2013-2014
Student Health Insurance Plan Brochure
EMORY UNIVERSITY

Your student health insurance coverage, offered by Aetna Student Health*, may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $2 million for policy years beginning on or after September 23, 2012, but before January 1, 2014. Restrictions for annual dollar limits for student health insurance coverage are $500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014. Your student health insurance coverage includes an annual limit of $500,000 per condition on all covered services including Essential Health Benefits. Other internal maximums (on Essential Health Benefits and certain other services) are described more fully in the benefits chart included inside this Plan summary. If you have any questions or concerns about this notice, contact (877) 261-8403. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.

* Fully insured Aetna Student Health Insurance Plans are underwritten by Aetna Life Insurance Company (Aetna) and administered by Chickering Claims Administrators, Inc. Aetna Student Health is the brand name for products and services provided by these companies and their applicable affiliated companies.

Underwritten by:
Aetna Life Insurance Company
(ALIC)

Policy Number 812808

EMORY UNIVERSITY STUDENT HEALTH AND COUNSELING SERVICES

1525 Clifton Road
Atlanta, Georgia 30322
(404) 727-7551

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

Welcome to Emory…or welcome back to Emory! We are very pleased to provide you with information about the 2013-14 Emory University Student Health Insurance Plan, underwritten by Aetna Life Insurance Company (Aetna) and administered by Aetna Student Health of Boston, MA. Aetna is one of the largest health insurance companies in the nation and is a name that students and their families recognize and can trust. We feel that this is an excellent insurance Plan, and we hope you will agree.

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

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

Students who wish to waive coverage in the Emory University Student Health Insurance Plan must use the Online Waiver System to waive out of the Emory/Aetna Plan. You will access the site by entering the Emory University OPUS system. **The waiver site opened on** Thursday, **May 2, 2013**. **The waiver process must be successfully completed by the first day of classes**, **August 28**, **2013**.

If you have not successfully completed a waiver by **August 28, 2013**, you will be automatically enrolled in the EUSHIP and billed for your insurance through Emory Student Financial Services.

If you are a new student admitted after **August 28, 2013**, your school or college will provide you with the necessary paperwork to complete the waiver process after the deadline. If you are currently insured, you will need to carefully review your health insurance Policy, verifying that your plan is domiciled in the United States and meets the necessary waiver requirements (including providing you with access to inpatient and outpatient care in Atlanta and not just in your home city or country). In order for an insurance plan to meet the Emory University mandatory insurance waiver criteria, the insurance plan must feature, at a minimum, all three of the following:

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

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

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

Please be aware the Emory/Aetna Student Health Insurance Plan meets, and in most cases significantly exceeds, these required coverage minimums. The Emory/Aetna Plan has no pre-existing condition limitations. In addition, in 2013-14, the Plan offers an Emory Core Network, with **90%** coverage with a **$150** annual **deductible** for covered services at Emory Health care (specialists, ER and in-patient), after the **copay** of **$25** for specialists and **$50** for ER (waived if admitted to the **hospital**). For more information about the 2013-14 Emory/Aetna Plan, visit the Student Health Services website at **www.studenthealth.emory.edu**. To read the 2013-14 Plan Brochure, go to **www.aetnastudenthealth.com**, click on "Find Your School" and enter Emory University. You will need Adobe Acrobat Reader to view the 2013-14 Brochure.

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

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

As with any health insurance plan, you need to carefully read the Brochure to make certain you understand the coverage and restrictions. However, I hope this overview will help you as you make your health insurance decisions for 2013-14 and beyond. If you have questions about the Emory University Student Health Insurance Plan, you can call the EUSHCS Student Health Insurance Office at **(404) 727-7560**.

Best wishes for a healthy and academically productive year!

Michael J. Huey, MD
Assistant Vice President and Executive Director
Emory University Student Health and Counseling Services

EMORY UNIVERSITY STUDENT HEALTH AND COUNSELING SERVICES

Emory University Student Health and Counseling Services (EUSHCS) offers responsive, convenient, confidential, and high-quality primary care medical services, counseling and psychological services, health promotion and dispensary services to all registered Emory students. The EUSHCS facilitates access to urgent and emergency services and provides referrals to specialty medical and mental health care providers. Our high standard of services has been recognized by the Accreditation Association for Ambulatory Health Care, Inc.

Website

The EUSHCS website **www.studenthealth.emory.edu** provides a wealth of information about student health topics and outlines how to access the vast range of services at Emory Student Health Services. Please use the EUSHCS website as a resource throughout your time at Emory University.

Primary Care

For students and spouses/domestic partners enrolled in the Aetna Student Health Insurance Plan (ASHIP) and residing in the Atlanta area, EUSHCS is your primary care provider under the plan. Except in an emergency, you must first seek care at the EUSHCS to receive the maximum benefit for medical and mental health services. When you are away from campus, you should seek care from a participating provider in Aetna's nationwide network, "Open Choice® PPO." You also have the option to seek Non-Preferred Care for standard limited coverage. A list of Aetna participating providers is available via Aetna's Docfind website at **www.aetnastudenthealth.com**.

Appointments

Appointments are recommended to address most of your health care needs. Appointments can be scheduled through your Patient Portal at **https://www.shspnc.emory.edu/login_directory.aspx**. However, urgent care and nurse visits are available during business hours, and students can consult with a health care provider by phone 24 hours a day, 365 days a year by calling the main appointment line at (**404)-727-7551 x0** for the after hour's doctor on call.

Emergency Care

Emory University Hospitals are the only Emory Core network emergency care hospitals for the Atlanta area. All non-Emory hospitals are considered Preferred Care hospitals and are covered at the in-network benefit level.

If you need emergency medical care, call **911** for immediate medical assistance.

You also can consult by phone any time of day or night, with a health care provider or counselor at the EUSHCS at **(404)-727-7551, x0** who can offer advice. In the event of your treatment or hospitalization at a Emory Hospital for which follow up with a specialist is required, Emory Health care will share relevant medical information as needed for the continuity of your care.

Fees

The Aetna Student Health Insurance Plan covers most services at EUSHCS (including most X-rays, lab tests, special procedures, and covered preventive care services). Services that are not deemed medically necessary may not be covered. Remember: the ASHIP is an Accident and Illness Policy; see "Exclusions" inside this Brochure.

There are several options for payment at EUSHCS: cash, personal check, or credit card (VISA, MasterCard) at the time of your visit; or the charge will be billed to your student account via Student Financial Services.

The inability to pay should never be a barrier to receiving needed health care. If you have concerns about expenses connected to medical or mental health care, discuss them with the billing office staff before or during your visit to EUSHCS.

Emory Student Health Services is also now a member of 42 national PPO networks, including most major insurance carriers with the exception of Blue Cross/Blue Shield (BC/BS), who, at this time, has denied requests to contract with any student health services, including EUSHCS. Therefore, students on BC/BS will be out of network at EUSHCS and will be responsible at the time of the visit for any charges incurred. The Emory Clinic and the Emory University Hospitals are BC/BS providers and are considered in-network.

Dispensary
A limited number of medications are available in prepackaged containers from the EUSHCS. If you have the Student Health Insurance Policy, the 2013-14 prescription benefit has increased to **$500,000** per policy year at EUSHCS and outside pharmacies. Medications at EUSHCS are available for a **$10** co-pay. Also, many prescription contraception medications are available with a $0 copayment.

Referrals
Under the Aetna policy, you must seek care at the EUSHCS first. If your care cannot be provided at the EUSHCS, your primary care provider or mental health provider may refer you to an Emory "Core provider or an Aetna Preferred Provider." To receive the maximum benefit for services, you must have a written referral to a Preferred Provider.

When you are away from campus, you do not need a referral to seek Preferred Care from Aetna's Preferred Provider Network or to seek Non-Preferred Care. For a complete list of referral requirements and exceptions, refer to the Referral Requirements on page 14 of the 2013-14 Aetna Insurance Brochure.

Care in Progress
If you have recently joined the ASHIP and are receiving care for a physical or mental health condition, you must be seen at the EUSHCS to begin initial care with a primary care provider or counselor. If necessary, s/he will provide a referral to a Preferred Provider for specialty care. If you have been continuously enrolled in the ASHIP and are receiving care from a specialist who is a Preferred Provider, you must get a new referral each Plan Year for each condition in order for on-going treatment to be covered. You should speak with your EUSHCS health care provider or contact the Referral Coordinator to renew all necessary referrals.

EUSHCS Hours
Visit **www.studenthealth.emory.edu** for a listing of EUSHCS's hours which vary during breaks, holidays, summer and winter session. Whenever EUSHCS is closed, you may consult by phone with the health care provider on call who can offer advice. In an emergency, call **911** or go the nearest hospital.

Services at EUSHCS
- Primary Care
- Women's Health Clinic
- Laboratory Services
- On-Site Specialty Clinics
- Prescription Medications
- Specialty Referrals
- Immunizations
- Allergy Shots: At EUSHCS, allergy treatment (administration of injections) is covered but serums are not. The preparation of allergy sera cannot be prepared at EUSHCS. Allergy desensitization treatment outside of EUSHCS, including sera and injections, are excluded from the plan.
- Counseling and Psychological Services
- Health Promotion
- Substance Abuse Consultations
- Nutrition Counseling
- Travel Clinic
- Billing Office

Your Patient Portal
"Your Patient Portal" **https://www.shspnc.emory.edu/login_directory.aspx** is a secure web portal, designed to facilitate confidential communication between EUSHCS staff and their patients and clients. When you visit Your Patient Portal (any time 24/7), you may:

- Receive urgent health messages as well as lab and X-ray results from your health care providers
- Review billing information
- Review and print your immunization history
- Complete required visit questionnaires and surveys
- Schedule some health care appointments online (view the list on the web portal)
- View a summary of your upcoming scheduled visits
- Cancel any EUSHCS appointments at any time

Graduated/Leave of Absence Students
If you graduate in **December 2013** or take a leave absence and do not return for the **2014 Spring Semester**, coverage will terminate on **January 7, 2014**.

