Be advised that you may be eligible for coverage under a group health plan of a parent’s employer or under a parent’s individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent’s employer plan or the parent’s individual health insurance issuer for more information.

Underwritten by:
Aetna Life Insurance Company (ALIC)

Policy Number: 711146
WHERE TO FIND HELP

In case of an emergency, call 911 or go directly to an emergency care facility.

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

Please contact:
Aetna Student Health
P.O. Box 981106
El Paso, TX 79998
(800) 239-9697

For questions about:
- ID Cards

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

For lost ID cards, contact:
Aetna Student Health
(800) 239-9697

Ann Arbor Students and Scholars - for questions about:
- Enrollment Process
- Waiver Process

Please contact:
University of Michigan International Center
603 East Madison Street
Ann Arbor, MI 48109-1370
(734) 647-2303
E-mail: ihi@umich.edu

Dearborn Students and Scholars - for questions about:
- Enrollment Process
- Waiver Process

Please contact:
Office of International Affairs
2174 UC
4901 Evergreen Rd
Dearborn, MI 48128-2406
(313) 583-6600
E-mail: international@umd.umich.edu

Flint Students and Scholars - for questions about:
- Enrollment Process
- Waiver Process
Please contact:
International Center
219 UCEN
303 East Kearsley St
Flint, MI 48502-1950
(810) 762-0867
E-mail: ic@umflint.edu

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

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

For questions about:
• Provider Listings

Please contact:
Aetna Student Health
(800) 239-9697

A complete list of providers can be found through Aetna’s DocFind® Service at www.aetnastudenthealth.com

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

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

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

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 University of Michigan. 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 of Michigan International Center in Ann Arbor during normal 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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THE UNIVERSITY OF MICHIGAN INTERNATIONAL STUDENT/SCHOLAR
HEALTH INSURANCE PLAN

The University of Michigan International Student/Scholar Health Insurance Plan has been developed especially for University of Michigan F-1 and J-1 International Students/Scholars and their accompanying dependents. The Plan, which is underwritten by Aetna Life Insurance Company (Aetna), provides coverage for illnesses and injuries that occur on and off campus (worldwide), and includes special cost-saving features to keep the coverage as affordable as possible. The University of Michigan is pleased to offer the Plan as described in this Brochure.

University of Michigan Information:
1. A listing of the Regents of the University of Michigan can be found at: http://www.regents.umich.edu/
2. A copy of the Non-Discrimination Policy Notice can be found at: http://www.hr.umich.edu/oie/ndpolicy.html

U.S. Government requirements for J1/J2 Visa Policyholders are satisfied under the University of Michigan International Plan.

STUDENTS/SCHOLARS ON THE ANN ARBOR CAMPUS

If you have a life-threatening emergency, call 911 or go directly to the nearest hospital emergency room. Options for the immediate area of the Ann Arbor campus include:
University of Michigan Medical Center, 1500 E. Medical Center Drive, Ann Arbor, MI 48109

A Deductible may apply to your visit, for details see the ‘Deductible’ section of the Summary of Benefits Chart on page 12.

If you need medical care, but it is not an emergency, you can avoid or reduce the Deductible by seeing the following health care providers first. For more specific information about referral requirements, please refer to the ‘Deductible’ section of the Summary of Benefits Chart on page 12.

University Health Service (students, spouses, scholars, same sex domestic partners, children age 10 or above)
University Health Service (UHS)
207 Fletcher Street
Ann Arbor, MI 48109
(734) 764-8320
Access to After Hours Care 866-204-1082 (toll-free) www.uhs.umich.edu

Packard Health (scholars, spouses, same sex domestic partners, children)
Packard Health
3174 Packard Road
Ann Arbor, MI 48108
Phone: (734) 971-1073
http://www.packardhealth.org

Packard Health West
501 North Maple Road
Ann Arbor, MI 48103
Phone: (734) 926-4900
http://www.packardhealth.org

East Ann Arbor Health Center (children under age 18)
General Pediatrics
East Ann Arbor Health and Geriatrics Center
4260 Plymouth Road
Ann Arbor, MI 48109-2701
Phone: 734-647-5715
http://www2.med.umich.edu/healthcenters/healthcentermain.cfm?hc_id=EAAP
STUDENTS/SCHOLARS ON THE DEARBORN CAMPUS
If you have a life-threatening emergency, call 911 or go directly to the nearest hospital emergency room.

A Deductible may apply to your visit; for details see the ‘Deductible’ section of the Summary of Benefits Chart on page 12.

STUDENTS/SCHOLARS ON THE FLINT CAMPUS
If you have a life-threatening emergency, call 911 or go directly to the nearest hospital emergency room. A Deductible may apply to your visit; for details see the ‘Deductible’ section of the Summary of Benefits Chart on page 12.

If you need medical care, but it is not an emergency, you may use the following providers:

Urban Health and Wellness Center
1153 William S. White Bldg.
Flint, MI 48502-1950
(810) 424-5269

POLICY PERIOD
1. Students: Coverage for all insured students enrolled for the Fall Semester, will become effective at 12:01 a.m. on September 1, 2013. Coverage becomes effective on that date or on the effective date printed on the “Temporary Insurance Certificate” received at the Mandatory Check-In program, whichever is later, each Policy Year. Your coverage is effective through the end date of your I-20 or DS-2019 form, or for F-1 students on post-completion Optional Practical Training (OPT), through the end of the OPT period.

2. Insured Dependents: Coverage will become effective on the same date the insured student’s coverage becomes effective. Coverage for insured dependents terminates in accordance with the termination provisions described in the Master Policy. Examples include, but are not limited to: the date the dependent no longer meets the definition of a dependent.

RATES
Students and scholars will be billed once each month.

Note: Students and scholars enrolled in the Plan for part or all of a calendar month will be billed for the entire calendar month, since the monthly premium cannot be pro-rated.

<table>
<thead>
<tr>
<th>Cost</th>
<th>Monthly Rate</th>
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<tbody>
<tr>
<td>Student/Scholar</td>
<td>$112</td>
</tr>
<tr>
<td>Student/Scholar and One Dependent</td>
<td>$408</td>
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<tr>
<td>Student/Scholar and Two or More Dependents</td>
<td>$704</td>
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The rates above include both premiums for the student health plan underwritten by Aetna Life Insurance Company, as well as University of Michigan’s administrative fee.

STUDENT/SCHOLAR COVERAGE

ELIGIBILITY
Eligibility for this Plan is limited to University of Michigan F-1 International Students or J-1 International Students or Scholars whose Forms I-20 or DS-2019 were issued by the University of Michigan. The accompanying dependents of these students and scholars are also eligible for this Plan.

University of Michigan - Ann Arbor Insurance Requirement
All University of Michigan (Ann Arbor) F-1 International Students whose Forms I-20 were issued by the University of Michigan (Ann Arbor), and their accompanying F-2 dependents are eligible for this Plan and must remain enrolled in the Plan throughout their stay as U-M F-1 students or F-2 dependents unless, in the judgment of the
University, comparable coverage is in effect under another insurance policy. The specific criteria used to determine comparability are posted on the International Center’s website at http://internationalcenter.umich.edu/healthins/waiver.html#standards.

All University of Michigan (Ann Arbor) J-1 International Students and Scholars whose Forms DS-2019 were issued by the University of Michigan (Ann Arbor) and their accompanying J-2 dependents are eligible for this Plan and must remain enrolled in the Plan throughout their stay as U-M J-1 students or scholars or J-2 dependents unless, in the judgment of the University, comparable coverage is in effect under another insurance policy. The specific criteria used to determine comparability are posted on the International Center’s website at http://internationalcenter.umich.edu/healthins/waiver.html#standards.

University of Michigan - Dearborn Insurance Requirement
All University of Michigan (Dearborn) F-1 International Students whose Forms I-20 were issued by the University of Michigan (Dearborn), and their accompanying F-2 dependents are eligible for this Plan and must remain enrolled in the Plan throughout their stay as U-M Dearborn F-1 students or F-2 dependents unless, in the judgment of the University, comparable coverage is in effect under another insurance policy.

All University of Michigan (Dearborn) J-1 International Students and Scholars whose Forms DS-2019 were issued by the University of Michigan (Dearborn) and their accompanying J-2 dependents are eligible for this Plan and must remain enrolled in the Plan throughout their stay as U-M J-1 students or scholars or J-2 dependents unless, in the judgment of the University, comparable coverage is in effect under another insurance policy. Information regarding the enrollment, billing or waiver procedures is contained within the University of Michigan Dearborn International Student Health Insurance Plan Notice. A copy of this Notice can be obtained from the International Office at 4901 Evergreen Road, 2174 University Center. For more information visit http://www.umd.umich.edu/css_health_int_obtain_waiver/.

University of Michigan - Flint Insurance Requirement
All University of Michigan-Flint F-1 International Students whose Forms I-20 were issued by the University of Michigan-Flint, and their accompanying F-2 dependents are eligible for this Plan and must remain enrolled in the Plan throughout their stay as UM-Flint F-1 students or F-2 dependents unless, in the judgment of the University, comparable coverage is in effect under another insurance policy.

All University of Michigan-Flint J-1 International Students and Scholars whose Forms DS-2019 were issued by the University of Michigan-Flint and their accompanying J-2 dependents are eligible for this Plan and must remain enrolled in the Plan throughout their stay as UM-Flint J-1 students or scholars or J-2 dependents unless, in the judgment of the University, comparable coverage is in effect under another insurance policy. Information regarding the enrollment, billing or waiver procedures is contained within the University of Michigan-Flint International Student Health Insurance Plan Notice. A copy of this Notice can be obtained from the UM-Flint International Center at 219 UCEN, 303 E. Kearsley St.

ENROLLMENT
All new University of Michigan F-1 International Students or J-1 International Students or Scholars whose Forms I-20 or DS-2019 were issued by the University of Michigan and their accompanying F-2 and J-2 dependents will be enrolled in the International Student/Scholar Health Insurance Plan as soon as the student or scholar has completed the mandatory check-in process, and coverage will become effective on the student or scholar's Form I-20 or DS-2019 start date (Form I-20, Item 5 or Form DS-2019, Item 3).

WAIVERS
University of Michigan - Ann Arbor Campus
If you are eligible for health insurance benefits administered by the University of Michigan Benefits office because you are or will be a University of Michigan employee or a U-M fellowship-holder whose fellowship includes GradCare, please enroll yourself and any eligible dependents in that coverage as soon as possible by following the procedures described at http://benefits.umich.edu/enrollment/index.html. Please also review the information available at http://www.benefits.umich.edu/benefitgroups/index.html carefully, or ask your department administrator for assistance, since specific procedures may be different depending on your “benefit group.” Once you and any accompanying F-2 or J-2 dependents are enrolled in these benefits, your International Student/Scholar Insurance Plan coverage will be cancelled and any needed adjustments (credits) will be made to your insurance account. The cancellation date will depend on the effective date of your University of Michigan benefits. No waiver request form is required since this is an automated process.
International Students and J-1 Exchange Visitors who would like to substitute private insurance or insurance provided by a sponsor for the International Student/Scholar Insurance Plan should fill out and submit the International Health Insurance Waiver Request Form, available on the International Center website, to request approval of an insurance waiver and cancellation of International Student/Scholar Insurance Plan coverage.

More information about requesting a waiver and about the coverage an insurance plan must have in order for a waiver to be approved is available at http://internationalcenter.umich.edu/healthins/waiver.html.

