

2009 - 2010

Student Health Insurance Plan Brochure

Rice University



RICE

*Underwritten by:
Aetna Life Insurance Company
(ALIC)*

Policy Number 890436

Where to Find Help

In case of an emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.
For non-emergency situations please visit or call Rice University Student Health Services at **(713) 348-4966**.

For questions about:

- * Insurance Benefits
- * Enrollment
- * Claims Processing

- * Pre-Authorization Requirements

Please contact:

Aetna Student Health
P.O. Box 15708
Boston, MA 02215-0014
(877) 375-7908

For questions about:

ID Cards

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

For lost ID cards, contact:

Aetna Student Health
(877) 375-7908 or visit www.aetnastudenthealth.com, click on “Find Your School’s Plan” from the quick links.

For questions about:

- * Enrollment Forms
- * Waiver Process
- * Dependent Enrollment

Please contact:

Chris Zalesky, Associate University Cashier
Rice University
Cashier’s Office – MS 55
PO Box 1892
Houston, TX 77521-1892
(713) 348-4946

For questions about:

- * On-Campus Health Services

Please contact:

Rice University
Student Health Services
Morton L Rich Health and Wellness
6100 Main St. MS #760
Houston, TX 77005
(713) 348-4966

For questions about:

- * Provider Listings

Please contact:

Aetna Student Health
(877) 375-7908

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

For questions about:

On Call International 24/7 Emergency Travel Assistance Services

Please contact:

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

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

IMPORTANT NOTE

Please keep this Brochure, as it provides a general summary of your coverage. A complete description of the benefits and full terms and conditions may be found in the Master Policy issued to Rice 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 Insurance Office, located in the Rice Counseling Center, during business hours.

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

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POLICY PERIOD

1. Annual: Coverage for all insured students enrolled in the Rice University Student Health Insurance program will become effective on August 15, 2009, and will terminate on August 14, 2010.
2. Fall Semester Students: Coverage for all insured students enrolled for the Fall Semester will become effective at on August 15, 2009, and will terminate at on December 31, 2009. (Please note that students expecting to graduate in December are encouraged to select the Fall Semi-Annual period to avoid paying the annual premium.)
3. Spring Semester Students: Coverage for all insured students enrolled for the Spring Semester will become effective at on January 1, 2010, and will terminate on August 14, 2010
4. Insured Dependents: Coverage will become effective on the same date the covered student’s coverage becomes effective.
5. Mid-Year Enrollment: Students who had previously waived coverage may enroll themselves and their eligible dependents after the deadline date only if there has been a significant life change (i.e., loss of prior coverage). If the completed Enrollment Form is submitted within 30 days of the qualifying event, coverage will be backdated to the date of the qualifying event. If the completed Enrollment Form is submitted after the 30 days of the qualifying event, it will not be accepted, and the student and/or dependent(s) will have to wait until the next annual open enrollment period to enroll. Please note that the completed Enrollment Form and premium should be submitted directly to Aetna Student Health. Premiums are not pro-rated other than below.

PREMIUM RATES

Premium Cost			
	Annual 8/15/09-8/14/10	Fall 8/15/09-12/31/09	Spring 1/01/10-8/14/10
Student	\$1,486	\$566	\$920
Spouse/Domestic Partner	\$2,037	\$775	\$1,262
Each Child	\$1,499	\$571	\$928

CONTINUATION PLAN

Continuation Plan		
	Fall 8/15/09-2/14/10	Spring 1/01/10-06/30/10
Student	\$1,512	\$1,512
Spouse/Domestic Partner	\$2,142	\$2,142
Each Child	\$1,577	\$1,577

RICE UNIVERSITY STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN

This is a brief description of the Accident and Sickness Medical Expense benefits available for Rice 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 Insurance Office, located in the Rice Counseling Center, during business hours.

STUDENT COVERAGE

ELIGIBILITY

All registered, full-time, degree-seeking students, as verified by the Cashier's office are required to have health insurance either through the Rice University Student Health Insurance Plan or through another individual or family plan. Students must actively attend classes for at least the first 31 days, after the date when coverage becomes effective. If the eligibility requirements are not met, Aetna's only obligation is to refund the premium, less any claims paid.

ENROLLMENT/WAIVER PROCESS

All full-time students are required to maintain health insurance through the school, or provide proof of comparable coverage. To ensure compliance with this University policy, all students are required to either enroll in the Rice University Student Health Insurance Plan, or file a Waiver Form indicating that other coverage is in place.

Students electing to enroll in the Rice University Student Health Insurance Plan may opt to be billed annually or semi-annually. Only newly registered students may waive coverage in the Spring. Enrollment and Waiver elections must be made online at www.studenthealthinsurance.rice.edu, and must be submitted by **September 4, 2009 (January 2, 2010** for newly registered Spring students).

Students who do not complete an Enrollment or Waiver Form by **September 4, 2009** will be considered non-compliant with university policy, and will have their registration put on hold. If it is determined that the student is uninsured, and needs to be covered under the Plan, coverage will be effective the date after the Enrollment/Waiver Form is received.

REFUND POLICY

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

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

DEPENDENT COVERAGE

ELIGIBILITY

Covered students may also enroll their lawful spouse /domestic partner (same sex or opposite sex) and unmarried dependent children who are under 25 years of age who are fully supported by the covered student. If you enroll a domestic partner, you will be required to complete an Affidavit of Domestic Partnership. This Affidavit is for use by Aetna Student Health for the sole purpose of determining your eligibility for domestic partnership under the student medical policy that provides coverage for domestic partners. A dependent child includes any grandchild/stepchild or legally adopted child, and/or child for whom the covered student must provide medical support under a Court Order.

ENROLLMENT

To enroll eligible dependent(s), a covered student must complete the Dependent Enrollment Form at www.studenthealthinsurance.rice.edu. Dependent enrollment Forms will not be accepted after September 4, 2009, unless there is a significant life change that directly affects their insurance coverage. (An example of a significant life change would be loss of health coverage under another health plan.) The Spring enrollment deadline is January 2, 2009.

NEWBORN INFANT AND ADOPTED CHILD COVERAGE

A child born to a Covered Person shall be covered for Accident, Sickness, and congenital defects, for 31 days from the date of birth. At the end of this 31 day period, coverage will cease under the Rice 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 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) 375-7908**.

CONTINUOUSLY INSURED

Persons who have remained continuously insured under this Policy or other policies will be covered for any Pre-Existing Condition, which manifests itself while continuously insured, except for expenses payable under prior policies in the absence of this Policy. Previously Covered Persons must re-enroll for coverage, including dependent coverage, by **September 4, 2009**, for the Fall Semester, and by **January 2, 2010**, for the Spring Semester in order to avoid a break in coverage for conditions which existed in prior policy years. Once a break in continuous coverage occurs, the Pre-Existing Conditions Limitation will apply (see page 9).

PREFERRED PROVIDER NETWORK

Aetna Student Health has arranged for you to access a Preferred Provider Network in your local community. Acute care facilities and mental health networks are available nationally if you require hospitalization outside the immediate area of the Rice 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 is available at the Rice University Health Services.

You may also obtain information regarding Preferred Providers by contacting Aetna Student Health at **(877) 375-7908**, or through the Internet by accessing DocFind at **www.aetnastudenthealth.com**.

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

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

PRE-AUTHORIZATION PROGRAM

You are required to obtain Pre-authorization/pre-certification by calling Aetna Student Health at **(877) 375-7908** (attention Managed Care Department) or (TDD) (800) 466-5996 before receiving the following services:

- All inpatient (non-emergency) admissions: The patient, Physician, or hospital must telephone at least three (3) business days prior to the planned admission.
- Notification of emergency admissions must be provided by the patient, patient’s representative, Physician, or hospital, telephoning within two (2) business days following admissions. Please note that pre-authorization/pre-certification of inpatient and/or listed services/procedures does not constitute a promise of benefits.

PRE-EXISTING CONDITIONS/ CONTINUOUSLY INSURED PROVISIONS

Definition of a Pre-existing Condition

A preexisting condition is any injury, sickness or condition that was diagnosed or treated, or would have caused a prudent person to seek diagnosis or treatment, within 12 months prior to the Covered Person's effective date of insurance.