You will then be eligible to extend coverage for an additional **3 months** under the continuation plan. You will have **31 days** from the termination date of your prior insurance to enroll (for costs and enrollment instructions, refer to page 11 of the brochure).

If you graduate in **May 2014**, coverage will remain active until the end of the policy year (medical students **7/14/14**; international students **7/31/14** and all other students **8/14/14**). You will also be able to extend coverage for an additional **3 months** under the continuation plan once your coverage terminates. Benefits under the continuation plan remain the same as the basic student plan.

THE EMORY UNIVERSITY STUDENT HEALTH INSURANCE PLAN

The Emory University Student Health Insurance Plan has been developed especially for Emory University students. The Plan provides coverage for **illnesses** and **injuries** that occur on and off campus, and includes special cost-saving features to keep the coverage as affordable as possible. Emory University is pleased to offer the Plan as described in this Brochure.

IMPORTANT NOTE

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

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

WHERE TO FIND HELP

In case of an emergency, call **911** or your local emergency hotline, or go directly to an emergency care facility.

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

Please contact:
Aetna Student Health
P.O. Box 981106
El Paso, TX 79998
(877) 261-8403

For questions about:
- ID Cards

ID cards will be issued as soon as possible and will be mailed to the preferred mailing address you have on file with OPUS. (International Students need to update your preferred address to an Atlanta address as soon as possible). If you need medical attention before the ID card is received, benefits will be payable according to the Policy. **You do not need an ID card to be eligible to receive benefits**. Once you have received your ID card, present it to the provider to facilitate prompt payment of your claims. **Note**: Please be advised you will receive a unique Aetna member ID number on your membership card.

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

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

For questions about:
- Enrollment Forms
- Online Waivers
- Compliance
- Certification

Please contact:
Emory University
Student Health Services Insurance Office
1525 Clifton Road
Atlanta, GA 30322
(404) 727-7560
mandatoryinsurance@listserv.cc.emory.edu

For questions about:
- Provider Listings

A complete list of providers can be found at the Emory University Health Services Insurance Office (EUSHS), or you can use Aetna's **DocFind®** Service at **www.aetnastudenthealth.com**. Click on "Find Your School" and enter "Emory University." You can use DocFind to find out whether a specific provider belongs to the Emory Core or Aetna's Preferred Provider network or to find Preferred Providers practicing in your area.
Or

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

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

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

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

Got Questions? Get Answers with Aetna Navigator®
As an Aetna Student Health Insurance Plan member, you have access to Aetna Navigator, your secure member website, packed with personalized claims and health information. You can take full advantage of our interactive website to complete a variety of self-service transactions online.

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

How do I register?
- Go to **www.aetnastudenthealth.com**.

Need help with registering onto Aetna Navigator?
Registration assistance is available toll free, Monday through Friday, from 7 a.m. to 9 p.m. Eastern Time at **(800) 225-3375**.

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EMORY UNIVERSITY STUDENT HEALTH INSURANCE PLAN

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

EMORY UNIVERSITY HEALTH INSURANCE REQUIREMENT

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

STUDENT COVERAGE

ELIGIBILITY

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

POLICY PERIODS

The Effective and Termination Dates of Coverage for each school are shown below:
Registered Emory University Students:

- Allied Health: **8/15/13 to 8/14/14**
- Business: **8/15/13 to 8/14/14**
- Emory College: **8/15/13 to 8/14/14**
- Graduate School of Arts and Sciences: **8/15/13 to 8/14/14**
- Law School: **8/15/13 to 8/14/14**
- Nursing School: **8/15/13 to 8/14/14**
- Oxford Campus: **8/15/13 to 8/14/14**
- School of Public Health: **8/15/13 to 8/14/14**
- Theology: **8/15/13 to 8/14/14**
- International Students: **8/01/13 to 7/31/14**
- School of Medicine: **7/15/13 to 7/14/14**

Please note that the Emory University Student Health Insurance Plan is an Annual Policy. Coverage purchased starting with the Fall 2013 Semester will continue through the following Summer 2014 Semester. Students enrolling during the Fall 2013 Semester are responsible for paying the insurance premium for the Spring/Summer Semester.

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

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

COVERAGE EFFECTIVE DATES

School of Medicine Students (1st Year through 4th Year Medical)		
Annual Coverage **7/15/13 – 7/14/14**	Spring/Summer Semester **1/8/14 - 7/14/14**	Summer Semester **5/18/14 – 7/14/14**
Waiver Deadline Date: **8/28/13**	Waiver Deadline Date: **1/19/14**	Waiver Deadline Date: **5/19/14**

International Students		
Annual Coverage **8/01/13 – 7/31/14**	Spring/Summer Semester **1/8/14 - 7/31/14**	Summer Semester **5/18/14 – 7/31/14**
Waiver Deadline Date: **8/28/13**	Waiver Deadline Date: **1/19/14**	Waiver Deadline Date: **5/19/14**

All Other Schools (including Laney School of Graduate Studies**)**		
Annual Coverage **8/15/13 – 8/14/14**	Spring/Summer Semester **1/8/14 – 8/14/14**	Summer Semester **5/18/14 – 8/14/14**
Waiver Deadline Date: **8/28/13**	Waiver Deadline Date: **1/19/14**	Waiver Deadline Date: **5/19/14**

ENROLLMENT

All degree-seeking and International Students who do not submit proof of comparable coverage through the Online Waiver system by the deadline date and who are automatically charged for the insurance will have an effective date of coverage as indicated in "Coverage Effective Dates". If you have other coverage and wish to waive enrollment in the Emory Student Health Insurance Plan as listed above, please submit proof of comparable coverage through the Online Waiver system by the waiver deadline dates of **August 28, 2013** for Fall Semester, **January 19, 2014** for new students enrolling for the Spring Semester, and **May 19, 2014** for new students enrolling for the Summer.

To Waive Online:

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

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

RATES

School of Medicine			
	Annual Term	**Spring/Summer Semester***	**Summer Semester***
	7/15/13 – 7/14/14	**1/8/14 – 7/14/14**	**5/18/14 – 7/14/14**
Student Only	**$2,744**	**$1,413**	**$430**
Spouse Only	**$6,423**	**$3,307**	**$1,021**
Child(ren) Only	**$2,885**	**$1,486**	**$460**

International Students			
	Annual Term	**Spring/Summer Semester***	**Summer Semester***
	8/1/13 – 7/31/14	**1/8/14 – 7/31/14**	**5/18/14 – 7/31/14**
Student Only	**$2,744**	**$1,540**	**$556**
Spouse Only	**$6,423**	**$3,611**	**$1,325**
Child(ren) Only	**$2,885**	**$1,621**	**$595**

All Other Schools			
	Annual Term	**Spring/Summer Semester***	**Summer Semester***
	8/15/13 – 8/14/14	**1/8/14 – 8/14/14**	**5/18/14 – 8/14/14**
Student Only	**$2,744**	**$1,642**	**$659**
Spouse Only	**$6,423**	**$3,854**	**$1,567**
Child(ren) Only	**$2,885**	**$1,731**	**$703**

*The rates above include both the premiums for the Student Health Plan underwritten by Aetna Life Insurance Company and Emory University's **$40** administrative charge.*

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

REFUND POLICY

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

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

CHANGE IN STATUS/QUALIFYING EVENT

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

DEPENDENT COVERAGE

ELIGIBILITY

Eligible students who do enroll may also cover their eligible **dependents**. **Dependent** eligibility and coverage period must be concurrent with the insured student's. Eligible **dependents** are defined as, the spouse or domestic partner (as defined below) residing with the **covered student** and children under 26 years of age.

Students must enroll their eligible **dependents** and must pay the required premium as described below:

1. By the deadline date for **dependent** enrollment (by **September 15**, **2013** for Fall Semester, **February 8**, **2014** for the **dependents** of new students enrolling for the Spring/Summer Semester, and **June 18**, **2014** for the **dependents** of new students enrolling for the Summer Semester.)
2. Within **31 days** after you acquire a new **dependent**.

3. Within **31 day**s after a **dependent** terminates coverage under another health insurance plan. The premium rate for the late addition of **dependents** will not be pro-rated. The student must pay the full premium for the enrollment period and the **dependent** will be made effective the date the enrollment application and premium are received and approved by Aetna Student Health.

To be considered a Domestic Partner, and eligible to be covered as a **dependent** of an insured student under the Emory University Student Health Insurance Plan, you must meet the following criteria:

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

NEWBORN INFANT AND ADOPTED CHILD COVERAGE

A child born to a **Covered person** shall be covered for **Accident**, **Sickness**, premature birth, and congenital defects, for **31 days** from the date of birth. At the end of this **31 day** period, coverage will cease under the Emory University Student Health Insurance Plan. To extend coverage for a newborn past the **31 days**, the **covered student** must:
1) enroll the child within **31 days** of birth, and 2) pay the additional pro-rated premium, starting from the date of birth. Coverage is provided for a child legally placed for adoption with a **covered student** for **31 days** from the moment of placement provided the child lives in the household of the **covered student**, and is **dependent** upon the **covered student** for support. To extend coverage for an adopted child past the **31 days**, the **covered student** must 1) enroll the child within **31 days** of placement of such child, and 2) pay any additional premium, if necessary, starting from the date of placement.

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

PREFERRED PROVIDER NETWORK

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

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

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

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

Continuity of Care

Any **covered person** who is receiving active health care services for a chronic or terminal illness or who is an inpatient, must have the right to continue to receive health care services from that physician for up to 60 days from the date of the termination of the physician's contract. Any pregnant **covered person** receiving treatment in connection with such pregnancy at the time of termination of the physician's contract must have the right to continue receiving health care services from that physician throughout the remainder of the pregnancy and six weeks post delivery care.

REFERRAL REQUIREMENTS

PLEASE NOTE: **THERE IS A MANDATORY REFERRAL REQUIREMENT UNDER THIS PLAN**. **STUDENTS AND DEPENDENTS (AGE 18 YEARS AND OVER) ARE REQUIRED TO BE SEEN AT EMORY UNIVERSITY STUDENT HEALTH AND COUNSELING SERVICES (EUSHCS) FIRST (OR AT OXFORD COLLEGE STUDENT HEALTH CENTER FOR OXFORD STUDENTS)**. **IF APPROPRIATE**, **EUSHCS WILL REFER THE COVERED PERSON TO AN OUTSIDE PROVIDER FOR TREATMENT**. **THERE WILL BE NO COVERAGE FOR TREATMENT RECEIVED WITHOUT A REFERRAL FROM EUSHCS**.

