

2008 - 2009



**University of
Connecticut**

**Student Health Services and Accident
and Sickness Insurance Plan Brochure
Regional Campus**

Aetna Student Health

Underwritten by:

Aetna Life Insurance Company
(ALIC)

Policy No. 697420

Please Note

This Policy excludes expenses incurred for Injury resulting from the play or practice of collegiate or intercollegiate sports. This exclusion does not apply to expenses incurred for Injury resulting from the participation in club sports or intramural athletic activities.

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Where to Find Help

For Questions About:

- Enrollment

Please contact:

Bailey Agencies Inc.

P.O. Box 1, 84 Plaza Court

Groton, CT 06340

(800) 321-4449 or **(860) 405-2112**

Got Questions? Get Answers with Aetna Navigator®

As an Aetna Student Health Student Accident and Sickness 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 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
- Click on “Find Your School.”
- Enter your school name and then click on “Search.”
- Click on Aetna Navigator and then the “Access Navigator” link.
- Follow the instructions for First Time User by clicking on the “Register Now” link.
- Select a user name, password, and security phrase.

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

Need help 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**.

For Questions About:

- Waiver Process

Please contact:

University of Connecticut

Student Health Service Insurance Coordinator

(860) 486-4535

For Questions About:

- Enrollment

Please contact:

Bailey Agencies Inc.

(800) 321-4449

(860) 405-2112

For Questions About:

- ID Cards
- Insurance Benefits
- Claims Processing
- Pre-Certification Requirements

Please contact:

Aetna Student Health

P.O. Box 15708

Boston, MA 02215-0014

(888) 834-4693

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

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

(888) 834-4693

For Questions About:

- Status of Pharmacy Claim
- Pharmacy Claim Forms
- Excluded Drugs and Pre-Authorization

Please contact:

Aetna Pharmacy Management

(800) 238-6279

For Questions About:

- Provider Listings

Students should access Aetna's DocFind® Service on Aetna Student Health's website:

www.aetnastudenthealth.com

Worldwide Web Access:

- Aetna Student Health: ***www.aetnastudenthealth.com***

Policy Period

1. **Students:** Coverage for all insured students enrolled for the Fall Semester will become effective at 12:01 a.m. on **August 15, 2008**, and will terminate at 12:01 a.m. on **August 15, 2009**.
2. **Second Semester students:** Coverage for all insured students enrolled for the Spring Semester will become effective at 12:01 a.m. on **January 1, 2009**, and will terminate at 12:01 a.m. on **August 15, 2009**.
3. **Insured dependents:** Coverage will become effective on the same date the insured student's coverage becomes effective, or the day after the postmarked date when the completed application and premium are sent, if later. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Master Policies. Examples include, but are not limited to: the date the student's coverage terminates and the date the dependent no longer meets the definition of a dependent.

Premium Rates*

2008/2009	Annual (8/15/08-8/14/09)	Second Semester (1/1/09-8/14/09)
Student**	\$1,150.00	\$ 803.00
Spouse	\$2,104.00	\$1,310.00
Child	\$1,238.00	\$ 766.00

*The rates above include both premium for the Student Health Plan administered by Aetna Life Insurance Company, as well as a University of Connecticut administration fee.

**Premium Rates are not pro-rated and no partial refunds will be given.

<p style="text-align: center;">University of Connecticut Student Accident and Sickness Insurance Plan Regional Campuses</p>
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This is a brief description of the Accident and Sickness Medical Expense benefit available for University of Connecticut 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. Please contact Aetna Student Health for information on how to view a copy of the Master Policy.

Student Coverage

Eligibility

All full-time students are required to be covered under the University of Connecticut Accident and Sickness plan, unless they have demonstrated through the completion of an On-Line Waiver that they are covered under a health insurance policy providing equal or better benefits than this program. Failure to complete an On-Line Waiver by **September 15, 2008** will result in a charge of **\$1,150.00** (for the Student Health Insurance Plan) being placed on the University Fee Bill.

No Fee Bill adjustments or refunds will be made after the waiver deadline. The deadline for filing the On-Line Waiver is **September 15, 2008**. For students entering the University during the Spring Semester, failure to complete and return an On-Line Waiver by **February 5, 2009** will result in a charge of **\$803** (for the Student Health Insurance Plan) being placed on the University Fee Bill.

Part-time students taking at least six-credit hours are eligible for coverage. Dependents of all insured students are also eligible for coverage under the Plan for an additional cost. An application for coverage may be obtained from the Bailey Agencies, Inc..

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased.

Home study, correspondence, Internet classes, and television (TV) courses do not fulfill the eligibility requirement that the student actively attends classes. If it is discovered that this eligibility requirement has not been met, our only obligation is to refund premium, less any claims paid.

Waiver Process/Procedure

Eligible full-time students will automatically be enrolled in this Plan, unless an online Waiver has been received by the University of Connecticut by:

Fall 9/15/08	Spring 2/5/09
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Dependent Coverage

Eligibility

Eligible students who enroll may also insure their eligible dependents. Eligible dependents are the spouse and unmarried children under 19 years of age who are not self-supporting. Dependent Eligibility expires concurrently with that of the insured student.

Enrollment

To enroll the dependent(s) of a covered student, please complete an Enrollment Form and return with payment to the Bailey Agencies Inc., 84 Plaza Court, Groton, CT 06340.

Please note: Previously Covered Persons must re-enroll for dependent coverage by **September 15, 2008** for the Fall Semester, and by **February 5, 2009** for the Spring Semester in order to avoid a break in coverage for conditions which existed in prior policy years. If the enrollment form is received after these dates, coverage will become effective the date after postmarked date. Once a break in continuous coverage occurs, a condition existing during such a break which is a Pre-Existing Condition will not be payable. See the Continuously Insured Section of this Brochure.

For information or general questions on dependent enrollment, contact Aetna Student Health at **(888) 834-4693**.

Newborn Infant and Adopted Child Coverage

A child born to a Covered Person shall be covered for Accident, Sickness, and congenital defects, for 31 days from the date of birth. At the end of this 31 day period, coverage will cease under the University of Connecticut Student Health Insurance Plan. To extend coverage for a newborn past the 31 days, the covered student must: 1) enroll the child within 31 days of birth; and 2) pay the additional premium, starting from the date of birth.

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

Continuously Insured

Persons who have remained continuously insured under this Policy, and prior student health insurance policies issued to the school, will be covered for any Pre-Existing Condition, which manifests itself while continuously insured, except for expenses payable under prior policies in the absence of this Policy. Previously Covered Persons must re-enroll for coverage, including dependent coverage, by **September 15, 2008**, for the Fall Semester, and by **February 5, 2009**, for the Spring Semester in order to avoid a break in coverage for conditions which existed in prior policy years. Once a break in continuous coverage occurs, the Pre-Existing Conditions Limitation will apply. The limitation will not apply if the individual seeking coverage under this Policy was previously covered under prior Creditable Coverage which was continuous to a date not less than 120 days prior to the effective date of coverage under this policy. (**Note:** 150 days prior to the effective date of coverage under this Policy if prior Creditable Coverage terminated due to an involuntary loss of employment.)

Premium Refund Policy

Any student withdrawing from school during the first 31 days of the period, for which premium has been paid, shall not be covered under the Policy, and a full refund of the premium will be made. (This refund policy will not apply to any student withdrawing, due to a covered Accident or Sickness.) Students withdrawing after such 31 days, will remain covered under the Policy for the full period, for which premium has been paid. **No refund will be allowed.**

A Covered Person entering the Armed Forces of any country will not be covered under the Policy, as of the date of such entry. A pro-rata refund of premium will be made for such person and any covered dependents, upon written request received by Aetna Student Health within 90 days of withdrawal from University of Connecticut.