Limitation

Pre-existing conditions are not covered if the person has a break in coverage. Expenses as a result of a Pre-Existing Condition will not be considered **Covered Medical Expenses** unless no charges are incurred or treatment rendered for the condition for a period of six months while covered under the Plan; or the **covered person** has been covered under the Plan for twelve consecutive months; whichever happens first.

Continuously Insured

Credit will be given for those persons covered under credible coverage, if the credible coverage was continuous to a date no more than 63 days prior to the insured's effective date under this Policy. For persons covered by a prior policy offered by the University, a break of coverage will not be considered if the plan was continuous to a date no more than 31 days prior to the insured's effective date under this policy.

"Creditable coverage" is a person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Such coverage includes coverage issued on a group or individual basis; Medicare; Medicaid; military-sponsored health care; a program of the Indian Health Service; a state health benefits risk pool; the Federal Employee's Health Benefit Plan (FEHBP); a public health plan as defined in the regulations; and any health benefit plan under Section 5(e) of the Peace Corps Act.

DESCRIPTION OF BENEFITS

Please Note:

The Rice 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 Rice University 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 Rice University, you may view it at the Student Insurance Office, located in the Rice Counseling Center, or you may contact Aetna Student Health at (877) 375-7908.

This Plan will never pay more than a lifetime maximum of \$500,000 per Accident and Sickness; \$3,000 for Prescriptions; or 60 visits for Outpatient Mental Health per Policy Year. 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

DEDUCTIBLES

The following Deductibles are applied before Covered Medical Expenses are payable:

\$250 for in-network per insured person per Policy Year

\$750 out-of-network per insured person per Policy Year

COINSURANCE

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

OUT OF POCKET MAXIMUMS

Once a covered individual has satisfied the **Out-of-Pocket Limit**, **Covered Medical Expenses** will be payable at 100% for the remainder of the Policy Year, up to any benefit maximum that may apply. Out-of-Pocket costs include deductibles, co-pays, and co-insurance.

Out-of-Pocket Limit: **\$3,000 per insured individual.**

All coverage is based on Reasonable Charges unless otherwise specified.

Inpatient Hospitalization Benefits	
Hospital Room and Board Expense	<p>Covered Medical Expenses are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge for a semi-private room.</p>
Intensive Care Unit Expense	<p>Covered Medical Expenses are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge for the Intensive Care Room Rate for an overnight stay.</p>
Miscellaneous Hospital Expense	<p>Covered Medical Expenses include, includes; among others; expenses incurred during a hospital confinement for: anesthesia and operating room; laboratory tests and x-rays; oxygen tent; and drugs; medicines; and dressings.</p> <p>Benefits are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge.</p>
Physician Hospital Visit/ Consultation Expenses	<p>Covered Medical Expenses for charges for the non-surgical services of the attending Physician, or a consulting Physician, are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge.</p>
Licensed Nurse Expense	<p>Covered Medical Expenses for inpatient treatment requiring a registered or licensed practical nurse <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge.</p>

Surgical Benefits (Inpatient and Outpatient)	
Surgical Expense	<p>Covered Medical Expenses for charges for surgical services performed by a Physician, are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge.</p>
Anesthetist and Assistant Surgeon Expense	<p>Covered Medical Expenses for the charges of an anesthetist and an assistant surgeon, during a surgical procedure, are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge.</p>
Ambulatory Surgical Expense	<p>Covered Medical Expenses for outpatient surgery performed in an ambulatory surgical center are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge</p> <p>Covered Medical Expenses must be incurred on the day of the surgery or within 48 hours after the surgery.</p>

Outpatient Benefits	
<p>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.</p>	
Emergency Room Expense	<p>Covered Medical Expenses incurred for treatment of an Emergency Medical Condition are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge after a \$50 Co-pay. (Co-pay will be waived if admitted) <u>Non-Preferred Care: 50%</u> of the Reasonable Charge after a \$50 Deductible. (Deductible will be waived if admitted)</p>
Urgent Care Expense	<p><i>Benefits include charges for treatment by an urgent care provider.</i></p> <p>Please note: A covered person <u>should not seek medical care or treatment from an urgent care provider if their illness, injury, or condition, is an emergency condition.</u> The covered person should go directly to the emergency room of a hospital or call 911 for ambulance and medical assistance.</p> <p><u>Urgent Care</u> Benefits include charges for an urgent care provider to evaluate and treat an urgent condition.</p> <p>Covered Medical Expenses for urgent care treatment are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge.</p> <p><i>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.</i></p> <p>Non-urgent care includes, but is not limited to, the following:</p> <ul style="list-style-type: none"> • Routine or preventive care (this includes immunizations), • Follow-up care, • Physical therapy, • Elective surgical procedures, and • Any lab and radiologic exams which are not related to the treatment of the urgent condition.

Ambulance Expense	<p>Covered Medical Expenses are payable as follows: 80% of the Actual Charge for the services of a professional ambulance to or from a hospital, when required due to the emergency nature of a covered Accident or Sickness.</p> <p><i>Benefits for Ambulance do not require pre-authorization.</i></p>
Pre-Admission Testing Expense	<p>Covered Medical Expenses for Pre-Admission testing charges while an outpatient before scheduled surgery are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge.</p>
Physician's Office Visits	<p>Covered Medical Expenses include the charges made by a physician including physician charges made for telemedicine or telehealth.</p> <p>Benefits are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge after a \$20 per visit Co-pay, <u>Non-Preferred Care: 50%</u> of the Reasonable Charge After a \$20 per visit Deductible,</p>
Laboratory and X-Ray Expense	<p>Covered Medical Expenses are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge.</p>
High Cost Procedures Expense	<p>Covered Medical Expenses include charges incurred by a covered person are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge.</p> <p>For purposes of this benefit, "High Cost Procedure" means any outpatient procedure costing over \$200.</p>
Therapy Expense	<p>Covered Medical Expenses include charges incurred by a covered person for the following types of therapy provided on an outpatient basis:</p> <ul style="list-style-type: none"> • Speech Therapy; • Inhalation Therapy; • Occupational Therapy • Radiation therapy; • Chemotherapy; including anti-nausea drugs used in conjunction with the chemotherapy; • Dialysis; and • Respiratory therapy <p>Expenses for Speech and Occupational Therapies are Covered Medical Expenses; only if such therapies are a result of injury or sickness.</p> <p>All therapy must be initiated within 6 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.</p> <p>Therapy Expense Benefits are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge.</p>

<p>Therapy Expenses (Chiropractic Care)</p>	<p>Covered Medical Expenses include charges incurred by a covered person for the following types of therapy provided on an outpatient basis:</p> <ul style="list-style-type: none"> • Chiropractic Care; <p>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.</p> <p>All therapy must be provided by a therapist who is licensed in accordance with state law; and practicing within the scope of their license.</p> <p>Therapy Expense Benefits are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge after a \$20 per visit Co-pay. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge after a \$20 per visit Deductible.</p>
<p>Durable Medical Equipment Expense</p>	<p>Covered Medical Expenses are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge.</p> <p>Benefits for Durable Medical Equipment do not require pre-authorization.</p>
<p>Prosthetic Devices Expense</p>	<p>Covered Medical expenses include charges for: artificial limbs, or eyes, and other non-dental prosthetic devices, as a result of an accident or sickness.</p> <p>Covered Medical Expenses do not include: eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet.</p> <p>Benefits are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge.</p>
<p>Prosthetic Devices Expense</p>	<p>Covered Medical expenses include charges for: artificial limbs, or eyes, and other non-dental prosthetic devices, as a result of an accident or sickness.</p> <p>Covered Medical Expenses do not include: eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet.</p> <p>Benefits are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge.</p>
<p>Prosthetic Devices Expense</p>	<p>Covered Medical expenses include charges for: artificial limbs, or eyes, and other non-dental prosthetic devices, as a result of an accident or sickness.</p> <p>Covered Medical Expenses do not include: eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet.</p> <p>Benefits are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge.</p>