Emory University Student Health and Counseling Services (EUSHCS) offers students primary and specialty services coordinated by EUSHCS. All **covered students** and **covered dependents** age 18 years or older in need of medical care should, except in the case of a medical emergency, first seek treatment and be evaluated at EUSHCS. You may be referred to an outside medical provider if required medical care is unavailable at the time of service. Students on the Oxford Campus must obtain a referral from the Oxford Campus Student Health Center. If you are enrolled in the Student Health Insurance Plan, a referral is necessary to receive benefits under your Student Health Insurance Plan, except in the following circumstances:

- Treatment of an Emergency medical condition; or
- When the EUSHCS (or the Oxford College Student Health Center for Oxford students) is closed; or
- When the service is rendered at another facility during breaks or vacation periods; or
- When medical care is received by a Covered person who is more than 50 miles from campus; or
- When medical care is received by a Covered person who is no longer able to use the EUSHCS due to a change in student status, such as graduating or LOA/withdrawal, or
- Ob/Gyn services; or
- Dermatological services; or
- Chiropractic services, or
- All X-rays, Labs, and High Cost Procedures.
- Preventive/Routine Services (services considered preventive according to Health Care Reform and/or services rendered not to diagnose or treat an Accident or Sickness).

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

NOTE: **Dependents** under age 18 are not permitted to use the EUSHCS and do not need a referral from EUSHCS in order to receive benefits for covered services.

PRE-CERTIFICATION PROGRAM

Pre-certification simply means calling Aetna Student Health prior to treatment to obtain approval for a medical procedure or service. Pre-certification may be done by you, your doctor, a hospital administrator, or one of your relatives. All requests for certification must be obtained by contacting Aetna Student Health at **(877) 261-8403** (attention Managed Care Department).

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

The following inpatient services require pre-certification:

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

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

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

Aetna Student Health's liability is limited to the reimbursement level provided under the health benefit plan for pre-certified services, where rendered within the time limits set in the pre-certification. There is no such liability if the member is no longer covered under the plan at the time the services are received, benefits under the contract or plan have been exhausted, or there is a substantiation of fraud by the member, provider, facility, or home health care provider.

DESCRIPTION OF BENEFITS*

Please Note:

THE EMORY UNIVERSITY STUDENT HEALTH INSURANCE PLAN MAY NOT COVER ALL OF YOUR HEALTH CARE EXPENSE.

The Plan excludes coverage for certain services and contains limitations on the amounts it will pay. Please read the Emory University Student Health Insurance Plan Brochure carefully before deciding whether this Plan is right for you. While this document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. If you want to look at the full Plan description, which is contained in the Master Policy issued to Emory University, you may view it at Student Health Services Insurance Office or you may contact Aetna Student Health at (877) 261-8403.

This Plan will never pay more than $500,000 Per Condition Per Policy Year for students or $500,000 Per Condition Per Policy Year for dependents. Additional Plan maximums may also apply. Some illnesses or injuries may cost more to treat and health care providers may bill you for what the Plan does not cover.

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

All insurance coverage is subject to the terms of the Master Policy and applicable state filings. Under health care reform legislation, student health plans may be required to eliminate or modify certain existing benefit plan provisions, including, but not limited to, exclusions and limitations. Aetna reserves the right to modify its products and services in response to federal and/or state legislation, regulation or requests of government authorities.

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

SUMMARY OF BENEFITS CHART

DEDUCTIBLES*
The following deductibles are applied before **Covered Medical Expenses** are payable:

CORE NETWORK PREFERRED CARE:
Student: **$150** per **Policy year**
Spouse: **$1,000** per **Policy year**
Child: **$1,000** per **Policy year**

NON-CORE NETWORK PREFERRED CARE:
Student: **$250** per **Policy year**
Spouse: **$2,000** per **Policy year**
Child: **$2,000** per **Policy year**

NON-PREFERRED CARE:
Student: **$400** per **Policy year**
Spouse: **$3,000** per **Policy year**
Child: **$3,000** per **Policy year**

*Per visit or admission copays do not apply towards satisfying the plan Deductible.

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

In compliance with Georgia State Mandate(s), the Annual Deductible is waived for Child Wellness Services Expense.

COINSURANCE
Covered Medical Expenses are payable at the coinsurance percentage specified below, after any applicable deductible, up to a maximum benefit of **$500,000** Per Condition Per Policy Year for students or **$500,000** Per Condition Per Policy Year **f**or dependents.

All coverage is based on Recognized charges unless otherwise specified.

Inpatient Hospitalization Benefits	
Room and Board Expense	**Covered Medical Expenses** including, but not limited to, inpatient services following a mastectomy or lymph node dissection as advised by the attending physician in consultation with the patient are payable as follows: Core Network: **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge for a semi-private room.

Intensive Care Room and Board Expense	**Covered Medical Expenses** are payable as follows: Core Network: **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge for the Intensive Care Room Rate for an overnight stay.
Miscellaneous Hospital Expense	**Covered Medical Expenses** are payable as follows: Core Network: **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge. **Covered Medical Expenses** include, among others; expenses incurred during a hospital confinement for: • Anesthesia and operating room; • Laboratory tests and X rays; • Oxygen treatment; and • Drugs; medicines; dressings.
Non-Surgical Physicians Expense	**Covered Medical Expenses** for charges for the non-surgical services of the attending Physician or a consulting Physician are payable as follows: Core Network: **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge. Benefits are limited to a maximum of **1** visit per day.
Surgical Expense - Inpatient	
Surgical Expense	**Covered Medical Expenses** for charges for surgical services performed by a Physician are payable as follows: Core Network: **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.
Anesthesia Expense	**Covered Medical Expenses** for the charges of anesthesia during a surgical procedure are payable as follows: Core Network: **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.

Assistant Surgeon Expense	**Covered Medical Expenses** for the charges of an assistant surgeon during a surgical procedure are payable as follows: Core Network: **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.
Surgical Expense - Outpatient	
Surgical Expense	**Covered Medical Expenses** for charges for surgical services performed by a Physician are payable as follows: Core Network: After a **$100** copay per surgery, **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.
Anesthesia Expense	**Covered Medical Expenses** for the charges of anesthesia during a surgical procedure are payable as follows: Core Network: **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.
Assistant Surgeon Expense	**Covered Medical Expenses** for the charges of an assistant surgeon during a surgical procedure are payable as follows: Core Network: **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.
Ambulatory Surgical Expense	Benefits are payable for **Covered Medical Expenses** incurred by a covered person for expenses incurred for outpatient surgery performed in a hospital outpatient surgery department or in an ambulatory surgical center. **Covered Medical Expenses** must be incurred on the day of the surgery or within 48 hours after the surgery. Core Network: **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.

Outpatient Benefits **Covered Medical Expenses** include but are not limited to: Physician's office visits, hospital or outpatient department or emergency room visits, durable medical equipment, clinical lab, or radiological facility.	
Hospital Outpatient Department Expense	**Covered Medical Expenses** includes treatment rendered in a Hospital Outpatient Department. **Covered Medical Expenses** do not include Emergency Room/Urgent Care Treatment, Walk-in Clinic, Therapy Expenses, Chemotherapy and Radiation, and outpatient surgical services, including physician, anesthesia and facility charges, which are covered as outlined under the individual benefit types listed in this schedule of benefits. Core Network: **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.
Walk-in Visit Clinic Expense	**Covered Medical Expenses** include services rendered in a walk-in clinic. Core Network: After a **$25** copay per visit, **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: After a **$25** copay per visit, **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: After a **$25** deductible per visit, **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.
Emergency Room Expense	**Covered Medical Expenses** incurred for treatment of an Emergency Medical Condition are payable as follows: Core Network: After a **$50** copay per visit (waived if admitted), **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: After a **$50** copay per visit (waived if admitted), **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: After a **$50** deductible per visit (waived if admitted), **80%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge. **Important Note:** Please note that as **Non-Preferred Care Providers** do not have a contract with **Aetna**, the provider may not accept payment of your cost share (your **deductible** and **coinsurance)** as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. Please send **Aetna** the bill at the address listed on the back of your member ID card and **Aetna** will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.
Urgent Care Expense	Benefits include charges for treatment by an urgent care provider. **Please note: A covered person should not seek medical care or treatment from an urgent care provider if their illness, injury, or condition, is an emergency condition. The covered person should go directly to the emergency room of a hospital or call 911 (or the local equivalent) for ambulance and medical assistance.** **Urgent Care** Benefits include charges for an urgent care provider to evaluate and treat an urgent condition. **Covered Medical Expenses** for urgent care treatment are payable as follows: Core Network: **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge.

Urgent Care Expense (continued)	Preferred Care: **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge. No benefit will be paid under any other part of this Plan for charges made by an urgent care provider to treat a non-urgent condition.
Ambulance Expense	**Covered Medical Expenses** are payable for the services of a professional ambulance to or from a hospital, when required due to the emergency nature of a covered Accident or Sickness. **Covered Medical Expenses** are payable as follows: Core Network: **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: **80%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.
Pre-Admission Testing Expense	**Covered Medical Expenses** for Pre-Admission testing charges while an outpatient before scheduled surgery are payable on the same basis as any other Sickness.
Physician's Office Visit Expense	**Covered Medical Expenses** are payable as follows: Core Network: After a **$25** copay per visit, **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: After a **$25** copay per visit, **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: After a **$25** deductible per visit, **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge. This benefit includes visits to specialists and telemedicine services.
Laboratory and X-ray Expense	**Covered Medical Expenses** incurred by a **covered person** for diagnostic X-rays are payable as follows: Core Network: After a **$25** copay per visit, **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: After a **$25** copay per visit, **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: After a **$25** deductible per visit, **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge. **Covered Medical Expenses** incurred by a **covered person** for laboratory services are payable as follows: Core Network: **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.