Preferred Provider Network

Aetna Student Health has arranged for you to access a Preferred Provider Network in your local community. Acute care facilities and mental health networks are available nationally if you require hospitalization outside the immediate area of the University of Connecticut campus. The University of Connecticut Student Health Insurance Plan for the 2008-2009 Policy Year has a Preferred Provider Network through Aetna. It is to your advantage to use a Preferred Provider because savings may be achieved from the negotiated charges these providers have agreed to accept as payment for their services. Preferred Providers are independent contractors and are neither employees nor agents of University of Connecticut, Aetna Student Health, or Aetna. You may obtain a complete listing of Preferred Providers by contacting Aetna Student Health at **(888) 834-4693** or by accessing Aetna's DocFind® Service at: www.aetnastudenthealth.com. Click on "Find Your School" and enter **697420** as your Policy Number.

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

Aggregate Maximum: The maximum benefit that will be paid under the Policy for all Covered Medical Expenses incurred by a Covered Person that accumulate during the Policy Year.

Brand-Name Prescription Drug or Medicine: A Prescription Drug which is protected by trademark registration.

Coinsurance: The percentage of Covered Medical Expenses payable by Aetna under this Accident and Sickness Insurance Plan.

Copay: The amount that must be paid by the Covered Person at the time services are rendered by a Preferred Provider. Copay amounts are the responsibility of the Covered Person.

Covered Medical Expenses: Those charges for any treatment, service, or supplies, covered by the Policy which are: (a) not in excess of the Reasonable and Customary Charges; or (b) not in excess of the charges that would have been made in the absence of this coverage; and (c) 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 or dependent whose coverage is in effect under the Policy. See the Eligibility sections of this Brochure for additional information.

Deductible: A specific amount of Covered Medical Expenses that must be incurred, and paid for, by the Covered Person before benefits are payable under the Plan. Deductible amounts are the responsibility of the Covered Person.

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.

It does include an Accident or serious illness such as heart attack, stroke, poisoning, loss of consciousness or respiration, and convulsions. It does not include elective care, routine care, care for non-emergency illness, or care required as a result of circumstances which would have been foreseen prior to the Covered Person's departure from the University area.

If a Covered Person believes that he or she may have an emergency condition, he or she may call the **9-1-1** telephone number for police and ambulatory assistance. Aetna will determine if a condition is an emergency condition based upon whether or not a prudent layperson, acting reasonably, would have believed that emergency medical treatment is needed.

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

Injury: Bodily Injury caused by an Accident. This includes related conditions and recurrent symptoms of such Injury.

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

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

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

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

- Information relating to the affected person's health status;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment;

- The opinion of health professionals in the generally recognized health specialty involved; and
- Any other relevant information brought to Aetna's attention.

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

- Those that do not require the technical skills of a medical, mental health, or 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 health care 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.

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

Non-Preferred Care: A health care service or supply furnished by a health care provider that is not a Preferred Care Provider, if, as determined by Aetna, (a) the service or supply could have been provided by a Preferred Care Provider; and (b) 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 (or Non-Preferred Provider): A health care provider that has not contracted to furnish services or supplies at a Negotiated Charge.

Outpatient Diabetic Self-Management Education Program: A scheduled program on a regular basis, which is designed to instruct a Covered Person in the self-management of diabetes. It is a day care program of educational services and self-care training (including medical nutritional therapy, proper use of equipment and supplies for the treatment of diabetes). The program must be under the supervision of an appropriately licensed, registered, or certified health care professional, whose scope of practice includes diabetic education or management.

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 any other practitioner that must by law be recognized as a doctor legally qualified to render treatment.

Pre-Existing Condition: Any Injury, Sickness, or condition for which any medical advice, diagnosis, care, or treatment was recommended or received within six months prior to the covered person's effective date of coverage. Routine follow-up care to determine whether a breast cancer has reoccurred in a Covered Person who has been previously determined to be breast-cancer-free shall not be considered as medical advice, diagnosis, care or treatment. Genetic information shall not be treated as a condition in the absence of a diagnosis of the condition related to such information and pregnancy shall not be considered a Pre-Existing Condition.

If a student has continuous coverage under the University of Connecticut Student Health Insurance Plan from one year to the next, an Accident or Sickness that first manifests itself during a prior year's coverage, shall not be considered a Pre-Existing Condition.

Preferred Care: Care provided by a Preferred Care Provider, or any health care provider for an emergency condition when travel to a Preferred Care Provider is not feasible.

Preferred Care Provider (or Preferred 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 which the Covered Person is a member.

Preferred Pharmacy: A Pharmacy, including a mail order Pharmacy, which is party to a contract with Aetna to dispense drugs to persons covered under the Policy, but only while the contract remains in effect, and when the Pharmacy dispenses a Prescription Drug under the terms of its contract with Aetna.

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.

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

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

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

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

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

Aetna may take into account factors, such as:

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

Sickness: A disease or illness including related conditions and recurrent symptoms of the Sickness. Sickness also includes pregnancy and complications of pregnancy.

Description of Benefits

Payment will be made as allocated herein for Covered Medical Expenses incurred for any one covered Accident or Sickness while insured under the Plan, not to exceed the Plan's Policy Year Maximum while continuously insured of \$50,000 for any covered Accident or Sickness.

Preferred Care: After a \$250 deductible, 90% of the Negotiated Charge

Non Preferred Care: After a \$500 deductible, 70% of the Negotiated Charge.

In addition to the Plan's Policy Year Maximum the Policy may contain benefit level maximums. Please review the Summary of Benefits section of this Brochure for any additional benefit level maximums.

The payment of any Copays, Deductibles, the balance above any Coinsurance amount, and any medical expenses not covered are the responsibility of the Covered Person.

To maximize your savings and reduce out-of-pocket expense, select a Preferred Provider. It is to your advantage to utilize a Preferred Provider because savings may be achieved from the negotiated charges these providers have agreed to accept as payment for their services.

Non-Preferred Care is subject to Reasonable Charge allowance maximums. Any charges in excess of the Reasonable Charge allowance are not covered under the Plan.

Pre-Certification Program

Pre-Admission and Outpatient Certification is designed to help you receive quality cost effective medical care. All requests for certification must be obtained by contacting Aetna Student Health. The following inpatient and outpatient services or supplies require Pre-Certification:

- All inpatient admissions, including length of stay, to a hospital, convalescent facility, 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.
- Home Health Care.
- **Pre-Certification does not guarantee the payment of benefits for your inpatient admission.** Each claim is subject to medical policy review, in accordance with the exclusions and limitations contained in the Policy, as well as a review of eligibility, adherence to notification guidelines, and benefit coverage under the Student Accident and Sickness Plan.
- 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** penalty.
- If you do not secure Pre-Certification for partial hospitalizations, outpatient treatment of mental and nervous disorders and substance abuse, or home health care services, your Covered Medical Expenses will be subject to a \$200 penalty.

Pre-Certification of Non-Emergency Inpatient Admissions, Partial Hospitalization, Identified Outpatient Services, and Home Health Services: 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.

The above provision will not operate to deny benefits for Medically Necessary inpatient hospital confinements. This includes such confinements for mental or nervous conditions for which coverage is required by the State of Connecticut.

Summary of Benefits Chart

The following chart shows a summary of the benefit coverage.

The following benefits are subject to the imposition of Policy limits and exclusions.

