



Control No. 812806

Blanket Student Accident and Sickness Insurance Policy

a contract between

Aetna Life Insurance Company

(A Stock Company herein called Aetna)

and

University of Virginia

(Policyholder)

Policy Number:	BP-812806
Date of issue:	June 21, 2006
Policy delivered in:	Virginia

This Policy will be construed in line with the law of the jurisdiction in which it is delivered.

This Policy takes effect at 12:01 A.M. standard time at the Policyholder's address on August 15, 2006. The **Policy Year** starts on August 15, 2006 and ends on August 15, 2007 at 12:01 A.M.

Based on timely premium payments by the Policyholder, Aetna agrees with the Policyholder, to pay benefits in line with the Policy terms.

The duties and the rights of all persons will be based solely on Policy terms. This Policy is non-participating.

Signed at Aetna's Home Office in Hartford, Connecticut on the date of issue.

A handwritten signature in cursive script that reads "Ronald H. Williams".

President

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, Connecticut 06156
860-273-0123

Policy Contents

This policy consists of:

The Face Page, Index, this Policy Contents page, and all the provisions of Parts I and II and the Policyholder's application, (a copy of which is attached); and

The provisions found in the Certificate (s) listed in this section.

The words "you" or "your" in any Certificate included in this policy, will refer to a covered student.

The Certificate (s) included in this policy are as follows:

A "Certificate" consists of a Certificate Base document ("Cert Base") and any Certificate Rider ("Rider") which may be issued to support or amend the Cert. Base.

Identification	Issue Date	Effective Date
Cert Base: 1	June 21, 2006	August 15, 2006

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PART I

STUDENT ACCIDENT AND SICKNESS INSURANCE

ELIGIBILITY, EFFECTIVE DATE OF INDIVIDUAL COVERAGE

Eligible Persons

Students: all classes of students are eligible except students in any class which is not listed in the Schedule of Benefits. A student is eligible only for the coverages shown in the Schedule of Benefits, which applies to his or her class.

Dependents: dependents of a **covered student** who meet the definition of a **dependent** under this Policy and are listed under the Schedule of Benefits.

Effective Date of Insurance

The coverage of each person who applies for coverage hereunder on or before the Effective Date hereof shall take effect on the Effective date of this Policy.

Coverage for each person applying for coverage hereunder after the Effective Date shall take effect on the date he or she submits a completed application or fails to submit a waiver form and pays the premium for the insurance.

Dependent insurance of a **covered student** becomes effective on the date the **covered student** becomes effective otherwise the insurance becomes effective on the date the **covered student** acquires a Dependent.

A newborn child shall be insured for **injury, sickness**, premature birth and medically diagnosed congenital defects and birth abnormalities from the moment of birth for an initial period of thirty-one days. To continue the insurance beyond this initial 31 day period, the **covered student** must notify Aetna or its agents of the birth and pay any additional premium required for the child's insurance within the 31 day period.

Coverage is provided for a child legally placed for adoption with a **covered student** from the moment of placement, for an initial period of thirty-one days, provided the child lives in the household of the **covered student** and is dependent upon the **covered student** for support. Notification of placement of such child and payment of any additional premium, if necessary, is required within 31 days from placement. To continue the insurance beyond this initial 31 day period, the **covered student** must notify Aetna or its agent of the placement of such child and pay any additional premium required for the child's insurance within the 31 day period.

Late Enrollment

If an application and premium payment for insurance are made more than 30 days following the date the Eligible Person or **Dependent** become eligible, then his or her insurance will become effective only if and when Aetna gives its written consent.

An eligible **dependent** will not be considered a late enrollee if the **covered student** is required to provide coverage for his or her eligible **dependent** as a result of a court order and written request for such coverage is made within 31 days of the court order. Such coverage will become effective on the date of the court order. If request for coverage is not made within 31 days of the court order, the **dependent's** coverage will be subject to all of the terms of this Policy.

An eligible student may not enroll for coverage under this Policy if he is not enrolled in the health service plan provided by the Policyholder. Once an eligible student makes a coverage selection under this Policy, he or she may not change his election.

PART I

STUDENT ACCIDENT AND SICKNESS INSURANCE

ELIGIBILITY, EFFECTIVE DATE OF INDIVIDUAL COVERAGE (Continued)

The Policyholder agrees to submit to Aetna within 20 days after the effective date of each **covered person's** insurance: (1) the name of each person who applied for coverage hereunder; (2) the effective date of insurance; and (3) the premium paid as to each such **covered person**. The insurance of those **covered persons** whose names and premiums were received more than 20 days after the date the insurance would have become effective will take effect on the date such name and premium is received by Aetna or an agent of Aetna except as may otherwise be provided above.

Change in Amounts

Covered Student

Status Change – If, at any time, the **covered student's** status changes so as to warrant an amount of coverage other than that for which the **covered student** is then covered, the amount of his or her coverage will be changed as follows:

An increase or reduction will be effective on the date of the status change.

Schedule or Benefit Level Change – If, at any time, any schedule or the level of any benefit is changed so as to warrant an amount of coverage other than that for which the **covered student** is then covered, the amount of coverage will be changed to the new amount.

The **covered student** may refuse an increase in Accidental Death and Dismemberment Coverage. This must be done within 31 days of the date it would have taken effect. If the **covered student** later elects the increase, it will be made on the date Aetna gives written consent.

All Changes – A retroactive change in a **covered student's** status will not result in a retroactive change in coverage. Any change in coverage will be effective on the date the change in status is made.

Covered Dependent

Status, Schedule, or Benefit Level Change – If, for any reason and at any time, a **dependent's** status, any schedule, or the level of any benefit for a **dependent** is changed so as to warrant an amount of coverage for a **dependent** other than that then in force, the amount of a **dependent's** coverage will be changed to the new amount.

Continually Insured Provision

“Continuously insured” means a person who was insured under prior Student Health Insurance policies issued to the school and is now insured under this Policy. Persons who have remained continuously insured will be covered for conditions first manifesting themselves while continuously insured except for expenses payable under prior policies in the absence of this Policy. Previously insured **dependents** and students must re-enroll for coverage in order to avoid a break in coverage for conditions which existed in prior **Policy Years**. Once a break in continuous insurance occurs, the definition of **injury** or **sickness** will apply in determining coverage of any condition which existed during such break.

PART II

STUDENT ACCIDENT AND SICKNESS INSURANCE

GENERAL PROVISIONS

ENTIRE CONTRACT CHANGES. The entire contract is made up of: (i) this Policy, including the Policyholder's application (a copy of which is attached); and (ii) the individual applications, if any, of **covered persons**. Statements made by the Policyholder or a **covered person** shall be deemed to be representations and not warranties. No such statement may be used in any contest of this insurance, unless the statements: (1) are contained in writing and signed by the applicant; and (2) a copy has been given to such person, or to his or her beneficiary or personal representative. Further, no statement by a **covered person**, except a fraudulent statement, will be used in defense to a claim for loss incurred after the coverage under which claim is made has been in effect for 2 years. This Policy may be changed at any time by written agreement between Aetna and the Policyholder. The consent of any student or other person is not needed. All agreements made by Aetna are signed by one of its executive officers. No other person can change or waive any of the Policy terms or make any agreement binding Aetna. The Policyholder will not have to give written approval of a change in the Policy if: (a) The Policyholder has asked for the change and Aetna has agreed to it; or (b) the change is needed so that the Policy will conform to any law, regulation or ruling of a jurisdiction that affects a person covered under this Policy or the federal government.

CERTIFICATE. Aetna will issue to the Policyholder a certificate. The certificate will set forth the insurance in force, and all terms and conditions related to the insurance, and to whom benefits are payable.

PREMIUMS. Aetna sets the premiums that apply to the coverage provided under this Policy. Those premiums are shown in a notice given to the Policyholder with or prior to delivery of this Policy. Aetna has the right to adjust the premium rate on each anniversary date of this Policy or when the terms of this Policy are changed. The Policyholder will be given notice of such premium adjustment at least 60 days before the date it is to take effect unless the change in Policy terms is to take effect before the 60 days.

PART II

STUDENT ACCIDENT AND SICKNESS INSURANCE

GENERAL PROVISIONS (Continued)

PAYMENT OF PREMIUMS. The Policyholder will pay premiums in advance. They may be paid at Aetna's Home Office or to its authorized agent. A premium is due to be paid on the first day of each Policy month. The Policyholder may change the number of premium payments as of a premium due date. This needs Aetna's written consent.

RENEWAL OF POLICY. With Aetna's consent, this Policy may be renewed for like periods by payment of the renewal premium at the premium rate in effect at that time. This renewal premium must be paid within the grace period. Aetna also has the right to refuse to renew this Policy.