University of Michigan - Dearborn Campus
If you are eligible for health insurance benefits administered by the University of Michigan Benefits office because you are or will be a University of Michigan-Dearborn employee or a U-M fellowship-holder whose fellowship includes GradCare, please enroll yourself and any eligible dependents in that coverage as soon as possible by following the procedures given to you by your hiring department. Once the Office of International Affairs is notified that you and any accompanying F-2 or J-2 dependents are enrolled in these benefits, your International Student/Scholar Insurance Plan coverage will be cancelled and any needed adjustments (credits) will be made to your insurance account. Since this is not an automatic process you or your hiring department must inform Office of International Affairs of your GradCare benefits otherwise you may be enrolled in both Aetna and GradCare.

Students/scholars who would like to substitute private insurance or insurance provided by a sponsor must request an insurance waiver by filling out the waiver request form and attaching information about the insurance coverage they want to substitute for the Aetna Plan. Upon approving a waiver, the Office of International Affairs will update Student Accounts and any necessary adjustments (credits) will be made. More information about requesting a waiver and about the coverage an insurance plan must have in order for a waiver to be approved is available at http://www.umd.umich.edu/css_health_int_obtain_waiver/.

University of Michigan - Flint Campus
The Flint International Center will issue Waiver Request Forms and verify any non-Aetna insurance coverage of any new and continuing F-1 students. Waiver forms can be obtained by visiting the International Center.

International Students and J-1 Exchange Visitors who would like to substitute private insurance or insurance provided by a sponsor for the International Student/Scholar Insurance Plan should fill out and submit the International Health Insurance Waiver Request Form, available on the International Center website, to request approval of an insurance waiver and cancellation of International Student/Scholar Insurance Plan coverage.

More information about requesting a waiver and about the coverage an insurance plan must have in order for a waiver to be approved is available at http://internationalcenter.umich.edu/healthins/waiver.html.

Students can request an insurance waiver by filling out the waiver request form and attaching information about the insurance coverage they want to substitute for the Aetna Plan. Upon approving a waiver, the Flint International Center will update Student Accounts and any necessary adjustment will be made. Waiver forms can be obtained at the International Center.

COVERAGE END DATE
Your coverage under the International Student/Scholar Insurance Plan will extend through the end date of your I-20 or DS-2019, or through the end of your F-1 post-completion Optional Practical Training for students who are recommended for post-completion OPT. If the end date of your I-20 or DS-2019 changes, the end date of your health insurance coverage will also change.

AUTOMATIC RE-ENROLLMENT IN THE INTERNATIONAL STUDENT/SCHOLAR INSURANCE PLAN UNIVERSITY OF MICHIGAN - ANN ARBOR CAMPUS
If your alternative coverage ends before the end of your stay as an F-1 or J-1 student or scholar, you will be re-enrolled in the International Student/Scholar Insurance Plan. Also, if a waiver request form has been approved for private insurance or insurance provided by a sponsor, and the time period for which the waiver has been approved has ended, and the waiver is not renewed or is not re-approved, you will be re-enrolled in the International Student/Scholar Insurance Plan if you have not yet completed your stay as an F-1 student or J-1 student or scholar. If you leave the University permanently before the end date of your I-20 or DS-2019, or leave the United States because you have decided not to complete your post-completion Optional Practical Training (OPT), please be sure to fill out the appropriate departure form. Forms are available at http://internationalcenter.umich.edu/immig/forms/. Please follow the instructions on the form that describe when and how to fill out the form and where to submit the form.
If you do not submit a departure form, the International Center will not know that you have ended your F-1 or J-1 stay, and you may be billed for health insurance, either because your enrollment in the International Student/Scholar Insurance Plan will be continued or because you will be automatically re-enrolled in the International Student/Scholar Insurance Plan if your alternative coverage and/or your insurance waiver ends before your I-20, DS-2019 or (for F-1 students on Optional Practical Training) your OPT end date.

If your immigration status has changed and you are no longer in F-1 or J-1 immigration status, it is your responsibility to notify the University by following the procedure explained at http://internationalcenter.umich.edu/intlstudents/faq.html#q19. You may have the option of continuing your University of Michigan International Student/Scholar Health Insurance Plan for a short period of time after your change of status. Please contact the U-M International Center’s Health Insurance office http://internationalcenter.umich.edu/healthins/hours.html for more information.

University of Michigan - Dearborn Campus
All re-enrollment requests must be initiated and approved through the Office of International Affairs located at 2174 University Center. The office can be reached by phone at (313) 583-6600 or by email at: international@umd.umich.edu.

University of Michigan - Flint Campus
All re-enrollment requests must be initiated and approved through the International Center. The office can be reached by phone at (810) 762-0867 or e-mail: ic@umflint.edu. You may visit the website for more information: http://www.umflint.edu/ic/.

REFUND POLICY

Leaving U-M or not enrolling in classes does not automatically cancel your participation in the Student/Scholar Health Insurance Plan.

UNIVERSITY OF MICHIGAN - ANN ARBOR CAMPUS
U-M F-1 or J-1 students or scholars who leave the University permanently earlier than they anticipated, should be sure to fill out the appropriate departure form so that the International Center can make appropriate adjustments to their SEVIS (Student Exchange Visitor Information System) records. Once this form is processed, the end date of your insurance coverage will also be adjusted if necessary. Departure forms are available at http://internationalcenter.umich.edu/immig/forms/. Please follow the instructions on the form that describe when and how to fill out the form and where to submit the form.

There are some situations in which you may need to visit the International Center Insurance Office to fill out and sign a Cancellation Form instead of or in addition to a departure form in order to change the end date of your insurance coverage. All Cancellation Forms must be approved by the Health Insurance Advisor. Please contact the Insurance Advisor at ihi@umich.edu for more information.

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.

UNIVERSITY OF MICHIGAN - DEARBORN CAMPUS
All coverage cancellation requests must be initiated and approved through the Office of International Affairs, 2174 UC. 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.

UNIVERSITY OF MICHIGAN - FLINT CAMPUS
All re-enrollment requests must be initiated and approved through the International Center. 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/same-sex domestic partner and dependent children to age 26. Dependent eligibility expires concurrently with that of the insured student.

ENROLLMENT
Accompanying F-2 and J-2 dependents of F-1/J-1 International Students and International Visiting Scholars will be enrolled in the International Student/Scholar Health Insurance Plan as soon as the student or scholar has completed the mandatory check-in process, and coverage will become effective on the student or scholar's Form I-20 or DS-2019 start date (Form I 20, Item 5 or Form DS-2019, Item 3).

For information or general questions on Dependent enrollment, please contact:
- Ann Arbor Campus: University of Michigan International Center – (734) 647-2303 or ihi@umich.edu
- Dearborn Campus: Office of International Affairs – (313) 583-6600 or international@umd.umich.edu
- Flint Campus: International Center – (810) 762-0867 or ic@umflint.edu

NEWBORN INFANT AND ADOPTED CHILD COVERAGE
A child born to a Covered Person shall be covered for Accident, Sickness, and congenital defects, for 31 days from the date of birth*. At the end of this 31 day period, coverage will cease under the University of Michigan International Student/Scholar 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 further assistance and premium information, please contact:
- Ann Arbor Campus: University of Michigan International Center – (734) 647-2303 or ihi@umich.edu
- Dearborn Campus: Office of International Affairs – (313) 583-6600 or international@umd.umich.edu
- Flint Campus: International Center – (810) 762-0867 or ic@umflint.edu

* Routine care/checkups for newborn children are not covered after discharge from the hospital, unless the child is enrolled in the Plan within 31 days of birth.

PREFERRED PROVIDER NETWORK
Aetna Student Health has arranged for you to access a Preferred Provider Network. Acute care facilities and mental health networks are available nationally if you require hospitalization outside the immediate area of the 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. You may obtain information regarding Preferred Providers by contacting Aetna Student Health at (800) 239-9697, or through the Internet by accessing DocFind® at www.aetnastudenthealth.com.

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

REFERRAL REQUIREMENTS (ANN ARBOR CAMPUS ONLY)
Students’ health care needs can best be satisfied when an organized system of health care providers at the University of Michigan Health Service manages the treatment. If you are enrolled in the Student/Scholar Health Insurance Plan, it is to your advantage to first seek treatment at the University Health Service in order to reduce your out-of-pocket expenses. The health care providers will then refer you, if appropriate, to an outside provider. For specific information about referral requirements for students, scholars, spouses and children, please refer to the Summary of Benefits charts under “Deductible.”
Please Note:

- **Covered Students**/scholars and their dependents who continue treatment of a condition from one **Policy Year** to the next do not need to obtain a new referral from the University Health Service. Refer to the Summary of Benefits Chart for details.

- The following services do not require a referral, and therefore the **Deductible** is waived for these services: Outpatient treatment of a mental and nervous disorder; maternity expenses; mammography expenses; Pap smear expenses and elective abortion expenses. **Copays** may still apply. Refer to the Summary of Benefits Chart for details.

**PRE-CERTIFICATION PROGRAM**

Pre-certification simply means calling Aetna Student Health prior to treatment to obtain approval for a medical procedure or service. Pre-certification may be done by you, your doctor, a hospital administrator, or one of your relatives. All requests for certification must be obtained by contacting Aetna Student Health at (800) 239-9697 (attention Managed Care Department).

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

2. **If you do not secure pre-certification** for partial hospitalizations, your Covered Medical Expenses will be subject to a $200 per admission Deductible.

The following inpatient services require pre-certification:

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

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

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

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

**DESCRIPTION OF BENEFITS**

Please Note:

**THE UNIVERSITY OF MICHIGAN INTERNATIONAL STUDENT/SCHOLAR HEALTH INSURANCE PLAN MAY NOT COVER ALL OF YOUR HEALTH CARE EXPENSE.**

The Plan excludes coverage for certain services and contains limitations on the amounts it will pay. Please read the University of Michigan International Student/Scholar Health Insurance Plan Brochure carefully before deciding whether this Plan is right for you. While this document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. If you want to look at the full Plan description, which is contained in the Master Policy issued to University of Michigan, you may view it at the University of Michigan International Center in Ann Arbor during normal business hours or you may contact Aetna Student Health at (800) 239-9697.

Some illnesses may cost more to treat and health care providers may bill you for what the Plan does not cover. Subject to the terms of the Policy, benefits are available for you only for the coverage listed below, and only up to the maximum amounts shown. Please refer to the Policy for a complete description of the benefits available.
All insurance coverage is subject to the terms of the Master Policy and applicable state filings. Under health care reform legislation, student health plans may be required to eliminate or modify certain existing benefit plan provisions, including, but not limited to, exclusions and limitations. Aetna reserves the right to modify its products and services in response to federal and/or state legislation, regulation or requests of government authorities.

*Benefit descriptions have been added to this brochure to help illustrate new Health Care Reform (HCR) requirements. HCR requirements are currently being filed for support in individual states and will appear in policy contracts and certificates of coverage once approved.

