100%** of Negotiated Charge thereafter. 
Non-Preferred Care: **60%** of the Reasonable Charge for the first **$50,000**; **100%** of the Reasonable Charge thereafter. |
| **Miscellaneous Hospital Expenses** | **Covered Medical Expenses** are payable as follows: 
Core Network: **100%** of Negotiated Charge. 
Preferred Care: **80%** of the Negotiated Charge for the first **$50,000**; **100%** of Negotiated Charge thereafter. 
Non-Preferred Care: **60%** of the Reasonable Charge for the first **$50,000**; **100%** of the Reasonable Charge thereafter. 

**Covered Medical Expenses** include, but are not limited to: laboratory tests, X-rays, surgical dressings, anesthesia, supplies and equipment use, and medicines. |
| **Physician Hospital Visit/Consultation Expenses** | **Covered Medical Expenses** for charges for the non-surgical services of the attending Physician, or a consulting Physician, are payable as follows: 
Core Network: **100%** of Negotiated Charge. 
Preferred Care: **80%** of the Negotiated Charge for the first **$50,000**; **100%** of Negotiated Charge thereafter. 
Non-Preferred Care: **60%** of the Reasonable Charge for the first **$50,000**; **100%** of the Reasonable Charge thereafter. 

Benefits are limited to **one** visit per day. |
| **Licensed Nurse Expenses** | Benefits include charges incurred by a Covered Person who is confined in a hospital as a resident bed-patient, and requires the services of a registered nurse or licensed practical nurse. 

**Covered Expenses** for a Licensed Nurse are covered as follows: 
Core Network: **100%** of Negotiated Charge. 
Preferred Care: **80%** of the Negotiated Charge for the first **$50,000**; **100%** of Negotiated Charge thereafter. 
Non-Preferred Care: **60%** of the Reasonable Charge for the first **$50,000**; **100%** of the Reasonable Charge thereafter. 

For purposes of determining this maximum, a shift means eight consecutive hours. |
### Surgical Benefits (Inpatient and Outpatient)

<table>
<thead>
<tr>
<th>Surgical Expenses</th>
<th>Covered Medical Expenses for charges for surgical services, performed by a Physician, are payable as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Core Network: 100% of Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Preferred Care: 80% of the Negotiated Charge for the first $50,000; 100% of Negotiated Charge thereafter.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: 60% of the Reasonable Charge for the first $50,000; 100% of the Reasonable Charge thereafter.</td>
</tr>
<tr>
<td>Anesthetist and Assistant Surgeon Expenses</td>
<td>Covered Medical Expenses for the charges of an anesthetist and an assistant surgeon, during a surgical procedure, are payable as follows:</td>
</tr>
<tr>
<td></td>
<td>Core Network: 100% of Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Preferred Care: 80% of the Negotiated Charge for the first $50,000; 100% of Negotiated Charge thereafter.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: 60% of the Reasonable Charge for the first $50,000; 100% of the Reasonable Charge thereafter.</td>
</tr>
<tr>
<td>Ambulatory Surgical Expenses</td>
<td>Covered Medical Expenses for outpatient surgery performed in an ambulatory surgical center are payable as follows:</td>
</tr>
<tr>
<td></td>
<td>Core Network: 100% of Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Preferred Care: 80% of the Negotiated Charge for the first $50,000; 100% of Negotiated Charge thereafter.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: 60% of the Reasonable Charge for the first $50,000; 100% of the Reasonable Charge thereafter.</td>
</tr>
</tbody>
</table>

**Covered Medical Expenses** must be incurred on the day of the surgery or within 48 hours after the surgery.

### Outpatient Benefits

**Covered Medical Expenses** include but are not limited to: Physician’s office visits, hospital or outpatient department or emergency room visits, durable medical equipment, clinical lab, or radiological facility.

<table>
<thead>
<tr>
<th>Hospital Outpatient Department or Walk-In Clinic Expenses</th>
<th>Covered Medical Expenses for outpatient treatment in a hospital are payable as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Core Network: After a $25 copay, 100% of the Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Preferred Care: After a $25 copay, 80% of the Negotiated Charge for the first $50,000; 100% of Negotiated Charge thereafter.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: After a $25 deductible, 60% of the Reasonable Charge for the first $50,000; 100% of the Reasonable Charge thereafter.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Room Expenses</th>
<th>Covered Medical Expenses incurred for treatment of an Emergency Medical Condition are payable as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Core Network: After a $50 copay (waived if admitted), 100% of the Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Preferred Care: After a $50 copay (waived if admitted), 80% of the Negotiated Charge for the first $50,000; 100% of Negotiated Charge thereafter.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: After a $50 deductible (waived if admitted), 80% of the Reasonable Charge for the first $50,000; 100% of the Reasonable Charge thereafter.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Urgent Care Expenses</th>
<th>Benefits include charges for treatment by an urgent care provider.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Please note: A COVERED PERSON should not seek medical care or treatment from an urgent care provider if their illness, injury, or condition, is an emergency condition. The COVERED PERSON should go directly to the emergency room of a hospital or call 911 for ambulance and medical assistance.</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>Benefits include charges for an urgent care provider to evaluate and treat an urgent condition.</td>
</tr>
<tr>
<td>----------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Covered Medical Expenses</strong> for urgent care treatment are payable as follows:</td>
<td></td>
</tr>
<tr>
<td><strong>Core Network:</strong> 100% of Negotiated Charge.</td>
<td></td>
</tr>
<tr>
<td><strong>Preferred Care:</strong> 80% of the Negotiated Charge for the first $50,000; 100% of Negotiated Charge thereafter.</td>
<td></td>
</tr>
<tr>
<td><strong>Non-Preferred Care:</strong> 60% of the Reasonable Charge for the first $50,000; 100% of the Reasonable Charge thereafter.</td>
<td></td>
</tr>
<tr>
<td><em>No benefit will be paid under any other part of this Plan for charges made by an urgent care provider to treat a non-urgent condition.</em></td>
<td></td>
</tr>
<tr>
<td>Non-urgent care includes, but is not limited to, the following:</td>
<td></td>
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<tr>
<td>• routine or preventive care (this includes immunizations),</td>
<td></td>
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<tr>
<td>• follow-up care,</td>
<td></td>
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<tr>
<td>• physical therapy,</td>
<td></td>
</tr>
<tr>
<td>• elective surgical procedures, and</td>
<td></td>
</tr>
<tr>
<td>• any lab and radiological exams which are not related to the treatment of the urgent condition.</td>
<td></td>
</tr>
</tbody>
</table>

| **Ambulance Expenses** | **Covered Medical Expenses** incurred 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 are payable as follows: |  |
|------------------------|---------------------------------------------------------------------------------------------------|  |
| **Core Network:** 100% of Negotiated Charge. |  |
| **Preferred Care:** 80% of the Negotiated Charge for the first $50,000; 100% of Negotiated Charge thereafter. |  |
| **Non-Preferred Care:** 60% of the Reasonable Charge for the first $50,000; 100% of the Reasonable Charge thereafter. |  |