GRACE PERIOD. The premium due date will be negotiated by Aetna and the Policyholder. The grace period of 31 days will be granted for the payment of each premium falling due after the first premium. During that period, this Policy shall continue in force. The Policyholder shall be liable to Aetna for the payment of the premium for the period this Policy continues in force.

NOTICE OF CLAIM. Written notice of claim must be given to Aetna within 30 days after the occurrence or commencement of any loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant or the beneficiary to Aetna at its Home Office in Hartford, Connecticut or to its authorized agent, with information sufficient to identify the **covered person**, shall be deemed notice to Aetna.

CLAIM FORMS. Upon receipt of a written notice of claim, Aetna or its authorized agent will give the claimant such forms as are usually given for filing proofs of loss. If such forms are not given within 15 days after the receipt of such notice, the claimant can fulfill the terms of this Policy as to proof of loss by giving written proof of: (i) the occurrence of the loss; and (ii) the nature of the loss; and (iii) the extent of the loss.

PART II

STUDENT ACCIDENT AND SICKNESS INSURANCE

GENERAL PROVISIONS (Continued)

REINSTATEMENT. If any renewal premium is not paid within the time granted the Policyholder for payment, a subsequent acceptance of premium by Aetna or by any agent duly authorized by Aetna to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy. Provided, however, that if Aetna or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Aetna or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless Aetna has previously notified the Policyholder in writing of its disapproval of such application. The reinstated Policy shall cover only loss resulting from such accidental **injury** as may be sustained after the date of reinstatement and loss due to such **sickness** as may begin more than 10 days after such date. In all other respects the Policyholder and Aetna shall have the same rights thereunder as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed herein or attached hereto in connection with the reinstatement. Any premium accepted in connection with the reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period for more than 60 days prior to the date of reinstatement.

PROOFS OF LOSS. Written proof of loss must be given to Aetna at Aetna's Home Office within 90 days after the date of such loss. Failure to give such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, proof must be given as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year after the deadline. Otherwise, late claims will not be covered.

TIME OF PAYMENT OF CLAIMS. Benefits payable under this Policy will be paid as they accrue and as soon as due written proof of such loss has been received by Aetna or its authorized agent.

PAYMENT OF CLAIMS. All benefits will be paid to the **covered student**. All or a portion of the benefits, if any, provided by this Policy may be paid directly to the **hospital** or person upon whose charges the claim is based or to the person who made payment on behalf of the **covered student**. The **covered person** must make a written request to Aetna before Aetna can do this. Aetna must receive the request no later than the time for filing proof of loss. If the **covered student** dies, Aetna will pay any accrued benefits at the time of death to the beneficiary or, if no beneficiary is designated and surviving, then as follows:

- a) the **covered student's** parents or legal guardian, if a minor;
- b) otherwise to the **covered student's** estate.

RECOVERY OF OVERPAYMENT. If a benefit payment is made by Aetna, to or on behalf of any **covered person**, which exceeds the benefit amount such **covered person** is entitled to receive in accordance with the terms of the group contract, Aetna has the right:

- to require the return of the overpayment on request;
- to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that **covered person** or another person in his or her family.

Such right does not affect any other right of recovery Aetna may have with respect to such overpayment.

PHYSICAL EXAMINATION. At Aetna's expense, Aetna has the right to have a **physician** examine a **covered person** when and so often as Aetna deems reasonably necessary while there is a claim pending under this Policy.

PART II

STUDENT ACCIDENT AND SICKNESS INSURANCE

GENERAL PROVISIONS (Continued)

LEGAL ACTIONS. No one may sue Aetna for payment of claims: (i) less than 60 days after due proof of claim is furnished; or (ii) more than 3 years after the date proof of claim is required by this Policy.

RECORDS MAINTAINED. The Policyholder shall maintain records of each person covered. The records shall show all data that is needed to administer this Policy.

EXAMINATION AND AUDIT. Aetna shall be allowed to examine and audit the Policyholder's books and records which pertain to this Policy at reasonable times. Aetna must also be allowed to do this within 3 years after the later of: (i) the date this Policy terminates; or (ii) until final settlement of all claims hereunder.

POLICYHOLDER ERROR. Clerical errors will not affect coverage in any way.

NOT IN LIEU OF WORKERS COMPENSATION. This Policy is not a Worker's Compensation Policy. It does not provide Worker's Compensation benefits.

DISCONTINUANCE OF POLICY. The Policyholder may terminate this Policy as to any or all coverage of all or any class of students. Aetna must be given written notice. The notice must state when such termination shall occur. It must be a date after the notice. It shall not be effective during a period for which a premium has been paid to Aetna as to the coverage.

Aetna has the right to terminate this Policy as to all or any class of students of a Policyholder at any time after the end of the grace period if the premium for student coverage has not been paid. Written notice of the termination date must be given by Aetna. This right is subject to the terms of any laws or regulations.

Aetna may also terminate this Policy in its entirety or as to any of all coverages of all or any class of students by giving the Policyholder advance written notice of when it will terminate. The date shall not be earlier than 31 days after the date of the notice unless it is agreed to by the Policyholder and Aetna.

If:

this Policy terminates as to any of the students of a Policyholder; and

premiums have not been paid for the period this Policy was in force for those students;

then the Policyholder shall be liable to Aetna for the unpaid premiums.

Your Blanket Student Accident And Sickness Coverage Plan

Medical Expense Benefits in this Plan are underwritten by Aetna Life Insurance Company of Hartford, Connecticut (called Aetna). The benefits and main points of the group contract for persons covered under this Plan are set forth in this Booklet. They are effective only while you are covered under the Blanket contract.

If you become covered, this Booklet will become your Certificate of Coverage. It replaces and supersedes all Certificates issued to you by Aetna under the Blanket contract.



President

Registrar

Cert. Base: 1
Issue Date: June 21, 2006
Effective Date: August 15, 2006

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STUDENT ACCIDENT AND SICKNESS INSURANCE

SECTION 1 - SCHEDULE OF BENEFITS

ELIGIBILITY

Registered domestic or international students who pay a Comprehensive Student Activity Fee which includes the Student Health Fee are eligible to purchase the Student Health Insurance Plan.

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

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

SCHEDULE OF ACCIDENT AND SICKNESS BENEFITS PLAN LEVEL LIMITS

FOR COVERED STUDENTS AND DEPENDENTS

Basic Accident Expense Benefit

Aggregate Maximum Benefit Limit per Accident :	\$ 1,000,000
Deductible Amount per year :	
Individual	\$ 150
Family	\$ 400

(a) **Covered Medical Expenses** for an **accident** will be payable on the same basis as for **sickness**.

Basic Sickness Expense Benefit

Aggregate Maximum Benefit Limit per Sickness :	\$ 1,000,000
Deductible Amount per year :	
Individual	\$ 150
Family	\$ 400

This Deductible Amount applies to all expenses except:

Mammogram Expense Benefits

Once the Aggregate Maximum Benefit is paid, no other Basic Benefits are payable in connection with the **Accident** or **Sickness**, even if other benefit maximums, such as day or visit maximums, have not been reached.

Certification Requirements

The **covered person** must obtain certification for certain types of expenses to avoid a reduction in benefits paid for that care. Certification for **Hospital** Admissions, **Residential Treatment Facility** Admissions.

Deductible Amount	\$ 200
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This **Deductible** Amount applies separately to each type of admission and care listed above.

The **Basic Sickness** Expense Benefits section of the Policy contains details of the types of care affected, how to get certification, and the effect on benefits for failure to obtain certification.

Benefits Payable

After any applicable deductible, the Health Expense Benefits payable under this Policy in a Policy Year are paid at the Covered Percentage which applies to the type of Covered Medical Expense which is incurred. Benefits may vary depending upon whether a Preferred Care Provider is utilized. A Preferred Care Provider is a health care provider who has agreed to provide services or supplies at a "negotiated charge."