**SUMMARY OF BENEFITS CHART**

<table>
<thead>
<tr>
<th>DEDUCTIBLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>The following <strong>Deductible</strong>s are applied before <strong>Covered Medical Expenses</strong> are payable:</td>
</tr>
<tr>
<td>Students: $50 per Condition per Lifetime</td>
</tr>
<tr>
<td>Spouse: $50 per Condition per Lifetime</td>
</tr>
<tr>
<td>Child: $50 per Condition per Lifetime</td>
</tr>
</tbody>
</table>

**SPECIAL NOTE FOR STUDENTS AND THEIR COVERED DEPENDENTS ON THE ANN ARBOR CAMPUS ONLY:** The **Deductible** should be waived, or reduced, if following conditions are met:

- If a student, **Dependent** spouse, same-sex domestic partner, **Dependent** child (age ten or older) or visiting scholar is first treated at, or referred by, the University Health Service, the **Deductible** will be waived;
- If a **Dependent** spouse, same-sex domestic partner or visiting scholar is first treated at, or referred by, Packard Health the **Deductible** will be $10 per Injury or Sickness;
- If a **Dependent** child is first treated at, or referred by, Packard Health or Pediatric Primary Care at the East Arbor Health Center (**under 18 years of age**), the **Deductible** will be $10 per Injury or Sickness.

The following services do not require a referral, and therefore the **Deductible** is waived for these services: Outpatient treatment of a mental and nervous disorder; maternity expenses; mammography expenses; Pap smear expenses, elective abortions. **Copays** still apply. Refer to the summary of benefits chart for details.

**Waiver of Deductible**

In compliance with Federal Health Care Reform legislation, the Deductible is waived for Preferred Care **Covered Medical Expenses** (refer to specific benefit types for list of services) rendered as part of the following benefit types: Routine Physical Exam Expense (**Office Visits**), Pap Smear Screening Expense, Mammogram Expense, Routine Screening for Sexually Transmitted Disease Expense, Routine Colorectal Cancer Screening, Routine Prostate Cancer Screening Expense, Well Woman Preventive Visits (**Office Visits**), Screening & Counseling Services (**Office Visits**), Routine Cancer Screenings (**Outpatient**), Prenatal Care (**Office Visits**), Comprehensive Lactation Support and Counseling Services (**Facility or Office Visits**), Breast Pumps & Supplies, Family Contraceptive Counseling Services (**Office Visits**), Female Voluntary Sterilization (**Inpatient and Outpatient**)

The **Deductible** is not applicable to the following **Covered Expenses**:

- Female Generic Contraceptive Devices
- Female Generic Contraceptive Prescription Drugs
- Female Over-the-Counter Contraceptive Methods

In addition to state and federal requirements for waiver of the **Deductible**, this plan will waive the **Deductible** for Prescribed Medicine Expenses, Mental Health Expense, Elective Abortion Expense and Maternity Expense.

**COINSURANCE**

**Covered Medical Expenses** are payable at the coinsurance percentage specified below up to an unlimited maximum benefit.

**BENEFIT ALLOCATION**

**Covered Medical Expenses** listed below are payable at the Negotiated/Reasonable/Actual Charge in accordance with the following reimbursement levels, **unless specifically noted otherwise** in the benefit descriptions below:

- **100%** for first $5,000 in paid benefits;
- **80%** for $5,001 to $40,000 in paid benefits;
- **100%** for $40,001 in paid benefits, to the **unlimited Maximum, per Condition**.
### OUT OF POCKET MAXIMUMS

Once the Out-of-Pocket Limit has been satisfied, **Covered Medical Expenses** will be payable at 100%, up to any benefit maximum that may apply. **Coinsurance** applies to the Out-of-Pocket Limit.

All coverage is based on Recognized Charges unless otherwise specified.

#### Inpatient Hospitalization Benefits

<table>
<thead>
<tr>
<th>Expense</th>
<th>Covered Medical Expenses are payable as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and Board Expense</td>
<td>Preferred Care: 100% of the Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge for a semi-private room.</td>
</tr>
<tr>
<td>Intensive Care Room and Board Expense</td>
<td>Preferred Care: 100% of the Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge for the Intensive Care Room Rate for an overnight stay.</td>
</tr>
<tr>
<td>Miscellaneous Hospital Expense</td>
<td>Covered Medical Expenses include, among others, expenses incurred during a hospital confinement for:</td>
</tr>
<tr>
<td></td>
<td>• Anesthesia and operating room,</td>
</tr>
<tr>
<td></td>
<td>• Laboratory tests and X rays,</td>
</tr>
<tr>
<td></td>
<td>• Oxygen tent, and</td>
</tr>
<tr>
<td></td>
<td>• Drugs, medicines, dressings.</td>
</tr>
<tr>
<td></td>
<td>Covered Medical Expenses are payable as follows:</td>
</tr>
<tr>
<td></td>
<td>Preferred Care: 100% of the Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge.</td>
</tr>
<tr>
<td>Non-Surgical Physicians Expense</td>
<td>Covered Medical Expenses for charges for the non-surgical services of the attending Physician, or a consulting Physician, are payable as follows:</td>
</tr>
<tr>
<td></td>
<td>Preferred Care: 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge.</td>
</tr>
</tbody>
</table>

#### Surgical Expense – Inpatient

<table>
<thead>
<tr>
<th>Expense</th>
<th>Covered Medical Expenses for charges for surgical services, performed by a Physician, are payable as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Expense</td>
<td>Preferred Care: 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge.</td>
</tr>
<tr>
<td>Anesthesia Expense</td>
<td>Covered Medical Expenses for the charges of anesthesia, during a surgical procedure, are payable as follows:</td>
</tr>
<tr>
<td></td>
<td>Preferred Care: 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge.</td>
</tr>
</tbody>
</table>
Assistant Surgeon Expense  | **Covered Medical Expenses** for the charges of an assistant surgeon, during a surgical procedure, are payable as follows:

**Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge.

**Non-Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge.

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Surgical Expense – Outpatient

Surgical Expense  | **Covered Medical Expenses** for charges for surgical services, performed by a Physician, are payable as follows:

**Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge.

**Non-Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge.

Anesthesia Expense  | **Covered Medical Expenses** for the charges of anesthesia, during a surgical procedure, are payable as follows:

**Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge.

**Non-Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge.

Assistant Surgeon Expense  | **Covered Medical Expenses** for the charges of an assistant surgeon, during a surgical procedure, are payable as follows:

**Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge.

**Non-Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge.

Ambulatory Surgical Expense  | Benefits are payable for **Covered Medical Expenses** incurred by a **Covered Person** for expenses incurred for outpatient surgery performed in a hospital outpatient surgery department or in an ambulatory surgical center. **Covered Medical Expenses** must be incurred on the day of the surgery or within 48 hours after the surgery.

**Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge.

**Non-Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge.

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

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Outpatient Benefits

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

Hospital Outpatient Department Expense  | **Covered Medical Expenses** include treatment rendered in a Hospital Outpatient Department.

**Covered Medical Expenses** do not include Emergency Room/Urgent Care Treatment, Walk-in Clinic, Therapy Expenses, Chemotherapy and Radiation, and outpatient surgical services, including physician, anesthesia and facility charges, which are covered as outlined under the individual benefit types listed in this schedule of benefits.

**Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge.

**Non-Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge.
| Walk-In Clinic Visit Expense | **Covered Medical Expenses** include services rendered in a walk-in clinic.  
**Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge  
**Non-Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge. |
|---|---|
| Emergency Room Expense | **Covered Medical Expenses** include medically necessary services provided for the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:  
- Serious jeopardy to the individual's health or to a pregnancy in the case of a pregnant woman,  
- Serious impairment to bodily functions, or  
- Serious dysfunction of any bodily organ or part.  

Benefits for Emergency Medical Services up to the point of stabilization are payable as follows:  
**Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge.  
**Non-Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge.  

**Important Note:** Please note that as **Non-Preferred Care Providers** do not have a contract with **Aetna**, the provider may not accept payment of your cost share (your deductible and coinsurance) as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. Please send **Aetna** the bill at the address listed on the back of your member ID card and **Aetna** will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill. |
| Urgent Care Expense | Benefits include charges for treatment by an urgent care provider.  
**Please note:** A Covered Person should not seek medical care or treatment from an urgent care provider if their illness, injury, or condition, is an emergency condition. The Covered Person should go directly to the emergency room of a hospital or call 911 (or the local equivalent) for ambulance and medical assistance.  
**Urgent Care**  
Benefits include charges for an urgent care provider to evaluate and treat an urgent condition.  
**Covered Medical Expenses** for urgent care treatment are payable as follows:  
**Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge.  
**Non-Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge.  
No benefit will be paid under any other part of this Plan for charges made by an urgent care provider to treat a non-urgent condition. |
| Ambulance Expense | **Covered Medical Expenses** are payable 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.  
**Covered Medical Expenses** are payable as follows:  
**Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge.  
**Non-Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge.  
Emergency medical health services include, but are not limited to, the use of emergency vehicles and emergency air transport to ensure the ability to stabilize the patient. |
<table>
<thead>
<tr>
<th>Pre-Admission Testing Expense</th>
<th><strong>Covered Medical Expenses</strong> for Pre-Admission testing charges while an outpatient before scheduled surgery are payable on the same basis as any other sickness.</th>
</tr>
</thead>
</table>
| Physician’s Office Visit Expense | **Covered Medical Expenses** are payable as follows:  
  *Preferred Care:* 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge.  
  *Non-Preferred Care:* 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge.  
  This benefit includes visits to specialists and coverage for Telemedicine Services.  
  "Telemedicine" means the use of an electronic media to link patients with health care professionals in different locations. To be considered telemedicine, the health care professional must be able to examine the patient via a real-time, interactive audio or video, or both, telecommunications system and the patient must be able to interact with the off-site health care professional at the time the services are provided. |
| Laboratory and X-ray Expense | **Covered Medical Expenses** are payable as follows:  
  *Preferred Care:* 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge.  
  *Non-Preferred Care:* 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge. |
| High Cost Procedures Expense | **Covered Medical Expenses** include charges incurred by a **Covered Person** for High Cost Procedures that are required as a result of injury or sickness. Expenses for High Cost Procedures, which must be provided on an outpatient basis; may be incurred in the following:  
  * A physician’s office; or  
  * Hospital outpatient department; or emergency room; or  
  * Clinical laboratory; or  
  * Radiological facility; or other similar facility; licensed by the applicable state; or the state in which the facility is located.  
  **Covered Medical Expenses** for High Cost Procedures include charges for the following procedures and services:  
  * C.A.T. Scan;  
  * Magnetic Resonance Imaging; and  
  * Contrast Materials for these tests.  
  **Covered Medical Expenses** include charges incurred by a **Covered Person** are payable as follows:  
  *Preferred Care:* 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge.  
  *Non-Preferred Care:* 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge. |
| Therapy Expense | **Covered Medical Expenses** include charges incurred by a **Covered Person** for the following types of therapy provided on an outpatient basis:  
  * Chiropractic Care,  
  * Speech Therapy,  
  * Inhalation Therapy,  
  * Cardiac Rehabilitation, or  
  * Occupational Therapy. |
Expenses for Chiropractic Care are **Covered Medical Expenses**, if such care is related to neuromusculoskeletal conditions and conditions arising from: the lack of normal nerve, muscle, and/or joint function.

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

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

**Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge.

**Non-Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge.

Benefits are limited to 1 visit per day for Physical, Occupational Therapy and Chiropractic Care.

**Covered Medical Expenses** for chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy, radiation therapy, tests and procedures, physiotherapy (for rehabilitation only after a surgery), and expenses incurred at a radiological facility. **Covered Medical Expenses** also include expenses for the administration of chemotherapy and visits by a health care professional to administer the chemotherapy. Such expenses are payable as follows:

**Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge.

**Non-Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge.

**Breast Feeding Durable Medical Equipment**
Coverage includes the rental or purchase of breast feeding *durable medical equipment* for the purpose of lactation support (pumping and storage of breast milk) as follows.