High Cost Procedures Expense	**Covered Medical Expenses** include charges incurred by **a covered person** for High Cost Procedures that are required as a result of injury or sickness. Expenses for High Cost Procedures; which must be provided on an outpatient basis; may be incurred in the following: • A physician's office; or • Hospital outpatient department; or emergency room; or • Clinical laboratory; or • Radiological facility; or other similar facility; licensed by the applicable state; or the state in which the facility is located. **Covered Medical Expenses** for High Cost Procedures include charges for the following procedures and services: • C.A.T. Scan; • Magnetic Resonance Imaging; and • Contrast Materials for these tests. **Covered Medical Expenses** include charges incurred by a **covered person** are payable as follows: Core Network: **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.
Therapy Expense	**Covered Medical Expenses** include charges incurred by a **covered person** for the following types of therapy provided on an outpatient basis: • Physical Therapy, • Chiropractic Care**,** • Speech Therapy, • Inhalation Therapy, • Cardiac Rehabilitation, or • Occupational Therapy. Expenses for Chiropractic Care are **Covered Medical Expenses** if such care is related to neuromusculoskeletal conditions and conditions arising from: the lack of normal nerve, muscle, and/or joint function. Expenses for Speech and Occupational Therapies are **Covered Medical Expenses;** only if such therapies are a result of **injury** or **sickness**. **Covered Medical Expenses** include charges incurred by a **covered person** are payable as follows: Core Network: After a **$25** copay per visit, **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: After a **$25** copay per visit, **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: After a **$25** deductible per visit, **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge. **Covered Medical Expenses** also include charges incurred by a **covered person** for the following types of therapy provided on an outpatient basis: • Radiation therapy, • Chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy, • Dialysis, and • Respiratory therapy.

Therapy Expense (continued)	Benefits for these types of therapies are payable as follows: Core Network: **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.

Durable Medical Equipment Expense	**Covered Medical Expenses** are payable as follows:
	
	Core Network: **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge.
	Preferred Care: **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge.
	Non-Preferred Care: **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.
	
	Breast Feeding Durable Medical Equipment
	Coverage includes the rental or purchase of breast feeding **durable medical equipment** for the purpose of lactation support (pumping and storage of breast milk) as follows.
	
	Core Network: **100%** of the Negotiated Charge.
	Preferred Care: **100%** of the Negotiated Charge.
	Non-Preferred Care: **70%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.
	
	Breast Pump
	C**overed expenses** include the following:
	• The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a **hospital**.
	• The purchase of:
	  • an electric breast pump (non-hospital grade), if requested within 60 days from the date of the birth of the child. A purchase will be covered once every five years following the date of the birth; or
	  • a manual breast pump, if requested within 6-12 months from the date of the birth of the child. A purchase will be covered once every five years following the date of the birth.
	• If an electric breast pump was purchased within the previous one period, the purchase of an electric or manual breast pump will not be covered until a five year period has elapsed from the last purchase of an electric pump.
	
	Breast Pump Supplies
	Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.
	
	Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. The covered person is responsible for the entire cost of any additional pieces of the same or similar equipment that he or she purchases or rents for personal convenience or mobility.
	
	Aetna reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **Aetna**.
	
	Limitations:
	Unless specified above, not covered under this benefit are charges incurred for:
	• Services which are covered to any extent under any other part of this Plan.

Prosthetic Devices Expense	Benefits include charges for: artificial limbs or eyes, wigs required as a result of chemo or radiation therapy, and other non-dental prosthetic devices as a result of an accident or sickness. **Covered Medical Expenses** do **not** include: eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet. **Covered Medical expenses** are payable as follows: Core Network: **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.
Physical Therapy Expense	**Covered Medical Expenses** for physical therapy are payable as follows when provided by a licensed physical therapist: Core Network: After a **$25** copay per visit, **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: After a **$25** copay per visit, **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: After a **$25** deductible per visit, **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.
Dental Injury Expense	**Covered Medical Expenses** include dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition: • Natural teeth damaged, lost, or removed, or • Other body tissues of the mouth fractured or cut due to injury. The accident causing the injury must occur while the person is covered under this Plan. Any such teeth must have been: • Free from decay, or • In good repair, and • Firmly attached to the jawbone at the time of the injury. ***The treatment must be done in the calendar 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. 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.

Dental Injury Expense (continued)	**Covered Medical Expenses** are payable as follows: Core Network: **90%** of the Actual Charge up to **$50,000**, thereafter **100%** of the Actual Charge. Preferred Care: **80%** of the Actual Charge up to **$50,000**, thereafter **100%** of the Actual Charge. Non-Preferred Care: **80%** of the Actual Charge up to **$50,000**, thereafter **100%** of the Actual Charge.
Allergy Testing Expense	**Covered Medical Expenses** include charges incurred by a covered person for diagnostic testing of allergies. **Covered Medical Expenses** include, but are not limited to, charges for the following: • laboratory tests, • physician office visits, • prescribed medications for testing of the allergy, including any equipment used in the administration of prescribed medication; and • other medically necessary supplies and services. No benefits are payable under this Policy for the treatment of allergies. **Covered Medical Expenses** are payable on the same basis as any other Sickness.
Diagnostic Testing For Learning Disabilities Expense	**Covered Medical Expenses** for diagnostic testing for: • Attention Deficit Disorder, or • Attention Deficit Hyperactive Disorder. are payable as follows: Core Network: **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge. Once a covered person has been diagnosed with one of these conditions, medical treatment will be payable as detailed under the outpatient Treatment of Mental and Nervous Disorders portion of this Plan.
Routine Physical Exam Expense	Benefits include expenses for a routine physical exam performed by a physician. If charges for a routine physical exam given to a child who is a covered dependent are covered under any other benefit section, those charges will not be covered under this section. A routine physical exam is a medical exam given by a physician, for a reason other than to diagnose or treat a suspected or identified injury or sickness. Included as a part of the exam are: • Routine vision and hearing screenings given as part of the routine physical exam, • X-rays, lab, and other tests given in connection with the exam, and • Materials for the administration of immunizations for infectious disease and testing for tuberculosis. Core Network: **100%** of the Negotiated Charge. Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.

Routine Physical Exam Expense (continued)	In addition to any state regulations or guidelines regarding mandated Routine Physical Exam services, **Covered Medical Expenses** include services rendered in conjunction with,
	• Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
	• For females, screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
	  • Screening and counseling services, such as:
	  o Interpersonal and domestic violence;
	  o Sexually transmitted diseases; and
	  o Human Immune Deficiency Virus (HIV) infections.
	  • Screening for gestational diabetes.
	  • High risk Human Papillomavirus (HPV) DNA testing for women age 18 and older and limited to once every three years.
	*Sexually transmitted disease counseling expense is limited to two counseling visits per Policy Year.
	
	• X-rays, lab and other tests given in connection with the exam.
	• Immunizations for infectious diseases and the materials for administration of immunizations that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
	• If the plan includes dependent coverage, for covered newborns, an initial **hospital** check-up.
	
	Important Note:
	For details on the frequency and age limits that apply to Routine Physical Exams and Routine Cancer Screenings, a covered person may contact his or her physician or Member Services by logging onto the Aetna website www.aetna.com or calling the toll-free number on the back of the ID card.
	
	For a **child** who is a covered dependent:
	
	• The physical exam must include at least:
	  • A review and written record of the patient's complete medical history,
	  • A check of all body systems, and
	  • A review and discussion of the exam results with the patient or with the parent or guardian.
	• For all exams given to covered dependent **under age 2, Covered Medical Expenses** will **not include** charges for the following:
	
	  • **More than** 6 exams performed during the first year of the child's life,
	  • **More than** 2 exams performed during the second year of the child's life.
	• For all exams given to a covered dependent from **age 2 and over**, **Covered Medical Expenses** will **not include** charges for **more than** one exam in 12 months in a row.
	
	For all exams given to a covered student or a spouse who is a covered dependent, **Covered Medical Expenses** will **not include** charges for **more than**:
	
	• One exam in 12 months in a row.
	
	Covered Medical Expenses incurred by a woman, are charges made by a physician for, one annual routine gynecological exam.
	
	Screening and Counseling Services:
	
	Covered Medical Expenses include charges made by a **physician** in an individual or group setting for the following:

Routine Physical Exam Expense (continued)	**Depression Screening** • This service is limited to once per year. **Obesity** Screening and counseling services to aid in weight reduction due to obesity. Coverage includes: • Preventive counseling visits and/or risk factor reduction intervention; • Medical nutrition therapy; • Nutritional counseling; and • Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease. Services in this category are subject to a combined limit of 26 individual or group visits by any recognized provider per Policy Year. The 10 Healthy Diet Counseling visits will be counted toward the total number of visits allowed for Obesity counseling. **Misuse of Alcohol and/or Drugs** Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment. Services in this category are subject to a combined limit of 5 individual or group visits by any recognized provider per Policy Year. **Use of Tobacco Products** Screening and counseling services to aid a covered person to stop the use of tobacco products. Coverage includes: • Preventive counseling visits; • Treatment visits; and • Class visits; to aid a covered person to stop the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including: • cigarettes; • cigars; • smoking tobacco; • snuff; • smokeless tobacco; and • candy-like products that contain tobacco. Services in this category are subject to a combined limit of 8 individual or group visits by any recognized provider per Policy Year. **Limitations:** Unless specified above, not covered under this Screening and Counseling Services benefit are charges incurred for: Services which are covered to any extent under any other part of this Plan Screening and Counseling Services are payable as follows: Core Network: **100%** of the Negotiated Charge. Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.