| **Pre-Admission Testing Expenses** | **Covered Medical Expenses** for Pre-Admission testing charges while an outpatient before scheduled surgery are payable as follows: |  |
|-----------------------------------|---------------------------------------------------------------------------------------------------|  |
| **Core Network:** 100% of Negotiated Charge. |  |
| **Preferred Care:** 80% of the Negotiated Charge for the first $50,000; 100% of Negotiated Charge thereafter. |  |
| **Non-Preferred Care:** 60% of the Reasonable Charge for the first $50,000; 100% of the Reasonable Charge thereafter. |  |
| *Please see the Definition of Pre-Admission Testing on page 45 for more detailed information on this benefit.* |  |

| **Physician’s Office Visits** | **Covered Medical Expenses** are payable as follows: |  |
|-------------------------------|---------------------------------------------------------------------------------------------------|  |
| **Core Network:** After a $25 copay, 100% of the Negotiated Charge. |  |
| **Preferred Care:** After a $25 copay, 80% of the Negotiated Charge for the first $50,000; 100% of Negotiated Charge thereafter. |  |
| **Non-Preferred Care:** After a $25 deductible, 60% of the Reasonable Charge for the first $50,000; 100% of the Reasonable Charge thereafter. |  |

| **Laboratory and X-Ray Expenses** | **Covered Medical Expenses** are payable as follows: |  |
|-----------------------------------|---------------------------------------------------------------------------------------------------|  |
| **Core Network:** 100% of Negotiated Charge. |  |
| **Preferred Care:** 80% of the Negotiated Charge for the first $50,000; 100% of Negotiated Charge thereafter. |  |
| **Non-Preferred Care:** 60% of the Reasonable Charge for the first $50,000; 100% of the Reasonable Charge thereafter. |  |
| High Cost Procedures Expenses | **Covered Medical Expenses** include charges incurred by a **Covered Person** are payable as follows:
Core Network: 100% of Negotiated Charge.
Preferred Care: 80% of the Negotiated Charge for the first $50,000; 100% of Negotiated Charge thereafter.
Non-Preferred Care: 60% of the Reasonable Charge for the first $50,000; 100% of the Reasonable Charge thereafter.

For purposes of this benefit, “High Cost Procedure” means any outpatient procedure costing over $200.

*Please see the Definition of High Cost Procedures on page 41 for more detailed information on this benefit.* |
| 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 and Hearing 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.

Physical therapy must be for rehabilitation only after a surgery. All other therapy must be initiated within six months of the onset of symptoms. All therapy must be provided by a therapist who is licensed in accordance with state law, and practicing within the scope of their license. All therapy must be completed within 60 days of the date that it starts.

Therapy Expense Benefits are covered at:
Core Network: After a $25 copay, 100% of the Negotiated Charge.
Preferred Care: After a $25 copay, 80% of the Negotiated Charge for the first $50,000; 100% of Negotiated Charge thereafter.
Non-Preferred Care: After a $25 deductible, 60% of the Reasonable Charge for the first $50,000; 100% of the Reasonable Charge thereafter.

**Covered Medical Expenses** also include charges incurred by a **Covered Person** for the following types of therapy provided on an outpatient basis:
- Radiation therapy; or
- Chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy.

Benefits for these types of therapies are payable for **Covered Medical Expenses** on the same basis as any other sickness. |
| Durable Medical Equipment Expenses | **Covered Medical Expenses** are payable as follows:
Core Network: 100% of Negotiated Charge.
Preferred Care: 80% of the Negotiated Charge for the first $50,000; 100% of Negotiated Charge thereafter.
Non-Preferred Care: 60% of the Reasonable Charge for the first $50,000; 100% of the Reasonable Charge thereafter. |
<table>
<thead>
<tr>
<th>Prosthetic Devices Expenses</th>
<th>Benefits include charges for: artificial limbs, or eyes, and other non-dental prosthetic devices, as a result of an accident or sickness.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Covered Medical Expenses</strong> do not include: eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet.</td>
</tr>
<tr>
<td></td>
<td><strong>Covered Medical Expenses</strong> are payable as follows:</td>
</tr>
<tr>
<td></td>
<td>Core Network: 100% of Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Preferred Care: 80% of the Negotiated Charge for the first $50,000; 100% of Negotiated Charge thereafter.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: 60% of the Reasonable Charge for the first $50,000; 100% of the Reasonable Charge thereafter.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dental Injury Expenses</th>
<th><strong>Covered Medical Expenses</strong> include dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Natural teeth damaged, lost, or removed, or</td>
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<tr>
<td></td>
<td>- 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.</td>
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<tr>
<td></td>
<td>Any such teeth must have been:</td>
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<tr>
<td></td>
<td>- Free from decay, or</td>
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<td></td>
<td>- In good repair, and</td>
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<td></td>
<td>- Firmly attached to the jawbone at the time of the injury.</td>
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<td></td>
<td><em>The treatment must be done in the calendar year of the accident or the next one.</em></td>
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<td></td>
<td>If:</td>
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<td></td>
<td>- Crowns (caps), or</td>
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<td></td>
<td>- Dentures (false teeth), or</td>
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<td>- Bridgework, or</td>
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<td></td>
<td>- In-mouth appliances,</td>
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<td></td>
<td>are installed due to such injury. <strong>Covered Medical Expenses</strong> include only charges for:</td>
</tr>
<tr>
<td></td>
<td>- The first denture or fixed bridgework to replace lost teeth,</td>
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<tr>
<td></td>
<td>- The first crown needed to repair each damaged tooth, and</td>
</tr>
<tr>
<td></td>
<td>- An in-mouth appliance used in the first course of orthodontic treatment after the injury.</td>
</tr>
<tr>
<td></td>
<td>Surgery needed to:</td>
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<tr>
<td></td>
<td>- Treat a fracture, dislocation, or wound.</td>
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<tr>
<td></td>
<td>- Cut out cysts, tumors, or other diseased tissues.</td>
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<tr>
<td></td>
<td>- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.</td>
</tr>
<tr>
<td></td>
<td>Non-surgical treatment of infections or diseases. This does not include those of, or related to, the teeth.</td>
</tr>
<tr>
<td></td>
<td><strong>Covered Medical Expenses</strong> are payable as follows:</td>
</tr>
<tr>
<td></td>
<td>Core Network: 100% of Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Preferred Care: 80% of the Negotiated Charge for the first $50,000; 100% of Negotiated Charge thereafter.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: 60% of the Reasonable Charge for the first $50,000; 100% of Reasonable Charge thereafter.</td>
</tr>
<tr>
<td></td>
<td>Benefits are limited to $200 per tooth, per condition/accident, per Policy Year.</td>
</tr>
</tbody>
</table>
| **Allergy Testing Expenses** | Benefits include charges incurred for diagnostic testing of allergies and immunology services. **Covered Medical Expenses** include, but are not limited to, charges for the following: laboratory tests, physician office visits, including visits to administer injections, prescribed medications for testing of the allergy, including any equipment used in the administration of prescribed medication, and other medically necessary supplies and services. **Covered Medical Expenses** are payable as follows:  
**Core Network:** 100% of Negotiated Charge.  
**Preferred Care:** 80% of the Negotiated Charge for the first $50,000; 100% of Negotiated Charge thereafter.  
**Non-Preferred Care:** 60% of the Reasonable Charge for the first $50,000; 100% of the Reasonable Charge thereafter. |
| **Diagnostic Testing for Learning Disabilities Expenses** | **Covered Medical Expenses** for diagnostic testing for:  
- Attention Deficit Disorder, or  
- Attention Deficit Hyperactive Disorder, or  
- Dyslexia.  
are payable up to a maximum of $1,000 per year as follows:  
**Core Network:** 100% of Actual Charge.  
**Preferred Care:** 80% of the Actual Charge for the first $50,000; 100% of Negotiated Charge thereafter.  
**Non-Preferred Care:** 60% of the Reasonable Charge for the first $50,000; 100% of the Reasonable Charge thereafter.  
Once a Covered Person has been diagnosed with one of these conditions, medical treatment will be payable as detailed under the outpatient Treatment of Mental and Nervous Disorders portion of this Policy. |
| **Routine Physical Exam Expenses** | Benefits include expenses for a routine physical exam performed by a physician.  
A routine physical exam is a medical exam given by a physician, for a reason other than to diagnose or treat a suspected or identified injury or sickness. Included as a part of the exam are:  
- X-rays, lab, and other tests given in connection with the exam, and  
- Materials for the administration of immunizations for infectious disease and testing for tuberculosis.  
**Core Network:** 100% of Negotiated Charge.  
**Preferred Care:** 80% of the Negotiated Charge for the first $50,000; 100% of Negotiated Charge thereafter.  
**Non-Preferred Care:** 60% of the Reasonable Charge for the first $50,000; 100% of the Reasonable Charge thereafter.  
For a **child** who is a covered dependent:  
- The physical exam must include at least:  
  - A review and written record of the patient's complete medical history,  
  - A check of all body systems, and  
  - A review and discussion of the exam results with the patient or with the parent or guardian.  
For all exams given to covered dependent **under age two**, **Covered Medical Expenses** will **not include** charges for the following:  
- **More than** six exams performed during the first year of the child's life,  
- **More than** two exams performed during the second year of the child's life. |
For all exams given to a covered student or covered dependent, **Covered Medical Expenses** will **not include** charges for **more than:**