**Preferred Care:** 100% of the Negotiated Charge.

**Non-Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge.

**Breast Pump**
**Covered Expenses** include the following:

- The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a *[hospital]*.
- The purchase of:
  - An electric breast pump (non-hospital grade), if requested within 30 days from the date of the birth of the child. A purchase will be covered once every five years following the date of the birth; or
  - A manual breast pump, if requested within 6-12 months from the date of the birth of the child. A purchase will be covered once every five years following the date of the birth.
- If an electric breast pump was purchased within the previous one period, the purchase of an electric or manual breast pump will *not* be covered until a five year period has elapsed from the last purchase of an electric pump.
<table>
<thead>
<tr>
<th>Durable Medical and Surgical Equipment Expense (continued)</th>
<th>Breast Pump Supplies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.</td>
<td></td>
</tr>
<tr>
<td>Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. The <strong>Covered Person</strong> is responsible for the entire cost of any additional pieces of the same or similar equipment that he or she purchases or rents for personal convenience or mobility.</td>
<td></td>
</tr>
<tr>
<td><strong>Aetna</strong> reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of <strong>Aetna</strong>.</td>
<td></td>
</tr>
<tr>
<td><strong>Limitations:</strong></td>
<td></td>
</tr>
<tr>
<td>Unless specified above, not covered under this benefit are charges incurred for:</td>
<td></td>
</tr>
<tr>
<td>• Services which are covered to any extent under any other part of this Plan.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Breast Pump Supplies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Limitations:</strong></td>
</tr>
<tr>
<td>Unless specified above, not covered under this benefit are charges incurred for:</td>
</tr>
<tr>
<td>• Services which are covered to any extent under any other part of this Plan.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prosthetic Devices Expense</th>
<th>Benefits include charges for: artificial limbs, or eyes, and other non-dental prosthetic devices, as a result of an accident or sickness.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Medical Expenses</strong> will include wigs as required as a result of chemo or radiation therapy.</td>
<td></td>
</tr>
<tr>
<td><strong>Covered Medical Expenses</strong> do not include: eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet.</td>
<td></td>
</tr>
<tr>
<td><strong>Covered Medical Expenses</strong> are payable as follows:</td>
<td></td>
</tr>
<tr>
<td><strong>Preferred Care:</strong> 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge.</td>
<td></td>
</tr>
<tr>
<td><strong>Non-Preferred Care:</strong> 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical Therapy Expense</th>
<th><strong>Covered Medical Expenses</strong> for physical therapy are payable as follows when provided by a licensed physical therapist:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Care: 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge.</td>
<td></td>
</tr>
<tr>
<td>Non-Preferred Care: 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge.</td>
<td></td>
</tr>
<tr>
<td>Benefits are limited to 1 visit per day for Physical, Occupational Therapy and Chiropractic Care.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dental Injury Expense</th>
<th><strong>Covered Medical Expenses</strong> include dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Natural teeth damaged, lost, or removed, or</td>
<td></td>
</tr>
<tr>
<td>• Other body tissues of the mouth fractured or cut due to injury. The accident causing the injury must occur while the person is covered under this Plan.</td>
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<tr>
<td>• Non-surgical treatment of infections or diseases. This does not include those of, or related to, the teeth.</td>
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</tr>
<tr>
<td>Any such teeth must have been:</td>
<td></td>
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<tr>
<td>• Free from decay, or</td>
<td></td>
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<tr>
<td>• In good repair, and</td>
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</tr>
<tr>
<td>• Firmly attached to the jawbone at the time of the injury.</td>
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<tr>
<td><strong>The treatment must be done in the calendar year of the accident or the next one.</strong></td>
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</tr>
<tr>
<td>Dental Injury Expense (continued)</td>
<td>If:</td>
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</tr>
<tr>
<td>• Crowns (caps), or</td>
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<tr>
<td>• Dentures (false teeth), or</td>
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<tr>
<td>• Bridgework, or</td>
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<tr>
<td>• In-mouth appliances,</td>
<td></td>
</tr>
<tr>
<td>Are installed due to such injury,</td>
<td></td>
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<tr>
<td>Covered Medical Expenses include</td>
<td></td>
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<tr>
<td>only charges for:</td>
<td></td>
</tr>
<tr>
<td>• The first denture or fixed</td>
<td></td>
</tr>
<tr>
<td>bridgework to replace lost teeth,</td>
<td></td>
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<tr>
<td>• The first crown needed to</td>
<td></td>
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<tr>
<td>repair each damaged tooth, and</td>
<td></td>
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<tr>
<td>• An in-mouth appliance used in</td>
<td></td>
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<tr>
<td>the first course of orthodontic</td>
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<tr>
<td>treatment after the injury.</td>
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<tr>
<td>• Surgery needed to:</td>
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<tr>
<td>• Treat a fracture, dislocation,</td>
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<tr>
<td>or wound.</td>
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<tr>
<td>• Cut out cysts, tumors, or</td>
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<tr>
<td>other diseased tissues.</td>
<td></td>
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<tr>
<td>• Alter the jaw, jaw joints,</td>
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<tr>
<td>or bite relationships by a</td>
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<tr>
<td>cutting procedure when appliance therapy alone cannot result in functional improvement.</td>
<td></td>
</tr>
</tbody>
</table>

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

100% of actual charge for first $5,000, then 80% to $40,000, then 100% of the Actual Charge.

<table>
<thead>
<tr>
<th>Dental Expense for Impacted Wisdom Teeth</th>
<th>Covered Medical Expenses for removal of one or more impacted wisdom teeth are payable as follows 100% of actual charge for first $5,000, then 80% to $40,000, then 100% of the Actual Charge</th>
</tr>
</thead>
</table>
| Allergy Testing Expense                  | Benefits include charges incurred for diagnostic testing of allergies  
**Covered Medical Expenses** include, but are not limited to, charges for the following:  
• Laboratory tests,  
• Physician office visits  
• Prescribed medications for testing of the allergy, including any equipment used in the administration of prescribed medication, and  
• Other medically necessary supplies and services,  
**Covered Medical Expenses** are payable on the same basis as any other sickness.  
No benefits are payable under this Policy for the treatment of allergies. |
| Diagnostic Testing For Learning Disabilities Expense | **Covered Medical Expenses** for diagnostic testing for:  
• Attention deficit disorder, or  
• Attention deficit hyperactive disorder  
Are payable as follows:  
Preferred Care: 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge  
Non-Preferred Care: 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge. |
| Routine Physical Exam Expense | Benefits include expenses for a routine physical exam performed by a physician.  
If charges for a routine physical exam given to a child who is a **Covered Dependent** are covered under any other benefit section, those charges will not be covered under this section.  
A routine physical exam is a medical exam given by a physician, for a reason other than to diagnose or treat a suspected or identified injury or sickness. Included as a part of the exam are:  
• Routine vision and hearing screenings given as part of the routine physical exam.  
• X-rays, lab, and other tests given in connection with the exam, and  
• Materials for the administration of immunizations for infectious disease and testing for tuberculosis.  
**Preferred Care visits** are payable at 100% of the Negotiated Charge.  
**Preferred care immunizations** are payable at 100% of the Negotiated Charge |
Routine Physical Exam Expense (continued)

Non-Preferred Care visits are payable at 100% for first $5,000, then 80% to $40,000, then 100%
of the Recognized Charge.

Non-Preferred Care immunizations are payable at 100% for first $5,000, then 80% to $40,000,
then 100% of the Recognized Charge.

In addition to any state regulations or guidelines regarding mandated Routine Physical Exam
services, Covered Medical Expenses include services rendered in conjunction with,

- Evidence-based items that have in effect a rating of A or B in the current recommendations of
  the United States Preventive Services Task Force.
- For females, screenings and counseling services as provided for in the comprehensive
guidelines recommended by the Health Resources and Services Administration. These
  services may include but are not limited to:
  - Screening and counseling services, such as:
    - Interpersonal and domestic violence;
    - Sexually transmitted diseases; and
    - Human Immune Deficiency Virus (HIV) infections.
  - Screening for gestational diabetes.
  - High risk Human Papillomavirus (HPV) DNA testing for women age 18 and older and
    limited to once every three years.

Sexually transmitted Disease counseling expense is limited to two counseling visits per Policy
Year.
- X-rays, lab and other tests given in connection with the exam.
- Immunizations for infectious diseases and the materials for administration of immunizations
  that have been recommended by the Advisory Committee on Immunization Practices of the
  Centers for Disease Control and Prevention.
- If the plan includes dependent coverage, for covered newborns, an initial hospital check up.

For a child who is a Covered Dependent:

- The physical exam must include at least:
  - A review and written record of the patient's complete medical history,
  - A check of all body systems, and
  - A review and discussion of the exam results with the patient or with the parent or
    guardian.
- For all exams given to Covered Dependent under age 2, Covered Medical Expenses will
  not include charges for the following:
  - More than 6 exams performed during the first year of the child's life,
  - More than 2 exams performed during the second year of the child's life.

For all exams given to a Covered Dependent from age 2 and over, Covered Medical Expenses will
not include charges for more than:
- One exam in 12 months in a row.

For all exams given to a Covered Student or a spouse who is a Covered Dependent, Covered
Medical Expenses will not include charges for more than:
- One exam in 24 months in a row.

Covered Medical Expenses incurred by a woman, are charges made by a physician for, one
annual routine gynecological exam.

Screening and Counseling Services:

Covered Medical Expenses include charges made by a physician in an individual or group
setting for the following:
| Routine Physical Exam Expense (continued) | **Obesity**  
Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:  
- Preventive counseling visits and/or risk factor reduction intervention;  
- Medical nutrition therapy;  
- Nutritional counseling; and  
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease. |
|----------------------------------------|----------------------------------|
| **Misuse of Alcohol and/or Drugs**  
Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment. | |
| **Use of Tobacco Products**  
Screening and counseling services to aid a **Covered Person** to stop the use of tobacco products.  
Coverage includes:  
- Preventive counseling visits;  
- Treatment visits; and  
- Class visits;  
To aid a **Covered Person** to stop the use of tobacco products.  
Tobacco product means a substance containing tobacco or nicotine including:  
- Cigarettes;  
- Cigars;  
- Smoking tobacco;  
- Snuff;  
- Smokeless tobacco; and  
- Candy-like products that contain tobacco. | |
| **Limitations:**  
Unless specified above, not covered under this Screening and Counseling Services benefit are charges incurred for:  
- Services which are covered to any extent under any other part of this Plan | |
| **Immunizations Expense**  
**Covered Medical Expenses** include:  
- Charges incurred by a **Covered Student** and dependent spouse for the materials for the administration of appropriate and **medically necessary** immunizations, and testing for tuberculosis, and  
- Charges incurred by a **Covered Dependent** up to age 19, for the materials for the administration of appropriate and **medically necessary** immunizations, when given in accordance with the prevailing clinical standards of the American academy of pediatrics.  
**Preferred Care:** 100% of the Negotiated Charge.  
**Non-Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge. | |
| **Consultant Expense**  
**Covered Medical Expenses include** the expenses for the services of a consultant. The services must be requested by the attending physician for the purpose of confirming or determining a diagnosis.  
**Covered Medical Expenses** are covered as follows:  
**Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge.  
**Non-Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge. |
## Treatment of Mental and Nervous Disorders Expense

| Inpatient Expense | Covered Medical Expenses | for the treatment of a mental and nervous disorders while confined as an inpatient in a hospital or facility licensed for such treatment are payable as follows:  
**Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge.  
**Non-Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge.  
Benefits are limited to **Max of 30 days per policy year for any one or related mental health condition.** |
| Outpatient Expense | Covered Medical Expenses | for outpatient treatment of a mental and nervous disorders are payable as follows:  
**Preferred Care:** Following $25 Copay, 100% of the Negotiated Charge.  
**Non-Preferred Care:** Following $50 Copay, 100% of the Recognized Charge. |