<p>Prosthetic Devices Expense</p>	<p>Covered Medical expenses include charges for: artificial limbs, or eyes, and other non-dental prosthetic devices, as a result of an accident or sickness.</p> <p>Covered Medical Expenses do not include: eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet.</p> <p>Benefits are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge.</p>
<p>Outpatient Physical Therapy Expense</p>	<p>Covered Medical Expenses for physical therapy are payable as follows when provided by a licensed physical therapist and only when physical therapy begins within 30 days immediately prior to or immediately following surgery:</p> <p><u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred care: 50%</u> of the Reasonable Charge.</p> <p>Maximum Benefit is \$1,000 Per Policy Year.</p>
<p>Dental Injury Expense</p>	<p>Covered Medical Expenses include dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition:</p> <ul style="list-style-type: none"> • Natural teeth damaged, lost, or removed, or • Other body tissues of the mouth fractured or cut due to injury. The accident causing the injury must occur while the person is covered under this Plan. <p>Any such teeth must have been:</p> <ul style="list-style-type: none"> • Free from decay, or • In good repair, and • Firmly attached to the jawbone at the time of the injury. <p>If:</p> <ul style="list-style-type: none"> • Crowns (caps), or • Dentures (false teeth), or • Bridgework, or • In-mouth appliances, <p>are installed due to such injury, Covered Medical Expenses include only charges for:</p> <ul style="list-style-type: none"> • The first denture or fixed bridgework to replace lost teeth, • The first crown needed to repair each damaged tooth, and • An in-mouth appliance used in the first course of orthodontic treatment after the injury. <p>Surgery needed to:</p> <ul style="list-style-type: none"> • Treat a fracture, dislocation, or wound. • Cut out cysts, tumors, or other diseased tissues. • Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement. <p>Non-surgical treatment of infections or diseases. This does not include those of, or related to, the teeth.</p> <p>Covered Medical Expenses are payable as follows:</p> <p>80% of Actual Charge.</p> <p>Benefits are limited to \$100 per tooth, per condition/accident, per Policy Year etc.</p>

<p>Diagnostic Testing for Attention Disorders and Learning Disabilities Expense</p>	<p>Covered Medical Expenses for diagnostic testing for:</p> <ul style="list-style-type: none"> • Attention deficit disorder, or • Attention deficit hyperactive disorder, or • Dyslexia. <p>are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge.</p> <p>Treatment of attention deficit disorder, attention deficit hyperactive disorder, or dyslexia is not covered. Please refer to policy exclusion #37 on page 33.</p>
<p>Well Baby Care Expense</p>	<p>Benefits include charges for routine preventive and primary care services, rendered to a covered dependent child on an outpatient basis.</p> <p>Routine preventive and primary care services are services rendered to a covered dependent child, from the date of birth through the attainment of two (2) years of age. Services include: initial hospital check-ups, other hospital visits, physical examinations, including routine hearing and vision examinations, medical history, developmental assessments, and materials for the administration of appropriate and necessary immunizations and laboratory tests, when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics.</p> <p>Covered Medical Expenses are payable as follows <u>Preferred Care: 80%</u> of the Negotiated Charge <u>Non-Preferred Care: 50%</u> of the Reasonable Charge.</p>
<p>Child Immunization Expense</p>	<p>Covered Medical Expenses are covered at 100% up to age 6, not subject to co-pay, deductible or coinsurance</p>
<p>Consultant or Specialist Expense</p>	<p>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.</p> <p>Covered Medical Expenses are covered as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge.</p>

Mental Health Benefits	
<p>Inpatient Expense Mental Health</p>	<p>Covered Medical Expenses include the diagnosis and inpatient treatment of mental illnesses.</p> <p>Covered Medical Expenses also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission, whereby 2 days of partial hospitalization may be exchanged for 1 day of full hospitalization.</p> <p>Benefits are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge.</p> <p><i>Benefits for partial hospitalization and/or inpatient benefits for treatment of mental and nervous disorders for adult members do not require pre-authorization.</i></p> <p>Benefits are limited to 30 days per condition, per Policy Year.</p> <p>Covered Medical Expenses also include inpatient treatment in crisis stabilization unit or residential treatment center for children and adolescents. <i>Pre-authorization for this adolescent benefit require pre-authorization.</i></p>
<p>Outpatient Expense Mental Health</p>	<p>Covered Medical Expenses include the diagnosis and outpatient treatment of mental illnesses.</p> <p>Benefits are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge.</p> <p><i>Benefits for outpatient benefits for treatment of mental and nervous disorders do not require pre-authorization.</i></p> <p>Benefits are limited to 60 visits per Policy Year etc.</p>

Substance Abuse Benefits	
<p>Inpatient Expense Substance Abuse</p>	<p>Covered Medical Expenses include the treatment of a substance abuse condition while confined as an inpatient in a hospital or facility licensed for such treatment.</p> <p>Covered Medical Expenses also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission, whereby 2 days of partial hospitalization may be exchanged for 1 day of full hospitalization.</p> <p>Benefits are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge.</p> <p>Benefits are limited to 30 days per condition, per Policy Year.</p>

<p>Outpatient Expense Substance Abuse</p>	<p>Covered Medical Expenses for outpatient treatment of a substance abuse condition are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge to a maximum of \$50 per visit <u>Non-Preferred Care: 50%</u> of the Reasonable Charge to a maximum of \$50 per visit.</p> <p>A referral is not required for this benefit.</p> <p>Outpatient treatment is payable up to a maximum of \$500, per Policy Year.</p>
<p>Maternity Benefits</p>	
<p>Maternity Expense</p>	<p>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.</p> <p>Any decision to shorten such minimum coverages shall be made by the attending Physician in consultation with the mother. In such cases, covered services may include: home visits, parent education, and assistance and training in breast or bottle-feeding.</p> <p>Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other sickness.</p> <p>A referral is not required for this benefit.</p>
<p>Well Newborn Nursery Care Expense</p>	<p>Benefits include charges for routine care of a covered person's newborn child as follows:</p> <ul style="list-style-type: none"> • Hospital charges for routine nursery care during the mother's confinement, but for not more than four days for a normal delivery, • Physician's charges for circumcision, and • Physician's charges for visits to the newborn child in the hospital and consultations, but for not more than 1 visit per day. <p>Covered Medical Expenses are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge.</p>

Additional Benefits	
<p>Prescription Drug Benefit</p>	<p>Prescription Drug Benefits are payable as follows:</p> <p><u>Preferred Care Pharmacy:</u> Following a \$25 Copay for each Brand Name Prescription Drug or a \$15 Copay for each Generic Prescription Drug.</p> <p><u>Non-Preferred Care Pharmacy:</u> Following a \$25 Deductible for each Brand Name Prescription or a \$15 Deductible for each Generic Prescription Drug.</p> <p>Covered Medical Expenses are payable up to a maximum of \$3,000 per Policy Year.</p> <p>This Pharmacy benefit is provided to cover Medically Necessary Prescriptions associated with a covered Sickness or Accident occurring during the Policy Year. Please use your Aetna Student Health ID card when obtaining your prescriptions</p> <p>Medications not covered by this benefit include, but are not limited to: allergy sera, all acne medications, drugs whose sole purpose is to promote or to stimulate hair growth, appetite suppressants, smoking deterrents, immunization agents and vaccines, and non-self injectables. <i>(This is only a partial list.)</i></p> <p>For assistance or for a complete list of excluded medications, or drugs requiring prior authorization, please contact Aetna Pharmacy Management at (800) 238-6279 (available 24 hours).</p> <p>Aetna Specialty Pharmacy provides specialty medications and support to members living with chronic conditions. The medications offered may be injected, infused or taken by mouth. For additional information please go to www.AetnaSpecialtyRx.com</p> <p>In all instances, either the actual cost of a drug or the above listed Copay will apply, whichever is less.</p>
<p>Diabetic Treatment, Supplies and Outpatient Diabetic Self-Management Expense</p>	<p>Covered Medical Expense includes expenses incurred for the diagnosis and treatment of diabetes, including those for drugs and diabetic supplies, equipment and an outpatient diabetic self-management education program prescribed as part of a treatment plan. Benefits are payable for Covered Medical Expenses on the same basis as any other analogous chronic medication condition. Covered Medical Expenses under this benefit include: office visits and consultations with physicians and practitioners for monitoring and treatment of diabetes, including office visits and consultations with appropriate specialists; immunizations provided under the Child Immunizations Expense benefit; immunizations for influenza and pneumococcus; inpatient, physician and practitioner services when the covered person is confined to a hospital, rehabilitation facility, or skilled nursing facility; inpatient and outpatient laboratory and diagnostic imaging services; diabetes equipment and supplies; and diabetes self-management training.</p> <p>Charges for a diabetic self-management education program are covered but only if:</p> <ul style="list-style-type: none"> • The covered person is a diabetic who is covered under this Policy and is not confined in a hospital or skilled nursing facility as a full-time inpatient; or • The person is covered under this Policy and cares for or helps care for a diabetic who is covered under this Policy and is not confined in a hospital or skilled nursing facility as a full-time inpatient. <p>Charges include tuition and fees.</p>