All coverage is based on Reasonable Charges unless otherwise specified.

<p>Covered Medical Expenses are payable at the Coinsurance percentage specified below, after any applicable Deductible, up to a maximum benefit of \$50,000 for any one Accident, or any one Sickness, per Policy Year.</p>	
<p>Policy Year Deductibles</p>	<p><i>Preferred Care:</i> \$250 <i>Non-Preferred Care:</i> \$500</p> <p>Please Note: The following expenses are not subject to the Policy Year Deductible: Outpatient Diagnostic Laboratory Expenses and Prescription Drug Expenses.</p>
<p>Inpatient Hospitalization Benefits</p>	
<p>Hospital Room and Board Expenses</p>	<p>Covered Medical Expenses are payable as follows: <i>Preferred Care:</i> After any applicable Deductible, 90% of the Negotiated Charge. <i>Non-Preferred Care:</i> After any applicable Deductible, 70% of the average semi-private room rate.</p> <p>Covered Medical Expenses include charges incurred in connection with mastectomies, lymph node dissections, including a minimum of 48 hours of inpatient care following the procedure, and for breast reconstructive surgery.</p>
<p>Miscellaneous Hospital Expenses</p>	<p>Covered Medical Expenses are payable as follows: <i>Preferred Care:</i> After any applicable Deductible, 90% of the Negotiated Charge. <i>Non-Preferred Care:</i> After any applicable Deductible, 70% of the Reasonable Charge.</p> <p>Covered Medical Expenses include, but are not limited to, laboratory tests, X-rays, surgical dressings, anesthesia, supplies and equipment use, and medicines.</p>
<p>Physician Hospital Visit/Consultation Expenses</p>	<p>Covered Medical Expenses for charges for the non-surgical services of the attending Physician, or a consulting Physician, are payable as follows: <i>Preferred Care:</i> After any applicable Deductible, 90% of the Negotiated Charge. <i>Non-Preferred Care:</i> After any applicable Deductible, 70% of the Reasonable Charge.</p> <p>Covered Medical Expenses are limited to one visit per day.</p>

Surgical Benefits (Inpatient and Outpatient)	
Surgical Expenses	<p>Covered Medical Expenses for charges for surgical services, performed by a Physician, are payable as follows:</p> <p>Preferred Care: After any applicable Deductible, 90% of the Negotiated Charge.</p> <p>Non-Preferred Care: After any applicable Deductible, 70% of the Reasonable Charge.</p> <p>Covered Medical Expenses are payable up to a \$5,000 per Injury or per Sickness. (Surgical facility charges are not subject to Surgical Maximum.)</p>
Outpatient Surgical Expenses	Covered Medical Expenses include charges incurred in connection with mastectomies, lymph node dissections, and for breast reconstructive surgery.
Anesthetist Expenses	<p>Preferred Care: After any applicable Deductible, 90% of the Negotiated Charge.</p> <p>Non-Preferred Care: After any applicable Deductible, 70% of the Negotiated Charge.</p>
Assistant Surgeon	Covered Medical Expenses for the charges of an assistant surgeon, during a surgical procedure, are payable up to 20% of Surgical Allowance.
Outpatient Benefits	
<p>Covered Medical Expenses include, but are not limited to, Physician's office visits, hospital or outpatient department or emergency room visits, durable medical equipment, clinical lab, or radiological facility up to a maximum of \$5,000. Outpatient benefits subject to a \$5,000 per condition per Policy Year maximum.</p>	
Hospital Miscellaneous Expenses	<p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: After any applicable Deductible, 90% of the Negotiated Charge.</p> <p>Non-Preferred Care: After any applicable Deductible, 70% of the Reasonable Charge.</p>
Emergency Room Expenses	<p>Covered Medical Expenses incurred for treatment of an Emergency Medical Condition are payable as follows:</p> <p>Preferred Care: After any applicable Deductible, 90% of the Negotiated Charge after \$50 per visit Copay.</p> <p>Non-Preferred Care: After any applicable Deductible, 70% of the Reasonable Charge after \$50 per visit Deductible.</p>
Physician's Office Visits Expenses	<p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: After any applicable Deductible, 100% after a \$25 per visit Copay.</p> <p>Non-Preferred Care: After any applicable Deductible, 70% of the Reasonable Charge.</p>

Outpatient Benefits (continued)	
Laboratory and X-ray Expenses	<p>Covered Medical Expenses are payable as follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 70% of the Reasonable Charge.</p> <p>Laboratory Expenses: Deductible waived.</p>
Physical Therapy Expenses	<p>Preferred Care: After any applicable Deductible, 100% of the Negotiated Charge after a \$25 Copay per visit. Non-Preferred Care: After any applicable Deductible, 70% of the Reasonable and customary charge.</p>
Mental Health and Substance Abuse Benefits	
Inpatient Expenses	<p>Preferred Care: After any applicable Deductible, 90% of the Negotiated Charge. Non-Preferred Care: After any applicable Deductible, 70% of the Reasonable Charge.</p>
<p><i>Covered Medical Expenses are payable on the same as any other Sickness for any one or related mental health condition. Includes the charges made for treatment received during partial hospitalization or intensive outpatient in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis. When approved, benefits will be payable in place of an inpatient admission, whereby two days of partial hospitalization or intensive outpatient treatment may be exchanged for one day of full hospitalization.</i></p>	
Outpatient Expenses	<p>Preferred Care: After any applicable Deductible, 100% after a \$25 Copay per visit. Non-Preferred Care: After any applicable Deductible, 70% of the Reasonable Charge.</p> <p>Covered Medical Expenses are payable up to a maximum of \$5,000 per Policy Year.</p>
Maternity Benefits	
Maternity Expenses	<p>Preferred Care: After any applicable Deductible, 90% of the Negotiated Charge. Non-Preferred Care: After any applicable Deductible, 70% of the Reasonable Charge.</p> <p>Covered Medical Expenses include inpatient care for a minimum of 48 hours, following vaginal delivery for the mother and her newly born child, or inpatient care for a minimum of 96 hours following cesarean section for the mother and her newly born child.</p> <p>Any decision to shorten such minimum coverages shall be made by the attending Physician, in consultation with the mother. In such cases, covered services may include: home visits, parent education, and assistance and training in breast- or bottle-feeding.</p> <p>Complications of pregnancy are payable on the same basis as any other Sickness.</p>

Additional Benefits	
Prescription Drug Benefit Expenses	<p>Preferred Care: \$15 Copay for generic drugs, \$30 Copay for each brand name drug.</p> <p>Non-Preferred Care: \$15 Copay for generic drugs, \$30 Copay for each brand name drug.</p> <p>Covered Pharmacy Expenses are payable up to a maximum of \$1,000 per Policy Year.</p> <p>Please note: You are required to pay in full at the time of service for all Prescriptions dispensed at Non-Preferred Pharmacies.</p> <p>Prior authorization is required for growth hormones, and for drugs which are used for the treatment of Malaria.</p> <p>Medications not covered by this benefit include, but are not limited to: drugs whose sole purpose is to promote or to stimulate hair growth and appetite suppressants.</p> <p>For assistance, or for a complete list of excluded medications, or drugs available with prior authorization, please contact (800) 238-6279.</p> <p>Please use your Aetna Student Health ID card when obtaining your Prescriptions.</p>
HPV Vaccine Gardasil	<p>After any applicable Deductible, benefits are payable at 90% of the Negotiated or Reasonable Charge after a \$15 per visit Copay/Deductible.</p>
Meningitis Vaccination Expenses	<p>Preferred Care: After any applicable Deductible, 90% of the Negotiated Charge.</p> <p>Non-Preferred Care: After any applicable Deductible, 70% of the Reasonable Charge.</p>
Hepatitis Vaccination Expenses	<p>Preferred Care: After any applicable Deductible, 90% of the Negotiated Charge.</p> <p>Non-Preferred Care: After any applicable Deductible, 70% of the Reasonable Charge.</p>
Consultant Expenses	<p>Preferred Care: After any applicable Deductible, 90% of the Negotiated Charge.</p> <p>Non-Preferred Care: After any applicable Deductible, 70% of the Reasonable Charge.</p>
Ambulance Expenses	<p>Covered Medical Expenses are payable, after any applicable Deductible, at 100% of the Reasonable Charge.</p> <p>Covered Medical Expenses for the service are limited to charges for transportation to the nearest hospital equipped to render treatment for the condition.</p> <p>For non-preferred ambulance services, this Policy will pay for expenses up to the maximum allowable rate established by the Department of Public Health.</p>