- One exam in 12 months in a row.

Also included as **Covered Medical Expenses** are charges made by a physician for one annual routine gynecological exam.

A referral is not required for this benefit.

Benefits are limited to **one** visit per Policy Year.

### Immunizations Expenses

**Covered Medical Expenses** include:

- charges incurred by a covered student and dependent spouse/qualified domestic partner for the materials for the administration of appropriate immunizations, and testing for tuberculosis, and
- charges incurred by a covered dependent up to age 19, for the materials for the administration of appropriate immunizations, when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics.

**Core Network:** 100% of Negotiated Charge.

**Preferred Care:** 80% of the Negotiated Charge for the first $50,000; 100% of Negotiated Charge thereafter.

**Non-Preferred Care:** 60% of the Reasonable Charge for the first $50,000; 100% of the Reasonable Charge thereafter.

### Consultant or Specialist Expenses

**Covered Medical Expenses** include the expenses for the services of a consultant or specialist, when referred by the School Health Services. The services must be requested by the attending physician for the purpose of confirming or determining to confirm or determine a diagnosis.

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

**Core Network:** 100% of Negotiated Charge.

**Preferred Care:** 80% of the Negotiated Charge for the first $50,000; 100% of Negotiated Charge thereafter.

**Non-Preferred Care:** 60% of the Reasonable Charge for the first $50,000; 100% of the Reasonable Charge thereafter.

### Mental Health Benefits

#### Inpatient Expenses

**Covered Medical Expenses** for the diagnosis and treatment of mental illnesses are payable on the same basis as any other condition.

**Covered Medical Expenses** also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission, whereby two days of partial hospitalization may be exchanged for one day of full hospitalization.

#### Outpatient Expenses

**Covered Medical Expenses** for the diagnosis and treatment of mental illnesses are payable on the same basis as any other condition.
### Substance Abuse Benefits

| Inpatient Expenses | Covered Medical Expenses for the treatment of alcoholism and drug addiction conditions while confined as an inpatient in a hospital or facility licensed for such treatment are payable on the same basis as any other condition.

Covered Medical Expenses also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission, whereby two days of partial hospitalization may be exchanged for one day of full hospitalization.

Coverage includes treatment rendered by a hospital or facility duly licensed in Georgia that specializes in the treatment of alcohol abuse. |
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Outpatient Expenses</td>
<td>Covered Medical Expenses for outpatient treatment of alcohol or drug addiction conditions are payable on the same basis as any other condition.</td>
</tr>
</tbody>
</table>

### Maternity Benefits

| Maternity Expenses | Covered Medical Expenses include inpatient care of the Covered Person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery.

Any decision to shorten such minimum coverages shall be made by the attending Physician in consultation with the mother. In such cases, covered services may include: home visits, parent education, and assistance and training in breast or bottle-feeding.

Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other sickness.

A referral is not required for this benefit. |
|---|---|
| Well Newborn Nursery Care Expenses | Benefits include charges for routine care of a Covered Person’s newborn child as follows:
- hospital charges for routine nursery care during the mother’s confinement, but for not more than four days for a normal delivery,
- physician’s charges for circumcision, and
- physician’s charges for visits to the newborn child in the hospital and consultations, but for not more than one visit per day.

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

### Additional Benefits

| Prescription Drug Benefits | Prescription Drug Benefits are payable as follows:

Preferred Care Pharmacy: Following a $25 copay for each Brand Name Prescription Drug or a $15 copay for each Generic Prescription Drug.

Non-Preferred Care Pharmacy: Following a $25 deductible for each Brand Name Prescription or a $15 deductible for each Generic Prescription Drug.

Covered Medical Expenses are payable up to a maximum of $1,500 per Policy Year.

This Pharmacy benefit is provided to cover Medically Necessary Prescriptions associated with a covered Sickness or Accident occurring during the Policy Year. Please use your Aetna Student Health ID card when obtaining your prescriptions. |
Prior Authorization is required for certain Prescription Drugs, including Imitrex, certain stimulants, growth hormones and for any Prescription quantities larger than a 30-day supply. *(This is only a partial list.)*

Students who require more than 30 days of ongoing prescription medications for travel or study abroad should contact Aetna Pharmacy Management at (800) 238-6279.