	<p>A "diabetic self-management education program" is a scheduled program on a regular basis which is designed to instruct a person in the self-management of diabetes. It is a day care program of educational services and self-care training. All of the following requirements must be met:</p> <ul style="list-style-type: none"> • A physician must direct and supervise the program. • The program's services and training must be rendered by health care professionals who are familiar with diabetes and its treatment. This includes physicians, R.N.'s, registered pharmacists, registered dietitians and licensed social workers. • The program must include: <ul style="list-style-type: none"> (1) training provided to a covered person after the initial diagnosis of diabetes in the care and management of that condition, including nutrition counseling and proper use of diabetes equipment and supplies; (2) additional training authorized on the diagnosis of a physician or other health care practitioner of a significant change in the covered person's symptoms or condition that requires changes in the qualified insured's self-management regime; and (3) periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes. <p>Not covered are:</p> <ul style="list-style-type: none"> • Program expenses incurred for a diabetic education program whose only purpose is weight control. • Program expenses incurred for a diabetic education program that is available to the public at no cost. <p>Diabetic Treatment and Supplies are covered as any other sickness.</p> <p>Outpatient Diabetic Self-Management Education Program Expenses are covered as any other sickness</p>
<p>Non Prescription Enteral Formula Expense</p>	<p>Benefits include charges incurred by a covered person for non-prescription enteral formulas, for which a physician has issued a written order, and are for the treatment of malabsorption caused by:</p> <ul style="list-style-type: none"> • Crohn's Disease, • Ulcerative colitis, • Gastroesophageal reflux, • Gastrointestinal motility, • Chronic intestinal pseudoobstruction, • Inherited diseases that may result in mental or physical retardation or death; • Phenylketonuria (an inherited condition that may cause severe mental retardation if not treated); and • Inherited diseases of amino acids and organic acids. <p>Covered Medical Expenses for inherited diseases of amino acids and organic acids, will also include food products modified to be low protein.</p> <p>Covered Medical Expenses are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge.</p>

<p>TMJ Expense</p>	<p>Covered Medical Expenses include charges incurred by a covered person for diagnostic, surgical and non-surgical treatment of Temporomandibular Joint (TMJ) Dysfunction.</p> <p>Benefits for diagnostic and non-surgical TMJ benefits are payable on the same basis as any other condition.</p> <p>Temporomandibular Joint Dysfunction Expense surgical benefits are subject to any Covered Percentages and maximums applicable to Hospital Expense and Surgical Expense.</p>
<p>Outpatient Contraceptive Drugs and Devices and Outpatient Contraceptive Services Expense</p>	<p>Covered Medical Expenses include:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> - Consultations; - Exams; - Procedures; and - Other medical services and supplies. <p>Benefits for contraceptive devices and outpatient contraceptive services will be subject to any Covered Percentages and Maximums applicable to Outpatient Physician Office Visit Expense and Prescription Medicine Expenses.</p> <p>Covered Medical Expenses for contraceptive drugs will be subject to any Covered Percentages and Maximums applicable to Prescription Medicine Expenses.</p> <p>Benefits are payable as follows: <u>Preferred Care:</u> 80% of the Negotiated Charge for consultations with \$20 Co-pay. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge for consultations with \$20 deductible.</p> <p>Covered Medical Expenses do not include:</p> <ul style="list-style-type: none"> • Charges for services which are covered to any extent; under any other part of this Plan; and • Charges incurred for contraceptive services; while confined as an inpatient; and charges incurred for duplicate; lost; stolen; or damaged; contraceptive devices.
<p>Gynecological Exam and Pap Smear Screening Expense</p>	<p>Covered Medical Expenses include an annual medically recognized diagnostic examination for the early detection of cervical cancer for women 18 years of age or older. Benefits include, at a minimum, a conventional pap smear screening or a screening using liquid based cytology methods, alone or in combination with another test approved by US FDA for detection of HPV.</p> <p>Benefits are payable as follows: <u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge.</p> <p>A referral is not required for this benefit</p>

<p>Mammography Expense</p>	<p>Covered Medical Expenses include one baseline mammogram for women between age 35 and 40. Coverage is also provided for one routine annual mammogram for women age 40 and older, as well as when medically indicated for women with risk factors who are under age 40. Risk factors for women under 40 are:</p> <ul style="list-style-type: none"> • Prior personal history of breast cancer • Positive Genetic Testings • Family history of breast cancer; or • Other risk factors <p>Mammogram screenings coverage must also include comprehensive ultrasound screening for the entire breast or breasts if a mammogram demonstrates heterogenous or dense breast tissue and when determined to be medically necessary by a licensed physician.</p> <p>Benefits are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge.</p> <p>A referral is not required for this benefit.</p>
<p>Mastectomy and Reconstructive Surgery Expense</p>	<p>Covered Medical Expenses includes expenses for charges incurred in connection with a mastectomy or lymph node dissection. Coverage includes:</p> <ul style="list-style-type: none"> • A minimum of 48 hours of inpatient care following a mastectomy; • A minimum of 24 hours of inpatient care following a lymph node dissection; • Reconstructive surgery on the breast on which surgery was performed and the non-diseased breast to achieve a symmetrical appearance; and • Prostheses and treatment of physical complications including lymphedemas, at all states of mastectomy. <p>A covered person may be discharged from inpatient care sooner if the covered person and the attending physician determine that a shorter period of inpatient care is appropriate.</p> <p>Benefits are payable on the same basis as any other condition.</p>
<p>Chlamydia Screening Test Expense</p>	<p>Benefits include charges incurred for an annual Chlamydia screening test.</p> <p>Benefits will be paid for Chlamydia screening expenses incurred for:</p> <ul style="list-style-type: none"> • Women who are: <ul style="list-style-type: none"> - Under the age of 20 if they are sexually active, and - At least 20 years old if they have multiple risk factors. • Men who have multiple risk factors. <p>Covered Medical Expenses are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge.</p>
<p>Routine Screening for Sexually Transmitted Disease Expense</p>	<p>Covered Medical Expenses include charges for covered persons who are at least 18 years old and who are sexually active for annual routine screening for sexually transmitted diseases.</p> <p>Benefits are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge.</p>

<p>Routine Colorectal Cancer Screening Expense</p>	<p>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:</p> <ul style="list-style-type: none"> • One fecal occult blood test every 12 months in a row • A Sigmoidoscopy at age 50 and every 3 years thereafter • One digital rectal exam every 12 months in a row • A double contrast barium enema, once every 5 years • A colonoscopy, once every 10 years • Virtual colonoscopy • Stool DNA. <p>Covered Medical Expenses are payable on the same basis as any other condition.</p>
<p>Routine Prostate Cancer Screening Expense</p>	<p>Covered Medical Expenses include charges incurred by a covered person for the screening of cancer as follows:</p> <ul style="list-style-type: none"> • For a male age 50 or over; one digital rectal exam and one prostate specific antigen test each Policy Year; or • At least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor; or • For symptomatic males of any age. <p>Benefits are payable on the same basis as any other condition.</p>
<p>Surgical Second Opinion Expense</p>	<p>Covered Medical Expenses will include a second opinion consultation by a specialist on the need for surgery which has been recommended by the covered person's physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation.</p> <p>Benefits are payable as follows: <u>Preferred Care:</u> 80% of the Negotiated Charge after a \$20 per visit Co-pay, <u>Non-Preferred Care:</u> 50% of the Reasonable Charge after a \$20 per visit deductible,</p>
<p>Elective Surgical Second Opinion Expense</p>	<p>Covered Medical Expenses will include a second opinion consultation by a specialist on the need for non-emergency elective surgery which has been recommended by the covered person's physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation.</p> <p>Benefits are payable as follows: <u>Preferred Care:</u> 80% of the Negotiated Charge after a \$20 per visit Co-pay, <u>Non-Preferred Care:</u> 50% of the Reasonable Charge after a \$20 per visit deductible.</p>
<p>Acupuncture in Lieu of Anesthesia Expense</p>	<p>Covered Medical Expenses include acupuncture therapy, when acupuncture is used in lieu of other anesthesia, for a surgical or dental procedure covered under this Plan.</p> <p>The acupuncture must be administered by a health care provider who is a legally qualified physician, practicing within the scope of their license.</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge.</p>