Additional Benefits (continued)	
Dental Expenses	<p>Benefits paid for injury to Sound, Natural Teeth and removal of impacted wisdom teeth only. \$125 per tooth for simple extraction. \$200 per tooth for complicated extraction, \$250 per tooth for repair of an accidental Injury.</p> <p>Preferred Care: After any applicable Deductible, 90% of the Negotiated Charge.</p> <p>Non-Preferred Care: After any applicable Deductible, 70% of the Reasonable Charge.</p>
Durable Medical Expenses	<p>Preferred Care: After any applicable Deductible, 90% of the Negotiated Charge.</p> <p>Non-Preferred Care: After any applicable Deductible, 70% of the Reasonable Charge.</p>
Routine Prostate Cancer Screening Expenses	<p>Although not incurred in connection with a Sickness or Injury, Covered Medical Expenses include charges incurred by a Covered Person for the screening of cancer as follows:</p> <ul style="list-style-type: none"> • One digital rectal exam and one prostate specific antigen test each Policy Year for: <ul style="list-style-type: none"> – A male who is symptomatic; – A male whose biological father or brother has been diagnosed with prostate cancer; and – A male age 50 or older. <p>Paid as any other Sickness.</p>
Mammogram Expenses	<p>Covered Medical Expenses include 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:</p> <ul style="list-style-type: none"> • A baseline mammogram for women between the ages of 35 to 40 or more frequently for women under 40 years of age if recommended by a Physician; • An annual mammogram for women ages 40 and older; or • More frequently based on the recommendation of the woman's Physician. <p>Paid as any other Sickness.</p>
Pap Smear Screening Expenses	<p>Covered Medical Expenses include one annual routine Pap smear screening. Covered Medical Expenses are payable on the same basis as any other outpatient expense.</p> <p>Paid as any other Sickness.</p>
Sexually Transmitted Disease Screening Expenses – <i>Male and Female</i>	<p>Includes screenings for Chlamydia, Gonorrhea, RPR (Rapid Plasma Reagent), Hepatitis A and Herpes 1 and 2 serology.</p>

Additional Benefits (continued)	
Elective Termination of Pregnancy Expenses	<p>Preferred Care: After any applicable Deductible, 90% of the Negotiated Charge up to \$400 maximum.</p> <p>Non-Preferred Care: After any applicable Deductible, 70% of the Reasonable Charge up to \$400 maximum.</p> <p>Includes expenses incurred for voluntary or elective abortions.</p>
Lyme Disease Treatment Expenses	<p>Covered Medical Expenses include charges incurred by a Covered Person for Lyme Disease Treatment:</p> <ul style="list-style-type: none"> • 30 days of intravenous antibiotic therapy; • 60 days of oral antibiotic therapy; and • Further Medically Necessary treatment if recommended by a Physician. <p>Paid as any other Sickness.</p>
Diabetic Treatment, Supplies Expenses and Self-Management Expenses	<p>Covered Medical Expenses incurred by a Covered Person for outpatient diabetic self-management education programs include:</p> <ul style="list-style-type: none"> • 10 hours of initial training visits provided to a Covered Person after the person is initially diagnosed with diabetes; • 4 hours of training visits for training and education that is Medically Necessary as a result of a subsequent diagnosis by a Physician of a significant change in the person's symptoms or condition which required modification of the individual's program of self-management of diabetes; and • 4 hours of training and education that is Medically Necessary because of the development of new techniques and treatment for diabetes. <p>Paid as any other Sickness.</p>
Infertility Services Expenses	<p>Even though not incurred for treatment of a disease or Injury, Covered Medical Expenses will include expenses incurred by a Covered Person for infertility if all of the following tests are met:</p> <ul style="list-style-type: none"> • There exists a condition that: <ul style="list-style-type: none"> – Is a demonstrated cause of infertility; and – Has been recognized by a gynecologist or infertility specialist; and – Is not caused by voluntary sterilization or a hysterectomy. <p>For a Covered Person who is: Under age 40 and unable to conceive or produce conception, or sustain a successful pregnancy during a one year period.</p> <p>Covered Medical Expenses include charges for the Medically Necessary expenses for the treatment and diagnosis of infertility, including, but not limited to the following:</p> <ul style="list-style-type: none"> • Ovulation induction with ovulatory stimulant drugs, subject to maximum of four courses of treatment in a Covered Person's lifetime. • Artificial insemination, subject to maximum of three courses of treatment in a Covered Person's lifetime.

Additional Benefits (continued)	
<p>Infertility Services Expenses <i>(continued)</i></p>	<ul style="list-style-type: none"> • In-vitro fertilization, uterine embryo lavage, embryo transfer, gamete intra-fallopian transfer, zygote intra-fallopian transfer, or low tubal ovum transfer for those Covered Person's unable to conceive or produce conception or sustain a successful pregnancy through less expensive and medically viable infertility treatment or procedures covered under the Policy, subject to a lifetime maximum of two cycles, with not more than two embryo implantations per cycle provided that each such fertilization or transfer is credited toward such maximum as one cycle. A Covered Person may forego a particular treatment or procedure if the member's Physician determines that such treatment or procedure is likely to be unsuccessful. <p>These expenses will be covered on the same basis as any other Sickness. A course of treatment is one cycle of treatment that corresponds to one ovulation attempt.</p> <p>The Lifetime Maximums stated above shall apply to any one continuous period of coverage under this Policy.</p>
<p>Tobacco Cessation Expenses</p>	<p>Benefits shall be paid as any other Sickness or Smoking Cessation Treatment.</p> <p>Smoking Cessation Treatment: includes the use of OTC or prescription FDA-approved nicotine replacement therapy when recommended and prescribed by a licensed Physician and used in combination with a per Policy year outpatient benefit of 8.5 hour smoking cessation counseling sessions provided by a qualified practitioner for each Insured Person.</p> <p>If the policy does not provide Prescription Drug benefits, benefits will not be paid for prescription nicotine replacement therapy.</p> <p>Benefits shall be subject to all deductible, copayments, coinsurance, limitations or any other provision of the policy.</p>
<p>Child Early Intervention Services/ Birth-to-Three Program Expenses</p>	<p>Covered Medical Expenses include coverage for Child Early Intervention Services. Child Early Intervention Services include services rendered to a covered dependent child of a Covered Person from birth to three years of age, who has been determined by the State of Connecticut to be qualified to participate in the Birth-to-Three Program. The Covered Person must submit proof of such qualification with the initial claim.</p> <p>These are the services, provided as part of an individualized family service plan, created by an interdisciplinary panel of the State of Connecticut. These include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Speech therapy given in connection with a speech impairment resulting from a congenital abnormality, disease, or Injury. • Occupational or physical therapy expected to result in significant improvement of a body function impaired by a congenital abnormality, disease, or Injury.