<u>COVERAGE</u>	<u>BENEFIT AMOUNT</u>	
	<u>Preferred Care</u>	<u>Non-Preferred Care</u>
HOSPITAL EXPENSE		
Covered Percentage	80%	70%
<p>Covered Medical Expenses incurred for an inpatient confinement following a laparoscopy-assisted vaginal hysterectomy or a vaginal hysterectomy are payable on the same basis as any other inpatient expense for a minimum of 24 hours following a laparoscopy-assisted vaginal hysterectomy or 48 hours following a vaginal hysterectomy. Covered Medical Expenses incurred for an inpatient confinement following a mastectomy are payable on the same basis as any other inpatient expense for a minimum of 24 hours following a partial or a total mastectomy with lymph node dissection or 48 hours following a radical or modified radical mastectomy.</p>		
SURGICAL EXPENSE		
Covered Percentage	80%	70%
Anesthesia Percentage	80%	70%
Assistant Surgeon Percentage	80%	70%
IN-HOSPITAL PHYSICIAN'S FEES EXPENSE		
Covered Percentage	80%	70%
OUTPATIENT EXPENSE		
Covered Percentage	80%	70%
OUT OF HOSPITAL PHYSICIAN'S FEES EXPENSE		
Covered Percentage	90%	90%
	After a \$20	After a \$40
	Per visit Copay	Per visit Deductible
OUTPATIENT DIAGNOSTIC AND LABORATORY EXPENSE		
Covered Percentage	80%	70%
EMERGENCY ROOM EXPENSES		
Covered Percentage	90%	90%
Copaymant or Deductible per Visit	\$ 75*	\$ 75*
*The per visit copay/deductible will be waived if admitted as an inpatient.		
AMBULANCE EXPENSE		
Covered Percentage	80%	
PRESCRIBED MEDICINES EXPENSE		
Covered Percentage	100% after an annual \$50 Prescription Drug Deductible	
Copay/Deductible per prescription		
Brand Name	\$ 30	
Generic	\$ 10	

	<u>Preferred Care</u>	<u>Non-Preferred Care</u>
HIGH COST PROCEDURES EXPENSE BENEFIT		
Covered Percentage	80%	70%
CHIROPRACTIC EXPENSES	90% after a \$20 copay per visit	70%
DENTAL INJURY EXPENSES	80%	
TEMPOROMANDIBULAR JOINT DYSFUNCTION		
Covered Percentage	80%	70%
ROUTINE PHYSICAL EXAMS		
Copay/Deductible per visit	\$ 20	\$ 100
Covered Percentage	90%	90%
IMMUNIZATIONS FOR CHILDREN UNDER AGE 7		
Covered Percentage	90%	90%
IMMUNIZATIONS FOR CHILDREN OVER AGE 7		
Covered Percentage	80%	70%
HOME HEALTH CARE EXPENSE		
Covered Percentage	80%	70%
Maximum Visits	90	
MAMMOGRAM EXPENSE	See Description of Coverage	
PAP SMEAR SCREENING EXPENSE	See Description of Coverage	
PREVENTIVE HEALTH CARE SERVICES EXPENSE		
Covered Percentage	90%	90%
CLEFT LIP/PALATE OR ECTODERMAL DYSPLASIA OF A DEPENDENT CHILD	See Description of Coverage	
PREVENTIVE HEALTH CARE SERVICES EXPENSES	See Description of Coverage	
DIABETIC TREATMENT EXPENSE	See Description of Coverage	
ALCOHOLISM, DRUG ABUSE, AND MENTAL DISORDER TREATMENT EXPENSE		
Non-Biologically based:		
Inpatient:		
Covered Percentage	80%	70%
Inpatient Day Maximum	30 days per Policy Year	
Outpatient:		
Covered Percentage/ Copay	90% after \$20 copay visits	70% for the first 5 visits 50% for the next 15 visits
Visit Maximum	20 visits per Policy Year	

Biologically based:

Inpatient:	<u>Preferred Care</u>	<u>Non-Preferred Care</u>
Covered Percentage	80%	70%
Outpatient:		
Covered Percentage/ Copay	90% after \$20 copay	90% after a \$40 deductible per visit

PAYMENT LIMITS

The following limits apply to **Covered Medical Expenses** which are payable at a rate greater than 50% and not applied against any deductible or copay amount.

Payment Limit which applies to Covered Medical Expenses for a Covered Person

When a **covered person's Covered Medical Expenses** for which no benefits are paid because the Covered Percentage reaches \$ 1,500 in a **Policy Year**, benefits will be payable at 100% for all of his or her **Covered Medical Expenses** to which this limit applies and which are incurred in the rest of that **Policy Year**, except those for Non-Preferred Care. When the amount reaches \$ 2,000, then benefits will be payable at 100% for all of his or her **Covered Medical Expenses** to which this limit applies and which are incurred in the rest of that **Policy Year**, including those for Non-Preferred Care.

Payment Limit which applies to Covered Medical Expenses for a Family

When a family's **Covered Medical Expenses** for which no benefits are paid because the Covered Percentage reaches \$ 3,000 in a **Policy Year**, benefits will be payable at 100% for all of their **Covered Medical Expenses** to which this limit applies and which are incurred in the rest of that **Policy Year**, except those for Non-Preferred Care. When the amount reaches \$ 4,000, then benefits will be payable at 100% for all of their **Covered Medical Expenses** to which this limit applies and which are incurred in the rest of that **Policy Year**, including those for Non-Preferred Care.

STUDENT ACCIDENT AND SICKNESS INSURANCE

SECTION 2 - DEFINITIONS

The following words and phrases when used in this Policy shall have, unless the context clearly indicates otherwise, the meaning given to them below:

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** from one **Policy Year** to the next.

Biologically-Based Mental Illness

This means any mental or nervous condition caused by a biological disorder of the brain that results in a clinically significant syndrome that substantially limits the person's functioning. The following are defined as biologically-based mental illness for an adult or child:

Schizophrenia;
Schizoaffective disorder;
Major depressive disorder;
Bipolar disorder;
Obsessive-compulsive disorder;
Panic disorder;
Attention deficit hyperactivity disorder;
Autism; and
Drug and alcohol addiction.

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

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

Not included are (a) false labor, occasional spotting, or **physician** prescribed rest during the period of pregnancy; (b) morning **sickness**; and (c) 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

Covered dependent: a **covered student's** dependent who is insured under this Policy.

Covered Medical Expense: those charges for any treatment, service, or supplies covered by this Policy which are:

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

Covered person: a **covered student** and any **covered dependent** while coverage under this Policy is in effect.

Covered student: a student of the Policyholder who is insured under this Policy.

Deductible: the amount of the **Covered Medical Expenses** that are paid by each **covered person** during the **policy year** before benefits are paid.

Dependent: (a) the **covered student's** spouse residing with the **covered student**; and (b) the **covered student's** unmarried child under the age of 19 years.

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 persons 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.

Effective Treatment of Alcoholism or Drug Abuse: a program of alcoholism or drug abuse therapy that is prescribed and supervised by a **physician** and either:

- has a follow-up therapy program directed by a **physician** on at least a monthly basis; or
- includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.

These are not effective treatment:

- Detoxification. This means mainly treating the after effects of a specific episode of alcoholism or drug abuse.
- Maintenance care. This means providing an environment free of alcohol or drugs.

Elective Treatment: Medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Covered Person's effective date of coverage. Elective treatment includes, but is not limited to, tubal ligation; vasectomy; breast reduction; sexual reassignment surgery; submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis, treatment for weight reduction; learning disabilities; temporomandibular joint (TMJ) dysfunction; immunization; vaccines; and routine physical examinations.

Hospital: a facility which meets all of these tests:

- it provides in-patient services for the care and treatment of injured and sick people; and
- it provides **room and board** services and nursing services 24 hours a day; and
- it has established facilities for diagnosis and major surgery; and
- it is run as a **hospital** under the laws of the jurisdiction which it is located.

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

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

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

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

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

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

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

In no event will the following services or supplies be considered to be Medically Necessary:

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

Night Care Treatment: a **partial confinement treatment** program given to a person who is confined during the night. A room charge is made by the **hospital** or treatment facility. A night care program must be available at least:

- 6 hours in a row a night; and
- 5 nights a week.

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

Partial Confinement Treatment: a plan of psychiatric services to treat alcoholism, drug abuse, or a mental disorder that meets these tests:

- it is carried out in a **hospital** or **treatment facility** on less than a full-time inpatient basis; and
- it is in accord with accepted medical practice for the condition of the person and does not require full-time confinement; and
- it is supervised by a **psychiatric physician** who weekly reviews and evaluates its effect.

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**.

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.

Plan Administrator: means Chickering Claims Administrators Inc.

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.

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

Psychiatric Physician: this is a **physician** who:

- specializes in psychiatry; or
- has the training or experience to do the required evaluation and treatment of mental illness.

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

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

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

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

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

Aetna may take into account factors, such as:

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

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

School Health Services: any organization, facility, or clinic operated, maintained, or supported by the school or other entity under contract to the school which provides health care services to enrolled students.

Semiprivate Rate: the charge for room and board which an institution applies to 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.

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**.

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

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

Surgical expense: charges by a **physician** for:

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

Surgical procedure:

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

Treatment Facility (Alcoholism or Drug Abuse): an institution that:

- Mainly provides a program for diagnosis, evaluation, and **effective treatment of alcoholism or drug abuse**.
- Makes charges.
- Meets licensing standards.
- Prepares and maintains a written plan of treatment for each patient. The plan must be based on medical, psychological, and social needs. It must be supervised by a **physician**.
- Provides, on the premises, 24 hours a day:

Detoxification services needed with its **effective treatment** program.