Dermatological Expense	<p>Covered Medical Expenses include charges for the diagnosis and treatment of skin disorders, excluding laboratory fees. Related laboratory expenses are covered under the Outpatient Expense Benefit.</p> <p>Benefits are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge.</p> <p><i>Covered Medical Expenses do not include treatment for acne, or cosmetic treatment and procedures.</i></p>
Podiatric Expense	<p>Covered Medical Expenses include charges for podiatric services, provided on an outpatient basis following an injury.</p> <p>Benefits are payable as follows: <u>Preferred Care: 80%</u> of the Negotiated Charge. <u>Non-Preferred Care: 50%</u> of the Reasonable Charge.</p> <p>Expenses for routine foot care, such as trimming of corns, calluses, and nails, are not Covered Medical Expenses.</p>
Home Health Care Expenses	<p>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:</p> <ul style="list-style-type: none"> (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 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 7 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. <p>Home Health Care Services</p> <ul style="list-style-type: none"> (1) Part-time or intermittent nursing care by: a registered nurse (R. N.), a licensed Practical nurse (L.P.N.), or under the supervision on an R.N. if the services of an R. N. are not available, (2) Part time or intermittent home health aide services, that consist primarily of care of a medical or therapeutic nature by other than an R.N., (3) Physical, occupational, speech therapy, or respiratory therapy, (4) Medical supplies, drugs and medicines, and laboratory services. However, these items are covered only to the extent they would be covered if the patient was confined to a hospital, (5) Medical social services by licensed or trained social workers, (6) Nutritional counseling. <p>Covered Medical Expenses will not include: 1) services by a person who resides in the covered person's home, or is a member of the covered person's immediate family, 2) homemaker or housekeeper services, 3) maintenance therapy, 4) dialysis treatment, 5) purchase or rental of dialysis equipment, or 6) food or home delivered services.</p> <p>A visit means a maximum of 4 continuous hours of home health service</p>

	<p>Benefits are payable as follows: <u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge.</p> <p>Covers expenses incurred within 12 months from the date of first home health care visit. Maximum number of covered visits is limited to 40. Four hours of home health aide service shall be considered as one home care visit.</p> <p><i>Benefits for Home Health Care expenses do not require pre-authorization.</i></p>
Hospice Benefit	<p>Covered Medical Expenses include charges for hospice care provided for a terminally ill covered person during a hospice benefit period.</p> <p>Benefits are payable as follows: <u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred care:</u> 50% of the Reasonable Charge.</p> <p><i>Please see definition on page 41 for more information on Hospice Care Expenses.</i></p> <p><i>Benefits for Hospice expenses do not require pre-authorization.</i></p>
Skilled Nursing Facility Expense	<p>Covered Medical Expenses include charges incurred by a covered person for confinement in a skilled nursing facility for treatment rendered:</p> <ul style="list-style-type: none"> • 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. <p>Covered Medical Expenses are payable as follows: <u>Preferred Care:</u> 80% of the Negotiated Charge for the semi-private room rate. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge for the semi-private room rate.</p>
Rehabilitation Facility Expense	<p>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.</p> <p>Covered Medical Expenses for Rehabilitation Facility Expense are covered as follows:</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge for the rehabilitation facility's daily room and board maximum for semi-private accommodations. <u>Non-Preferred Care:</u> 50% of the Reasonable Charge for the rehabilitation facility's daily room and board maximum for semi-private accommodations.</p> <p><i>Benefits for Rehabilitation Facility expenses do not require pre-authorization.</i></p>
Newborn Hearing Screening Expense	<p>Covered Medical Expenses include:</p> <ul style="list-style-type: none"> • A screening test for hearing loss from birth through the date a child is 30 days old. • Necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old. <p>Benefits are payable on the same basis as any other condition.</p> <p>Covered Medical Expenses are not subject to Annual Deductible or Copay.</p>

Acquired Brain Injury Expense	<p>Covered Medical Expenses include expenses incurred by a covered person for: cognitive rehabilitation therapy, cognitive speech/communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services or community reintegration services, if such services are necessary as a result of and related to an acquired brain injury.</p> <p>Benefits are payable on the same basis as any other condition.</p>
Dental Anesthesia	<p>Anesthesia will be covered if a member is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental or medical reason as determined by the individual's physician or by the dentist providing the dental care.</p> <p>Benefits are payable as any Anesthetist Expense.</p>
Childhood Immunizations Expense	<p>Covered Medical Expenses include charges made by a physician for materials and the administration of the following immunizations given to dependent children from birth to age 6:</p> <ul style="list-style-type: none"> • Diphtheria; • Haemophilus influenza type B; • Hepatitis B; • Measles; • Mumps; • Pertussis; • Polio; • Rubella; • Tetanus; • Varicella; and • Any other immunization required under the laws of the State of Texas. <p>Not included in this benefit are charges made by a physician for an office visit for such administration.</p> <p>Benefits are payable as follows: <u>Preferred Care: 100%</u> of the Negotiated Charge <u>Non-Preferred Care: 100%</u> of the Reasonable Charge.</p> <p>Covered Medical Expenses are not subject to the Annual Deductible.</p>
Loss Or Impairment Of Speech Or Hearing Expense	<p>Covered Medical Expenses also include expenses incurred by a covered person for medically necessary care and treatment of loss or impairment of speech or hearing.</p> <p>Benefits are payable on the same basis as any other physical illness.</p>
Osteoporosis Detection and Prevention Expense	<p>Covered Medical Expenses include coverage for medically accepted bone mass measurement to detect low bone mass and to determine the enrollee's risk of osteoporosis and fractures associated with osteoporosis.</p> <p>Benefits are payable on the same basis as any other physical illness.</p>

ADDITIONAL SERVICES AND DISCOUNTS

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

Aetna VisionSM 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's Informed Health[®] Line:

Get answers from a registered nurse at any time. 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.
- Discuss more than 5,000 health and wellness topics.

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.

Beginning RightSM 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.

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 AdvantageTM Dental benefits and insurance plan**, you select a primary care dentist (PCD) and have most of your preventive and restorative services covered by a copayment or reduced fee for each visit. Enroll online at www.aetnastudenthealth.com.

Price: \$156 Student only
 \$308 Student + 1 Dependent
 \$587 Student + 2 Dependents

Aetna Student Assistance Program (SAP) As a complement to the Rice University Counseling Center, the Aetna Student Assistance Program offers you balance associated with the unique challenges of college life.

With the Aetna Student Assistance Program (SAP), you automatically receive the following services:

- **Interactive Web Resources:** With our easy-to-use web resources, you can search for information on relationships, stress, academics, finances, and other issues of special interest...comfortably and privately. Visit www.aetnasap.com, and enter "RICE" as the School ID.

Vital SavingsSM on Dental* is a dental discount program helping you and your dependents save an average of 15% to 50% on a wide array of dental services. The cost of the Vital Savings on Dental is included in your medical plan cost. Enroll online at www.aetnastudenthealth.com.

**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 discounted services. Discounts are subject to change without notice. Discount programs may not be available in all states.

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

The SAP is administered by Aetna Behavioral Health, LLC. All SAP calls are confidential, except as required by law (i.e., when a person’s emotional condition is a threat to himself/herself or others, or there is suspected abuse of a minor child, and in some areas, spousal or elder abuse).

GENERAL PROVISIONS

STATE MANDATED BENEFITS

The Plan will pay benefits in accordance with any applicable Texas State Insurance Law(s).