## Alcoholism and Drug Addiction Treatment Expense

| Inpatient Expense | Covered Medical Expenses | for the treatment of a substance abuse condition while confined as an inpatient in a hospital or facility licensed for such treatment are payable as follows:  
**Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge.  
**Non-Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge.  
Benefits are limited to **Max of 30 days per policy year.** |
| Outpatient Expense | Covered Medical Expenses | for outpatient treatment of a substance abuse condition are payable as follows:  
**Preferred Care:** Following $25 Copay, 100% of the Negotiated Charge.  
**Non-Preferred Care:** Following $50 Copay, 100% of the Recognized Charge. |

## Maternity Benefits

| Maternity Expense | Covered Medical Expenses | include inpatient care of the **Covered Person** and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery.  
Any decision to shorten such minimum coverages shall be made by the attending Physician in consultation with the mother. In such cases, covered services may include: home visits, parent education, and assistance and training in breast or bottle-feeding.  
**Covered Medical Expenses** for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other sickness.  
**Prenatal Care**  
Prenatal care will be covered for services received by a pregnant female in a physician's, obstetricians, or gynecologist's office but only to the extent described below.  
Coverage for prenatal care under this benefit is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).  
**Comprehensive Lactation Support and Counseling Services**  
**Covered Medical Expenses** will include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy and in the post partum period by a certified lactation support provider. The "post partum period" means the 60 day period directly following the child's date of birth. **Covered Expenses** incurred during the post partum period also include the rental or purchase of breast feeding equipment as described below. |
| Maternity Expense (continued) | Lactation support and lactation counseling services are **Covered Expenses** when provided in either a group or individual setting.  
**Covered Medical Expenses** for Prenatal Care and Comprehensive Lactation Support and Counseling Services are payable as follows:  
**Preferred Care:** 100% of the Negotiated Charge.  
**Non-Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge. |
| Well Newborn Nursery Care Expense | Benefits include charges for routine care of a **Covered Person**’s newborn child as follows:  
- Hospital charges for routine nursery care during the mother’s confinement, but for not more than four days,  
- Physician’s charges for circumcision, and  
- Physician’s charges for visits to the newborn child in the hospital and consultations, but for not more than 1 visit per day.  
**Covered Medical Expenses** are payable as follows:  
**Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge.  
**Non-Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge. |
| Additional Benefits | **Prescribed Medicines Expense**  
Prescription Drug Benefits are payable as follows:  
**Preferred Care Pharmacy:** 90% of the Negotiated Charge.  
**Non-Preferred Care Pharmacy:** 90% of the Recognized Charge.  
You must pay out of pocket for Prescriptions at a Non-Preferred Pharmacy and then submit the receipt with a Prescription Claim Form for reimbursement.  
This Pharmacy benefit is provided to cover Medically Necessary Prescriptions associated with a covered Sickness or Accident occurring during the Policy Year. **Covered Medical Expenses** also include prescription smoking cessations aids. Please use your Aetna Student Health ID card when obtaining your prescriptions.  
Prior Authorization may be required for certain Prescription Drugs and some medications may not be covered under this Plan. For assistance and a complete list of excluded medications, or drugs requiring prior authorization, please contact Aetna Pharmacy Management at **888 RX-AETNA** (available 24 hours).  
Aetna Specialty Pharmacy provides specialty medications and support to members living with chronic conditions. The medications offered may be injected, infused or taken by mouth. For additional information please go to [www.AetnaSpecialtyRx.com](http://www.AetnaSpecialtyRx.com) Contraceptive Drugs and Device benefits are illustrated under the Family Planning Benefit of this Policy.  
Benefits include coverage for:  
- Off-label use of FDA approved prescription drugs, including any medically necessary supplies to administer the drug; and  
- Drugs used in antineoplastic therapy and the reasonable cost of administration of these drugs. |
| Diabetic Testing Supplies Expense | **Please Note:** Covered Medical Expenses for prescribed supplies for the treatment of diabetes will not be subject to the listed per Policy Year Prescription Drug limit.  

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

Diabetic Testing Supplies are limited to:  
- Lancet devices, including spring-powered lancet devices  
- Glucose monitors, and blood glucose monitors for the legally blind,  
- Test strips, visual readings and urine testing strips,  
- Syringes,  
- Insulin pumps and medical supplies required for the use of an insulin pump.  

Other items, used in the treatment of diabetes, are not Covered Medical Expenses.  

**Covered Medical Expenses** are payable on the same basis any other sickness.  

Coverage includes insulin, non-experimental medication for controlling blood sugar, and medications used in the treatment of foot ailments, infections, and other medical conditions of the foot, ankle, or nails, associated with diabetes, if prescribed by allopathic or osteopathic physician. |
| --- | --- |
| Hypodermic Needles Expense | **Covered Medical Expenses** for hypodermic needles and syringes used in the treatment of diabetes are payable on the same basis as any other sickness.  

**Please Note:** Covered Medical Expenses for prescribed supplies for the treatment of diabetes will not be subject to the listed per Policy Year Prescription Drug limit.  

**Covered Medical Expenses** are payable on the same basis any other sickness. |
| Outpatient Diabetic Self-Management Education Programs Expense | **Covered Medical Expenses** for outpatient diabetic self-management education programs are payable:  

**Covered Medical Expenses** are payable on the same basis any other sickness. |
| Non-Prescription Enteral Formula Expense | Benefits include charges incurred by a Covered Person for non-prescription enteral formulas, for which a physician has issued a written order, and are for the treatment of malabsorption caused by:  
- Crohn’s disease,  
- Ulcerative colitis,  
- Gastroesophageal reflux,  
- Gastrointestinal motility,  
- Chronic intestinal pseudoobstruction, and  
- Inherited diseases of amino acids and organic acids.  

**Covered Medical Expenses** for inherited diseases of amino acids and organic acids, will also include food products modified to be low protein.  

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

Preferred Care: **100%** for first **$5,000**, then **80%** to **$40,000**, then **100%** of the Negotiated Charge.  

Non-Preferred Care: **100%** for first **$5,000**, then **80%** to **$40,000**, then **100%** of the Recognized Charge. |
| Pap Smear Screening Expense | **Covered Medical Expenses include** one annual routine pap smear screening for women age 18 and older.  

Benefits are payable as follows:  

Preferred Care: **100%** of the Negotiated Charge.  

Non-Preferred Care: **100%** for first **$5,000**, then **80%** to **$40,000**, then **100%** of the Recognized Charge. |
| **Mammogram Expense** | Benefits are payable for charges for mammograms. The charges must be incurred while a **Covered Person** is insured for these benefits.

Benefits will be paid for Expenses  incurred for the following:
- A baseline mammogram for women between the ages of 35 to 40, and
- A mammogram every year or more frequently based on the recommendation of the woman's **physician**, for women 40 years of age and older.

**Covered Medical Expenses also include** breast cancer diagnostic services, breast cancer rehabilitative services, and breast cancer outpatient treatment services.

Benefits are payable as follows:

- **Preferred Care:** 100% of the Negotiated Charge.
- **Non-Preferred Care:**
  - 100% for first $5,000,
  - then 80% to $40,000,
  - then 100% of the Recognized Charge. |

| **Mastectomy and Prosthetic Devices Expense** | **Covered Medical Expenses** include charges incurred by a **Covered Person** for prosthetic devices to maintain or replace body parts of a **Covered Person** who has undergone a mastectomy.

**Covered Medical Expenses** include charges for the cost and fitting of a prosthetic device.

**Covered Medical Expenses** are payable on the same basis any other sickness. |

| **Elective Abortion Expense** | If, as a result of pregnancy having its inception during the Policy Year, a **Covered Person** incurs expenses in connection with an elective abortion, a benefit is payable.

**Covered Medical Expenses** for Elective Abortion Expense are covered as follows:

- **Preferred Care:** 100% of the Negotiated Charge.
- **Non-preferred Care:** 100% of the Recognized Charge.

This benefit is in lieu of any other Policy benefits.

Benefits are limited to **Limited to $485 per Policy Year**. |

| **Family Planning Expense** | For females with reproductive capacity, **Covered Medical Expenses** include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this benefit must be approved by the Food and Drug Administration (FDA).

Coverage includes counseling services on contraceptive methods provided by a **physician**, obstetrician or gynecologist. Such counseling services are **Covered Medical Expenses** when provided in either a group or individual setting.

The following contraceptive methods are **Covered Expenses** under this benefit:

- **Voluntary Sterilization**

**Covered Expenses** include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.

**Covered Expenses** under this **Preventive Care** benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement. |
### Family Planning Expense (continued)

#### Covered Expenses

**Contraceptives**

- Female contraceptives that are *generic prescription drugs*. The prescription must be submitted to the pharmacist for processing. *This contraceptives benefit covers only generic prescription drugs.*
- Female contraceptive devices and related services and supplies that are generic prescription devices when prescribed in writing by a **physician**. *This contraceptives benefit covers only those devices that are generic prescription devices.*
- FDA-approved female over-the-counter contraceptive methods that are prescribed by your **physician**. The **prescription** must be submitted to the pharmacist for processing. These items are limited to one per day and a 30 day supply per **prescription**.

**Limitations:**

Unless specified above, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this Plan;
- Services and supplies incurred for an abortion;
- Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care;
- Services which are for the treatment of an identified **illness** or **injury**;
- Services that are not given by a **physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams;
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA;
- Male contraceptive methods, sterilization procedures or devices;
- The reversal of voluntary sterilization procedures, including any related follow-up care.

**Important note:** Brand-Name Prescription Drug or Devices will be covered at 100% of the Negotiated Charge, including waiver of Deductible if a Generic Prescription Drug or Device is not available in the same therapeutic drug class or the prescriber specifies Dispense as Written.

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

- **Preferred Care:** 100% of the Negotiated Charge.
- **Non-Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge.

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#### Chlamydia Screening Test Expense HCR Requirements illustrated under Routine Physical Exam Benefit type

Benefits include charges incurred for an annual Chlamydia screening test.

Benefits will be paid for Chlamydia screening expenses incurred for:

- Women who are:
  - Under the age of 20 if they are sexually active, and
  - At least 20 years old if they have multiple risk factors.
- Men who have multiple risk factors.