Immunizations Expense	**Covered Medical Expenses** include: • charges incurred by a covered student and dependent spouse for the materials for the administration of appropriate and **medically necessary** immunizations, and testing for tuberculosis, and • charges incurred by a covered dependent up to age 19, for the materials for the administration of appropriate and **medically necessary** immunizations, when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics. Core Network: **100%** of the Negotiated Charge. Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge. **Covered Medical Expenses do not include** a physician's office visit in connection with immunization or testing for tuberculosis.
Consultant Expense	**Covered Medical Expenses** include the expenses for the services of a consultant. The services must be requested by the attending physician for the purpose of confirming or determining a diagnosis. **Covered Medical Expenses** are payable as follows: Core Network: After a **$25** copay per visit, **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: After a **$25** copay per visit, **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: After a **$25** deductible per visit, **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.
Treatment Of Mental And Nervous Disorders Expense	
Inpatient Expense	**Covered Medical Expenses** for the diagnosis and treatment of mental illnesses are payable as follows: Core Network: **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge. **Covered Medical Expenses** also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health.
Outpatient Expense	**Covered Medical Expenses** for the diagnosis and treatment of mental illnesses are payable as follows: Core Network: After a **$10** copay per visit, **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: After a **$10** copay per visit, **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: After a **$10** deductible per visit, **80%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.

Alcoholism And Drug Addiction Treatment Expense	
Inpatient Expense	**Covered Medical Expenses** for the treatment of alcoholism and drug addition conditions while confined as a inpatient in a hospital or facility licensed for such treatment are payable as follows: Core Network: **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge. **Covered Medical Expenses** also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. Coverage includes treatment rendered by a hospital or facility duly licensed in Georgia that specialized in the treatment of alcohol abuse.
Outpatient Expense	**Covered Medical Expenses** for outpatient treatment of alcohol or drug addiction conditions are payable as follows: Core Network: **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: **80%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.
Maternity Benefits	
Maternity Expense	**Covered Medical Expenses** include inpatient care of the covered person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery. Any decision to shorten such minimum coverages shall be made by the attending Physician in consultation with the mother. In such cases, covered services may include: home visits, parent education, and assistance and training in breast or bottle-feeding. **Covered Medical Expenses** for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other Sickness. **Prenatal Care** Prenatal care will be covered for services received by a pregnant female in a **physician's**, obstetrician's, or gynecologist's office but only to the extent described below. Coverage for prenatal care under this benefit is limited to pregnancy-related **physician** office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).

Maternity Expense (continued)	**Comprehensive Lactation Support and Counseling Services** **Covered Medical Expenses** will include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy and in the post partum period by a certified lactation support provider. The "post partum period" means the 60 day period directly following the child's date of birth. **Covered expenses** incurred during the post partum period also include the rental or purchase of breast feeding equipment as described below. Lactation support and lactation counseling services are **covered expenses** when provided in either a group or individual setting. **Covered Medical Expenses** for Prenatal Care and Comprehensive Lactation Support and Counseling Services are payable as follows: Core Network: **100%** of the Negotiated Charge. Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: After **$25** deductible per visit, **70%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.
Well Newborn Nursery Care Expense	Benefits include charges for routine care of a covered person's newborn child as follows: • hospital charges for routine nursery care during the mother's confinement, but for not more than four days for a normal delivery, • physician's charges for circumcision, and • physician's charges for visits to the newborn child in the hospital and consultations, but for not more than 1 visit per day. **Covered Medical Expenses** are payable as follows: Core Network: **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.
Additional Benefits	
Prescribed Medicines Expense	Prescription Drug Benefits* are payable as follows: Preferred Care Pharmacy: **100%** of the Negotiated Charge, following a **$25 Copay** for each Brand Name Prescription Drug or a **$15 Copay** for each Generic Prescription Drug. Non-Preferred Care Pharmacy: **100%** of the Recognized Charge, following a **$25** Deductible for each Brand Name Prescription or a **$15** Deductible for each Generic Prescription Drug. You must pay out of pocket for Prescriptions at a Non-Preferred Pharmacy and then submit the receipt with a Prescription Claim Form for reimbursement. **Covered Medical Expenses** are payable up to a maximum of **$500,000** per Policy Year. This Pharmacy benefit is provided to cover Medically Necessary Prescriptions associated with a covered Sickness or Accident occurring during the Policy Year. **Covered Medical Expenses** also include prescription smoking cessations aids. Please use your Aetna Student Health ID card when obtaining your prescriptions. Prior Authorization may be required for certain Prescription Drugs and some medications may not be covered under this Plan. For assistance and a complete list of excluded medications, or drugs requiring prior authorization, please contact Aetna Pharmacy Management at **(888) RX-AETNA** or **(888) 792-3862** (available 24 hours).

Prescribed Medicines Expense (continued)	Aetna Specialty Pharmacy provides specialty medications and support to members living with chronic conditions. The medications offered may be injected, infused or taken by mouth. For additional information please go to **www.AetnaSpecialtyRx.com**. *Contraceptive Drugs and Device benefits are illustrated under the Family Planning Benefit of this Policy. **Please Note: Covered Medical Expenses** for prescribed supplies for the treatment of diabetes will not be subject to the listed per Policy Year Prescription Drug limit.
Diabetic Testing Supplies Expense	Benefits include charges for testing material used to detect the presence of sugar in the person's urine or blood for monitoring glycemic control. Diabetic Testing Supplies are limited to: • Lancet devices, • glucose monitors, and • test strips. Syringes, insulin, or other items used in the treatment of diabetes are not covered by this benefit. **Covered Medical Expenses** are payable as any Sickness.
Hypodermic Needles Expense	**Covered Medical Expenses** for hypodermic needles and syringes used in the treatment of diabetes are payable as any Sickness.
Outpatient Diabetic Self-management Education Programs Expense	**Covered Medical Expenses** for outpatient diabetic self-management education programs are payable as any Sickness.
Temporomandibular Joint Dysfunction Expense	**Covered Medical Expenses** include charges incurred by a **covered person** for surgical and non-surgical treatment of Temporomandibular Joint (TMJ) Dysfunction. Temporomandibular Joint Dysfunction Expense Benefits may include examinations, radiographs for diagnostic purposes, splint therapy, diagnostic or therapeutic masticatory muscle and temporomandibular joint injections and are payable as any Sickness.
Pap Smear Screening Expense	**Covered Medical Expenses** include one annual routine pap smear screening for women age 18 and older or more frequently based on the recommendation of the woman's physician. Benefits are payable as follows: Core Network: **100%** of the Negotiated Charge. Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.
Mammogram Expense	Benefits are payable for charges for mammograms. The charges must be incurred while a **covered person** is insured for these benefits. Benefits will be paid for Expenses incurred for the following: • A baseline mammogram for women between the ages of 35 to 40, and • A mammogram every two years, or more frequently based on the recommendation of the woman's **physician** for women ages 40 to 50, • A mammogram on an annual basis for women 50 years of age and older.

Mammogram Expense (continued)	• For any "female at risk" when ordered by a **physician**. "Female at risk" means a woman who:
	  • has a personal history of breast cancer,
	  • a personal history of biopsy proven benign breast disease,
	  • a grandmother, mother, sister or daughter who has had breast cancer, or
	  • not given birth prior to age 30.
	
	Benefits are payable as follows:
	
	Core Network: **100%** of the Negotiated Charge.
	Preferred Care: **100%** of the Negotiated Charge.
	Non-Preferred Care: **70%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.

Elective Abortion Expense	If, as a result of pregnancy having its inception during the Policy Year, a covered person incurs expenses in connection with an elective abortion, a benefit is payable. **Covered Medical Expenses** for Elective Abortion Expense are covered as follows: Core Network: **90%** of the Negotiated Charge. Preferred Care: **80%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge. This benefit is in lieu of any other Policy benefits. Benefits are limited to a maximum of **$500** per **Policy Year**.
Family Planning Expense	For females with reproductive capacity, **Covered Medical Expenses** include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this benefit must be approved by the Food and Drug Administration (FDA). Coverage includes counseling services on contraceptive methods provided by a **physician**, obstetrician or gynecologist. Such counseling services are **Covered Medical Expenses** when provided in either a group or individual setting. The following contraceptive methods are **covered expenses** under this benefit: *Voluntary Sterilization* **Covered expenses** include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants. **Covered expenses** under this *Preventive Care* benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement. *Contraceptives* **Covered expenses** include charges made by a **physician** or **pharmacy** for: • female contraceptives that are **generic prescription drugs**. The prescription must be submitted to the pharmacist for processing. *This contraceptives benefit covers only **generic prescription drugs**.* • female contraceptive devices and related services and supplies that are generic prescription devices when prescribed in writing by a **physician**. *This contraceptives benefit covers only those devices that are generic prescription devices.* • FDA-approved female over-the-counter contraceptive methods that are prescribed by your **physician**. The **prescription** must be submitted to the pharmacist for processing. These items are limited to one per day and a 30 day supply per **prescription**.

Family Planning Expense (continued)	**Limitations:** Unless specified above, not covered under this benefit are charges for: • Services which are covered to any extent under any other part of this Plan; • Services and supplies incurred for an abortion; • Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care; • Services which are for the treatment of an identified **illness** or **injury**; • Services that are not given by a **physician** or under his or her direction; • Psychiatric, psychological, personality or emotional testing or exams; • Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA; • Male contraceptive methods, sterilization procedures or devices; • The reversal of voluntary sterilization procedures, including any related follow-up care. **Covered Medical Expenses** are payable as follows: Core Network: **100%** of the Negotiated Charge. Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge. **Important note:** Brand-Name Prescription Drug or Devices will be covered at **100%** of the Negotiated Charge, including waiver of Annual Deductible if a Generic Prescription Drug or Device is not available in the same therapeutic drug class or the prescriber specifies Dispense as Written.

Chlamydia Screening Test Expense	**Covered Medical Expenses** include charges incurred by a **covered person** for an annual chlamydia screening test.
	
	As used above, “chlamydia screening test” means any laboratory test of the urogenital tract that specifically detects for infection by one or more agents of chlamydia trachomatis, and which test is approved for such purposes by the FDA. Benefits will be paid for chlamydia screening expenses incurred for:
	
	• Women who are:
	  • under the age of 30 if they are sexually active, and
	  • at least 30 years old if they have multiple risk factors.
	• Men who have multiple risk factors.
	
	Covered Medical Expenses are payable as follows:
	
	Core Network: **100%** of the Negotiated Charge.
	Preferred Care: **100%** of the Negotiated Charge.
	Non-Preferred Care: **70%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.