Infirmary – level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical services that may be required.

Supervision by a staff of **physicians**.

Skilled nursing care by licensed nurses who are directed by a full – time R.N.

If a facility is located in Virginia, only the first 3 tests above will apply.

STUDENT ACCIDENT AND SICKNESS INSURANCE

SECTION 2 - DEFINITIONS

Copay: this is a fee charged to a person for **Covered Medical Expenses**.

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

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

Non-Preferred Care: a health care service or supply furnished by a health care provider 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**.

Preferred Care: care provided by:

- a person's **Primary Care Physician**, or a **Preferred Care Provider** on the referral of the **Primary Care Physician**; or
- a **Non-Preferred Care Provider** on the referral of the person's **Primary Care Physician** and if approved by Aetna; or
- any health care provider for an **emergency condition** when travel to a **Preferred Care Provider** or referral by a person's **Primary Care Physician** prior to treatment is not feasible.

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 the person is member.

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

Emergency Admission: one where the **physician** admits the person to the **hospital** or **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.

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

- the onset of or change in a disease;
- 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.

STUDENT ACCIDENT AND SICKNESS INSURANCE

SECTION 2 - DEFINITIONS

Home Health Agency:

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

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

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

Home Health Care Plan: a written program 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.

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.

STUDENT ACCIDENT AND SICKNESS INSURANCE

SECTION 2 - DEFINITIONS

The following definitions are used in describing Prescribed Medicine Expenses.

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

Generic Prescription Drug or Medicine: a **prescription drug** which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

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.

Pharmacy: an establishment where **prescription drugs** are legally dispensed.

Preferred Care: care provided by:

- a **Preferred Care Provider**; or
- a health care provider that is not a **Preferred Care Provider** for an **emergency medical condition** when travel to a **Preferred Care Provider** is not feasible.

Preferred Pharmacy: a **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
- when such a **pharmacy** dispenses a **prescription drug** under the terms of its contract with Aetna.

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

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

Prescription Drugs: any of the following:

- A drug, biological, or compounded **prescription** which, by law, may be dispensed only by **prescription**.
- Injectable insulin, disposable needles and syringes when prescribed and purchased at the same time as insulin, and disposable diabetic supplies.

STUDENT ACCIDENT AND SICKNESS INSURANCE

SECTION 3 - ELIGIBILITY, EFFECTIVE DATE OF INDIVIDUAL COVERAGE

Eligible Persons

Students

All classes of students are eligible except:

- students in any class which is not listed in the Schedule of Benefits.

Each student in an eligible class, as determined by the school in which he or she enrolled, is eligible for coverage under this Policy and is eligible to submit a written request for insurance with respect to his or her eligible dependents.

Dependents: dependents of a **covered student** who meet the definition of a dependent under this Policy and are listed under the Schedule of Benefits.

Effective Date of Insurance

The coverage of each person who applies for coverage hereunder on or before the Effective Date hereof shall take effect on the Effective Date of this Policy.

Coverage for each person applying for coverage hereunder after the Effective Date shall take effect on the date he or she either submits a completed application or fails to submit a waiver form, and pays the premium for the insurance.

Dependent insurance of a **covered student** becomes effective on the date the **covered student** becomes effective; otherwise the insurance becomes effective on the date the **covered student** acquires a **dependent**.

A newborn child shall be insured for **injury, sickness**, premature birth and medically diagnosed congenital defects and birth abnormalities from the moment of birth for an initial period of thirty-one days. To continue the insurance beyond this initial 31 day period, the **covered student** must notify Aetna or its agent of the birth and pay any additional premium required for the child's insurance within the 31 day period.

Coverage is provided for a child legally placed for adoption with a **covered student** from the moment of placement, for an initial period of thirty-one days. Notification of placement of such child and payment of any additional premium, if necessary, is required within 31 days from placement. To continue the insurance beyond this initial 31 day period, the **covered student** must notify Aetna or its agent of the placement of such child and pay any additional premium required for the child's insurance within the 31 day period.

Late Enrollment

If an application and premium payment for insurance are made more than 30 days following the date the Eligible Person or Dependent become eligible, then his or her insurance will become effective only if and when Aetna gives its written consent.

An eligible **dependent** will not be considered a late enrollee if a court order requires the **covered student** to provide coverage for his or her eligible **dependent**. Such coverage will become effective on the date of the court order. Any limitation as to a **Pre-Existing Condition** may apply.

Once an eligible student makes a coverage selection under this Policy, he or she may not change his or her selection.

The Policyholder agrees to submit to Aetna within 20 days after the effective date of each **covered person's** insurance: (1) the name of each person who applied for coverage hereunder; (2) the effective date of insurance; and (3) the premium paid as to each such **covered person**. The insurance of those **covered persons** whose names and premiums were received more than 20 days after the date the insurance would have become effective will take effect on the date such name and premium is received by Aetna or an agent of Aetna except as may otherwise be provided above.

Change In Amounts

Covered Student

Status Change - If, at any time, the **covered student's** status changes so as to warrant an amount of coverage other than that for which the **covered student** is then covered, the amount of his or her coverage will be changed as follows:

An increase or reduction will be effective on the date of the status change.

Schedule or Benefit Level Change - If, at any time, any schedule or the level of any benefit is changed so as to warrant an amount of coverage other than that for which the **covered student** is then covered, the amount of coverage will be changed to the new amount.

All Changes - A retroactive change in a **covered student's** status will not result in a retroactive change in coverage. Any change in coverage will be effective on the date the change in status is made.

Covered Dependent

Status, Schedule, or Benefit Level Change - If, for any reason and at any time, a **dependent's** status, any schedule, or the level of any benefit for a **dependent** is changed so as to warrant an amount of coverage for a **dependent** other than that then in force, the amount of a **dependent's** coverage will be changed to the new amount.

Continuously Insured Provision

“Continuously insured” means a person who was insured under prior Student Health Insurance policies issued to the school and is now insured under this Policy. Persons who have remained continuously insured will be covered for conditions first manifesting themselves while continuously insured except for expenses payable under prior policies in the absence of this Policy. Previously insured **dependents** and students must re-enroll for coverage in order to avoid a break in coverage for conditions which existed in prior **Policy Years**. Once a break in continuous insurance occurs, the definition of **Pre-Existing Condition** will apply in determining coverage of any condition which existed during such break.

STUDENT ACCIDENT AND SICKNESS INSURANCE

SECTION 4 - TERMINATION OF COVERAGE, EXTENSION OF BENEFITS, CONTINUATION

TERMINATION OF STUDENT COVERAGE

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

- (a) the date this Policy terminates;
- (b) the last day for which any required premium has been paid;
- (c) the date on which the **covered student** withdraws from the school because of entering the armed forces of any country.

Premiums will be refunded on a pro-rata basis when application is made within 90 days from withdrawal.

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

TERMINATION OF DEPENDENT COVERAGE

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

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

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 or her own living. Such proof will not be required more often than once each year after 2 years from the date the child reached the age at which insurance would have ceased if the child were not incapacitate. The premium due for the child's insurance will be the same as for a child who is not so incapacitated.

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

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

EXTENSION OF BENEFITS

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

CONTINUATION OF COVERAGE

Eligibility

A **covered student's** insurance under this Policy normally terminates when the student no longer meets the eligibility requirements. However, such student may elect to continue coverage under this Policy if:

- (a) the student's insurance under this Policy is terminating due to other loss of eligibility; and
- (b) the student's coverage has not been canceled under this Policy due to fraud or misrepresentation; and
- (c) the student has been continuously insured under this Policy for at least six (6) consecutive months.

Each eligible student who elects to continue coverage is also eligible for continued coverage for his or her eligible **dependents** provided such **dependent** was also continuously insured under this Policy for at least six (6) consecutive months.

A **covered student** may elect that coverage be continued for up to nine (9) months. The **Plan Administrator** will provide the premium rate for the elected period upon request.

Enrollment

To continue coverage, the student must apply to Aetna within 31 days following the date the student's coverage would otherwise terminate under this Policy.

Coverage

Benefits provided during the period of continued coverage are limited to an **aggregate maximum** benefit of \$ 1,000,000 per **covered person**.

Termination of Continued Coverage

A **covered person's** coverage under this continuation provision will end on the first to occur of:

- (a) the date at the end of the last period for which any required premium has been paid;
- (b) the date at the end of the elected period of continued coverage;
- (c) the date this Policy terminates; or
- (d) the date this Policy terminates coverage for the class of student under which the person is eligible to be covered.

Expenses incurred after the **covered person's** termination of insurance under this provision will be paid in accordance with the Extension of Benefits Provision of this Policy.