SUBROGATION/REIMBURSEMENT

RIGHT OF RECOVERY PROVISION

Immediately upon paying or providing any benefit under this Plan, Aetna shall be subrogated to all rights of recovery a Covered Person has against any party potentially responsible for making any payment to a Covered Person, due to a Covered Person's Injuries or illness, to the full extent of benefits provided, or to be provided by Aetna. In addition, if a Covered Person receives any payment from any potentially responsible party, as a result of an Injury or illness, Aetna has the right to recover from, and be reimbursed by the Covered Person for all amounts this Plan has paid, and will pay as a result of that Injury or illness, up to and including the full amount the Covered Person receives, from all potentially responsible parties. A "Covered Person" includes for the purposes of this provision, anyone on whose behalf this Plan pays or provides any benefit, including but not limited to the minor child or Dependent of any Covered Person, entitled to receive any benefits from this Plan.

As used in this provision, the term "responsible party" means any party possibly responsible for making any payment to a Covered Person or on a Covered Person's behalf due to a Covered Person's injuries or illness or any insurance coverage responsible making such payment, including but not limited to:

- Uninsured motorist coverage,
- Underinsured motorist coverage,
- Personal umbrella coverage,
- Med-pay coverage,
- Workers compensation coverage,
- No-fault automobile insurance coverage, or
- Any other first party insurance coverage.

The Covered Person shall do nothing to prejudice Aetna's subrogation and reimbursement rights. The Covered Person shall, when requested, fully cooperate with Aetna's efforts to recover its benefits paid. It is the duty of the Covered Person to notify Aetna within 45 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim, to recover damages, due to injuries sustained by the Covered Person.

The Covered Person acknowledges that this Plan's subrogation and reimbursement rights are a first priority claim against all potential responsible parties, and are to be paid to Aetna before any other claim for the Covered Person's damages. This Plan shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the Plan will result in a recovery to the Covered Person, which is insufficient to make the Covered Person whole, or to compensate the Covered Person in part or in whole for the damages sustained. This Plan is not required to participate in or pay attorney fees to the attorney hired by the Covered Person to pursue the Covered Person's damage claim. In addition, this Plan shall be responsible for the payment of attorney fees for any attorney hired or retained by this Plan. The Covered Person shall be responsible for the payment of all attorney fees for any attorney hired or retained by the Covered Person or for the benefit of the Covered Person.

The terms of this entire subrogation and reimbursement provision shall apply. This Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party, and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits this Plan provided. This Plan is entitled to recover from any and all settlements or judgments, even those designated as "pain and suffering" or "non-economic damages" only.

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

Coordination of Benefits

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

EXTENSION OF BENEFITS

If Basic Sickness Expense, Supplemental Sickness Expense coverage for a **covered person** ends while he is **totally disabled**, benefits will continue to be available for expenses incurred for that person, only while the **covered person** continues to be **totally disabled**. Benefits will end three months from the date coverage ends.

If a Covered Person is confined to a hospital on the date his or her insurance terminates, expenses incurred after the termination date and during the continuance of that hospital confinement, shall be payable in accordance with the policy, but only while they are incurred during the 90 day period, following such termination of insurance.

TERMINATION OF INSURANCE

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

TERMINATION OF STUDENT COVERAGE

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

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

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

TERMINATION OF DEPENDENT COVERAGE

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

- (a) For a child, on the first premium due date following the first to occur of:
 - (1) The date the child is no longer chiefly dependent upon the student for support and maintenance,
 - (2) The date of the child's marriage, and
 - (3) The child's 25th birthday,
- (b) The date the **covered student** fails to pay any required premium.
- (c) For the spouse, the date the marriage ends in divorce or annulment.
- (d) The date **dependent** coverage is deleted from this Policy.
- (e) For a domestic partner, the earlier to occur of:
 - 1) The date this Policy no longer allows coverage for domestic partners, and
 - 2) The date of termination of the domestic partnership. In that event, a completed and signed declaration of Termination of Domestic Partnership must be provided to the Policyholder.
- (f) The date the **dependent** ceases to be in an eligible class.

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

Continuation of Coverage

Once a student's eligibility through the Rice University Student Health Insurance Plan expires, a student may be eligible to continue coverage in the Plan for a maximum of six months, or until August 14, 2010, whichever occurs first. To continue coverage, you must enroll and make the premium payment within 31 days after the termination of eligibility under the active Student Health Insurance Plan. You must have been insured under the active Student Health Insurance Plan for at least three months prior to terminate of your coverage in order to be eligible for the Continuation Plan. Information on the Continuation Plan is available by contacting Aetna Student Health at (877) 375-7908.

EXCLUSIONS

This Policy does not cover nor provide benefits for:

1. Expense incurred for services normally provided without charge by the Policyholder's Health Service; Infirmary or **Hospital**; or by health care providers employed by the Policyholder.
2. Expense incurred for eye refractions; vision therapy; radial keratotomy; eyeglasses; contact lenses (except when required after cataract surgery); or other vision or hearing aids; or **prescriptions** or examinations except as required for repair caused by a covered **injury**.
3. Expense incurred as a result of **injury** due to participation in a riot. "Participation in a riot" means taking part in a riot in any way; including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense; so long as they are not taken against persons who are trying to restore law and order.
4. Expense incurred as a result of an **accident** occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation; except as a fare-paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.
5. Expense incurred as a result of an **injury** or **sickness** due to working for wage or profit or for which benefits are payable under any Workers' Compensation or Occupational Disease Law.
6. Expense incurred as a result of an **injury** sustained or **sickness** contracted while in the service of the Armed Forces of any country. Upon the **covered person** entering the Armed Forces of any country; the unearned pro-rata premium will be refunded to the Policyholder.
7. Expense incurred for treatment provided in a governmental **hospital** unless there is a legal obligation to pay such charges in the absence of insurance.
8. Expense incurred for **elective treatment** or elective surgery except as specifically provided elsewhere in this Policy and performed while this Policy is in effect.
9. Expense incurred for cosmetic surgery; reconstructive surgery; or other services and supplies which improve; alter; or enhance appearance; whether or not for psychological or emotional reasons; except to the extent needed to:

Improve the function of a part of the body that:

- Is not a tooth or structure that supports the teeth; and
- Is malformed:

This exclusion will not apply to reconstructive surgery for craniofacial abnormalities performed on a dependent child who is under 18 years of age. As used here, "reconstructive surgery for craniofacial abnormalities" means reconstructive surgery:

- To improve the function of; or
- To attempt to create a normal appearance of;

An abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections or disease.

- As a result of a severe birth defect; including harelip; webbed fingers; or toes; or
- As direct result of:
 - Disease; or
 - Surgery performed to treat a disease or **injury**.

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

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

10. Expense incurred as a result of preventive medicines; serums; vaccines or oral contraceptive unless otherwise provided in the policy.
11. Expense incurred as a result of commission of a felony.
12. Expense incurred for voluntary or elective abortions unless otherwise provided in this Policy.
13. Expense incurred after the date insurance terminates for a **covered person** except as may be specifically provided in the Extension of Benefits Provision.
14. Expense incurred for services normally provided without charge by the school and covered by the school fee for services.
15. Expense incurred for any services rendered by a member of the **covered person's** immediate family or a person who lives in the **covered person's** home.
16. Expense incurred by a **covered person** not a United States Citizen for services performed within the **covered person's** home country.
17. Expense incurred for treatment of temporomandibular joint dysfunction except for **medically necessary** diagnostic and surgical treatments and associated myofascial pain,
18. Expense for allergy serums and injections.
19. Expenses for treatment of **injury** or **sickness** to the extent that payment is made; as a judgment or settlement; by any person deemed responsible for the **injury** or **sickness** (or their insurers).
20. Expense incurred for which no member of the **covered person's** immediate family has any legal obligation for payment.
21. Expense incurred for **custodial care**. **Custodial care** means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes **room and board** and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:
 - By whom they are prescribed; or
 - By whom they are recommended; or
 - By whom or by which they are performed.
22. Expense incurred for the removal of an organ from a **covered person** for the purpose of donating or selling the organ to any person or organization. This limitation does not apply to a donation by a **covered person** to a spouse; child; brother; sister; or parent.
23. Expenses incurred for blood or blood plasma; except charges by a hospital for the processing or administration of blood.
24. Expenses incurred for the repair or replacement of existing artificial limbs; orthopedic braces; or orthotic devices.