Routine Screening for Sexually Transmitted Disease Expense	**Covered Medical Expenses** include charges for covered persons who are at least 18 years old and who are sexually active for annual routine screening for sexually transmitted diseases. Benefits are payable as follows: Core Network: **100%** of the Negotiated Charge. Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.

Routine Colorectal Cancer Screening Expense	Even though not incurred in connection with a sickness or injury, benefits include charges for colorectal cancer examination and laboratory tests, for any nonsymptomatic person age 50 or more, or a symptomatic person under age 50, for the following: • One fecal occult blood test every 12 months in a row, • A Sigmoidoscopy at age 50 and every 3 years thereafter, • One digital rectal exam every 12 months in a row, • A double contrast barium enema, once every 5 years, • A colonoscopy, once every 10 years, • Virtual colonoscopy, and • Stool DNA. Benefits are payable as follows: Core Network: **100%** of the Negotiated Charge. Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.
Routine Prostate Cancer Screening Expense	**Covered Medical Expense** includes charges incurred for lab tests for routine prostate specific antigen tests as follows: • for a covered male age 40 to 45, if ordered by a **physician**, and • for covered male age 45 or older, one each **Policy Year**. Benefits are payable as follows: Core Network: **100%** of the Negotiated Charge. Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.
Second Surgical Opinion Expense	**Covered Medical Expense**s will include expenses incurred for a second opinion consultation by a specialist on the need for surgery which has been recommended by the covered person's physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation. **Covered Medical Expenses** are payable same basis as any other Sickness.
Acupuncture In Lieu Of Anesthesia Expense	**Covered Medical Expenses** include acupuncture therapy, when acupuncture is used in lieu of other anesthesia, for a surgical or dental procedure covered under this Plan. The acupuncture must be administered by a health care provider who is a legally qualified physician, practicing within the scope of their license. Core Network: **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.

Dermatological Expense	**Covered Medical Expenses** include charges for the diagnosis and treatment of skin disorders, excluding laboratory fees. Related laboratory expenses are covered under the Outpatient Expense Benefit. Benefits are payable on the same basis as any other Sickness. **Covered Medical Expenses** do not include cosmetic treatment and procedures.
Podiatric Expense	**Covered Medical Expenses** include charges for podiatric services, provided on an outpatient basis following an injury. Benefits are payable same basis as any other Sickness. Expenses for routine foot care, such as trimming of corns, calluses, and nails, are **not Covered Medical Expenses**.
Home Health Care Expense	**Covered Medical Expenses** include charges incurred by a covered person for home health care services made by a home health agency pursuant to a home health care plan, but only if: • The services are furnished by, or under arrangements made by, a licensed home health agency, • The services are given under a home care plan. This plan must be established pursuant to the written order of a physician, and the physician must renew that plan every 60 days. Such physician must certify that the proper treatment of the condition would require inpatient confinement in a hospital or skilled nursing facility if the services and supplies were not provided under the home health care plan. The physician must examine the covered person at least once a month, • Except as specifically provided in the home health care services, the services are delivered in the patient's place of residence on a part-time, intermittent visiting basis while the patient is confined, • The care starts within 7 days after discharge from a hospita**l** as an inpatient, and • The care is for the same condition that caused the hospital confinement, or one related to it. Core Network: **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge. Benefits are limited to a maximum of **40** visits per Policy Year.
Transfusion or Dialysis of Blood Expense	**Covered Medical Expenses** include charges for the transfusion or dialysis of blood, including the cost of: whole blood, blood components, and the administration thereof. Benefits are payable same basis as any other Sickness.
Licensed Nurse Expense	Benefits include charges incurred by a covered person who is confined in a hospital as a resident bed-patient, and requires the services of a registered nurse or licensed practical nurse. **Covered Expenses** for a Licensed Nurse are payable as follows: Core Network: **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Preferred Care: **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge.

Skilled Nursing Facility Expense	**Covered Medical Expenses** include charges incurred by a covered person for confinement in a skilled nursing facility for treatment rendered: • in lieu of confinement in a hospital as a full time inpatient, or • within 24 hours following a hospital confinement and for the same or related cause(s) as such hospital confinement. **Covered Medical Expenses** are payable as follows: Core Network: **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge for the semi-private room rate. Preferred Care: **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge for the semi-private room rate. Non-Preferred Care: **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge for the semi-private room rate.
Rehabilitation Facility Expense	**Covered Medical Expenses** include charges incurred by a covered person for confinement as a full time inpatient in a rehabilitation facility. Confinement in the rehabilitation facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of hospital or skilled nursing facility confinement. **Covered Medical Expenses** for Rehabilitation Facility Expense are covered as follows: Core Network: **90%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge for the rehabilitation facility's daily room and board maximum for semi-private accommodations. Preferred Care: **80%** of the Negotiated Charge up to **$50,000**, thereafter **100%** of the Negotiated Charge for the rehabilitation facility's daily room and board maximum for semi-private accommodations. Non-Preferred Care: **60%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge for the rehabilitation facility's daily room and board maximum for semi-private accommodations.
Autism Expense	**Covered Medical Expenses** include expenses incurred by a **covered person** for services for the diagnosis and treatment of autism. Autism Expense Benefits are payable for **Covered Medical Expenses** on the same basis as any other **sickness**. Autism means: A developmental neurological disorder, appearing in the first three years of life, which affects normal brain functions and is manifested by compulsive, ritualistic behavior and severely impaired social interaction and communication skills.
Child Wellness Services Expense Benefit	The charges below are included as **Covered Medical Expense** even though they are not incurred in connection with an injury or disease. They are included only for a dependent child under 6 years of age. Child Wellness Services Expense Benefits are charges for Child Wellness Services. "Child Wellness Services" means **physician**-delivered or **physician** supervised services which shall include coverage for services delivered at the intervals and scope stated below. Included are: • A review and written record of the child's complete medical history. • Physical examination. • Developmental and behavioral assessment. • Anticipatory guidance. • Appropriate immunizations. • Laboratory tests.

Child Wellness Services Expense Benefit (continued)	All of the above will be in keeping with prevailing medical standards. **Covered Medical Expense** will only include charges of one **physician** for Child Wellness Services performed at birth and at approximately each of the following ages: • 2 months, • 4 months, • 6 months, • 9 months, • 12 months, • 15 months, • 18 months, • 2 years, • 3 years, • 4 years, and • 5 years. Any applicable **Deductible Amount** Per **Policy Year** will not apply to this benefit. Benefits are payable as follows: Core Network: **100%** of the Negotiated Charge. Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge up to **$50,000**, thereafter **100%** of the Recognized Charge. Not covered are charges incurred for: • services which are covered to any extent under any other part of this Plan, • services which are for diagnosis or treatment of a suspected or identified injury or disease, • services not performed by a **physician** or under his or her direct supervision, • medicines, drugs, appliances, equipment or supplies, or • dental exams.
Dental Anesthesia Expense	**Covered Medical Expenses** for general anesthesia and associated hospital or ambulatory surgical facility charges in conjunction with dental care provided to a person insured or otherwise covered under such Plan are payable as any Sickness if such person is: • Seven years of age or younger or is developmentally disabled, • An individual for which a successful result cannot be expected from dental care provided under local anesthesia because of a neurological or other medically compromising condition of the insured, or • An individual who has sustained extensive facial or dental trauma, unless otherwise covered by workers' compensation insurance.
Telemedicine Expense	Telemedicine is the practice by a duly licensed **Physician** or other health care provider acting within the scope of such provider's practice, of health care delivery, diagnosis, consultation, treatment, or transfer of medical data by means of audio, video, or data communications which are used during a medical visit with a patient or which are used to transfer medical data obtained during a medical visit with a patient. Standard telephone, facsimile transmissions, unsecured electronic mail, or a combination thereof do not constitute telemedicine services. **Covered Medical Expenses** are payable as any Sickness.
Ovarian Cancer Surveillance Screening Expense	**Covered Medical Expenses** include coverage for surveillance tests for women age 35 and over at risk for ovarian cancer. Benefits are payable as any Sickness.

Osteoporosis Prevention, Diagnosis and Treatment Expense	**Covered Medical Expenses** include coverage for scientifically proven bone mass measurement (bone density testing) for the prevention, diagnosis, and treatment of osteoporosis for qualified individuals. If you are an: • Estrogen-deficient woman or individual at clinical risk of osteoporosis as determined directly or indirectly by a physician and who is considering treatment; • Individual with osteoporotic vertebral abnormalities; • Individual receiving long-term glucocorticoid (steroid) therapy; • Individual with primary hyperparathyroidism; or • Individual being monitored directly or indirectly by a physician to assess the response to or efficacy of approved osteoporosis drug therapies. Coverage will include a radiologic or radio isotopic procedure or other technologies approved by the United States Food and Drug Administration and performed on an individual for the purpose of identifying bone mass or detecting bone loss. Benefits will be payable on the same basis as any Sickness.
Bone Marrow Transplant Expense	**Covered medical Expenses** include coverage for bone marrow transplants for the treatment of breast cancer and Hodgkin's disease. Benefits are payable on the same basis as any other Sickness.
Heart Transplant Expense	**Covered Medical Expense** include coverage for human heart transplants, including any charges for acquisition, transportation, or donation of a human heart when a human heart transplant is performed. Benefits are payable on the same basis as any other Sickness.
Clinical Trials for Childhood Cancer Expense	**Covered Medical Expenses** include coverage for routine medical costs for dependent children in a clinical trial for cancer who were diagnosed with cancer prior to their 19th birthday. **Covered Medical Expenses** are payable on the same basis as any other Sickness.

GENERAL PROVISIONS

STATE MANDATED BENEFITS

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

RIGHT OF RECOVERY

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

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

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

EXTENSION OF BENEFITS

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

If a **covered person** is confined to a **hospital** or under treatment for a covered condition on the date his or her Basic Sickness Expense coverage terminates, charges incurred during the continuation of that **hospital confinement** or for that treatment of the covered condition shall also be included in the term "Expense", but only while they are incurred during the 31 day period following such termination of insurance.