Additional Benefits (continued)	
Child Early Intervention Services/ Birth-to-Three Program Expenses <i>(continued)</i>	<ul style="list-style-type: none"> • Clinical psychological tests or treatment in connection with a disease, including a mental disorder or an Injury. • Skilled nursing services, on a part-time or intermittent basis, given by a R.N. or by a L.P.N. <p>Paid as any other Sickness.</p> <p>Maximum Per Policy Year: \$5,000</p> <p>Lifetime Maximum: \$9,600</p>
Tumor and Leukemia Expenses	<p>Covered Medical Expenses include charges incurred by a Covered Person for:</p> <ul style="list-style-type: none"> • The surgical removal of tumors; or • For the treatment of leukemia. <p>Such charges include:</p> <ul style="list-style-type: none"> • Outpatient chemotherapy; • Reconstructive surgery; • Non-dental prosthesis including any maxillo-facial prosthesis used to replace an anatomic structure lost during treatment for head or neck tumors or any appliances essential for the support of such prosthesis; • Outpatient chemotherapy following surgical procedures due to treatment of tumors; • A wig, if prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy, up to a maximum yearly benefit of at least \$350; • For the purposes of the surgical removal of breast due to tumors, the maximum yearly benefit for prosthesis is at least \$300 for each breast removed. <p>This benefit will not operate to reduce or deny benefits as proved under the Mastectomy and Reconstructive Surgery benefit. Benefits will be paid on the same basis as any other applicable expense under this Plan.</p>
Accidental Ingestion of Controlled Substances Expenses	<p>Covered Medical Expenses incurred for accidental ingestion of controlled substances are payable as follows:</p> <p>Preferred Care: Covered as any other Sickness.</p> <p>Covered Medical Expenses are payable up to 30 days per Policy Year for inpatient expenses and up to a maximum of \$500 per Policy Year for Non-Preferred Care: Covered as any other Sickness.</p> <p>Covered Medical Expenses are payable up to 30 days per Policy Year for inpatient expenses and up to a maximum of \$500 per Policy Year for outpatient expenses.</p>

Additional Benefits (continued)	
Pediatric Preventive Care Expenses	<p>Benefits will be paid the same as another other Sickness exclusive of any Deductible provision in this policy for the cost of Pediatric Preventive Care Services provided for the ages specified below:</p> <p>“Pediatric preventive care services” are those services recommended by the committee on practice and ambulatory medicine of the American Academy of Pediatrics when delivered, supervised, prescribed or recommended by a Physician and rendered to a child from birth through age six (6). All such services must be in keeping with the prevailing medical standards. Benefits are payable on a per visit basis to one health care provider per visit. Benefits shall be subject to all copayment, coinsurance, limitations, or any other provisions of the policy.</p>
Pediatric Hearing Aid Expenses	<p>Covered Medical Expenses include charges incurred by covered dependents age 12 years of age and younger for hearing aids.</p> <p>Paid as any other Sickness.</p> <p>Maximum per 24 months: \$1,000</p>
Ostomy Appliances and Supplies Expenses	<p>Covered Medical Expenses include charges incurred by a Covered Person for ostomy surgery, including appliances and supplies relating to ostomy including, but not limited to:</p> <ul style="list-style-type: none"> • Collection devices; • Irrigation equipment and supplies; • Skin barriers; and • Skin protectors. <p>As used here:</p> <p>“Ostomy” includes colostomy, ileostomy, and urostomy.</p> <p>Paid as any other Sickness.</p> <p>Maximum per Policy Year: \$1,000</p>
Home Health Care Expenses	<p>Covered Medical Expenses include charges incurred by a Covered Person for home health care services made by a home health agency pursuant to a Home Health Care Plan, but only if:</p> <ol style="list-style-type: none"> a) Continued hospitalization would otherwise have been required if home health care was not provided; b) The services are furnished by, or under arrangements made by, a licensed home health agency; c) The services are given under a Home Health Care Plan. This Plan must be established pursuant to the written order of a Physician, and the Physician must renew that Plan every 60 days. Such Physician must certify that the proper treatment of the condition would require inpatient confinement in a hospital if the services and supplies were not provided under the Home Health Care Plan. The Physician must examine the Covered Person at least once a month;

Additional Benefits (continued)

Home Health
Care Expenses
(continued)

- d) 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;
- e) The care starts within 7 days after discharge from a hospital as an inpatient; and
- f) The care is for the same condition that caused the hospital confinement, or one related to it.

Provisions a), e), and f) above shall not apply to Covered Persons diagnosed as Terminally Ill by a Physician. Such a home health care plan may be so established and approved at anytime irrespective of whether such Covered Person was so confined, or if confined, irrespective of such 7-day period.

- a) Part-time or intermittent nursing care by: a registered nurse (R.N.), or by a licensed practical nurse (L.P.N.) under the supervision of an R.N. if the services of an R.N. are not available;
- b) Part time or intermittent home health aide services, that consist primarily of care of a medical or therapeutic nature by other than an R.N. or L.P.N.;
- c) Physical, occupational, speech therapy, or respiratory therapy;
- d) Medical supplies, Prescription Drugs and medicines, and laboratory services. However, these items are covered only to the extent they would be covered if the Covered Person was confined to a hospital;
- e) Nutritional counseling; and
- f) Medical Social Services to or for the benefit of a Covered Person diagnosed as Terminally Ill.

As used here:

“Terminally Ill” means a prognosis by a Physician of six months or less to live.

“Medical Social Services” means services rendered under the direction of a Physician by a qualified social worker. This is one who holds Master's Degree from an approved school of social work. Some services included are: 1) Assessment of the social, psychological, and family problems arising from the Covered Person's illness and treatment; 2) Suitable action and use of community resources to help resolve such problems; 3) Taking part in the making of the Covered Person's treatment plan.

“Home Health Care Plan” means, for a person diagnosed as Terminally Ill:

- This is a written program for continued health care and treatment in a Covered Person's home. It must be prescribed in writing by the attending Physician; and

Additional Benefits (continued)	
Home Health Care Expenses <i>(continued)</i>	<ul style="list-style-type: none"> • An alternative to inpatient hospital care. <p>Covered Medical Expenses will not include: 1) services by a person who resides in the Covered Person’s home, or is a member of the Covered Person’s immediate family; 2) homemaker or housekeeper services; 3) maintenance therapy; 4) dialysis treatment; 5) purchase or rental of dialysis equipment; or 6) food or home-delivered services.</p> <p>Coverage: After any applicable Deductible, 75% of the Reasonable Charge after a \$50 per visit Deductible.</p> <p>Maximum visits per Calendar Year: 80</p> <p>Maximum Social Services per Calendar Year: \$200 for a terminally ill insured person for any 12-month period.</p>
Pain Treatment Expenses	<p>Covered Medical Expenses include charges incurred by a Covered Person for Pain treatment ordered by a Pain Management Specialist which may include all means Medically Necessary to make:</p> <ul style="list-style-type: none"> • The diagnosis and development of a treatment plan for Pain; and • Necessary medications and procedures. <p>As used here:</p> <p>“Pain” means a sensation in which a Covered Person experiences severe discomfort, distress, or suffering due to provocation of sensory nerves.</p> <p>“Pain Management Specialist” means a Physician who is credentialed by the American Academy of Pain Management or who is a board-certified anesthesiologist, neurologist, oncologist, or radiation oncologist with additional training in the management of Pain.</p> <p>Paid as any other Sickness.</p>
Craniofacial Disorder Expenses	<p>Covered Medical Expenses include charges for Covered Treatment incurred by a dependent up to age 19 for a craniofacial disorder, including congenital cleft lip or palate. Covered Treatment does not include cosmetic surgery.</p> <p>As used here:</p> <p>“Covered Treatment” means orthodontic processes, treatment and appliances prescribed by a Craniofacial Team recognized by the American Cleft Palate-Craniofacial Association.</p> <p>“Craniofacial Team” is a multidisciplinary group of practitioners that coordinates care for a child with congenital or acquired abnormalities of the craniofacial complex, including structures in the skull, face, and neck.</p> <p>Paid as any other Sickness.</p>