Medications not covered by this benefit include, but are not limited to: allergy sera, drugs whose sole purpose is to promote or to stimulate hair growth, appetite suppressants, and non-self injectables. *(This is only a partial list; please see the EUSHS for a complete list of all medications that are not covered by this benefit.)*

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

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

In addition to the benefit listed to the left, students are also eligible for a $500 drug benefit at the student health center after a $10 copay per fill.

<table>
<thead>
<tr>
<th>Diabetic Testing Supplies and Treatment Expenses</th>
<th>Covered Medical Expenses</th>
<th>Diabetic Testing Supplies are limited to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>• Lancet devices;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• glucose monitors;</td>
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<td></td>
<td></td>
<td>• test strips;</td>
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<td>• Blood glucose monitors and blood glucose monitors for the legally blind;</td>
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<td></td>
<td>• Test strips for blood glucose monitors;</td>
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<td>• Visual reading and urine test strips;</td>
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<tr>
<td></td>
<td></td>
<td>• Insulin;</td>
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<td></td>
<td></td>
<td>• Injection aids;</td>
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<tr>
<td></td>
<td></td>
<td>• Syringes;</td>
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<tr>
<td></td>
<td></td>
<td>• Lancets;</td>
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<tr>
<td></td>
<td></td>
<td>• Insulin pumps, infusion devices, and appurtenances thereto;</td>
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<tr>
<td></td>
<td></td>
<td>• Oral hypoglycemic agents;</td>
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<tr>
<td></td>
<td></td>
<td>• Podiatric appliances for prevention of complications associated with diabetes; and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Glucagon emergency kits.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Covered Medical Expenses</strong> are payable as any Sickness.</td>
</tr>
</tbody>
</table>

| Hypodermic Needles Expenses | Covered Medical Expenses | Covered Medical Expenses for hypodermic needles and syringes used in the treatment of diabetes are payable as any Sickness. |