This provision is subject to all of the terms of this Policy.

STUDENT ACCIDENT AND SICKNESS INSURANCE

SECTION 5 - COVERAGE

MEDICAL EXPENSE BENEFITS

Medical Expense Benefits Coverage is expense-incurred coverage only and not coverage for the disease or **injury** itself. This means that Aetna will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for medical expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an **accident, injury, or sickness** which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by Aetna. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

Aetna assumes no responsibility for the outcome of any covered services or supplies. Aetna makes no express or implied warranties concerning the outcome of any covered services or supplies.

The Schedule of Benefits shows the **deductible**, covered percentages, and maximum benefits that apply to **Covered Medical Expenses** described in this Section.

BASIC ACCIDENT EXPENSE BENEFITS

Accident Expense Benefits are payable for **Covered Medical Expenses** incurred by each **covered person**. Such expense must be incurred as a result of accidental **injury**.

Covered Medical Expenses include expenses for hospital, surgical or medical treatment, services or supplies incurred by a **covered person** by reason of **injury**. The benefits will be provided to the same extent that benefits are provided under this Policy for expenses incurred on account of **sickness**. An expense is incurred on the date the service is performed or the supply is purchased.

Covered Medical Expense incurred for services and supplies:

- (a) must be **medically necessary**;
- (b) must be prescribed or ordered by the attending **physician**; and
- (c) will not include amounts in excess of the **reasonable and customary** charge.

Proof must be received that the **Covered Medical Expenses** were solely the result of an **injury** sustained by the **covered person**. The first such expense must be incurred within 30 days after the date of the **accident** causing the **injury**. Aetna will pay for **Covered Medical Expenses** which are the direct result of the **accident**, and from no other cause, within the **Policy Year** in which the **accident** occurred.

No more than the Aggregate Maximum Benefit will be paid for all **Covered Medical Expenses** incurred for any one **accident**.

The **Deductible Amount** will be applied separately to each **accident**.

The Aggregate Maximum Benefit Limit, Dental Injury Maximum, and **Deductible Amount** per **accident** and **Deductible Amount** per **Policy Year** are shown in the Schedule of Benefits.

BASIC SICKNESS EXPENSE BENEFITS

Covered Medical Expenses include the Basic Sickness Expense Benefit Provisions which follow, when expenses are incurred by a **covered person** by reason of **sickness**.

Covered Medical Expense incurred for services and supplies:

- (a) must be **medically necessary**;
- (b) must be prescribed or ordered by the attending **physician**; and
- (c) will not include amounts in excess of the **reasonable and customary** charge.

No more than the Aggregate Maximum Benefit will be paid for all **Covered Medical Expenses** incurred for any **one sickness**. Aetna will pay for **Covered Medical Expenses** which are the direct result of **sickness**, and from no other cause, within the **Policy Year** of the onset of the **sickness**.

The Aggregate Maximum Benefit Limit and **Deductible** are shown in the Schedule of Benefits.

HOSPITAL EXPENSE

Hospital Room and Board Expense

Covered Medical Expenses include Hospital **Room and Board** Expense incurred for the period of confinement, including expense for a **birthing center** for treatment in connection with pregnancy. However, the covered **room and board** expense does not include any charge in excess of the Daily **Room and Board** Maximum.

Miscellaneous Hospital Expense

“Miscellaneous Hospital Expense” includes, among others, expenses incurred during a **hospital confinement** for:

- anesthesia and operating room;
- laboratory tests and X-rays;
- oxygen tent; and
- drugs, medicines, dressings.

The Covered Percentage Daily **Room and Board** Maximum, and the Miscellaneous **Hospital** Expense Maximum are shown in the Schedule of Benefits.

SURGICAL EXPENSE

Covered Medical Expenses include expenses incurred by a **covered person** for surgery provided by a **hospital** on an inpatient or outpatient basis. When **injury** or **sickness** requires two or more surgical procedures which are performed through the same approach, and at the same time or immediate succession, **Covered Medical Expenses** only include expenses incurred for the most expensive procedure.

Anesthetic Expense

If, in connection with such operation, the **covered person** requires the services of an anesthetist who is not employed or retained by the **hospital** in which the operation is performed, the expenses incurred will be **Covered Medical Expenses**. Not more than the Anesthesia Maximum will be paid per operation.

Assistant Surgeon Expense

If, in connection with such operation, the **covered person** requires the services of an Assistant Surgeon, the expenses incurred will be **Covered Medical Expenses**. Not more than the Assistant Surgeon Maximum will be paid per operation.

The Covered Percentage, Maximum per Operation, Anesthesia Maximum, and the Assistant Surgeon Maximum are shown in the Schedule of Benefits.

IN-HOSPITAL PHYSICIAN'S FEES EXPENSE

When a **covered person** who is confined as an inpatient in a **hospital** requires the services of a **physician** who is not the **physician** who may have performed surgery on the **covered person**, this Policy will pay for charges made by the **physician**. Not more than Visit Maximum will be paid for any visit, and not more than the Maximum Number of Visits will be covered per **Policy Year**.

The Covered Percentage is shown in the Schedule of Benefits.

OUT-PATIENT EXPENSE

Covered Medical Expenses include expenses incurred by a **covered person** for the use of diagnostic X-ray, laboratory services, or an emergency or operating room including expenses incurred for an **ambulatory surgical center**.

The Covered Percentage is shown in the Schedule of Benefits.

OUT OF HOSPITAL PHYSICIAN'S FEES EXPENSE

Subject to the Exception below:

If a **covered person** requires the services of a **physician** while not confined as an inpatient in a **hospital**, **Covered Medical Expenses** include the charges made by the **physician**.

The Covered Percentage is shown in the Schedule of Benefits.

Exception

If the services are in connection with surgery and the **physician** is the surgeon who performed the surgery, no benefits are payable under this provision.

AMBULANCE EXPENSE

When a **covered person** requires the use of an ambulance in an emergency, this Policy will pay for the charges incurred.

The Covered Percentage is shown in the Schedule of Benefits.

DURABLE MEDICAL AND SURGICAL EQUIPMENT

Covered Medical Expense includes **durable medical and surgical equipment**. In lieu of rental, the following may be covered:

the initial purchase of such equipment if Aetna is shown that long term care is planned and that such equipment: either cannot be rented, or is likely to cost less to purchase than to rent;

repair of purchased equipment;

replacement of purchased equipment if Aetna is shown that it is needed due to a change in the person's physical condition; or

it is likely to cost less to purchase a replacement than to repair existing equipment or to rent like equipment.

Aetna assumes no responsibility for the outcome of any covered services or supplies.

MAMMOGRAM EXPENSE BENEFIT

Benefits are payable for charges for mammograms. The charges must be incurred while a **covered person** is insured for these benefits.

Benefits will be paid for expenses incurred for the following:

- (1) One baseline mammogram, for a person age 35 but less than 40; and
- (2) One mammogram each calendar year, for a person age 40 or over, or more frequently based on the recommendation of the woman's **physician**.

If, by reason of similar benefits provisions elsewhere contained, this Policy provides for reimbursement for the same charges, no benefits shall be payable under those provisions. These benefits are in place of all other benefits of this Policy.

MATERNITY EXPENSE BENEFITS

Maternity Expense Benefits are payable to the same extent as any other **sickness** for covered expenses incurred by a **covered person**.

Covered expenses include:

- (a) in-patient care for a minimum of 48 hours following vaginal delivery for the mother and her newly born child; or
- (b) in-patient care for a minimum of 96 hours following cesarean section for the mother and her newly born child.

Any decision to shorten such minimum coverages shall be made by the attending **physician** in consultation with the mother and done in accordance with the rules and regulations promulgated by the department of public health. In such cases, covered services may include home visits, parent education, and assistance and training in breast or bottle feeding.

If another benefit provision contained in this policy provides for reimbursement for the same charges for which a benefit would be payable under this provision, no benefits shall be payable under that provision. These benefits are in place of all other like benefits of this policy.

This provision is subject to all the terms of this policy.

CERTIFICATION FOR INPATIENT ADMISSIONS

If:

- a **covered person** becomes confined in a **hospital** or **treatment facility** as a full-time inpatient; and
- it has not been certified that such confinement (or any day of such confinement) is **medically necessary**; and
- the confinement has not been ordered and prescribed by a **physician** who is a **Preferred Care Provider**;

Covered Medical Expenses incurred on any day not certified during the confinement will be paid as follows:

- As to **Hospital** and **Treatment Facility** Expenses incurred during the confinement:

If certification has been requested and denied:

No benefits will be paid for **Hospital** and **Treatment Facility** Expenses incurred for board and room.