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

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

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

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

- Have been granted treatment investigational new drug (IND); or Group c/treatment IND status; or
- Are being studied at the Phase III level in a national clinical trial; sponsored by the National Cancer Institute;

If Aetna determines that available; scientific evidence demonstrates that the drug is effective; or shows promise of being effective; for the disease.

26. Expenses incurred for gastric bypass; and any restrictive procedures; for weight loss.
27. Expenses incurred for breast reduction/mamoplasty.
28. Expenses incurred for gynecal mastea (male breasts).
29. Expenses incurred for any sinus surgery; except for acute purulent sinusitis.
30. Expense incurred for; or related to; services; treatment; testing; educational testing; training; or medication for Attention Deficit Disorder; Attention Deficit Hyperactive Disorder; or Learning Disabilities; or other developmental delays.
31. Expense incurred for acupuncture; unless services are rendered for anesthetic purposes.
32. Expense incurred for alternative; holistic medicine; and/or therapy; including but not limited to; yoga and hypnotherapy.
33. Except when **medically necessary** for the treatment of diabetes, expense for: (a) care of flat feet; (b) supportive devices for the foot; (c) care of corns; bunions; or calluses; (d) care of toenails; and (e) care of fallen arches; weak feet; or chronic foot strain; except that (c) and (d) are not excluded when **medically necessary**; because the **covered person** suffers from circulatory problems.
34. Expense incurred when the person or individual is acting beyond the scope of his/her/its legal authority.
35. Expense incurred for hearing aids; the fitting; or prescription of hearing aids.

36. Expenses incurred for hearing exams, except for hearing screening benefit that is mandated for children.
37. Expense for services or supplies used to treat conditions related to autism; hyperkinetic syndromes; learning disabilities; behavioral problems; mental retardation; or senile deterioration; beyond the period necessary to diagnose the condition.
38. Expense for care or services to the extent the charge would have been covered under Medicare Part A or Part B; even though the **covered person** is eligible; but did not enroll in Part B.
39. Expense for charges for failure to keep a scheduled visit; or charges for completion of a claim form.
40. Expense for the cost of supplies used in the performance of any occupational therapy.
41. Expense for personal hygiene and convenience items; such as air conditioners; humidifiers; hot tubs; whirlpools; or physical exercise equipment; even if such items are prescribed by a **physician**.
42. Expense for services or supplies provided for the treatment of obesity and/or weight control.
43. Expense for incidental surgeries; and standby charges of a **physician**.
44. Expense for treatment and supplies for programs involving cessation of tobacco use.
45. Expense incurred as a result of **dental** treatment; including extraction of wisdom teeth; except for treatment resulting from **injury to sound natural teeth**; as provided elsewhere in this Policy.
46. Expense incurred for injury resulting from the play or practice of intercollegiate sports; (participating in sports clubs; or intramural athletic activities; is not excluded).
47. Expense for contraceptive methods; devices or aids; and charges for services and supplies for or related to gamete intrafallopian transfer; artificial insemination; in-vitro fertilization (except as required by the state law); or embryo transfer procedures; elective sterilization or its reversal; or elective abortion; unless specifically provided for in this Policy.
48. Expenses incurred for massage therapy.
49. Expense incurred for; or related to; sex change surgery; or to any treatment of gender identity disorder.
50. Expense for charges that are not **reasonable charges**; as determined by Aetna.
51. Expense for charges that are not **recognized charges**; as determined by Aetna; except that this will not apply if the charge for a service; or supply; does not exceed the **recognized charge** for that service or supply; by more than the amount or percentage; specified as the Allowable Variation.
52. Expense for charges that are not **reasonable charges**; as determined by Aetna; except that this will not apply if the charge for a service; or supply; does not exceed the **reasonable charge** for that service or supply; by more than the amount or percentage; specified as the Allowable Variation.
53. Expense for treatment of **covered students** who specialize in the mental health care field; and who receive treatment as a part of their training in that field.
54. Expenses for treatment of **injury** or **sickness** to the extent payment is made; as a judgement or settlement; by any person deemed responsible for the **injury** or **sickness** (or their Insurers).

55. Expenses for routine physical exams; including expenses in connection with well newborn care; routine vision exams; routine dental exams; routine hearing exams; immunizations; or other preventive services and supplies; except to the extent coverage of such exams; immunizations; services; or supplies is specifically provided in the Policy.
56. Expense incurred for a treatment; service; or supply; which is not **medically necessary**; as determined by Aetna; for the diagnosis care or treatment of the **sickness** or **injury** involved. This applies even if they are prescribed; recommended; or approved; by the person's attending **physician**; or **dentist**.

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

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

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

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

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

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

DEFINITIONS

Accident

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

Actual Charge

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

Aggregate Maximum

The maximum benefit that will be paid under this Policy for all **Covered Medical Expenses** incurred by a covered person that accumulate **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:
 - Physicians who practice surgery in an area **hospital**, and
 - **Dentists** who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by a R.N.
- Is equipped and has trained staff to handle medical emergencies.
- It must have:
 - A physician trained in cardiopulmonary resuscitation, and
 - A defibrillator, and
 - A tracheotomy set, and
 - A blood volume expander.
- Has a written agreement with a **hospital** in the area for immediate emergency transfer of patients. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. The program must include reviews by physicians who do not own or direct the facility.
- Keeps a medical record on each patient.

Birthing Center

A freestanding facility that:

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

Brand Name Prescription Drug or Medicine

A **prescription drug** which is protected by trademark registration.

Complications of Pregnancy

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

- Acute nephritis or nephrosis, or
- Cardiac decompensation or missed abortion, or
- Similar conditions as severe as these.

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

Complications of Pregnancy also include:

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

Copay

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

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

Covered Dental Expenses

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

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

Covered dependent

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

Covered Medical Expense

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

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

Covered person

A **covered student** 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 or she performs.

Dependent

(a) the **covered student's** spouse; or (b) the person identified as a same or opposite sex 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/children who are under 25 years of age.

The term "child" includes:

- Your biological children.
- Your adopted children.
- Your stepchildren.
- For Health Expense Coverage, your grandchild whom you support on the date of his or her initial application for coverage.

The term **dependent** does not include a person who is: (a) an eligible student.

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 Equipment and Supplies

New or improved diabetes equipment or supplies, including improved insulin or another prescription drug, approved by the United States Food and Drug Administration if the equipment or supplies are determined by a physician or other health care practitioner to be medically necessary and appropriate.

(a) Equipment and supplies for the treatment of diabetes for which a physician or practitioner has written an order, including:

- (1) Blood glucose monitors, including those designed to be used by or adapted for the legally blind;
- (2) Test strips specified for use with a corresponding glucose monitor;
- (3) Lancets and lancet devices;
- (4) Visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein;
- (5) Insulin and insulin analog preparations;
- (6) Injection aids, including devices used to assist with insulin injection and needleless systems; E28
- (7) Insulin syringes;
- (8) Biohazard disposal containers;
- (9) Insulin pumps, both external and implantable, and associated appurtenances, which include:
 - (A) Insulin infusion devices;
 - (B) Batteries;
 - (C) Skin preparation items;
 - (D) Adhesive supplies;
 - (E) Infusion sets;
 - (F) Insulin cartridges;
 - (G) Durable and disposable devices to assist in the injection of insulin; and
 - (H) Other required disposable supplies;
- (10) Repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump;
- (11) Prescription medications which bear the legend 'Caution: Federal Law prohibits dispensing without a prescription' and medications available without a prescription for controlling the blood sugar level;
- (12) Podiatric appliances, including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes; and
- (13) Glucagon emergency kits.

(b) As new or improved treatment and monitoring equipment or supplies become available and are approved by the United States Food and Drug Administration, such equipment or supplies shall be covered if determined to be medically necessary and appropriate by a treating physician or other practitioner through a written order.

(c) All supplies, including medications, and equipment for the control of diabetes shall be dispensed as written, including brand name products, unless substitution is approved by the physician or practitioner who issues the written order for the supplies or equipment.

Diabetes Self-Management Education

(a) Diabetes self-management training by a health care practitioner or provider who is:

- (1) Licensed, registered, or certified in this state to provide appropriate health care services; and
- (2) Acting within the scope of practice authorized by the license, registration, or certification.