<table>
<thead>
<tr>
<th>Outpatient Diabetic Self-management Education Programs Expenses</th>
<th>Covered Medical Expenses</th>
<th>Covered Medical Expenses for outpatient diabetic self-management education programs are payable as any Sickness.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Please see the definition on page 40 of this Brochure for more information on Diabetic Self-Management Education Programs.</strong></td>
</tr>
</tbody>
</table>
| Temporomandibular Joint Dysfunction (TMJ) | **Covered Medical Expenses** include charges incurred by a **Covered Person** for surgical and non-surgical treatment of Temporomandibular Joint (TMJ) Dysfunction.  
Temporomandibular Joint Dysfunction Expense Benefits may include examinations, radiographs for diagnostic purposes, splint therapy, diagnostic or therapeutic masticatory muscle and temporomandibular joint injections and are payable as any Sickness. |
|---|---|
| Outpatient Contraceptive Drugs And Devices And Outpatient Contraceptive Services Expenses | **Covered Medical Expenses** include:  
- Charges incurred for contraceptive drugs and devices that by law need a **physician's prescription**, and that have been approved by the FDA.  
- Related outpatient contraceptive services such as:  
  - Consultations;  
  - Exams;  
  - Procedures; and  
  - Other medical services and supplies.  
Benefits will be paid on the same basis as any other outpatient prescription drug.  
**Covered Medical Expenses** do not include:  
- charges for services which are covered to any extent; under any other part of this Plan, or under any other group plan, and  
- charges incurred for contraceptive services, while confined as an inpatient, and  
- charges incurred for duplicate, lost, stolen, or damaged, contraceptive devices.  
A referral is not required for this benefit. |
| Pap-smear Expenses | **Covered Medical Expenses** include one annual routine Pap-smear screening for women age 18 and older or more frequently based on the recommendation of the woman's physician.  
Core Network: 100% of Negotiated Charge.  
Preferred Care: 80% of the Negotiated Charge for the first $50,000; 100% of Negotiated Charge thereafter.  
Non-Preferred Care: 60% of the Reasonable Charge for the first $50,000; 100% of the Reasonable Charge thereafter.  
A referral is not required for this benefit. |
| Mammogram Expense Benefits | Benefits are payable for charges for mammograms. The charges must be incurred while a **Covered Person** is insured for these benefits.  
Benefits will be paid for **Expenses** incurred for the following:  
1. A baseline mammogram for women between the ages of 35 to 40, and  
2. A mammogram every two years, or more frequently based on the recommendation of the women's **physician** for women ages 40 to 50,  
3. A mammogram on an annual basis for women 50 years of age and older.  
4. For any "female at risk" when ordered by a **physician**. "Female at risk" means a woman who:  
   - has a personal history of breast cancer,  
   - a personal history of biopsy proven benign breast disease,  
   - a grandmother, mother, sister or daughter who has had breast cancer, or  
   - not given birth prior to age 30.  
Core Network: 100% of Negotiated Charge.  
Preferred Care: 80% of the Negotiated Charge for the first $50,000; 100% of Negotiated Charge thereafter. |
<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Preferred Care: 60%</td>
<td>of the Reasonable Charge for the first $50,000; 100% of the Reasonable Charge thereafter.</td>
</tr>
<tr>
<td>A referral is not required for this benefit.</td>
<td></td>
</tr>
<tr>
<td>Elective Abortion Expenses</td>
<td>If a Covered Person incurs expenses in connection with an elective abortion, a benefit is payable.</td>
</tr>
<tr>
<td></td>
<td>Benefits are payable up to a maximum of $500 per year as follows:</td>
</tr>
<tr>
<td></td>
<td><strong>Covered Medical Expenses</strong> are payable on the same basis as any other condition.</td>
</tr>
<tr>
<td></td>
<td>This benefit is in lieu of any other Policy benefits.</td>
</tr>
<tr>
<td>Chlamydia Screening Test Expense</td>
<td><strong>Covered Medical Expenses</strong> include charges incurred by a <strong>Covered Person</strong> for an annual Chlamydia screening test.</td>
</tr>
<tr>
<td></td>
<td>As used above, “Chlamydia screening test” means 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. Benefits will be paid for Chlamydia screening expenses incurred for:</td>
</tr>
<tr>
<td></td>
<td>• Women who are:</td>
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<td></td>
<td>o under the age of 30 if they are sexually active; and</td>
</tr>
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<td></td>
<td>o at least 30 years old if they have multiple risk factors.</td>
</tr>
<tr>
<td></td>
<td>• Men who have multiple risk factors.</td>
</tr>
<tr>
<td></td>
<td><strong>Covered Medical Expenses</strong> are payable as follows:</td>
</tr>
<tr>
<td></td>
<td>Core Network: 100% of Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Preferred Care: 80% of the Negotiated Charge for the first $50,000; 100% of Negotiated Charge thereafter.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: 60% of the Reasonable Charge for the first $50,000; 100% of the Reasonable Charge thereafter.</td>
</tr>
<tr>
<td>Routine Colorectal Cancer Screening Expense</td>
<td>Even though not incurred in connection with a sickness or injury, benefits include charges for colorectal cancer examination and laboratory tests, for any nonsymptomatic person age 50 or more, or a symptomatic person under age 50, for the following:</td>
</tr>
<tr>
<td></td>
<td>• One fecal occult blood test every 12 months in a row</td>
</tr>
<tr>
<td></td>
<td>• A Sigmoidoscopy at age 50 and every three years thereafter</td>
</tr>
<tr>
<td></td>
<td>• One digital rectal exam every 12 months in a row</td>
</tr>
<tr>
<td></td>
<td>• A double contrast barium enema, once every five years</td>
</tr>
<tr>
<td></td>
<td>• A colonoscopy, once every ten years</td>
</tr>
<tr>
<td></td>
<td>• Virtual colonoscopy</td>
</tr>
<tr>
<td></td>
<td>• Stool DNA</td>
</tr>
<tr>
<td></td>
<td><strong>Core Network</strong>: 100% of Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Preferred Care: 80% of the Negotiated Charge for the first $50,000; 100% of Negotiated Charge thereafter.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: 60% of the Reasonable Charge for the first $50,000; 100% of the Reasonable Charge thereafter.</td>
</tr>
<tr>
<td>Routine Prostate Cancer Screening Expense</td>
<td><strong>Covered Medical Expense</strong> includes charges incurred for lab tests for routine prostate specific antigen tests as follows:</td>
</tr>
<tr>
<td></td>
<td>• for a covered male age 40 to 45, if ordered by a physician; and</td>
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<tr>
<td></td>
<td>• for covered male age 45 or older, one each Policy Year.</td>
</tr>
<tr>
<td>Benefit</td>
<td>Covered Medical Expenses</td>
</tr>
<tr>
<td>-----------------------------</td>
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</tr>
<tr>
<td>Surgical Second Opinion</td>
<td>Core Network: 100% of Negotiated Charge. Preferred Care: 80% of the Negotiated Charge for the first $50,000; 100% of Negotiated Charge thereafter. Non-Preferred Care: 60% of the Reasonable Charge for the first $50,000; 100% of the Reasonable Charge thereafter.</td>
</tr>
<tr>
<td>Elective Surgical Second</td>
<td>Core Network: After a $25 copay, 100% of the Negotiated Charge. Preferred Care: After a $25 copay, 80% of the Negotiated Charge for the first $50,000; 100% of Negotiated Charge thereafter. Non-Preferred Care: After a $25 deductible, 60% of the Reasonable Charge for the first $50,000; 100% of the Reasonable Charge thereafter.</td>
</tr>
<tr>
<td>Opinion Expenses</td>
<td>Acupuncture in Lieu of Anesthesia Expenses</td>
</tr>
<tr>
<td>Dermatological Expenses</td>
<td>Core Network: 100% of Negotiated Charge Preferred Care: 80% of the Negotiated Charge for the first $50,000; 100% of Negotiated Charge thereafter. Non-Preferred Care: 60% of the Reasonable Charge for the first $50,000; 100% of the Reasonable Charge thereafter.</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
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<td>---------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Podiatric Expenses</td>
<td><strong>Covered Medical Expenses</strong> include charges for podiatric services, provided on an outpatient basis following an injury. Benefits are payable on the same basis as any other condition. Expenses for routine foot care, such as trimming of corns, calluses, and nails, are not <strong>Covered Medical Expenses</strong>.</td>
</tr>
</tbody>
</table>
| Home Health Care Expenses             | **Covered Medical Expenses** include charges incurred by a Covered Person for home health care services made by a home health agency pursuant to a home health care Plan, but only if:  
(a) The services are furnished by, or under arrangements made by, a licensed home health agency,  
(b) The services are given under a home care Plan. This Plan must be established pursuant to the written order of a physician, and the physician must renew that Plan every 60 days. Such physician must certify that the proper treatment of the condition would require inpatient confinement in a hospital (or skilled nursing facility) if the services and supplies were not provided under the home health care Plan. The physician must examine the Covered Person at least once a month,  
(c) Except as specifically provided in the home health care services, the services are delivered in the patient's place of residence on a part-time, intermittent visiting basis while the patient is confined,  
(d) The care starts within seven days after discharge from a hospital as an inpatient, and  
(e) The care is for the same condition that caused the hospital confinement, or one related to it.  
**Core Network: 100% of Negotiated Charge.**  
**Preferred Care: 80% of the Negotiated Charge for the first $50,000; 100% of Negotiated Charge thereafter.**  
**Non-Preferred Care: 60% of the Reasonable Charge for the first $50,000; 100% of the Reasonable Charge thereafter.**  
Benefits are limited to 40 visits per Policy Year. |                                                                           |
| Transfusion or Dialysis of Blood Expenses | **Covered Medical Expenses** include charges for the transfusion or dialysis of blood, including the cost of: whole blood, blood components, and the administration thereof. Benefits are payable on the same basis as any other condition. |                                                                           |
| Skilled Nursing Facility Expenses      | **Covered Medical Expenses** include charges incurred by a Covered Person for confinement in a skilled nursing facility for treatment rendered:  
- in lieu of confinement in a hospital as a full time inpatient, or  
- within 24 hours following a hospital confinement and for the same or related cause(s) as such hospital confinement.  
**Covered Medical Expenses** are payable on the same basis as any other condition.  
*Benefits for Skilled Nursing require pre-certification.* |                                                                           |
| Rehabilitation Facility Expenses      | **Covered Medical Expenses** include charges incurred by a Covered Person for confinement as a full time inpatient in a rehabilitation facility. Confinement in the rehabilitation facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of hospital or skilled nursing facility confinement.  
**Covered Medical Expenses** for Rehabilitation Facility Expense are payable on the same basis as any other condition.  
*Benefits for Rehabilitation Facility expenses require pre-certification.* |                                                                           |
**Vision Care Exam Expenses**

Benefits include charges for any service shown below, which is furnished by a legally qualified ophthalmologist or optometrist.

**Routine Eye Exam Expenses:** Charges for a complete eye exam that includes refraction. A routine eye exam does not include charges for a contact lens exam.

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

**Covered Medical Expenses** will be payable as follows:

- **Core Network:** 100% of Negotiated Charge up to a maximum of $500 per Policy Year.
- **Preferred Care:** 100% of Negotiated Charge up to a maximum of $500 per Policy Year.
- **Non-Preferred Care:** 100% of Negotiated Charge up to a maximum of $500 per Policy Year.

Maximum benefit of $500 per Policy Year.

**Limitations**

The following limitations apply:

No benefits will be payable for a charge which is:

- 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 any vision care supply.
- For a service received while the person is not a Covered Person.
- For a service which does not meet professionally accepted standards.