Benefits for all other **Hospital** and **Treatment Facility** Expenses will be paid at the Covered Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is not **medically necessary**:

No benefits will be paid for **Hospital** and **Treatment Facility** Expenses incurred for board and room.

As to all other **Hospital** and **Treatment Facility** Expenses:

Expenses, up to the Certification **Deductible Amount**, will not be deemed to be **Covered Medical Expenses**.

Expenses for such expenses in excess of the Certification **Deductible Amount** will be paid at the Covered Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is **medically necessary**:

Hospital and Treatment Facility Expenses, up to the Certification **Deductible Amount**, will not be deemed to be **Covered Medical Expenses**.

Benefits for all other **Hospital and Treatment Facility** Expenses will be payable at the Covered Percentage.

- As to other **Covered Medical Expenses**:

Benefits will be paid at the Covered Percentage.

Whether or not a day of confinement is certified, no benefit will be paid for expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this policy; except that, if certification has been given for a day of confinement, the exclusion of services and supplies because they are not **medically necessary** will not be applied to expenses for **hospital or treatment facility** board and room.

Certification of days of confinement can be obtained as follows:

If the admission is a **non-urgent admission**, the **covered person** must get the days certified by calling the **Plan Administrator**. This must be done at least 3 days before the date the **covered person** is scheduled to be confined as a full-time inpatient. If the admission is an **emergency** or an **urgent admission**, the **covered person**, the **covered person's physician**, or the **hospital or treatment facility** must get the days certified by calling the **Plan Administrator**.

This must be done:

- before the start of a confinement as a full-time inpatient which requires an **urgent admission**; or
- not later than 1 business day following the start of a confinement as a full-time inpatient which requires an **emergency admission**; unless it is not possible for the **physician** to request certification within that time. In that case, it must be done as soon as reasonably possible.

If, in the opinion of the **covered person's physician**, it is necessary for the **covered person** to be confined for a longer time than already certified, the **covered person**, the **physician**, or **hospital or treatment facility** may request that more days be certified by the **Plan Administrator**. This must be done no longer than on the last day that has already been certified.

Written notice of the number of days certified will be sent promptly to the **hospital or treatment facility**. A copy will be sent to the **covered person** and to the **physician**.

STUDENT ACCIDENT AND SICKNESS INSURANCE PROVISIONS

SECTION 5 - COVERAGE (Continued)

BASIC SICKNESS EXPENSE BENEFIT

DENTAL EXPENSE

If a **covered person** incurs expenses for services of a dentist or dental surgeon as a result of an accidental **injury**, this plan will pay for the charges made by the dentist or dental surgeon. Not more than the Maximum per Tooth will be paid.

Covered Medical Expenses also include expenses for the treatment of the mouth, teeth, and jaws, but only those for services rendered and supplies needed for the following treatment of or related to conditions of the:

- mouth, jaws, jaw joints; or
- supporting tissues (this includes bones, muscles, and nerves).

Dental work, surgery, and **orthodontic treatment** needed to remove, repair, replace, restore, or reposition:

- natural teeth damaged, lost, or removed; or
- other body tissues of the mouth fractured or cut;

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

Any such teeth must have been:

- free from decay; or
- in good repair; and
- firmly attached to the jaw bone at the time of the **injury**.

The treatment must be done in the **Policy Year** of the **accident** or the next one.

If:

- crowns (caps); or
- dentures (false teeth); or
- bridgework; or
- in-mouth appliances;

are installed due to such **injury**, **Covered Medical Expenses** include only charges for:

- the first denture or fixed bridgework to replace lost teeth;
- the first crown needed to repair each damaged tooth; and
- an in-mouth appliance used in the first course of **orthodontic treatment** after the **injury**.

Not included are charges:

- to remove, repair, replace, restore, or reposition teeth lost or damaged in the course of biting or chewing;
- to repair, replace, or restore fillings, crowns, dentures, or bridgework;
- for periodontal treatment;
- for dental cleaning, in-mouth scaling, planing, or scraping;
- for myofunctional therapy; this is:

muscle training therapy; or
training to correct or control harmful habits.

Covered Medical Expenses also include:

Surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out cysts, tumors, or other diseased tissues.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Non-surgical treatment of infections or diseases. This does not include those of or related to the teeth.

The Covered Percentage and Maximum are shown on the Schedule of Benefits.

PAP SMEAR SCREENING EXPENSE

Benefits will be paid for Expenses incurred for an annual Pap smear screening for women 18 years of age and older.

If, by reason of similar benefits provisions elsewhere contained, this Policy provides for reimbursement for the same charges, no benefits shall be payable under those provisions. These benefits are in place of all other benefits of this Policy.

HOME HEALTH CARE EXPENSE

Covered Medical Expenses include expenses incurred by a **covered person** for health care services.

Covered Home Health Care Services are the services and supplies shown in the List of Covered Home Health Care Services below, but only if:

- (a) The services are furnished by, or under arrangements made by, a licensed **Home Health Agency**.
- (b) The services are given under a home care plan. This plan must be established pursuant to the written order of a **physician** and the **physician** must renew that plan every 60 days.
- (c) Except as specifically provided in the List of Covered Home Care Services, the services are delivered in the patient's place of residence on a part-time, intermittent, visiting basis while the patient is confined.
- (d) The care starts within 7 days after discharge from a **hospital** as an inpatient.
- (e) The care is for the same condition that caused the hospital confinement, or one related to it.

HOME HEALTH CARE SERVICES

- (1) Part-time or intermittent nursing care by a registered nurse (R.N.), a licensed Practical nurse (L.P.N.), or under the supervision of a R.N. if the services of a R.N. are not available.
- (2) Part time or intermittent **Home Health Aide** services that consist primarily of care of a medical or therapeutic nature by other than a R.N.
- (3) Physical, occupational, or speech therapy.
- (4) Medical supplies, drugs and medicines, and laboratory services. But, these items are covered only to the extent they would be covered if the patient was confined to a **hospital**.

Home Health Care Expense 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.

No more than the Maximum Visits will be covered in a **Policy Year**. A visit means a maximum of 4 continuous hours of home health service.

If, by reason of similar benefit provisions elsewhere contained, this Policy provides for reimbursement for the same charges, no benefits shall be payable under those provisions. These benefits are in place of all other benefits under this Policy.

The Covered Percentage and Maximum Visits are shown on the Schedule of Benefits.

HIGH COST PROCEDURES EXPENSE BENEFIT

High Cost Procedures Expense Benefits are payable for **Covered Medical Expenses** incurred by a **covered person** as a result of **injury** or **sickness**. Such expense may be incurred in the following:

- (a) a **physician's** office; or
- (b) a **hospital** outpatient department or emergency room; or
- (c) a clinical laboratory; or
- (d) a radiological facility or other similar facility licensed by the state.

Covered expenses include, but are not limited to, charges for the following procedures and services:

- (a) C.A.T. Scan;
- (b) Magnetic resonance imaging; and
- (c) Laser treatment.

“High cost procedures” means any outpatient procedure costing over \$200.

This provision is subject to all the terms of this Policy.

PREVENTIVE HEALTH CARE SERVICES EXPENSES

The charges below are included as **Covered Medical Expenses** even though they are not incurred in connection with an **injury** or disease. *Preventive Health Care Services Expenses*

These are the charges incurred for Preventive Health Care Services.

Preventive Health Care Services

These are services provided for a routine physical exam of the child. Included are:

- A review and written record of the child's complete medical history.
- Taking measurements and blood pressure.
- Developmental and behavioral assessment.
- Vision and hearing screening.
- Other diagnostic screening tests including:
 - one series of hereditary and metabolic tests performed at birth;
 - urinalysis, tuberculin test, and blood tests such as hematocrit and hemoglobin tests.
- Immunizations for infectious disease.
- Counseling and guidance of the child and the child's parents or guardian on the results of the physical exam.

Covered Medical Expenses will only include charges incurred for:

- The first 9 exams performed during the first 2 years of the child's life.
- One exam performed during each year of life thereafter through age 6.

Not covered are charges incurred for:

- Services which are covered to any extent under any other part of this Policy;
- Services which are covered to any extent under any other group plan sponsored by the Policyholder;
- Services which are for diagnosis or treatment of a suspected or identified **injury** or disease;
- Services not performed by a **physician** or under his or her direct supervision;
- Medicines, drugs, appliances, equipment, or supplies;
- Dental exams.

ALCOHOLISM, DRUG ABUSE OR MENTAL DISORDERS TREATMENT EXPENSE

Certain expenses for the treatment shown below are **Covered Medical Expenses**. If a person is a full-time inpatient either:

- in a **hospital**; or
- in a **treatment facility**;

then the coverage is as shown below.