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

- **Preferred Care:** 100% of the Negotiated Charge.
- **Non-Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge.
| Routine Screening For Sexually Transmitted Disease Expense *HCR Requirements illustrated under Routine Physical Exam Benefit type | **Covered Medical Expenses** include charges for **Covered Person**s who are at least 18 years old and who are sexually active for annual routine screening for sexually transmitted diseases. Benefits are payable as follows:  
**Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge.  
**Non-Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge. |
| --- | --- |
| Routine Colorectal Cancer Screening Expense | 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:  
- 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.  
**Covered Medical Expenses** are payable as follows:  
**Preferred Care:** 100% of the Negotiated Charge.  
**Non-Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge. |
| Routine Prostate Cancer Screening Expense | **Covered Medical Expenses** include charges incurred by a **Covered Person** for the screening of cancer as follows:  
- For a male age 50 or over, one digital rectal exam and one prostate specific antigen test each Policy Year.  
Benefits are payable as follows:  
**Preferred Care:** 100% of the Negotiated Charge.  
**Non-Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge. |
| Second Surgical Opinion Expense | **Covered Medical Expenses** will include expenses incurred for a second opinion consultation by a specialist on the need for surgery which has been recommended by the **Covered Person**'s physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation.  
Benefits are payable on the same basis as any other sickness. |
| Acupuncture in Lieu of Anesthesia Expense | **Covered Medical Expenses** include acupuncture therapy, when acupuncture is used in lieu of other anesthesia, for a surgical or dental procedure covered under this Plan.  
The acupuncture must be administered by a health care provider who is a legally qualified physician, practicing within the scope of their license.  
**Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge.  
**Non-Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge. |
| Dermatological Expense | **Covered Medical Expenses** include charges for the diagnosis and treatment of skin disorders, excluding laboratory fees. Related laboratory expenses are covered under the Outpatient Expense Benefit.  
**Covered Medical Expenses** are payable on the same basis as any other Sickness.  
**Covered Medical Expenses** do not include treatment for acne, or cosmetic treatment and procedures. |
|------------------------|--------------------------------------------------------------------------------------------------|
| Podiatric Expense | **Covered Medical Expenses** include charges for podiatric services, provided on an outpatient basis following an injury.  
**Covered Medical Expenses** are payable on the same basis as any other Sickness.  
Expenses for routine foot care, such as trimming of corns, calluses, and nails, are **not Covered Medical Expenses.** |
| Home Health Care Expense | **Covered Medical Expenses** include charges incurred by a **Covered Person** for home health care services made by a home health agency pursuant to a home health care plan, but only if:  
- The services are furnished by, or under arrangements made by, a licensed home health agency  
- 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 the plan every 60 days. Such physician must certify that the proper treatment of the condition would require inpatient confinement in a hospital [or skilled nursing facility] if the services and supplies were not provided under the home health care plan. The physician must examine the **Covered Person** at least once a month  
- 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  
- The care starts within 7 days after discharge from a hospital as an inpatient, and  
- The care is for the same condition that caused the hospital confinement, or one related to it.  
**Home Health Care Services**  
- Part-time or intermittent nursing care by: a registered nurse (R. N.), a licensed Practical nurse (L.P.N.), or under the supervision on an R.N. if the services of an R. N. are not available,  
- Part time or intermittent home health aide services, that consist primarily of care of a medical or therapeutic nature by other than an R.N.,  
- Physical, occupational. speech therapy, or respiratory therapy,  
- Medical supplies, drugs and medicines, and laboratory services. However, these items are covered only to the extent they would be covered if the patient was confined to a hospital,  
- Medical social services by licensed or trained social workers,  
- Nutritional counseling.  
**Covered Medical Expenses** will **not** include:  
- Services by a person who resides in the **Covered Person's** home, or is a member of the **Covered Person's** immediate family,  
- Homemaker or housekeeper services,  
- Maintenance therapy,  
- Dialysis treatment,  
- Purchase or rental of dialysis equipment, or  
- Food or home delivered services.  
**Home Health Care Expense** benefits are payable as follows:  
**Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge.  
**Non-Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge. |
| Transfusion or Dialysis of Blood Expense | **Covered Medical Expenses** include charges for the transfusion or dialysis of blood, including the cost of: whole blood, blood components, and the administration thereof. **Covered Medical Expenses** are payable on the same basis as any other Sickness. |
| Hospice Expense | **Covered Medical Expenses** include charges for hospice care provided for a terminally ill **Covered Person** during a hospice benefit period. Benefits are payable as follows:  
**Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge.  
**Non-Preferred care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge. |
| Licensed Nurse Expense | Benefits include charges incurred by a **Covered Person** who is confined in a hospital as a resident bed-patient, and requires the services of a registered nurse or licensed practical nurse. **Covered Expenses** for a Licensed Nurse are covered as follows:  
**Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge.  
**Non-Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge. |
| Skilled Nursing Facility Expense | **Covered Medical Expenses** include charges incurred by a **Covered Person** for confinement in a skilled nursing facility for treatment rendered:  
- In lieu of confinement in a hospital as a full time inpatient, or  
- Within 24 hours following a hospital confinement and for the same or related cause(s) as such hospital confinement.  
**Covered Medical Expenses** are payable as follows:  
**Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge for the semi-private room rate.  
**Non-Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge for the semi-private room rate. |
| Rehabilitation Facility Expense | **Covered Medical Expenses** include charges incurred by a **Covered Person** for confinement as a full time inpatient in a rehabilitation facility. Confinement in the rehabilitation facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of hospital or skilled nursing facility confinement.  
**Covered Medical Expenses** for Rehabilitation Facility Expense are covered as follows:  
**Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Negotiated Charge for the rehabilitation facility’s daily room and board maximum for semi-private accommodations  
**Non-Preferred Care:** 100% for first $5,000, then 80% to $40,000, then 100% of the Recognized Charge for the rehabilitation facility’s daily room and board maximum for semi-private accommodations. |
INTERNATIONAL STUDENT/SCHOLAR HEALTH INSURANCE VISION PLAN

University Health Service (UHS) will manage the vision benefit for those insured by the International Student/Scholar Health Insurance Plan. This service is not underwritten by Aetna.

The UHS Eye Care Clinic will provide one routine eye exam per Policy Year/per enrollee with $15 Copay per exam as long as the individual is enrolled in the International Student/Scholar Health Insurance Plan at the time of service.

The routine eye exam will include:
- Refraction and dilation of the eyes
- Health history
- Check of the interior and exterior eye as well as surrounding area for defects, disease, and clarity of vision
- Eye coordination
- Color vision
- Depth perception
- Refractive error and field of vision

Not Included: Contact Lenses evaluation or fitting. Additional fees will be charged if these services are performed and will be the patient’s financial responsibility.

VISION CARE PROVIDER OF YOUR CHOICE
In some instances you may need to use a Vision Care Provider other than UHS. UHS will reimburse the Policyholder when a routine eye exam is received outside of UHS at a Vision Care Provider of your choice. UHS will reimburse for one routine eye exam per Policy Year/per enrollee not to exceed a benefit maximum of $30, after applying the $15 Copay per exam, and subject to UHS guidelines.

The reimbursement option is limited to:
- Infant/toddlers under three years of age
- Students/Scholars studying out of the Ann Arbor area

The University Health Service Eye Care Clinic is located at:
207 Fletcher Street
Ann Arbor, MI 48109-1050
http://www.uhs.umich.edu/eyecare
For an appointment call: (734) 764-8320.

For eligible reimbursement of eligible services provided by a Vision Care Provider of your choice, send your original paid receipt to:

University of Michigan/University Health Service:
Managed Care/Student Insurance Office
207 Fletcher Street
Ann Arbor, MI 48109-1050
www.uhs.umich.edu
mancare-stuins@umich.edu

Please remember to make a copy of your receipt for your own records.
GENERAL PROVISIONS

STATE MANDATED BENEFITS
The Plan will pay benefits in accordance with any applicable Michigan 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.

EXCESS PROVISION
This Plan is an excess only Plan. As an excess only Plan, this Plan pays its Covered Medical Expenses after any other medical coverage. This Plan's liability will be determined without consideration to any limitation clause or clauses regarding other coverage contained in any other medical coverage. Benefits Payable under this Plan shall be limited to the Plan's Covered Medical Expense and reduced by the amount paid or payable by any other medical coverage. However, consideration will be given to the other medical coverage’s liability due to a provider contract or other reasons when calculating this Plan’s Benefits Payable.
For the purposes of calculating a benefit under this Plan, the liability of the other medical coverage shall be considered and shall not depend upon whether timely application for benefits from other medical coverage is made by you or on your behalf. If any other medical coverage provides benefits on an excess only basis, the coverage for the Covered Member which has been in effect the longest shall pay benefits first.

“Other medical coverage” means any reimbursement for or recovery of any element of incurred covered charges available from any other source whatsoever whether through an insurance policy or other type of coverage, except gifts and donations, including but not limited to the following:

- Any group, accident-only, blanket, or franchise policy of accident, disability, health, or accident and sickness insurance.
- Any arrangement of benefits for members of a group, whether insured or uninsured.
- Any prepaid service arrangement such as Blue Cross or Blue Shield, group practice plans or health maintenance organizations.
- Any amount payable as a benefit for accidental bodily injury arising out of a motor vehicle accident to the extent such benefits are payable under the medical expense payment provision (or, by whatever terminology used to include such benefits mandated by law) of any motor vehicle insurance policy.
- Any amounts payable for injuries related to your job to the extent that he or she actually received benefits under a Workers’ Compensation Law.
- Social Security Disability Benefits, except that Other Medical Insurance shall not include any increase in Social Security Disability Benefits payable to you after you become disabled while insured hereunder.
- Any benefits payable under any program provided or sponsored solely or primarily by any governmental agency or subdivision or through operation of law or regulation.

**HMO/PPO Provision** – In the event that Covered Expenses are denied under a Health Maintenance Organization, Preferred Provider Organization (PPO) or other group medical plan the member has in force, and such denial is because care or treatment was received outside of the network’s geographic area, benefits will be payable under this coverage, provided the expense is a covered expense.

**EXTENSION OF BENEFITS**

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 31 day period, following such termination of insurance.

**TERMINATION OF INSURANCE**

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

**TERMINATION OF STUDENT COVERAGE**

- Insurance for a Covered Student will end on the first of these to occur:
  - The date This Plan terminates,
  - The last day for which any required premium has been paid,
  - 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,
  - 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:

- For a child, on the last day of the Policy Period following the child’s 26th birthday.
- The date the Covered Student fails to pay any required premium.
- For the spouse, the date the marriage ends in divorce or annulment.
- The date dependent coverage is deleted from This Plan.
- For a domestic partner, the earlier to occur of:
  - The date this Plan no longer allows coverage for domestic partners, and
  - The date of termination of the domestic partnership. In that event, a completed and signed declaration of Termination of Domestic Partnership must be provided to the Policyholder.
  - The date the dependent ceases to be in an eligible class.

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

INCAPACITATED DEPENDENT CHILDREN

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

Due proof of the child's incapacity and dependency must be furnished to Aetna by the Covered Student within 31 days after the date insurance would otherwise cease. Such child will be considered a Covered Dependent, so long as the Covered Student submits proof to Aetna each year, that the child remains physically or mentally unable to earn his own living. The premium due for the child's insurance will be the same as for a child who is not so incapacitated.

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

- The date specified under the provision entitled Termination of Dependent Coverage, or
- The date the child is no longer incapacitated and dependent on the Covered Student for support.

CONTINUATION OF COVERAGE

Once an International Student or International Visiting Scholar’s status as a University of Michigan F-1 or J-1 visa holder ends, the International Student or International Visiting Scholar may be eligible to continue coverage in this Plan for a period not to exceed a maximum of three months. The length of the continuation shall be determined by the date your coverage ends under the F-1 or J-1 status with the University (as reported to Aetna Student Health), not to exceed the normal Policy termination date, and must be purchased in three (3) month intervals, or the lesser thereof based on the F-1/J-1 end date. To be eligible for Continuation, you must have been enrolled under the University of Michigan International Student Health Insurance Plan prior to the start of the Continuation. International Students or International Visiting Scholars may also cover eligible Dependents under this provision. Coverage for Dependents shall be for the same period as the student/scholar, and the Dependents must have been covered under the Plan prior to the Continuation start date. Enrollment in the Continuation Coverage must be completed by the end of the month in which your eligibility under this provision begins.