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<table>
<thead>
<tr>
<th>Vision Care Supply Expenses</th>
<th>Benefits include charges for eyeglasses (lenses and frames) and contact lenses, when prescribed by a legally qualified ophthalmologist or optometrist.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Covered Medical Expenses</strong> for vision care supplies will be payable as follows:</td>
</tr>
<tr>
<td></td>
<td><strong>Core Network:</strong> 100% of Negotiated Charge up to a maximum of $500 per Policy Year.</td>
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<tr>
<td></td>
<td><strong>Preferred Care:</strong> 100% of Negotiated Charge up to a maximum of $500 per Policy Year.</td>
</tr>
<tr>
<td></td>
<td><strong>Non-Preferred Care:</strong> 100% of Negotiated Charge up to a maximum of $500 per Policy Year.</td>
</tr>
<tr>
<td></td>
<td>Maximum benefit of $500 per Policy Year.</td>
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<tr>
<td></td>
<td>If contact lenses are required to correct visual acuity to 20/40 or better in the better eye, and such correction cannot be obtained with conventional lenses, or if aphakic lenses are prescribed after cataract surgery has been performed, the maximum benefit payable during a Covered Person’s lifetime for all such contact and aphakic lenses is $500.</td>
</tr>
<tr>
<td></td>
<td><strong>Limitations</strong></td>
</tr>
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<td></td>
<td>The following limitations apply:</td>
</tr>
<tr>
<td></td>
<td>No benefits will be payable for a charge which is:</td>
</tr>
<tr>
<td></td>
<td>• For a vision care supply that is a <strong>Covered Medical Expense</strong> in whole or in part, under any other part of this Policy, or under any other group plan.</td>
</tr>
<tr>
<td></td>
<td>• For a vision care supply for which a benefit is provided in whole or in part, under any workers' compensation law, or any other law of like purpose.</td>
</tr>
<tr>
<td></td>
<td>• For special procedures. This means things such as orthoptics or vision training.</td>
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<td></td>
<td>• For any supply which does not meet professionally accepted standards.</td>
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<tr>
<td></td>
<td>• For a supply received while the person is not covered.</td>
</tr>
</tbody>
</table>
| Treatment Of Autism Expenses (if plan covers neurological disorders, then must cover autism) | **Covered Medical Expenses** include expenses incurred by a **Covered Person** for services for the diagnosis and treatment of autism. Autism Expense Benefits are payable for **Covered Medical Expenses** on the same basis as any other sickness.  
  
Autism means:  
A developmental neurological disorder, appearing in the first three years of life, which affects normal brain functions and is manifested by compulsive, ritualistic behavior and severely impaired social interaction and communication skills. |
|---|---|
| Child Wellness Services Expense Benefits | The charges below are included as **Covered Medical Expense** even though they are not incurred in connection with an injury or disease. They are included only for a dependent child under six years of age.  
  
Child Wellness Services Expense Benefits are charges for Child Wellness Services.  
  
"Child Wellness Services" means **physician**-delivered or **physician** supervised services which shall include coverage for services delivered at the intervals and scope stated below. Included are:  
  - A review and written record of the child's complete medical history.  
  - Physical examination.  
  - Developmental and behavioral assessment.  
  - Anticipatory guidance.  
  - Appropriate immunizations.  
  - Laboratory tests.  
  
All of the above will be in keeping with prevailing medical standards.  
  
**Covered Medical Expense** will only include charges of one **physician** for Child Wellness Services performed at birth and at approximately each of the following ages:  
  - 2 months;  
  - 4 months;  
  - 6 months;  
  - 9 months;  
  - 12 months;  
  - 15 months;  
  - 18 months;  
  - 2 years;  
  - 3 years;  
  - 4 years; and  
  - 5 years.  
  
Benefits are payable on the same basis as any other expense.  
  
Any applicable deductible amount per Policy Year will not apply to this benefit.  
  
Not covered are charges incurred for:  
  - services which are covered to any extent under any other part of this Plan;  
  - services which are for diagnosis or treatment of a suspected or identified injury or disease;  
  - services not performed by a **physician** or under his or her direct supervision;  
  - medicines, drugs, appliances, equipment or supplies; or  
  - dental exams. |
<table>
<thead>
<tr>
<th>Clinical Trials – Childhood Cancer</th>
<th><strong>Covered Medical Expenses</strong> include coverage for routine patient care costs incurred for covered dependent children in connection with approved clinical trial programs for the treatment of children’s cancer with respect to those dependent children who have been diagnosed with cancer prior to their 19th birthday and are enrolled in an approved clinical trial program for treatment of children’s cancer and are not otherwise eligible for benefits, payments, or reimbursements from any other third party payors. Benefits are payable as any Sickness.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Anesthesia Expenses (Must cover if dental services are covered on Plan.)</td>
<td><strong>Covered Medical Expenses</strong> for general anesthesia and associated hospital or ambulatory surgical facility charges in conjunction with dental care provided to a person insured or otherwise covered under such Plan are payable as any Sickness if such person is: 1. Seven years of age or younger or is developmentally disabled; 2. An individual for which a successful result cannot be expected from dental care provided under local anesthesia because of a neurological or other medically compromising condition of the insured; or 3. An individual who has sustained extensive facial or dental trauma, unless otherwise covered by workers’ compensation insurance.</td>
</tr>
<tr>
<td>Telemedicine Expenses</td>
<td>Telemedicine is the practice by a duly licensed <strong>Physician</strong> or other health care provider acting within the scope of such provider’s practice, of health care delivery, diagnosis, consultation, treatment, or transfer of medical data by means of audio, video, or data communications which are used during a medical visit with a patient or which are used to transfer medical data obtained during a medical visit with a patient. Standard telephone, facsimile transmissions, unsecured electronic mail, or a combination thereof do not constitute telemedicine services. <strong>Covered Medical Expenses</strong> are payable as any Sickness.</td>
</tr>
<tr>
<td>Ovarian Cancer Surveillance Screening Expenses</td>
<td><strong>Covered Medical Expenses</strong> include coverage for surveillance tests for women age 35 and over at risk for ovarian cancer. Benefits are payable as any Sickness.</td>
</tr>
</tbody>
</table>

**ADDITIONAL AVAILABLE BENEFITS**  
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](http://www.aetnastudenthealth.com).

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

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

**Aetna Weight Management℠ Discount Program**: Helps you achieve your weight loss goals and develop a balanced approach to your active lifestyle. This program provides members and their eligible family members’
access to discounts on Jenny Craig® weight loss programs and products. Start with a FREE 30-day trial membership* then choose either a 6* or 12* month program** that's right for you. You also receive individual weight loss consultations, personalized menu planning, tailored activity planning, motivational materials and much more.

* Offer is good at participating centers in the United States, Canada and Puerto Rico and through Jenny Direct at-home. Additional cost for all food purchases and shipping where applicable.

** Additional weekly food discounts will grow throughout the year, based on active participation.

Find a meal plan that works for you at eDiets®: Get a personalized plan for healthy eating that fits your lifestyle, and save 25% 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!

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!

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

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

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

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

*Not all topics discussed within the Audio Health Library are Covered Expenses under your Health Insurance Plan.