Additional Benefits (continued)

<p>Anesthesia for Certain One-Day Dental Service Expenses</p>	<p>Covered Medical Expenses also include expenses for general anesthesia, nursing, and related hospital services provided in conjunction with inpatient, outpatient, or one day dental services when the following conditions are met:</p> <ul style="list-style-type: none">– The anesthesia, nursing and related hospital services are deemed Medically Necessary by the treating dentist or oral surgeon; and– The Covered Person is either (a) determined by a licensed dentist in conjunction with a Physician who specializes in primary care, to have a dental condition of significant dental complexity that it requires certain dental procedures to be performed in a hospital; or (b) a Covered Person who has a developmental disability, as determined by a Physician, that places the Covered Person at serious risk.
<p>Non-Prescription Enteral Formula Expenses</p>	<p>Covered Medical Expenses include charges incurred by a Covered Person for Amino Acid Modified Preparations and Low Protein Modified Food Products for the treatment of Inherited Metabolic Diseases. Coverage also includes Specialized Formulas for covered dependents up to age eight when such Specialized Formulas are necessary for the treatment of a disease or condition and are administered under the direction of a Physician.</p> <p>“Amino Acid Modified Preparation(s)” means a product intended for the dietary treatment of an Inherited Metabolic Disease under the direction of a Physician.</p> <p>“Low Protein Modified Food Product(s)” means a product formulated to have less than 1 gram of protein per serving and intended for the dietary treatment of an Inherited Metabolic Disease under the direction of a Physician.</p> <p>“Specialized Formula(s)” means a nutritional formula that is exempt from the general requirements for nutritional labeling, and is intended for use solely under the medical supervision in the dietary management of specific diseases.</p> <p>“Inherited Metabolic Disease” means:</p> <ul style="list-style-type: none">• HIV;• Phenylketonuria and other metabolic diseases;• Hypothyroidism;• Galactosemia;• Sickle cell disease;• Cystic fibrosis;• Maple syrup urine disease;• Homocystinuria;• Biotinidase deficiency;

Additional Benefits (continued)	
Non-Prescription Enteral Formula Expenses (continued)	<ul style="list-style-type: none"> • Congenital adrenal hyperplasia; • Fatty, amino, and organic acid disorders; and • Such other tests for inborn errors or metabolism as shall be prescribed by the Department of Health. <p>Covered Medical Expenses paid on the same basis as outpatient Prescription Drugs.</p>
Hypodermic Needles Expenses	<p>Covered Medical Expenses will not accrue towards or be subject to any maximum that applies to Prescription Drugs, and including expenses incurred by a Covered Person for hypodermic needles and syringes used:</p> <ul style="list-style-type: none"> • In the treatment of diabetes; or • In connection with other injectable drugs provided that coverage for such injectable Prescription Drugs is provided elsewhere in this Policy. <p>Paid as any other Sickness provided such medications are covered under this Plan.</p>

Additional Services and Discounts

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

Aetna Vision SM Discount Program ¹	The Aetna Vision discount program helps you save on many eye care products, including sunglasses, contact lenses, non-prescription sunglasses, contact lens solutions and other eye care accessories. Plus, you can receive up to a 15% discount on LASIK surgery (the laser vision correction procedure).
Fitness Program ¹	<p>Aetna's Fitness Program provides members with access to services provided by GlobalFitTM, the nation's most comprehensive provider of fitness clubs and programs supporting members' healthy lifestyles. Members can access GlobalFit's national network of nearly 10,000 fitness clubs at preferred rates* or GlobalFit's other programs and services, such as at-home weight loss programs, home fitness options and even one-on-one health coaching services.</p> <p><i>*At some clubs, participation may be restricted to new club members.</i></p>
eDiets ^{®1}	25% discount on weekly dues for an eDiet membership.
Zagat Survey [®] Healthy Dining ¹	30% discounts on online subscriptions to restaurant and lifestyle guides.
SpaWish [®] Gift Certificate ¹	Spa gift certificates redeemable at a national network of 1,300 day spas.
Mayo Clinic Bookstore.com ¹	Discounts for books on health and wellness.

Additional Services and Discounts (continued)

<p>Aetna's Informed Health[®] Line²</p>	<p>Get credible health information 24 hours a day from Informed Health Line. Call us toll free, anytime day or night, 365 days a year.</p> <p>You never know when a health question might come up. Informed Health Line connects you to a team of registered nurses experienced in providing information on a variety of health topics – 24 hours a day, 7 days a week.</p> <p>You also have access to our Audio Health Library, a recorded collection of thousands of health topics that's available in English or Spanish. Transfer easily to an Informed Health Line registered nurse at any time during your call.</p> <p>Or, to get credible health information online, register for Aetna Navigator (visit www.aetnastudenthealth.com to register), our password-protected member website. After logging in, click on <i>Take Action on Your Health, Treating Illness</i> and then <i>Health A-Z</i>.</p> <p>To reach an Informed Health Line Nurse, please call (800) 556-1555.</p> <p>For TDD (hearing and speech impaired only), please call (800) 270-2386.</p> <p><i>*Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Also, the topics discussed by the nurses, on the audio tapes or online may not necessarily be covered by your health Plan.</i></p>
<p>Health and Wellness Resources²</p>	<p>This dynamic, interactive website will give you health care and assessment tools to calculate body mass index, financial health, risk activities and health and wellness indicators. The site provides resources for wellness programs and activities.</p>
<p>Aetna Natural Products and ServicesSM Program^{1,2,3}</p>	<p>Save on acupuncture, chiropractic care, massage therapy and dietetic counseling. Also, save on over-the-counter vitamins, herbal and nutritional supplements and other health-related products. All products and services are delivered through American Specialty Health Networks, Inc. and Healthyroads, Inc.</p>

Optional Dental Products

<p>Vital SavingsSM on Dental⁴</p>	<p>Vital SavingsSM on Dental by Aetna is a dental discount program helping you and your dependents save an average of 30- to 50-percent on a wide array of dental services. Student: \$29. Student + 1 Dependent: \$59. Student + 2 or more Dependents: \$73. Enroll online at www.aetnastudenthealth.com.</p>
<p>Aetna Dental[®] PPO⁵</p>	<p>With our Aetna Dental[®] PPO plan, you can choose to visit a participating or non-participating dentist for care. Enroll and search dentists online at www.aetnastudenthealth.com. Price: \$302 Student only, \$310 Spouse and \$445 Child(ren).</p>

¹Discount programs provide access to discounted prices and are NOT insured benefits.

²Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professionals.

³These services, programs or benefits are offered by vendors who are independent contractors and not employees or agents of Aetna.