Coverage under the Continuation provision cannot be carried over from one Policy Year to the next.

Please see the chart below for examples of how this provision may affect you.

<table>
<thead>
<tr>
<th>F-1/J-1 coverage ends:</th>
<th>Continuation option(s):</th>
<th>Coverage under Continuation ends:</th>
<th>Deadline to enroll for Continuation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 30, 2013</td>
<td>3 month</td>
<td>December 31, 2013</td>
<td>October 31, 2013</td>
</tr>
</tbody>
</table>
Questions relating to this provision or Continuation enrollment should be directed to Aetna Student Health at (800) 239-9697.

Note: Coverage under this provision ceases on the date this Plan terminates.

EXCLUSIONS

This Plan does not cover nor provide benefits for:

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

2. 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.

3. 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 or as provided elsewhere in this plan.

4. 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.

5. 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.

6. 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.

7. 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.

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

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

10. Expense incurred for cosmetic surgery, reconstructive surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons, except to the extent needed to: a) Improve the function of a part of the body that is not a tooth or structure that supports the teeth, and is malformed as a result of a severe birth defect, including harelip, webbed fingers, or toes, or as direct result of disease, or surgery performed to treat a disease or injury. b) Repair an injury (including reconstructive surgery for prosthetic device for a Covered Person).
Person who has undergone a mastectomy) which occurs while the Covered Person is covered under this Policy. Surgery must be performed in the calendar year of the accident which causes the injury, or in the next calendar year.

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

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

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

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

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

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


18. Expense for allergy serums and injections.

19. Treatment for injury to the extent benefits are payable under any state no-fault automobile coverage, first party medical benefits payable under any other mandatory No-fault law.

20. Expense 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.

21. 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.

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

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

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

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


27. Expenses incurred for gynecomastia (male breasts).

28. Expenses incurred for any sinus surgery, except for acute purulent sinusitis.
29. Expense incurred by a **Covered Person**, not a United States citizen, for services performed within the **Covered Person’s** home country, if the **Covered Person’s** home country has a socialized medicine program.

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, unless otherwise provided in this Plan.

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

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

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

36. Expense incurred for hearing aids, the fitting, or prescription of hearing aids.

37. Expenses incurred for hearing exams not performed in conjunction with a routine physical exam.

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 telephone consultations (except telemedicine services), charges for failure to keep a scheduled visit, or charges for completion of a claim form.

40. 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.

41. Expense for services or supplies provided for the treatment of obesity and/or weight control, unless specifically provided in the policy.

42. Expense for incidental surgeries, and standby charges of a physician.

43. Expense for treatment and supplies for programs involving cessation of tobacco use, unless otherwise provided for in this plan.

44. 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.

45. Expenses incurred for massage therapy.

46. Expenses incurred for, or in connection with, speech therapy. This exclusion does not apply for charges for speech therapy that is expected to restore speech to a person who has lost existing function (the ability to express thoughts, speak words, and form sentences), as a result of an accident or sickness.

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

48. 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.

49. 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.

50. 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.

51. Expense incurred for a treatment, service, or supply, which is not medically necessary, as determined by Aetna, for the diagnosis care or treatment of the sickness or injury involved. This applies even if they are prescribed, recommended, or approved, by the person’s attending physician, or dentist. In order for a treatment, service, or supply, to be considered medically necessary, the service or supply must: a) be care, or treatment, which is likely to produce a
significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the sickness or injury involved, and the person's overall health condition, b) be a diagnostic procedure which is indicated by the health status of the person, and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the sickness or injury involved, and the person's overall health condition, and c) as to diagnosis, care, and treatment, be no more costly (taking into account all health expenses incurred in connection with the treatment, service, or supply), than any alternative service or supply to meet the above tests. In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration: 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: a) those that do not require the technical skills of a medical, a mental health, or a dental professional, or b) those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, or any persons who is part of his or her family, any healthcare provider, or healthcare facility, or c) those furnished solely because the person is an inpatient on any day on which the person's sickness or injury could safely, and adequately, be diagnosed, or treated, while not confined, or 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.

52. Expenses incurred for the treatment of acne.
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 per injury or illness.

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.
- 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: is a prescription drug with a proprietary name assigned to it by the manufacturer or distributor and so indicated by Medispan or any other similar publication designated by Aetna, an affiliate or third party vendor.

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 decompensating or missed abortion, or
- Similar conditions as severe as these.
Not included is (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 recognized 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 Provider:** This is any dentist, group, organization, dental facility, or other institution, or person.

**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 residing with the **Covered Student**, or (b) the person identified as a domestic partner in the "Declaration of Domestic Partnership" which is completed and signed by the **Covered Student**, and (c) the **Covered Student**’s unmarried child under the age of 26. The term “child” includes a **Covered Student**’s step-child, adopted child, and a child for whom a petition for adoption is pending. The term dependent does not include a person who is: (a) an eligible student, or (b) a member of the armed forces.

**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:
- 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,
- Temporomandibular joint dysfunction (TMJ),
- Treatment of infertility

**Emergency Admission:** One where the physician admits the person to the hospital or residential treatment facility right after the sudden and at that time, unexpected onset of a change in a person's physical or mental condition which:
- Requires confinement right away as a full-time inpatient, and
- If immediate inpatient care was not given could, as determined by Aetna, reasonably be expected to result in:
  - Loss of life or limb, or significant impairment to bodily function, or permanent dysfunction of a body part.

**Emergency Medical Condition:** The sudden and, at that time, unexpected onset of a change in a person's physical or mental condition requiring immediate medical, surgical, or psychiatric care, which if not performed right away 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. It does include an accident or serious illness such as heart attack, stroke, poisoning, loss of consciousness or respiration, and convulsions. It does not include elective care, routine care, care for a non-emergency illness, or care required as a result of circumstances which would have been foreseen prior to the **Covered Student**’s departure from the college area.
**Generic Prescription Drug**: is a prescription drug, whether identified by its chemical, proprietary, or non-proprietary name that is accepted by the U.S. Food and Drug Administration (FDA) as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by Medispan or any other publication designated by Aetna, an affiliate or third party vendor.

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

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

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

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

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

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

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

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

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

**Injectable Drug(s)** are prescription drugs when an oral alternative drug is not available, unless specifically excluded as described in the Exclusion section of this Policy.

**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.

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

Non-Occupational Disease: A non-occupational disease is a disease that does not:

- Arise out of (or in the course of) any work for pay or profit, or
- Result in any way from a disease that does. A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the Covered Student:
  - Is covered under any type of workers' compensation law, and
  - Is not covered for that disease under such law.

Non-Occupational Injury: A non-occupational injury is an accidental bodily injury that does not:

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

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

- The service or supply could have been provided by a Preferred Care Provider, and
- The provider is of a type that falls into one or more of the categories of providers listed in the directory.
Non-Preferred Care Provider:
- A health care provider that has not contracted to furnish services or supplies at a negotiated charge, or
- A Preferred Care Provider that is furnishing services or supplies without the referral of a School Health Services

Non-Preferred Drug: is a **brand-name prescription drug** or **generic prescription drug** that does not appear on the preferred drug list.

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

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

One Sickness: a sickness and all recurrences and related conditions which are sustained by a **Covered Person**.

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

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

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

Pharmacy: An establishment where prescription drugs are legally dispensed.

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

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

Preferred Care: Care provided by:
- A **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 Drug is a brand-name prescription drug or generic prescription drug that appears on the preferred drug list.

Preferred Drug Exclusion List is a list of prescription drugs in the preferred drug list that are identified as excluded under the plan. This list is subject to periodic review and modification by Aetna.

Preferred Drug List is a listing of prescription drugs established by Aetna or an affiliate which includes both brand-name prescription drugs and generic prescription drugs. This list is subject to periodic review and modification by Aetna. A copy of the preferred drug list will be available upon the Covered Person’s request or may be accessed on the Aetna website at www.aetna.com/formulary.

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 Drug is a drug, biological, or compounded prescription which, by State or Federal Law, may be dispensed only by prescription and which is required by Federal Law to be labeled “Caution: Federal Law prohibits dispensing without prescription.” This includes an injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.

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.

Provider is any recognized health care professional, pharmacy or facility providing services with the scope of their license.

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.

**Self-injectable Drug(s)** are **prescription drugs** that are intended to be self-administered by injection to a specific part of the body to treat certain chronic medical conditions.

**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.

**Specialty Care Drugs** are **prescription drugs** including **injectable drugs**, infusion and oral drugs prescribed to address complex, chronic diseases with associated co-morbidities such as cancer, rheumatoid arthritis, hemophilia, multiple sclerosis, and which are listed in the **specialty care drug** list

**Specialty Pharmacy Network** is a network of **pharmacies** designated to fill **prescriptions** for **injectable drugs**, **self-injectable drugs** and **specialty care drugs**.

**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.
• Have 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:
This includes but is not limited to:
• 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,
• Electro cauterization,
• 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, for any questions.

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

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.
APPEALS PROCEDURE

Definitions

**Adverse Benefit Determination (Decision):** A denial; reduction; termination of; or failure to; provide or make payment (in whole or in part) for a service, supply or benefit.

Such **adverse benefit determination** may be based on:
- Your eligibility for coverage.
- Coverage determinations, including plan limitations or exclusions.
- The results of any Utilization Review activities.
- A decision that the service or supply is **experimental or investigational**.
- A decision that the service or supply is not **medically necessary**.

As to medical and **prescription drug** claims, an **adverse benefit determination** also means the termination of a **Covered Person**'s coverage back to the original effective date (rescission) as it applies under any rescission provision appearing in the Policy.

**Appeal:** An oral or written request to Aetna to reconsider an **adverse benefit determination**.

**Complaint:** Any oral or written expression of dissatisfaction about quality of care or the operation of the Plan.

**Concurrent Care Claim Extension:** A request to extend a course of treatment that was previously approved.

**Concurrent Care Claim Reduction or Termination:** A decision to reduce or terminate a course of treatment that was previously approved.

**External Review:** A review of an **adverse benefit determination** or a **final adverse benefit determination** by an Independent Review Organization/External Review Organization (ERO) assigned by the State Insurance Commissioner Aetna or the U.S. Office of Personnel Management, as determined by Aetna and made up of **physicians** or other appropriate health care **providers**. The ERO must have expertise in the problem or question involved.

**Final Adverse Benefit Determination:** An **adverse benefit determination** that has been upheld by Aetna at the exhaustion of the appeals process.

**Pre-service Claim:** Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

**Post-Service Claim:** Any claim that is not a “Pre-Service Claim.”

**Urgent Care Claim:** Any claim for medical care or treatment in which a delay in treatment could:
- Seriously jeopardize your life or health;
- Jeopardize your ability to regain maximum function;
- Cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- In the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

**Full and Fair Review of Claim Determinations and Appeals**
As to medical and **prescription drug** claims and **appeals** only, Aetna will provide you with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue. This will be provided to you in advance of the date on which the notice of the **final adverse benefit determination** is required to be provided so that you may respond prior to that date.