Hospital

Expenses for the following are covered:

- Treatment of the medical complications of alcoholism or drug abuse. This means things such as cirrhosis of the liver, delirium tremens, or hepatitis.
- **Effective treatment of alcoholism or drug abuse**. This is covered only if there is not a separate **treatment facility** section.
- Treatment of **mental disorders**.

Treatment Facility

Certain expenses for the **effective treatment of alcoholism or drug abuse** are covered. The expenses are those for:

- **Board and room**. Not covered is any charge for daily **board and room** in a private room over the Private Room Limit.
- Other **necessary** services and supplies.

Inpatient Day Maximum

Benefits will not be payable for more than the Inpatient Day Maximum in any one **Policy Year** for all **Covered Medical Expenses** incurred for **effective treatment of alcoholism or drug abuse** and treatment of mental disorders. This Inpatient Day Maximum will be reduced by any days of confinement for **day/night care treatment** for alcoholism or drug abuse and the treatment of mental disorders in the same **Policy Year** that are considered to be inpatient days, as provided in the next paragraph.

The Covered Percentage is shown on the Schedule of Benefits.

DAY/NIGHT CARE TREATMENT OF ALCOHOLISM, DRUG ABUSE OR MENTAL DISORDERS

If a person is participating in a **partial confinement treatment program**, the person may elect to have up to 10 of the full-time inpatient days covered above in the same **Policy Year** be covered for charges incurred for **day/night care treatment** in the **partial confinement treatment program**. For the purposes of calculating 10 days of treatment in a **partial confinement treatment program**, each 1.5 treatment sessions will be considered to be one day.

A treatment session starts when the person enters the place of treatment. It ends when he or she leaves it after one **day/night care treatment**. It includes all services and supplies furnished.

The Covered Percentage is shown on the Schedule of Benefits.

No benefits are paid under any other part of this Policy for charges incurred for a treatment session for which a benefit is paid under this section.

OUTPATIENT TREATMENT OF ALCOHOLISM, DRUG ABUSE OR MENTAL DISORDERS

Expenses incurred by a person for the **effective treatment of alcoholism or drug abuse** or the treatment of mental disorders while the person is not confined as a full-time inpatient in a **hospital or treatment facility** during any one **Policy Year** for visits, other than visits solely for medication management, in excess of the Visit Maximum will not be covered.

The Covered Percentage and the Maximum Benefit are shown on the Schedule of Benefits.

The Covered Percentage shown for visits over 5 will not apply to such visits that are solely for medication management; instead, the Covered Percentage shown for the first 5 visits will apply.

STUDENT ACCIDENT AND SICKNESS INSURANCE PROVISIONS CONCERNING

SECTION 5 - COVERAGE (Continued)

BASIC SICKNESS EXPENSE BENEFIT

PRESCRIBED MEDICINES EXPENSE

If a **covered person** requires medicines not normally stocked by the **School Health Services**, and if a **prescription drug** is dispensed by a **pharmacy** to a person for treatment of a **sickness** or **injury**, a benefit will be paid, determined from the Benefit Amount subsection, but only if the **pharmacy's** charge for the drug is more than the **copay** or **deductible** amount per **prescription** or refill. The **prescriptions** must be filled at a **Preferred Pharmacy**.

The benefit amount for each covered **prescription drug** or refill prescribed by a **preferred pharmacy** will be an amount equal to the Covered Percentage of the total charges. The total charge is determined by:

- the **preferred pharmacy**; and
- Aetna.

Any amount so determined will be paid to the **preferred pharmacy** on your behalf.

No benefit will be paid for a **prescription drug** dispensed by a **non-preferred pharmacy** under this benefit section except for an **emergency condition**, in which case the benefit will be payable at the preferred level of coverage.

Limitations

No benefits are paid under this section:

- For a device of any type unless specifically included as a **prescription drug**.
- For any drug entirely consumed at the time and place it is prescribed.
- For more than a 90 day supply per **prescription** or refill.
- For the administration or injection of any drug through medical necessity.
- For any disposable hypodermic needles and syringes for the purpose of administering injectable drugs unless such drugs are specifically included as a **prescription drug**.
- For any refill of a drug if it is more than the number of refills specified by the **prescriber**. Before recognizing charges, Aetna may require a new **prescription** or evidence as to need:

if the **prescriber** has not specified the number of refills; or

if the frequency or number of **prescriptions** or refills appears excessive under accepted medical practice standards.

- For any refill of a drug dispensed more than one year after the latest **prescription** for it or as permitted by the law of the jurisdiction in which the drug is dispensed.
- For any drug provided on an inpatient or outpatient basis in any health care facility to the extent benefits are paid for it under any other part of this policy or under any other medical or **prescription drug** expense benefit plan carried or sponsored by the Policyholder.
- For immunization agents and vaccines.
- For biological sera and blood products.
- For vitamins.
- For nutritional supplements.
- For any contraceptive drugs, except oral contraceptives.
- For any fertility drugs.
- For any smoking cessation aids or drugs.
- For appetite suppressants.
- For allergy sera.
- For Viagra.
- For therapeutic devices or appliances.
- For drugs whose sole purpose is to promote or stimulate hair growth (e.g., Rogaine, Propecia) or for cosmetic purposes only (e.g., Renova).
- For disposable needles and syringes, unless prescribed and dispensed at the same time as insulin.

Certification For Certain Prescription Drugs

Certification of more than a 90 day supply of a **prescription** or refill, and of the necessity of certain **prescription drugs** is required before the drug is dispensed by a **pharmacy**.

Expenses incurred will be payable as follows:

- If certification has been requested and the drug is necessary, benefits will be payable at the applicable Covered Percentage.
- If certification has not been requested and the drug is necessary, no benefits will be payable.
- If the drug is not necessary, no benefits will be payable whether or not certification has been requested.

Certification Procedures

It is the **covered person's** responsibility to arrange for the **prescriber** of the drug to call to request certification. This call must be made as soon as reasonably possible before the drug is to be dispensed. Copies of laboratory and/or medical records may be requested. If such information is requested, it must be provided in order to certify the necessity of the drug.

Written notice of the certification decision will be sent promptly to the **covered person**. This notice will show:

- the approved period of certification, during which time any authorized refills of the drug may be dispensed; or
- when certification is denied, the procedure to follow to appeal the decision.

If the drug is to be dispensed after the certification period ends, certification must again be requested, as described above.

List of Prescription Drugs

The following **prescription drugs** require certification before the drug is dispensed:

- Growth hormones.
- Quantities larger than 30 days.
- Drugs which are used for the treatment of Malaria.

This benefit is provided to cover **prescription** expenses associated with **sickness** or **injury** occurring during the **Policy Year**. If, by reason of similar benefit provisions elsewhere contained, this Policy provides for reimbursement for the same charges, no benefits shall be payable under those provisions. These benefits are in place of all other benefits of this Policy. Not more than Maximum Annual Benefit will be paid during any one **Policy Year**.

The **Copay per Prescription, Deductible per Prescription**, and the Annual Deductible are shown on the Schedule of Benefits.

TREATMENT EXPENSES FOR CLEFT LIP/PALATE OR ECTODERMAL DYSPLASIA OF A DEPENDENT CHILD

Charges incurred for "covered treatment" given to a **dependent** child for a congenital cleft lip or cleft palate or ectodermal dysplasia shall be included as **Covered Medical Expenses**. They are included to the extent they would have been so included if incurred for treatment of a disease.

"Covered treatment" means any of the services or supplies listed below given for cleft lip or cleft palate or ectodermal dysplasia or for any other condition related to or developed as a result of the cleft lip or cleft palate or ectodermal dysplasia:

- Oral surgery and facial surgery. This includes pre-operative and post operative care performed by a **physician**.
- Oral prosthesis treatment; obturators and orthotic appliances.
- Initial installation of partial or full removable dentures or of fixed bridgework.
- Replacement of dentures by dentures or fixed bridgework by fixed bridgework when required as a result of structural changes in the mouth or jaw due to growth.
- Cleft orthodontic therapy.
- Diagnostic services of a **physician** to find out if and to what extent the child's ability to speak or hear has been lost or impaired.
- Rehabilitative services given by a **physician** that is expected to restore or improve the child's ability to speak.
- Psychological assessment and counseling.
- Genetic assessment and counseling for the child and the child's parents.
- Hearing aids.

A legally qualified audiologist or speech therapist to be a "**physician**" for the purposes of this section.

Charges for the following are not included:

- Oral prosthesis, dentures, or bridgework ordered before the child becomes covered or ordered while covered but installed or delivered more than 60 days after termination of coverage.
- Services given to treat delays of speech development unless such delays are shown to be caused by cleft lip or cleft palate or ectodermal dysplasia or any condition related to or developed as a result of cleft palate or ectodermal dysplasia.
- The following if rendered or performed before the child becomes covered or after termination of coverage:

Hearing aid evaluation tests.