⁴The Vital Savings by Aetna[®] program (the “Program”) is not insurance. The Program provides Members with access to discounted fees pursuant to schedules negotiated by Aetna Life Insurance Company for the Vital Savings by Aetna[®] discount program. The Program does not make payments directly to the providers participating in the Program. Each Member is obligated to pay for all services or products but will receive a discount from the providers who have contracted with the Discount Medical Plan Organization to participate in the Program. Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, CT 06156, 1-877-698-4825, is the Discount Medical Plan Organization.

⁵The University of Connecticut Student Accident and Sickness Plan is underwritten by Aetna Life Insurance Company (ALIC). The Plan is administered by Chickering Claims Administrators, Inc. **Aetna Student Health is the brand name for products and services provided by these companies.**

General Provisions

State Mandated Benefits

This Plan will always pay benefits in accordance with any applicable Connecticut Insurance Law(s).

Subrogation/Reimbursement Right of Recovery Provision

Immediately upon paying or providing any benefit under this Plan, Aetna shall, to the extent permitted by law, be subrogated to all rights of recovery a Covered Person has against any party potentially responsible for making any payment to a Covered Person, due to a Covered Person’s Injuries or illness, to the full extent of benefits provided, or to be provided by Aetna. In addition, if a Covered Person receives any payment from any potentially responsible party, as a result of an Injury or illness, Aetna has the right to recover from, and be reimbursed by, the Covered Person for all amounts this Plan has paid, and will pay as a result of that Injury or illness, up to and including

the full amount the Covered Person receives, from all potentially responsible parties. A “Covered Person” includes, for the purposes of this provision, anyone on whose behalf this Plan pays or provides any benefit, including but not limited to the minor child or dependent of any Covered Person entitled to receive any benefits from this Plan.

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

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

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

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

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

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

Multiple Coverage Under the Policy

If a Covered Person is covered under the Policy, both as a covered student and a covered dependent, or as a covered dependent of two covered students, the following will apply:

- The Covered Person's coverage in each capacity under the Policy will be set up as a separate "Plan."
- The order in which various plans will pay benefits will apply to the "Plans" set up above and to all other plans.
- This provision will not apply more than once to figure the total benefits payable to the person for each claim under the Policy.

Limitations

Pre-Existing Condition limitation: Expenses incurred by a Covered Person as a result of a Pre-existing Condition will not be considered a Covered Medical Expense unless (a) no charges are incurred or treatment rendered for the condition for a period of six months while covered under this Policy; or (b) the Covered Person has been covered under this Policy for 12 consecutive months, whichever happens first. This exclusion does not apply if a Covered Person has creditable coverage and such coverage terminated within 120 days, or 150 days if involuntarily unemployed, prior to the effective date of coverage.

Special Rules as to a Pre-Existing Condition

If a Covered Person has creditable coverage and such coverage terminated within 120 days, or 150 days if involuntarily unemployed, prior to the effective date of coverage, then:

- Any limitation as to coverage for a Pre-Existing Condition under this Policy will not apply for that Covered Person.

or

- any limitation as to a Pre-Existing Condition under this Policy will apply for that Covered Person only to the extent that such limitation would have applied if he or she had remained covered under the prior creditable coverage.

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

Exclusions

This list is a partial list. Please refer to the School's Master Policy on file at the school for a complete list of exclusions.

This Plan neither covers nor provides benefits for:

1. Expenses incurred as a result of dental treatment, except for treatment resulting from Injury to sound, natural teeth.
2. Expenses incurred for services normally provided without charge by the Policyholder's Health Service, Infirmary or Hospital, or by health care providers employed by the Policyholder.
3. Expenses incurred for annual eye exams, eye refractions, vision therapy, radial keratotomy, eyeglasses, contact lenses (except when required after cataract surgery), or other vision or hearing aids (except as set forth in the Pediatric Hearing Aid Expense Benefit), or Prescriptions or examinations, except as required for repair caused by a covered Injury.
4. Expenses incurred as a result of Injury due to participation in a riot. "Participation in a riot" means taking part in a riot in any way, including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense, so long as they are not taken against persons who are trying to restore law and order.
5. Expenses incurred as a result of an Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a scheduled airline, maintaining regular published schedules, on a regularly established route.
6. Expenses incurred as a result of an Injury or Sickness, for which benefits are payable under any Worker's Compensation or Occupational Disease Law. This exclusion will not apply to the following:
 - A Covered Person who is a sole proprietor or business owner, who is not covered under Connecticut Statute Chapter 568 – Workers' Compensation Act (Chapter 568), or who accepts the provisions of Chapter 568, Section 31-275 (10); and
 - A Covered Person who is a corporate officer of a corporation, whether or not he or she is excluded, or has requested exclusion, from coverage under Chapter 568 as allowed by Connecticut Statute, Section 31-275 (9) (B) (V).
7. Expenses incurred as a result of Injury sustained or Sickness contracted while in the service of the Armed Forces of any country. Upon the Covered Person entering the Armed Forces of any country, the unearned pro-rata premium will be refunded to the Policyholder.
8. Expenses incurred for treatment provided in a governmental Hospital, unless there is a legal obligation to pay such charges, in the absence of insurance.

9. Expenses incurred for plastic surgery, cosmetic surgery, reconstructive surgery, or other services and supplies, which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons. This exclusion will not apply to the extent needed to:

- (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 Sickness 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 Policy Year of the Accident which causes the Injury, or in the next Policy Year.

10. Expenses for Injuries sustained as a result of a motor vehicle accident, to the extent that benefits are payable under other valid and collectible insurance, whether or not a claim is made for such benefits.

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

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

13. Expenses incurred for the treatment of temporomandibular joint dysfunction, and associated myofascial pain, unless otherwise provided in the Policy.

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

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

16. Expenses incurred for Injury resulting from the play or practice of collegiate or intercollegiate sports. This exclusion does not apply to expenses incurred for Injury resulting from the participation in sports clubs or intramural athletic activities.

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

18. Expenses for treatment for Injury to the extent benefits are payable under any state no-fault automobile coverage, or any first party medical benefits payable under any other mandatory no-fault law.

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

20. Expenses incurred for voluntary or elective abortions, unless otherwise provided in this Policy.

21. Expenses for treatment of Injury or Sickness to the extent payment is made, as a judgment or settlement, by any person deemed responsible for the Injury, or Sickness (or their Insurers).

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

23. Expenses incurred for, or in connection with, procedures, services, or supplies, that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:

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

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

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

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

- Have been granted treatment investigational new drug (IND), or Group c/treatment IND status; or
- Are being studied at the Phase III level in a national clinical trial, sponsored by the National Cancer Institute; or
- If Aetna determines that available, scientific evidence demonstrates that the drug is effective, or shows promise of being effective, for the disease.

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

25. Expenses incurred for breast reduction/mammoplasty.

26. Expenses incurred for gynecal mastea (male breasts).

27. Expenses incurred for any sinus surgery unless caused by an Accident or illness, or acute purulent sinusitis.

28. Expenses 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.
29. Expenses incurred for acupuncture, unless services are rendered for anesthetic purposes.
30. Expenses incurred for alternative, holistic medicine, and/or therapy, including but not limited to, yoga and hypnotherapy.
31. Expenses for: (a) care of flat feet; (b) supportive devices for the foot; (c) care of corns, bunions, or calluses; (d) care of toenails; and (e) care of fallen arches, weak feet, or chronic foot strain, except that (c) and (d) are not excluded when Medically Necessary, because the Covered Person is diabetic, or suffers from circulatory problems.
32. Expenses incurred for custodial care, private duty nursing services and supplies provided by a sanitarium, or rest cures. 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.
33. Expenses incurred when the person or individual is acting beyond the scope of his/her/its legal authority.
34. Expenses incurred for hearing aids, the fitting, or Prescription of hearing aids, except as set forth in the Pediatric Hearing Aid Expense Benefit.
35. Expenses incurred for hearing exams.
36. Expenses for transplants, other than cornea and kidney.
37. Expenses for care or services to the extent the charge was paid by Medicare Part A or Part B.
38. Expenses for telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
39. Expenses for the cost of supplies used in the performance of any occupational therapy.
40. Expenses for personal hygiene and convenience items, such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if such items are prescribed by a Physician.