Prior to issuing a **final adverse benefit determination** based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of **final adverse determination** is required.
Claim Determinations – Health Coverage

Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below. As to medical and prescription drug claims only, if Aetna makes an adverse benefit determination, written notice will be provided to you, or in the case of a concurrent care claim, to your provider.

Urgent Care Claims

Aetna will notify you of an urgent care claim decision as soon as possible, but not later than 72 hours after the claim is made.

If more information is needed to make an urgent care claim decision, Aetna will notify the claimant within 72 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide Aetna with the additional information. Aetna will notify the claimant within 48 hours of the earlier to occur:

- The receipt of the additional information; or
- The end of the 48 hour period given the physician to provide Aetna with the information.

Pre-Service Claims

Aetna will notify you of a pre-service claim decision as soon as possible, but not later than 15 calendar days after the claim is made. Aetna may determine that due to matters beyond its control an extension of this 15 calendar day claim decision period is required. Such an extension, of no longer than 15 additional calendar days, will be allowed if Aetna notifies you within the first 15 calendar day period. If this extension is needed because Aetna needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Post-Service Claims

Aetna will notify you of a post-service claim decision as soon as possible, but not later than 30 calendar days after the claim is made. Aetna may determine that due to matters beyond its control an extension of this 30 calendar day claim decision period is required. Such an extension, of no longer than 15 additional calendar days, will be allowed if Aetna notifies you within the first 30 calendar day period. If this extension is needed because Aetna needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Concurrent Care Claim Extension

Following a request for a concurrent care claim extension, Aetna will notify you of a claim decision for urgent care as soon as possible but not later than 24 hours, provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. A decision will be provided not later than 15 calendar days with respect to all other care, following a request for a concurrent care claim extension.

Concurrent Care Claim Reduction or Termination

Aetna will notify you of a claim decision to reduce or terminate a previously approved course of treatment with enough time for you to file an appeal.

As to medical and prescription drug claims only, if you file an appeal, coverage under the plan will continue for the previously approved course of treatment until a final appeal decision is rendered. During this continuation period, you are responsible for any copayments, coinsurance, and deductibles; that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under appeal. If Aetna's initial claim decision is upheld in the final appeal decision, you will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.
Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a network provider you must call or write Member Services. The complaint must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written response within 30 calendar days of the receipt of the complaint, unless more information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations

You may submit an appeal if Aetna gives notice of an adverse benefit determination. This Plan provides for one level of appeal. As to medical and prescription drug claims only, a final adverse benefit determination notice may also provide an option to request an External Review (if available).

You have 180 calendar days with respect to Health Claims following the receipt of notice of an adverse benefit determination to request your Level One appeal. Your appeal may be submitted orally or must be submitted in writing and must include:

- Your name.
- The school's name.
- A copy of Aetna’s notice of an adverse benefit determination.
- Your reasons for making the appeal.
- Any other information you would like to have considered.

Send your written appeal to the address shown on the notice of adverse benefit determination, or you may call in your appeal using the telephone number listed on the notice.

You may also choose to have another person (an authorized representative) make the appeal on your behalf. You must provide written consent to Aetna.

As to medical and prescription drug claims only, you may be allowed to provide evidence or testimony during the appeal process in accordance with the guidelines established by the Federal Department of Health and Human Services.

Appeal – Medical and Prescription Drug Claims

A review of an Appeal of an adverse benefit determination shall be provided by Aetna personnel. They shall not have been involved in making the adverse benefit determination.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)

Aetna shall issue a decision within 72 hours of receipt of the request for an appeal.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)

Aetna shall issue a decision within 30 calendar days of receipt of the request for an appeal.

Post-Service Claims

Aetna shall issue a decision within 60 calendar days of receipt of the request for an Appeal.

Exhaustion of Process

You must exhaust the applicable Level One processes of the Appeal Procedure before you:

- Contact the Michigan Department of Insurance to request an investigation of a complaint or appeal; or
- File a complaint or appeal with the Michigan Department of Insurance; or
- Establish any:
  - Litigation;
  - Arbitration; or
  - Administrative proceeding;

Regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the Appeals Procedure.
As to medical and prescription drug claims only, under certain circumstances you may seek simultaneous review through the internal Appeals Procedure and External Review processes—these include Urgent Care Claims and situations where you are receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.

**Important Note:**
As to medical and prescription drug claims only, if Aetna does not adhere to all claim determination and appeal requirements of the Federal Department of Health and Human Services, you are considered to have exhausted the appeal requirements and may proceed with External Review or any of the actions mentioned above. There are limits, though, on what sends a claim or an appeal straight to an External Review. Your claim or internal appeal will not go straight to External Review if:
- A rule violation was minor and isn't likely to influence a decision or harm you;
- It was for a good cause or was beyond Aetna’s control; and
- It was part of an ongoing, good faith exchange between you and Aetna.

**External Review**

As to medical and prescription drug claims only, you may receive an adverse benefit determination or final adverse benefit determination because Aetna determines that:
- The claim involves medical judgment;
- The care is not necessary or appropriate;
- A service, supply or treatment is experimental or investigational in nature.

In these situations, you may request an External Review if you or your provider disagrees with Aetna’s decision.

To request an External Review, any of the following requirements must be met:
- You have received an adverse benefit determination notice by Aetna, and Aetna did not adhere to all claim determination and appeal requirements of the Federal Department of Health and Human Services.
- You have received a final adverse benefit determination notice of the denial of a claim by Aetna.
- Your claim was denied because Aetna determined that the care was not necessary or appropriate or was experimental or investigational.
- You qualify for a faster review as explained below.

The notice of adverse benefit determination or final adverse benefit determination that you receive from Aetna will describe the process to follow if you wish to pursue an External Review, and include a copy of the Request for External Review Form.

You must submit the Request for External Review Form to the U.S. Office of Personnel Management within 123 calendar days of the date you received the adverse benefit determination or final adverse benefit determination notice. You also must include a copy of the notice and all other pertinent information that supports your request.

The U.S. Office of Personnel Management will contact the ERO that will conduct the review of your claim. The ERO will select one or more independent clinical reviewers with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow Aetna’s contractual documents and plan criteria governing the benefits. You will be notified of the decision of the ERO usually within 45 calendar days of Aetna’s receipt of your request form and all the necessary information.

A faster review is possible if your physician certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would:
- Seriously jeopardize your life or health; or
- Jeopardize your ability to regain maximum function; or
- If the adverse benefit determination relates to experimental or investigational treatment, if the physician certifies that the recommended or requested health care service, supply or treatment would be significantly less effective if not promptly initiated.
You may also receive a faster review if the **final adverse benefit determination** relates to an admission; availability of care; continued **stay**; or health service for which you received **emergency care**, but have not been discharged from a facility.

Faster reviews are decided within 72 hours after **Aetna** receives the request.

**Aetna** will abide by the decision of the ERO, except where **Aetna** can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the ERO to **Aetna**. **Aetna** is responsible for the cost of sending this information to the ERO and for the cost of the external review.

For more information about the Appeals Procedure or **External Review** processes, call the Member Services telephone number shown on your ID card.

**Michigan DOI**

If, after exhausting the internal appeals procedures, the **Covered Person**, the **Covered Person**’s **physician**, or the **hospital** is still dissatisfied with Aetna’s response, the **Covered Person** may be eligible to file a request for an External Review with the Michigan Insurance Commissioner. Information about filing a request for an External Review may be obtained by contacting: Michigan Insurance Commissioner 1-877-999-6442

When filing a request for an External Review, the **Covered Person** will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the External Review.

**PRESCRIPTION DRUG CLAIM PROCEDURE**

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

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

**WORLDWIDE TRAVEL ASSISTANCE SERVICES**

**On Call International**

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

**Services rendered without On Call International’s coordination and approval are not covered. No claims for reimbursement will be accepted. If the Member is able to leave the Member’s host country by normal means, On Call International will assist the Member in rebooking flights or other transportation. Expenses for non-emergency transportation are the Member’s responsibility.**

**On Call phone number: 1-866-525-1956 or collect 1-603-328-1956**

A brief description of these benefits is outlined below.

**Accidental Death and Dismemberment (ADD) Benefits**

These benefits are underwritten by United States Fire Insurance Company (USFIC) and include the following: Benefits are payable for the Accidental Death and Dismemberment of **Covered Persons**, up to a maximum of **$10,000**.
Medical Evacuation and Repatriation (MER) Benefits
The following benefits are underwritten by United States Fire Insurance Company (USFIC) with medical and travel assistance services provided by On Call. These benefits are designed to assist Covered Persons when traveling more than 100 miles from home or when traveling in a foreign country, anywhere in the world.

- Unlimited Emergency Medical Evacuation
- Unlimited Medically Supervised Repatriation
- Unlimited Return of Deceased Remains
- Unlimited Family Reunion (airfare only)
- $2,500 Return of Traveling Companion
- $2,500 Return of Dependent Children
- $2,500 Bereavement Reunion - in the event of a Covered Person’s death, On Call will fly a family member to identify the remains and accompany the remains back to the deceased’s home country
- $2,500 Emergency Return Home in the event of death or life-threatening illness of a parent, sibling or spouse
- $1,000 Return of Personal Belongings

Natural Disaster and Political Evacuation Services (NDPE)
The following benefits are underwritten by United States Fire Insurance Company (USFIC) with medical, travel, and security assistance services provided by On Call.

If a Covered Person requires emergency evacuation due to governmental or social upheaval, which places him/her in imminent bodily harm (as determined by On Call security personnel in accordance with local and U.S. authorities), On Call will arrange and pay for his/her transportation to the nearest safe location, and then a one-way economy class airline ticket to his/her home country.

If a Covered Person requires emergency evacuation due to a natural disaster, which makes his/her location Uninhabitable, On Call will arrange and pay for his/her evacuation from a safe departure point to the nearest safe haven, and then home.

If the Covered Person is delayed at the safe haven, On Call shall arrange and pay for reasonable lodging expenses up to $100 per day for a maximum of three days. (Economy airfare and lodging costs shall not exceed a combined single limit of $5,000 USD per Covered Person).

Subject to a maximum benefit of $100,000 per Covered Person per Event.

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

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

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

The information contained above is a just summary of the ADD, MER, WETA, and NDPE benefits and services available through On Call. For a copy of the plan documents applicable to the ADD, MER, WETA and NDPE coverage, including a full description of coverage, exclusions and limitations, please contact Aetna Student Health at www.aetnastudenthealth.com or (800) 966-7772

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

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

Chickering Claims Administrators, Inc. (CCA) provides access to certain Accidental Death and Dismemberment (AD&D); Medical Evacuation/Repatriation (MER); Natural Disaster and Political Evacuation (NDPE); and Worldwide Emergency Travel Assistance (WETA) coverages and services through a contractual relationship with On Call International, LLC (On Call). AD&D coverage is underwritten by Fairmont Specialty dba United States Fire Insurance Company (USFIC). MER, NDPE and WETA membership services are administered by On Call.

CCA and On Call are independent contractors and not employees or agents of the each other. Neither CCA nor any of its affiliates provides or administers ADD, MER, NPDE and WETA benefits/services and neither CCA nor any of its affiliates is responsible in any way for the benefits/services provided by or through On Call.

These services, programs or benefits are offered by vendors who are independent contractors and not employees or agents of Aetna.
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 981106
El Paso, TX 79998
(800) 239-9697
www.aetnastudenthealth.com

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

Policy No. 711146

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