TERMINATION OF INSURANCE

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

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

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

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

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

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

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

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

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

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

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

CONTINUATION OF COVERAGE

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

Continuation of Coverage	**Three months**
Student	**$1,768**
Spouse/Domestic Partner	**$4,009**
Child(ren)	**$1,797**

EXCLUSIONS

This Plan does not cover nor provide benefits for:

1. Expense incurred for services normally provided without charge by the Policyholder's Health Service, Infirmary or Hospital, or by health care providers employed by the Policyholder.

2. Expense incurred for eye refractions, vision therapy, radial keratotomy, eyeglasses, contact lenses (except when required after cataract surgery), or other vision or hearing aids or prescriptions or examinations except as required for repair caused by a covered injury or as provided elsewhere in this plan.

3. Expense incurred as a result of injury due to participation in a riot. "Participation in a riot" means taking part in a riot in any way, including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense so long as they are not taken against persons who are trying to restore law and order.

4. Expense incurred as a result of an accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation except as a fare-paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.

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

6. Expense incurred as a result of an injury sustained or sickness contracted while in the service of the Armed Forces of any country. Upon the covered person entering the Armed Forces of any country, the unearned pro-rata premium will be refunded to the Policyholder.

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

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

9. Expense incurred for cosmetic surgery, reconstructive surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons, except to the extend needed to: a) Improve the function of a part of the body that is not a tooth or structure that supports the teeth, and is malformed as a result of a severe birth defect, including harelip, webbed fingers, or toes, or as direct result of disease, or surgery performed to treat a disease or injury. b) Repair an injury (including reconstructive surgery for prosthetic device for a covered person who has undergone a mastectomy) which occurs while the covered person is covered under this Plan. 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 incurred as a result of commission of a felony.

12. Expense incurred after the date insurance terminates for a covered person except as may be specifically provided in the Extension of Benefits Provision.

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

14. 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.

15. Expense for allergy serums and injections outside of EUSHS.

16. 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).

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

18. 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.

19. 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.

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

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

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

cause death within one year, in the absence of effective treatment, and b) The care or treatment is effective for that disease, or shows promise of being effective for that disease, as demonstrated by scientific data. In making this determination, Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved. Also, this exclusion will not apply with respect to drugs that: a) Have been granted treatment investigational new drug (IND), or b) Group c/treatment IND status, or c) Are being studied at the Phase III level in a national clinical trial, sponsored by the National Cancer Institute, d) If Aetna determines that available, scientific evidence demonstrates that the drug is effective, or shows promise of being effective, for the disease.

23. Expenses incurred for any restrictive procedures for weight loss, except for bariatric surgery and gastric bypass.

24. Expenses incurred for breast reduction/mammoplasty.

25. Expenses incurred for gynecomastia (male breasts).

26. Expense incurred by a covered person not a United States citizen for services performed within the covered person's home country if the covered person's home country has a socialized medicine program.

27. Expense incurred for acupuncture unless services are rendered for anesthetic purposes.

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

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

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

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

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

33. Expense for care or services to the extent the charge would have been covered under Medicare Part A or Part B even though the covered person is eligible; but did not enroll in Part B.

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

35. Expense for personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment even if such items are prescribed by a physician.

36. Expense for incidental surgeries and standby charges of a physician.

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

38. Expense for charges for services and supplies for or related to gamete intrafallopian transfer, artificial insemination, in-vitro fertilization (except as required by the state law) or embryo transfer procedures, elective sterilization or its reversal, or elective abortion unless specifically provided for in this Policy.

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

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

41. Expenses for routine physical exams, including expenses in connection with well newborn care, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage of such exams, immunizations, services, or supplies is specifically provided in the Policy.

42. Expense incurred for a treatment, service, or supply, which is not medically necessary, as determined by Aetna, for the diagnosis care or treatment of the sickness or injury involved. This applies even if they are prescribed, recommended, or approved, by the person's attending physician, or dentist. In order for a treatment, service, or supply, to be considered medically necessary, the service or supply must: a) be care, or treatment, which is likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the sickness or injury involved, and the person's overall health condition, b) be a diagnostic procedure which is indicated by the health status of the person, and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the sickness or injury involved, and the person's overall health condition, and c) as to diagnosis, care, and treatment, be no more costly (taking into account all health expenses incurred in connection with the treatment, service, or supply), than any alternative service or supply to meet the above tests. In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration: information relating to the affected person's health status, reports in peer reviewed medical literature, reports and guidelines published by nationally recognized health care organizations that include supporting scientific data, generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment, the opinion of health professionals in the generally recognized health specialty involved, and any other relevant information brought to Aetna's attention. In no event will the following services or supplies be considered to be medically necessary: a) those that do not require the technical skills of a medical, a mental health, or a dental professional, or b) those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, or any persons who is part of his or her family, any healthcare provider, or healthcare facility, or c) those furnished solely because the person is an inpatient on any day on which the person's sickness or injury could safely, and adequately, be diagnosed, or treated, while not confined, or those furnished solely because of the setting, if the service or supply could safely and adequately be furnished in a physician's or a dentist's office, or other less costly setting.

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

DEFINITIONS

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

Actual Charge: the charge made for a covered service by the provider who furnishes it.

Aggregate Maximum: the maximum benefit that will be paid under this Policy for all **Covered Medical Expenses** incurred by a **covered person** that accumulate in one **Policy Year**.

Ambulatory Surgical Center: a freestanding ambulatory surgical facility that:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Makes charges.
- Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period.
- performed and during the recovery period.
- Extends surgical staff privileges to: physicians who practice surgery in an area hospital; and dentists who perform oral surgery.
- Have at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by a R.N.

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

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

Brand-Name Prescription Drug is a **prescription drug** with a proprietary name assigned to it by the manufacturer or distributor and so indicated by Medispan or any other similar publication designated by Aetna or third party vendor.

Complications of Pregnancy: conditions which require **hospital** stays before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy. These conditions are:
- acute nephritis or nephrosis; or
- cardiac decompensation or missed abortion; or
- preclampsia; or
- similar conditions as severe as these.

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

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

Copay: this is a fee charged to a person for **Covered Medical Expenses**.For Prescribed Medicines Expense; the copay is payable directly to the pharmacy for each: prescription; kit; or refill; at the time it is dispensed. In no event will the copay be greater than the pharmacy's charge per: prescription; kit; or refill.

Covered Dental Expenses: those charges for any treatment; service; or supplies; covered by this Policy which are:

- not in excess of the **recognized charge**; or
- not in excess of the charges that would have been made in the absence of this coverage; and incurred while

this Policy is in force as to the **covered person.**

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

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

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

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

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

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

Dental Consultant: a **dentist** who has agreed to provide consulting services in connection with the Dental Expense Benefit

Dental Provider: This is any **dentist**; group; organization; dental facility; or other institution; or person

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

Dependent: (a) the **covered student's** spouse residing with the **covered student,** or (b) the person identified as a domestic partner in the "Declaration of Domestic Partnership" which is completed and signed by the **covered student,** and (c) the **covered student's** child under the age 26. The term "child" includes a covered student's biological child, 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.

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

Designated Care Provider: A health care provider or **pharmacy** that is affiliated; and has an agreement with the **School Health Services** to furnish services and supplies at a **negotiated charge**

Durable Medical and Surgical Equipment: no more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

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

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

Elective Treatment: medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the **covered person**'s effective date of coverage. **Elective treatment** includes; but is not limited to:

- vasectomy;
- breast reduction;
- treatment for weight reduction;
- learning disabilities; and
- treatment of infertility;

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

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

Emergency Medical Condition: This means a recent and severe medical condition; including, but not limited to; severe pain; which would lead a prudent layperson possessing an average knowledge of medicine and health; to believe that his or her condition; **sickness**; or **injury;** is of such a nature that failure to get immediate medical care could result in: Placing the person's health in serious jeopardy; or Serious impairment to bodily function; or Serious dysfunction of a body part or organ; or In the case of a pregnant woman; serious jeopardy to the health of the fetus.

Generic Prescription Drug is a **prescription drug**, whether identified by its chemical, proprietary, or non-proprietary name that is accepted by the U.S. Food and Drug Administration (FDA) as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by Medispan or any other publication designated by Aetna or third party vendor.

Home Health Agency:

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

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

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

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

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

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

Hospital: a facility which meets all of these tests:

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

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

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

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

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

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

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

Medically Necessary: a service or supply that is: necessary; and appropriate; for the diagnosis or treatment of a **sickness;** or **injury;** based on generally accepted current medical practice. In order for a treatment; service; or supply to be considered medically necessary; the service or supply must:

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

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

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

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

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

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

Non-Occupational Disease: A **non-occupational disease** is a disease that does not: arise out of (or in the course of) any work for pay or profit; or result in any way from a disease that does. A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the covered student: is covered under any type of workers' compensation law; and is not covered for that disease under such law.

Non-Occupational Injury: A non-occupational injury is an accidental bodily **injury** that does not: arise out of (or in the course of) any work for pay or profit; or result in any way from an injury which does.

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

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

Non-Preferred Care Provider:

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

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

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

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

Orthodontic Treatment: any

- medical service or supply; or
- dental service or supply; furnished to prevent or to diagnose or to correct a misalignment:
- of the teeth; or
- of the bite; or
- of the jaws or jaw joint relationship; whether or not for the purpose of relieving pain.

Not included is:

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

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

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

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

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

Preferred Care: care provided by

- a **covered person's primary care physician**; or a **preferred care provider** on the referral of the **primary care**
- **physician**; or
- a health care provider that is not a **Preferred Care Provider** for an **emergency medical condition** when travel to a **Preferred Care Provider;** or referral by a **covered person's primary care physician** prior to treatment; is not feasible; or a Non-Preferred Urgent Care Provider when travel to a Preferred Urgent Care Provider for treatment is not feasible; and if authorized by Aetna

Preferred Care Provider: a health care provider that has contracted to furnish services or supplies for a **negotiated charge**; but only if the provider is; with Aetna's consent; included in the directory as a **Preferred Care Provider** for:

- the service or supply involved; and
- the class of **covered persons** of which you are

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
- while 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.