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

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

Beginning Right® Maternity Program: Give your baby a healthy start. Our Beginning Right Maternity Program comes with your Health Insurance Plan. Use it throughout your pregnancy and after your baby is born. If you have health conditions or risk factors that may need special attention, we can help. Our nurses can give you personal case management to help you find ways to lower your risks. The more you know the better chance you have for good health … for you and your baby.
Aetna Natural Products and Services℠ Discount Program: Offers members access to reduced rates on services from natural therapy professionals, including acupuncturists, chiropractors, massage therapists and dietetic counselors, and access to discounts on over-the-counter vitamins, herbal and nutritional supplements and health-related products, such as foot care and natural body care products.

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

With our Aetna Dental® PPO insurance plan, participating dentists have agreed to provide services at a negotiated rate for covered services, as well as reduced fees for certain non-covered services such as cosmetic tooth whitening, so you generally pay less out of pocket. Enroll and search dentists online at www.aetnastudenthealth.com.

Price:
- $260 Student
- $268 Spouse
- $359 Child(ren)

*In Texas, the Preferred Provider Organization (PPO) plan is known as the Participating Dental Network (PDN).

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

Price:
- $25 Student Only
- $44 Student + 1 Dependent
- $63 Student + 2 Dependents

*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 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.

The Aetna Dental PPO and Dental Indemnity insurance plans are underwritten by Aetna Life Insurance Company.
GENERAL PROVISIONS

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

RIGHT OF RECOVERY REIMBURSEMENT
As used herein, the term “Third Party”, means any party that is, or may be, or is claimed to be responsible for injuries or illness to a Covered Person. Such injuries or illness are referred to as “Third Party Injuries.” “Third Party” includes any party responsible for payment of expenses associated with the care of treatment of Third Party injuries.

If the Covered Person has a claim for damages or a right to recover damages from a Third Party or parties for an illness or injury for which benefits are payable under this Plan, Aetna may have a right for recovery. Aetna’s right of recovery shall be limited to the recovery of any benefits paid for identical Covered Medical Expenses under this Plan, but shall not include non-medical items. Money received for future medical care or pain and suffering may not be recovered. Aetna’s right of recovery may include compromise settlements. The Covered Person’s attorney must inform Aetna of any legal action or settlement agreement at least ten days prior to settlement or trial. Aetna will then notify the Covered Person of the amount it seeks to recover for covered benefits paid. Aetna’s recovery may be reduced by the pro-rata share of the Covered Person’s attorney’s fees and expenses of litigation.

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

EXTENSION OF BENEFITS
If Basic Sickness Expense coverage for a Covered Person ends while he/she is totally disabled, benefits will continue to be available for expenses incurred for that person, only while the Covered Person continues to be totally disabled. Benefits will end 90 days from the date coverage ends.

If a Covered Person is confined to a hospital or under treatment for a covered condition on the date his/her insurance terminates, charges incurred during the continuation of that hospital confinement or for that treatment of the covered condition shall also be included in the term “Expense”, but only while they are incurred during the 90 day period following such termination of insurance benefits will continue to be available for a Covered Person who incurs medical expenses directly relating to a pregnancy that began before coverage under the Policy ceased. This benefit will be covered only for the period of the pregnancy. Termination of Insurance Benefits are payable under the 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 INSURANCE
Benefits are payable under this Policy only for those Covered Expenses incurred while the Policy is in effect as to the Covered Person. No benefits are payable for expenses incurred after the date the insurance terminates, except as may be provided under the Extension of Benefits provision.
**TERMINATION OF STUDENT COVERAGE**

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

1. the date this Policy terminates,
2. the last day for which any required premium has been paid,
3. the date on which the **covered student** withdraws from the school because of entering the armed forces of any country. Premiums will be refunded on a pro-rata basis when application is made within 90 days from withdrawal,
4. 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:

1. For a child, on the first premium due date following the first to occur of:
   a. the date the child is no longer chiefly dependent upon the student for support and maintenance;
   b. the date of the child’s marriage;
   c. the child’s 26th birthday, provided that the child is chiefly dependent upon the **covered student** for support and maintenance and that in each **Policy Year**, since reaching age 19, the child has been enrolled for five months or more as a full-time student at a postsecondary institution of higher learning or if not so enrolled, would have been eligible to be so enrolled and was prevented from enrolling due to illness or injury; and
   d. the child’s 19th birthday if not attending school as stated in (3) above.
2. The date the **covered student** fails to pay any required premium.
3. For the spouse, the date the marriage ends in divorce or annulment.
4. The date dependent coverage is deleted from this Policy.
5. For a domestic partner, the earlier to occur of:
   a. the date this Policy no longer allows coverage for domestic partners, and
   b. the date of termination of the domestic partnership. In that event, a completed and signed declaration of Termination of Domestic Partnership must be provided to the Policyholder.
6. The date the **dependent** ceases to be in an eligible class.

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

**INCAPACITATED DEPENDENT CHILDREN**

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

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

The child's insurance under this provision will end on the earlier of:

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

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

<table>
<thead>
<tr>
<th>Continuation of Coverage</th>
<th>Three months</th>
<th>Six months</th>
<th>Nine months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$1,400</td>
<td>$2,333</td>
<td>$2,914</td>
</tr>
<tr>
<td>Spouse/Domestic Partner</td>
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<td>$5,290</td>
<td>$6,614</td>
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<tr>
<td>Child(ren)</td>
<td>$1,423</td>
<td>$2,369</td>
<td>$2,963</td>
</tr>
</tbody>
</table>

**EXCLUSIONS**

This Policy does not cover nor provide benefits for:

1. 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.

2. 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.

3. 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.

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

5. 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.

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

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

8. 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 cleft lip, 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.
9. 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.

10. 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.

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

12. Expenses incurred after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits Provision.

13. Expenses incurred for services normally provided without charge by the school and covered by the school fee for services.

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

15. Expenses incurred by a Covered Person not a United States Citizen for services performed within the Covered Person's home country.


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

18. Expenses incurred for experimental or investigative procedures.

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

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

24. Expenses incurred for gastric bypass, and any restrictive procedures, for weight loss.

25. Expenses incurred for breast reduction/mammoplasty.

26. Expenses incurred for gynecomastia (male breasts).

27. Expenses incurred for any sinus surgery, except for acute purulent sinusitis.
28. Expenses incurred for acupuncture, unless services are rendered for anesthetic purposes.

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

30. Expenses incurred for hearing aids, the fitting, or prescription of hearing aids.

31. Expenses incurred for routine hearing exams.

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

33. Expenses 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.

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

35. Expenses for charges that are not reasonable charges, as determined by Aetna.

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

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

38. Expenses for routine dental exams, routine hearing exams, or other preventive services and supplies, except to the extent coverage of such services, or supplies is specifically provided in the Policy.

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 from one Policy Year to the next.