(b) "Self-management training" includes:

- (1) Training provided to a qualified enrollee, after the initial diagnosis of diabetes, in the care and management of that condition, including nutrition counseling and counseling on the proper use of diabetes equipment and supplies;
- (2) Additional training authorized on the diagnosis of a physician or other health care practitioner of a significant change in the qualified enrollee's symptoms or condition that requires changes in the qualified enrollee's self-management regime; and
- (3) Periodic or episodic continuing education training prescribed by an appropriate health care practitioner as warranted by the development of new techniques or treatments for diabetes.

(c) If the diabetes self-management training is provided on the written order of a physician or other health care practitioner, including a health care practitioner practicing under protocols jointly developed with a physician, the training must also include:

- (1) A diabetes self-management training program recognized by the American Diabetes Association;

- (2) diabetes self-management training provided by a multidisciplinary team:
- (A) the nonphysician members of which are coordinated by:
 - (i) A diabetes educator who is certified by the National Certification Board for Diabetes Educators; or
 - (ii) An individual who has completed at least 24 hours of continuing education that meets guidelines established by the Texas Board of Health and that includes a combination of diabetes-related educational principles and behavioral strategies;
 - (B) That consists of at least a licensed dietitian and a registered nurse and may include a pharmacist and a social worker; and
 - (C) Each member of which, other than a social worker, has recent didactic and experiential preparation in diabetes clinical and educational issues as determined by the member's licensing agency, in consultation with the commissioner of public health, unless the member's licensing agency, in consultation with the commissioner of public health, determines that the core educational preparation for the member's license includes the skills the member needs to provide diabetes self-management training;
- (3) Diabetes self-management training provided by a diabetes educator certified by the National Certification Board for Diabetes Educators; or
- (4) Diabetes self-management training that provides one or more of the following components:
- (A) A nutrition counseling component provided by a licensed dietitian, for which the licensed dietitian shall be paid;
 - (B) A pharmaceutical component provided by a pharmacist, for which the pharmacist shall be paid;
 - (C) A component provided by a physician assistant or registered nurse, for which the physician assistant or registered nurse shall be paid, except that the physician assistant or registered nurse may not be paid for providing a nutrition counseling or pharmaceutical component unless a licensed dietitian or pharmacist is unavailable to provide that component; or
 - (D) A component provided by a physician.
- (d) An individual may not provide a component of diabetes self-management training under Subsection (c)(4) unless:
- (1) The subject matter of the component is within the scope of the individual's practice; and
 - (2) The individual meets the education requirements, as determined by the individual's licensing agency in consultation with the commissioner of public health.

Directory

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

Durable Medical and Surgical Equipment

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

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

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

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), unless otherwise provided in this Plan;
- Immunization, unless otherwise provided in this Plan
- Treatment of infertility, and
- Routine physical examinations.

Emergency Admission

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

- Requires confinement right away as a full-time inpatient, and
- If immediate inpatient care was not given could, as determined by Aetna, reasonably be expected to result in:
 - Loss of life or limb, or
 - Significant impairment to bodily function, or
 - Permanent dysfunction of a body part.

Emergency Condition

This is any traumatic injury or condition which:

- Occurs unexpectedly,
- Requires immediate diagnosis and treatment, in order to stabilize the condition, and
- Is characterized by symptoms such as severe pain and bleeding.

Emergency Medical Condition

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

- Placing the person's health in serious jeopardy, or
- Serious impairment to bodily function, or
- Serious dysfunction of a body part or organ, or
- Serious disfigurement; 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.

Home Health Agency

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

Home health aide

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

Home Health Care

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

Home Health Care Plan

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

Hospice

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

Hospice benefit period

A period that begins on the date the attending **physician** certifies that the **covered person** is a terminally ill patient who has less than 6 months to live. It ends after 6 months (or such later period for which treatment is pre-authorized) 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 or her, or any person who is part of his or her family, any healthcare provider, or healthcare facility, or
- Those furnished solely because the person is an inpatient on any day on which the person's **sickness** or **injury** could safely and adequately be diagnosed or treated while not confined, or
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished, in a **physician's** or a **dentist's** office, or other less costly setting.

Medication Formulary

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

Member Dental Provider

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

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

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

Member Dental Provider Service Area

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

Negotiated Charge

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

Non-Occupational Disease

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

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

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

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

Non-Occupational Injury

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

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

Non-Preferred Care

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

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

Non-Preferred Care Provider

- A health care provider that has not contracted to furnish services or supplies at a **negotiated charge**, or

Non-Preferred Pharmacy

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

Non-Preferred Prescription Drug Expense

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

One Sickness

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

Orthodontic treatment

Any

- Medical service or supply, or
 - Dental service or supply,
- furnished to prevent or to diagnose or to correct a misalignment:

- Of the teeth, or
 - Of the bite, or
 - Of the jaws or jaw joint relationship,
- whether or not for the purpose of relieving pain. Not included is:

- The installation of a space maintainer, or
- Surgical procedure to correct malocclusion.

Out-of-Area Emergency Dental Care

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

Out-of-Pocket Limit

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

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

- **Deductibles**,
- **Copays**,
- Expenses that are not **Covered Medical Expenses**,
- Expenses for **designated care** or **non-preferred care**,
- Penalties,
- Expenses for prescription drugs, and
- Other expenses not covered by this Policy.

Partial hospitalization

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

Pharmacy

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

Physician

(a) legally qualified **physician** licensed by the state in which he or she practices, and (b) any 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-Existing Condition

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

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 law; may be dispensed only by **prescription**; and
- Any drug prescribed to treat a **covered person** for a covered chronic, disabling, or life-threatening illness if the drug: (1) has been approved by the Food and Drug Administration for at least one indication; and (2) is recognized for treatment of the indication for which the drug is prescribed in: (A) a standard drug reference compendium; or (B) substantially accepted peer-reviewed medical literature;

For the purposes of administering benefits, any of the following items, even though a physician's prescription is not required:

Injectable insulin; disposable needles and syringes; when 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.

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 2 or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Service Area

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

Sickness

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

Skilled Nursing Facility

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

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

Sound Natural Teeth

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

Surgery Center

A free standing ambulatory surgical facility that:

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

- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by a registered nurse.
- Is equipped and has trained staff to handle medical emergencies.
- It must have:
 - A **physician** trained in cardiopulmonary resuscitation, and
 - A defibrillator, and
 - A tracheotomy set, and
 - A blood volume expander.
- Has a written agreement with a hospital in the area for immediate emergency transfer of patients. Written procedures for such a transfer must be displayed, and the staff must be aware of them.
- Provides an ongoing quality assurance program. The program must include reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient.

Surgical assistant

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

Surgical expense

Charges by a **physician** for,

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

Surgical procedure

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

Totally Disabled

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

Urgent Admission

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

- The onset of or change in a disease, or
- The diagnosis of a disease, or
- An **injury** caused by an **accident**, which, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.

Urgent Condition

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

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

Urgent Care Provider

This is:

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

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

Walk-in Clinic

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

CLAIM PROCEDURE

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

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

1. Bills must be submitted within 90 days from the date of treatment.
2. Payment for Covered Medical Expenses will be made directly to the hospital or physician concerned, unless bill receipts and proof of payment are submitted.
3. If itemized medical bills are available at the time the claim form is submitted, attach them to the claim form. Subsequent medical bills should be mailed promptly to the above address.
4. 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 one hundred eighty (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

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 [Insert School Specific Customer Service Number].

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)
- \$2,500 Joining of Ill Family Member Accommodations
- Return of Traveling Companion
- \$2,500 Emergency Return Home in the event of death or life-threatening illness of a parent or sibling

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

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

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

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

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

Got Questions? Get Answers with Aetna's Navigator[®]

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

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

How do I register?

- Go to www.aetnastudenthealth.com
- Find your school in the School Directory
- Click on Aetna Navigator® Member Website and then the “Register for Aetna Navigator” link.
- Follow the instructions for the registration process, including selecting a user name, password and security phrase.

Need help with registering onto Aetna Navigator?

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

NOTICE

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

Administered by:

Aetna Student Health.
P.O. Box 15708
Boston, MA 02215-0014
(877) 375-7908
www.aetnastudenthealth.com

Underwritten by:

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

Policy No. 890436

The Rice 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.