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

Primary Care Physician:
This is the **Preferred Care Provider** who is:

- selected by a person from the list of **Primary Care Physician**s in the **directory**;
- responsible for the person's on-going health care; and
- shown on Aetna's records as the person's **Primary Care Physician**.

For purposes of this definition, a **Primary Care Physician** also includes the **School Health Services**

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

Recognized Charge: Only that part of a charge which is recognized is covered. The recognized charge for a service or supply is the lowest of:The provider's usual charge for furnishing it; and The charge Aetna determines to be appropriate; based on factors such as the cost of providing the same or a similar service or supply; and the manner in which charges for the service or supply are made; and The charge Aetna determines to be the recognized charge percentage made for that service or supply. In some circumstances; Aetna may have an agreement; either directly or indirectly; through a third party; with a provider which sets the rate that Aetna will pay for a service or supply. In these instances; in spite of the methodology described above; the recognized charge is the rate established in such agreement. In determining the recognized charge for a service or supply that is: Unusual; or Not often provided in the area; or Provided by only a small number of providers in the area Aetna may take into account factors, such as: The complexity; The degree of skill needed; The type of specialty of the provider; The range of services or supplies provided by a facility; and The recognized charge in other areas.

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

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

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

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

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

Semi-private Rate: the charge for **room and board** which an institution applies to the most beds in its semiprivate rooms with 2 or more beds. If there are no such rooms; Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

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

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

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

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

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

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

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

Surgery Center: a free standing ambulatory surgical facility that: Meets licensing standards. Is set up, equipped and run to provide general surgery. Makes charges. Is directed by a staff of physicians. At least one of them must be on the premises when surgery is performed and during the recovery period. Has at least one certified anesthesiologist at the site when surgery which requires general or spinal anesthesia is performed and during the recovery period. Extends surgical staff privileges to: physicians who practice surgery in an area hospital; and dentists who perform oral surgery. Has at least 2 operating rooms and one recovery room. Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery. Does not have a place for patients to stay overnight. Provides, in the operating and recovery rooms, full-time skilled nursing services directed by a registered nurse. Is equipped and has trained staff to handle medical emergencies. It must have: a physician trained in cardiopulmonary resuscitation; and a defibrillator; and a tracheotomy set; and a blood volume expander. Has a written agreement with a hospital in the area for immediate emergency transfer of patients. Written procedures for such a transfer must be displayed; and the staff must be aware of them. Provides an ongoing quality assurance program. The program must include reviews by physicians who do not own or direct the facility. Keeps a medical record on each patient

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

Surgical Expense: charges by a **physician** for;

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

Surgical Procedure - This includes but is not limited to:

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

Therapeutic Drug Class:
A group of drugs or medications that have a similar or identical mode of action or exhibit similar or identical outcomes for the treatment of a disease or **injury**. Therapeutic Drug Class determinations are based on industry standards and information available from such organizations as The Agency for Healthcare Research and Quality (AHRQ), a division of the U.S. Department of Health and Human Services.

Totally Disabled: due to disease or **injury**; the **covered person** is not able to engage in most of the normal activities of a person of like age and sex in good health.

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

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

Urgent Condition: This means a sudden illness; **injury;** or condition; that:

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

Urgent Care Provider:
This is:

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

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

Walk-in Clinic: a clinic with a group of **physicians;** which is not affiliated with a **hospital;** that provides: diagnostic services; observation; treatment; and rehabilitation on an outpatient basis.

CLAIM PROCEDURE

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

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

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

1. Bills must be submitted within 120 days from the date of treatment.
2. Payment for Covered Medical Expenses will be made directly to the hospital or physician concerned, unless bill receipts and proof of payment are submitted.
3. If itemized medical bills are available at the time the claim form is submitted, attach them to the claim form. Subsequent medical bills should be mailed promptly to the above address.
4. You will receive an "Explanation of Benefits" when your claims are processed. The Explanation of Benefits will explain how your claim was processed, according to the benefits of your Student Accident and Sickness Insurance Plan.

APPEALS PROCEDURE

Definitions

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

Such **adverse benefit determination** may be based on:

- Your eligibility for coverage.
- Coverage determinations, including plan limitations or exclusions.

- The results of any Utilization Review activities.
- A decision that the service or supply is **experimental or investigational**.
- A decision that the service or supply is not **medically necessary**.

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

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

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

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

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

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

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

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

Post-Service Claim: Any claim that is not a "Pre-Service Claim."

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

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

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

Claim Determinations – Health Coverage

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

Urgent Care Claims

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

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

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

Pre-Service Claims

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

Post-Service Claims

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

Concurrent Care Claim Extension

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

Concurrent Care Claim Reduction or Termination

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

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

Complaints

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

Appeals of Adverse Benefit Determinations

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

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

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

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

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

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

Appeal – Medical and Prescription Drug Claims

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

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 72 hours of receipt of the request for an **appeal**.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 30 calendar days of receipt of the request for an **appeal**.

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

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

- Contact the Georgia Department of Insurance to request an investigation of a **complaint** or **appeal**; or
- File a complaint or **appeal** with the Georgia Department of Insurance; or
- Establish any:
  litigation;
  arbitration; or
  administrative proceeding;

regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the Appeals Procedure.

As to medical and **prescription drug** claims only, under certain circumstances you may seek simultaneous review through the internal Appeals Procedure and **External Review** processes—these include **Urgent Care Claims** and situations where you are receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.

Important Note:

As to medical and **prescription drug** claims only, if **Aetna** does not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services, you are considered to have exhausted the **appeal** requirements and may proceed with **External Review** or any of the actions mentioned above. There are limits, though, on what sends a claim or an **appeal** straight to an **External Review**. Your claim or internal **appeal** *will not* go straight to **External Review** if:

- a rule violation was minor and isn't likely to influence a decision or harm you;
- it was for a good cause or was beyond **Aetna's** control; and
- it was part of an ongoing, good faith exchange between you and **Aetna**.

External Review

As to medical and **prescription drug** claims only, you may receive an **adverse benefit determination** or **final adverse benefit determination** because **Aetna** determines that:

- the claim involves medical judgment;
- the care is not **necessary** or appropriate;
- a service, supply or treatment is **experimental or investigational** in nature.

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

To request an **External Review**, any of the following requirements must be met:

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

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

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

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

A faster review is possible if your **physician** certifies (by telephone or on a separate *Request for External Review Form*) that a delay in receiving the service would:

- seriously jeopardize your life or health; or
- jeopardize your ability to regain maximum function; or
- if the **adverse benefit determination** relates to **experimental or investigational** treatment, if the **physician** certifies that the recommended or requested health care service, supply or treatment would be significantly less effective if not promptly initiated.

You may also receive a faster review if the **final adverse benefit determination** relates to an admission; availability of care; continued **stay;** or health service for which you received **emergency care**, but have not been discharged from a facility.

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

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

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

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

PRESCRIPTION DRUG CLAIM PROCEDURE

Preferred Care
When obtaining a covered Prescription, please present your Aetna ID card to Preferred Pharmacy along with your applicable Copay. The Pharmacy will submit a claim to Aetna for the drug.

When you need to fill a Prescription and do not have your ID card with you, you may obtain your Prescription from an Aetna Preferred Pharmacy and be reimbursed by submitting a completed Aetna Prescription Drug claim form. A claim form is available at Student Health Services or by calling **(888) RX-AETNA** or **(888) 792-3862**. You will be reimbursed for covered medications directly by Aetna. Please note, in addition to your Copay, you may be required to pay the difference between the retail price you paid for the prescription drug and the amount Aetna would have paid if you had presented your ID card and the Pharmacy had billed Aetna directly.

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

Non-Preferred Care
You may obtain your Prescription from a Non-Preferred Pharmacy and be reimbursed by submitting a completed Aetna Prescription Drug claim form. You will be reimbursed for covered medications at the Recognized charge allowance, less any applicable Deductible, directly by Aetna. You will be responsible for any amount in excess of the Recognized charge.

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

Claim forms, Pharmacy locations, and claims status information can be obtained by contacting Aetna Pharmacy Management at **(888) RX-AETNA** or **(888) 792-3862**.

When submitting a claim, please include all Prescription receipts, indicate that you attend Emory University, and include your name, address, and student identification number.

WORLDWIDE TRAVEL ASSISTANCE SERVICES

On Call International

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

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

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

A brief description of these benefits is outlined below.

Accidental Death and Dismemberment (ADD) Benefits

These benefits are underwritten by United States Fire Insurance Company (USFIC) and include the following:
Benefits are payable for the Accidental Death and Dismemberment of **Covered Persons**, up to a maximum of **$10,000.**

Medical Evacuation and Repatriation (MER) Benefits

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

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

Natural Disaster and Political Evacuation Services (NDPE)

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

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

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

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

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

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

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

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

The information contained above is a just summary of the ADD, MER, WETA, and NDPE benefits and services available through On Call. For a copy of the plan documents applicable to the ADD, MER, WETA and NDPE coverage, including a full description of coverage, exclusions and limitations, please contact Aetna Student Health at www.aetnastudenthealth.com or (877) 261-8403.

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

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

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

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

These services, programs or benefits are offered by vendors who are independent contractors and not employees or agents of Aetna.

Got Questions? Get Answers with Aetna's Navigator®

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

- Review who is covered under your plan.
- Request member ID cards.
- View Claim Explanation of Benefits (EOB) statements.
- Estimate the cost of common health care services and procedures to better plan your expenses.

- Research the price of a drug and learn if there are alternatives.
- Find health care professionals and facilities that participate in your plan.
- Send an e-mail to Aetna Student Health Customer Service at your convenience.
- View the latest health information and news, and more!

How do I register?
- Go to **www.aetnastudenthealth.com**

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

Need help with registering onto Aetna Navigator?
Registration assistance is available toll free, Monday through Friday, from 7 a.m. to 9 p.m. Eastern Time at **(800) 225-3375**.

NOTICE

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

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Underwritten by:
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Policy No. **812808**

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