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

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

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

Complications of Pregnancy
Conditions which require hospital stays before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy. These conditions are:
• acute nephritis or nephrosis, or
• cardiac decompensation or missed abortion, or
• similar conditions as severe as these.
Not included are (a) false labor, occasional spotting or physician prescribed rest during the period of pregnancy, (b) morning sickness, (c) hyperemesis gravidarum and preclampsia, and (d) similar conditions not medically distinct from a difficult pregnancy.

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

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 person identified as a domestic partner in the "Declaration of Domestic Partnership" which is completed and signed by the covered student, and (c) the covered student’s unmarried child under the age of 19 years (or through age 25 if a student provided that the dependent meets the eligibility requirements as stated in the Termination of Dependent Coverage section of this Policy). 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 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 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:
  - A physician’s office, or
  - Hospital outpatient department, or emergency room, or
  - Clinical laboratory, or
  - Radiological facility, or other similar facility, licensed by the applicable state, or the state in which the facility is located.
Home Health Agency
- an agency licensed as a home health agency by the state in which home health care services are provided, or
- an agency certified as such under Medicare, or
- an agency approved as such by Aetna.

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

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

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

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

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

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

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

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

Injury
Bodily injury caused by an accident. This includes related conditions and recurrent symptoms of such injury.
**Intensive Care Unit**
A designated ward, unit, or area within a hospital for which a specified extra daily surcharge is made and which is staffed and equipped to provide, on a continuous basis, specialized or intensive care or services, not regularly provided within such hospital.

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

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

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

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

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

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

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

**Medication Formulary**
A listing of prescription drugs which have been evaluated and selected by Aetna clinical pharmacists, for their therapeutic equivalency and efficacy. This listing includes both brand name and generic prescription drugs. This listing is subject to periodic review, and modification by Aetna.
Member Dental Provider
Any dental provider who has entered into a written agreement to provide to covered students the dental care described under the Dental Expense Benefit.

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

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

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

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:
  o of the teeth, or
  o of the bite, or
  o 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.

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 not less than four hours and not more than twelve hours in any 24 hour period under a program based in a hospital.

Pharmacy
An establishment where prescription drugs are legally dispensed.

Physician
(a) legally qualified physician licensed by the state in which he/she practices, 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 physical condition,
• the charge for the surgery is a Covered Medical Expense under this Plan,
• the tests are done while the person is not confined as an inpatient in a hospital,
• the charges for the tests would have been covered if the person was confined as an inpatient in a hospital,
• the test results appear in the person's medical record kept by the hospital or surgery center where the surgery is to be done, and
• the tests are not repeated in or by the hospital or surgery center where the surgery is done.

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

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

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

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

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

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

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

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

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

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

which, while not needing an emergency admission, is severe enough to require confinement as an inpatient in a hospital within 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. You will receive an “Explanation of Benefits” when your claims are processed. The Explanation of Benefits will explain how your claim was processed, according to the benefits of your Student Accident and Sickness Insurance Plan.

HOW TO APPEAL A CLAIM
In the event a Covered Person disagrees with how a claim was processed, he/she may request a review of the decision. The Covered Person's 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
PREFERRED CARE
When obtaining a covered Prescription, please present your Aetna ID card to Preferred Pharmacy along with your applicable Co-pay. The Pharmacy will submit a claim to Aetna for the drug.

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. A claim form is available at Student Health Services or by calling (800) 238-6279. You will be reimbursed for covered medications directly by Aetna. Please note, in addition to your copay, you may be required to pay the difference between the retail price you paid for the prescription drug and the amount Aetna would have paid if you had presented your ID card and the Pharmacy had billed Aetna directly.

Information regarding Preferred Care Pharmacy locations is available by accessing the Internet at: www.aetnastudenthealth.com.

NON-PREFERRED CARE
You may obtain your Prescription from a Non-Preferred Pharmacy and be reimbursed by submitting a completed Aetna Prescription Drug claim form. You will be reimbursed for covered medications at the Reasonable Charge allowance, less any applicable deductible, directly by Aetna. You will be responsible for any amount in excess of the Reasonable Charge.

Please Note: You will be required to pay in full at the time of service for all Prescriptions dispensed at a Non-Participating Pharmacy.

Claim forms, Pharmacy locations, and claims status information can be obtained by contacting Aetna Pharmacy Management at (800) 238-6279. When submitting a claim, please include all Prescription receipts, indicate that you attend Emory University, and include your name, address, and student identification number.
ON CALL INTERNATIONAL

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

Accidental Death and Dismemberment (ADD) Benefits

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

NOTE: For most school Plans, ADD benefits are provided by Aetna Life Insurance Company (ALIC). However, in some states, ADD benefits may be provided through a contractual relationship between Chickering Claims Administrators, Inc. (CCA) and On Call International (On Call). ADD coverage provided through On Call is underwritten by United States Fire Insurance Company (USFIC). Please refer to your school's Policy to determine whether ALIC or USFIC underwrites ADD benefits for your specific Plan. Should you have questions or need to file a claim please contact (877) 261-8403.

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

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

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

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

WORLDWIDE EMERGENCY TRAVEL ASSISTANCE (WETA) SERVICES
On Call provides the following travel assistance services:

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

NOTE: In order to obtain coverage, all MER and WETA services must be provided and arranged through On Call. Reimbursement will NOT be provided for any such services not provided and arranged through On Call. Although certain medical services may be covered under the terms of the Covered Person’s Student Health Insurance Plan (the “Plan”), On Call does not provide coverage for medical treatment rendered by doctors, hospitals, pharmacies or other health care providers. Coverage for such services will be provided in accordance with the terms of the Plan and exclusions and limitations may apply.
To obtain MER and WETA benefits/services, or for any questions related to those benefits/services, please call On Call International at the following numbers listed on the On Call ID card provided to Covered Persons when they enroll in the Plan: Toll Free 1- (866) 525-1956 or collect 1-(603) 328-1956. All Covered Persons should carry their On Call ID cards when traveling.

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

**AETNA NAVIGATOR®**

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

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

**How do I register?**

- Go to [www.aetnastudenthealth.com](http://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.

Your registration is now complete, and you can begin accessing your personalized information!

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

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

**NOTICE**

Aetna considers nonpublic personal member information confidential and has policies and procedures in place to protect the information against unlawful use and disclosure. When necessary for your care or treatment, the operation of your health Plan, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals, and other caregivers), vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. Participating Network/Preferred Providers are also required to give you access to your medical records within a reasonable amount of time after you make a request. By enrolling in the Plan, you permit us to use and disclose this information as described above on behalf of yourself and your dependents. To obtain a copy of our Notice of Privacy Practices describing in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Customer Services number on your ID card or visit [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com).
Administered by:
Aetna Student Health
P.O. Box 15708
Boston, MA 02215-0014
(877) 261-8403
www.aetnastudenthealth.com

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

Policy No. 812808

The Emory University Student Health Insurance Plan (the “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.