Oral and facial surgery.

Cleft orthodontic therapy.

For diagnosis or rehabilitative services rendered before the child becomes eligible for coverage or after termination of coverage.

- For special education for a child whose ability to speak or hear is lost or impaired. This includes lessons in sign language.
- For hearing examinations required as a condition of employment.

STUDENT ACCIDENT AND SICKNESS INSURANCE

SECTION 6 - EXCLUSIONS AND LIMITATIONS

This Policy 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** 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**.
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, but, as to benefits payable under Workers' Compensation, only if:
 - the Workers' Compensation Commission denies benefits for the **injury** or **sickness** and the **covered person** does not request a review of the denial within 20 days; or
 - the Workers' Compensation Commission has, after review of an award, denied benefits for the **injury** or **sickness**.
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 plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons. This exclusion will not apply to the extent needed to:
 - Improve the function of a part of the body that:
 - is not a tooth or structure that supports the teeth; and
 - is malformed:
 - as a result of a severe birth defect; including harelip, webbed fingers, or toes; or
 - as direct result of:
 - disease; or
 - surgery performed to treat a disease or **injury**.

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

in the calendar year of the accident which causes the **injury**; or

in the next calendar year.

10. Expense covered by any other valid and collectible medical, health, or accident insurance to the extent that benefits are payable under other valid and collectible insurance whether or not a claim is made for such benefits.
11. Expense for **injuries** sustained as the result of a motor vehicle accident to the extent that benefits are payable under other valid and collectible insurance whether or not claim is made for such benefits.
12. Expense incurred as a result of commission of a felony.
13. 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.
14. Expense incurred for a treatment; service; or supply; which is not **Medically Necessary**; as determined by Aetna; for the diagnosis care or treatment of the Sickness or Injury involved. This applies even if they are prescribed; recommended; or approved; by the person's attending Physician; or dentist.

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

Be care; or treatment; which is likely to produce a significant positive outcome as; and no more likely to produce a negative outcome than; any alternative service or supply; both as to the Sickness or Injury involved; and the person's overall health condition;

Be a diagnostic procedure which is indicated by the health status of the person; and be as likely to result in information that could affect the course of treatment as; and no more likely to produce a negative outcome than, any alternative service or supply; both as to the Sickness or Injury involved; and the person's overall health condition; and

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

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

In no event will the following services or supplies be considered to be **Medically Necessary**:

Those that do not require the technical skills of a medical; a mental health; or a dental professional; or

Those furnished mainly for the personal comfort or convenience of the person; any person who cares for him or her; or any persons who is part of his or her family; any healthcare provider; or healthcare facility; or

Those furnished solely because the person is an inpatient on any day on which the person's Sickness or Injury could safely; and adequately; be diagnosed; or treated; while not confined; or those furnished solely because of the setting; if the service or supply could safely and adequately be furnished in a Physician's or a dentist's office; or other less costly setting.

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15. Expense incurred for **injury** resulting from the play or practice of intercollegiate sports (participation in sports clubs or intramural athletic activities is not excluded).
 16. Expense incurred by a **covered person** not a United States citizen for services performed within the **covered person's** home country.
 17. Expense for allergy serums and injections unless otherwise provided in this Policy.
 18. Expenses incurred beyond the end of the **Policy Year** in which the **injury** or initial medical treatment of the **sickness** or **injury** took place.
 19. Expense for charges for or related to artificial insemination, in-vitro fertilization, or embryo transfer procedures, elective sterilization or its reversal unless coverage for such methods, devices, aids, or procedures are specifically provided for in this Policy.
 20. Expenses for treatment of **injury** or **sickness** to the extent that payment is made, as a judgment or settlement, by any person deemed responsible for the **injury** or **sickness** (or their insurers).
 21. Expenses incurred for or in connection with: procedures; services; or supplies that are, as determined by Aetna, to be experimental or investigational. A drug; a device; a procedure; or treatment will be determined to be experimental or investigational if:

There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature; to substantiate its safety and effectiveness; for the disease or injury involved; or

If required by the FDA; approval has not been granted for marketing; or

A recognized national medical or dental society or regulatory agency has determined; in writing; that it is experimental; investigational; or for research purposes; or

The written protocol or protocols used by the treating facility; or the protocol or protocols of any other facility studying substantially the same drug; device; procedure; or treatment; or the written informed consent used by the treatment facility; or 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 disease; if Aetna determines that:

The disease can be expected to cause death within one year; in the absence of effective treatment; and

The care or treatment is effective for that disease; or shows promise of being effective for the 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 panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

22. Expense incurred for which no member of the **covered person's** immediate family has any legal obligation for payment.
23. 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.
24. 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.

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25. Expenses incurred for blood or blood plasma, except charges by a **hospital** for the processing or administration of blood.
 26. Expenses incurred for the repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices.
 27. Expense incurred for, or related to, services, treatment, education testing, or training related to learning disabilities or developmental delays.
 28. Expense incurred for, or related to, sex change surgery or to any treatment of gender identity disorders.
 29. Those for routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is specifically provided in the Policy.
 30. Expenses incurred for gastric bypass, and any restrictive procedures, for weight loss.
 31. Expenses incurred for breast reduction/mammoplasty.
 32. Expenses incurred for gynecomastia (male breasts).
 33. Expenses incurred for sinus surgery, except for acute purulent sinusitis.
 34. Expenses for charges that are not reasonable charges, as determined by Aetna.
 35. Expenses for treatment of covered students who specialize in the mental health care field, and who receive treatment as part of their training in that field.
 36. Expenses for: (a) care of flat feet; (b) supportive devices for the foot; (c) care of corns, bunions, or calluses; (d) care of toenails; and (e) care 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 for circulatory problems.
 37. Expenses incurred for elective treatment or elective surgery except as specifically provided elsewhere in the Policy and performed while the Policy is in effect.

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

STUDENT ACCIDENT AND SICKNESS INSURANCE

SECTION 6 - EXCLUSIONS AND LIMITATIONS

PRE-EXISTING CONDITIONS LIMITATION: Expenses incurred by a **covered person** as a result of a **Preexisting Condition** will not be considered **Covered Medical Expense** unless (a) no charges are incurred or treatment rendered for the condition for a period of three months while covered under this Policy, or (b) the **covered person** has been continuously insured or has been covered under this Policy for twelve consecutive months, whichever happens first.

EFFECT OF BENEFITS UNDER OTHER PLANS

Some persons have health coverage in addition to coverage under this Plan. When this is the case, the benefits from "other plans" will be taken into account. This may mean a reduction in benefits under this Plan. The combined benefits will not be more than the expenses recognized under these plans.

In a **Policy Year**, this Plan will pay:

- its regular benefits in full; or
- a reduced amount of benefits. To figure this amount, subtract B. from A. below:
 - A. 100% of "Allowable Expenses" incurred by the **covered person** for whom claim is made.
 - B. The benefits payable by the "other plans". (Some plans may provide benefits in the form of services rather than cash payments. If this is the case, the cash value will be used.)

"Allowable Expenses" means any **necessary** and reasonable health expense, part or all of which is covered under any of the plans covering the **covered person** for whom claim is made.

The difference between the cost of a private **hospital** room and the **semiprivate rate** is not considered an Allowable Expense under the above definition unless the patient's stay in a private **hospital** room is **medically necessary**, either in terms of generally accepted medical practice or as specifically defined in this Plan.

To find out whether the regular benefits under this Plan will be reduced, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.
2. A plan which covers a person other than as a **dependent** will be deemed to pay its benefits before a plan which covers the person as a **dependent**; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:
 - secondary to the plan covering the person as a **dependent**; and
 - primary to the plan covering the person as other than a **dependent**;

the benefits of a plan which covers the person as a **dependent** will be determined before the benefits of a plan which:

- covers the person as other than a **dependent**; and
 - is secondary to Medicare.
3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a **dependent** of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a **dependent** of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

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4. In the case of a dependent child whose parents are divorced or separated:
- If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.
 - If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a **dependent** of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.
 - If there is not such a court decree:

If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a **dependent** of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a **dependent** of the parent without custody.

If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a **dependent** of the parent with custody shall be determined before the benefits of a plan which covers that child as a **dependent** of the stepparent. The benefits of a plan which covers that child as a **dependent** of the stepparent will be determined before the benefits of a plan which covers that child as a **dependent** of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:

- regarding right of continuation pursuant to federal or state law; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

Aetna has the right to release or obtain any information and make or recover any payment it considers necessary in order to administer this provision.

When this provision operates to reduce the total amount of benefits otherwise payable as to a **covered person** during a **Policy Year**, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this Plan.

Other Plan

This means any other plan of health expense coverage under:

- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.