41. Expenses for services or supplies provided for the treatment of obesity and/or weight control.
42. Expenses incurred for the use of orthotics, unless used exclusively to promote healing.
43. Expenses incurred for outpatient treatment in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion, or subluxation, in the human body, for purposes of removing nerve interference as a result of or related to: distortion, misalignment, or subluxation in the vertebral column, except as provided elsewhere in the Policy.
44. Expenses incurred for massage therapy.
45. Expenses incurred for, or in connection with, speech therapy. This exclusion does not apply for charges for speech therapy that is expected to restore speech to a person who has lost existing function (the ability to express thoughts, speak words, and form sentences), as a result of an Accident or Sickness.
46. Expenses for charges that are not Reasonable Charges, as determined by Aetna.
47. Expenses arising from a Pre-Existing Condition. This exclusion does not apply if a Covered Person has creditable coverage and such coverage terminated within 120 days, or 150 days if involuntarily unemployed, prior to the effective date of coverage.
48. 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.
49. Expenses incurred for a treatment, service, or supply, which is not Medically Necessary, as determined by Aetna, for the diagnosis, care or treatment of the Sickness or Injury involved. This applies even if they are prescribed, recommended, or approved, by the person's attending Physician, or dentist.

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

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

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

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

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

- Those that do not require the technical skills of a medical, mental health, or 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 health care provider or health care facility; or
- Those furnished solely because the person is an inpatient on any day on which the person's Sickness or Injury could safely, and adequately, be diagnosed, or treated, while not confined, or those furnished solely because of the setting, if the service or supply could safely and adequately be furnished in a Physician's or a dentist's office, or other less costly setting.

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

<h3>Extension of Benefits</h3>

Covered students and dependents that do not re-enroll for coverage after his or her insurance terminates, are covered for any condition which first manifested itself during the period for which he or she was previously insured during the Policy Year. Expenses incurred after the termination date, shall be payable in accordance with the Policy, but only while they are incurred during the 30-day period, following such termination of insurance.

Termination of Insurance

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

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 Student Health
P.O. Box 15708
Boston, MA 02215-0014
(888) 834-4693
(617) 218-8400 (outside United States)

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

1. Bills must be submitted within 90 days from the date of treatment.
2. Payment for Covered Medical Expenses will be made directly to the hospital or Physician concerned, unless bill receipts and proof of payment are submitted.
3. If itemized medical bills are available at the time the claim form is submitted, attach them to the claim form. Subsequent medical bills should be mailed promptly to the above address.
4. In the event of a disagreement over the payment of a claim, a written request to review the claim must be mailed to Aetna, within one year from the date appearing on the Explanation of Benefits.
5. You will receive an "Explanation of Benefits" when your claims are processed. The Explanation of Benefits will explain how your claim was processed, according to the benefits of your Student Accident and Sickness Insurance Plan.

How to Appeal a Claim

In the event a Covered Person disagrees with how a claim was processed, he/she may request a review of the decision. The Covered Person's requests must be made in writing within sixty (60) days of receipt of the Explanation of Benefits (EOB). The Covered Person's request must include why he/she disagrees with the way the claim was processed. The request must also include any additional information that supports the claim (e.g., medical records, Physician's office notes, operative reports, Physician's letter of medical necessity, etc.). Please submit all requests to:

Aetna Student Health
P.O. Box 15717
Boston, MA 02215-0014

Prescription Drug Claim Procedure

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

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

On Call International

Aetna Student Health has contracted with On Call International (On Call) to provide Covered Persons with access to certain accidental death and dismemberment benefits, worldwide emergency travel assistance services and other benefits.

A brief description of these benefits is outlined below.

Accidental Death and Dismemberment (ADD) Benefits⁶

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) Benefits⁶

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

- Unlimited Emergency Medical Evacuation
- Unlimited Medically Supervised Repatriation (while traveling or on campus)
- Unlimited Return of Mortal Remains (while traveling or on campus)
- \$2,500 Joining of Ill Family Member Accommodations
- Return of Traveling Companion

World Emergency Travel Assistance (WETA) Services⁶

On Call provides the following travel assistance services:

- 24/7 Emergency Travel Arrangements
- Translation Assistance
- Emergency Travel Funds Assistance
- Lost Luggage and Travel Documents Assistance
- Assistance with Replacement of Credit Card/Travelers Checks
- 24/7 U.S. Nurse Help Line

- Medical/Dental/Pharmacy Referral Service
- Hospital Deposit Arrangements
- Dispatch of Physician
- Emergency Medical Record Assistance

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

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

NOTE: In order to obtain coverage, all MER and WETA services must be provided and arranged through On Call. Reimbursement will not be provided for any 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, USFIC nor WETA provides 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 and limitations may apply.

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

Aetna Student Health is the brand name for products and services provided by Aetna Life Insurance Company and Chickering Claims Administrators, Inc, (CCA). CCA and On Call are independent contractors and not employees or agents of the other. CCA provides access to ADD, MER and WETA benefits/services through a contractual arrangement with On Call. However, neither CCA nor any of its affiliates provides or administers ADD, MER or 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, USFIC or VSC. Premiums/fees for benefits/services provided through On Call, USFIC and VSC are included in the Rates outlined in this Brochure.

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

Health Care Providers

Total number of participating primary care Physicians located in:

Fairfield County	744
Hartford County	793
Litchfield County	123
Middlesex County	164
New Haven County	911
New London County	183
Tolland County	86
Windham County	89

Total number of participating specialists located in:

Fairfield County	2,642
Hartford County	3,075
Litchfield County	588
Middlesex County	490
New Haven County	3,382
New London County	735
Tolland County	378
Windham County	215

Total number of participating hospitals located in:

Fairfield County	6
Hartford County	9
Litchfield County	3
Middlesex County	1
New Haven County	9
New London County	2
Tolland County	2
Windham County	2

Total number of participating pharmacies in:

Fairfield County	141
Hartford County	184
Litchfield County	45
Middlesex County	30
New Haven County	176
New London County	44
Tolland County	26
Windham County	21

Additional Information

This Plan is underwritten by Aetna Life Insurance Company, which was incorporated in Connecticut on June 14, 1853. Aetna Life Insurance Company is wholly owned by Aetna Inc.

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. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits.

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.

Administered by:

Aetna Student Health
P.O. Box 15708
Boston, MA 02215-0014
(888) 834-4693 (toll free)
www.aetnastudenthealth.com

Underwritten by:



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

Policy No. 812830

The Student Health Services and Accidental and Sickness Insurance Plan (the “Plan”) is underwritten by Aetna Life Insurance Company (ALIC). The Plan is administered by Chickering Claims Administrators, Inc. **Aetna Student Health is the brand name for products and services provided by these companies.**

NOTICE

Aetna considers nonpublic personal Covered Person 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 Aetna Student Health Connection Link on the Internet at ***www.aetnastudenthealth.com***.

